

## M. E. Voisin Her Majesty's Senior Coroner Area of Avon

29th August 2018 REF: 4

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
	THIS REPORT IS BEING SENT TO:
	Foreign & Commonwealth Office
	Kings Charles Street
	London
	SW1A 2AH
1	CORONER
	I am M E Voisin Senior Coroner for <b>Area of Avon</b>
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. <a href="http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7">http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7</a> <a href="http://www.legislation.gov.uk/uksi/2013/1629/part/7/made">http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</a>
3	INVESTIGATION and INQUEST
	On 28/05/2014 I commenced an investigation into the death of Henry Jack MILLER. The investigation concluded at the end of the inquest. The conclusion of the inquest was: Accident
4	CIRCUMSTANCES OF THE DEATH
	Henry Miller died on 23rd April 2014 at Vereda El Aguacate, Mocoa, Putumayo, Columbia. He died as a result of intoxication after consuming a psychoactive substance during a tribal ceremony. He was struggling to breathe after the ceremony and it was decided that he should be taken to hospital. On the way to the hospital he was left dead by the side of the road.
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. —
	Many travellers go to this area of Columbia and some will consider participating in a tribal ceremony

when Yage will be consumed. Many will check with the FCO about any issues or warnings about their travel plans. I would therefore ask you to consider whether a warning or advice should be issued to such travellers exploring this area of Columbia so that they can receive well informed guidance before traveling and deciding whether it is safe to participate in such a ceremony.

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 26 <sup>th</sup> October 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 – the family of the deceased.  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	29/08/2018  Signature  M E Vølsin Senior Coroner Area of Avon