REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Jigsaw Homes Tameside, 249 Cavendish Street, Ashton-Under-Lyne, OL6 7AT.
1	CORONER I am Christopher Murray, Assistant Coroner, for the Coroner Area of Greater Manchester South.
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 30th December 2020 an investigation was opened into the death of Barry Martin. On 25th February 2021 an inquest was opened into the death of Barry Martin who died at [redacted] Hyde SK14 3EG aged 59 years. The investigation concluded at the end of the inquest which I heard on 15th June 2021. Following a post mortem examination conducted on 30th December 2020 the medical cause of death was confirmed as : 1 (a) Acute left ventricular failure (b) Coronary atherosclerosis with superimposed acute pneumonia By way of conclusion, I recorded a narrative conclusion of Natural Causes contributed to by self-neglect.

4	CIRCUMSTANCES OF THE DEATH Barry Martin had recent history of self-neglect, depression and heavy alcohol consumption. After concerns were raised for his welfare, Greater Manchester Police attended the properly and forced entry of [redacted] on 10th December 2020. He confirmed he was dependant but had no intent to self-harm. The front door through which the police had entered the property was subsequently boarded up. Whilst it is possible there were no other exit routes through external doors he could have climbed through a window. Following further concerns raised by his family, Greater Manchester Police attended [redacted] again on 24th December 2020 and found Mr Martin deceased. He died from acute heart failure precipitated by an acute pneumonia and bronchitis on a background of moderate coronary artery disease and physical frailty. He had neglected himself and had not been eating properly.
5	<u>CORONER'S CONCERNS</u> 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. – After concerns were raised for his welfare, Mr Martin's front door to his house was boarded up following a forced entry by Greater Manchester Police on 10th December 2020. There were no other exit routes from the property as there was no key available to Mr Martin to be able to use the rear door being the only other door. I am concerned that if occupied houses have to be boarded up that proper checks are made that there are other alternative safe exit routes for residents.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you and 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 5th November 2021. 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. I have also sent a copy of my report to Greater Manchester Police who may find it useful or of interest. 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	Dated: 10th September 2021 Signature:  Christopher Murray HM Assistant Coroner, Manchester South.