

for Leicester (City and South)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: Mr Norman Lamb Minister of State for Care and Support Department of Health Richmond House 79 Whitehall London SW1A 2NS
1	CORONER
	I am Mrs C E Mason, Senior Coroner for Leicester (City and South Leicestershire)
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST
	On 07/10/2014 I commenced an investigation into the death of Brenda Kathryn Gabrielle Leyland, 63 . The investigation concluded at the end of the inquest on 20 March 2015. The conclusion of the inquest was Suicide.
4	CIRCUMSTANCES OF THE DEATH Brenda Leyland was found deceased in a hotel room at the Marriott Hotel, Leicester on the 4th October 2014. She had recently been upset by public exposure in the media and had been researching ways to end her life. The cause of death was 1a) Asphyxia Inhalation of helium and 2) Citalopram toxicity. The deceased was able to buy helium gas freely and had bought two canisters for the purpose of committing suicide.
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) That helium gas is freely available in canisters and there appears to be no controlling measures on how many canisters can be bought by an individual.
	(2) The size of the helium canisters are of large volume.(3) There is no modified control valve attached to the canisters hich would restrict the volume of gas being released.

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.

I understand that a Regulation 28 letter was sent to you from the Area Coroner of Birmingham and Solihull on the 9th July 2014 regarding concerns into the death of Mr David Reginald Giles to which he received a reply from you on the 10 September 2014 referring him to another Regulation 28 letter you had received regarding the death of Matthew Satterthwaite (by the Manchester Coroner) and that the response to Mr Giles' death was pertinent. In that letter (undated) you say that 'officials continue to work with relevant organisations to explore other options to reduce the risk associated with helium supplied by members' and that you could not confirm what the other options might be at that time as they were still being considered. Please now indicate to me how you have proceeded with this work with relevant organisations and whether you are now in a position to reduce the risk posed by the supply of helium.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 15 May 2015. 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 and Sky News

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 20 Mareh 2045

Signature Mrs CE Mason Senior Coroner for Leicester (City and South)