REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Secretary of State for Health and Social Care**
1	**CORONER** I am Adrian Farrow, 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.
3	**INVESTIGATION and INQUEST** On 1st September 2020, an investigation was commenced into the death of Jordan Peter Clare, aged 22 years. The investigation concluded at the end of the Inquest on 14th October 2022. The conclusion of the inquest was **misadventure in that that he died of hypoxic brain injury as a result of suspension by a ligature in a state of distress at an unresolved housing issue.**
4	**CIRCUMSTANCES OF THE DEATH** Mr Clare had diagnoses of ADHD, attachment and conduct disorder and suffered from anxiety and depression. He had historically been addicted to Class A drugs and this led him into conflict with the criminal law and with his family which had resulted in a restraining order which restricted contact with his family and periods in custody. He had significant support from a number of sources: he was supervised by the probation service and the police "Spotlight" team; he was working with Mosaic – an organisation who assist with drug misuse; the local authority Leaving Care team provided assistance on a voluntary basis as he was over 21 years old. The local authority housing organisation provided him with the tenancy of a flat in Marple and as part of that tenancy, he had an Offender Support Worker who assisted him. He had regular contact with his General Practitioner. Notwithstanding the involvement of the various agencies there was no single individual or agency responsible for the co-ordination of the package of care, support and resources. Whilst there was sharing of information between some individuals involved, it was not structured, formalised or supervised. In practice, the Housing Offender Support worker, whose role did not require any formal social work or mental health care qualifications became the person upon whom Mr Clare relied. An issue between Mr Clare and a neighbour developed over a period between June 2020 and his death on 26th August 2020, during the latter stages of which, he began to voice intentions to take his own life. On 26th August 2020, in a series of calls and messages to the police, Housing Officer and the Offender Support Worker, Mr Clare expressed extreme distress about the apparent lack of progress about the dispute with his neighbour and progressively, made threats to take his own life, which he did during a final call to the Housing Offender Support Officer by suspending himself by a ligature at his home.
5	**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 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. – The Inquest heard evidence from the Head of Service for Safeguarding and Learning for Stockport Metropolitan Borough Council. She highlighted a long-standing gap in provision, which was described as extending across most if not all local authorities, for vulnerable adults who have complex needs, but who do not fall into the existing framework of social services, Care Act provision or formal mental health supervision. The effect of that gap is that there is no identifiable individual who is a single point of contact in such cases equivalent to a social worker or care co-ordinator. The result is that many vulnerable adults with complex needs have no such arrangements in place for contact, collating and sharing of information and deployment of services and assistance, support or safeguarding. Where such arrangements are in place, they are necessarily ad hoc in nature in differing frameworks, levels and standards, and can devolve by default to an individual who, whilst well-motivated, may lack the skills and training to properly perform the function, particularly when the vulnerable adult may be in crisis.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 21st May 2023, 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] (on behalf of the family of Jordan Clare) via Leigh Day Solicitors and Stockport Homes Limited. I have also sent it to Head of Service for Safeguarding and Learning for Stockport Metropolitan Borough Council 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	**Adrian Farrow** **HM Assistant Coroner**  **26.03.2023**