

David Ridley HM Senior Coroner for Wiltshire and Swindon

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	Ms. Margot James MP
	Minister for Digital & the Creative Industries
	Department for Digital, Culture, Media & Sport 100 Parliament Street
	LONDON
	SW1A 2BQ
1	CORONER
	I am David Ridley, HM Senior Coroner for Wiltshire and Swindon
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/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST
	On the 11 January 2018 I commenced an investigation into the death of Bradley Robert Michael Trevarthen , and an Inquest into his death was opened by me on the 18 January 2018. On the 25 April 2019 I concluded Brad's Inquest. I found that the medical cause of death was
	1a) Hanging.
	In box 3 in the Record of Inquest I recorded how, when and where Brad came by his death as follows:-
	At some point after 1541 on Wednesday 10 January 2018 Bradley hanged himself by the neck at his home in Durrington, Wiltshire. He was discovered at around 1640 and despite advanced life support measures was confirmed as having died at 1812 at Salisbury District Hospital in Wiltshire the same day.
	Having considered the evidence I felt that there was insufficient evidence to make a finding of fact that on a balance of probabilities that Brad had intended to take his life at that time and therefore recorded as a conclusion one of – Accident. Such a conclusion is recorded were a finding is made that someone has died, as in Brad's case, as a result of an unintended consequence of a deliberate act.
4	CIRCUMSTANCES OF THE DEATH
	It is fair to say that all unnatural deaths generally speaking are tragic but in the case of Brad it is even more tragic because Brad was a schoolboy and at the time of his death was aged 13 Having left school for the day on Wednesday 10 January 2018. Brad was subsequently found by

his younger sister suspended from the bannister at his home in Durrington in Wiltshire at approximately at 1640 the same day. At about an hour earlier he had Instagrammed a friend in respect of which he was aware that a school friend of his had spoken to a teacher earlier that day and he was hopeful that he would get some support and help. A couple of Brad friends had become increasingly concerned for Brad especially following their return to school about a week earlier and had spoken to the Head of Year that morning. I was satisfied having heard the evidence that an immediate risk of harm was not conveyed to the Head of Year and in fact one of the students who spoke with the teacher in evidence indicated that he personally did not think that Brad would go through with his actions and take his own life.

The evidence was clear that shortly before the return to school, for the Spring term, that Brad's outlook had changed and when talking about self-harm and suicide Brad's tone took a more serious nature and this ultimately was of concern to his friends. As I sure you are aware communication these days is not simply face to face and in the digital age there are many internet based communication platforms that people, especially young persons, use to communicate and one of those platforms was Discord and before returning to school Brad appeared to be expressing thoughts of taking his own life and this continued whilst gaming following their return to school. He actually indicated that he had made an attempt 2 days earlier but his friends for fear that their parents would ban them from using their electronic equipment did not communicate this to anybody.

What was apparent from the evidence was that Brad was becoming increasingly aware of the concept of suicide and exploring methods. There was evidence that pointed to him if not directly viewing the video footage taken by **set and set and**

The reason why I did not return a suicide conclusion was primarily having regard to the Instagram message that Brad sent to his friend approximately an hour before he was found which did not point to an immediate risk of death and no note was left at the time. I found more likely than not that Brad was experimenting with the method, however, it is not commonly known that having placed an ligature around ones neck that it can compress nerves and blood vessels that can lead to unconsciousness in a matter of seconds and unless there is somebody there to cut you down the likely outcome is death.

5 CORONER'S CONCERNS

It will come as no surprise that my concern here relates to the internet and the regulation of it. Brad had access to the worldwide web however as with other cases that I am sure you are aware of that have been highlighted of late, my concern here is that some of the material Brad was exposed to was of a nature that a young person of his age should not be exposed to as they cannot, in my view, properly assimilate and process the information that they view. The amount of information on the subject of self-harm and suicide that is currently available to young persons on the internet goes beyond freedom of expression and I am concerned that the extent of such information Normalises actions which at the end of the day are simply not normal. It is not normal to self-harm and it is not normal to perform an act which results in that person's own death.

I fully appreciate that the responsibility does not rest solely with Parliament, but the control of this entity has to start somewhere although I fully accept that to counter such activity will involve the combined efforts of Parliament, internet service providers, internet site owner, schools and colleges, parents/guardians as well as the young person's themselves.

I can take judicial notice of when I was growing up that I do not recall ever discussing self-harm and suicide in the same way as it is discussed now, and I fear that the abundance of this type of information and the ease of its accessibility is leading to this concept of Normalisation of such actions. Yes, it is totally right that we should be open about mental health issues but the abundance of information that is out there on self-harming and suicide methods is a step too far hence my concern.

6	ACTION SHOULD BE TAKEN
	In my opinion action should be taken to prevent future deaths and I believe 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, namely by 24 June 2019. 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
	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	Dated 29 April 2019
	Signature David W. G. Ridley HM Senior Coroner for Wiltshire and Swindon

