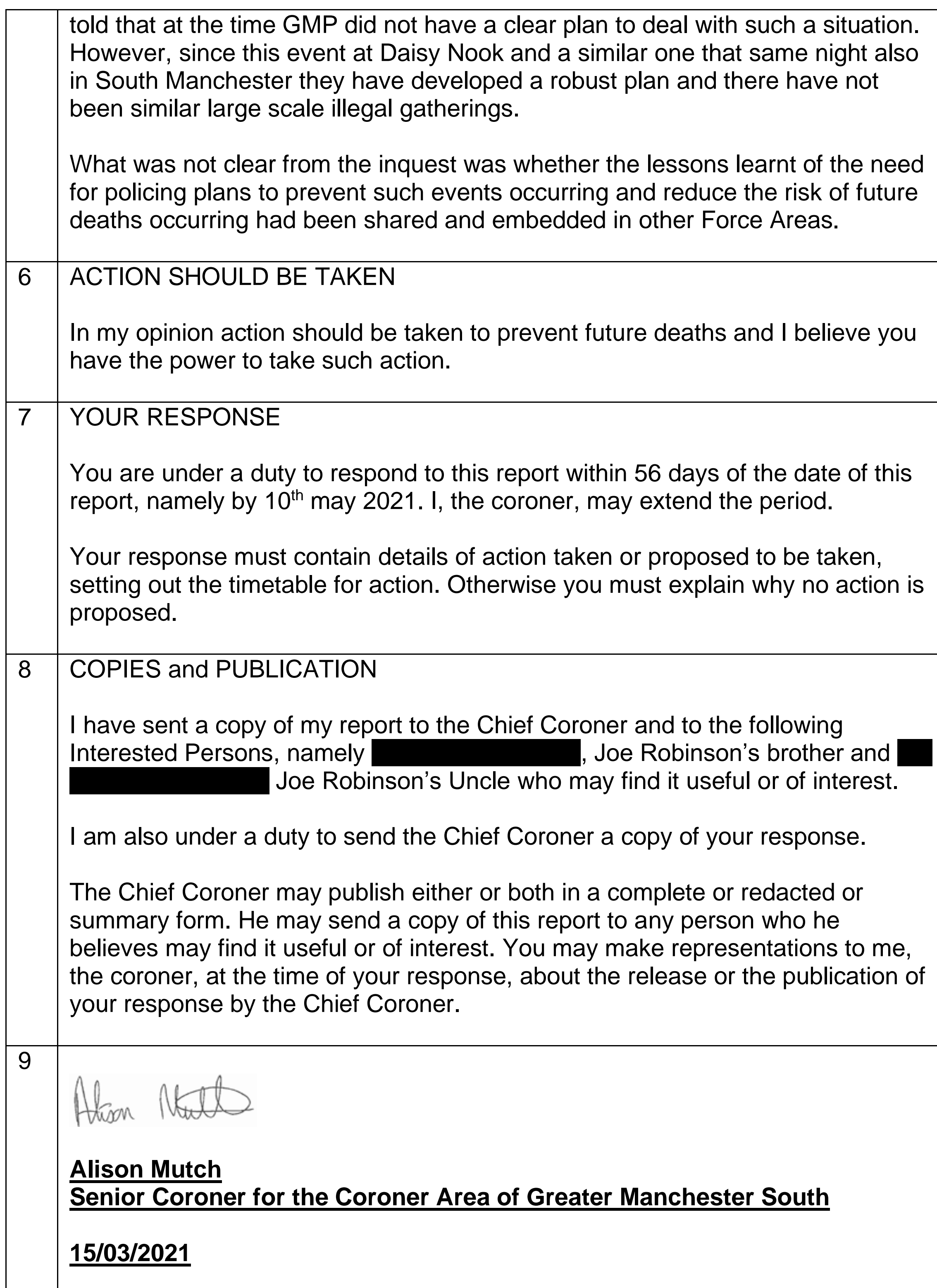
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Home Secretary and National Police Chiefs Council
1	CORONER I am Alison Mutch , Senior Coroner, for the Coroner Area of Greater Manchester 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 15th June 2020, I commenced an investigation into the death of Joe Peter Robinson. The investigation concluded on the 11th February 2021 and the conclusion was one of drug related death. The medical cause of death was: **1a) combined drug toxicity.**
4	CIRCUMSTANCES OF THE DEATH In the early hours of 14th June 2020, Joe Peter Robinson became unwell and collapsed by the side of Ashton Canal near Cinderhall Farm. Attempts to resuscitate him were unsuccessful. The post mortem examination found he had died from a combination of MDMA and Ketamine.
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 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. – The inquest heard that Joe Peter Robinson attended a large gathering with approximately 4,000 people in attendance. The gathering was not licensed and was in breach of the Coronavirus legislation. Alcohol and drugs were available and there were no first aid or paramedic facilities available on the site of the event. Social distancing was not followed. The evidence before the inquest was that Greater Manchester Police became aware of the event but felt unable to prevent it from continuing. The inquest was



	told that at the time GMP did not have a clear plan to deal with such a situation. However, since this event at Daisy Nook and a similar one that same night also in South Manchester they have developed a robust plan and there have not been similar large scale illegal gatherings. What was not clear from the inquest was whether the lessons learnt of the need for policing plans to prevent such events occurring and reduce the risk of future deaths occurring had been shared and embedded in other Force Areas.
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 10th may 2021. 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 , Joe Robinson's brother and Joe Robinson's Uncle 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 **Alison Mutch** **Senior Coroner for the Coroner Area of Greater Manchester South** **15/03/2021**