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 30 March 2023 I commenced an investigation into the death of William James Armstrong aged 24. The investigation concluded at the end of the inquest on 06 June 2023. The medical cause of death was determined to be: 1a. [redacted] Toxicity I returned a narrative conclusion that William James Armstrong died as the consequence of the effects of a significant quantity of [redacted] deliberately self-administered in circumstances where his intentions remain unclear by reason of a combination of recently consumed alcohol and a prodromal insidious onset of an undiagnosed psychotic illness. 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 that had included episodic low mood, with fleeting examples of previous suicidal ideation, but no formal mental health diagnosis had been made. He had been treated conservatively and discharged by local community-based mental health services following the deceased's non-engagement. In October 2022, a consultant psychiatrist assessed the deceased to be in a phase of gradual decline with fluctuating symptoms that included hallucinations with distorted thinking and perception suggestive of a prodromal insidious onset of a psychotic illness with decline in social functioning. The views of the psychiatrist were communicated to the deceased's general practitioner, who having

discussed matters with the deceased and his family, persevered with a conservative, reactive pathway of primary care and did not refer the deceased to further community mental health intervention as suggested by the psychiatrist, but whether this decision had any bearing upon the outcome remains unclear.

At 10.58pm on the 22nd of May 2021, North West Ambulance Service received an emergency call from the deceased, informing them that he had consumed an quantity of [redacted] with 'metformin blue' 15 minutes earlier, that he was now not breathing normally and in effect, he was seeking to be rescued. The call was categorised as a 'Category 2' response using the prevailing Medical Priority Dispatch System. By reason of operational conditions that evening, there was an 89-minute delay in response with an ambulance arriving on scene at 11.27pm. The deceased was found collapsed, unresponsive in room 49 of the hotel. He failed to respond to resuscitation and was confirmed as dead at 11.37pm.

Police investigations established that the deceased had booked into the hotel at about 9pm that night and had earlier acquired the [redacted] using the internet from a source in Russia. No note or other evidence of intention was discovered. Toxicological samples from the deceased confirmed the presence of significant levels of alcohol and a fatally toxic amount of [redacted] albeit the precise quantity or time of ingestion could not be quantified. The consequence of the delayed paramedic response cannot be established due to the rapidity of effect and highly toxic consequence of methemoglobinemia that arises following ingestion of [redacted]

5 CORONER'S CONCERNS

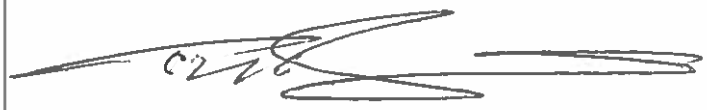
During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

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 William James Armstrong 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 North West Ambulance Service 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**