

## **Karen Dilks Senior Coroner for the City of Newcastle Upon Tyne**

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO: Mr Charles Hoult, Director of Hoults Ltd Walker Road, Newcastle upon Tyne, NE6 2HL
1	CORONER
	I am Karen Dilks, Senior Coroner for the City of Newcastle Upon Tyne
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/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	INVESTIGATION and INQUEST
	On the 9 November 2016, I commenced an Investigation into the death of Ellie Mae Knowles.
	The Investigation concluded at the end of the Inquest on the 3 July 2018.
	The conclusion of the Inquest was Misadventure.
4	CIRCUMSTANCES OF THE DEATH
	On the 5 November 2016, Ms Knowles attended a Dance Music event, organised by Shindig Events Ltd, within Warehouse 34, Hoults Yard, Newcastle upon Tyne. The Yard and Warehouse is owned by Hoults Ltd. Methylenedioxymethamphetamine (MDMA) is acknowledged to be used in association with and at Dance Music Events.
	Entry to the event was by ticket only. At the point of entry, ticket holders were subjected to limited search. No female staff were onsite to effect searches of female ticket holders.
	Ms Knowles entered the event with a quantity of MDMA in her possession which she consumed within the main dance floor of Warehouse 34. Many other ticket holders including Ms Knowles boyfriend and other friends used MDMA and/or other controlled substances.
	Ms Knowles became unwell and was assisted to the first aid area.
	One qualified first aider (Level 3, Emergency Care Assistant) was in attendance. Ms Knowles was assessed, the seriousness of her condition identified and emergency assistance called. She later died due to Methylenedioxymethamphetamine Toxicity.
	Shindig Events Ltd subcontracted responsibility for provision of first aid and security requirements for the event. No written record of the assessment of Ms Knowles and action by the Emergency Care Assistant was retained.
	No records of attending security staff and their requisite licence to operate was kept.
	No written guidance on required search procedures or upon seizure of items including controlled drugs, following such search was given.
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## 5 CORONER'S CONCERNS

Although evidence was given on behalf of Hoults Ltd that no further similar events are to be held within Warehouse 34, Hoults Yard, a licence permitting such events in the future remains in force.

The MATTERS OF CONCERN are as follows. -

Senior Coroner for the City of Newcastle Upon Tyne

(1) That Hoults Ltd should establish a robust internal protocol requiring consultation with Northumbria Police Licensing Officer, Newcastle City Council Licensing Officer and all other appropriate stakeholders as a precondition to the planning and holding of similar dance music events within their premises at any future time.

## 6 **ACTION SHOULD BE TAKEN** To prevent future deaths I believe you, Charles Hoult, Director of Hoults Yard Ltd, have powers to take such action.. YOUR RESPONSE 7 You are under a duty to respond to this report within 56 days of the date of this report, namely by 12 September 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: Mr and Mrs Pegdon Neil Bainbridge, Director of Shindig Events Ltd I have also sent it to Chief Inspector Pickett of Northumbria Police and Kerry Walker, Newcastle City Council Legal Services Department 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. **Dated 18 July 2018** 9 Signature