Report to Prevent Future Deaths
(*Coroners (Investigations) Regulation 28)*

	THIS REPORT IS BEING SENT TO: 1. Rt Hon Jeremy Hunt MP, Secretary of State for Health 2. [redacted] Lifeskills Medical UK
1	**CORONER** I am Selena Lynch senior coroner for the coroner area of South London
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 18th June 2014 I commenced an investigation into the death of Rio Andrew, age 15. The investigation concluded at the end of the inquest on 6th January 2016. The conclusion of the inquest was that Rio died from multiple organ failure due to acute MDMA (3,4-Methylenedioxymethylamphetamine) intoxication, having taken MDMA some time late on the 14th or early 15th June 2014. I concluded that his death was drug related.
4	**CIRCUMSTANCES OF THE DEATH** Rio attended an illegal rave at a large disused Post Office building in Croydon. He became unwell as a result of taking MDMA and was taken to the "medics". The organisers of the rave had arranged for a private company to provide event medical cover at the venue. The company was registered with the Care Quality Commission (CQC) who regulate "transport services, triage and medical advice provided remotely". They do not regulate treatment provided through temporary arrangements for sporting or cultural events. One of the "medics" provided by the company had received classroom training from Lifeskills Medical UK. His practical work (necessary to complete his certification) was being mentored and signed off by an ambulance technician whose qualifications have not been found acceptable to Lifeskills Medical UK
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 **MATTERS OF CONCERN** are as follows. – (1) The regulation of the private company by the CQC provided false security as to what was in fact being regulated. The only activity that was regulated was transport from the rave in an ambulance on a public road, which activity was not in fact needed because Rio was handed over to the London Ambulance Service outside the venue. The level of medical knowledge displayed by the private medical staff was poor. The exemption for temporary arrangements means that the provision of medical assistance at events is entirely unregulated. This includes not only illegal raves, but legal events such as sporting events, fetes and festivals. (2) This lack of regulation extends to individuals calling themselves ambulance technicians. They are not regulated and the title is not protected. (3) Individuals undergoing training at Lifeskills UK Ltd (and possibly other private training providers) are left to find their own mentor(s) without checks being made by the company as their suitability or any register or panel from which the choice can be made.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **22nd March 2016** I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: - the family of Rio Andrew - [redacted] (Pioneer Medical Solutions Ltd) and to the local safeguarding board. I have also sent it to the following, who may find it useful or of interest: - The Care Quality Commission - Pearson Education Limited - Association of Ambulance Chief Executives [redacted] 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** **26th January 2016**	Donna Lynch **SIGNED BY CORONER**