Coroner Service
West Sussex, Brighton & Hove

Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Minister for Veterans and People, Ministry of Defence
1	**CORONER** I am Joseph TURNER, Area Coroner for the coroner area of West Sussex, Brighton and Hove
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 01 November 2023 I commenced an investigation into the death of Aeran Luke Sebastian TAYLOR aged 38. The investigation concluded at the end of the inquest on 22 January 2025. The conclusion of the inquest was that: On 27 October 2023 Aeran Taylor was sadly found deceased at his home address in Crawley. There was evidence of drug use but nothing to indicate intent, or the involvement of a 3rd party. Post mortem analysis showed the presence of multiple substances combined to fatal toxic effect, likely as a result of an accidental overdose.
4	**CIRCUMSTANCES OF THE DEATH** Mr Taylor had rapidly fallen into drug addiction, having been discharged from the Army for substance misuse in December 2006, following an operational tour to Iraq (Op Telic 7 – Nov 2005-May 2006) with the Royal Regiment of Fusiliers. He was subsequently diagnosed with PTSD arising from combat operations. Despite the payment of compensation by MoD, and prior engagement with and help from Combat Stress, as well as with and from local GP, Housing, and Adult Addiction services in West Sussex at the time of his death, he had relapsed into addiction and had not fully recovered from PTSD. He was under probation at the time of his death. His death resulted from an accidental overdose of primarily illicit drugs.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: - When found to have taken illicit drugs months after completing an operational tour, there appears to have been no inquiry or check as to possible correlation with potential PTSD or other reasons for the behaviour, such as a lack of effective post-tour decompression. - There appears to have been no formal, clinical assessment of mental health at point of discharge, which may have identified the emergence of PTSD. I understand this may now be routine, or more prevalent, but there remains a community of veterans at risk for whom no such assessment may have been in place. - I heard evidence of a lack of awareness of regimental welfare staff and the role such organisations can play in supporting veterans. Again, those now serving may be more aware but there appears to be a community of veterans at risk who may

	remain unaware, including as to how such organisations fit and work within the overall veteran support landscape. - Despite the introduction of Op Courage and sharing of information between - and recognised efforts by - MoD, NHS and organisations such as Combat Stress to treat individuals, there appears to remain a lack of readily available, fully funded, long term rehabilitation and substance abuse recovery for veterans with PTSD at risk, notably for those only diagnosed well after leaving the Armed Forces, and/or who are 'long term cases' for whom treatment has not succeeded and/or who have relapsed after and despite such interventions.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 March 28, 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 [redacted] (mother) and [redacted] (sister) I have also sent it to The Chief Executive, Combat Stress who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	Dated: 31/01/2025 Joseph Turner Joseph TURNER Area Coroner for West Sussex, Brighton and Hove