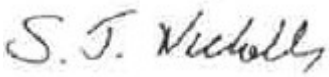
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Levelling Up.** **2. Secretary of State for the Home Office.**
1	**CORONER** I am Stephen John Nicholls, Assistant Coroner, for the Coroner Area of Dorset
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 25th April 2022, an investigation was commenced into the death of David Honnor, born on the 3rd March 1946. The investigation concluded at the end of the Inquest on the 24th August 2022. The Medical Cause of Death was: 1a Asphyxia. The conclusion of the Inquest recorded Suicide.
4	**CIRCUMSTANCES OF THE DEATH** **The deceased was diagnosed with oesophageal cancer in 2021. He underwent radiotherapy treatment. His conditioned worsened in 2022, he had a stent fitted in March 2022. On the 21st March 2022 he attended hospital and had a chest X ray. He was asked to return to the hospital later that day. He had obtained a [redacted] gas cannister, how and when is not clear. [redacted] with the intention of ending his life.**

5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are as follows: 1. During the inquest evidence was heard that: i. Mr Honnor had researched on the internet how to obtain a [redacted] gas cannister with a view to ending his life. ii. It is not known when or where he purchased this item. iii. There is no restriction on members of the public purchasing these items. iv. Separate consideration needs to be given to the labelling and colouring of gas cylinders to enable emergency services to respond to any risk arising at an incident. v. The police found the vehicle with Mr Honnor in and the cannister. They removed him to commence CPR. The officers put themselves at risk in entering the vehicle which contained the gas cannister. Evidence was heard at the inquest from a police inspector that officers attending emergencies need to be able to identify gas cannisters by colour coding. vi. The gas cylinder had the following labelling: [redacted] and details the warnings of gas under pressure, odourless and asphyxiation- do not inhale. Non-in-flammable, Non -toxic Gas2 with an emergency phone number. 2. I have concerns with regard to the following: i. I have concerns that members of the public are able to purchase or acquire [redacted]. ii. I have concerns that these products should be licensed. iii. I have concerns that there is no colour coding of gas cylinders to assist first response emergency services. iv. I have concerns as to whether the safety information on these gas cannisters is clear and sufficient.

6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or 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, 25th October 2022. 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] 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** **30th August 2022**	**Signed**  **Stephen J Nicholls**