REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Department for Levelling Up, Housing and Communities (Local Government.)
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 28th November 2023 I commenced an investigation into the death of Lee Francis MCHALE. The investigation concluded on the 17th June 2024 and the conclusion was one of suicide. The medical cause of death was **1a) Multi Organ Failure 1b Paracetamol Overdose**
4	CIRCUMSTANCES OF THE DEATH On 23rd November 2023 Lee Francis McHale was admitted to hospital. He had taken [redacted] paracetamol tablets the day before. He was treated but continued to deteriorate. On 25th November 2023 he died at Tameside General Hospital. The inquest heard that he had incurred debts prior to his death as a consequence of the gap between his housing benefit entitlement and actual rent. This arose due to the "bedroom tax". He had a larger property from when he had fostered children. However he had had to give up fostering and was as a consequence reliant on benefits. He was at risk of eviction at the time of his death.
	<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. – The inquest was told that once Mr McHale was no longer able to foster he began to claim benefits including housing benefit. However the property he resided in was larger than a single occupancy property because he had previously fostered children. As a consequence he was subject to the so called “bedroom tax”. This meant that there was a gap between housing benefit and his actual rent. Therefore he rapidly went into arrears with his rent and liable to be evicted. He did not feel able to deal with the situation. He was worried about moving from his home in part because he had allowed one of his now adult foster children to continue living with him. He had allowed that because he was concerned that person would otherwise become homeless. Ultimately he took a catastrophic paracetamol overdose.
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 28th August 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**  **03.07.2024**