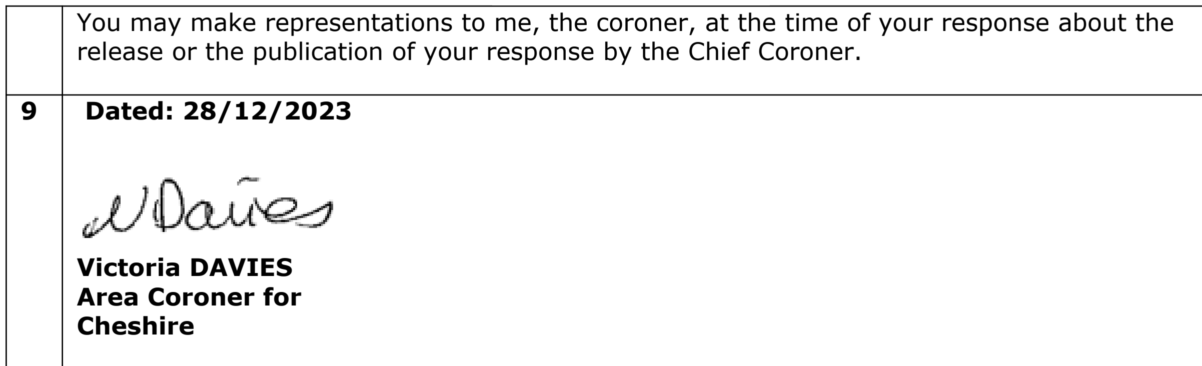
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **Department for Health and Social Care** **National Crime Agency** **Department for Science, Innovation & Technology**
1	**CORONER** I am Victoria DAVIES, Area Coroner for the coroner area of Cheshire
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 17 November 2017 I commenced an investigation into the death of Adrian Brendan GALLAGHER aged 24. The investigation concluded at the end of the inquest on 19 December 2023. The conclusion of the inquest was that: This was a death due to suicide.
4	**CIRCUMSTANCES OF THE DEATH** Adrian Gallagher had a history of mental health struggles dating back to 2013, with no definitive diagnosis. On 12 June 2017 he was admitted to Hollins Park Hospital as an informal patient, but was discharged at his request on 16 June 2017. The same day, he was taken to hospital having been found intoxicated at a bridge, with suicidal ideation. He was formally sectioned under the Mental Health Act the following day and re-admitted to Hollins Park. During the admission, Adrian's condition appeared to stabilise with changes to his medication, and he was allowed long periods of unescorted leave. By August 2017 he was awaiting a bed at Lea Court, a rehabilitation unit, and was spending the majority of the day away from the hospital. His presentation during this period did not give the hospital team or his parents cause for concern in relation to self harm/ suicidal ideation. On 9 November 2017 Adrian returned to hospital following a period of leave at his father's house. No concerns or changes to his presentation were noted. Sadly, he was found deceased in bed the following morning, with his death confirmed at 08.50 on 10 November 2017. His death was due to an intentional overdose. Police interrogation of Adrian's phone after his death identified that on 12 September 2017 he made a purchase from . It is not clear from the phone records what that purchase was, but it was the evidence at the inquest that the most likely purchase was . It was the evidence of the attending police officer that, although not easy to do, you can also buy pentobarbital through the site.

5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) [redacted] is available to anyone to purchase online, directly from the company. The company appears to have some link to the UK as there is a UK helpline number. The [redacted] appears to provide step by step instruction on how to end your life using certain methods, including how to make the death appear to be due to natural causes and therefore avoid referral to the coroner. Whilst the introduction suggests it is aimed at those who are elderly and long-term suffering, there is also reference to suicide for other reasons within the book and is likely to appear to vulnerable mental health patients. According to the evidence of the police officer, you can also buy drugs to end your life through this website. The only check on age and ID appears to be after a purchase, to allow you access to online forums where you can get further advice on best methods. The [redacted] has been banned in Australia (and possibly other countries) as it is deemed to encourage/ assist in suicide. The [redacted], in some format, is also available on Amazon (and I am writing to Amazon directly to flag this).
6	**ACTION SHOULD BE TAKEN** In my opinion 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, namely by February 22, 2024. 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 Mr Gallagher's family Mersey Care NHS Foundation Trust 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 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 by the Chief Coroner.
9	**Dated: 28/12/2023**  **Victoria DAVIES** **Area Coroner for Cheshire**