H M Senior Coroner for Gloucestershire
Ms Katy Skerrett

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mr Shaun Clee, Chief Executive, 2Gether NHS Foundation Trust, Rikenel HQ, Montpellier Gloucester GL1 1LY, and** **Mr David Biddle, CEO Change Grow Live, 3rd Floor, Tower Point, 44 North Road, Brighton, East Sussex, BN1 1YR**
1	**CORONER** I am Katy Skerrett, Senior Coroner for Gloucestershire.
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 the 16th March 2017 an inquest was opened into the death of Shane Dean Hardy. The investigation concluded at the end of the inquest on the 5th December 2017. The conclusion of the inquest was Accidental Death. The medical cause of death was hanging.
4	**CIRCUMSTANCES OF THE DEATH** This 29 year old man ("Shane") had a long history of involvement with mental health services, and his primary problems were linked to his abuse of alcohol and illicit drug substances. He had taken multiple overdoses, often whilst under the influence of alcohol or drugs, and would seek help shortly thereafter. He was living in supported accommodation. His last telephone contact with alcohol rehabilitation services was on the 14th February 2017. On the 24th February 2017 he was arrested and placed a ligature around his neck. He was formally assessed under the mental health act, and was found to not be suffering from a mental health illness. On the 28th February 2017 Shane was told by his accommodation provider that he was to be moved into different accommodation. On the 2nd March 2017 Shane cut himself, took an overdose and was admitted to hospital. The following day he was assessed by a mental health professional. Whilst he referred to a number of life stressors, no evidence of a mental health illness was found. He was discharged from hospital on the 3rd March. On the 4th March Shane moved into his new accommodation. He was booked into his accommodation, and a welfare check was carried out on the 4th March. On the 5th March Shane collected his script from the pharmacy. On the 8th March 2017 Shane spoke to a security guard at approximately 7 am. He enquired when the staff start, and complained about his current accommodation. He did not express any suicidal ideation. He walked from the office to a semi private area just off the main drive. He then placed a belt around his neck. At approximately 11.35 am other residents found Shane's body hanging from a tree. Paramedics attended and pronounced him deceased at 11.47 am.
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) Individuals who suffer with addictions and mental health difficulties can fall between the services. Mental health services consider it not to be a mental health issue, and refer to alcohol treatment services. If the individual then refuses to engage with the latter, the individual is left receiving no assistance.

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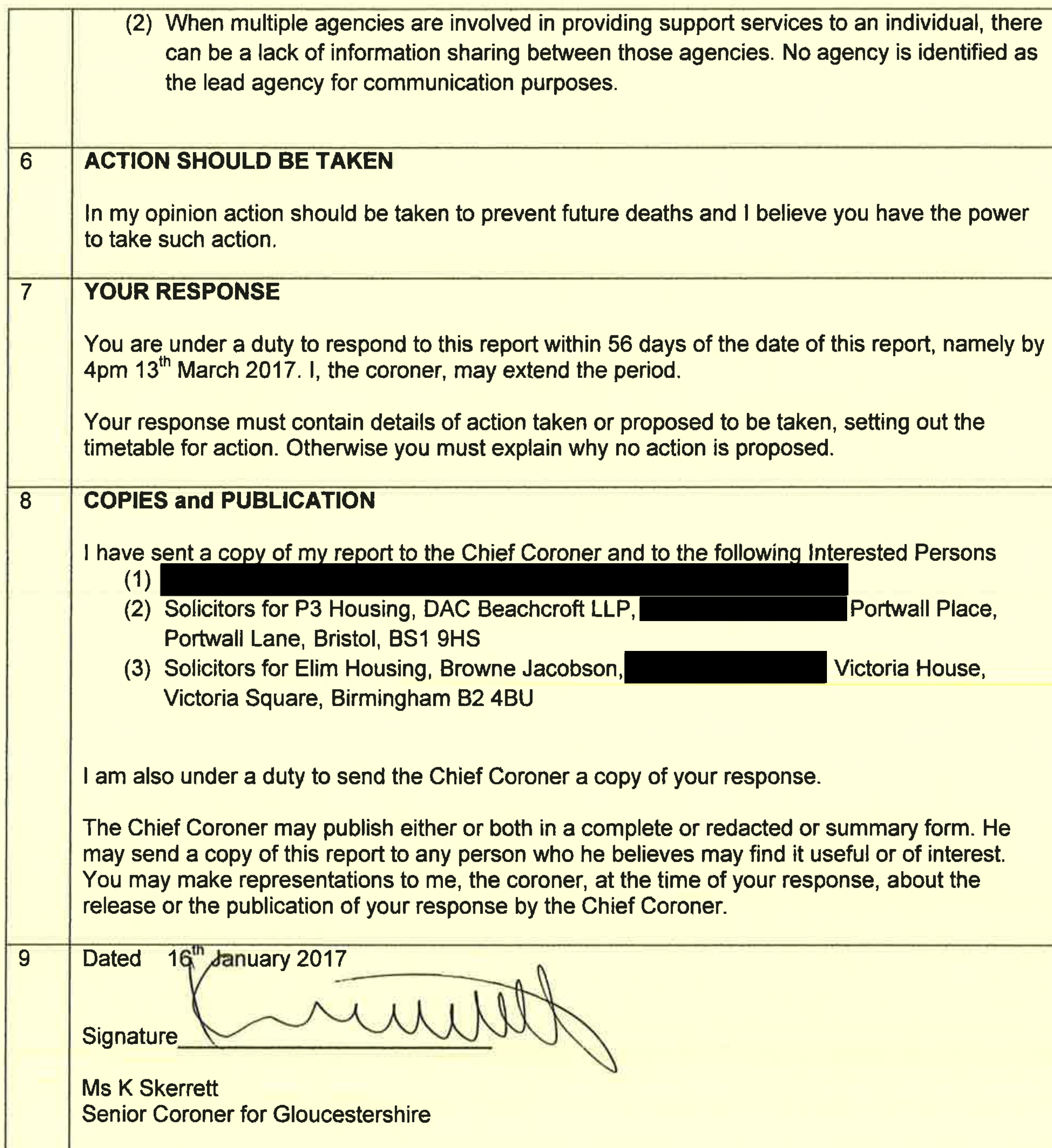

	(2) When multiple agencies are involved in providing support services to an individual, there can be a lack of information sharing between those agencies. No agency is identified as the lead agency for communication purposes.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent 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 4pm 13th March 2017. 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 (1) (2) Solicitors for P3 Housing, DAC Beachcroft LLP, Portwall Place, Portwall Lane, Bristol, BS1 9HS (3) Solicitors for Elim Housing, Browne Jacobson, Victoria House, Victoria Square, Birmingham B2 4BU 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	Dated 16th January 2017 Signature__________________________ Ms K Skerrett Senior Coroner for Gloucestershire