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Dying Homeless: Preventing Future Deaths

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Executive Summary

Examining Prevention of Future Deaths reports (PFDs) issued by Coroners across England and Wales and published by the Chief Coroner, this research has identified that a growing number of reports are focused on issues connected to the deaths of people experiencing homelessness. Furthermore, these reports are identifying more issues relating to housing in which action could be taken to save lives at a national scale. It finds that:

- There has been a significant growth in PFDs relating to people who are experiencing homelessness or who are precariously housed: from 18 PFDs in five years (2017-21) to 38 PFDs in three years (2023-25). This is an increase of an average 3.6 pa to 12.67 p.a. and a percentage increase of 252%. In the same period, the total number of PFDs issued increased by 46%.
- There is notable regional disparity in Coronial practice, with some areas issuing very few or no PFDs relating to the deaths of people experiencing homelessness, despite evidence of deaths of people experiencing homelessness in those areas.
- Analysis of the recipients of these PFDs demonstrates a significant growth in the number of reports addressed to organisations with responsibility for housing, including Central and local government and third sector organisations. These reports went from an average of 1 a year in 2017-21 (5 PFDs) to a report every 8 weeks between 2023-2025 (20 PFDs). Analysis of the reports themselves demonstrates a growing number focus on systemic and substantive issues connected to housing and homelessness, raising concerns at a national level, including:
    - the impact of a lack of social housing;
    - the 'bedroom tax';
    - a nationwide lack of adequate facilities to house people experiencing mental health challenges, both short and longer term; and
    - failures in providing adequate accommodation for people with intersecting vulnerabilities. This included those leaving care and young gay and trans people.
- There are other common themes across the reports, including concerns about problems with procedures and systems which might cause other deaths.
- The reports suggest that family play a role in inquests which lead to reports, as all reports identified appear to have been copied to family. As it is not uncommon for people experiencing homelessness to experience family breakdown and have strong relationships with others in their community, it is surprising that there are not reports which are copied to others, including support workers, and this may be an area in which Coroners could improve practice.
- There are ways in which the system could be improved, as set out in recommendations at the end of this report, with recommendations made for the attention of individual Coroners, the Chief Coroner, the Ministry of Justice, and for recipients of PFDs generally.

Details from many of the PFDs which form the basis of this report are included in the body of the analysis. They can be very difficult to read, setting out details of the lives and deaths of people who died while experiencing homelessness, as well as missed steps and opportunities not taken. This report seeks to draw on their stories to suggest ways in which lives could be saved in the future.

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Introduction

The focus of this research is the deaths of people experiencing homelessness, and reports by Coroners which identify that action could be taken to prevent future deaths from taking place.

As with all research exploring death, it is necessary to acknowledge a central fact: that death is both individual and collective. Every single early preventable death of a person experiencing homelessness is a loss of a human being who deserved to be honoured, respected, and treated with dignity. At the same time, viewed from a population wide perspective, it is clear that early preventable deaths caused by homelessness is a growing public health concern, while the central role that safe and secure housing plays in the wider determinants of health is now widely evidenced and acknowledged. Critically, both perspectives point to a single conclusion; that deaths of people experiencing homelessness constitute an urgent call for action which must be collectively faced.

When someone dies and the cause of death is not known, the death was violent, unnatural or in state detention, a Coroner must investigate. If in the course of that investigation, the Coroner identifies something which might cause the deaths of others, they have a duty to report their concern to someone who they believe could take action to save lives. Since 2013, these Prevention of Future Death reports (PFDs) have been published by the Chief Coroner (alongside any response to the report, if a response has been sent).

Not all deaths will require investigation by a Coroner, and not all investigations by a Coroner will lead to a PFD. As a subset of a subset, the numbers of PFDs may appear small, but emerging from a legal process of scrutiny of death by an independent Coroner, they constitute a particularly important indicator of issues which require public attention. This research suggests that there is significance in the growth in numbers identified, together with a shift in the change of focus of PFDs onto issues of housing and homelessness, as well as a variation in which areas of the country are producing PFDs.

The report is in four substantive parts, with three appendixes. Part 1 sets out the context for the research, while Part 2 sets out some statistics drawn from the analysis, including the numbers from different regions. Part 3 analyses common themes in the reports identified, and Part 4 sets out recommendations for change. A full list of the PFDs issued in 2017-21 and 2023-2025 in which the person who died was homeless or precariously housed is set out in Appendix 1. Excerpts of the relevant law are set out in Appendix 2, and the methodology is in Appendix 3 (including explanation of how homelessness is defined and identified in the research).

1. Context – deaths of people who are experiencing homelessness

There is a growing number of people experiencing homelessness. The Homelessness Monitor, an annual academic analysis of homelessness, found in relation to England in 2025 that

> In the context of economic challenges, rising housing costs, and shortfalls between housing benefit and private rents, homelessness in England has continued to rise. The total number of households experiencing the worst forms of homelessness ('core' homelessness, which includes rough sleeping, sofa surfing, and staying in hostels, refuges, or unsuitable temporary accommodation) now stands at just under 300,000. The number of households assessed by local authorities to be homeless or at risk of homelessness ('statutory' homelessness), wider use of temporary accommodation, and official estimates of rough sleeping have also all risen in 2024 compared to the previous year.

While, in relation to Wales,

> Although rates of core homelessness in Wales are lower than in England, they have risen more sharply in Wales than in either England or Scotland.

The number of people dying while experiencing homelessness is increasing year on year. The Dying Homeless Project has counted 8,523 deaths across the UK since 2017, including 1,313 in 2022, 1,474 in 2023 and 1,611 in 2024 (of which 1,142 were in England and 90 were in Wales). This project was initiated in 2017 by the Bureau of Investigative Journalism, and is now undertaken by the Museum of Homelessness. The project counts actual deaths rather than relying on estimates or projections, and data is collected and cross correlated from a variety of sources, including reporting from individuals and organisations, Freedom of Information responses by local authorities and housing bodies, Coroners reports and media reports.

People who are homeless die younger. The Office for National Statistics produced experimental statistics on the deaths of homeless people in England and Wales between 2013 and 2021. They consistently found that the mean age at death was in the mid 40s for both men and women (compared to 76 years and 81 years in the general population). This was also consistent with previous research (Thomas 2012). Analysis by the Dying Homeless Project provides a more nuanced and detailed picture, confirming a pattern of deaths for individuals in their 40s and 50s, but pointing to wide regional variation (as discussed below).

People who are homeless are more likely to die whatever their age. For example, research in 2012 found that 'At the ages of 16-24, homeless people are at least twice as likely to die as their housed contemporaries; for 25-34 year olds the ratio increases to four to five times, and at ages 35-44, to five to six times. Even though the ratio falls back as the population reaches middle age, homeless 45-54 year olds are still three to four times more likely to die than the general population, and 55-64 year olds one and a half to nearly three times.' (Thomas 2012)

The causes of death of people experiencing homelessness are very different to the rest of the population. Both the Dying Homeless project and the ONS experimental statistics consistently identify predominant causes of death for people experiencing homelessness: around 44% are drug and alcohol related and suicide accounted for 11-13%. By comparison, these factors accounted for 3% of overall deaths in the same period.

Many of these deaths are preventable. For example, in relation to health care, one English study of 3,882 hospital admissions linked to 600 deaths of people who were homeless found

that nearly one in three deaths could have been prevented if there had been timely and effective health care (Aldridge et al 2019). The authors noted that the 'high burden of amenable deaths highlights the extreme health harms of homelessness and the need for greater emphasis on prevention of homelessness and early healthcare interventions.'

There is widespread regional variation. The Dying Homeless project identified that in 2024, in the towns and cities of the North East, average median age was 41, in London, 53. It provides a detailed breakdown and finds that London had the highest number of deaths recorded (326) while the North East had the fewest (46). The South East (186), South West (147) and North West (117) also all had over 100 deaths, and the report notes that 'When population size is taken into consideration, the South West region had the second highest rate of reported deaths in England, behind only London' and there were particularly steep increases from previous years in the East Midlands, East of England and the South West. In relation to specific cities, 32 deaths were identified in Bristol, 31 in Southampton, 36 in Brighton, 22 in Nottingham, and 21 in Exeter. Deaths in urban areas was around two times higher than in rural areas. The ONS statistics consistently suggested that the highest numbers of deaths were in London and the North West of England, and that the death rate had increased in every region between 2013 and 2021.

Deaths of people who are homeless are much more likely to be referred to a Coroner for investigation. For example, ONS statistics noted that 85.2% of the deaths they identified in 2021 were 'certified' by a Coroner. Appendix 1 sets out details of the law, including when deaths must be referred to a Coroner, and where a death is violent, unnatural or in state detention, or the cause of death is unknown, a Coroner must open an investigation. If, in the course of that investigation, it is clear that in the future, circumstances creating a risk of other deaths will occur (or will continue to exist), and the Coroner considers that action should be taken – whether to prevent the occurrence or continuation of those circumstances, or to eliminate or reduce the risk of deaths they create – they must report their concerns. This report (known as a Prevention of Future Deaths report, or PFD) must be sent to someone who the Coroner believes may have power to take action. That person must respond, and the Chief Coroner publishes these reports and responses.

More broadly, housing (or lack of housing) is a foundational determinant of health and in relation to healthcare specifically, improving access for people experiencing homelessness is a particular focus for the NHS. There is growing compelling evidence of the ways in which housing contributes to health, including work on the wider determinants of health by Marmot (2010; 2020), which identify that

> Housing is a foundational determinant of health. Beyond mere shelter, housing conditions profoundly impact health outcomes, with substandard living environments contributing to a myriad of health risks. For example, exposure to mould, damp, and indoor pollutants to inadequate heating, overcrowding, and insecure tenure, and the quality and stability of housing significantly influence physical and mental health. (Institute of Health Equity)

People experiencing homelessness fall with the inclusion health framework;

> an umbrella term used to describe people who are socially excluded, who typically experience multiple overlapping risk factors for poor health, such as poverty, violence and complex trauma. This includes people who experience homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and Traveller communities, sex workers, people in contact with the justice system and victims of modern slavery.

> People belonging to inclusion groups, tend to have very poor health outcomes, often much worse than the general population and a lower average age of death. This contributes considerably to increasing health inequalities.
>
> Poor access to health and care services and negative experiences can also be commonplace for inclusion health groups due to multiple barriers, often related to the way healthcare services are delivered.

The Homeless and Inclusion Health Barometer in 2024 found that

> In response to rising levels of need, increasing demand for services and reductions in funding, the NHS, housing and social care services are becoming less and less flexible while at the same time raising their thresholds; people have to be sicker, more vulnerable or more distressed before they can get any help at all. For people facing homelessness, in contact with the criminal justice or immigration systems, or experiencing other forms of multiple exclusion, this crisis is a threat to life.

(also see specific guidance on 'All Our Health' from the Office for Health Improvement and Disparities (formerly Public Health England).

2. Prevention of Future Deaths reports

Figure 1 below sets out the numbers of PFDs identified for each year in which the person who died was homeless or precariously housed. It also identifies the numbers sent to housing authorities. In relation to housing authorities, it breaks down who received reports into Central/Local Government and the Third Sector. Readers should note that one PFD could be sent to a number of different recipients.

The reason it is important to divide recipients into housing and non-housing authorities is because this assists analysis of whether the PFD focuses on housing as a particular issue which requires action to save future lives, and the geographic scale which is focused on. As this research shows, six different housing authorities were identified as being in a position to take action to prevent future deaths in 2017-21. All of these were local/regional government. In 2023-25, in three years instead of five, there were eight PFDs in which Coroners addressed housing-related concerns to central government, as well as 15 different local authorities and five third sector organisations addressed.

More reports are identifying more issues at a national scale relating to housing in which action could be taken to save lives.

Figure 1: PFDs identified in the research

Year	PFDs	PFDs sent to housing authorities	Central Government	Local Government	Third sector
2017	2	1		2	
2018	3	0			
2019	6	2		2	
2020	3	1		1	
2021	4	1		1*	
2023	7	4		6*	1
2024	13	7	5	2	1
2025	18	9	3	7	3

* The Mayor of London and the West London Alliance are both counted as local government for these purposes

Variations between Coroner Areas

It is not easy to directly compare numbers of people dying while experiencing homelessness with PFDs connected to homelessness, partly because there can be a significant delay between when the death occurs and the publication of a PFD (as shown in Figure 1 below). For example, there were seven PFDs published in 2023 which related to deaths from August 2016 to May 2023.

However, it is possible to contrast the data with available regional data. There are some inquests in which more than one PFD is produced by the Coroner, and in the data set considered in this report, there were 39 PFDs relating to the deaths of 33 people between 2023-2025: one from Wales, and 32 from England. It is possible to use this data to make a rough comparison with the numbers of people who died while experiencing homelessness, as reported by the Dying Homeless project. They have identified that 3001 people have died while experiencing homelessness in England between 2022 and 2024, and provide breakdowns of where these deaths occurred.

It would be expected that there would be a correlation between the regional spread of people dying while experiencing homelessness and the numbers of PFDs published from each region

(note that percentages are rounded to the nearest whole number). However, there are significant differences in some regions. Figure 2 below sets out details.

Figure 2: PFDs by region between 2023-2025

Region	Name on PFD	Death	PFD	Coroner Area
North East	1. Andrew Naylor	2022	2024	Durham & Darlington
	2. Dean Bradley	2021	2025	Teesside & Hartlepool
North West	3. Tobias Mannering-Jones	2023	2024	Manchester South
	4. Colin Waterhouse	2023	2024	Manchester South
	5. Lee McHale	2023	2024	Manchester South
	6. Paul Williams	2024	2025	Manchester South
	7. William Bissett	2023	2025	Liverpool & Wirral
	8. Charlotte Tetley	2024	2025	Cheshire
Yorkshire & the Humber	9. Mollie Stansfield	2019	2023[1]	Kingston Upon Hull & East Riding of Yorkshire
	10. Benjamin Nelson-Roux	2020	2023	North Yorkshire & York
	11. Jason Myles	2024	2025	Kingston Upon Hull & East Riding of Yorkshire
East Midlands				
West Midlands	12. Andrew Bowles	2023	2023	Birmingham & Solihull
	13. Darren Doherty	2023	2024	Staffordshire & Stoke on Trent
South West	14. Callum Hargreaves	2024	2025	Cornwall & Isles of Scilly
	15. Christopher O'Donnell	2023	2025	Wiltshire & Swindon
	16. Gemma Weeks	2025	2025	Dorset
South East	17. Francis Williams	2023	2024	West Sussex, Brighton & Hove
	18. Axel Price	2021	2024	West Sussex, Brighton & Hove
	19. Matthew Sheldrick	2022	2024	West Sussex, Brighton & Hove
	20. Kirsten Hocking	2023	2024	West Sussex, Brighton & Hove
London	21. Lance Walker	2016	2023	West London
	22. Oleg Khala	2022	2023	Inner West London
	23. Igor Szalapski	2023	2023	Inner North London
	24. Sydney Piper	2023	2024	East London
	25. Emily Collishaw	2023	2024	Outer South London
	26. Joanita Nalubowa	2020	2024	Inner North London
	27. Jagjeet Singh	2024	2024	Inner North London
	28. Hayley Beavington	2024	2025	Inner North London
	29. Derrick Tully	2024	2025	Inner North London
	30. Alexi Susiluoto	2024	2025	Inner North London
	31. Jonathan Hamer	2024	2025	West London
East of England	32. Molly-Ann Sergeant	2020	2023	Essex
Wales	33. Marc Davies	2024	2025	Gwent

[1] Note that this PFD was issued on 19 December 2022 but was published on 4 January 2023 so is included in the 2023 figures

Strikingly, Manchester accounted for 2% of deaths (55 deaths between 2022-24) but 12% of investigations which gave rise to PFDs in 2023-25 (4 of 33). It is also striking that 115 people have died in Brighton in the period 2022-2024, 4% of the total in England, and there were 4 PFDs in the period 2023-25 (12%). 31% of deaths between 2022-24 were in London (935), and one third of PFDs were from London (11 of 33).

However, in the South East excluding Brighton, 359 deaths of people experiencing homelessness occurred (12% of deaths in 2022-24), and there have not yet been any associated PFDs. There were no PFDs from the East Midlands (162 deaths) and only one from the East of England where 230 people died in 2022-24.

Focusing on specific cities, there were no PFDs arising from deaths in Bristol (93 deaths identified in 2022-24), Southampton (49 deaths) Nottingham (40 deaths), Cambridge (40 deaths) Exeter (37 deaths).

Further research is needed into the relationship between the number of deaths of people experiencing homelessness in particular areas and the number of PFDs issued in those areas.

3. Common themes in reports

Housing/homelessness

The reports reviewed reveal growing concerns with homelessness prevention and issues relating to housing and homelessness. Coroners sent five reports to six public authorities with some responsibility for housing or homelessness in 2017-21 (four to local authorities and one to the Mayor of London). In 2023-25, 20 reports were sent to 28 public authorities or third sector organisations with responsibility for housing.

In some of these cases, issues were focused on a local level, including three reports which flagged concerns with **cuckooing** of tenants (Callum Hargreaves, Hayley Beavington & Derrick Tulley), but unlike the PFDs in 2021-23, many addressed concerns directly to national government, including with concerns including **affordability and availability of housing**. An example is the PFD relating to Lee McHale. He died as a result of multi-organ failure due to a paracetamol overdose, with a conclusion of suicide by the Coroner. The PFD, sent to the Ministry of Housing, Communities and Local Government (MHCLG), states that

> 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 [sic] 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.

It is notable that it is directly addressed to central Government rather than local government, and so is focused on the policy at a systemic level, rather than on the question of how it is implemented and administered locally.

Another PFD sent to MHCLG highlighted the challenges of living in unsuitable accommodation and bidding for alternative properties. It followed an investigation into the death of Colin Waterhouse, and the Coroner set out concerns 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.

Concerns with the impact of a lack of availability of housing were described in the PFD relating to the death of Paul Williams sent to MHCLG and published in January 2025. In it, the Coroner describes him as

> 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 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 housing situation … had a significant impact on his mental health and contributed to his deteriorating condition.'

Similar themes can be identified in the case of Callum Hargreaves, a young man who died in Cornwall, in a set of circumstances which prompted the Coroner to send 5 different PFD reports, one of which was sent to MHCLG and which focuses on housing allocation:

> The court heard that, as at January 2025, there were approximately 26,000 families registered on the Cornwall Homechoice Register which is the service for letting council and housing association homes to rent in Cornwall. The court also heard there may only be about 1,000 properties available to let annually. This has obvious implications for Cornwall Council's ability to provide accommodation for those who are homeless whether or not they present with priority needs. As matters of fact, it was established in evidence that there were long periods when Callum was homeless and further, that frustrations in relation to his housing situation contributed to his mental state at the time of his death.'

Once again, it is a shortage of public housing at a national level rather than the lack of housing locally or the local administration of their homelessness application which is the focus of the PFD, as both of these PFD are not addressed to the local authority who is responsible for administering the allocation of social housing, but to central Government.

Other nationwide issues are identified in the reports. For example, following an investigation into the death of another young man, Lance Walker, the Coroner identified the nationwide problem of unregulated accommodation for **18-21 year old care leavers**, which was inadequate to meet 'the complex needs of some of our most vulnerable individuals', who local authorities are duty bound to house.

Another example focused on **inflexibility in the system and a lack of perceived discretion.** This PFD related to the death of Joanita Nalubowa. She was living on Teesside, and was detained under the Mental Health Act. When it came to her release and where she should be provided with accommodation, there were very good reasons for her not to go back to Teesside – she had a family and support network in London, she was divorced from her former partner in Stockton and there were concerns he was abusive, she otherwise had few ties to the area to which she had said she would 'rather die than return'. The Coroner found that

> (6) It was clear to treating clinicians that securing the right accommodation was paramount to her mental health prognosis and to her future more generally.
>
> (7) It was clear to treating clinicians that surrounding the Deceased with a positive supportive network of family was crucial in maintaining mental health.
>
> (8) Despite all of the above, the existing framework/rules were such that all London boroughs, correctly applying the relevant criteria, rejected the Deceased's applications for accommodation in London.
>
> (9) The witness evidence was clear that there was no "discretion" and that London Boroughs and treating clinicians alike were powerless. The Deceased was therefore discharged to Stockton, against her wishes, against medical advice, away from her support network, and to an area where she would have to at best face her demons and at worst be in physical danger.

> (10) Shortly after being told she was being discharged to Stockton, the Deceased suspended herself using a ligature.

The Coroner stated that there was evidence at the inquest that

> this situation is not uncommon, with those detained under the MHA not infrequently having social circumstances such that their historical place of residency is, for whatever reason, deeply inappropriate (or even dangerous).

Mental health provision

A common theme was **an absence of adequate facilities to house or support individuals** experiencing poor mental health (sometimes temporarily for assessment).

For example, in the 2017-21 cases, in the case of Allan Joslin, in a report sent to NHS England, the Coroner found that there was 'no adequate mental health care facility or safe room to deal with a patient who presented with complex needs including the need for mental health assessment, and drug and alcohol dependency issues, who was also violent.' In the case of Georgie Nelson, a young woman 'who was likely to suffer with severe mental illness the whole of her life and was extremely vulnerable' and who had lived in supported housing 'longer than the allocated placement time … There was simply no suitable place for her to go.' The lack of a long term placement for Michael Cox was similarly at the centre of the PFD following his death; described as having a long history of mental illness, and living in a care home which had a zero tolerance policy to alcohol, the Coroner found there was a shortage of suitable placements for people similar to him.

In the cases from 2023-2025, further similar concerns were identified, as is illustrated by the PFD in the case of Jagjeet Singh sent to the Department for Health and Social Care (DHSC) and NHS England, in which the Coroner stated 'there is a chronic shortage of mental health beds and not just in London but nationally. It was described to me as a crisis.'

In other cases, concerns were expressed relating to **decisions to discharge individuals**. In the case of Matthew Jones, the inquest concluded with a narrative conclusion that his death was drug related but the discharge from hospital to accommodation which was not supported more than minimally, negligibly or trivially contributed to it. Similarly, concerns were set out in the PFD in the case of Charlotte Tetley, who – the Coroner found – was discharged by the bed management team despite concerns from doctors, and 'suffered a deterioration in mental health following a decision to remove her from the inpatient bed list on the 25 June 2024, and subsequent accommodation difficulties.' In the case of James Herbertson, when he was discharged from detention under the Mental Health Act, the Coroner found that 'both the initial accommodation offered and the accommodation at Grange Hotel were unsuitable for someone with the mental health and alcohol misuse issues that James had.'

Coroners highlighted the ways in which **intersecting characteristics including youth, sexuality and gender** might cause additional vulnerability in a series of cases involving the deaths of young people, including that of Georgia Nelson highlighted above. In the case of Bejamin Nelson-Roux, the Coroner noted that he was a victim of child criminal exploitation and a 'regular user of alcohol and drugs' who was placed in an adult homeless hostel, and the Coroner expressed concerns that the search for hostels did not extend beyond the county boundary and there was a lack of a residential substance misuse treatment unit for under 18s. In the case of Axel Price, a young trans man with mental health needs, the Coroner for West Sussex noted that while 'substantial changes have been made locally' national action on the transition from child to adult health and social care support was needed. In the PFD relating to the death of Tobias Mannering-Jones, a young gay man who also had need for mental health support, the Coroner identified 'a national picture of delays and long waiting lists for

those seeking help with their mental health', and expressed wider concerns about someone with the same characteristics as Tobias;

> 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.
>
> 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.

There were also numerous cases in which procedures and processes were identified which caused risks of future deaths for people in need of particular mental health support, which are discussed further below.

Care for those intoxicated

Concerns with protecting those individuals who had need for mental health support but were intoxicated were expressed in the case of Dean Bradley, where the Coroner stated that

> 1) Current resources for safeguarding those with mental health illnesses whilst intoxicated may be placing people at risk.
>
> 2) I heard evidence that a person who was suicidal, suffering with mental health concerns and was intoxicated could not be adequately safeguarded until he was sufficiently sober to allow a mental health assessment.

Other cases highlighted concerns about the approach of the police to people experiencing homelessness who were intoxicated, including the cases of Joseph Agnew in London and Eugeniusz Niedziolko in Wiltshire.

Release from prison

A concern that it was 'not apparent at the inquest that any help had been offered to the deceased with regards to accommodation following his release from prison' was expressed in the inquest into the death of Thomas Lear, while in the case of William Bissett, the Coroner set out concerns about the process for release from prison. The PFD in his case notes that he 'was informed that he would not be allowed to return home. No sufficient attempt was made to engage with Mr Bissett to discuss accommodation in the event that he was unable to find a place to live himself' and it was clear he had nowhere to go, but there was a lack of planning and lack of engagement which 'left Mr Bissett only with the knowledge that he would probably have to live the rest of his life separated from his wife. No attempt was made to help him come to terms with this reality.' In the case of Darren Doherty, the Coroner found that on his release from prison he had no accommodation, and this meant he was unable to be referred to mental health support services or access a GP.

Kirsten Hocking died the day after she was released from prison. The Coroner found that she needed a specialist rehabilitation placement, and

> For women like Kirsten, who self-harm, rehabilitation accommodation is very scarce. She was a part of a cohort for whom there is a real gap in provision. In this case,

> Kirsten was lucky. She able to secure a specialist placement. However, the offer was fragile and the extent of that fragility was not properly communicated and understood. There was therefore insufficient focus on Kirsten's need to reduce her self-harming. The placement was withdrawn, just a month prior to release. There was then insufficient focus on the reality that another specialist placement was unlikely to be found and so non-specialist accommodation would need to be identified with a network of support built around that. In the end, alternative non-specialist accommodation was sought and found, but only a day prior to release, and with little support in place, and none over that first weekend. Kirsten had by then been seriously destabilised.

This relationship between prison release, homelessness and death is something which the Prisons and Probation Ombudsman has described as 'a considerable issue' (see here).

Concerns with procedures

In 2017-21, many PFDs identified highlighted very similar issues, commonly related to discharging people from prison or hospital treatment, including detention under the Mental Health Act, with PFDs sent to NHS Trusts, Central Government, HM Prison and Probation Service and police forces amongst others. In these, **failing to plan properly** or provide support as a result of **inadequate training** is a common theme, as for example in the PFD sent on 3 June 2019 to the Secretary of State for Health relating to the death of Matthew Jones which was concerned with an absence of appropriate training for clinicians and healthcare workers involved in the delivery of mental health services, and consequently, "a poor appreciation … of the importance of ensuring that 'housing' is part of any hospital discharge planning."

Some highlight **inadequate risk assessments**, as in the case of Mary Gwanyama where the informal risk assessments 'failed to place any weight on the impact on Mary of a discharge with an inchoate plan for her housing and arrived at an incorrect assessment of her risk.' Failures with planning and joint working are emphasised, such as in the PFD sent to Sussex Partnership NHS Trust in the case of James Herbertson which notes that housing is 'a matter for the local authority, but the Trust staff work with partner agencies in the planning for a s.117 discharge.' Similarly, in the case of Todd Salter, the PFD flags '[g]enerally poor engagement and collaborative working with both agencies and family alike', while others cite failures of coordination and sharing information and failures to refer, eg from homeless services to mental health services. **Record keeping** is a perennial concern identified, as is failure to collect appropriate evidence to inform decisions taken, including talking to those closest to the affected person, as is seen in the case of Toby Nieland; a person who the Coroner described as 'suffer[ing] from an advanced progressive addiction overlaid with a vulnerable personality amounting to a complex Dual Diagnosis – the significance of which was not appreciated and therefore not managed adequately or appropriately.'

In the cases from 2023-June 2025, many similar issues can be identified, for example a focus on **planning and risk assessment** in the case of Molly-Ann Sergeant, where a recent diagnosis of autism and risk of suicide was not fully taken into account when planning release from detention under the Mental Health Act. In the PFD relating to the death of Oleg Khala, the Coroner noted issues with processes in the Crisis Assessment and Treatment Team at Chelsea and Westminster Hospital, and a risk of inappropriate discharge, while in the case of Andrew Naylor, the Coroner noted that

> (1) There is no specific protocol or policy in place to ensure that patients are warned of the acute risk of respiratory depression and death following administration of the drug [REDACTED], should they drink alcohol or misuse drugs.

(2) There appears to be a lack of a joined up process between acute clinicians, alcohol and drug treatment teams, and mental health teams, to consider the safety of a discharge, and to ensure that crucial information relevant to risk is shared appropriately (which may also be, to an extent, hampered by a continuing inability to see each other's records), and whether discharge should be delayed or care stepped down, until a place of safety is identified, and to ensure that a robust safety plan is in place upon discharge.

(3) There was no consideration given by either the acute or mental health teams to contacting the deceased's family or friends, which may have provided an essential safety net in the absence of accessible professional support. The [Tees, Esk and Wear Valleys NHS Trust] are candid that work in relation to this issue is a work in progress and remains incomplete.

Similar issues with communication with the family of the deceased were noted in the case of Jonathan Hamer, along with concerns about the need to regularly review cases and ensure they are adequately prioritised.

Concerns with the **training and management of staff** were identified in a series of PFDs relating to the deaths of Igor Szalapski (the operation of Depaul's London Youth Hub), Mollie Stansfield (staff not understanding the process of implementing s.5(2) of the Mental Health Act 1983), Francis Williams (probation officers' management of IPP offenders), and Sydney Piper (support worker at Outlook Care Ltd). As in the case of Andrew Naylor – others identified concerns with **inadequately joined up processes and joint working** such as in the cases of Axel Price (links between child and adult mental health services) and Alexi Susiluoto, in which the Coroner noted a concern with 'two related issues:

a. That substance misuse and mental health treatment is routinely provided by different organisations, despite close interplay between these conditions and that this can result in significant complexities for agencies caring for the same patient. I understand that this aspect is part of the current review;

b. However, I also heard that the review is not taking into consideration the additional issues that arise when a patient with dual diagnoses is also homeless. Evidence presented at the inquest set out that this already complex situation is often compounded by homelessness, since individuals are often moved between temporary accommodation and therefore between different mental health trust and substance misuse providers. In Mr Susiluoto's case, this resulted in significant confusion as to who was providing his care and which local authority would fund potential substance misuse treatment.

Similarly, in the case of Emily Collishaw, the Coroner noted that

Emily's mother reported that it took some time for the organizations working with her daughter to agree their roles and that the degree of support was insufficient to maintain her physical health or promote abstinence over such a long period of six months before she died. The family felt that the referral for residential care should have been made earlier, especially as her housing situation was a risk to her health.

Many reports identified the need for improved **information sharing and record keeping**, including many of those already described above, and also Andrew Bowles, who was described as having 'an extensive mental health history with incidents of self-harm and suicidal intent' and who told paramedics and the triage nurse that he had been hearing voices that were telling him to hurt himself and others, but the mental health team were not able to access the records relating to this.

Errors/flaws with PFDs

A review of the PFDs sent, and responses to those PFDs, reveals some errors, including for example, PFDs being sent to the wrong recipient, for example in the case of Sydney Piper where the Coroner addressed concerns to London Borough of Waltham Forest:

> Mr Piper's death was the latest in a series of deaths investigated by this court in which homeless persons have died in tents and encampments in wooded areas along the A406 and the periphery of Epping Forest due to high risk behaviours including, but not limited to, crush injuries, fire, third party assaults and drug misuse. The monitoring and policing of such encampments is, in the view of the court, lacking which increases the risk of fatal harm.

In response, LB Waltham Forest state that they understand that the relevant land is owned and managed by the Corporation of London, but go on to explain how parks and open spaces are managed in the borough.

In some PFDs reviewed, Coroners demonstrate understanding of legislative requirements relating to housing and homelessness, but in others, understanding of relevant law and policy might have been more clearly evidenced in the PFD. For example, it is stated that they correctly applied 'the relevant criteria' in relation to Joanita Nalubowa's case (discussed above), but this is not clearly explained in the PFD, and nor is it precisely clear on what basis the local authorities asserted that they had no 'discretion' to provide housing for her (an issue which was disputed by the Secretary of State in her response). In another example, in the case of Vadims Aleksejevs, who died after living on a 'campsite' with other people experiencing homelessness, the Coroner stated that it was unclear 'if there is any statutory duty to house vulnerable individuals living on such campsites.'

Responses

Those who receive a PFD are required to provide a response (usually in the form of a letter) within 56 days (which can be extended).

In the PFDs between 2023 and 2025, there are some responses in all but one case (Lance Walker).

One PFD only has a partial response, as Essex Partnership NHS Foundation Trust has not replied to the PFD relating to the death of Molly Sergeant (Essex Council has), and sometimes responses from different recipients are combined (eg Andrew Bowles, Benjamin Nelson-Roux). It was unclear if all recipients have replied in the case of Francis Williams as recipients are (unusually) redacted, and sometimes the PFD is forwarded on to a more appropriate recipient (eg Lee McHale, in which DWP replied rather than MHCLG). Although the precise figure depends on the variables above, this is a response rate of over 95%.

In the PFDs from 2017-21, there are no responses at all to four of the reports (Thomas Lear, Martin Tilley, Eugeniusz Niedziolko and Heather Birchall), and a partial response in one (Lindsey Hassall, with no response from Change, Grow, Live), so there is a completed response rate of 72%. It is not possible to determine whether there were responses but these were not published or whether there were no responses.

The Preventable Future Deaths Tracker is an excellent resource for identifying numbers of responses generally, and it notes that for only around 60% of PFDs published are there a full set of published responses.

There is no power to oblige recipients to respond, or power to follow up on a failure to respond or failure to deal with all the issues in a given response. The only mechanisms for doing so

are via publicity (and the Chief Coroner publishes a list of non-respondents) or if issues arise in another subsequent inquest. This is why there is value in Coroners cross referring to potentially relevant PFDs to see if there are similar themes which might arise, as is evidenced in the PFD relating to Axel Price, in which the Coroner noted that

> Substantial changes have been made locally by Sussex Partnership Foundation NHS Trust around the transition of those from CAMBS to Adult health services **but looking at other Prevention of Future Death Reports this is not just a local issue.** There is a lack of national guidance and support in relation to the multi-agency approach that is needed to support those young people transitioning to adult health and social care services. Unless this is addressed nationally, sadly other deaths will occur.

This is clearly good practice and ought to be encouraged.

Reviewing responses, it is clear that in many instances, action has been taken in response to the concerns raised by the Coroner. In other instances, there is no action proposed, and in others, the response does not engage adequately with the concerns raised by the Coroner. Coroners cannot follow up in such instances, and there is no other official mechanism for doing so; with no way to scrutinise what action has or has not been taken following the exchange of correspondence.

Issues with the PFDs in the cases of Lee McHale and Joanita Nalubowa are set out in the associated short policy report, and it is clear that many responses address only part of the concern raised by the Coroner or pass responsibility elsewhere. However, given the range of recipients and the lack of data relating to actions actually taken in individual instances (as opposed to what is included in the response provided to the Coroner), this research does not purport to evaluate the efficacy of actions taken in response to reports generally. Campaigners have long called for a national oversight mechanism, and their concerns about the limitations with the system (including failures to response and failures to take action) have been echoed in research (see Bremner et al 2023). If implemented, it will be important to ensure that this system specifically includes the need to carefully scrutinise reports relating to the deaths of people experiencing homelessness. There are also very good arguments for going further, and providing a mechanism which can compel responses and call/recall witnesses to scrutinise action taken or not taken following receipt of a PFD. It will also be important to ensure the system is clearly connected to other relevant investigatory systems, for example, Safeguarding Adult Reviews.

Role of the family of the deceased and others ('chosen family')

In every single PFD considered in this research, copies of the PFD were sent to members of the family (in a very few cases, redaction makes it impossible to confirm that they were immediate family members but there are indications in the reports that there was evidence from family and so it is reasonable to presume they were sent the PFD).

It is not possible to state definitively whether this means that in each case considered, the family were involved in the inquest itself, or were sent a copy but did not otherwise take part in the hearing. In some instances, PFDs refer to evidence provided by family (see for example, the PFD relating to Emily Collison), while in others, there is insufficient detail in the PFD to determine either way (for an example, see the PFD relating to Darren Doherty). However, research has shown that family often play a key role in the inquest process, including through raising potential lines of concern for the Coroner to investigate, receiving disclosure and asking questions in the inquest (Kirton-Darling 2022).

People who are homeless are more likely to be estranged from their family. Statistics show that being asked to leave accommodation by family or friends is consistently one of the most

common causes of homelessness amongst those who approach the local authority for assistance and are determined to be entitled to some form of assistance. Domestic abuse and non-violent relationship breakdown are also identified as significant causes of homelessness, and research has highlighted the ways in which

> family and other 'anchor' social relationships – argued to be an especially important 'buffer' to homelessness – can be put under considerable strain by the stressors associated with poverty in the household. There is also now extensive international evidence on the interrelationship between poverty and domestic violence, which in turn is a key trigger for homelessness amongst women and children. Thus people facing poverty may find their social as well as material capital depleted, while also being more likely to experience personal circumstances that lay them open to homelessness, again reinforcing the potential interconnectedness between structural and more personal or interpersonal causes of homelessness. (Bramley & Fitzpatrick 2018, references omitted)

Coroners have discretion (which must be lawfully exercised) to permit anyone with a sufficient interest to be involved in an inquest – and some Coroners have stated in academic research interviews that they might be more likely to do so if there was no one who fell into the categories of family automatically entitled to be involved (see Kirton-Darling 2022). In a case of a death of someone who was experiencing homelessness, given the likelihood that family might not have been closely involved in their lives, it is more likely that there are good arguments for others close to the deceased to be granted interested person status, whether or not family members are willing to be involved. For an example of a case in which a support worker was granted interested person status (where family was represented), see the PFD relating to Matthew Sheldrick (and also see the inquest into the death of Nonita Grabovskyte as an example of an NGO being granted interested person status). However, there is anecdotal evidence of individuals (such as support workers) not being permitted to take part in the inquest.

4. Recommendations

The Chief Coroner should:

- Ensure that the reports published in the PFD database can be organised by reference to the wider determinants of health identified by Marmot (2010; 2020) and inclusion health groups to enable them to more clearly connect to public health policy and practice. While this is being developed, a homelessness/precariously housed tag should be created on the PFD database. The PFD database should also be further improved to enable organisations and individuals to sign up to email alerts relating to specific areas.
- Ensure there is specific training for Coroners and their officers on the law, policy and practice relating to housing and homelessness which should promote consistency and ensure reports are as focused and effective as possible. This training should explore trauma and deaths of despair drawing from the Dying Homeless project, as well as the implications for the investigation process of the prevalence of breakdowns with traditional family relationships amongst people experiencing homelessness.
- Develop guidance supporting cross-referencing of reports, in order to strengthen reports and identify where responses to previous concerns addressed the issues raised or alternatively had not reduced risks or had created new risks. This guidance should also address cross-referencing with local Safeguarding Adult Review findings, to ensure that systems to identify issues which might prevent future deaths are as closely integrated as possible (Coroners might, for example, ask local Safeguarding Adult Boards for details of relevant recommendations relating to issues raised in an investigation).

Most **Coroners** have not issued any reports relating to a person experiencing homelessness. Given the clear evidence connecting homelessness/precarious housing and preventable deaths, all Coroners should reflect on their statutory responsibilities and seek to identify risks of future deaths for people experiencing homelessness or in precarious housing. All Coroners should include the date of death when writing a PFD where it is possible to ascertain this.

Central Government should implement proposals for a National Oversight Mechanism and should prescribe that the new system includes specific focus on the deaths of people experiencing homelessness. It should additionally consider means to enable the follow up and further scrutiny of issues identified in PFDs, and should work to ensure that training is provided for professionals involved in housing which sets out the issues identified in these PFDs, to seek to avoid similar circumstances arising in future.

The **Ministry of Justice** should consider how to improve data collection, and should require Coroners return details of housing status, as better statistical data would be available if Coroners were required to provide details of housing status in their statistical returns.

All recipients, including central government in particular must seek to ensure they address the root causes of issues raised in Prevention of Future Death reports.

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The Homelessness Monitor: https://www.crisis.org.uk/ending-homelessness/homelessness-monitor/

Appendix 1: PFDs of people experiencing homelessness

Note – shaded in grey = PFD sent to a housing recipient

2017-21

No.	PFD record no.	Name of deceased	Coroner / Area	PFD recipients	Date of report	Date of death (month/year)
1.	2017-0065	Vadims Aleksejevs	Hassan Shah Northamptonshire	Northampton Borough Council; Northampton County Council	03/03/2017	Nov-16
2.	2017-0429	Lindsey Hassall	Alison Mutch Manchester South	Pennine Care NHS Trust; Change Glow Live; Heaton Norris Health Centre	30/11/2017	Nov-16
3.	2018-0071	Martin Tilley	Caroline Saunders Gloucestershire	Gloucestershire Care Services NHS Trust	12/03/2018	Oct-17
4.	Not provided	Eugeniusz Niedziolko	David Ridley Wiltshire and Swindon	Wiltshire Police; South Western Ambulance Service; College of Policing; National Police Chiefs' Council Lead in relation to Mental Health	10/07/2018	Feb-17
5.	Not provided	Thomas Lear	Margaret Jones Stoke on Trent and Staffordshire North	Longton Police Station; Ministry of Justice	11/10/2018	Jan-18
6.	2019-0028	Tyrone Givans	Mary Hassell London Inner North	HMP Pentonville; Care UK; NOMS	23/01/2019	Mar-18
7.	2019-0140	Georgia Nelson	Fiona Wilcox London Inner West	Royal Borough of Kensington and Chelsea; Central and North West London NHS Trust	29/04/2019	May-18
8.	2019-0187	Matthew Jones	Emma Whitting Bedfordshire and Luton	Department for Health & Social Care	03/06/2019	Mar-18
9.	2019-0203	Michael Cox	Andrew Cox	Cornwall Council	20/06/2019	Apr-17

			Cornwall and Isles of Scilly			
10.	2019-0223	Heather Birchall	David Ridley Wiltshire and Swindon	Department of Health and Social Care	28/06/2019	Jun-18
11.	2019-0241	Allan Joslin	Lydia Brown Exeter and Greater Devon	NHS England	17/07/2019	May-18
12.	2020-0078	Joseph Mochan	Veronica Hamilton-Deeley Brighton and Hove	Brighton & Hove Council; Brighton & Hove Clinical Commissioning Group	25/03/2020	Dec-19
13.	2020-0134	Gary Etherington	Andrew Harris London Inner South	Oxleas NHS Foundation Trust	26/06/2020	Nov-18
14.	2020-0164	Toby Nieland	Timothy Brennand Lincolnshire	South Lincolnshire Clinical Commissioning Group; Lincolnshire County Council (Public Health Division); We Are With You charity; Lincolnshire Partnership NHS Foundation Trust	26/08/2020	May-18
15.	2021-0055	Joseph Agnew	Andrew Harris London Inner South	City of London Police; Metropolitan Police Service; College of Policing Units; Mayor of London	26/02/2021	Dec-16
16.	2021-0078	James Herbertson	Penelope Schofield West Sussex	Sussex Partnership NHS Foundation Trust	15/03/2021	Apr-19
17.	2021-0117	Mary Gwanyama	Caroline Topping Surrey	Surrey and Borders Partnership	21/04/2021	May-18
18.	2021-0281	Todd Salter	Nicola Mundy South Yorkshire East	National Probation Service	18/05/2021	Oct-19

2023-2025

No.	PFD record no.	Name of deceased	Coroner / Area	PFD recipients	Date of report	Date of death (month/year)
1.	2022-0408	Mollie Stansfield	Paul Marks Kingston Upon Hull & East Riding of Yorkshire	NHS England; Chief Coroner; Royal College of Psychiatrists; Royal College of Nursing; NHS Scotland; NHS Northern Ireland	19/12/2022	Jul-19
2.	2023-0062	Lance Walker	Lydia Brown West London	Department for Health & Social Care; Department for Education; London Borough of Ealing; London Borough of Islington; West London Alliance	19/01/2023	Aug-16
3.	2023-0078	Molly-Ann Sergeant	Sonia Hayes Essex	Essex Partnership NHS Foundation Trust; Essex County Council	19/02/2023	Oct-20
4.	2023-0103	Benjamin Nelson-Roux	Jon Heath North Yorkshire & York	Harrogate Borough Council; North Yorkshire County Council	23/03/2023	Apr-20
5.	2023-0231	Oleg Khala	Fiona Wilcox Inner West London	West London NHS Trust	06/07/2023	Jan-22
6.	2023-0423	Andrew Bowles	Ana Samuel Birmingham & Solihull	Sandwell and West Birmingham NHS Trust; Birmingham and Solihull Mental Health NHS Foundation Trust	31/10/2023[2]	May-23
7.	2023-0445	Igor Szalapski	Mary Hassell Inner London North	Depaul UK	13/11/2023	Apr-23
8.	2024-0143	Tobias Mannering-Jones	Alison Mutch Manchester South	Department for Local Government	14/03/2024	Feb-23
9.	2024-0145	Sydney Piper	Graeme Irvine East London	London Borough of Waltham Forest; Outlook Care Ltd	15/03/2024	Mar-23

[2] Note that this is incorrectly dated in part of the report published on the Chief Coroner website

10.	2024-0169	Francis Williams	Nick Armstrong West Sussex, Brighton & Hove	[Redacted]	27/03/2024	Jan-23
11.	2024-0197	Darren Docherty	Emma Serrano, Staffordshire and Stoke on Trent	HMP Stoke Health Local Authority for Stoke on Trent	14/04/2024	Aug-23
12.	2024-0195	Axel Price	Penelope Schofield West Sussex, Brighton & Hove	Department of Health and Social Care	15/04/2024	Apr-21
13.	2024-0248	Colin Waterhouse	Alison Mutch Manchester South	Ministry of Housing, Communities & Local Government	07/05/2024	Sep-23
14.	2024-0367	Andrew Naylor	Janine Richards Durham & Darlington	County Durham and Darlington NHS Foundation Trust; Tees, Esk and Wear Valleys NHS Foundation Trust	04/06/2024	Oct-22
15.	2024-0431	Emily Collishaw	Andrew Harris Outer South London	NHS England Department of Health and Social Care Ministry of Housing, Communities & Local Governments SE London Integrated Care Board	27/06/2024	Sept-23
16.	2024-0356	Lee McHale	Alison Mutch Manchester South	Department for Levelling-Up, Housing and Communities	03/07/2024	Nov-23
17.	2024-0453	Joanita Nalubowa	Harry Lambert Inner London North	Ministry of Housing, Communities and Local Government	13/08/2024	Dec-20
18.	2024-0606	Jagjeet Singh	Melanie Lee Inner North London	NHS England; Department for Health and Social Care	04/11/2024	Mar-24
19.	2024-0617	Kirsten Hocking	Nick Armstrong West Sussex, Brighton & Hove	HMPPS Steps2Recovery	11/11/2024	May-23
20.	2024-0689	Matthew Sheldrick	Penelope Schofield West Sussex, Brighton & Hove	Sussex ICB	16/12/2024	Nov-22
21.	2025-0036	Paul Williams	Alison Mutch Manchester South	Ministry of Housing, Communities and Local Government	21/01/2025	Jul-24

22.	2025-0046	William Bissett	Nicholas Rheinberg Liverpool & Wirral	HMP Wymott; HM Prison & Probation Service	27/01/2025	Oct-23
23.	2025-0087	Jason Myles	Paul Marks Kingston Upon Hull & East Riding of Yorkshire	East Riding of Yorkshire Council Highways Dept	14/02/2025	Feb-24
24.	2025-0097	Hayley Beavington	Mary Hassell Inner North London	North London NHS Foundation Trust	20/02/2025	Sep-2024
25.	2025-0164	Derrick Tully	Melanie Lee Inner London North	London Borough of Islington Council; Daryel Care	28/03/ 2025	Mar-24
26.	2025-0185	Alexi Susiluoto	Richard Brittain Inner London North	Parliamentary Under-Secretary of State for Public Health and Prevention; Parliamentary Under-Secretary of State (Minister for Homelessness and Democracy)	04/04/2025	May-24
27.	2025-0184	Jonathan Hamer	Lydia Brown West London	South West London and St George's Hospitals NHS Trust	10/04/2025	Apr-24
28.	2025-0263	Callum Hargreaves	Andrew Cox Cornwall and Isles of Scilly	Cornwall Council (Care and well-being)	28/05/2025	Jan-24
29.	2025-0259	Callum Hargreaves	Andrew Cox Cornwall and Isles of Scilly	Ministry of Housing, Communities and Local Government	28/05/2025	Jan-24
30.	2025-0260	Callum Hargreaves	Andrew Cox Cornwall and Isles of Scilly	Sanctuary Housing	28/05/2025	Jan-24
31.	2025-0261	Callum Hargreaves	Andrew Cox Cornwall and Isles of Scilly	Cornwall Council (Housing)	28/05/2025	Jan-24
32.	2025-0262	Callum Hargreaves	Andrew Cox Cornwall and Isles of Scilly	NHS Cornwall Isles of Scilly ICB	28/05/2025	Jan-24
33.	2025-0248	Dean Bradley	Clare Bailey Teesside & Hartlepool	Department of Health and Social Care; Integrated Care Board (NHS North East and North Cumbria);	28/05/2025	Oct-21

				Tees Esk and Wear Valley NHS Mental Health Foundation Trust; Middlesbrough Council; Stockton Council; Hartlepool Council; Redcar Council		
34.	2025-0369	Christopher O'Donnell	Ian Singleton Wiltshire & Swindon	Home Group Limited	21/07/2025	Dec-23
35.	2025-0428	Gemma Weeks	Brendan Allen Dorset	Secretary of State for the Home Department; Secretary of State for Health And Social Care; Secretary of State for Education	19/08/2025	Jan-25
36.	2025-0466	Charlotte Tetley	Sarah Murphy Cheshire	Chief Executive of Cheshire and Wirral Partnership NHS Trust	14/09/2025	Sep-24
37.	2025-0465	Charlotte Tetley	Sarah Murphy Cheshire	Chief Constable of Cheshire Police	14/09/2025	Sep-24
38.	2025-0525	Marc Davies	Caroline Saunders Gwent	Monmouthshire County Council; MJ Events	20/10/2025	Oct-24

Appendix 2: the law

The definition of homelessness

Section 175 of the Housing Act 1996 provides that

> (1) A person is homeless if he has no accommodation available for his occupation, in the United Kingdom or elsewhere, which he—
>
> > (a) is entitled to occupy by virtue of an interest in it or by virtue of an order of a court,
> >
> > (b) has an express or implied licence to occupy, or
> >
> > (c) occupies as a residence by virtue of any enactment or rule of law giving him the right to remain in occupation or restricting the right of another person to recover possession.
>
> (2) A person is also homeless if he has accommodation but—
>
> > (a) he cannot secure entry to it, or
> >
> > (b) it consists of a moveable structure, vehicle or vessel designed or adapted for human habitation and there is no place where he is entitled or permitted both to place it and to reside in it.
>
> (3) A person shall not be treated as having accommodation unless it is accommodation which it would be reasonable for him to continue to occupy.

It goes to define 'threatened with homelessness', stating that a person will be threatened with homelessness if it is likely that they will become homeless within 56 days.

Section 176 provides further detail on the meaning of accommodation available for occupation, providing that

> Accommodation shall be regarded as available for a person's occupation only if it is available for occupation by him together with—
>
> (a) any other person who normally resides with him as a member of his family, or
>
> (b) any other person who might reasonably be expected to reside with him.
>
> References in this Part to securing that accommodation is available for a person's occupation shall be construed accordingly.

Section 177 provides that it is not reasonable to continue to occupy accommodation where it is probable that this will lead to violence or domestic abuse against a person or those who reside with them, and further that, when considering if it would be reasonable to continue to occupy, 'regard may be had to the general circumstances prevailing in relation to housing in the district of the local housing authority to whom he has applied for accommodation or for assistance in obtaining accommodation.'

Guidance is given on how to interpret and apply the test in the Homelessness Code of Guidance, Chapter 6: Homeless or threatened with homelessness.

Referrals to Coroners

The Coroners and Justice Act 2009, s.18 provides the power for Government to make regulations about when doctors must notify Coroners about a death.

By virtue of this, the Notification of Deaths Regulations 2019, SI 2019/1112 (see R.3) provide that registered medical practitioners must notify the Coroner if they suspect the death was due to:

> (i) poisoning, including by an otherwise benign substance;
>
> (ii) exposure to or contact with a toxic substance;
>
> (iii) the use of a medicinal product, controlled drug or psychoactive substance;
>
> (iv) violence;
>
> (v) trauma or injury;
>
> (vi) self-harm;
>
> (vii) neglect, including self-neglect;
>
> (viii) the person undergoing a treatment or procedure of a medical or similar nature; or
>
> (ix) an injury or disease attributable to any employment held by the person during the person's lifetime;

They must also notify if the death does not fall into any of these categories but they suspect the death was unnatural; if the cause of death is unknown; if they suspect that the person died while in custody or otherwise in state detention; if they reasonably believe there is no attending practitioner or the attending practitioner is not available to sign off the death; or if they are unable to ascertain the identity of the person who died.

Alternatively, under the Medical Certificate of Cause of Death Regulations 2024, SI 2024/492, a death might be referred to a Coroner by an attending practitioner who is not able to establish the cause of death (R.3(1)(b)(ii)), or it might be referred to the Coroner by a medical examiner (R.10).

Note that regulations may change and readers ought to check to ensure the provisions as described above are still in force at the time of reading before relying on them. For example, various amendments (reflected in the discussion above) were made by the Cremation, Coroners and Notification of Deaths (England and Wales) (Amendment) Regulations 2024, SI 2024/668.

Investigations by Coroners and the requirement to hold an inquest

The Coroners and Justice Act 2009 provides that a coroner must conduct an investigation if they have reason to suspect that (s.1(2)):

> (a) the deceased died a violent or unnatural death,
>
> (b) the cause of death is unknown, or
>
> (c) the deceased died while in custody or otherwise in state detention.

If the cause of death becomes clear during that investigation, and before the inquest hearing has begun, the coroner must discontinue the investigation if they think it is not necessary to continue (this doesn't apply where the death is violent, unnatural or in state custody) (s.4).

If the investigation is not discontinued, the coroner must hold an inquest (s.6).

The duty to report to prevent future deaths

The duty on Coroners to report is contained in paragraph 7 of Schedule 5 of the Coroners and Justice Act 2009. It provides that:

> 7 (1) Where—
>
> (a) a senior coroner has been conducting an investigation under this Part into a person's death,
> (b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and
> (c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,
>
> the coroner must report the matter to a person who the coroner believes may have power to take such action.
>
> (2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.
>
> (3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner.

Further provision in relation to this duty is made in Part 7 of the Coroners (Investigations) Regulations 2013, SI 2013/1629. In Regulation 28, this provides that

> (1) This regulation applies where a coroner is under a duty under paragraph 7(1) of Schedule 5 to make a report to prevent other deaths.
>
> (2) In this regulation, a reference to “a report” means a report to prevent other deaths made by the coroner.
>
> (3) A report may not be made until the coroner has considered all the documents, evidence and information that in the opinion of the coroner are relevant to the investigation.
>
> (4) The coroner—
>
> > (a) must send a copy of the report to the Chief Coroner and every interested person who in the coroner's opinion should receive it;
> >
> > (b) must send a copy of the report to the appropriate Local Safeguarding Children Board or as the case may be the appropriate Safeguarding Children Board (which have the same meaning as in regulation 24(3)) where the coroner believes the deceased was under the age of 18; and
> >
> > (c) may send a copy of the report to any other person who the coroner believes may find it useful or of interest.
>
> (5) On receipt of a report the Chief Coroner may—
>
> > (a) publish a copy of the report, or a summary of it, in such manner as the Chief Coroner thinks fit; and
> >
> > (b) send a copy of the report to any person who the Chief Coroner believes may find it useful or of interest.

While Regulation 29 provides that

(1) This regulation applies where a person is under a duty to give a response to a report to prevent other deaths made in accordance with paragraph 7(1) of Schedule 5.

(2) In this regulation, a reference to “a report” means a report to prevent other deaths made by the coroner.

(3) The response to a report must contain—

(a) details of any action that has been taken or which it is proposed will be taken by the person giving the response or any other person whether in response to the report or otherwise and set out a timetable of the action taken or proposed to be taken; or

(b) an explanation as to why no action is proposed.

(4) The response must be provided to the coroner who made the report within 56 days of the date on which the report is sent.

(5) The coroner who made the report may extend the period referred to in paragraph (4) (even if an application for extension is made after the time for compliance has expired).

(6) On receipt of a response to a report the coroner—

(a) must send a copy of the response to the report to the Chief Coroner;

(b) must send a copy to any interested persons who in the coroner's opinion should receive it; and

(c) may send a copy of the response to any other person who the coroner believes may find it useful or of interest.

(7) On receipt of a copy under paragraph (6)(a) the Chief Coroner may—

(a) publish a copy of the response, or a summary of it, in such manner as the Chief Coroner thinks fit; and

(b) send a copy of the response to any person who the Chief Coroner believes may find it useful or of interest (other than a person who has been sent a copy of the response under paragraph (6)(b) or (c)).

(8) A person giving a response to a report may make written representations to the coroner about—

(a) the release of the response; or

(b) the publication of the response.

(9) Representations under paragraph (8) must be made to the coroner no later than the time when the response to the report to prevent other deaths is provided to the coroner under paragraph (4).

(10) The coroner must pass any representations made under paragraph (8) to the Chief Coroner who may then consider those representations and decide whether there should be any restrictions on the release or publication of the response.

The Chief Coroner publishes reports at: https://www.judiciary.uk/prevention-of-future-death-reports/

The Chief Coroner's Guidance for Coroners on the Bench, including Chapter 16. Reports to prevent future deaths (PFDs) is available here: https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-for-coroners-on-the-bench/ and the Chief Coroner's guidance on PFDs is available here: https://www.judiciary.uk/guidance-and-resources/revised-chief-coroners-guidance-no-5-reports-to-prevent-future-deathsi/

Appendix 3: methodology

The analysis in this paper focuses on two periods: 2017-2021, and 2023-2025. Comparing these periods shows a 46% increase in all PFDs sent (from 2183 in 2017-21, against 1909 in 2023-25).

Defining homelessness and precariously housed

This research focused on individuals who fell within the statutory definition of homeless or threatened with homelessness in the Housing Act 1996, to include those living in emergency accommodation and those who face imminent eviction, and uses the term 'precariously housed' to seek to make this accessible to a non-legally trained audience. However, it should be noted that it is very challenging to determine from the available details in PFDs whether or not individuals who are in accommodation might be homeless because it is accommodation which it would be unreasonable for them to continue to occupy within the definition in s.175(3) of the Housing Act 1996. It has been necessary to exercise judgment, and in a small number of cases where the details in the PFD suggested that the individual was in accommodation which was a serious risk to their health in some way, the PFD has been included in the dataset, but it is not possible in every case to definitively conclude that the individual would have been determined to be homeless within the statutory definition based on the available information. It should also be noted that it is likely that there will be cases which have been missed which might fall into this category because of the lack of detail on this point.

Defining housing authorities

For the purposes of this research, I have identified housing authorities as those public or private organisations who have explicit housing duties or carry out functions which are directly related to providing homes for individuals. I have therefore included local governments where the PFD was addressed generally to the local authority or was addressed to those within the local authority who exercise housing functions, but not where it was addressed to other parts of a local authority (eg the public health or care and wellbeing teams). I have also included regional organisations/bodies which exercise housing functions. At national level, I have included central government departments with direct housing responsibilities (primarily the Ministry for Housing, Communities and Local Government, although this government department has changed names during the periods covered by the research), and it has also included third sector organisations where the PFD suggested they provided housing.

2017-21

To analyse reports specifically relating to homelessness, a researcher coded every PFD from 1 January 2017 to 31 December 2021. These reports are made public by the Chief Coroner, but the contents are not searchable. The researcher identified every PFD where there was any reference to homelessness or some form of precarious housing situation, with examples including living in a hostel or temporary accommodation, and 60 PFDs fell into this category. These were further sifted, to identify whether the deceased might be described as homeless, in emergency accommodation, or threatened with homelessness at the time of their death, and 18 cases were identified as falling within scope. A clear limitation of the data is reliance

on what details Coroners include in their reports, and some could have been missed where homelessness was not discussed.

Sifting of the data set required the exercise of judgment, for example in cases where the deceased was described as having been evicted in the days before their death with no reference as to where they were then living, where they were described as due to lose their home in the future or were described as homeless but currently in state detention (those on remand or due to be released were included). Those in long term supported housing were only included if there was something in the PFD to indicate this was not going to continue (for example a reference to the deceased being reluctant to move to a new supported housing placement).

In addition, the author searched for all PFDs sent to the Ministry of Housing between 1 January 2017 and 31 December 2021. There were 7 results. None of these cases related to homelessness or housing precarity.

2023-25

PFDs published after 1 January 2023 can be searched for specific terms, and the database to 31 December 2025 was searched for the following terms:

Search term	**Number of records between 2023-2025**
Homeless	25
Accommodation	103
Eviction	9
Sleeping rough	6
Ministry of Housing (note that the Chief Coroner's office has helpfully categorised PFDs sent to the Department for Levelling Up, Housing and Communities between 2021 and 2024 as letters to MHCLG)	19
Threatened with homelessness	0
Lose his/her/their home	0
Total	**162***

*note that some PFDs appear in more than one search

Once again, a limitation of this data is that cases where homelessness is not discussed will not be picked up, and in addition, cases where a different forms of words is used will not appear in this data set. The results of the above search terms were sifted, with (for example) cases excluded where the deceased was described as living in long term supported accommodation having been previously homeless, or where the deceased was killed by someone who was homeless. 38 reports were identified as being cases where the deceased was homeless or precariously housed.

Further details

The initial five year period was selected in order to provide a large multi-year data set for analysis. The later period was chosen on the basis that it was possible to search the text of the PFDs.

In both periods, the relevant date used for inclusion was the date the report was published by the Chief Coroner, not the date the report was made by the Coroner. In the period 2017-21, it was not unusual for there to be a considerable lag between these dates, but no PFDs issued in 2016 met the sift criteria in any event. In the later period, as part of the administrative improvements made by the Chief Coroner, the delay between making and publishing a PFD has significantly reduced, with most reports published very shortly after they are made by an individual Coroner.