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:** **1 Department for Health and Social Care, National Suicide Prevention Strategy Advisory Group** **2 Department for Science, Innovation and Technology**
1	**CORONER** I am Miss Laurinda Bower, HM Area Coroner for the coroner area of Nottingham City and Nottinghamshire
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 11 May 2023, I opened an inquest touching the death of Bethany Paige Langton, aged 22 years. The inquest concluded on 8 July 2024. The conclusion of the inquest was that Beth had died by suicide.
4	**CIRCUMSTANCES OF THE DEATH** On 18 February 2023, Bethany Paige Langton was discovered deceased inside her bedroom at [redacted], having died following the ingestion of [redacted] which she had sourced online in January 2023. Beth had used the internet to research how to die using [redacted] and followed the advice she had found online. Beth deliberately ingested the substance with the intention of bringing about her death. Beth was vulnerable having been diagnosed with complex mental health diagnoses.
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: 1. The continued ease of availability of [redacted] to members of the public. The substance is lethal when ingested, even in relatively small quantities. It's use in suicide is increasing. The substance is readily available to purchase online without the need for any explanation of the purchaser's intended use for the substance, or an end user certificate/licence to track where it is being distributed. 2. Lack of awareness amongst businesses that the substance is being obtained for this purpose.

	The company who supplied Beth with the [redacted] used in her death, had no idea that the substance might be sourced by individuals for this purpose. Had they have been aware of the risk, they would likely have improved systems for investigating the intended use, or would have stopped offering the item for sale to individuals, as they have now done so. 3. Beth used the internet to research how to source and use [redacted] to bring about her death. She followed that guidance meticulously. That same guidance was still readily available on the internet at the time of her inquest, although I believe it might now have been removed. What system is in place to ensure that such websites are detected promptly and made unavailable to the public in a timely fashion?
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 Thursday 26 September 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 [redacted] **This report is shared with the recipients in unredacted form, but any published version of this report shall be redacted to avoid the risk of becoming a source of information available on the internet about this substance** 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: 30 July 2024**

	 **Miss Laurinda Bower** **HM Area Coroner** **Nottingham City and Nottinghamshire**