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:** **1 Tees Esk & Wear Valley NHS Foundation Trust**
1	**CORONER** I am Catherine CUNDY, Area Coroner for the coroner area of North Yorkshire and York
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 23 October 2024 I commenced an investigation into the death of Victoria Anne TAYLOR aged 34. The investigation concluded at the end of the inquest on 03 September 2025. The conclusion of the inquest was that: On the 22nd of October 2024 the body of Victoria Anne Taylor was recovered from the River Derwent near Malton, North Yorkshire by an underwater search unit. She was pronounced deceased at the scene on the same date.
4	**CIRCUMSTANCES OF THE DEATH** Ms Taylor's mental health deteriorated significantly between May 2024 and her death, with an escalation in incidents of suicidal ideation, threatened and actual self harm, and episodes of binge drinking. Her suicidal ideation exhibited a preoccupation with going into the river, which she actually entered in July 2024 and from which she had to be extricated. Ms Taylor was reported missing from home on 1 October 2024. On 22 October 2024 her body was recovered from the River Derwent near Malton, North Yorkshire by an underwater search unit.
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: (brief summary of matters of concern) Ms Taylor was assessed on three separate occasions between mid-May 2024 and the end of August 2024 by members of the Crisis and Acute Hospitals Liaison Teams. Ms Taylor was clear during all three assessments that her episodes of binge drinking and impulsive acts of self harm were the result of unresolved childhood trauma. Despite that, secondary mental health services considered there was no role for them in offering support or a treatment pathway to her. The safety plans agreed following these assessments were therefore limited and offered Ms Taylor no additional support beyond that which she was already accessing through the Horizons service. The assessment documents contained no discussion of treatment pathways for addressing trauma which might be accessed through the Community Mental Health Team, and no indication that such pathways had been

	offered to Ms Taylor and rejected by her. Instead, it was suggested at the second assessment that Ms Taylor may wish to refer herself to a named private psychotherapy service at some point in the future. There was no rationale included in the second assessment for naming this service, and no explanation of what it might provide or why this could not be offered on the NHS via the CMHT. When Ms Taylor indicated at her third assessment that she had left a message with this private provider and received no response from them, the third safety plan simply suggested she try again. Mental Health services were aware at the time of the second and third assessments that a number of agencies were involved with Ms Taylor, but no multi-agency meeting or approach was suggested or called by them to consider the most appropriate support for Ms Taylor.
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 October 31, 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] I have also sent it to **Horizons Scarborough** **Derwent Practice (Malton)** **Department of Health & Social Care - Prevention of Future Death Reporting** 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: 05/09/2025** [redacted] **Catherine CUNDY**

	Area Coroner for **North Yorkshire and York**