REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Rt Hon James Cleverley MP, Secretary of State for the Home Office (Border Force) The Rt Hon Victoria Atkins MP, The Secretary of State Department of Health and Social Care The Rt Hon Lucy Fraser KC MP, The Secretary of State for Culture, Media and Sport OFCOM [redacted], Vice President and Managing Director, Google UK & Ireland [redacted] Vice President and UK & Ireland Manager Amazon UK Assistant Chief Constable [redacted], British Transport Police, National lead for suicide prevention at The National Police Chiefs Council
1	**CORONER** I am Paul Rogers, HM Assistant Coroner, for the Coroner Area of Inner West London
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 5th December 2023 evidence was heard touching the death of Chloe Elizabeth MACDERMOTT. She died on 23rd May 2021 aged 43 years. **Medical Cause of Death** I (a) [redacted] toxicity **How, when, where Chloe Elizabeth MACDERMOTT came by her death:**

	Chloe Elizabeth Macdermott had been struggling with her mental health for some years prior to her death. She became increasingly suicidal and researched ways to end her life [redacted]. On or about 21st May 2021 she formed an association with two other persons with whom she planned to end her life. She had purchased [redacted] using Amazon US. On 22nd May 2021 whilst her husband was away from home, she contacted the persons she had discussed committing suicide with and an agreement was made to act that night. Chloe and one other person in a different part of the UK ingested [redacted] around midnight between 22nd and 23rd May 2021. Chloe died in the early hours of 23rd May 2021 from the effects of [redacted] toxicity on her bed in her home [redacted] r **Conclusion of the Coroner as to the death:** Suicide
4	**Circumstances of the death:** Extensive evidence was heard by the court in the form of written and oral evidence, including expert evidence. Of particular significance for the purpose of this report are the following matters: (1) Chloe was able to purchase the product used over the internet and have it delivered to her home in the UK. Enquiries showed the product was purchased using Amazon in the United States. (2) [redacted] and other such forums encourage suicide, assist it by provision of information about suicide methods, counsel suicide by providing information about it and thereby potentially facilitate the commission of a criminal offence in the United Kingdom.
5	**Matters of Concern:** (3) [redacted] is a forum that permits material to be exchanged and viewed within its open chatrooms whereby suicide is encouraged, assisted, counselled and procured through the provision and exchange of information and methods. (4) [redacted] (5) No age or other restrictions are in place to prevent access to children, vulnerable teenagers and vulnerable adults. (6) No prominent signposting is in place to organisations from whom help is available to prevent suicide. (7) Posts are made by users containing details of methods of suicide without any effective administration to remove such harmful content.

	(8) [redacted] (9) The availability of [redacted] through the internet and its delivery to individual users in the UK with a non-commercial or agricultural use. (10) The ability for UK users to purchase [redacted] through Amazon in the United States and to take delivery in the United Kingdom without effective border and/or custom controls.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. It is for each addressee to respond to matters relevant to them.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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: The Family of Chloe Macdermott The Metropolitan Police Central NWL NHS Trust [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	**19th December 2023**

	Paul Rogers **HM Assistant Coroner Inner West London** **Inner West London Coroner's Court** **33 Tachbrook Street** **London SW1P 2ED**