



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	<p>Secretary of State for the Home Department Home Office 2 Masham Street LONDON SW1P 4DF</p>
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 30th of September 2020 and an Inquest heard before me on the 9th of August 2022 that concluded the Investigation. The medical cause of death was determined to be: 1a [REDACTED] toxicity I returned a narrative conclusion that Matthew Joseph O'Reilly died as the consequence of a deliberate act of recent self-ingestion on an unknown 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 On the 25th of September 2020, following concerns for his welfare having not responded to telephone calls, the deceased was discovered collapsed and unresponsive within his locked room at his student accommodation in [REDACTED]. He failed to respond to attempted resuscitation and was verified dead by attending paramedics. The deceased's postmortem samples revealed the presence of recently ingested, significant and fatally toxic levels of [REDACTED] The deceased had acquired a quantity of [REDACTED] from an unknown source delivered to his address several weeks earlier, but the precise circumstances, quantity or reasons for which the deceased had obtained and later ingested this chemical could not be established.



The samples also revealed the deceased to have recently consumed, at therapeutic levels, Ibuprofen and Metoclopramide, prescribed and used by the deceased to manage the symptoms of his diagnosed Crohn's Disease.

No evidence of previous or enduring low mood or self-harm was established, no letter or note of intent was discovered, with other evidence establishing contra-indicators to the deceased's actions being construed as an intentional act of self-harm.

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 or 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.
- d. From the specific example of 247 supplies in a 12 month period, police established that 45 purchasers were confirmed as deceased (these deaths were in relation to supplies to UK customers and purchasers from abroad) and only 15 purchases were confirmed to have taken place for legitimate purposes (meat curing etc.).

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 <ol style="list-style-type: none">1. The family of Michael Joseph O'Reilly2. 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 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