Karen Dilks
Senior Coroner for the City of Newcastle upon Tyne

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Right Honourable Damian Hinds, Secretary of State for Education. Dept for Education, 20 Great Smith Street, Westminster, London, SW1P 3BT**
1	**CORONER** I am Karen Dilks, Senior Coroner, for the Coroner area of 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 15 December 2016 I commenced an investigation into the death of Edward James Farmer, 20yrs. The investigation concluded at the end of the inquest on 25 October 2018. The conclusion of the inquest was: Narrative: Died due to the toxic effects of the consumption of an excessive amount of alcohol in a short period of time and in part because the inherent risks of doing so were not known.
4	**CIRCUMSTANCES OF THE DEATH** Edward James Farmer was a first-year student at Newcastle University.

He was a member of the Agricultural Society.

On 12 December 2016 an initiation event was organised by the Agricultural Society. Both organisers and attendees were aware of the nature of the event and that Initiations were prohibited by the University.

Initiation events had continued to take place for many years notwithstanding the University's prohibition.

On 12 December 2016 Mr Farmer attended the said Initiation Event together with approximately 20 to 30 other first-year students.

All involved knew or believed the aim of the event to be that first-year students would consume large quantities of alcohol and take part in such activities as eating rotten substances and head shaving.

Mr Farmer and other first-year students were accompanied throughout the event by second-year students who actively encouraged the drinking of large quantities of alcohol.

Between approximately 8pm and 10pm on 12 December 2016 Mr Farmer consumed between 6/8 treble vodka and orange drinks. In addition he consumed undiluted spirits from various bottles, the volume of which is unknown.

Several students were drunk and vomiting.

Mr Farmer was extremely drunk. He was unable to walk unaided. He was carried on to a Metro Train and taken to the home of a second-year student to be "looked after".

He was checked regularly and found to be snoring loudly. He did not vomit.

He was last checked between 2:30 and 3:30am on 13 December 2016.

At 4:43am on 14 December he was found unresponsive without signs of breathing or pulse.

He was taken by car to the Royal Victoria Infirmary in Newcastle in the belief that this would expedite his arrival at hospital. The premises where he was staying being within a short distance from the said hospital.

Despite maximum medical intervention he died due to a hypoxic brain injury the consequence of a prolonged cardio respiratory arrest.

There was overwhelming evidence that those involved in the organisation of and who attended the Initiation Event on 12 December were unaware of the inherent

	risks of excessive alcohol consumption and that snoring is an indicator of respiratory depression. There was further clear evidence that the issues in Mr Farmer's case were both national and local issues.
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 could 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) That consideration be given to conducting a national campaign dealing with the: a. Inherent risks of alcohol consumption within a short period b. How to identify persons at risk c. The importance of timely medical intervention The campaign should address the inherent risks of participating in initiation events.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you the Right Honourable Damian Hinds, Secretary of State for Education 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 6 February 2019. 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: • [redacted] I have also sent it to: • Chief Inspector Pickett of Northumbria Police Licencing Department

	• [redacted] Newcastle City Council, Legal Services Dept 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	**12 December 2018** **Signed by Karen Dilks (Senior Coroner)**