North East Kent Coroners' Service
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Telephone: [redacted]
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Date: 19 May 2025
Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Kent Central Ambulance Service

1. CORONER

I am Ms. Catherine Wood, Assistant Coroner for North East Kent

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 4 July 2024 I commenced an investigation into the death of Emily Rose STOKES. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Drug related death

1a MDMA Toxicity

1b

1c

1d

II

4. CIRCUMSTANCES OF THE DEATH

Emily Stokes was 17 years old and a looked after child, having been in foster care since 2012.

Since 17 May 2024 she had been living in a semi independent placement in Chingford following the breakdown in her foster care placement in Kent. She had made plans to meet friends at the Worried about Henry music festival at Dreamlands in Margate, Kent on 29 June 2024. Her friends reported that she had taken MDMA possibly shortly before she entered the festival but she was also seen taking a tablet not long after she arrived at the festival. There had been bag and pat down searches undertaken by security staff for all those entering the festival but no drugs were found in any search she underwent as she would not have been allowed entry. She started behaving erratically and assistance was sought and she was taken to the on site medical tent arriving at approximately 15.23 and was distressed and agitated as well as tachycardic and hyperpyrexial. A set of observations recorded at 15.34 showed a respiratory rate of 28, saturations of 94%on air, a blood pressure of 143/119 and a heart rate of 186 with a temperature of 40.6 degrees and a NEWS score of 9. At 15.43 ambulance crew working for providers at the event were radioed and asked to return to the site to take Emily to hospital. They arrived back at the medical tent shortly after 4pm and are seen leaving the medical tent with the private ambulance crew at 16.16 and they left the site at 16.19. During this time Emily remained hyperpyrexial, tachycardic, distressed and confused and no attempts at reducing her temperature were undertaken. No pre alert call was made to the hospital and the journey was made without lights and sirens. The journey time was approximately 5 or 6 minutes so she arrived at the Queen Elizabeth the Queen Mother hospital at approximately 16.25/6. Emily was then assisted back up the stretcher by a paramedic and there was then a delay in her being triaged due to communication issues between the private ambulance staff and the triage nurse. The paramedic who had assisted in moving Emily recognised the severity of Emily's presentation and assisted with getting her moved to the resuscitation area in the emergency department. She was documented as having been seen by a doctor at 16.45 although the timings were written retrospectively and accounts indicated that as she was wheeled into the resuscitation bay the doctor was present. It was recognised that she was critically unwell and cooling measures were instituted and intravenous benzodiazepines given as she was displaying the ill effects of MDMA toxicity and suffering from serotonin syndrome. Intensive care clinicians were called and the team were preparing to intubate her when she suffered a cardiac arrest and despite efforts at resuscitation which lasted more than an hour she was pronounced dead shortly after 6pm.

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. -

(1) Private ambulance providers were used and the training of the staff involved was minimal, the evidence heard indicated that they had a qualification called First Response Emergency Care level 4 which was a five day course and had little experience or training in relation to management of patients having taken drugs. Given that the teams on site were present and ambulances available at a music event where the risk of drug taking was deemed to be high more training should have been provided to assist the staff in how to safely manage those under the influence of illicit substances.

(2) There was a lack of clarity regarding who had responsibility for making a pre alert call to the hospital and given this young girl was significantly unwell this should have been done. This in part may have been due to the lack of recognition of the seriousness of her symptoms and

therefore potentially linked with training of staff.

(3)The ambulance did not have the same equipment which an NHS Ambulance would have on board and was in essence very little more than a means of transport from the venue to the hospital and may have given a false sense of reassurance.

6. ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you Kent Central Ambulance Service 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 14 July 2025. 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 Emily's parents, Waltham Forest Council Corporate parent, Sands Heritage Ltd Dreamland, Manchett Security, Integrated Medical Services, South East Coast Ambulance Service (SECAmb) and East Kent Hospitals NHS Trust (EKHT)and to the LOCAL SAFEGUARDING BOARD.

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.

19 May 2025

Signature 

Catherine Wood Assistant Coroner for North East Kent