Coroner ME Hassell
HM Senior Coroner
Inner North London

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Advisory Council on the Misuse of Drugs, 4th floor NE Quarter, Peel Building, 2 Marsham Street, London, SW1P 4DP** **2. [redacted], Office for Health Improvement and Disparities, Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU**
1	**CORONER** I am Sarah Bourke, HM Assistant Coroner, for the coroner area of Inner North London
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 29 September 2024, Assistant Coroner Stevens commenced an investigation into the death of Frederick Ireland-Rose aged 30 years. The investigation concluded at the end of the inquest on 9 January 2025. The conclusion of the inquest was: *Mr Ireland-Rose died in hospital on 19 September 2024. Prior to his death, he had taken cannabis, and some medications sourced from outside the UK. It is unclear how he came to ingest a nitazene substance or whether he knowingly did so. It is possible that the nitazene was ingested by vaping.* I returned a conclusion that Mr Ireland-Rose's death was drug related. The medical cause of death was: 1a Hypoxic brain injury 1b Acute opioid toxicity (N-Pyrrolidino isotonitazene).
4	**CIRCUMSTANCES OF THE DEATH**

	Mr Ireland-Rose had a history of opiate misuse. He was using cannabis and cannabinoid vapes to enable him to withdraw from opiates. He had been abstinent from opiates for about 10 days prior to his death and was well-motivated to remain opiate free. On the afternoon of 15 September 2025, Mr Ireland-Rose was found unresponsive at his home with a vape in his hand. Paramedics were called and managed to resuscitate him using advanced life support techniques. He remained unconscious and was taken to hospital. His sedation was removed soon after admission and he never regained consciousness. A CT scan of his brain demonstrated diffuse hypoxic ischaemic encephalopathy which was not compatible with extended life. Mr Ireland-Rose died in hospital on 19 September 2024. Mr Ireland-Rose was known to purchase cannabinoid vaping fluids online from unknown sources outside the UK. Toxicology analysis found N-pyrrolidino isotonitazene at a level of 0.37 ng/ml in a sample of Mr Ireland-Rose's blood. The Toxicologist reported that this is "a potent synthetic opioid" which is "thought to be similar or greater in potency to isotonitazene which is estimated to be approximately 20 times more potent than fentanyl". The Toxicologist also reported that "nitazenes are illicit synthetic opioids which have recently emerged in the heroin supply in the UK". There was no evidence to suggest that Mr Ireland-Rose had used street heroin prior to his death. The Toxicologist confirmed that nitazenes can be ingested from a vape and that they have been detected in refillable vapes and vapes bought illicitly.
5	**<u>CORONER'S CONCERNS</u>** During the course of the inquest the evidence 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 use of nitazenes as an adulterant to street heroin is well known. The presence of nitazenes in vaping fluids is less well known. (2) The level of nitazenes ingested by vaping will vary enormously depending on the frequency and extent of inhalations taken by the user. Consequently, the potential risk of overdose is significant. (3) Public health measures are in place through statutory and voluntary sector drug misuse services to inform heroin users of the risks of nitazene adulteration. Cannabinoid vape users will often not be known to drug services and therefore may not be aware of the risks posed by nitazenes in vape fluids. (4) Drug services often issue Naloxone to be used in the event of an opiate/opioid overdose. Cannabinoid vape users may not be aware of Naloxone or may have problems accessing it.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 2 August 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 Family of Frederick Ireland-Rose 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. She may send a copy of this report to any person who she 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	**Sarah Bourke,** **HM Assistant Coroner** **6 June 2025**