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** An Investigation into the death commenced on the 8th of Janaruay 2021 and an Inquest heard before me on the 2nd of December 2022 that concluded the Investigation. The medical cause of death was determined to be: 1a [redacted] toxicity I returned a narrative conclusion that Chantelle Williams died as the consequence an unknown quantity of recently self-administered [redacted] in circumstances where her 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** The deceased had a complex medical history that included previously diagnosed Bi-Polar Affective Disorder, Obsessive-Compulsive Disorder, Emotional Unstable Personality Disorder, Post Traumatic Stress Disorder, Schizoaffective Disorder and recently had been diagnosed to be suffering from Autistic Spectrum Disorder. She had a long history of treatment and care by her local Mental Health Trust that had included phases of both conservative community-based treatment and intensive crisis resolution home based treatment with 8 previous phases of both voluntary and involuntary hospital in-patient treatment and care. Her presentations had included enduring self-harming thoughts and actions with persistent suicidal ideation, previous overdose, impulsivity and emotional dysregulation, and auditory, visual and olfactory hallucination with pseudo-hallucinations within psychotic relapse phases that were diagnosed to be both trauma-induced and associated as a manifestation of her

	obsessive-compulsive disorder. The deceased had been in receipt of regular depot anti-psychotic medication. Following her acquiring a quantity of [redacted] from an internet-based source, she had deliberately ingested a significant, but non-fatal dose on the basis of her using this substance as a form of self-harm in October 2019 culminating in her voluntary informal admission to the Keats Ward of the Meadowbrook Unit of Salford Royal Hospital, Stott Lane, Salford on the 26th of November 2019 where she received ongoing active care, supervision, treatment and monitoring. Had the deceased sought to be discharged or attempted to leave without clinical approval, it is likely that she would have been detained pursuant to the provisions of the Mental Health Act 1983 because of her assessed high risk of self-harm. In February 2020, the deceased had acquired a further quantity of [redacted] whilst on ward and self-ingested a small quantity by reason of an act of self-harm, informing healthcare staff of her actions resulting in medical intervention. A multidisciplinary team review meeting interpreted that she was using such overdoses as a method of communicating her ongoing distress. Healthcare staff were aware of the deceased's ongoing possession of [redacted] and the high risk of self-harm with significant risk of deliberate or inadvertent overdose and her presumed or known possession of [redacted] was managed conservatively by reason of the deceased's status as a voluntary inpatient who had been continually assessed to have capacity. On the 29th of May 2020 at approximately 6.45am the deceased was observed in her room on Keats Ward in a collapsed, unresponsive and cyanosed condition. She was being observed hourly and had last been seen alive at about 6am. An immediate 'crash call' was made but she failed to respond to attempted resuscitation and was verified as dead at 7.20am that morning. Post-mortem samples from the deceased revealed the presence of fatally toxic levels of both [redacted] and [redacted], likely from a single batch of [redacted] the deceased had previously sourced, retained and hidden. The evidence does not establish the precise quantity or time she ingested the [redacted] but was analysed to be at levels that would rapidly, within minutes, precipitate unconsciousness, hypoxia and cardio-respiratory failure. The deceased had, incidentally, been properly prescribed promethazine – a sedating antihistamine to assist her sleep, that would also have produced an antiemetic effect. Police recovered no note or evidence of her intentions and were able to establish no suspicious circumstances or third-party involvement.
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 Chantelle Williams 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 Police Greater Manchester Mental Health 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**