HM Coroner
County of Cumbria
Regulation 28

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Secretary of State for Health Matt Hancock**
1	**CORONER** I am Dr Nicholas Shaw Assistant Coroner for **County of Cumbria**
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/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 08/09/2020 I commenced an investigation into the death of Lee ELLIOTT. The investigation concluded at the end of the inquest 25th November 2020. The short form conclusion recorded was Suicide and the record of inquest was as follows: "Lee Elliott died at his residence [redacted], Workington on 6th February 2020. He had been troubled by mental health symptoms for a few months, had previously expressed suicidal ideation, and was being treated for depression by his general practitioner. He purchased [redacted] which he ingested causing his death". Medical Cause of death was 1a [redacted] Poisoning
4	**CIRCUMSTANCES OF THE DEATH** Lee Elliott had appeared to have been struggling with his mental health for a few months, he had admitted to an attempt to hang himself late in 2019, was reported at times to have had some possibly psychotic symptoms and received a severe head injury which he declined to explain. He was seeing his GP regularly and being treated with antidepressant medication. At his last GP appointment shortly before he died he denied ongoing suicidal ideation. However on 6th February 2020 he was found deceased in his bedroom. Two glasses were found, one empty and the other half full of a pale yellow liquid. There was a handwritten note next to the glass which read, 'DON'T DRINK, POISON SORRY LOVE YOU ALL'. There was an arrow on the note pointing to the fluid in the glass. An empty packet labelled "[redacted] Extra – pure 99.9%" along with packaging indicating a purchase using [redacted] from a company in the south of England was recovered by the police who attended. A further consignment of this chemical was delivered to Lee's home the following day from Poland. Examination of Lee's [redacted] search terms relating to various suicide methods including [redacted] poisoning. THE ABOVE INFORMATION HAS BEEN PROVIDED BY THE POLICE
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. –

	[BRIEF SUMMARY OF MATTERS OF CONCERN] (1) [redacted] is being advocated by [redacted] easily found on the [redacted] as a reliable and pain free way of taking one's life. Often advice is given on the use of prescription medications to take to minimise any nausea caused when a solution of this substance is drunk. Links can be found to discussion groups which may encourage vulnerable and sick people to attempt to take their lives. (2) [redacted] [and other toxic substances] are easily and cheaply obtainable in small amounts by [redacted] purchase with no safeguards. (3) I am aware the senior coroner for West Yorkshire [East] issued a regulation 28 report to you in September referring to the death of Joseph Nihill who died in similar circumstances. I wish to echo all the concerns raised in that report, and also advise that I am to hear an inquest in the new year touching on the death of a young female student who whose medical cause of death has also been given as [redacted] Toxicity.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 14th January 2021 . 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. [redacted], Lee's parents 2. Mr Kevin McLoughlin, senior coroner for West Yorkshire (East) 3. Ms Nadia Persaud, senior coroner for East London 4. Mr [redacted], Metalchem Ltd, 492 Falmer Road, Brighton BN2 6LH 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	26/11/2020 Dr Nicholas Shaw Assistant Coroner **County of Cumbria**