	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **National Crime Agency** **Department for Science, Innovation & Technology**
1	**CORONER** I am Ms Emma Hillson, Assistant Coroner for the coroner area of Cornwall and the Isles of Scilly.
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 7th July 2023, I commenced an investigation into the death of Guy Douglas Scotchford. The investigation concluded at the end of the inquest on 30th January 2024. I recorded the cause of death as 1a) Asphyxiation My conclusion as to the death was as follows: Suicide

4	**CIRCUMSTANCES OF THE DEATH** Guy Scotchford had a long history of mental health problems with chronic suicidal ideation and believed he was suffering from a condition called Mast Cell Activation Syndrome, something he had researched extensively. This impacted on his day-to-day health and well being. He had a complex past medical history to include depression, [redacted] addiction and chronic multi system, medically unexplained symptoms of unclear cause. There had not been a formal diagnosis of Mast Cell Activation Syndrome as there was minimal evidence to reach this but he was under specialist care provided by the Clinical Immunology Department at Derriford Hospital who were providing valuable advice and guidance to manage his symptoms. Guy had previously disclosed to his sister, GP and Mental Health Services that he had researched ways to end his life and at one stage stated he had a plan in place but that he did not intend to act on those plans. He had some contact with mental health services and engaged in 3 intervention sessions with Wellbeing Coaches in October 2022 following which he reported feeling better. His final contact with the Mental Health Connect team was on 15th May 2023 when he reported ongoing chronic suicidal ideation. He agreed to contact with his GP and a safety plan was discussed. A review was held with his GP on 31st May 2023 at which time his physical and mental health was discussed at length. There was no change in his chronic suicidal thoughts, and he was keen to explore treatment and support for his condition. He declined any referral for further mental health or psychology services at that time. Guy contacted his sister on the telephone in the early hours of 1st July 2023 and his opening comment was that he loved her. She stated that she would call him later. On attempting to contact him later that morning she was unable to get a response and raised a concern for welfare. Police officers attended his home address and he was found deceased in the bath. His death was confirmed at 15:24 on 1 July 2023. His death was due to Asphyxiation. Police Officers at the scene located a printed 60-page document at his home address titled "[redacted]" which had been printed from a website - [redacted]. [redacted]. Police enquiries confirmed that this company received and delivered an order and they also provided a copy invoice dated 28/04/2022.

5	**CORONER'S CONCERNS** During the course of the investigation, the evidence has 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. It was clear from the evidence of the investigating officer that the website ([redacted] is still active and from this website a [redacted]" can be downloaded. This document gives a direct link to a company from which [redacted] can be purchased in the UK and home delivered. The police investigation determined that this named company did receive and supply that order. The downloaded document provides step by step instruction on how to end your life with specific advice and direction on the use of certain equipment. The investigating officer made a recent internet search of this website which states that it provides practical DIY information to enable readers to take control over their own life and death. This website is available to anyone to access online.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 27 March 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 Guy Scotchford's family. I am also under a duty to send the Chief Coroner a copy of your response and all interested person who in my opinion should receive it.

	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	**31 January 2024**  **Signature** **Emma Hillson** **Assistant Coroner for Cornwall and Isles of Scilly**