H G Mark Bricknell
Senior Coroner
for County of Herefordshire

30th June 2023

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive, Herefordshire Council
1	**CORONER** I am Hugh Gregory Mark Bricknell, Senior Coroner for County of Herefordshire
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 9 November 2022 I commenced an investigation into the death of Sam Malcolm TAYLOR. The investigation concluded at the end of the inquest on 21 June 2022. The conclusion of the inquest was narrative.
4	**CIRCUMSTANCES OF THE DEATH** The deceased SAM MALCOLM TAYLOR suffered mental health issues and had on previous occasions attempted suicide. Paperwork found on the deceased suggested the deceased had recently been admitted into hospital due to a suicide attempt which had left him in a coma for 3 days. Updates on the note stated the deceased would feel suicidal if he returned to the tent he seemed to be staying in. The deceased was found in his tent alone next to the RIVER WYE located by members of the public.
5	**CORONER'S CONCERNS** 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. – (1) A prevention duty was owed to the deceased and due to Herefordshire Council communication process failure, contact was not made with him or those with whom he had approved contact prior to his death. (2) Evidence suggests that in reality Mr Taylor would have met the threshold for vulnerability set out in the Housing Act 1996 but the failure to progress the application resulted in this never being established.

	(3) A system for identifying process failure should be in place and effective.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, [redacted] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 21 August 2023. 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: [redacted] Hereford and Worcestershire Health & Care NHS Trust. 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	30th June 2023 Signature HG Mark Bricknell, HM HG Mark Bricknell