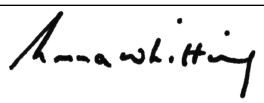
Senior Coroner - Emma Whitting
Bedfordshire & Luton
REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: Secretary of state, Rt Hon Oliver Dowden CBE MP Department for Digital, Culture, Media & Sport 100 Parliament Street London SW1A 2BQUnited Kingdom
1	**CORONER** I am Emma WHITTING, Senior Coroner for the area of Bedfordshire and Luton Coroner Service
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 Thirteenth August 2019 I commenced an Investigation into the death of Jerrelle MCKENZIE aged 21. The investigation concluded at the end of the inquest on Fourteenth July 2020. The conclusion of the inquest was Drug related. Ia Drug Overdose
4	**CIRCUMSTANCES OF THE DEATH** The Deceased was admitted to Luton & Dunstable Hospital during the early evening of 3 August 2019, having admitted to taking an overdose of **Dinitrophenol tablets (DNP**). Despite appropriate treatment, his condition deteriorated and he passed away there later that evening; his death being confirmed at 21:00 hours. Post-mortem evidence confirmed a DNP blood level of approximately 76 mg/l which it appeared he had accessed over the internet (dark-web) in an attempt to lose weight and improve his body image.
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) The Deceased had taken an overdose of **Dinitrophenol (DNP)** yet this drug was banned in the UK in 1938 due to its harmful effects; (2) It appears that the Deceased, who was an intelligent and thoughtful individual, was drawn to consuming **DNP** to lose weight and improve his body image and it was believed that this was through the influence of social media; (3) Despite its ban, it is thought that the Deceased was able access the **DNP** over the Internet ("dark web")

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you Secretary of State 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 11 September 2020. 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 Deceased's family. I have also sent it to [redacted] of **The Food Standards Agency, National Food Crime Unit** who may find it useful or of interest. I am also under a duty to send the Chief Coroner a copy of your Response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	 Emma WHITTING Senior Coroner for Bedfordshire and Luton Coroner Service Dated: 17 July 2020