REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) Secretary of State for Health and Social Care** **2) Secretary of State for Local Government** **3) Greater Manchester Integrated Care**
1	**CORONER** I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 22nd February 2023 I commenced an investigation into the death of Tobias Ryse Mannering-Jones. The investigation concluded on the 29th January 2023 and the conclusion was one of **Suicide**. The medical cause of death was **1a) Hanging.**
4	**CIRCUMSTANCES OF THE DEATH** Tobias Mannering-Jones was very vulnerable. He became homeless at the end of December 2022. He had no support network. He generally slept at the Hostel for homeless people in Tameside where he was exposed to abuse due to his sexuality, felt unsafe, and was in the company of people who were significantly greater users of hard drugs. He had mental health issues dating back to his childhood trauma that were greatly exacerbated by his homelessness. He increased his use of drugs to cope with his deteriorating situation, he was also sexually exploited. After he became homeless, he sought help for his spiralling situation. On 6th January he saw the mental health worker attached to his GP practice. Concerns regarding his vulnerability in the homeless accommodation were expressed. He spoke to that worker again on the 9th February at an appointment. His contacts with other agencies in the interim were not known of.

	He was also seen by Pennine Care Mental Health Liaison after he went to A&E on 15th January, 17th January and 14th February 2023. He indicated thoughts of self-harm with a key issue being his homelessness and the consequential impact on his mental health, drug use and support network exacerbated by the fact he had no telephone or address. He contacted CGL for help on 6th February 2023 to try and obtain help for substance misuse. Attempts to contact him for assessment were unsuccessful given his lack of a telephone. He was under the care of the neighbourhood mental health team and had been offered support from the Big Life Group previously. He was still awaiting assessment for therapy. Contact ceased with them, and they were not involved in planning how his discharges from the acute hospital would be managed in the community. Adult Social Care were contacted, by Tobias, asking for help on 8th February 2023. He was allocated a Social Worker on 14th February. Attempts to contact Tobias were unsuccessful due to his lack of telephone and homelessness. On 21st February 2023 Tobias was found [redacted] at Portland Basin Marina. Police found no suspicious circumstances. Post-mortem examination included toxicology. He was found to have evidence of limited cocaine use and alcohol use in the hours prior to his death. He had last been seen alive the afternoon before. No concerns for welfare had been raised following him last being seen. It is probable that had Tobias not been homeless, isolated and vulnerable and had there been a co-ordinated approach to supporting him he would not have taken his own life on 21st February 2023.
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 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. – 1. The inquest was told that Tobias had sought and had been referred for mental health support however due to the high demand and long waiting lists

	he was still on a waiting list at the time of his death. The evidence before the inquest was that long delays were still an issue and were not restricted to Tameside but were part of a national picture of delays and long waiting lists for those seeking help with their mental health. 2. The inquest also heard evidence of the impact of homelessness and consequential vulnerability on a young person like Tobias and that the demands on Local Authorities meant that even where vulnerability was recognised there were not resources to offer sustained support and stable housing solutions. The evidence was that as a consequence young vulnerable people had to rely on homeless shelters where they were exposed to additional negative influences and as in Tobias's case abuse due to their sexuality. 3. Evidence was also heard that a person who has to rely on a homeless shelter can then become uncontactable to public service providers as they have no address for contact which means they then have even less chance of accessing support. 4. The inquest was told that young adults who are homeless are often sexually exploited and that those who identify as LGBTQIA can be particularly vulnerable and that the underlying vulnerability and risk was not always appreciated by those dealing with young homeless people and that it could be mistaken by agencies as a lifestyle choice rather than what it actually was, i.e., exploitation by an older adult. 5. The evidence before the inquest was that where multiple agencies were involved it was fundamental that one agency/person took overall ownership/responsibility to ensure a coordinated and effective approach using regular MDTs to understand the information that all agencies had in their possession and to offer effective support.
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 9th May 2024. 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 namely 1) [redacted] on behalf of the Family; 2) Tameside Metropolitan Borough Council; 2) Pennine Care NHS Foundation Trust and 4) CGL (Change, Grow, Live), 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	**Alison Mutch** **HM Senior Coroner**  **14.03.2024**