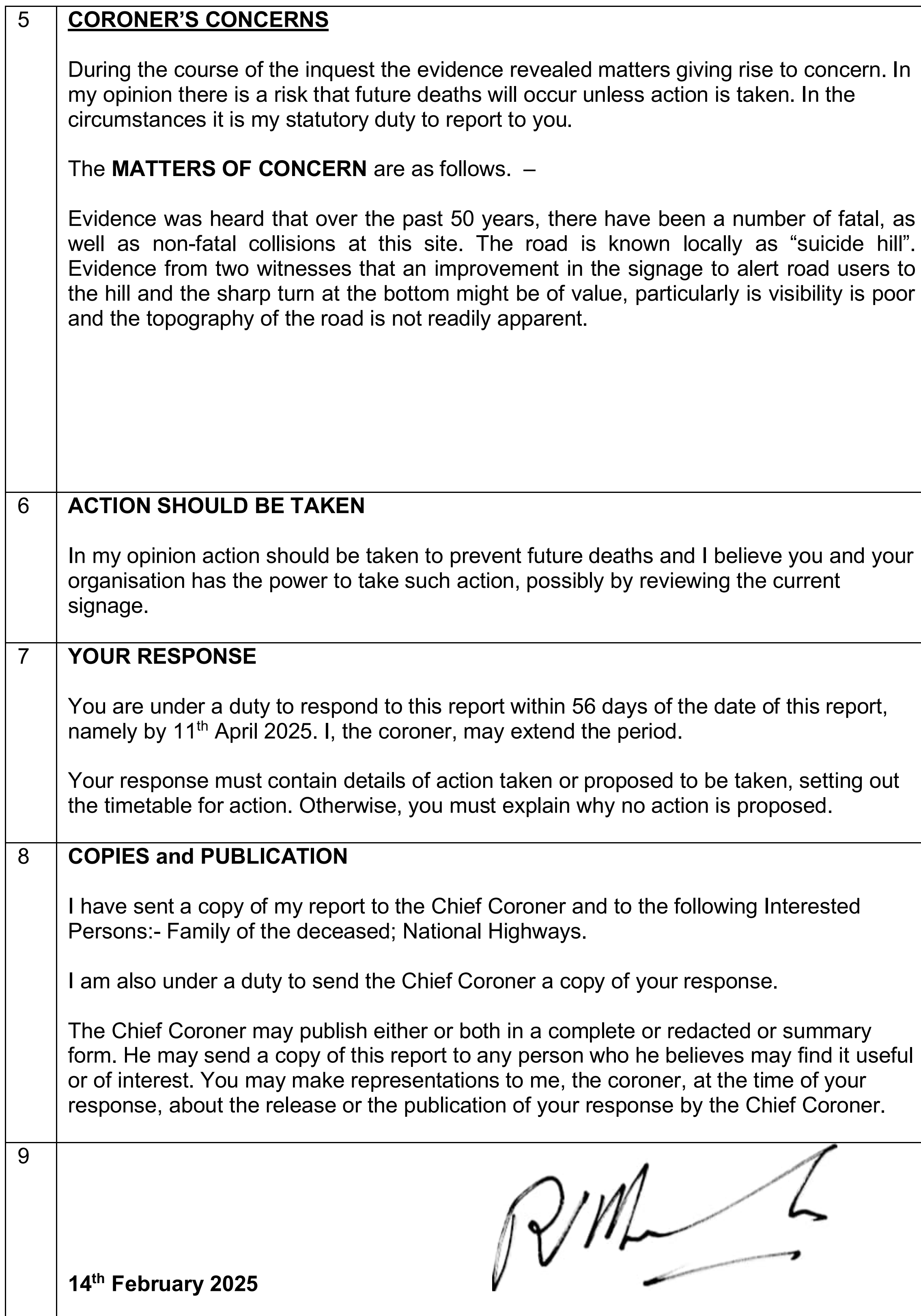
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This form is to be used ***after*** *an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. ERYC Highways Department**
1	**CORONER** I am Professor Paul Marks, Senior Coroner, for the Coroner Area of City of Kingston Upon Hull and the County of the East Riding of Yorkshire.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 16th February 2024, I commenced an investigation into the death of Jason Myles, aged 58 years. The investigation concluded at the end of the inquest on 31st January 2025. The conclusion of the inquest was: **SUICIDE**
4	**CIRCUMSTANCES OF THE DEATH** On the morning of 7th February 2024, Jason Myles who was accompanied by his dog, left his house from where he was due to be evicted at noon, in a Mercedes Vito van registration number [redacted]. The weather conditions were clear, and the carriageway was dry. His vehicle entered a sharp left-hand bend at excessive speed and made no clear attempt to negotiate it, thereby resulting in a collision with a wall, and thereafter with disused cattle shed. He was not wearing a seat belt and as a result of the impact, he sustained head and chest injuries that were incompatible with life, and he died at the scene. The evidence heard and taken at its highest, indicates that Mr Myles intended to take his own life. The incident occurred on the [redacted], East Riding of Yorkshire.



5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – Evidence was heard that over the past 50 years, there have been a number of fatal, as well as non-fatal collisions at this site. The road is known locally as "suicide hill". Evidence from two witnesses that an improvement in the signage to alert road users to the hill and the sharp turn at the bottom might be of value, particularly is visibility is poor and the topography of the road is not readily apparent.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation has the power to take such action, possibly by reviewing the current signage.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 11th April 2025. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:- Family of the deceased; National Highways. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**14th February 2025**