REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], Chief Executive OFCOM Riverside House 2a Southwark Bridge Road London SE1 9HA The Department for Science, Innovation and Technology 100 Parliament Street London SW1A 2BQ
1	**CORONER** I am Kirsten Heaven, Assistant Coroner, for the coroner area of SWANSEA & NEATH PORT TALBOT
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 7 March 2025 an inquest was heard into the death of Rhiannon Auriol Mary Williams. The medical cause of death was: 1a Asphyxia 1b Combined Drug Toxicity and Neck Ligature and Submersion II Selective Serotonin Inhibitors Withdrawal The conclusion of the inquest was: Suicide
4	CIRCUMSTANCES OF THE DEATH Rhiannon Auriol Mary Williams was age 24 at the time of her death. Rhiannon was an exceptionally bright, talented and creative person who excelled academically and who was loved and supported by her family. Rhiannon's mental health deteriorated at a time when she suddenly stopped taking SSRI medication and a result, she experienced withdrawal symptoms which caused anxiety. Rhiannon was also concerned that she may have autism spectrum disorder, and her counsellor

	documented that she was displaying traits of this disorder. For at least a year prior to her death and possibly longer Rhiannon experienced suicidal thoughts. From May 2023 Rhiannon's suicidal thoughts and distress worsened although the full extent of Rhiannon's thoughts and distress was kept hidden from her family. In the months before her death Rhiannon started researching websites relating to suicide and in the month of her death, Rhiannon undertook a Tik Tok search of 'drowning in the bath'. On 15 September 2023 Rhiannon accessed a website called [redacted]. This website describes itself as a community that discusses mental illness and suicide from the perspective of suicidal people, as well as the moral implications of the act itself and actively encourages people to commit suicide. It also encourages individuals to hide their thoughts and actions from their loved ones. There is no moderation of this website. Rhiannon used this website to download a detailed document entitled '[redacted] guide' which describes in detail how to use these medications to bring about death. There is evidence that Rhiannon used the internet to obtain [redacted]. There is also evidence that Rhiannon had written down and practised the method that she eventually used on the day of her death – information also likely obtained from the above website / social media. On 16 September 2023 Rhiannon was found [redacted]. Toxicology findings confirmed the presence of [redacted] at an elevated level which would have had a sedatory effect and likely impairment of Rhiannon's respiration.
5	**CORONER'S CONCERNS** During the inquest the evidence revealed matters giving rise to a 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 make a report under paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. The **MATTERS OF CONCERN** are as follows – Rhiannon accessed an online 'suicide forum' where she was able to access information on how to take her own life and where she obtained advice/information on misleading professionals and her family as to her thoughts and intentions. Rhiannon also accessed a social media platform to obtain information about the method Rhiannon used to take her own life. A similar concern was raised by Patricia Harding Senior Coroner for Central and South East Kent in a Prevent Future Death report of 2019 raising a similar concern in respect of 'suicide forums'. The response from the Department for Digital, Culture, Media & Sport of 14 January 2020 referred to The Online Harms White Paper. I am aware of The Online Safety Act 2023 and also BBC reporting -https://www.bbc.co.uk/news/uk-67082224 - touching upon whether this Act is in fact sufficient to deal with the risks posed by 'suicide websites'. I am concerned about the risk to life posed by the website and social media platform considered in this inquest and so draw them to your attention.
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 **7th May 2025.** 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 Rhiannon Williams. 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	12 March 2025