

Regulation 28: Prevention of Future Deaths report

Haaris Amin BHATTI (died 20.07.25)

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| | <p>THIS REPORT IS BEING SENT TO:</p> <p>1. The owner and manager Fold Nightclub Gillian House Stephenson Street Canning Town London E16 4SA</p> |
| 1 | <p>CORONER</p> <p>I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Poplar Coroner's Court Bow Coroner's Court</p> |
| 2 | <p>CORONER'S LEGAL POWERS</p> <p>I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.</p> |
| 3 | <p>INVESTIGATION and INQUEST</p> <p>On 24 July 2025, I commenced an investigation into the death of Haaris Bhatti, aged 23 years. The investigation concluded at the end of the inquest on 22 January 2026.</p> <p>I made a determination that death was drug related.</p> <p>The medical cause of death was: 1a [REDACTED] toxicity.</p> |
| 4 | <p>CIRCUMSTANCES OF THE DEATH</p> <p>Haaris took drugs on a recreational basis but was not a frequent user of [REDACTED].</p> |

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| | <p>Just before entering Fold Nightclub at 1.20am on Saturday, 19 July 2025, he swallowed [REDACTED]. During his time at the nightclub, he snorted more drugs.</p> |
| 5 | <p>CORONER'S CONCERNs</p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows.</p> <p>At approximately 4.45am, Haaris was noted by nightclub staff to be unwell and was taken to the welfare room in a wheelchair. He was very hot, had an extremely fast heart rate and extremely high blood pressure, and appeared to the club first aider to be psychotic. He was monitored and he later explained that he had taken [REDACTED].</p> <p>However, there was a failure by club staff to call an ambulance until 5.57am. Staff agreed with me at inquest that they should have called an ambulance as soon as they got Haaris into the welfare room and saw his condition.</p> <p>The delay in seeking definitive medical care decreased Harris's chance of survival. The delay did not seem to me to be simply about any individual member of staff, but rather it reflected the club's training and culture as a whole. Staff were concerned for Haaris, but this concern did not translate into effective management of his medical emergency.</p> |
| 6 | <p>ACTION SHOULD BE TAKEN</p> <p>In my opinion, action should be taken to prevent future deaths and I believe that you have the power to take such action.</p> |
| 7 | <p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 25 March 2026. I, the coroner, may extend the period.</p> <p>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.</p> |

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| 8 | <p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the following.</p> <ul style="list-style-type: none"> • The parents of Haaris Bhatti • HHJ Alexia Durran, the Chief Coroner of England & Wales <p>I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.</p> <p>The Chief Coroner may publish either or both in a complete or redacted or summary form. She may send a copy of this report to any person who she 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.</p> |
| 9 | <p>DATE</p> <p>27.01.26</p> <p>SIGNED BY SENIOR CORONER</p> <p><i>ME Hassell</i></p> |