

What coroners keep telling festival medical and welfare teams

Lessons from published Prevention of Future Deaths reports: spotting people in trouble, medical capability, hospital pre-alerts, drug supply and drug checking. Full report

Operational

Tactical

Strategic

Correct as of	20 October 2026
Applies to	Festival and outdoor event organisers, welfare, stewarding, security and event medical teams
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Read this first. This report summarises concerns that coroners have published in Prevention of Future Deaths reports, and the published responses. It reports what the coroners wrote. It does not add findings of people who died or name the events. It is general information, not legal or clinical advice.



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About this report. It expands OTAS Brief CI-001 with the coroners' concerns in each report, the published responses, the lessons in general terms for each level, a pre-season checklist and a briefing for stewards and welfare teams. Section 9 lists what we could not confirm. To ask for this report in another format, use the contact details on the OTAS Insights page.

1 Summary

Coroners in England and Wales have published a run of Prevention of Future Deaths reports after drug-related deaths at music festivals. Read together, three recent reports raise the same practical concerns: people who were visibly unwell were not stopped and helped, medical and transport crews were not trained or equipped for drug-affected patients, nobody was clearly responsible for warning the hospital, and drugs were easy to buy on site [1][3][5].

This report sets out what each coroner wrote, what the published responses say, and the lessons in general terms for each level. It does not name the people who died, the events or the organisations involved. It reports the coroners' concerns and does not add findings of its own.

It is general information for event professionals, correct as of 20 October 2026. It is not legal or clinical advice.

At a glance. What the reports ask festival teams to think about.

- **Spot and act.** One coroner recorded a teenager walking for about 90 minutes while visibly unwell and passing at least one checkpoint, with no staff or volunteers intervening [1].
- **Medical cover that fits the risk.** Another coroner said private ambulance staff had minimal training in managing drug-affected patients at an event where the risk of drug taking was "deemed to be high" [3].
- **Pre-alert.** It was unclear who should warn the hospital, and no pre-alert call was made [3].
- **Drug supply.** A third coroner heard evidence of an open drug trade in campsites, with nothing seen to disrupt it [5].
- **Drug checking.** The Home Office supports licensed back-of-house testing, not individual results [2][7].
- **Regulation is changing.** In England, event healthcare comes into CQC registration, in full from 6 December 2027 [11].

2 How these reports work

When anything revealed by an investigation gives rise to a concern that circumstances creating a risk of other deaths will occur or continue, and the coroner thinks action should be taken, the senior coroner must report the matter to a person who may have the power to act [9]. The person who receives the report must respond in writing within 56 days, giving details of action taken or proposed, with a timetable, or explaining why no action is proposed [10]. Copies go to the Chief Coroner and are published [9].

These are concerns about future risk. They are written so that someone with power to act responds. They are not a verdict on the event. We quote and summarise the coroners' own words and the published responses.

3 The three reports

Reference	Coroner area and date	Circumstances, in general terms
2023-0303	West Yorkshire (Eastern), 21 August 2023	A 16-year-old at a large three-day festival in August 2022. Medical cause of death included MDMA intoxication [1].
2025-0372	North East Kent, 19 May 2025	A 17-year-old at a music festival in June 2024. Medical cause of death MDMA toxicity [3].
2025-0395	Hampshire, Portsmouth and Southampton, 1 August 2025	A 22-year-old at a multi-day festival in August 2024, who bought and took MDMA on site [5].

Table 1. The reports reviewed. Each is published with its responses on the Courts and Tribunals Judiciary website.

4 What the coroners raised

4.1 Staff and volunteers not stepping in

In 2023-0303 the coroner recorded that the young person walked around the site for approximately 90 minutes after signs of an adverse reaction developed. He was unable to walk straight, pale, sweating profusely and agitated, and in the later stages needed help from two other teenagers to stay on his feet. He passed through at least one checkpoint staffed by stewards or security, and "no staff or volunteers spotted the need to intervene" [1]. The coroner said further instruction or training for festival staff and volunteers was required on the need to be proactive, particularly given the prevalence of illicit drugs and teenagers [1].

4.2 Medical crews and drug-affected patients

In 2025-0372 the coroner was concerned that the private ambulance staff had been trained to a minimal level and had little training or experience in managing patients who had taken drugs. Given that teams and ambulances were present at a music event where the risk of drug taking was deemed to be high, the coroner said more training should have been provided [3]. The report records that the patient had a temperature of 40.6 degrees and a heart rate of 186, and that no attempts to reduce her temperature were made while she was with the private ambulance crew [3].

4.3 Who warns the hospital

The same coroner found it unclear who was responsible for making a pre-alert call to the hospital. None was made, and there was a delay in triage at hospital because of communication issues [3].

4.4 Vehicles that look like more than they are

The coroner noted that the private ambulance had less equipment than an NHS ambulance and was "very little more than a means of transport", and said it "may have given a false sense of reassurance" [3].

4.5 Open drug supply

In 2025-0395 the coroner heard evidence that drugs were freely available, with dealers walking through the campsites calling out what they had, as regularly as every twenty minutes, and that witnesses saw nothing done to try to disrupt the trade [5]. The coroner was concerned that an unchecked, open trade will create a risk of future deaths [5].

4.6 Confiscate and admit

The same coroner heard that people found bringing drugs in who are not considered dealers have their drugs confiscated and are still allowed onto site. The coroner was concerned that this leaves no disincentive and gives rise to demand on site [5].

4.7 Under-18s and national data

In 2023-0303 neither the organiser nor the licensing authority had accurate numbers of under-18s attending. The coroner also heard that four to five people die each year from drug-related causes at British festivals, that there is no body overseeing festival safety nationally and no central record of casualties, and called for national data [1].

4.8 Drug checking

The 2023-0303 coroner asked for authoritative Home Office guidance on front-of-house drug testing [1].

5 What the responses say

5.1 The Home Office (2023-0303)

The Home Office reply points to Safety Advisory Groups and the licensing objectives, and says policing decisions are operational [2]. On training, it says SIA licensing covers security guards and door supervisors, whose minimum training includes drug awareness, but that stewards and unpaid volunteers do not need SIA licences. It encourages event coordinators to consider the enhanced skills needed and to communicate them to security contractors and, separately, to volunteers and stewards [2].

On drug checking, it says anyone possessing or supplying controlled drugs, including a drug checking service, needs a Home Office controlled drugs licence, in England, Scotland and Wales [2][8]. In Northern Ireland, a licence from the Department of Health is needed instead [14]. The government "recognises the potential harm reduction benefits of back-of-house" services, which test surrendered or confiscated drugs and enable local public alerts, but do not give individuals their results. It does not expect individual results to be given, which would be front-of-house testing, and it encourages organisations to plan ahead for a licence [2]. Its 2024 statement repeats that position and says there has been no change [7].

5.2 The ambulance provider (2025-0372)

The provider's published response describes event scoping and risk assessment, a dedicated event team trained in drug and alcohol intoxication, red flags and escalation, crews empowered to pre-alert hospitals on their own with clinical support available, a pre-event vehicle checklist, a clinical inventory benchmarked to the NHS, pre-event briefings and a medical operational plan for each event [4].

5.3 The police (2025-0395)

The police response says drug supply management on site is the organiser's responsibility under national event guidance, with the police working through the Safety Advisory Group. It says the entry policy is in line with national guidance, and describes improvements in 2025 with more expected in 2026 [6].

6 What to do

Operational

- Treat anyone who is pale, sweating heavily, agitated or unable to walk straight as a medical concern, and get help [1].
- Know how to call medical help from your post and where the medical and welfare points are.
- Stay with the person until help arrives and pass on what you saw.
- Medical crews: if in doubt, pre-alert the hospital, following your provider's procedure [4].

Tactical

- Brief every steward, security officer and volunteer to be proactive about welfare, not only security [1][2].
- Agree in writing who makes the hospital pre-alert, and test it before opening [3][4].
- Ask your medical provider to show how its plan covers drug-affected patients, set by its clinicians [3][4].
- Check transport vehicles and their equipment against what the medical plan says they are for [3][4].
- Make sure welfare, medical and security teams share one radio or reporting route.

Strategic

- Commission medical and transport capability against the event's risk profile, not just the expected headcount [3].
- Know your audience, including how many under-18s attend [1].
- Review drug supply disruption and the entry policy with the police and the Safety Advisory Group [5][6].
- If you want drug checking, plan early for a licence, allowing time for a compliance visit: from the Home Office in England, Scotland and Wales, or from the Department of Health in Northern Ireland [2][7][8][14].
- In England, check whether your medical provider must register with CQC, and when [11][12].
- Record and review welfare and medical incidents each year.

Action box

Level	Do this
Operational	Treat visible distress as medical, call for help, stay with the person, pre-alert if in doubt.
Tactical	Proactive welfare briefings, a written pre-alert rule, a medical plan for drug-affected patients, vehicles checked.
Strategic	Capability matched to risk, audience data, supply and entry policy with the SAG, licences and registration on time.

7 Tools

7.1 Pre-season checklist

When	Check	Who
Now	Risk profile agreed, including drugs, heat and the age of the audience	Strategic
Now	Medical provider's CQC position confirmed, for events in England	Strategic
Now	Any drug checking licence application planned	Strategic
Before contract	Medical plan covers drug-affected patients and hospital transfer	Tactical
Before contract	Pre-alert responsibility agreed in writing	Tactical
Before build	Supply disruption and entry policy agreed with police and the SAG	Strategic
Before opening	Stewards, security and volunteers briefed on spotting and acting	Tactical
Each day	Welfare and medical incidents logged and reviewed	Operational

Table 2. Pre-season checklist. Adapt it to your event, your risk assessment and the advice you receive.

7.2 Steward and volunteer briefing (about 1 minute)

"Your job tonight includes looking after people, not just checking tickets. If you see someone who is pale, sweating heavily, agitated or struggling to stand, treat it as a medical concern. Call _____ on _____ straight away and give your location. Stay with them until help arrives and tell the medical team what you saw. You will not get anyone into trouble by asking for help. The nearest medical point is _____ and welfare is _____. Any questions?"

8 Frequently asked questions

What is a Prevention of Future Deaths report?

A report a coroner in England and Wales must send when an investigation reveals a risk of other deaths and action should be taken. The recipient must respond within 56 days [9][10].

What do coroners keep raising about festivals?

Staff not intervening with visibly unwell people, medical crews not trained or equipped for drug-affected patients, unclear hospital pre-alerts and easy access to drugs on site [1][3][5].

Is drug checking at festivals legal in the UK?

In England, Scotland and Wales, back-of-house testing of surrendered or confiscated drugs can run under a Home Office controlled drugs licence. Northern Ireland has its own licensing, through the Department of Health. The Home Office does not support giving individuals their results [2][7][14].

Do event medical providers need to register with CQC?

In England, many will. Applications opened in September 2026 and the rules take full effect on 6 December 2027. First aid alone is not regulated [11][12].

Who is responsible for drug supply on a festival site?

The police response to one report says it is the organiser's responsibility under national event guidance, with the police working through the Safety Advisory Group [6].

9 What we don't know yet

- **How many deaths there are.** The coroner in 2023-0303 heard there is no central record of festival casualties [1]. We found no official annual figure.
- **The Event Healthcare Standard.** UKHSA's review informs a new standard for event healthcare. We found no publication date [13].
- **Drug checking policy.** The latest Home Office statement we found is from May 2024 [7].
- **Scotland and Northern Ireland.** These reports are made under the law of England and Wales. Other nations have their own systems.
- **Later reports.** Other reports may have been published since. We reviewed these three because they are recent and festival-related.

10 Sources

All web sources were opened and checked on 20 October 2026. Some report links carry the name of the person who died, as published by the Courts and Tribunals Judiciary.

1. Courts and Tribunals Judiciary, Prevention of Future Deaths report 2023-0303 (Senior Coroner, West Yorkshire (Eastern), dated 21 August 2023), with the published responses. <https://www.judiciary.uk/prevention-of-future-death-reports/david-celino-prevention-of-future-deaths-report/>
2. Home Office, response to Prevention of Future Deaths report 2023-0303 (Minister of State for Crime, Policing and Fire). <https://www.judiciary.uk/wp-content/uploads/2023/09/2023-0303-Response-from-Home-Office.pdf>
3. Courts and Tribunals Judiciary, Prevention of Future Deaths report 2025-0372 (North East Kent Coroner's Service, dated 19 May 2025). <https://www.judiciary.uk/prevention-of-future-death-reports/emily-stokes-prevention-of-future-deaths-report/>
4. Response to Prevention of Future Deaths report 2025-0372 from the private ambulance provider (dated 7 July 2025). <https://www.judiciary.uk/wp-content/uploads/2025/07/2025-0372-Response-from-Kent-Central-Ambulance-Service.pdf>
5. Courts and Tribunals Judiciary, Prevention of Future Deaths report 2025-0395 (Hampshire, Portsmouth and Southampton, dated 1 August 2025). <https://www.judiciary.uk/prevention-of-future-death-reports/benjamin-buckfield-prevention-of-future-deaths-report/>
6. Response to Prevention of Future Deaths report 2025-0395 from the police force. <https://www.judiciary.uk/wp-content/uploads/2025/08/2025-0395-Hampshire-and-IOW-Constabulary.pdf>
7. Home Office, 'Licensed drug testing continues at music festivals this summer' (news story, 24 May 2024). <https://www.gov.uk/government/news/licensed-drug-testing-continues-at-music-festivals-this-summer>
8. Home Office, 'Controlled drugs: domestic licences' (guidance). <https://www.gov.uk/guidance/controlled-drugs-domestic-licences>
9. Coroners and Justice Act 2009, Schedule 5, paragraph 7, action to prevent other deaths (England and Wales). <https://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7>
10. The Coroners (Investigations) Regulations 2013 (SI 2013/1629), regulation 29, response to a report on action to prevent other deaths. <https://www.legislation.gov.uk/uksi/2013/1629/regulation/29>

11. Care Quality Commission (CQC), 'Registration applications now open for event healthcare providers' (published 24 September 2026). <https://www.cqc.org.uk/news/registration-applications-now-open-event-healthcare-providers>
12. CQC, 'Supporting registration guidance for delivering treatment of disease, disorder or injury at events: relevant exceptions to registering'. <https://www.cqc.org.uk/guidance-regulation/providers/registration/supporting-registration-guidance-delivering-tddi/exceptions>
13. UK Health Security Agency (UKHSA), 'Healthcare provision at events: a rapid scoping review' (published 19 February 2026). <https://www.gov.uk/government/publications/healthcare-provision-at-events-a-rapid-scoping-review>
14. Department of Health (Northern Ireland), 'Controlled drugs' (controlled drug licensing in Northern Ireland, under the Misuse of Drugs Regulations (Northern Ireland) 2002). <https://www.health-ni.gov.uk/articles/controlled-drugs>

11 About this report

Published by OTAS Live Ltd. General information only, correct as of 20 October 2026. It summarises published coroners' reports and responses in general terms. It is not legal or clinical advice and does not suggest that any person or organisation was at fault.

Interest: OTAS Live Ltd, which publishes EPGN, sells event operations services.

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