REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Department for Levelling Up, Housing and Communities (Local Government.)**
1	**CORONER** I am Alison Mutch ,Senior Coroner, for the coroner area of 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 2nd August 2024 I commenced an investigation into the death of Paul Williams. The investigation concluded at the end of the inquest on 9th December 2024. **The conclusion of the inquest was suicide. The medical cause of death was 1a) hanging.**
4	**CIRCUMSTANCES OF THE DEATH** On 9th July 2024, Paul Williams was found suspended from a ligature outside Screwfix at Unit 5 Haigh Park. Police found no suspicious circumstances.
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 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 that Paul Williams was a hard working family man in employment. He and his family had been evicted from their privately rented accommodation and became homeless. They were given a period of 2 weeks to leave the property and find alternative accommodation. Whilst looking for accommodation the family was forced to live in separate locations. In his case that included living in a vehicle in the week. The inquest was told that the family was a priority case but a shortage of public housing meant that in total they had to wait almost 3 months before suitable accommodation became available. The evidence before the inquest was that the housing situation including the eviction, the homelessness and need to live separately whilst waiting for suitable accommodation to become available had a significant impact on his mental health and contributed to his deteriorating condition.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 18th March 2025. 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 the partner of Mr Williams 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**  **21/01/2025**