	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Secretary of State for the Department for Digital, Culture, Media & Sport, 100 Parliament St, London SW1A 2BQ** **2. The Secretary of State for the Home Office, 2 Marsham Street, London, SW1P 4DF** **3. Joint Select Committee for the Draft Online Safety Bill**
1	**CORONER** I am JONATHAN STEVENS, Assistant Coroner, for the coroner area of Inner North 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.
3	**INVESTIGATION and INQUEST** On 4th of June Senior Coroner Hassell commenced an investigation into the death of BERENICE NADIKA BELL [age 28]. The investigation concluded at the end of the inquest on 12th October 2021. The conclusion of the inquest was that death was a [redacted]
4	**CIRCUMSTANCES OF THE DEATH** Berenice had booked into an Airbnb and was found dead in that accommodation on 20th May 2021. She left a note stating [redacted]. Evidence from a psychotherapist revealed that Berenice had sought psychotherapy help in April 2021. Berenice had no known previous mental history but the consultation with the psychotherapist revealed that she had been feeling anxious and depressed for some time. Berenice also revealed to the psychotherapist that she had attempted to purchase [redacted] in January/February 2021 with her life savings but had been scammed and she lost the money and [redacted]. Berenice booked into an Airbnb accommodation having obtained [redacted]. She was found dead on 20.5.21 by the owner of the Airbnb having failed to check out of the accommodation.
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) [redacted] is the single largest cause of death in the UK for people under 35. (2) Evidence was provided by the family that Berenice had accessed various [redacted] that provide information and assist people to [redacted]. [redacted] family and mental health professionals. (3) The family have discovered through a support group that other parents who have lost their children to [redacted] have also discovered, after the deaths of their children, that their own children were also accessing [redacted] before they died.
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 17th January 2021. 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 [redacted], parents of the deceased. I have also sent a copy the following person who may find it useful or of interest: [redacted] (Media Adviser), Samaritans, The Upper Mill, Kingston Road, Ewell, Surrey, KT17 2AF. I am also under a duty to send the Chief Coroner a copy of your response. 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. 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	**22nd November 2021** **SIGNED**