REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Secretary of State for Business and Trade 2. Secretary of State for Culture, Media and Sport 3. Secretary of State for Science, Innovation and Technology 4. Chair British Aerosol Manufacturers Association CORONER 1 I am Andrew Bridgman, Assistant Coroner, for the coroner area of South Manchester 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 **INVESTIGATION and INQUEST** 3 On 06.05.25 an investigation commenced into the death of Oliver Luke Gorman who died on 05.05.25 in his bedroom at his home. Oliver was 12 years of age, having been born on 08.11.12. The inquest concluded on 23.10.25. The medical cause of death was 1a) Inhalation of butane gas How, when and where At about 17.54hrs on 5 May 2025 Oliver Luke Gorman was found deceased in his bed at home, having recreationally inhaled Conclusion Misadventure CIRCUMSTANCES OF THE DEATH On the afternoon of 05.05.25 Oliver and his family returned home from a Bank Holiday weekend in Wales. Oliver said he was tired and went up to his bedroom. When his mother called for him just before 6.00pm he didn't respond. Thinking that Oliver had his headphones on she went up to the bedroom. Mum called 999 and carried out CPR until He was completely unresponsive. paramedics arrived and took over. No cardiac rhythm was ever achieved. Oliver was transferred to Tameside General Hospital where CPR was stopped and death confirmed. t fell from Oliver's bed when his mother pulled the duvet An empty can of back. Other empty cans were found in the room by Greater Manchester Police on their attendance and scene assessment. Just prior to going away for the weekend Mum had approached Oliver's school to report some concerns about bullying. Following Oliver's death, the school and other agencies tried to investigate those concerns but Oliver's tragic death so affected his friends and fellow pupils making the investigation difficult and nothing substantive was found. In

	any event, on the evidence if there was an element of bullying in Oliver's life it did not play a part in his death.
	1 heard evidence from Oliver's school that the recreational craze of spray (to experience the buzz from the propellant's butane and/or propane is widespread on social media, including and particularly Tiktok.
	The school's Summer 25 Safeguarding Letter added Trends and Challenges which already included,
	It was not possible to access Oliver's mobile phone to determine whether Oliver had indulged in directly from Tiktok. The evidence was that it was however a challenge or practice known to be disseminated through Tiktok.
5	CORONER'S CONCERNS
	During the course of the inquest the evidence revealed matters giving rise to concern. Oliver's death from inhalation of the propellant (butane and/or propane) used in aerosols is one of a number of deaths in the past few years. Over the past few years there have been a number of reported deaths in teenagers from the recreational use of spray. Nothing appears to have changed in response to those deaths in my opinion there is a risk that future deaths will 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. No Age Restriction
	The age restriction on the purchase of butane for refilling cigarette lighters (and the like) is 18 years of age. I understand the legislation is primarily aimed at preventing the misuse of butane. The age restriction on the purchase of aerosol paints is 16 years of age. I understand that the legislation is aimed at reducing incidents of graffiti and preventing the misuse of butane/propane -
	There is no age restriction on the purchase of aerosol or other products containing butane/propane as the propellant, their misuse is as equally dangerous.
	An age restriction on such products would also likely heighten parental awareness of the dangers of such products.
	2. Adequacy of Warning The warnings on the cans of process of the danger/risk of inhaling the aerosol spray were, in my opinion, inadequate in terms of visibility and wording.
	The warning was set in an area outline of about 12mm x 12mm, in black or white writing depending on the background colour of the can. It was lost amongst all the other information and writing on the can. At least the 'inflammable content' warning was outlined in red.

The warning stated "SOLVENT ABUSE CAN KILL INSTANTLY".

Many people (both adults and children) may not equate inhalation of aerosol spray with solvent abuse. Thus, the warning does not appear to properly describe the risks of using/misusing using the product. That risk being inhalation of this aerosol spray can cause instant death.

3. Social media content and access

The posting of challenges such as those listed above, and no doubt others, on social media platforms will continue to take the lives of young, impressionable and/or vulnerable children/teenagers unless the platform providers take responsibility fortheir content and/or toxic algorithms either voluntarily or through Government action. The former seems unlikely.

Further the age restriction of 13 years formost social media platforms appears to have been determined in relation to data protection laws rather than of the nature of the content to which they will be exposed, again via any toxic algorithms or any searches they may make.

6 ACTION SHOULD BE TAKEN

In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you 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. 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 namely, who may find it useful or of interest.

- 1. Oliver's Family
- 2. Oliver's school,
- 3. Tameside MBC

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. 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 <u>Dated this 4th</u> November 2025

Andrew Bridgman HM Assistant Coroner