in conjunction with

Families and Survivors to Prevent Online Suicide Harms

Missed chances, lost lives

How a substance and suicide forum cost lives and the state missed countless chances to act

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Forward from Families and Survivors to Prevent Online Suicide Harms

Adam, Aimee, Claire, Grace, Hannah, Immy, Lucas, Tom, Vlad.

Our loved ones no longer with us are the inspiration for this report, and it is dedicated to them. They are the hope that things can and must change.

Lives lost far too young. They all were encouraged to end their lives on a pro-suicide forum or are believed to have accessed it. Most used a deadly substance advertised on there or were given instructions on how to end their lives on the site.

They are nine of many. As this report sets out, at least 133 lives in the UK have been lost because of this forum and the poison it promotes. There are likely to be countless more.

We have come together with a brave survivor of the forum to demand change. To demand answers to the missed opportunities that could have saved them.

But most of all to ensure no other loved one or family has to go through the pain and grief, or the harm suffered from this website which exists solely to encourage others to die.

We hope this report will serve as a wake-up call to Government, to Ofcom, to those in charge of frontline services, policing, health services and the Border Force, that much more needs to be done.

This is a story about a deadly forum and lethal poison but also about a state that has acted too slowly in the wake of countless warnings. Further delay will cost more lives.

Lucas was 16. Vlad 17. Aimee 21. Grace, Hannah and Tom 22. Immy 25. Adam 28 and Claire 41. The youngest person we know of who has lost their life after using the forum was just 13.

They were drawn into a dark world that was allowed to exist online and continues to exist through the use of a VPN. We believe our loved ones suffered coercion, grooming, instruction on how to end their lives. Most accessed a poison that was allowed to cross borders or was readily available domestically. This is still the case today.

Our loved ones had their lives ahead of them. They were struggling but instead of finding hope they found despair. Instead of being protected they were left vulnerable. And instead of a state doing all it can to save lives there are lessons left unlearned, opportunities were missed and warnings ignored.

It is now time to learn those lessons and listen to those warnings. Anything less would be a disservice to the 133 lives lost. A dereliction of the state's duty to protect lives.

We believe the best avenue for change is for a public inquiry to further identify what went wrong and what needs to change.

This report sets out the issues and suggested solutions, but to uncover the true scale of this nightmare and the systemic action needed to save lives, nothing less than a public inquiry will suffice.

So we call on the Prime Minister Keir Starmer to read this report and then to meet with families and survivors and commit to a public inquiry.

While we wait, we all fear that further lives will be lost.

Members of Families and Survivors to Prevent Online Suicide Harms

Families and Survivors to Prevent Online Suicide Harms was founded in Spring 2025 and brings together bereaved families and those who have been directly impacted by the pro-suicide forum.

The group, convened by Molly Rose Foundation, unites around their grief and personal experiences and holds a shared purpose of preventing more lost lives by raising public awareness of the issues around the forum and substance.

The group has been campaigning for Ofcom to act more quickly to ensure the forum can no longer be accessed by UK users, for better regulation of the poison, and for Government to act on the warnings raised and systemic failures that have led to devastating harm.

Members are now calling for a public inquiry into the response to the forum and have written to the Prime Minister urging him to commit to one.

This report has been produced in collaboration with Families and Survivors to Prevent Online Suicide Harms. At Molly Rose Foundation, we believe it is critical that the voices of lived experience are heard by policy makers, and that their experiences and insights drive meaningful change.

Summary

Since 2019, the UK has seen a sudden and then sustained increase in deaths by suicide attributable to a single poisonous substance.[1] At least 133 lives have been lost,[2] but the true figure could be far higher.

The rise in deaths linked to this substance has been primarily driven by the emergence of an online suicide forum that has actively promoted the substance as a suicide method. The forum provides encouragement and instruction on how to die by suicide, with members glorifying the substance and actively providing information and signposting on how to procure it.

While there can be little doubt that the forum has been created and exploited for malign purposes – targeting vulnerable people and in some cases even grooming them to take their lives – perhaps the most disturbing part of this story is the array of missed opportunities to identify and act.

This report tells the story of countless missed opportunities for the government, regulators and the state to act in the face of clear warnings. Research suggests that on a per capita basis the UK has been more affected than any other country in the world.[3]

Despite multiple warnings from coroners, the sustained efforts of civil society, and years of courageous campaigning from bereaved families, numerous red flags have been missed. The urgency of this escalating threat has been largely neglected.

This is nothing less than a fundamental failure of the state to protect its vulnerable citizens, and it is an example of institutional failure characterised by inertia and inaction in the face of an inherently preventable online harm.

This is a scandal that, while still largely unknown, we believe deserves to be seen alongside other similar institutional failures of our time – scandals such as Hillsborough, Horizon, the Infected Blood scandal or Grenfell.

Urgent action must now be taken. We need to see immediate action to address a real and present ongoing risk to vulnerable lives. Action must be taken to block access to this pro-suicide forum for UK users, and to protect its vulnerable users who may be influenced and put at risk by its nihilist agenda.

Longer-term lessons must also be learned. In this report, we set out 4 main areas where crucial opportunities to join the dots have been missed. The scale of institutional failure means that nothing less than a public inquiry is now appropriate.

1 For reasons of public safety, in this report we will not name either the substance or forum. This reflects best practice and media reporting guidelines. Sinyor, M. (2024) The Kenneth Law media event – the dangerous natural experiment. Editorial. Crisis, Journal of Crisis Intervention and Suicide Prevention: 45 (1), pp1–7.

2 Queen Mary University of London (2024) Analysing the Evidence: an Interview with Prof Amrita Ahluwalia. Available on QMUL's website.

3 Das, S (2025) Emerging trends of self-harm using [redacted] in an online suicide community: observational study using Natural Language Processing Analysis. JMIR Mental Health.

This report tells a story of countless lives lost and malign actors who have preyed on vulnerable people, using a forum to instruct, encourage and in some cases groom people to take their own lives.

However, it also tells a story of institutional failure – with a catalogue of missed opportunities that have resulted in a significant human and economic cost being borne.[4]

Crucial lessons must now be learnt. A public inquiry is urgently required.

The missed opportunities to act

From 2019, when UK deaths linked to this substance started to significantly increase, coroners issued at least 40 Prevention of Future Deaths reports (PFDs) raising urgent matters of concern about the substance and/or forums and the risks they presented to future lives.

Three Government departments – DHSC, the Home Office and DSIT/DCMS – were sent PFDs raising relevant matters of concern some 43 times alone. These PFDs raised concerns about either the substance or suicide forums a combined total of 65 times.

Multiple red flags have been missed, dots inadequately joined up, and central government and multiple public bodies have overseen a consistently insufficient response to a predictable but entirely preventable harm.

What must happen now?

There are four main lessons that must be learned immediately.

1. Online access to the forum for UK users

The forum that has promoted and popularised use of this substance as a suicide method primarily exists to cause harm to users, and every effort should be taken to ensure it is no longer available.

However, the UK's response to this forum so far has consistently poor. The Online Safety Act took years to reach the statute book. When regulation took effect, Ofcom and the former Technology Secretary inexplicably declined to enact powers that were explicitly amended into the Act to tackle small but high-harm sites.

Earlier this month, Ofcom signalled that it appeared to be relying on the site voluntarily geo-blocking its site to UK users – in effect, signalling it will not take further enforcement action despite the forum still being readily available via a VPN.[5]

4 Molly Rose Foundation estimates the economic cost of the 133 deaths to be £1.5bn. This estimate of the Value of Preventable Fatalities (VPF) is calculated using the J value model. The J value is understood to be a more accurate metric to assume the economic costs of technology-facilitated harm as it more appropriately takes into account the typically younger age profile of victims.

5 Ofcom (2025) Ofcom issues update on Online Safety Act Investigations. Published on October 13, 2025.

Ofcom's failure to respond appropriately to a forum that continues to represent an immediate and ongoing threat to life is, to put it bluntly, staggering. Many will legitimately fear that the forum's decision to voluntarily geo-block itself is a short-term tactic designed to diminish Ofcom's appetite to seek a permanent remedy through the UK courts.

Ofcom's approach appears to be playing directly into the hands of this nihilistic forum – and it means that further UK lives remain at risk.

Even if the regulator did take steps that eventually led to the forum's closure, the current legislative framework means that if and when the forum was no longer available, we cannot have confidence that 'regulatory whack-a-mole' will simply enable another replica site to emerge and take its place.

2. The Poisons Act and the regulatory framework for supply

The Poisons Act framework has demonstrably failed to protect vulnerable users from harm, with insufficient focus on the risks associated with uses of the substance for the purposes of suicide.

The Government's response to the emerging harm posed by the substance has been sorely lacking, palpably hampered by a lack of strategic direction and poorly aligned objectives across central Government departments.

The Home Office should commit to strengthening the Poisons Act without further delay – a necessary and entirely proportionate measure to prevent the substance being sold for the purposes of suicide from domestic sellers, and to better police imports of the substance likely to be used for this purpose at our borders.

A Home Office Minister should assume overall responsibility for tackling the growing risks posed by suicide-related offences, with a more co-ordinated strategic response to criminal and malign threat actors being established across central government, law enforcement and the UK Border Force.

3. A National Oversight Mechanism to ensure coronial recommendations result in meaningful change

Dozens of Prevention of Future Deaths reports have raised repeated and sustained concerns about the substance and the forum that has promoted its use for suicide.

However, in the absence of a National Oversight Mechanism, these multiple red flags were repeatedly missed. The important warnings being issued by coroners should have been a powerful chance to identify and respond to these emerging risks much earlier, but instead we lost valuable time while it was instead left to civil society, law firms, and bereaved families themselves to join the dots and demand appropriate action.

A National Oversight Mechanism should now be introduced without any further delay. Such a body should have a statutory role to track, collate and analyse recommendations arising from Prevention of Future Deaths reports. It should have necessary powers to investigate, request information and highlight ongoing failures where appropriate.[6]

6 Molly Rose Foundation is one of 72 signatories to Inquest's campaign for an independent oversight mechanism.

Government should also commit to an exercise to identify the scale of risk and harm posed by the substance and suicide forums to date. Patchy and inconsistent data collection processes can partly explain why the urgency to act on this forum and the substance have been consistently lacking.

We believe there are likely to be valuable lessons for the UK's early detection and monitoring processes, and it is important these are learned in anticipation of future risks that may emerge, for example the popularisation of new substances.[7]

4. Improving downstream opportunities to protect people procuring the substance for suicide

Multiple opportunities have been missed to protect vulnerable people attempting to procure the substance for the purposes of suicide, including from overseas sellers.

A lack of effective co-ordination and training between the UK Border Force and local police forces means that vital opportunities to perform welfare checks and persuade those seeking to procure the substance to agree to its safe disposal have been missed.

In cases where the substance is obtained and taken, an antidote called Methylene Blue can effectively reverse the harmful effects. However, as it stands only two of England's 15 Ambulance Trusts currently stock Methylene Blue. Progress towards a wider rollout remains frustratingly slow. DHSC should urgently look to encourage further progress towards an England-wide rollout.

In some cases, consignments of the substance were received, and deaths took place while the vulnerable person was in a psychiatric hospital and receiving in-patient care.

This suggests concerning gaps in training and operational processes, and an urgent need to improve knowledge and understanding of the substance and the risks about how it can be procured so readily.

7 We are aware that another substance is already been promoted by suicide forums and that many of the issues identified in this report also apply in relation to the supply and availability of it.

Mental health and helpline resources

This report makes extensive references to suicide and poor mental health. Please note that trusted help and support is available 24/7 if you need help or support.

SHOUT – Text **MRF** to **85258**
Confidential crisis text line for anyone, any age - Free 24/7

Papyrus HOPELINE247 – **0800 068 4141**
pat@papyrus-uk.org
Confidential helpline for people under 35 or anyone concerned about a young person - Free 24/7

NSPCC Childline – 0800 1111
Confidential support for young people under 19 - Free 24/7

Samaritans – Call **116 123** – jo@samaritans.org
A safe place to talk about whatever's getting to you - Free 24/7

In an emergency don't be afraid to dial **999**

The impact of the substance and coroners' responses – an analysis of PFDs

Following an inquest or investigation into a death, coroners in England and Wales have a duty to report deaths where they believe that action should be taken to prevent similar deaths. They do so by issuing a Regulation 28 notice, also referred to as Prevention of Future Death report (PFD).

PFDs are issued to organisations or individuals who the coroner believes have the power to act to prevent future deaths. Recipients must respond within 56 days.

During autumn 2025, Molly Rose Foundation undertook a systematic review of 47 Prevention of Future Death Reports[8] where deaths were directly connected the substance and/or forums.[9]

Our analysis shows that governments have been repeatedly warned about the risks associated with the substance and the forum. This underscores the scope for vital improvements to ensure that emerging trends from PFD reports are more readily identified and understood.

Our analysis finds that:

- 40 of the 47 PFDs called for action to be taken to address risks associated with either the substance and/or suicide forums.
- Since 2019, concerns relating to either the substance or suicide forums have been raised with three Government departments at least 65 times.
- Coroners have repeatedly issued warnings about the ease with which victims are able to easily procure the substance, gaps in the Poisons Act framework which have enabled ease of supply, and inadequate operational responses once the substance had been purchased.
- Coroners also raised strong concerns about the availability of suicide forums and the active role they play in encouraging vulnerable young people to die by suicide.
- There was a dramatic increase in PFDs issued in relation the substance and suicide forums after 2019. This corresponds to the forum's rapid growth and role in popularising the substance as a suicide method.
- Victims of both the substance and online forums tended to be in their early 20s, with many known to be vulnerable and struggling with their mental health. Around half were known to support services such as local health services or police.

It is important to recognise that the actual number of PFDs issued relating to the substance and suicide forum, and indeed the number of deaths associated with them, are likely to be considerably higher than those identified here.

This reflects challenges with the consistency with which PFDs are issued, issues with the level of detail included in reports, and a level of redaction in reports which can make it challenging to determine whether cases involved this substance or forum.

8 Over 1,000 PFDs were sourced from the Preventable Deaths Tracker and analysed to identify those which related to deaths attributable to the substance and suicide forums.

9 The vast majority of PFDs included a formal conclusion that victims had died by suicide. A small number did not, stating for example that victims' 'intentions were unclear'.

Our findings

Coroners have repeatedly made Government aware of the risks that the substance and online forums pose

Our analysis shows that Government and other large public bodies have had repeated warnings about the impact of the substance and online forums, over a period of many years. Three Government departments – the Department of Health and Social Care (DHSC), the Home Office and the Department of Science, Innovation and Technology (DSIT)/Department of Culture Media and Sport (DCMS)[10] – have been warned on dozens of occasions.

Each PFD received by Government is an opportunity where meaningful action could have been taken to prevent the loss of vulnerable, often young, lives. As this report sets out, Government has failed to respond adequately, with action delayed or clearly insufficient to the scale of the problem.

Of the 47 PFDs we analysed, 40 raised specific issues ('matters of concern') relating to the substance and/or suicide forums, with most raising multiple concerns. Of these, 28 PFDs raised concerns about the substance, and 30 raised concerns about suicide forums.

PFDs raising concerns about the substance and/or forum were issued to a total of 91 recipients. 60 of these were large public bodies, including Government departments, regulators, National Health bodies and National Policing bodies.

Three Government departments – DHSC, the Home Office and DSIT/DCMS – were issued PFDs on 43 occasions. One or more matters of concern relating to either the substance or forums were raised with these departments a combined total of 65 times.

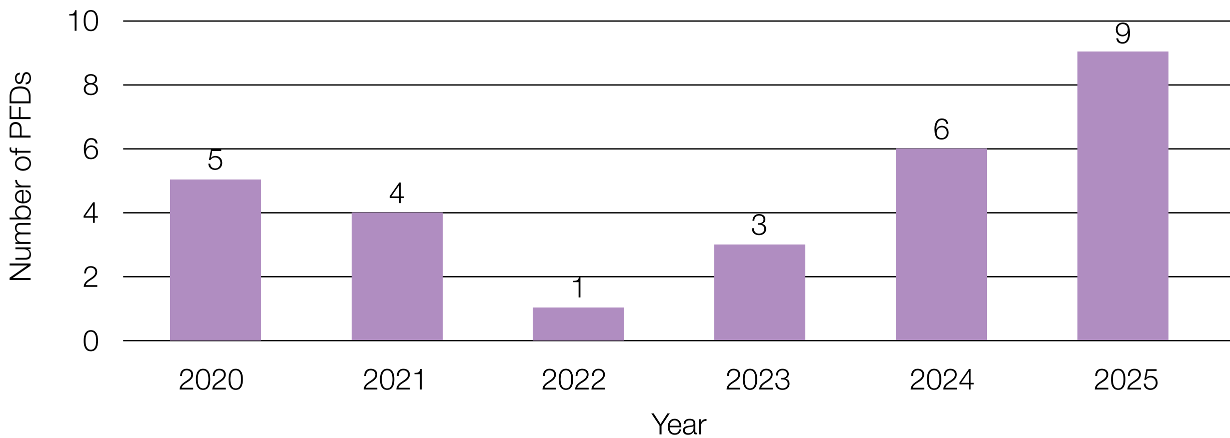
Concerns about the substance

As Figure 1 demonstrates, at least 28 PFDs have raised one or more matters of concern relating to the substance from 2020 onwards. Primarily, these concerns related to either the ease with which victims were able to access the substance or the operational response once the substance had already been procured.

Government departments have been sent PFDs raising matters of concern relating to the substance at least 31 times. The Home Office has received 14 PFDs, DHSC has received 13, and NHS England has received three.

10 These are grouped as responsibility for Online Safety moved from DCMS to DSIT in February 2023.

Figure 1: Timeline of PFDs where coroners raised specific concerns about the substance

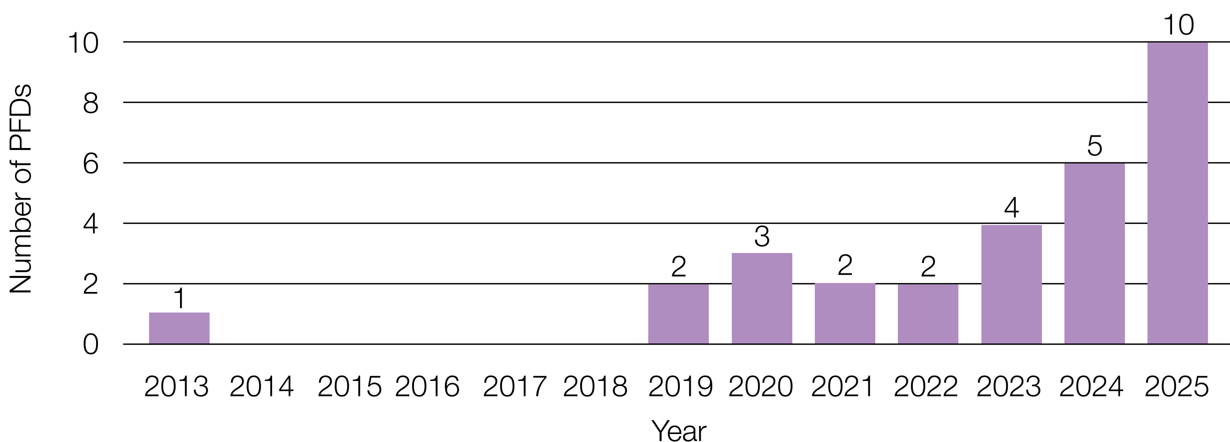


Concerns about suicide forums

As Figure 2 shows, since 2019 at least 29 PFDs have raised one or more matters of concern relating to the availability and harm caused by suicide forums. In contrast, only one PFD raised similar concerns in the previous six years, powerfully underscoring the rapid growth of the forum and its role in contributing to deaths.

Government departments have been sent PFDs raising matters of concern relating to suicide forums at least 35 times. DSIT/DCMS received 13 PFDs with relevant concerns, DHSC received 11, and the Home Office and Ofcom received 10 and six PFD's respectively.

Figure 2: Timeline of PFDs where coroners raised specific concerns about suicide forum



The growing threat posed by the substance and suicide forums

Our analysis demonstrates the rapid emergence of the threats posed by the substance and the suicide forum since 2019, with a dramatic increase in deaths connected to both the substance and suicide forums from this time onwards.

PFDs make clear that many victims were highly vulnerable – either struggling with their mental health or known to have a history of self-harm, suicide attempts, or suicide ideation. In this context, easy

access to pro-suicide spaces and information on suicide methods clearly played an active role in encouraging many to take their own lives.

Victims of both the substance and suicide forums tended to be young, with all 47 victims having a median of just 25 and three victims of suicide forums aged 16 or under.

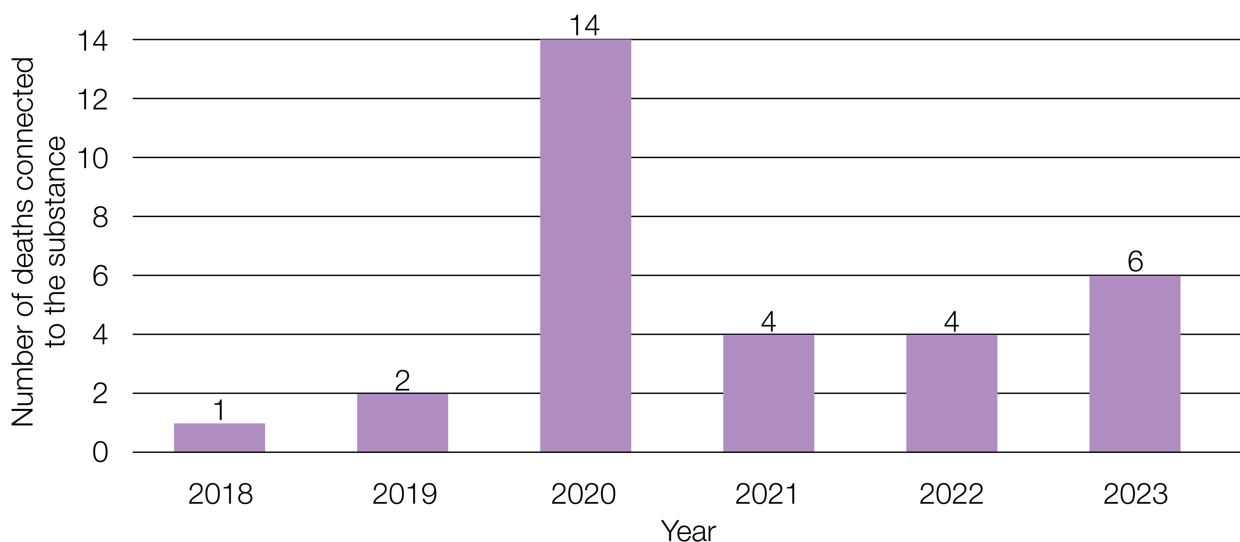
Concerningly, over half of the victims were known to local support services – pointing to numerous missed opportunities where intervention might have been able to prevent deaths.

The emergence and impact of the substance

According to our analysis, at least 32 deaths were linked to the substance between August 2018 and December 2023. The actual figure will be higher – for example, we understand that there have been deaths attributable to the substance where no Prevention of Future Deaths report was issued.

As shown in Figure 3, there was a significant spike in deaths from 2019 onwards, in line with wider evidence for the increasing use of the substance as a suicide method. While there was a particular spike in 2020, it is difficult to unpack from our analysis the potential role of the pandemic amid the wider growth and popularisation of the substance on suicide forums.

Figure 3: Timeline of deaths connected to the substance, as identified in PFDs



Most victims of the substance were young, with ages ranging between 21 and 49, and a median age of 26.[11] 53% of deaths involved males, with 47% female.[12]

Though data was not consistently recorded, many victims were known to have pre-existing vulnerabilities. 2 victims were recorded as having SEND, and 70% were known to have a history of mental health difficulties. 52% were recorded as having a history of self-harm, suicide ideation or suicide attempts.

Around half (48%) of victims were known to support services, including local healthcare, mnetla health services or police.

11 Data on victims' age was included in 25 of 32 PFDs.
12 Victim's gender is not recorded in a standardised manner in PFDs, and was inferred using pronouns and other information.

Many victims had found out about the substance on a suicide forum, with most easily purchasing it online

Of the 32 victims of the substance, 12 were known to have found out about it on an online suicide forum. However, this is likely to be an underestimate, with many PFDs not including any detail on online activities.[13] One coroner described how a victim's activity on a suicide forum included 'discussing and seeking advice from fellow users in respect of methods of self-harm/suicide including the purchasing and use of [the substance]'.

In cases where the information was recorded, all of those who had purchased the substance had done so online. Only 6 PFDs mentioned specific sellers, including 2 mentions of Amazon and 4 mentions of eBay. Purchases via eBay related to deaths between February and August 2020, despite a 2021 eBay response to a PFD stating that the company had globally prohibited the sale of the substance two years earlier.

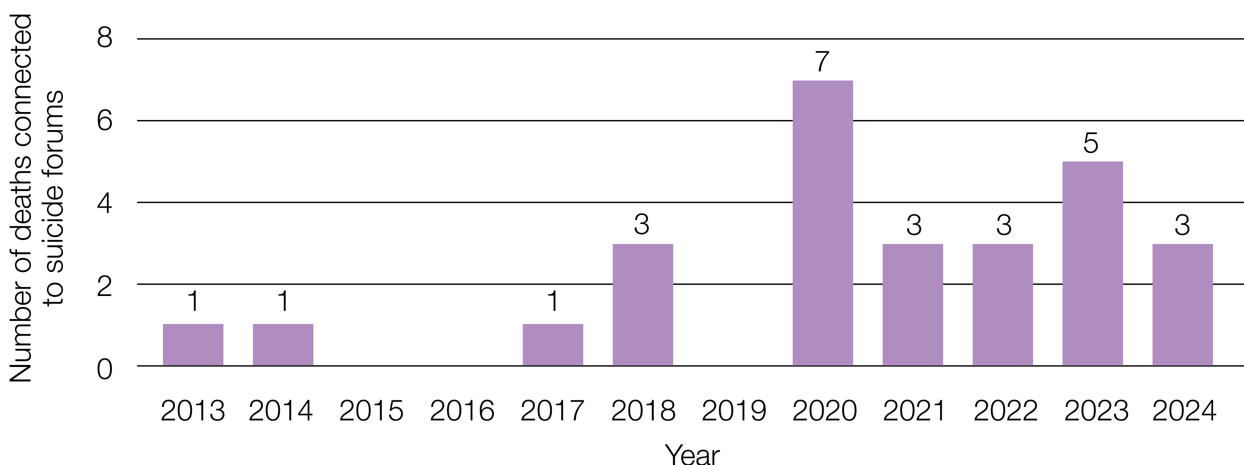
In the 11 cases where this was mentioned, **7 people had procured the substance from an international supplier, and 3 had bought it domestically**. One person had bought the substance from both.

Multiple victims were recorded as having received a welfare check, conducted after Border Force had alerted local police that a victim had ordered the substance. In all cases, local police were unable to prevent victims from dying by suicide. One PFD described how local police had spoken to a female victim about her reasons for purchasing the substance, but took no further action after she 'reassured them as to its use'.

The emergence and impact of suicide forums

Our analysis identified at least 27 deaths connected to pro-suicide forums, with the vast majority coinciding with the forum being established in 2018. See Figure 4.

Figure 4: Timeline of deaths connected to suicide forums, as identified in PFDs



13 This likely reflects the approach taken by police and coronial investigations, in particular whether devices have been interrogated properly to understand the online activities of the deceased. Evidence from lived experience campaigners in Families and Survivors to Prevent Online Suicide Harms shows the majority of those who took the substance had visited the forum or were heavily suspected of doing so.

According to our data, victims whose PFDs referenced interaction with suicide forums tended to be young, with a median age of 24.[14] Three victims were aged 16 or under, including a 16-year-old girl, a 14-year-old girl, and a 13-year-old boy. Over half of the victims (56%) identified as female, and 44% male.

Again, most victims were known to have pre-existing vulnerabilities. Two victims (7%) were recorded as having SEND, while 70% were known to have a history of mental health difficulties. 52% were recorded as having a history of self-harm, suicide ideation or suicide attempts.

Victims of suicide forums were slightly more likely to be in contact with existing sources of support, with over half (56%) known to local health services or police.

Victims were able to freely access suicide forums, receiving instruction and encouragement on how to die by suicide

Most coroners described how victims had used suicide forums to learn about specific suicide methods, including the substance. Many victims were described as visiting forums in order to 'seek information relating to methods of ending life'. One coroner describing how other forum users recommended that a 23-year-old man 'consider' the substance as 'it's the most popular method here and it's easy to obtain (most of the time)'. Many victims had also discovered information on where to source the substance, and even which drugs would limit nausea while consuming it.

Eight PFDs described how victims had accessed specific publications detailing various suicide methods, including the use of the substance. These included full-length books available for download or physical purchase on Amazon, as well as other online 'guides' or 'ebooks'. A 29-year-old man, for example, was described as being 'careful and methodical in the actions he took to end his own life' after referring to a 'handbook'.

> *"The [ebook] appears to provide step by step instruction on how to end your life using certain methods, including how to make the death appear to be due to natural causes."* – PFD for 24-year-old man

In several cases, online forums had provided advice on how to conceal suicidal intention from loved ones or support services. For example, a 24-year-old woman had received advice from other forum members on 'how to mislead mental health professionals to avoid being sectioned', something that allowed her to 'frustrate a mental health assessment and thereafter take her own life'.

Some PFDs specifically recorded how **suicide forums had encouraged vulnerable people to take their own life**. For one 29-year-old man, the coroner reflected that 'the suicide-promoting website appeared to Act as a trigger in his decision to take his own life'. The coroner presiding over the Inquest into the death of a 13-year-old boy reflected that his active participation in discussion forums seemed to indicate 'an obsession with suicide'.

Multiple victims had interacted with suicide forums while under the supervision of health services. A 24-year-old man had 'openly discussed his plans to end his own life' on online chatrooms while sectioned in hospital. Similarly, a 47-year-old woman had 'extensively researched' suicide methods and then ordered a toxic substance to her home while under section.

14 Data on victims' age was available for 23 of 27 PFDs.

Coroners have repeatedly called for action across a range of areas

Coroners have consistently raised matters of concern relating to the substance and the forum, including the easy availability of both the substance and forum, shortcomings around the Poisons Act framework, and the operational response once a substance had been procured and/or taken.

Concerns relating to the availability of the substance

The majority of PFDs raised concerns about victims' ability to easily procure the substance, flagging this repeatedly between 2020 and 2025. A November 2020 PFD raised concerns that the substance 'can readily be bought via the [internet]… without restriction'. Almost four years later, little seemed to have changed, with a 2024 PFD describing the substance's 'easy availability and growing popularity for people seeking to end their own lives', with another coroner reflecting that victims 'had no difficulty obtaining it'.

Many pointed to gaps within the Poisons Act and accompanying guidance. Multiple PFDs spotlighted a lack of adequate restrictions on the sale of the substance, beyond its status as a 'reportable' substance and therefore sellers' obligations to report suspicious transactions. In November 2024, one coroner pointed to the fact that the prevention of suicide and self-harm was not a 'policy objective' of the Poisons Act, resulting in a lack of impetus to control access to the general public.

Coroners were also heavily critical of guidance provided to domestic sellers, with concerns continuing to be raised after the Home Office updated its guidance. In July 2025, a coroner who has issued eight separate PFDs relating to deaths involving the substance and/or forums, raised a range of concerns about ongoing gaps within the guidance, including its lack of focus on 'deliberate misuse [of poisons] in the sense of suicide/self-harm'.

> "*The published Guidance (commenced in 2014 and updated in August 2024) does not give specific guidance or suggested training to sellers, particularly [the substance] acquired by members of the public, particularly over 'online marketplaces' in circumstances of the purchase on a 'one off' basis for the means of self-harming."* – Raised in 8 PFDs issued to the Home Office, 2025

Writing in 2024, one coroner reflected that 'the company who supplied [a 22 year old who died in February 2023] had 'no idea that the substance might be sourced by individuals for this purpose'. On top of the lack of protection when the substance was bought domestically, **multiple PFDs flagged that there were 'no restrictions' on purchasing the substance from abroad**.

Others raised concerns about the substance continuing to be available at such a high level of purity, despite voluntary guidance being issued to manufacturers and sellers advising changes to the composition in which the substance is sold. In July 2025, a coroner reflected that there 'does not appear to have been consideration as to whether to the purity can be diluted', particularly given 'the risk to life that they can pose'. This was not the first time this coroner had raised these specific concerns, Another coroner reflected that it was in the scope of the Poisons Act to specify 'concentration limits' which change the obligations on sellers, citing substances where this was already applied.

Concerns around the operational response post-procurement

Around a third of PFDs relating to the substance raised concerns about operational responses once it had been procured, identifying a range of missed opportunities to prevent victims' deaths. **Multiple coroners raised concerns about the actions of local police in conducting 'safe and well' checks or preventing delivery.** The family of a victim who died in February 2020, for example, had been unable to 'escalate their concerns' with police to prevent delivery of a package to a victim.

One coroner raised serious concerns about poor joint working between Border Force and local police. Writing in April 2024, he described how Border Force had seized a consignment of the substance, but had failed to communicate with local police on when this would be released or what action they had taken to communicate with the victim.

Four PFDs raised concerns that the antidote to the substance was not readily available for ambulance staff, raising this between January 2020 and November 2024. Two noted that carrying the antidote had been successfully trialled elsewhere, while one cited evidence that using the antidote when a victim arrived at hospital was typically too late.

Coroners' concerns relating to Online Suicide Forums

The vast majority of PFDs expressed strong concerns about the role played by forums and the ease with which they could be discovered, including on search engines. One coroner writing in November 2024 reflected that all it took was a 'basic search on Google' to 'reveal a significant number of forums and blogs, where users are able to obtain all manner of guides to completing suicide'.

Coroners expressed profound dismay over the content and discussion available on forums, including detailed advice on suicide methods, how substances and other methods of ending life could be purchased, and even how to hide suicidal intention from loved ones and support services.

Multiple PFDs referenced the profound danger easily accessible forums posed to vulnerable people already struggling with their mental health. The coroner for a 23-year-old victim described how such discussion spaces 'bestow a legitimacy on self-harming behaviour', drawing those already struggling into a 'deteriorating cycle by discussing methods of ending their lives'. This was substantiated by the coroner for a 13-year-old boy, writing how online discussion of suicide 'normalised' the idea of taking his life.

Several explicitly raised that suicide forums were in breach of the Suicide Act 1961, making it clear that online suicide forums were actively assisting suicide, and therefore breaking the law.

One Coroner raised concerns about the ability of healthcare professionals to address online risks. The coroner for a female victim who had ordered a harmful substance while detained under the mental health acted flagged that staff 'lacked any practical ability or means to know of, monitor or respond to [the victim's] internet use'.

Government responses to Prevention of Future Deaths reports

Of the 60 Government departments and other large public bodies[15] who had received PFDs raising specific concerns about the substance and/or suicide forums, as of September 2025, 39 responses were available on the Judiciary website. This is clearly a desperately low figure, although we cannot be sure whether this reflects delays in uploading responses or a failure from large public bodies to respond.

Among the 39 responses that were available and analysed, 13 responses came from DHSC, 9 from DCMS/DSIT, 5 from the Home Office and 5 from Ofcom. The majority of these responses were prepared from 2021 onwards.

Responses to concerns about the substance referenced a range of actions, though Government itself recognises more is necessary

Almost all responses reference ongoing cross-government action to address the risks posed by the substance. DHSC and Home Office responses from 2021/22, for example, mention cross-department collaboration 'to explore what further steps we can take to prevent further tragedies'. Later responses refer to joint working under the 2023 Suicide Prevention Strategy.

Responses repeatedly mention of the DHSC-led Concerning Methods Working Group. In a 2024 response, DHSC described how this group worked across Government 'to ensure rapid, targeted action has been taken to tackling the substance in question', stating that at that time there were '30 live actions and interventions' aimed at reducing public access to suicide methods.

Many referenced work to ensure the effective function of the Poisons Act. Across 2021–2025, these typically outlined the substance's status as a reportable poison, as well as ongoing work to help manufacturers and suppliers 'meet their requirements under the Poisons Act'. One DHSC response written in April 2021 posited that 'significant progress [had] already been made on limiting the availability of [the substance]', although our analysis identified 15 additional PFDs relating to deaths connected to the substance after this point.

Multiple DHSC responses referenced monitoring of trends in suicides. A 2025 response for example, outlined the range of methods used by the Concerning Methods Working Group to 'monitor trends of this substance and other concerning methods', including the use of ONS data, data supplied by the Office for Health Improvement and Disparities, and making better use of national near real-time suspected suicide surveillance data supplied by local police forces. As set out later in the report, we identify substantial divergencies between this group's analysis of trends and the separate tracking being undertaken by other sources, including Queen Mary University London (QMUL).

Multiple Home Office responses mentioned action to strengthen the operational response of Border Force and local police. This included the development and introduction of guidance for Border Force officers if they become aware of goods containing items intended to assist with suicide.

Recent responses suggest that Government acknowledges that further action is necessary. Three Home Office responses, written in February, May and July 2025, specify that further action may be needed. One outlined that Home Office officials were working with DHSC to 'consider the potential benefits and proportionality of further regulation', including 'seeking to address' victims ability

15 Including regulators, the NHS and national policing bodies.

to procure the substance from overseas without restrictions, as well as issues around the 'purity and quantities… available for sale'. Another referenced a 'cross-government workshop' that took place in June 2025.

Opportunities to act against suicide forums have been largely wasted, with Government waiting for the introduction of the Online Safety Act

Responses to concerns about suicide forums demonstrate a disturbing lack of urgency, with little action mentioned beyond waiting for the Online Safety Act to come into force.

Depending on when PFDs were issued, responses to online concerns almost all referenced either the Online Harms White Paper (2019–22), the Online Safety Bill (2022–23) or the Online Safety Act (2023–25) – outlining how the Act would, when passed, address all the concerns raised by Coroners.

Responses often used the same template, outlining the offences that suicide forums would be in breach of, plans for the implementation of the Act (including duties on search and user-to-user services) and plans for enforcement.

There were also limited mentions of teaching online safety in schools and collaboration between DSIT and the NCA to address online suicide offences.

While the Online Safety Act is a hugely important vehicle, substantial delays in passing the Act – and a further 18 months before Royal Assent and the illegal part of the regime taking effect – means that many of these responses essentially read as placeholders for further action years down the line.

Further delays associated with Ofcom's investigation. which has already taken six months, have furthered the timescales before material action will finally be taken.

Key findings: Four areas where chances were missed, and lessons must be learned

In recent years, the UK has seen a sudden and then sustained increase in deaths by suicide linked to a single substance. This rise directly corresponds with the emergence of an online forum that has promoted and encouraged its use as a preferred suicide method.

In this report, we set out the urgent steps that Government, regulators and frontline responders should take, and we catalogue numerous examples where the state has missed crucial opportunities to intervene and protect vulnerable lives.

In the following chapters, we highlight 4 main areas where chances to detect and disrupt preventable harm have been missed, and where lessons must now be urgently learnt:

1 Online regulation

Steps should have been taken sooner to prevent access to the forum for UK users. Further action is urgently required to crack down on the harm posed by this forum, and to stop others from quickly emerging to take its place.

2 Poisons regulation

The Poisons Act regulatory framework has failed to protect vulnerable users from harm, with insufficient focus on the risks associated with uses of the substance for suicide. The Government's response has been slow, insufficient and hampered by a poorly aligned strategic response across departments.

3 Insufficient traction from coronial concerns about risks to future lives

Dozens of Prevention of Future Deaths reports have raised concerns about the substance and the forum that promotes it. In the absence of a National Oversight Mechanism, multiple red flags have been missed – and harm has been allowed to continue largely unchecked.

4 Frontline responders

Downstream opportunities have been repeatedly missed, with legislative and operational shortcomings impeding the ability of UK Border Force to police the substance at our borders. Crucial opportunities haven't been taken to support people while still attempting to procure the substance, or to ensure an antidote is widely available and can be readily administered in the event that a suicide attempt is made.

Lesson 1: Online regulation and suicide forums

For many years, a major pro-suicide forum has been freely available to UK users and has been able to operate with complete impunity.

The primary function of this site is to promote, instruct and enable suicide – with the forum acting as a de facto marketplace for the promotion and sale of poisonous substances; users being encouraged, instructed and offered practical advice on suicide methods; and the existence of forum threads that actively facilitate the formation of suicide pacts. In turn, these threads appear to have been mis-used by malign actors to groom scores of vulnerable people, including teens and young adults, into taking their own lives.

Governments and regulators have been aware for many years of the egregious harm posed by this site, but despite multiple warnings from coroners, have been far too slow to grasp the threat that it poses. The regulator actively chose not to recommend the use of categorisation powers, which were explicitly amended into the Online Safety Act to address to the risks posed by such small but high-harm sites, despite deep opposition from Parliament and running against the consensus opinion of experts and civil society groups.

Earlier this year, Ofcom launched an enforcement investigation into the forum. In response, the site has currently chosen to voluntarily geo-block its site for UK users – although the site can still be readily accessed through VPNs, and many may suspect that this is a temporary tactic to forestall the platform being permanently blocked in UK courts.

Regulatory and legislative lessons must now be learned. As it is currently drafted, the Online Safety Act has been shown to be poorly placed to respond to the scale and nature of the harm posed by pro-suicide sites. The regulatory process has proven slow and cumbersome in the face of immediate, imminent risk to life.

Additional legislation is urgently required to prevent the entirely foreseeable potential of 'regulatory whack-a-mole' – a situation in which this forum is ultimately closed down, but another one quickly takes its place.

> "This site in particular has become a place where on top of just talking about suicide, you're given suggestions on how to act on those thoughts and encouragement from other users."
>
> Ilse – survivor of the pro-suicide forum

Context

The pro-suicide forum – established with nihilist intent

The pro-suicide forum was founded in March 2018 after a previous subreddit was banned on Reddit.[16] As of September 2025, the forum has over 58,000 members and receives 10 million page views per month. According to the New York Times, the site was founded by two men from the US and Uruguay who self-describe as 'incels'[17], who also run a number of other extreme misogynistic and manosphere forums.

Nihilistic violent ideologies have been linked to a number of online suicide-related threats, including the 'sharp rise' in the threat posed by Com groups, rapidly growing online networks of teenage boys and young men that target young girls for the purposes of sadistic exploitation and extreme violence.[18] This includes the grooming of vulnerable young girls for the purposes of suicide and self-harm acts.

The forum enables public and private discussions relating to suicidality and suicide methods. Research has found that most new users were only active in the first few weeks after opening their accounts and that their first posts typically focused on suicide and suicide methods.[19]

The forum has extensively promoted poisonous substances and has allegedly been used to connect vulnerable young users with sellers of the substance. This allegedly includes the Canadian Kenneth Law who will shortly stand trial on 14 counts of first-degree murder linked to the supply of the substance.[20] The site features a number of high-risk features and appears to have been used by a range of malign actors to encourage or instruct suicide acts.

A number of other countries have taken swift action to prevent or frustrate action to this site. Australian and Italian law enforcement has sought to block the site, and Germany has blocked the forum from appearing in search engine results.[21] However, Google and other search companies have declined regulatory approaches to delist the site from search results, citing the need to balance safety with the company's free speech principles.

> "This website isn't a safe space – it's a toxic breeding ground, where users are told to end their lives and instructed on how to do so by others. It is a space where despair is fuelled and suicide is ridiculed, and spoken about as casually as a decision to buy a new jacket or book a holiday. Its users are told by strangers that their loved ones don't care about them, isolating them further and fuelling their loneliness." – Adele Zeynep Walton, Aimee's sister, in Logging Off.

16 Das, S (2025) Emerging trends of self-harm using [redacted] in an online suicide community: observational study using Natural Language Processing Analysis. JMIR Mental Health.

17 Twohey, M .and Dance, G. (2021) Where the despairing log-on, and learn ways to die. Published in the New York Times, December 9, 2021. The Center for Countering Digital Hate has identified one of the incel forums run by the founders of this forum as the largest of its kind dedicated to incel ideology. Ahmed, I (2022) The Incelosphere: spacing pathways into Incel communities and the harms they pose to women and children. Center for Countering Digital Hate.

18 The FBI has warned of the 'sharp' rise in the threat posed by Com groups, alongside warnings issued by numerous other global law enforcement agencies including the National Crime Agency, Europol and Canadian authorities.

19 Sartori, E. et al (2023) The Impact of Covid 19 on Online Discussions: the Case Study of the [redacted] Forum. WWW 23: Proceedings of the ACM Web Conference 2023. Association for Computing Machinery, pp 4060–4064.

20 Twohey, M .and Dance, G. (2021) Where the despairing log-on, and learn ways to die. Published in the New York Times, December 9, 2021.

21 Bridges, A. (2022) there is a pro-suicide websites linked to deaths in Australia. Getting it shut down is not so simple. ABC News. Published 15 November 2022.

The Online Safety Act

The Online Safety Act places a series of requirements on user-to-user platforms, including this pro-suicide forum. The forum faces a number of specific regulatory duties, including a duty to identify, mitigate and manage the risks of harm from illegal content and activity; duties to prevent children from seeing priority forms of harmful content; and a requirement to assess and mitigate reasonably foreseeable harms, including suicide and self-harm material.

However, Ofcom recommended to the then Secretary of State Peter Kyle not to enact additional powers that were specifically amended into the Act by the House of Lords and that were designed to give the regulator additional leverage when tackling the risks posed by such small but high harm sites.[22]

In a move that raised substantive questions about the regulator's approach, Ofcom declined powers to designate sites as Category 1 based on both size and risk,[23] a move that would have placed additional obligations on this pro-suicide forum (and that in turn would have likely strengthened the regulator's case when applying to a court for business disruption measures).

The Secretary of State's decision to uphold Ofcom's advice was met with deep dismay in Parliament and across civil society. In the Lords, peers passed a Motion of Regret, a rare parliamentary mechanism voicing their disapproval with the relevant secondary legislation being enacted.[24] There was also sustained opposition to this approach in the Commons, with the former Secretary of State Jeremy Wright concluding that the approach was 'specifically contrary to what Parliament had intended' when the Online Safety Act was passed.[25]

> "It is shocking that children across the UK can so easily access a forum where suicide is openly discussed and encouraged. It isn't a space for support or compassion, they provide shopping lists of deathly equipment and lethal substances, scripts to evade questions from parents or support services, step-by-step instructions, and even chilling descriptions of what their final dying sensations will be. It is the digital equivalent to a stranger standing at the school gates, handing out suicide manuals to children. Any parent would be horrified that such a blatant danger to young people is being allowed to not just exist but to flourish, especially after so many coroners have raised red flags."
>
> Alison Webb, mother of Lucas, 16, who took his own life after visiting the pro-suicide forum. Within an hour, he had bought the equipment itemised on a shopping list advertised on the forum along with detailed instructions for implementation.

Ofcom's investigation and voluntary geo-blocking

Despite its earlier decision not to seek additional powers, Ofcom acted quickly to use its broader investigatory powers to act against the forum. In April 2025, the regulator announced it was opening

22 Ofcom (2024) Categorisation research and advice submitted to Secretary Of State. Published March 25, 2024.
23 The Online Safety Act Network has provided excellent analysis of Ofcom's approach to the categorisation of services in the Act
24 Ofcom (2025) Investigation into an online suicide discussion forum and its compliance with duties to protect users from illegal content. Published April 9, 2025.
25 House of Commons (2025) Draft Online Safety Act 2023 (Category One, Category 2A and Category 2B Threshold Conditions) Regulations 2025. Hearing of the Delegated Legislation Committee, debated on February 4, 2025.

a formal investigation into the forum for suspected non-compliance with its risk assessment, illegal content and information notices duties.[26]

In turn, this led to the forum being voluntarily geo-blocked for UK users. Although this means the platform is no longer immediately accessible to UK users, in practice the forum can still readily accessed by a VPN. For much of spring 2025, the forum continued to host a banner page that directly encouraged UK users to continue to access the site through such means.

While Ofcom's investigation continued, the regulator declined to provide ongoing updates to bereaved families and civil society. However, in a deeply troubling update issued in Octobr 2025, Ofcom appeared to suggest that it would be satisfied not to take further enforcement action so long as the voluntary geo-block remained in effect.

This means that the forum remains readily accessible to UK users via a VPN, and the forum is likely to be able to continue causing harm to vulnerable people.

There are growing concerns among civil society and lived experience campaigners that Ofcom has failed to grasp the urgency of taking action against this forum, and that its processes and investigatory stance risk further exacerbating the already lengthy timescales to conclude its work. In a markedly different stance to that adopted by other regulators (and Ofcom's own approach in respect of other areas of online safety), the regulator has so far declined to proactively engage with the considerable experience and insight of lived experience campaigners, civil society groups and legal experts who collectively have many years of pooled experience and evidence of these risks.

We strongly believe this evidence could potentially strengthen the regulator's ambition and/or expedite the timescales that would enable it to move into active enforcement against the site, assuming it continues to exercise non-compliance.

Ofcom should stand ready to make an application to the High Court for a Service Disruption Order that would permanently block the site in the UK, and its reluctance to do risks further UK lives.

> "The presence of a site that gives vulnerable people step-by-step, explicit instructions for suicide, almost cajoling them into it, is incredibly dangerous. Just because you have to use a VPN to get to it, that is not any sort of safeguard at all. Ofcom has to do all it can to shut this website down, even if that's in the knowledge that it could pop up somewhere else; it has to be prepared for that and to have a strategy."
>
> Pete Aitken, whose daughter Hannah died from the substance and is suspected of using the pro-suicide forum

26 House of Lords (2025) Online Safety Act 2023 (Category One, Category 2A and Category 2B Threshold Conditions) Regulations 2025. Volume 843: debated on February 24, 2025.

The pro-suicide forum and its impact in the UK

Analysis suggests that on a per capita basis UK users of the forum are more likely than users from any other country to post they were either sourcing or intending to take a poisonous dose of the substance.[27]

Between March 2018 and September 2022, academic analysis identified 107 UK users who were attempting to procure the substance. This amounted to 27% of all users whose geographical location could be identified.

Over this time period, the UK was the second largest market for supplying the substance among forum users, with 303 posts claiming to have secured the substance from UK sources. Only the United States was mentioned more frequently (with 586 references.) Canada was referenced 129 times.

This analysis illustrates that the UK had a particularly significant problem with vulnerable people using the forum with the intention to source or procure the substance in poisonous amounts. It adds to the concern that the UK could and should have acted more quickly to identify and react to the growing trend of attempts to procure the substance for suicide or self-injury related purposes.

This analysis also underlines that the UK has had a particular problem with domestic sources of supply, with the UK becoming something of a ‘hot spot’ for forum members who claimed to have sourced or purchased of the substance over this period.

What needs to happen?

1. Ofcom must finish the job

The forum’s decision to voluntarily geo-block for UK users must in no way dilute the urgency of Ofcom’s investigation and any enforcement action that may follow. The forum previously blocked UK access following earlier contact from the regulator only to reinstate it several days later. Many may therefore suspect that the forum’s decision to geo-block is primarily a calculated tactic to delay the regulator’s work and/or frustrate any attempts to permanently block access to the forum in UK courts.

Ofcom’s recent announcement to rely on the site’s own voluntary geo-blocking, rather than proceeding to apply for a Service Disruption Order to permanently block the forum to UK users, suggests a woeful lack of ambition in the face of immediate and imminent risk to life

Ofcom should not only be prepared to apply for a Service Disruption Order, it must also be prepared to go further. For as long as this forum remains readily accessible using a VPN, the lives of vulnerable young people remain at risk. Ofcom must therefore be prepared to use all of the powers at its disposal, including the use of substantial fines and criminal sanctions. The egregious harm and priority offences being facilitated on this forum means that it is inherently proportionate and justifiable course of action, and ultimately it is only this magnitude of action that may eventually lead to the closure of this most appalling of sites.

27 Das, S (2025) Emerging trends of self-harm using [redacted] in an online suicide community: observational study using Natural Language Processing Analysis. JMIR Mental Health.

2. Legislative reform

The response to this forum has brought into focus structural weaknesses with the Online Safety Act. Legislative amends are urgently required to enable swifter action against platforms that present a vital and immediate risk to vulnerable users, with the speed of the regulator's investigations – which it presumably deems necessary under the current legal framework – poorly placed to respond to a site that continues to represent a substantial and ongoing threat to life.

The Government should therefore amend the Act to provide additional powers targeting platforms where a Coroner has identified that there is an immediate and ongoing substantial risk to life.

Where one or more Prevention of Future Deaths reports are received, we recommend that Ofcom should be granted powers to issue emergency notices setting out measures that platforms must take to immediately reduce or eliminate the potential for further harm.

Where a platform fails to respond or take the necessary measures within 28 days, Ofcom should then be able to apply for an interim set of service or business disruption measures from a UK court, in effect providing an expedited and streamlined set of measures in extreme cases – such as this site – where there is an immediate and pressing 'vital interest' basis to act.

3. Amending the Act to prevent 'regulatory whack-a-mole'

The Online Safety Act should be urgently amended to prevent the entirely foreseeable potential of 'regulatory whack-a-mole' – a situation in which this forum is ultimately closed down, but another site immediately takes its place.

As it stands, there is nothing to prevent the suicide forum's owners from being able to wholescale move their operations to an entirely new site, and in turn, being able to effectively frustrate regulatory action by essentially re-setting the regulatory clock.

Ofcom should be given powers to identify and respond to circumstances where it reasonably believes that regulatory whack a mole is taking place, and where it believes there are credible public safety risks that may result.

While there are clearly important issues relating to free expression and other fundamental rights that would carefully need to be worked through, evidence of 'regulatory whack-a-mole' should also provide grounds for the issuing of the emergency notices set out above.

4. Existing regulatory vehicles

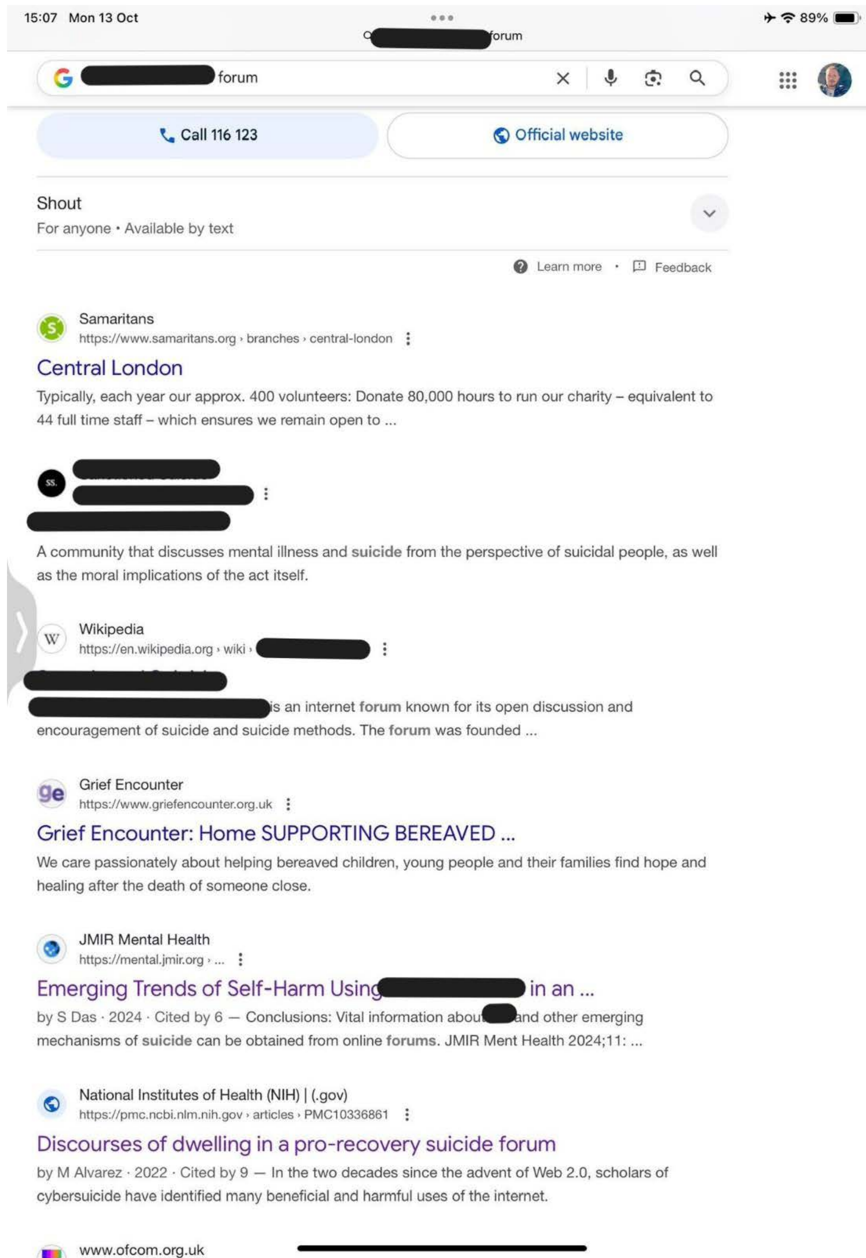
Ofcom must be prepared to use its existing powers to tackle the upstream ways in which pro-suicide forums are signposted to vulnerable groups, for example through search engines and AI chatbots.

Under the Online Safety Act, search engines are required to take appropriate moderation action against suicide or self-harm content, which could include deprioritising a site in search results or preventing it appearing altogether.

However, as it stands, there is no evidence that major search engines have taken anywhere near satisfactory steps to comply with these requirements, other than including a banner message signposting to mental health resources.

For example, on Google the forum remains easily searchable by name, and among other top search results is an academic paper that explicitly mentions the substance. This includes an accompanying description that the poison can be 'readily obtained from online forums'.

The page 1 search results on Google when searching for the forum by name, conducted in October 2025.



Lesson 2: Poisons regulation

Since 2019, a sudden and then sustained increase in deaths by suicide can be attributed to a single poisonous substance. As set out in the previous section, most this rise can be attributed to a malign pro-suicide forum, although details of the substance are also found in readily available e-books and 'poison handbooks.'

The rapid growth of the risk posed by this substance and forum has exposed substantial weaknesses in the current regulatory regime. The regulatory framework for the substance was substantially weakened in 2015. Despite some additional strengthening in 2023, the regulatory approach remains poorly targeted to the scale of the threat – and indeed to the emergence of other similar poisons in future.

Much of this stems from failures within Government – in particular, the Home Office has been slow to respond, and while it has indicated it may consider further measures to tighten supply, has refused to even meet or discuss with civil society and lived experience groups.

A lack of clear and effective strategic responsibility within Government has almost certainly impeded further action form being taken, and in our assessment, this is an institutional failure that is likely to have cost lives.

Context

The substance

Since 2019, the UK has seen a rapid and then sustained trend of a substance being used in cases of self-harm and suicide. The substance has a number of entirely legitimate uses, including as a food preservative and colouring agent.[28] Harm therefore occurs where the substance is ingested in toxic and potentially lethal amounts.

The rise in deaths by suicide linked to the substance directly corresponds with its promotion on the pro-suicide forum, its promotion as a 'pain free' suicide method in widely available e-books, and with the increased availability of 'suicide kits' on online marketplaces and websites that supply the substance in addition to instructional material.

Research finds that there was a sharp uptick in references to the substance on the suicide forum in the second half of 2019,[29] which directly corresponds to an increase in deaths by suicide associated with intentional consumption of the substance.[30]

28 Cvetković, Danica et al. (2019) [redacted] food poisoning in one family. Forensic science, medicine, and pathology, 15,1: 102–105.

29 Das, S et al (2024) Emerging trends of self-harm using [redacted] in an online suicide community: observational study using Natural Language Processing Analysis. JMIR Mental Health 2024, 11: e53730.

30 Mudan, A et al (2020) Severe methemoglobinemia and death from intentional [redacted] ingestions. Journal of Emergency Medicine, 59, 3, e85–88.

The consumption of this substance induces methemoglobinemia, a condition that causes hypoxia and if not treated promptly can lead to death.[31] While the unintentional consumption of the substance due to poor storage practices is of concern, multiple studies have asserted that the 'global popularisation' of this substance has been directly facilitated by the pro-suicide forum highlighted in this report.

Professor Amrita Ahluwalia, a pharmacology professor at Queen Mary University of London, has been supporting UK investigations linked to the substance. Her toxicology analysis indicates that at least 133 people may have died since 2019 as a result of ingesting it.[32]

Between January 2018 and December 2023, there were nearly 1,900 attempts for primary care information about the substance by UK healthcare professionals through TOXBASE, the primary clinical toxicology database of the National Poisons Information Service.[33]

Professor Ahluwalia has stated her concern that the substance 'is being misused and resold by unscrupulous people to vulnerable individuals'.[34]

Regulation under the Poisons Act

The substance is currently designated as a 'reportable' poison under Schedule 1 of the Poisons Act. However, the substance is not currently designated as a higher-risk 'regulated' poison, having been deregulated as part of the Deregulation Act 2015.

As a reportable substance, suppliers in Great Britain do not require a licence but are instead required to report suspicious transactions to the Home Office. In practice, this means that domestic procurement will usually result in the supplier asking for the reason for the purchase but would not automatically trigger a welfare check in the event of concerns about a purchase being made for reasons relating to suicide.

Under the 2015 Deregulation Act, the substance's designation as a 'regulated poison' was removed. Designation as a regulated substance or poison means that its sale and supply to the public is subject to specific requirements, including holding a licence for supply with Great Britain, recording details of transactions made, and in respect of imports to the UK, the supplier being able to demonstrate a recognised licence from another jurisdiction.

Oversight of and responsibility for the Poisons Act sits with the Home Office. While the Poisons Act explicitly requires the regulation of poisons that can be used to harm the public, a seemingly broad requirement encompassing all relevant matters of public safety, in evidence following the death of Hannah Aitken the Home Office described its application of the Poisons Act regime much more narrowly.

Specifically, the Home Office position is described as 'having specific policy aims in relation to countering terrorism', but that 'suicide prevention is not a policy aim'.

31 Stevenson, L et al. (2022) Forensic Sci Med Pathol. 25, 18(3), pp 311–318.
32 Queen Mary University of London (2024) Analysing the Evidence: an Interview with Prof Amrita Ahluwalia. Available on QMUL's website.
33 Witness statement from the National Poisons Information Service in the inquest into Hannah Aitken's death.
34 Queen Mary University of London (2024) Analysing the Evidence: an Interview with Prof Amrita Ahluwalia. Available on QMUL's website.

Analysis suggests that the UK appears to have become one of the largest sources of supply for the substance among members of the suicide forum. Between March 2018 and September 2022, 303 posts claimed to have sourced the substance from the UK, second only to the United States. While for methodological reasons we cannot be sure whether this reflects legitimate or illicit sellers of the substance, this clearly suggests that there were substantial weaknesses with the existing regulatory response that were being readily exploited by purchasers and sellers.

In respect of illicit and illegitimate sellers, it also points to a potentially insufficient law enforcement response.

> "Had this been a regulated poison, Hannah wouldn't have been able to obtain it at all. She would have needed a license and that would have stopped that train in its tracks."
>
> Pete Aitken, father of Hannah

Steps taken to prevent the lethality of the substance

While the Home Office has to date stopped short of reclassifying the substance as a regulated poison, other steps have been taken to reduce the harm associated with its procurement for suicide and self-harm purposes.

In 2024, the National Police Chief Council Lead for Suicide Prevention Paul Crowther set out action being taken to reduce the immediate risk associated with ingestion of the substance. He stated that 'all suppliers have been directed to mix the substances with other products […] which lead to vomiting on ingestion'.[35] While clearly only a voluntary measure, this shift in product formulation is an important and welcome step.

Other ad hoc steps have been taken by individual suppliers. In at least one case, a legitimate supplier decided to stop supplying the substance after making a transaction which led to a person taking their own life. In a response to a Prevention of Future Death report, they stated:

> *'we withdrew the listing immediately back in April 2020 when we became aware that it was being recommended on these dreadful suicide forums for young people – notably [the pro-suicide forum and another redacted site] – both of which are sadly still active.'*

> Vlad was just 17 when he ingested the substance after being encouraged to do so on the pro-suicide forum. He is one of the youngest people believed to have used it.
>
> Vlad was diagnosed with autism, depression and anxiety. He was one of many vulnerable young people to have accessed the substance via the forum, where it is believed his vulnerability was preyed on.
>
> Vlad ordered a number of substances from abroad which got through customs and ultimately used them to end his life
>
> His sister Mia has since exchanged messages with moderators on the site and believes it is responsible for grooming people to end their life, including by using this substance.

35 Response from British Transport Police to the Regulation 28 request issued following the inquest into Chloe MacDermott's death.

What needs to happen?

1. Re-designation of the substance as a regulated poison

There is a compelling case to redesignate the substance as a reportable poison under the Poisons Act, as part of an urgent refocusing of the Government's approach towards harm reduction and suicide prevention.

While the decision to declassify the substance in 2015 may have been justifiable at the time, the material and sustained increase in deaths linked to the substance since 2019 should have already been grounds for an urgent review and upgrading of the regulatory scheme.

The Home Office has suggested a range of reasons why this hasn't happened, but these appear to be secondary considerations – with the primary driver being the Home Office's decision to focus the Act predominantly on combatting terrorism, rather than on broader threats to life.

Evidence in the inquest into the death of Hannah Aitken indicated that no analysis had been undertaken into the legitimate use of the substance compared to its usage for self-harm and suicide.[36]

2. The Home Office must enforce the full scope of the Poisons Act, with ministerial responsibility for all related public safety risks

The failure to quickly and effectively respond to the growing threat posed by this substance is primarily a function of fractured departmental responsibilities – it represents an institutional failure that has contributed to the loss of scores of UK lives.

The Home Office has displayed a fundamental disconnect in its approach, with the Security Minister confirming to Parliament that the Poisons Act is the appropriate vehicle to regulate the substance in this context,[37] while his officials have instead adopted a wholly different approach that focuses narrowly on counter terrorism, rather than the broader threats to public safety and the potential for loss of life.

Suicide prevention has essentially become an exercise in departmental 'pass the parcel'.

In Hannah Aitken's inquest, the Home Office described that its regular reviews of the Poisons Act focus on the pre-cursors for explosives, actively involving departmental officials, policing and the intelligence services. The official giving evidence, Shaun Hipgrave, pointed to an entirely different response for suicide prevention, pointing to DHSC's mechanisms to identify and respond to new and emerging suicide threats. There was no meaningful indication these systems were adequately linked.[38]

More recently, the Home Office has sought to distance itself from a focus on suicide prevention in its entirety, highlighting 'ongoing work across Government to explore regulatory options for the substance that extend beyond the Poisons Act'.[39]

36 Evidence provided by the Home Office during Hannah Aitken's inquest.
37 Parliamentary answer given the Security Minister, Dan Jarvis, on 6 May 2025. House of Commons (2025) Poisons: Sales. UIN 48303.
38 Evidence provided during Hannah Aitken's inquest.
39 In written correspondence with Molly Rose Foundation.

3. Taking action to restrict international supply

As it stands, the Poisons Act does not apply to overseas retailers, which means there is limited enforcement on international sales.

There is currently no legal or regulatory restriction to prevent cheap, high-purity forms of the poison substance being brought into the UK – with poison sellers seemingly driven by a range of commercial and malign motivations operating out of a range of jurisdictions, including Ukraine, Malaysia and Canada.

Current powers to identify and seize poisonous substances are generally limited, with the powers available to Border Force enabling them to either hold suspicious parcels for 30 days or to seize them only in cases where there are grounds to suspect an offence.

Border Force's powers to seize parcels are being constrained by a lack of strategic policing and cross-working with law enforcement authorities. As set out in the following chapter, we therefore call for the adoption of a new strategic approach to the policing of suicide-related offences – with a sustained focus on intelligence and threat sharing.

Legislative amendments may also be appropriate, for example through amending the powers available to Border Force under the Police and Criminal Evidence Act, or through amending the offences relating to the encouraging or assisting of suicide and self-harm offences to explicitly include cases where a poisonous substance is knowingly being sold for the purposes of suicide or self-injury.

David Parfett's son Tom was 22 when he used the pro-suicide forum to order the substance from Canadian seller Kenneth Law.

David worked with The Times journalist James Beale to help expose Kenneth Law, resulting in his arrest. He is currently awaiting trial in Ontario on charges of murder and assisting suicide.

Since Tom's death, David has been able to successfully order the substance on numerous occasions, including from UK sellers.

"I know from my own personal experience having ordered it three times now that it still gets through to people. It's a scandal that we're letting people still take their own lives. And to be clear, this was from a seller in the UK. It wasn't even a seller from abroad. Actually having a container with this poison delivered through my door, knowing that was what my son had done, made me sick."

Lesson 3: The need for a National Oversight Mechanism and a strategic response to suicide offences

This report has highlighted an often shocking failure to adequately respond to repeated concerns raised by coroners, civil society groups, people with lived experience, and legal and medical experts.

Insufficient action has been taken in response to numerous Prevention of Future Death reports issued to the Government, with one or more matters of concern raised by coroners to DSIT, DHSC and HO a combined total of 65 times.

Our analysis not only points to countless red flags that have been either missed or insufficiently acted on in the face of institutional inertia and delay, but to deeper systemic issues around how the UK Government, regulators and other public bodies respond to coronial recommendations and ensure that much-needed lessons translate into practical policy change.

Other opportunities have also been missed to intervene and act in the face of the rapidly emerging risk posed by this forum and substance. It is clear that the UK's early warning mechanisms for suicide prevention have either failed to identify the risks posed by the substance quickly enough, or that any recommendations made have fallen on deaf ears in the context of the cross-Government mechanisms and complicated lines of responsibility spread across multiple government departments.

It seems apparent that the Government's Suicide Prevention Strategy has paid insufficient attention to the risks of suicide associated with malign actors, and that further investment and strategic emphasis is needed to identify and disrupt the harm caused by pro-suicide forums and broader suicide and self-harm offenders.

There are clear opportunities for a strategic law enforcement response to suicide and self-harm offences, with particular merit in a better organised, more strategic response to new and emerging suicide-related threats.

Necessary changes to the coronial system, law enforcement response and the strategic responsibilities for suicide offences across Government can collectively ensure the lessons from this forum and substance are appropriately learnt – and that the UK state is better prepared to protect its most vulnerable citizens from new and emerging suicide-related threats.

Context

Coronial recommendations and Prevention of Future Deaths reports

In each of the 74 coroner areas in England and Wales, coroners have the power under the Coroners and Justice Act 2009 to issue a report to a person, organisation, local authority or government department where they believe action can be taken to prevent future deaths. Prevention of Future Deaths reports (also known as Regulation 28 notices) are not mandatory.[40]

As it stands, where a coroner issues a Prevention of Future Deaths report, recipients have 56 days to respond to any matters of concern raised. There is currently no formal mechanism to track how and whether recipients of a PFD enact any changes set out.

There are also no formalised or funded state arrangements to analyse new or emerging trends, blunting the potential resource of Prevention of Future Deaths reports to act as a crucial part of an early warning system that can identify new and emerging issues.

In the absence of centralised and systematic oversight mechanisms, it has instead been left to civil society, law firms and academics to collate and monitor Regulation 28 notices and responses to them. Organisations such as INQUEST have undertaken deeply valuable work to monitor and track PFDs and responses across a broad range of issues.

Separately, Dr Georgia Richards at King's College London oversees the Preventable Deaths Tracker, the UK's first centralised surveillance tool of PFD reports and responses. This database operates with limited financial support and is entirely reliant on continuing external funding to cover its ongoing running costs.

England's Suicide Prevention Strategy

In 2023, the UK Government published its Suicide Prevention Strategy for England, an ambitious strategy that aims to reduce deaths by suicide in the five years to 2028, with initial reductions observed within half this time or sooner.[41]

The strategy identifies a number of priority groups including children and young people, people in contact with mental health services, and people with an autism diagnosis. It also highlights online safety as being a primary focus area.

DHSC has primary responsibility for suicide prevention policy, but suicide prevention is operationalised as a cross-government issue, with specific actions and mechanisms being led by a wide range of departments and organisations.

Multiple PFDs emphasise the Online Safety Act as a primary vehicle to deliver improved technology-facilitated suicide outcomes. The strategy makes a brief reference to tackling at source the suppliers of harmful substances, but does not make reference to the broader risks being posed by malign actors – including those who facilitate and run this forum and the emerging threat being posed by organised online groups.

40 Analysis from Kings College London suggests that just 2.9% of preventable deaths result in a Prevention of Future Deaths report being prepared. These powers are set out in the Coroners (Investigations) Regulations 2013.

41 Department of Health and Social Care (2023) Suicide prevention in England: five year cross sector strategy.

What needs to happen?

1. The establishment of a National Oversight Mechanism for preventable deaths

A National Oversight Mechanism should be established as a matter of urgency to track, collate and analyse matters of concern arising from Prevention of Future Deaths reports, public enquiries and other official hearings.[42]

As it stands, hundreds of vital concerns are made each year following inquests and inquiries, yet there is no overall system in place to identify new and emerging trends, ensure that matters of concerns raised in PFD are acted upon, and to track the effectiveness of any measures that are taken.

In the case of the suicide forum and the substance, the PFD process has resulted in a steady stream of broadly consistent matters of concern, including those in respect of the forum, stronger regulation of the substance, and more effective measures to prevent it being imported from suspicious sellers.

Other than securing a cottage industry of Government responses that broadly reiterate steps that have already been taken, multiple PFDs have seemingly been unable to secure sufficient traction to cut across ineffective cross-Government arrangements and deep and sustained institutional inertia. The current system simply isn't working.

It is therefore time for a new independent public body to be created that is responsible for the collation and analysis of PFD reports and responses. This body should be equipped with appropriate statutory information gathering and disclosure powers to enable it to follow up on progress and to enable it to escalate and share repeated and thematic concerns.

Any oversight mechanism should also make arrangements for external academic and civil society inputs, enabling the mechanism to benefit from specialist interest and expertise and to ensure the broadest possible response to the monitoring and analysis of deaths.

2. Improvements to the coronial process, including further training

Coroners should receive additional training to ensure they can operate within the full scope of the coronial and investigatory powers that are available to them. Additional training would not only prove beneficial to bereaved families but would help to ensure the coronial process discharges its public protection functions most effectively.

As it stands, families report very mixed experiences regarding the approach of coroners to investigating the source of the substance, the online activity of the deceased, and how each may have played a role in their death. We are aware of coroners who deem it beyond the scope of the inquest to consider the role that activity on a suicide forum may have played in a death.

This stance not only causes distress to the families concerned (and means that important factors in how someone came by their death may not be considered); it can also mean that vital issues that could subsequently inform Regulation 28 concerns – and that in turn could lead to meaningful legislative, policy or operational change – are ultimately overlooked.

42 Molly Rose Foundation is one of 72 signatories to Inquest's campaign for an independent oversight mechanism.

Training is needed to ensure a more consistent approach to the coronial process – ensuring that bereaved families do not receive a postcode lottery service, and coroners are aware of when and how they should investigate these issues in determining how someone came by their death, including how to gather evidence of online behaviour and to assess the impact of online harms on the deceased's state of mind. People with lived experience should be actively involved in the development of these training materials.

At present, there are often inconsistencies in how substance-related deaths are recorded in Records of Inquest (this is particularly the case in respect of Box 2, the Medical Cause of Death.) This could be readily addressed through a combination of additional training and updated guidance from the Chief Coroner. Taken together, these measures would enable more reliable data collection, and in turn, for the scale of risks and harm to be more readily identified and understood.[43]

Training should also be provided to encourage coroners to prepare Prevention of Future Deaths reports in a consistent manner. PFDs typically vary in the information they provide, with key demographic, health and psychographic information provided inconsistently. It is also unclear how recipients for PFDs are identified by coroners, with not all being sent to the bodies with the power to address the risk to lives identified.

There can be substantial delays in uploading PFDs and responses to the Judicial Database. According to analysis from the Preventable Deaths Tracker, published responses to PFDs are only available in full in only three-fifths of cases (60.7%.) In one in four cases, no responses have either been received or made publicly available. It is unacceptable for a risk to life to be brought to the attention of a State body and no action be taken. There is a compelling case that sanctions should be brought to apply for failures to respond to PFDs.

3. Clear strategic responsibility and a strategic mission for suicide-related offences

A clear cross-government approach to suicide offences is urgently required, with strategic responsibility ultimately sitting under a Home Office Minister.

In practice, it is clear that the issues raised surrounding this forum and the substance have been allowed to fall through the cracks, with responsibility split across four separate departments. All too often, it appears that government departments have opted to 'pass the parcel' in the absence of a strategic, cross-government mechanism to respond to the forum, the substance and broader similar issues.

We are particularly concerned that some departments, including the Home Office, have refused to even engage with civil society and lived experience campaigners on their concerns.

As part of its remit, the Home Office should work with law enforcement agencies, including the National Crime Agency and National Police Chiefs Council, to develop a more effective strategic policing response to the emerging threats posed by suicide offences.

43 For example, where death has followed ingestion of the substance, we are aware of Records of Inquests that record 'poisoning', 'toxicity' or 'ingestion' of the named substance as the medical cause of death, but also where the blood disorder that results from ingesting the substance or simply 'toxicity' is recorded. Coroners (as well as many others involved with an investigation following a death such as police or medical professionals) also frequently interchangeably use the name of the substance and the chemical it converts into once inside the body, including on Records of Inquests.

We see particular merit in the Home Office adopting a version of the 4P policing model, its highly effective means of responding to other serious and organised threats.[44] A more organised and appropriately resourced response could pay dividends, not only in terms of identifying and disrupting illicit sellers, but in contributing to a whole system response that can in turn enable and underpin a broader range of other upstream prevention activities.

For example, a police intelligence function focused on suicide offences could meaningfully support Ofcom's work to identify and take action against websites that facilitate or enable illegal suicide acts. Similarly, improved intelligence could enable law enforcement and Border Force to detect and take more effective action against imports linked to suspicious sellers, with Border Force able to intercept and seize parcels where the police intelligence identifies that substances are linked to an ongoing criminal investigation.

4. Improving data collection and increasing the focus on malign actors in the Suicide Prevention Strategy

Although England's Suicide Prevention Strategy references the need for action to 'tackle at source the suppliers of harmful substances',[45] in practice this has evidently not translated into an adequately coherent and strategic government and multiagency response.

While this primarily reflects issues around government co-ordination and a lack of clear departmental and ministerial responsibility, we are also concerned that the early warning mechanisms established by DHSC may have compounded the lack of strategic focus on these risks.

DHSC claims that while 'it observed an increase in the number of suicides using [the substance] a few years ago, we have not found concrete evidence that the numbers have increased in the last few years and since the Concerning Methods Working Group was set up.[46] These claims seem difficult to reconcile with the data being provided from other sources, not least the toxicological analysis from QMUL[47], analysis of trends from publicly available PFD reports, and the National Crime Agency currently linking 99 deaths to the alleged Canadian seller Kenneth Law.

While data collection for suicides is appreciably challenging, and analysis from other jurisdictions also points to challenges in establishing accurate data on substance-related deaths,[48] there are prima facie grounds to conclude that DHSC may have underestimated the actual scale of deaths linked to the substance and its growing promotion on online forums.

DHSC does report some success from its current arrangements, with claims that its Concerning Methods Working Group has made and implemented over 30 recommendations in relation to the substance. However, this has palpably not been enough to prevent the ongoing risk to vulnerable groups and to prevent future deaths.

44 For more information on the 4P model, see College of Policing (2025) 4P Approach to Dismantling Serious Organised Crime.
45 Department of Health and Social Care (2023) Suicide prevention in England: five year cross sector strategy.
46 DHSC's response to the Prevention of Future Deaths report issued following the inquest of Hannah Aitken, sent in January 2025. The Emerging Methods Working Group has been referenced in DHSC's responses to PFDs since at least early 2021.
47 As set out earlier in the report, QMUL analysis suggests at least 133 deaths linked to the forum between 2019 and 2024.
48 For example, Bloom et al identified a marked discrepancy between the incidence of deaths attributed to the substance that were reported to medical examiners and those reported to Poison Control Centers in New York: Bloom et al (2024) Comparing confirmed [substance] suicide deaths with poison center surveillance estimates. JAMA Netw Open, 7(9): e2434192. Drawing on the epidemiology of an increase in suicide deaths linked to the substance, Nogar et al underscore the importance of improved data sharing on a real-time basis between public health agencies: Nogar, J et al (2024) Suicide and the Epidemiology of a Toxin That Kills Quickly – data sharing between public health agencies. JAMA Netw. Open, 7(9), e: 2434126.

There is a common and persistent frustration among people with lived experience of the substance and forum that there have been a lack of meaningful opportunities to engage with Government departments, the regulator, and most of the public bodies with a role to play in preventing further deaths. We therefore recommend that each of these bodies improve their approach to meaningful engagement with people with lived experiences, and that in the case of the Home Office ministerial lead, a lived experience advisory board should be established.

While online safety is a core component of the Suicide Prevention Strategy, we are concerned that unless greater strategic emphasis is placed on online suicide offences, this part of the strategy risks falling badly short.

DSIT has announced much-needed legislative action in this area, including the upgrading of self-harm offences under the Online Safety Act.[49] However, Ofcom has in our assessment consistently failed to demonstrate an adequate sense of urgency or focus on illegal suicide threats, and we are not aware of any published outputs that set out the anticipated contribution of its online safety regulatory approach to meeting the ambitious targets laid out in the Suicide Prevention Strategy.

49 Announcement made by the new Technology Secretary Liz Kendall in September 2025.

Lesson 4: downstream and operational responses

Throughout this report we have highlighted how a range of upstream opportunities to tackle and disrupt the risks posed by this forum and the substance have been missed. Where action has been taken, it has typically failed to respond to the growing scale and nature of the harm that's been observed.

While upstream measures are of course the most important means to prevent further harm, downstream opportunities have also been missed. For example, improvements are needed to ensure there is a more cohesive and effective response to the substance being imported by suspicious sellers, with a lack of effective coordination between Border Force and local law enforcement, and the current constraints of the Poisons Act substantially impeding effective interception of the substance at our borders.

In cases where the substance is taken, an antidote called Methylene Blue can be administered and is highly effective. Despite promising trial results, Methylene Blue is currently only stocked by two ambulance services across England. There are compelling grounds for this antidote to be made more readily available UK-wide, acting on matters of concern raised repeatedly in Prevention of Future Deaths Reports.

Context

The importing of the substance for the purposes of suicide

In recent years, a growing number of international sellers have been importing the substance to the UK, with sellers allegedly importing the substance from countries including Canada, Ukraine, Malaysia and Vietnam. In many of these cases, sellers appear to be actively capitalising on the promotion of the substance as a suicide method on the forum.

As it stands, the UK Border Force has no powers to seize the substance under the Poisons Act, and it can only use its powers to seize items where it has prior knowledge that its use would be a danger to a person. According to a Molly Rose Foundation Freedom of Information request, Border Force identified 21 suspicious packages in the four years up to and including 2023/24, and only nine seizures were successfully made.

The tragic case of Dr Jonathan Shaw highlights the considerable shortcomings associated with imports of the substance and shortcomings in the operational response. Dr Shaw procured the substance from a company based in Malaysia, and his was one of the few cases where, at the request of the National Fast Parcel Targeting Team, the UK Border Force initially withheld this item.[50]

50 Prevention of Future Deaths report following the inquest into Dr Jonathan Shaw's death.

Nine days later, the UK Border Force released the parcel following a check undertaken by Greater Manchester Police (GMP). The coroner overseeing Dr Shaw's inquest determined that a lack of coordination between Border Force and GMP 'represented a significant missed opportunity',[51] as it was likely that Dr Shaw would have agreed to the safe destruction of the package if he had been asked to consider this prior to taking physical possession of it.

Dr Shaw subsequently died as a result of ingesting a toxic dose.

Ambulances and the supply of Methylene Blue

In a small number of areas in England, ambulance forces stock the primary antidote used to reverse the physiological effects of an overdose of the poisonous substance, Methylene Blue. This antidote has to be administered swiftly, with academic reports stating that Methylene Blue 'is an effective but time-sensitive antidote that has the potential to save lives when administered early.'[52]

In 2019, the West Midlands Ambulance Service received a PFD report that led to a trial of the antidote being made supplied to its hazard response team (HART) paramedics.[53] The West Midlands HART unit is one of 15 paramedic teams across England, providing urgent paramedic care to any persons within a hazardous environment or situation.

Figures suggest that the West Midlands HART team has attended nine cases of suspected poisoning since it started its trial of Methylene Blue. The antidote was administered in four of these cases. Three of these patients subsequently survived.[54]

We understand that the Association of Ambulance Chief Executives is continuing to review clinical best practice around the availability and supply of Methylene Blue, with a further meeting due to take place this month.[55] A second ambulance service, the Yorkshire Ambulance Service, now also supplies the antidote to its HART teams and advanced paramedic critical care teams.

However, progress around the uptake of Methylene Blue remains agonisingly slow, with each individual ambulance service responsible for delivering and determining whether to introduce a new medicine, based on multiple factors including the logistical, financial and training considerations involved.

The National Poisons Information Service (NPIS) has claimed that 'the evidence from the pilot study was insufficient to change NPIS policy but we are interested in the possibility of specialist ambulances carrying it.'[56]

51 ibid.
52 Garcia-Galindo, C, et al (2024) Massive [redacted] overdose: a case for prehospital methylene blue. Prehosp Emergency Care, 28(7), pp970–974.
53 An academic review into the West Midlands pilot is expected to be published shortly.
54 Evidence provided at Hannah Aitken's inquest.
55 Correspondence between the Association of Ambulance Chief Executives CEO and a member of the Families and Survivors to prevent Online Suicide Harms.
56 Response from NARU to a Prevention of Future Deaths report issued following the inquest into Chloe MacDermott's death.

What needs to happen?

1. A strengthened response to imports of substances likely to be used for suicide

Under the current framework, the UK Border Force has legal powers to seize a consignment of the substance. As set out earlier in the report, this is a function of the substance being classified as a reportable substance under the Poisons Act.

Without urgent reclassification, the risks associated with imports from suspicious sellers will only continue to grow, and the likelihood is that further lives will continue to be lost.

As it stands, the UK Border Force can use section 19 of the Police and Criminal Evidence Act to stop and hold a substance, where there is an ongoing police investigation or police interest in a particular consignment. As recent examples have shown, it remains far too easy to be able to import this substance from international sellers already known to police.

The adoption of a more strategic policing approach, structured along the 4P model, would undoubtedly enable a stronger and more coherent response to policing the substance at our borders. As an immediate complimentary measure, the Government could also look to increase the time period during which packages can be impounded at the border from 30 to 90 days.

Dr Shaw's death highlighted substantial weaknesses in joint working between the UK Border Force and national and local law enforcement, with an urgent need to develop training and guidance for police forces and Border Force around the management of consignments of this substance when it is reasonably likely this been ordered for the purposes of suicide.

As it stands, there is no legal requirement for the UK Border Force to alert the local police force before a consignment is released, or to request a welfare check during which the recipient could be invited to agree to the safe destruction of the parcel. This should be addressed as a matter of urgency.

We strongly encourage the National Police Chiefs Council, Home Office and UK Border Force to commit to developing improved protocols and training materials, and to subsequently report of these efforts.

2. A national rollout of Methylene Blue

There is growing academic and international support for increased awareness and availability of Methylene Blue among emergency responders,[57] and the UK should act quickly to encourage a broader rollout across each of England's 15 ambulance trusts.

In the United States, academics from the Centres for Disease Control have concluded that, alongside providing better information on the growing risks posed by this substance, improving information on and the supply of Methylene Blue 'constitutes a prudent public health action'.[58] Evidence-based reviews have recommended the stocking of Methylene Blue as an emergency antidote based on analysis from the United States, Japan, Greece, Italy and Canada.[59]

57 Garcia-Galindo, C, et al (2024) Massive [redacted] overdose: a case for prehospital methylene blue. Prehosp Emergency Care, 28(7), pp970–974.
58 Mack, K. et al (2024) Special report from the CDC: suicide rates, [redacted] suicides, and online content, United States. Journal of Safety Research, 89, pp361–368.
59 ibid.

There is a compelling case for DHSC to step in and encourage much swifter adoption of Methylene Blue among critical care and specialist HART teams, and if individual ambulance trusts continue to feel that further evidence is required, to encourage participation in larger-scale pilots.

We applaud the Yorkshire Ambulance Service for being the first trust in England to supply the substance to advanced critical care paramedics. Evidence from Hannah Aitken's inquest suggested that critical care paramedics may be better placed to carry the antidote than HART teams because of their broader geographical reach and the specialist training and equipment they currently benefit from.[60]

In the last year, the Emergency Capabilities Unit (former the National Ambulance Resilience Unit) has taken the welcome step of drafting a template written instruction for the supply and administration of Methylene Blue.[61] The production of this PGD template is a welcome step to facilitating a broader rollout across England's ambulance trusts, but urgent further action is undoubtedly still required.

Pete Aitken, the father of Hannah, learnt that the paramedics who treated his daughter hadn't received any training on responding to the substance she had taken:

"Hannah had no realistic prospect of being successfully treated for poisoning once she had taken the substance, as attending paramedics neither had the training to recognise that type of poisoning, nor the antidote to administer. What we've learned from Hannah's inquest is this poison is incredibly fast-acting; but if you get to the patient before they go into cardiac arrest, the antidote is fairly easy to administer intravenously and doesn't have any dramatic side effects. Apparently Hannah showed all the signs of poisoning, and if the paramedics had known and carried the antidote, then perhaps she could have been saved."

3. Police welfare checks

Welfare checks have become a fairly common aspect of suicide prevention. Performed correctly, these checks have the potential to be life-saving interventions for persons in suicidal crises.

While systematic research into the effectiveness of UK welfare checks is sparse, the experience of many people with lived experience has at best been mixed. Welfare checks have been hampered by the lack of effective cross-working between agencies outlined above. Many members of the Families and Survivors group report checks have been inconsistent, ineffective or sometimes cursory in nature.

Further action is palpably required to ensure that welfare checks are performed effectively, sensitively and in a trauma informed fashion. We therefore recommend that the Home Office, National Police Chiefs Council and College of Policing come together to develop and rollout new training and resources for law enforcement or other professionals tasked with performing welfare checks.

These agencies should actively seek to engage people with lived experience in the development of these materials, and in their subsequent evaluation.

60 Evidence from Hannah Aitken's inquest.
61 Correspondence between the Association of Ambulance Chief Executives CEO and a member of the Families and Survivors to prevent Online Suicide Harms.

Consideration should also be given to the role that specialist suicide prevention teams could play in respect of undertaking welfare checks. Having specialist teams who are able to understand and perform welfare checks effectively, and who may can be better placed to understand the role of welfare checks when triggered by Border Force arrangements, could provide a powerful route to persuade recipients of consignments of the substance to agree to their safe disposal.

Ilse took the substance after coming across the pro-suicide forum when searching for methods to end her life. Through the forum she discovered and then contacted Canadian seller Kenneth Law to purchase the poison.

Ilse survived thanks to being treated with Methylene Blue which was stocked in the hospital to which she was taken.

When The Times broke the story about Kenneth Law and his activities, Canadian investigators found lists of Law's customers, which included Ilse, and the National Crime Agency informed her local police force who knocked at her front door to carry out a welfare check:

"They came to check if I was still alive. I told them: 'Yes I'm alive, but you're a bit late because I took it four months ago.' They asked if I was doing better and I said I was. I offered them more information; my emails and correspondence about how I got the poison but they weren't interested. They also didn't ask if I had any poison left, which I thought was shocking. I feel like they should have done that."

4. Community responses and improved data sharing

Whilst many people who have died by suicide linked to this forum and substance are previously known to support services before their deaths, national figures demonstrate that over two thirds of all individuals who have died by suicide in England are not known to mental health services in the 12 months before their death.[62] Our analysis of PFDs suggests that around half of deaths linked to the substance involved people not previously known to mental health agencies.

Whilst there is clearly more work to be done with regard to improving funding for and access to mental health services, as well as further upstream work to tackle the broader drivers of suicidality, there is also substantial merit in the adoption of a national Multi Agency Risk Management system for individuals vulnerable to suicide, enabling community and support service referrals – and crucially, introducing a positive duty on support services in relation to data sharing.

A Multi Agency Risk Management Arrangement for suicidal people was first recommended by the then-NPCC lead for suicide prevention in 2016.[63] It would enable clinicians, police and first responders to have a better understanding of possible victims of suicide, and create a route for community referrals from friends, family and educators to raise concerns in a safe and productive way.

62 People known to be in contact with mental health services represent around 27% of all deaths by suicide in England – on average around 1,300 people each year. This includes anyone in contact with mental health community services, people in inpatient settings, and anyone that has been in contact with these services within 12 months. – Suicide Prevention in England: 5-year cross-sector Strategy 2023.

63 Written evidence submitted by the National Police Chiefs' Council (NPCC) Suicide Prevention and Response Portfolio lead to the Home Affairs Select Committee: https://committees.parliament.uk/writtenevidence/70909/pdf/

The positive duty in relation to data sharing would make it a legal requirement for services to be joined up in their approach and actively take steps to ensure they are sharing data relating to vulnerable individuals at risk of suicide.

This could be particularly beneficial to support police, crisis teams or first responders, ensuring they have access to all relevant information during crises, when undertaking a welfare check or attending a suspicious scene after an emergency call.

Conclusion

This report has highlighted a catalogue of missed opportunities to prevent deaths by suicide attributable to a single substance and suicide forum.

With at least 133 lives lost, but potentially many more, this is a story of institutional failure across multiple Government departments and public bodies. The State has failed to act decisively in the face of inherently preventable harm.

There can be no doubt that a statutory public inquiry is now warranted. This should explore how so many chances were missed, the lives that could have been saved, and how the ongoing risk to future lives can be addressed.

It is only through a statutory public inquiry that lessons can appropriately be learned. A public inquiry will allow necessary scrutiny of the systems and processes that were and should be in place to identify and respond to the growing use of the substance.

A public inquiry must identify and understand the scale of harm facilitated by suicide forums, including the impact of countless missed opportunities to prevent the forum from continuing to promote, encourage and instruct on the use of the substance as a suicide method.

An inquiry must also identify and recommend changes to how Government departments work collectively, in order to work effectively, to respond to new and emerging suicide-related risks.

Our analysis has shown that coroners issued Prevention of Future Deaths reports raising matters of concern about the substance and forum on at least 40 separate occasions, the recipients of which included 60 large public bodies including the Home Office, the Department of Health and Social Care, and the Department for Science, Innovation and Technology.

Many departments provided repetitive responses to PFDs, pointing to the other as the responsible body, with insufficient if any action being taken to address the ongoing risk to lives – or to even understand the scale of the risk of harm taking place.

A public inquiry is now an important and necessary vehicle to ensure that much needed lessons can be learned. In the meanwhile, Government, Ofcom and frontline bodies should commit to urgent improvements to how they tackle and respond to this most pressing of threats.

The nihilistic intention of this forum, coupled with the institutional failures of the State to act quickly in the face of the harm it has caused, has cost countless lives and untold trauma to the families affected. For far too long, their pain has gone unrecognised by the system. Their calls to learn lessons have gone unheeded.

It is now time for the Prime Minister to act decisively and constructively – to do the right thing by the traumatised families and survivors, but to also ensure that everything possible is done to ensure the preventable harm they have endured is never again borne by anyone else.

Afterword from Families and Survivors to Prevent Online Suicide Harms

This report sets out a series of lessons that must be learned to save lives. These lessons come not just from statistics or research, but from the harms we have lived and the loved ones we've lost.

From the role of the pro-suicide forum to easy access to the poison, missed opportunities from Prevention of Future Death reports and a series of frontline failings, the state has questions to answer.

Successive Governments have failed to get to grips with a crisis that has cost at least 133 lives, our loved ones included.

What is important now is not blame but decisive change that will mean more vulnerable young people are not put at risk of entirely preventable harm.

Each of our own circumstances has contributed to the lessons outlined in this report, and we sincerely hope these can lead to change, and prevent future lives being lost.

That's why with Molly Rose Foundation, Leigh Day, Inquest, MPs and others we're calling for a public inquiry to address these concerns and provide concrete solutions to what is nothing less than a scandal.

With the response to PFDs slow and cumbersome at best, we urgently need a National Oversight Mechanism that tracks and collates recommendations from coroners so 65 warnings don't get lost again.

We need regulatory regimes that can act dynamically to harm, both online risks and those caused by substances that can be used to self-harm.

And we need a frontline response, from Border Force to ambulance services, that can respond to harm and protect vulnerable people in need.

The fundamental first principle of society and the state should be to protect citizens and prevent harm. Regrettably, the State has failed in this instance on numerous occasions.

It cannot be allowed to fail again, and this is the message we have sent to the Prime Minister and Ministers on the eve of this report being published.

We hope they will listen and commit to a public inquiry that is conducted in a sensitive and timely manner.

Appendix 1: The 40 Prevention of Future Deaths reports raising matters of concern about the substance and/or suicide forums

Age	Gender	Date of death	Date of Report	Substance concern	Forum concern	Addressees (Large Public Bodies Only)
21	M	18/01/2013	20/11/2013	No	Yes	House of Commons
24	M	10/11/2017	28/12/2023	No	Yes	DHSC, DSIT, NCA
13	M	10/01/2018	29/04/2019	No	Yes	DCMS
33	F	20/08/2018	27/01/2020	Yes	No	
24	F	29/08/2018	03/12/2019	No	Yes	DCMS
25	M	17/08/2019	31/01/2020	Yes	No	
26	M	05/02/2020	29/01/2021	Yes	No	DHSC, Home Office
N/A	M	06/02/2020	26/11/2020	Yes	Yes	DHSC
49	M	08/02/2020	20/11/2020	Yes	Yes	DHSC
23	M	23/02/2020	23/05/2025	Yes	Yes	Home Office
33	M	11/03/2020	23/05/2025	Yes	Yes	Home Office
23	M	31/03/2020	29/07/2021	Yes	No	DHSC
23	M	06/04/2020	18/09/2020	Yes	Yes	DHSC
N/A	F	29/05/2020	23/05/2025	Yes	Yes	Home Office
21	F	13/06/2020	29/11/2021	Yes	No	Home Office
22	F	08/07/2020	07/06/2024	Yes	No	NHS England
N/A	F	19/07/2020	04/11/2021	Yes	Yes	DHSC
26	F	27/08/2020	25/10/2023	Yes	Yes	DCMS, NHS Wales, Ofcom
N/A	M	25/09/2020	23/05/2025	Yes	Yes	Home Office
45	F	27/02/2021	23/05/2025	Yes	Yes	Home Office
28	F	20/05/2021	20/11/2021	No	Yes	DCMS, Home Office
24	M	22/05/2021	23/05/2025	Yes	Yes	Home Office
43	F	23/05/2021	19/12/2023	Yes	Yes	Home Office, DHSC, DSIT, NPCC, Ofcom

Age	Gender	Date of death	Date of Report	Substance concern	Forum concern	Addressees (Large Public Bodies Only)
37	M	28/06/2021	23/05/2025	Yes	Yes	Home Office
29	M	29/10/2021	18/03/2022	No	Yes	DHSC
23	F	10/04/2022	14/10/2022	Yes	Yes	DHSC
24	M	22/04/2022	29/02/2024	Yes	Yes	DHSC, NHS England, Ofcom
41	M	03/07/2022	12/01/2023	Yes	Yes	DHSC, DCMS
30	M	24/10/2022	09/07/2025	Yes	No	DHSC, Home Office
14	F	02/02/2023	05/03/2024	No	Yes	DCMS, Ofcom
22	F	18/02/2023	30/07/2024	Yes	Yes	DHSC, DSIT
N/A	M	01/07/2023	31/01/2024	No	Yes	DSIT, NCA
45	M	09/08/2023	23/05/2025	Yes	Yes	Home Office
22	F	14/09/2023	14/11/2024	Yes	No	DHSC, Home Office
24	F	16/09/2023	12/03/2025	No	Yes	DSIT, Ofcom
37	M	02/10/2023	13/11/2024	Yes	No	NHS England
N/A	M	02/12/2023	25/04/2024	Yes	No	Home Office, NPCC
61	F	21/02/2024	26/02/2024	No	Yes	DCMS, Department for Business and Trade
47	F	30/05/2024	13/06/2025	No	Yes	NHS England
58	F	09/07/2024	14/11/2024	No	Yes	DCMS, Ofcom

Appendix 2: Methodology and limitations of PFD analysis

In autumn 2025, MRF identified and analysed 47 Prevention of Future Death Reports (PFDs) relating to deaths connected to online suicide forums and/or the substance. Alongside these PFDs, we also reviewed a selection of responses from Government and other public bodies.

This work had a number of key aims:

- To understand the characteristics of victims in more detail
- To identify patterns in the circumstances of victims' deaths
- To identify key concerns Coroners have raised with Government and other organisations, and what action has been promised in response

Methodology

PFDs were identified from a database collated by the Preventable Deaths Tracker[64], using a set of 12 search terms relating to either the substance or suicide forums. The resulting 1000+ PFDs were then screened using pre-agreed inclusion criteria to identify those in scope for analysis.

For example, though many PFDs did not mention the substance by name (including a significant number where the substance's name was redacted), they were deemed in scope if other contextual information – e.g. references to legitimate uses of the substance or detail within responses – suggested that they were likely to refer to the substance. Similarly, though a small number of coroners were unable to conclude that victims had definitely died by suicide, PFDs were included if they suggested a victim's death was directly connected to either suicide forums or the substance.

Statistical analysis was then used to describe patterns in victims' characteristics, alongside thematic analysis of victims' experiences, coroners' concerns and responses from Government and other organisations.

Responses to PFDs were prioritised for review if they had been issued by Government departments, regulators, national health organisations or national policing bodies.

Limitations to PFD analysis

It is important to note that the PFDs analysed here do not include all those who have died in connection with the substance or suicide forums – in fact, they are likely to be a small proportion of the total. As such, this data should be interpreted as representative of characteristics, experiences and coroners' concerns that may apply to a much larger group of victims.

64 https://preventabledeathstracker.net/about/

There a range of reasons for this. While every death suspected to be a suicide will result in an inquest, whether or not an inquest produces a PFD depends on decisions by individual coroners. This creates a 'postcode lottery' for whether deaths produce PFDs. The 47 PFDs in this sample, for example, were completed by 37 coroners, covering only 27 of 74 areas across England and Wales. Eight were written by a single coroner.

PFDs are also written inconsistently, with variable amounts of redaction. As such, despite careful selection of a broad range of search terms, our initial search is likely to have missed relevant reports.

Inconsistent reporting also means that we are only able to report on the data that was available within each PFD. As such, where we say X% of victims had a certain characteristic, this is likely to be an underestimate as there is not standardised for recording key information such as SEND, existing support or even age. Additionally, what some coroners found relevant others did not, meaning there may be more similarities in the cases that were not reported on.

There are also gaps in responses from Government and other organisations. Despite, having a statutory duty to respond within 56 days, many were not available on the Judiciary website.

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