	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **Re Max Carlton-Smith, case ref 01191-13** **THIS REPORT IS BEING SENT TO:** **Secretary of State for Health, Rt. Hon Jeremy Hunt, Richmond House, 79 Whitehall, London SW1A 2NS**
1	**CORONER** I am Dr Andrew Harris, Senior Coroner, London Inner South
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INQUEST** On 6th September 2013, I opened an inquest into the death of: **Max Carlton-Smith,** aged 21 years, died 1st September 2013 I concluded the inquest at a full hearing on 15th December 2014. The medical cause of death was multi-organ failure from MDMA/ecstasy overdose.
4	**CIRCUMSTANCES OF THE DEATH** *Max Carlton-Smith was found in cardiac arrest by LAS at 05.32 in [redacted] after taking MDMA at an illegal rave nearby. He had collapsed after being intoxicated in a trance and those attending did not summon emergency medical assistance immediately. He was pronounced dead at the scene at 06.23 on 01.09.13 at Kings College Hospital. He died of an accidental drug overdose.*
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTER OF CONCERN** is as follows. – The organizers of the unlicensed rave had not provided on-site medical assistance and had spent between 12 and 42 minutes before calling the ambulance service, when the deceased collapsed. There was inadequate ventilation for a very hot venue, and fire exits and procedure had not been regulated. The organizers had taken over an empty squatted commercial building and barricaded against those who attempted to enter, (including police, who attended and spoke earlier to a security man and then later following complaints of noise). I concluded that had the event been licensed and normal facilities and regulation in place, he would probably not have died when he did. Police evidence was that they had no power to enter (nor had the ambulance service) a commercial premises (as opposed to private premises) that had been squatted unless a crime had been committed or in an emergency. There were not resources available on this weekend to close down the venue when the rave was taking place, without diverting all the officers in the borough force. It was reported that the MPS now has disseminated to boroughs notice of a facility to access officers from other areas and that the borough police were more likely to intervene in the future. In the event it was reported that 21 officers attended but people left and evaded statements or gave false contact details, so that none of the organizers or staff have been traced.

	DS Howell specifically recommended that this report be written as the police would like the power to enter squatted commercial premises, to prevent an illegal rave being held, which was more efficient and effective than trying to intervene when it was in operation. Given the increased risks of death associated with unlicensed raves, these proposals would seem to prevent future deaths.
6	**ACTION SHOULD BE TAKEN** In my opinion action, should be taken to consider this or other legislative change that might prevent future deaths. I believe that the Secretary of State is in a position to consider who would be most appropriate to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **March 10th 2015.** I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed. If you require any further information or assistance about the case, please contact the case officer, [redacted] [redacted]
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted] (father), [redacted] (mother). I am also copying this report to the following persons: [redacted], Lambeth Borough Police Commander Sir Bernard Hogan-Howe, Commissioner of Metropolitan Police [redacted] London Ambulance Service [redacted] Commissioner of London Fire Brigade. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**[DATE]** Drafted 30.12.14 **[SIGNED BY CORONER]** [signature] Sent 14.1.15