

REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#).

1. CORONER

I am Jyoti Gill, Assistant Coroner for Kent and Medway.

2. DATE OF REPORT

3 August 2026

3. 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. THIS REPORT IS BEING SENT TO

1. The Chief Executive of Adult Social Services for Kent
2. The Kent and Medway Safeguarding Adults Board

You are under a duty to respond to this report within 56 days of the date of this report, namely by 28 September 2026. I, the coroner, may extend the period if an appropriate application is made.

4. YOUR RESPONSE

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.

I have a duty to send a copy of your response to the Chief Coroner.

In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision.

Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.

The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages [Non-responses to Prevention of Future Death \(PFD\) reports - Courts and Tribunals Judiciary](#)

5. SUMMARY OF CORONER'S CONCERN

My concerns relate to the adequacy of the multi-agency response to repeated self-neglect referrals and the failure to escalate concerns in circumstances indicating significant vulnerability.

6. ACTION SHOULD BE TAKEN

In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.

7. INVESTIGATION and INQUEST

On 1 July 2025 I commenced an investigation into the death of Richard Preece, aged 42 Years.

The investigation concluded at the end of the inquest on 25 June 2026. The conclusion of the inquest was that Mr Preece died having taken a fatal level of [REDACTED], the intention for which remains unclear

Richard Preece was found deceased at his home address of Invictus Games House, 4 Richard Corben Way, Aylesford, Kent on 30 June 2025. The toxicology report noted that [REDACTED] were present at potentially fatal levels. Mr Preece's cause of death was due to [REDACTED] toxicity.

1a [REDACTED] Toxicity

1b

1c

1d

II

8. CIRCUMSTANCES OF THE DEATH

[Please explain the relevant circumstances of the individual's death, ideally this should be in no more than 500 words]

Mr Richard Preece lived alone at his home address of 4 Richard Corben Way, Aylesford. The accommodation is for ex-servicemen and women and is partially run by the Royal British Legion Industries (RBLI). Mr Preece was known to Social Services, and the RBLI as having ongoing issues with his mental health. He was described as reclusive and a hoarder (evident from his property). The RBLI, responsible for upkeep of the property, have attended the address on numerous occasions due to safety concerns resulting from the above.

The RBLI had been attempting to arrange a home visit to see Mr Preece along with Social Services. A home visit had been arranged to see Mr Preece on the 30/06/25 along with a member of Social Services. Mr Preece was not answering calls prior to their attendance. On attendance at the address there was no answer to knocking. [REDACTED], an employee of RBLI entered the property which was not secure. This was not uncommon for Mr Preece. Mr Preece was found deceased on the sofa, heavily decomposed. [REDACTED] immediately left the address and called for emergency services.

It was noted that inside the address there was clear evidence of hoarding. The floor could not be seen in the lounge, with empty takeaway boxes, bin bags and other items left around the house. There was no space to freely move, the only space being occupied by the deceased on the sofa. Mr Preece was found on the sofa, slumped on his right side wearing a t-shirt and trousers. Due to the level of decomposition, a decision was made by attending DI to complete body examination at the mortuary.

9. CORONER'S CONCERNS

During the course of the inquest I heard evidence 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:

[250-word statement addressing what circumstances of the death have led to the coroner's concern, and why the coroner thinks the person to whom the report is directed is responsible for taking action to prevent future deaths. This statement must not propose what action should be taken, as coroners cannot make recommendations].

Despite three separate safeguarding referrals for self-neglect (2022, 2024 and 2025), involving concerns about hoarding, poor personal care, social isolation, PTSD, anxiety/agoraphobia, chronic pain, financial difficulties and disengagement from services, there was no timely escalation to a multi-agency meeting.

Adult Social Care was attempting assessment, but no earlier formal multi-agency review occurred. The case appears to have fallen between services because Mr Preece would not engage. We heard in evidence that an earlier self-neglect meeting may have been beneficial and that the first time one was considered was towards the end of June 2025.

Mr Preece had a military career and served multiple tours in Iraq and Afghanistan. He was medically discharged following serious injuries sustained in Afghanistan. The injuries resulted in chronic pain, multiple back operations and ongoing mobility difficulties. Evidence from his sister was that he suffered from PTSD, struggled to adapt to civilian life following discharge, and continued to experience significant physical and psychological difficulties, including problems managing his chronic pain.

Opportunities to share information, co-ordinate agency responses and assess Mr Preece's needs appear to have been missed. I am concerned that, where vulnerable adults repeatedly decline engagement, there may be insufficient arrangements to ensure escalating safeguarding concerns are brought together and reviewed through a structured multi-agency process, creating a risk that future deaths may occur. I am also concerned as to whether existing procedures adequately identify when safeguarding concerns should be escalated to a multi-agency self-neglect process notwithstanding the absence of consent.

10. COPIES AND PUBLICATION OF THIS REPORT

I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it.

I also may send a copy of the report to any other person who I believe may find it useful or of interest.

I can confirm I have sent the report to:
[please do not use individual's names, but instead roles/titles]

1. Mr Preece's Family
2. The Chief Executive of Adult Social Services for Kent
3. The Kent and Medway Safeguarding Adults Board

I also have a duty to send a copy of the report to the Chief Coroner.

You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's [PFD Publication Policy \(2026\)](#) Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

Signature



**Chief
Coroner**

RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS

REGULATION 29 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

When a coroner sends a prevention of future deaths (PFD) report to a person or organisation, they must respond within 56 days. Recipients of a PFD report can apply to the coroner for an extension. A response to a PFD report must detail the action taken or to be taken, whether in response to the report or otherwise, or it must explain why no action is proposed.

The purpose of the response template below is to promote clarity, ensure that responses address the coroner's concerns directly and transparently, and support consistency and good practice across organisations and sectors.

It does not restrict how a person or organisation formulates their response; recipients remain responsible for determining what action is appropriate and for ensuring that their response accurately reflects the steps taken or planned.

In accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#), any representations regarding publication of a response should be sent to the coroner. These representations should be made at the same time as the response is provided. The coroner will pass any representations received to the Chief Coroner for a decision.