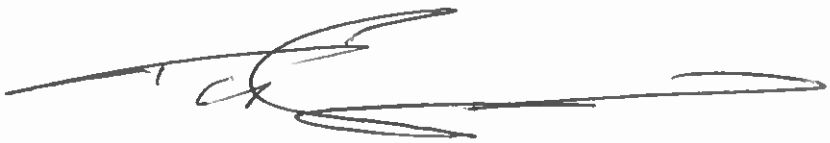
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

*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 04 September 2020 I commenced an investigation into the death of Samuel David Dickenson aged 33. The investigation concluded at the end of the inquest on 09 August 2022. The medical cause of death was determined to be 1a. [redacted] toxicity I returned a short form conclusion that Samuel David Dickenson died as the reuslt of suicide. 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 history of known episodic low mood, anxiety and depression that had been treated conservatively in the community. At 2.15am on the 11th of March 2020, North West Ambulance Service received a telephone call from the deceased, disclosing that he had recently consumed a quantity of [redacted] that he had acquired over the internet. Emergency services promptly attended at his residence at [redacted], Leigh and discovered the deceased, collapsed and unresponsive in his bedroom. Active resuscitation was commenced, and the deceased was transferred to Royal Albert Edward Infirmary, Wigan. He failed to respond to active and sustained further attempted resuscitation and was confirmed dead at 3.52am that morning. From within the deceased's residence, police recovered a padded postal envelope addressed to the deceased next to an opened sealable sachet bag labelled "[redacted] - Pure 99.9% 50g" that the deceased had acquired on the 21st of February 2020 from an internet-based company licensed to sell controlled poisons, including [redacted]. On the deceased's computer, police recovered a document titled 'Suicide.Note.txt' containing unequivocal expressions of his intent.

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 Sodium Nitrate/Nitrite 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. 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 ligitimate 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 1. The family of Samuel David Dickenson 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 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**