#### **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**

## THIS REPORT IS BEING SENT TO:

Rt Hon B Johnson MP Secretary of State for Foreign and Commonwealth Affairs Foreign Office King Charles Street London SW1A 2AH

#### 1 CORONER

I am Mr Andrew Haigh senior coroner for the coroner area of Staffordshire 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 INVESTIGATION and INQUEST

On 4<sup>th</sup> July 2017 I commenced an investigation into the death of Adrian Nicholas KING aged 39 years. The investigation concluded at the end of the inquest on 15<sup>th</sup> February 2018. The conclusion of the inquest was 'Collapse in hot desert followed by limited medical treatment'

## 4 CIRCUMSTANCES OF THE DEATH

Mr King died in hospital in Egypt on 29th May 2017. On 18th May he had gone on an excursion which included riding a quad bike into the desert. He had become unwell and collapsed. There were problems with the insurance to cover his medical treatment. He died from kidney failure.

## 5 CORONER'S CONCERNS

During the course of the inquest the evidence revealed a matter 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 indication given to me in evidence at the inquest was that the extent of Mr King's medical treatment had been affected by problems with his insurance cover. Family members told me that when they became aware of his illness and hospitalization in Egypt they made numerous telephone calls attempting to speak to the consulate in Egypt in an effort to assist with what was going on. These calls were either not answered or curtailed very quickly without progress being made. It is not possible to say if it is likely that Mr King could have been saved but this remains an unanswered possibility. However it strikes me as important that if people in Britain are seeking to contact a British embassy or consulate abroad in order to assist with medical treatment for someone who is ill in that foreign country then the channel of communication should be open.

For the avoidance of doubt this concern relates to events prior to death. It has nothing to do with Coroners seeking to obtain information from abroad after a body from abroad comes back to England and Wales. That system is presently managed by and I am grateful for the assistance it provides on a regular basis.

## 6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

#### 7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by 24<sup>th</sup> April 2018. 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 :

(Adrian's mother) (Adrian's father)

I have also sent it to who may find it useful or of interest.

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 27.2.2018

Andrew A Haigh HM Senior Coroner Staffordshire (South)

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