

13 January 2014

Chief Coroner's Office 11th Floor Thomas More Royal Courts of Justice Strand London WC2A 2LL

> Our ref: JSP/KA/02665-2012 Your ref:

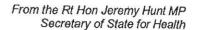
Dear Sirs

RE: Martin Daffydd BARKER (Deceased)

I enclose herewith a copy of the letter I have received from the Rt. Hon Jeremy Hunt MP in response to my Regulation 28 Report.

Yours faithfully

Joanne Kearsley
Area Coroner





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De Mr. Kearley,

Thank you for your letter following your inquest into the death of Martin Daffydd Barker. I am sorry that you did not receive an earlier reply. In your report you detailed the circumstances around Mr Barker's death following ingestion of MDMA.

In the early hours of 10 December 2012, Mr Barker was assessed as requiring emergency admission to hospital and transferred to Salford Royal Hospital in an ambulance run by the independent provider, Manchester Medical Services. Upon arrival at the hospital Mr Barker was in cardiac arrest.

I understand from your report that the Manchester Medical Services ambulance crew had neither the telephone number which goes directly to the emergency resuscitation area of Salford Royal hospital, nor the code to allow them to gain entry once they had arrived. Consequently, there was a delay in providing treatment for Mr Barker.

Concluding your report, you raised concerns about guidelines for independent providers and Trusts covering access to appropriate numbers and codes which would prevent incidents like this occurring in future.

I am satisfied that meetings and discussions that have taken place locally involving Manchester Medical Services, Salford Royal NHS Foundation Trust and the North West Ambulance Service, as set out in their responses to you, will help to ensure that a similar situation does not arise again with these organisations.

Turning to the wider picture, doors at hospitals are often locked to ensure the safety and security of staff and patients at times when very little activity is expected. It would not be reasonable to allow unrestricted access to all areas of the hospital, particularly when few staff are on duty overnight.

As you will appreciate, independent providers of ambulance services do not fall directly within the remit of the Department of Health. They are however required to register with, and be inspected by, the Care Quality Commission. I therefore propose to share this case with the CQC so that they can consider whether adequate arrangements for access to emergency departments need to be part of the inspection portfolio for such organisations. Patients might reasonably expect independent ambulance providers to have in place arrangements to access emergency departments to which they might be required to take patients, and that reasonable access should be granted.

Furthermore, public events are required to comply with the Health and Safety Executive (HSE) Event Safety Guide, which is a guide to health, safety and welfare at music and similar events. The guide covers arrangements for emergency care and transfer. Plans for such events must be approved by the local authority and, depending on the overall risk score, should be assessed by the NHS ambulance service - even where the NHS is not providing the medical cover.

I therefore intend to write to the HSE to bring this case to their attention. Responsibility for licensing, including arrangements for medical cover at events, sits with local authorities. It should, for example, be possible for HSE to amend the Purple Guide to indicate more explicitly the arrangements that need to be in place for independent ambulance services to contact and access receiving emergency departments. It may be reasonable that local authorities should satisfy themselves that this has been adequately addressed before granting an application. However this would ultimately be a matter for the HSE to decide.

I hope that this response is helpful and I am grateful to you for bringing the circumstances of Mr Barker's death to my attention.

In simens

JEREMY HUNT