

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: ██████████, Vice President and Managing Director, Google UK & Ireland, 1 St. Giles High Street, London, WC2H 8AG
1	CORONER I am Edmund Gritt, Assistant Coroner, for the coroner area of South 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/ukxi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST On 28th November 2023, a coronial investigation was commenced into the death of Leo Alexander Barber who was aged 16 years when he died on 28th November 2023. I assumed conduct of the coronial investigation in November 2024. The investigation concluded at the end of Leo's inquest on 18th September 2025.

	I recorded Leo's medical cause of death as: 1a Multiple injuries. 1b Collision with train. I recorded a short-form conclusion of: Suicide.
4	CIRCUMSTANCES OF THE DEATH In the summer and autumn of 2023, Leo suffered a severe deterioration in his mental health. He remained living at home with his family while under the care of crisis mental health services. At about 4am on 28th November 2023, unknown to his family, Leo left the house; he walked to nearby railway tracks and stepped in front of a fast-moving train. Of relevance to this Report, I recorded on Leo's Record of Inquest: "Leo's actions were contributed to by his exposure to a website forum [REDACTED] [REDACTED] on which individuals exchange information as to methods of suicide." On the basis of evidence from Leo's parents and from the police investigation, I made the following findings of fact (of relevance to this Report): 1. Using his Gmail address, on 26th August 2023 Leo opened an account on a website [REDACTED] Insofar as the evidence I have heard, this website acts as a forum for people to discuss the methods of

suicide. ... those who post appear to share information as to the mechanics of how to end their lives. I did not see any postings of express incitement or direct encouragement that Leo should do end his life. And it would seem that he came to the site because he was already subject to suicidal ideation. But for an extremely vulnerable person such as Leo, it would provide an environment in which he might find collective approval for taking the step of ending his life and be reinforced in that step by that approval. It is notable that the posts responding to Leo's 23rd November 2023 post (as to ending his life by being struck by a train) are discouraging as to the particular method but not as to any decision to end his life. Indeed, the post which referred to Leo's "*SI*" – which I determine means 'survival instinct' – could very well have had a provocative effect in the sense that Leo felt he needed to overcome his 'survival instinct'.

2. It is evident from the content of some of his posts that Leo had read material on the site (other than that in evidence) though there is no evidence of what that content was.
3. I conclude that Leo's exposure to the website [REDACTED] probably would have acted to reinforce his decision to end his life and as such contributed to causing his death.

Furthermore, I also noted that:

	4. The police undertook an investigation of Leo's online activity in the months before his death and were able to do so only because Leo's parents were able to provide them with Leo's believed usernames and passwords. Without that, my investigation would have been frustrated and incomplete in respect of a matter of grave concern.
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) A 16-year-old child in severe mental health crisis was able to access online material which reinforced his decision to end his life. He registered on the [REDACTED] site using his Gmail address and accessed the material on his Android OS 'phone. I am concerned that there is a risk of future deaths among those in mental health crisis including children while such material is accessible to vulnerable individuals online. (2) In the course of my investigation, I issued a Schedule 5 notice to Ofcom to exercise its power under Section 101 of the Online Safety Act 2023 to obtain evidence from Google relating to Leo's online activity before his death. No material was provided by Google under this procedure. I

	understand that Google's position is that the service provider holding such data (Google LLC) is not within the jurisdiction of England and Wales but is within the US jurisdiction and subject to the laws of the USA which prohibit compliance with my Schedule 5 notice under the Section 101 process. I express no view either way on any legal issue as to conflict of laws. As I noted, but for the happenstance that Leo's parents were able to provide the police with Leo's believed usernames and passwords, my investigation would have been frustrated and incomplete in respect of a matter of grave concern. The risk that future coronial investigations might be so frustrated does itself give rise to the risk of future deaths, in that coronial investigations cumulatively mitigate the risk of such deaths. I am therefore concerned that there is a risk of future deaths where vulnerable individuals in England and Wales may access potentially harmful online material from a service provider not within the jurisdiction of England and Wales (as opposed to a service provider within the jurisdiction of England and Wales which would be subject to the Section 101 coronial investigative process).
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 4th December 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) Leo's parents: [REDACTED] and to the Bromley Safeguarding Children Partnership as the local child safeguarding board. I have also sent it to the following persons who may find it useful or of interest: (i) Ofcom (ii) The British Transport Police (iii) The Metropolitan Police

	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 other 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. She 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.
9	9th October 2025  Edmund Gritt Assistant Coroner (South London)