HM Coroner's Court
A Block – Ground Floor
County Hall
Victoria Road
Chelmsford
CM1 1LX

Telephone: 0333 013 5000
coroner@essex.gov.uk

HM Senior Coroner for Essex

ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Advisory Council on the Misuse of Drugs** ACMD Secretariat 2 Marsham Street London SW1P 4DP
1	**CORONER** I am Eleanor McGann, Area Coroner, for the coroner area of Essex
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 30th April 2013 I commenced an investigation into the death of Bradley Geoffrey Michael Cockel, who was 20 years of age. The investigation concluded at the end of the inquest on 28th May 2014. The conclusion of the inquest was – Drug Overdose. The medical cause of death was 1a) 25B-NBOMe intoxication.
4	**CIRCUMSTANCES OF THE DEATH** Bradley Geoffrey Michael Cockel of Beaufort Gardens, Braintree was found deceased on 27th April 2013 at Bramble Road Witham.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. 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) At the time of the death this drug was not controlled and not covered by any

	legislation. (2) There are several other chemical compounds of this drug. (3) (3) NBOMes are not currently controlled under the 1971 Misuse of Drugs Act, but as of June 2013 some, but not all of the compounds, were controlled for sale under a Temporary Banning order.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 August, 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 [redacted] (Parents of the deceased) and to [redacted] from the Essex and Kent Serious Crime Directorate. 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	**9th June 2014** **Area Coroner for Essex**