

IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Hannah Mary AITKEN
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: 1. [REDACTED] Home Secretary 2. [REDACTED] Secretary of State for Health and Social Care
1	CORONER Ms Anna Loxton, HM Assistant Coroner for Surrey
2	CORONER'S LEGAL POWERS I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	INVESTIGATION and INQUEST Hannah Mary Aitken died on 14 th September 2023, aged 22. Her inquest was opened on 28 th September 2023. Evidence was heard between 30 th September and 4 th October 2024 and Findings and Conclusion were given on 7 th November 2024. I recorded a conclusion of Suicide. I found the medical cause of death to be: 1a. [REDACTED] 2. Autism, Attention Deficit Hyperactivity Disorder, Anxiety and Depression
4	CIRCUMSTANCES OF THE DEATH On 14 th September 2023, Hannah Aitken died at her supported accommodation in Caterham, Surrey, from an overdose of a poisonous substance, namely [REDACTED] which she had obtained [REDACTED] with the intention of ending her life from a company [REDACTED]. Miss Aitken confirmed with the company by email on 30 th August 2023 that she intended to use this for [REDACTED]. The substance was recorded as delivered on the afternoon of 14 th September. Miss Aitken was

	subsequently heard to call out to her support workers for help, stating she had taken an overdose. She would not provide details of the substance and had hidden the packaging. She became unresponsive and subsequently suffered cardiac arrest, from which she could not be resuscitated despite prompt attendance and efforts from South East Coast Ambulance. Miss Aitken had a long-standing mental health background of autism spectrum disorder and attention deficit hyperactivity disorder, requiring extensive periods of inpatient admission, and was under the care of the Tandridge Community Mental Health Recovery Service, Surrey and Borders Partnership. Miss Aitken detailed an intention to end her life in a notebook, which was written some weeks prior to her death at around the time of ordering the substance. This was located on her bed after her death.
5	CORONER'S CONCERNS [REDACTED] The Court heard anecdotal evidence from three Emergency Medical Consultants and others witnesses that in their direct experience, the use of [REDACTED] for self-harm is increasing. However, none were aware of a central monitoring system which is able to record incidents of [REDACTED] poisoning. [REDACTED] are reportable substances under the Poisons Act 1972. The only obligation under this legislation is that domestic sellers must report reasonable grounds for believing transactions are suspicious. There are no restrictions on the import of [REDACTED] from abroad. Since 2020, the Home Office has received at least five Prevention of Future Death Reports relating to [REDACTED]. The Home Secretary has recently provided reassurance in response to the Regulation 28 report relating to the death of Dr Jonathan Shaw that <i>"the Home Office is actively exploring legislative and policy options, including working with or alongside officials of other Government Departments as appropriate, for the control of [REDACTED] (and other similar substances)"</i>. The Home Office has clarified in evidence during this inquest that the policy objective of the Poisons Act 1972 is to control access to explosives

	precursors and poisons and to detect terrorist use of these substances to illicitly manufacture explosives or to cause harm to third parties. Prevention of suicide/self-harm is not a policy objective of the Home Office under this Act, and this falls under the remit of the Department for Health and Social Care. No evidence was provided that there is active consideration of controlling access to these substances to the general public, whether under the remit of the Home Office or any other Government department. Whilst these substances have legitimate uses, including [REDACTED] [REDACTED] there does not appear to have been consideration as to whether the purity can be diluted, or any other measures taken, to reduce the risk posed by the quantities in which these substances are currently sold, against the risk to life that they can pose. The MATTERS OF CONCERN are: - [REDACTED] can be purchased domestically with no restrictions save a duty on sellers to report suspicious transactions; - [REDACTED] can be purchased from abroad and imported to Great Britain with no restrictions; [REDACTED] - The quantities and purity in which [REDACTED] are sold do not appear to be those required for their legitimate use, for example in [REDACTED] - It does not appear there is any consideration of regulating/monitoring the use of [REDACTED] outside the limited provisions of the Poisons Act 1972, and it is not clear which Government department would be responsible for this. Consideration should be given to whether any steps can be taken to address the above concerns.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
7	YOUR RESPONSE

	You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	COPIES I have sent a copy of this report to the following: 1. See names in paragraph 1 above 2. [REDACTED] and [REDACTED] c/o [REDACTED] [REDACTED], Associate Solicitor, Leigh Day, Panagram, 27 Goswell Road, London EC1M 7AJ [REDACTED] 3. The Chief Coroner In addition to this report, I am 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 at the time of your response, about the release or the publication of your response by the Chief Coroner.
	Signed: ANNA LOXTON DATED this 14th day of November 2024