Karen Dilks
Senior Coroner for the City of Newcastle Upon Tyne

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Neil Bainbridge, Director of Shindig Events Ltd, 71 Cleveland Road, North Shields, NE29 0NW**
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 taken and action by the Emergency Care Assistant of 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 oral evidence of remedial action and change in practice was provided by Shindig Events Ltd, the Coroner remained concerned as detailed below: The **MATTERS OF CONCERN** are as follows. – (1) No evidence was provided of written guidance/direction for Shindig Events Ltd employees and/or those with whom they subcontract of standards required in respect of: a. Numbers and qualifications of first aid staff to be provided at dance music events b. Robust recording by first aid staff of patients attended and action taken c. Numbers of security staff required at dance music events d. Scrutiny of the licence to operate status of security staff e. Extent of search of ticket holders required to be undertaken by security staff f. Robust system for recording items (including controlled drugs) seized at search and safe storage of those items
6	**ACTION SHOULD BE TAKEN** To prevent future deaths I believe you, Neil Bainbridge, Director of Shindig Events Ltd, have powers 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 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 Charles Hoult, Director of Hoults 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.
9	Dated 18 July 2018 Signature _____ Senior Coroner for the City of Newcastle Upon Tyne

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