His Majesty's Senior Coroner for The County of Devon, Plymouth and Torbay
Philip Spinney

9 March 2026
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: NORTH DEVON COUNCIL

CORONER

1 I am Stephen Covell one of the Assistant Coroners for Coroner Area of Devon, Plymouth and Torbay

CORONER'S LEGAL POWERS

I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and
2 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

INVESTIGATION and INQUEST

On 18 April 2024 Phillip Spinney Senior Coroner for the Coroner Area of Devon, Plymouth and Torbay commenced an investigation into the death of Taylor Malcolm Maddox formerly Darryn Malcolm Bell. I concluded the investigation at the end of the inquest on 26 February 2026. The
3 conclusion of the inquest was that Taylor was pronounced deceased at 1436 on 9 April 2024 in his car at the car park at North Devon District Hospital Raleigh Park Barnstaple due to [redacted] toxicity. The Deceased had taken his own life with an overdose of painkilling medication. The medical cause of death was 1a [redacted] Toxicity. I returned a short form conclusion of suicide.

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CIRCUMSTANCES OF THE DEATH

Taylor was born on 22 April 1981 and was 42 years of age at the time of his death. Taylor had a history of mental health illness including depression and traits of personality disorders. Taylor had previously attempted to take his own life with drug overdoses on two occasions. On 9 February 2024 Taylor was admitted as an informal patient to Moorland View Psychiatric Ward North Devon District Hospital having presented the day before to the Emergency Department of the hospital saying that he had plans to take his own life and could not keep himself safe. Whilst at Moorland View Taylor explained that the principal triggers for his feelings of hopeless and the desire to end his life were joblessness and homelessness. Taylor was discharged from Moorland View on 21 March 2024. His mood and optimism about the future had improved. Part of the preparation for Taylor's discharge was for him to find accommodation to which he could move on discharge. Taylor had been designated a housing officer from North Devon Council to assist him find accommodation. Taylor reported that he was struggling to find accommodation due his being on benefits. He also reported that he was experiencing difficulties getting responses from the housing officer and as a consequence he had been unable to arrange a deposit to secure an offer of accommodation. Taylor's discharge facilitator at the hospital reported multiple attempts to contact the housing officer went unanswered.

4 An application to North Devon Council for emergency accommodation on discharge was rejected on the basis that Taylor did not meet the priority need criteria for temporary accommodation.

Ultimately Taylor was unable to find to find permanent accommodation and was discharged to short term step-down accommodation available to him for a limited period.

On 27 March 2024 the Home Treatment Team supporting Taylor received an email from North Devon Council Housing Department confirming that Taylor needed to source his own private rented accommodation.

Taylor left the step-down accommodation on 3 April 2024. He indicated that his intention was to sleep in his car for a couple of days until his benefits arrived to enable him to finance temporary hotel accommodate while he found a job.

The last contact with Taylor was on 3 April 2024. He failed to attend a follow up meeting with the Home Treatment Team on 5 April 2024

On 9 April 2024 Taylor was found unresponsive in his car which was parked in a corner of the car park of North Devon District Hospital.

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. –

Following Taylor's death Devon Partnership NHS Trust conducted a patient safety incident investigation. In the sections 'Safety Actions and Ongoing Improvement Work' and 'Summary of multi-disciplinary case discussion 27 January 2025' of the subsequent report, which followed the investigation, staff team members reported difficulties with securing housing for patients upon their discharge from hospital were exacerbated by challenges communicating with North Devon Council's Housing Options Service. Emails to the housing officer from the discharge facilitator on Taylor's behalf had not been answered and when a response was received, it was to advise that Taylor was not eligible for emergency accommodation and would need to source his own. The team also queried the rationale of the housing team which would decline a house to a person they deemed too high a risk but would often determine that a person leaving hospital was not high enough need to qualify for emergency accommodation
5 and the highest level of priority..

The staff team members at Devon Partnership NHS Trust considered that unstable housing likely contributed to Taylor's distress and difficulties in his last weeks

[redacted], Taylor's Responsible Clinician at Moorview Ward, recorded difficulties which the team and Taylor had experienced due to lack of timely and effective responses from North Devon Council housing team in pages 31 and 32 his report dated 16 September 2024.

.The particular concerns are;

(1) Patients awaiting discharge from psychiatric hospital in North Devon are not being supported in a timely and effective way to assist them secure accommodation.

(2) The assessment process for entitlement to emergency accommodation and/or other assistance with securing accommodation in North Devon does not give adequate weight to the vulnerability of those with a psychiatric illness and the potential effect of unstable housing and homelessness on their mental health.

(3) If vulnerable persons being discharged from hospital are not being provided with adequate and timely housing support and their needs adequately assessed there is an increased risk that they will relapse and their mental state will deteriorate.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you North Devon Council have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 5 May 2026. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons; [redacted] Taylor's mother and Devon Partnership NHS Trust.

8 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 March 2026

Signature

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[redacted]

Stephen Covell Assistant Coroner for the Coroner Area of Devon, Plymouth and Torbay.