REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive of the Health and Safety Executive, Director of the National Ambulance Resilience Unit
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 3rd May 2016 I commenced an investigation into the death of Faye Allen. The investigation concluded on the 5th March 2019 and the conclusion was one of **Drug-Related Death**
4	CIRCUMSTANCES OF THE DEATH On 1st May 2016 Faye Allen attended an event, at the Victoria Warehouse. Once in the event she consumed MDMA that had been brought into the venue by another person. At 03:47 she was clearly unwell and taken to the medical porta cabin arriving at about 04:02. Observations showed she was clearly unwell. At 04:33 an ambulance was called. One arrived at 04:54. As Faye Allen was being transported to the Manchester Royal Infirmary, she went into respiratory arrest. On arrival at Manchester Royal Infirmary, unsuccessful attempts were made to resuscitate her. She died at Manchester Royal Infirmary on 2nd May 2016.
5	<u>CORONER'S CONCERNS</u> 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. – During the course of the inquest the issue of the availability of

	paramedics and other medical assistance was considered. The inquest was referred to the National Ambulance Service Guidance for preparing an Emergency Plan specifically Annex B which feeds into the Purple Guide. The annex and its tables set out staffing levels that are recommended for different event types. However, it became clear during the evidence that the recommended levels of staffing could be interpreted in different ways and that for example fist aiders deployed in areas other than the medical cabin area were being counted as part of the resource. This meant that the actual staff directly deployed to deal with medical issues in the medical area could vary widely and be significantly below the numbers set out in the tables.
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 24th June 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 namely Mrs Maxine Allen, Faye Allen's mother, 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	**Alison Mutch OBE** **HM Senior Coroner** **29.04.2019**