REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Secretary of State for Levelling Up, Housing and Communities**
1	**CORONER** I am Alison Mutch, HM 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 12th September 2023 I commenced an investigation into the death of Colin Waterhouse. The investigation concluded on the 2nd April 2024 and the conclusion was one of **suicide.** The medical cause of death was 1a) Hanging.
4	**CIRCUMSTANCES OF THE DEATH** Colin Waterhouse was diagnosed with pancreatic cancer and given indication that the average survival time was 8 - 10 months. Palliative treatment was offered. He was referred to cancer support services. He found his accommodation in social housing difficult and it impacted his mental health significantly whilst he was also struggling to deal with his cancer diagnosis. He became eligible to bid for alternative properties as a consequence of his health. He struggled to make bids and navigate the complex system. This was exacerbated by a shortage of social housing. On 11th September 2023 he was found suspended by a ligature [redacted]
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. – The inquest heard evidence that the social housing where Mr Waterhouse lived was such that it was impacted his overall health and wellbeing after his terminal cancer diagnosis. It was recognised that his housing was impacting his mental wellbeing but the support services available to him (as a palliative care patient) did not have the resources/capacity to assist him in moving to alternative accommodation for the last few months of his life. The evidence was that because he lived in social housing he had to bid for alternative accommodation. The bidding process was digital and he struggled to manage that. In addition even if he made a bid the chances of success were extremely slim given the huge demand for property. The inquest was told as an illustration that the Housing Association that he was a tenant of had 35,000 properties but a waiting list of 17,000.
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 2nd July 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 [redacted], on behalf of the family, 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**  **07.05.2024**