REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Home Secretary**
1	**CORONER** I am Philip Barlow, assistant coroner, for the coroner area of Northamptonshire
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 29 March 2018 I commenced an investigation into the death of Jack Knapman, age 21. The investigation concluded at the end of the inquest on 13 December 2022. The conclusion of the inquest was a narrative conclusion that Jack died as an unintended consequence of taking dinitrophenol (DNP) for weight loss and body-building.
4	**CIRCUMSTANCES OF THE DEATH** 1. On 21 and 22 March 2018 Jack took a substantial quantity of Dinitrophenol (DNP) [redacted] for the purpose of losing weight and body-building. He developed severe toxicity and was admitted to Northampton General Hospital. Despite treatment he suffered a cardiac arrest from which he could not be resuscitated and he died shortly after 1am on 23 March 2018. 2. The inquest received evidence from the National Food Crime Unit (NFCU) and from an expert in DNP poisoning. Most of the sale of DNP is on-line. The Food Standards Agency had become aware of Jack's purchase of DNP and there was an admitted delay in sending him a letter warning of the risk, although it was not possible to conclude that this made a material difference to the outcome. 3. The evidence was that, at the time of Jack's death, there were delays in identifying sites selling DNP, getting them taken down, obtaining lists of customers, and sending warning letters to those customers. It is important to recognise that new policies are now in place at the NFCU which provide for more effective action and timescales.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – DNP is a highly toxic substance. It should never be used for human consumption. Nevertheless some people do use it to assist with weight loss and body-building. There have been many deaths associated with the use of DNP and it has been the subject of previous Prevention of Future Death Reports from coroners. The inquest heard that the number of deaths associated with the use of DNP has fallen but that the risk of further deaths remains for as long as it continues to be available and used for human consumption.

	The inquest was told that, following recent consultation, the Home Office intends to add DNP to the list of regulated poisons as an amendment to the Poisons Act 1972. The evidence at the inquest was that this would be a welcome action to help reduce its availability. However, after DNP is categorised as a poison it seems that it is not clear which organisation or Department of Government should have responsibility for monitoring and preventing its sale for human consumption. This would include identification of sites offering it for sale, investigation and enforcement. My concern is that a lack of clarity on this issue might delay an effective response to any site advertising DNP. This would clearly put lives at risk.
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 7 February 2023. 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. Mr and Mrs Knapman 2. Food Standards Agency 3. Health Security Agency 4. Northampton General Hospital 5. Northamptonshire Police I have also sent it to [redacted] who gave evidence and may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**16 December 2022** **Philip Barlow**