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** [redacted] Secretary of State for the Home Department Home Office 2 Masham Street LONDON SW1P 4DF
1	**CORONER** I am Mr Timothy W Brennand, HM Senior Coroner for the coroner area of Manchester West.
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 14 August 2023 I commenced an investigation into the death of Andrew Alexander Roger BROWN aged 45. The investigation concluded at the end of the inquest on 19 April 2024. The medical cause of death was determined to be: 1a [redacted] I returned a narrative conclusion that Andrew Alexander Roger BROWN died as the consequence of a self-administered quantity of [redacted] in circumstances where his intentions remain unclear. Reporting restrictions were imposed in this case because of an ongoing criminal investigation in the United Kingdom, Europe and the United States of America, the case being one of a cluster of eight similar cases upon the Greater Manchester West jurisdiction. Reporting restrictions were lifted on the 19th of April 2024. This report is being published following updates from Greater Manchester Police and suicide prevention organisations received on the 14th of March 2025.
4	**CIRCUMSTANCES OF THE DEATH** Between January and June 2023, for reasons that could not be established, the deceased had acquired and retained amongst his possessions at his residence, at least 3 consignments of the registered poison [redacted] obtained on the internet. He had a medical history that included episodic mixed anxiety and depressive disorder, his relapse profile being linked to dysfunctionality within his domestic matrimonial circumstances. On the morning of the 9th of August 2023, the deceased was discovered by a family member, collapsed and unresponsive within the bedroom of his residence at [redacted], Wigan. Paramedics attended promptly, establishing the deceased to be dead and beyond attempted resuscitation.

A Greater Manchester Police investigation concluded there to be an absence of evidence that supported a viable suggestion of there being third party involvement or suspicious circumstances in the case. Beyond an 'Advanced Decision to Refuse Treatment' document found by paramedics on the deceased's bed, no direct evidence of the deceased's intent was recovered or could be identified from the evidence secured at the scene or otherwise.

A forensic post mortem examination established the sole cause of death to have been [redacted] toxicity, albeit the evidence could not establish either directly or by inference in what quantity, at what time, in what circumstances and for what reason the deceased had self-administered an amount of [redacted] that could be presumed to have been dissolved in liquid and thereafter ingested at his own hand. Of a number of possible inferences that could be drawn as to his intentions, including his actions being influenced by illogical, strange and disordered thinking in the context of emotional dysregulation arising from his personal circumstances and mental health history, the more likely factor that motivated his actions was a manifestation of fleeting, ill-considered, irrational self-harming ideation acted out as a means of displaying a desire for rescue and help, the deceased naively failing to appreciate or understand the potential lethality of ingestion of even a modest quantity of [redacted] his death being an inadvertent and unintended consequence of his deliberate actions.

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)

1. [redacted] is a reportable poison as well as a reportable explosives precursor within the terms, meaning and effect of Part 4 of Schedule 1A of the Poisons Act 1972 with the consequence that:
a. The Poisons Act 1972 sets out the legal obligations in relation to the sale, purchase, and use of these chemicals for suppliers, professional users and members of the public.
b. The published Guidance (commenced in 2014 and updated in August 2024) does not give specific guidance or suggested training to sellers, particularly [redacted] acquired by members of the public, particularly over 'online marketplaces' in circumstances of the purchase on a 'one off' basis for the means of self-harming.
c. Whilst there is a legal duty on persons selling this substance to report "suspicious" transactions within 24 hours to the Home Office, the purchase of small quantities is being presumed to be connected to the many legitimate uses of the substance (such as food preservation, fertilizer etc) rather than in fact, being evaluated as a member of the public seeking purchase of modest quantities used as their chosen means by which to end life.
d. The current Home Office guidance and supporting video, leaflet and posters do not reference [redacted] as a specific example of concern and focuses on the phenomenon of 'malicious' misuse and not deliberate misuse in the sense of suicide/self-harm.

2. The police investigation into one UK based source of supply revealed in 247 cases separate supplies of 500 grams of less of [redacted] to customers in the UK and Europe, police established that 85 of these individuals who were traceable had either died as the consequence of self-ingestion of the substance, or had purchased it with a view to having the means to use this method to end

	their life in circumstances where: a. the vendors of the [redacted] were not aware of this potential misuse of the substance. b. the small quantities being purchased had been incorrectly evaluated to be an increase in individuals pursuing recreational home-curing/food preservations as a hobby, being an artefact of 'lockdown' living following the COVID national pandemic emergency. c. Vendors were unaware that their website/details were being distributed as part of internet information platforms designed to aid, abet, assist or promote suicide methods. 3. The police investigation revealed the ability of members of the public to access a number of websites, primarily created in the USA, Canada and Mexico that promoted information as to how to access: a. Poisons that could bring about death b. How, in what way and with with other necessary preparations (in particular -antiemetic medications) the poisons should be administered. c. Sourcing such poisons/chemicals/medications in the Uk and abroad.
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 May 16, 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 1. The family of Andrew Alexander Roger BROWN 2. HHJ Alexia Durran – The Chief Coroner of England and Wales Chief Coroner's Office 11th Floor, Thomas More Building Royal Courts of Justice Strand LONDON I have also sent it to Greater Manchester Mental Health Greater Manchester Police Shevington Surgery who may find it useful or of interest. 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: 23rd May 2025**  **Mr Timothy W Brennand** **HM Senior Coroner for** **Manchester West**