REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Greater Manchester Police – Chief Constable** **2. Cheshire Constabulary – Assistant Chief Constable** **3. Cumbria Constabulary – Chief Constable** **4. Lancashire Constabulary – Assistant Chief Constable** **5. Merseyside Police – Chief Superintendent (RR Command)** **6. British Transport Police – FCR Operations Manager** **7. North West Ambulance Service – Chief Executive** **8. North West Fire Control – Senior Operations Manager** **9. Lancashire Fire and Rescue Service – Group Manager** **10. Merseyside Fire and Rescue Service – Station Manager** **11. Greater Manchester Integrated Care Board – Chief Nursing Officer** **12. Lancashire and South Cumbria Integrated Care Board – Chief Nurse** **13. Cheshire and Merseyside Integrated Care Board – Chief Nurse**
1	**CORONER** I am Adrian Farrow, Assistant coroner, for the coroner area of 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 29th November 2022 an investigation was commenced into the death of Claire Nicole Briggs, aged 42 years. The investigation concluded at the end of the inquest on 12th July 2023. The conclusion of the inquest was that she died of a propranolol overdose on 28th November 2022 at Stepping Hill Hospital, Stockport, having taken approximately [redacted] propranolol tablets from previous prescriptions. She declined to be taken to hospital by the police for the critical time period after she had taken the tablets. There were 2 admitted failings by the North West Ambulance Service effectively to conduct clinical reviews of the incident which were not in themselves causative of her death, but the combined effect of those failings, the absence of any method within the NHS Pathways system to identify high risk overdoses and the pressures on the deployment of ambulances on that day combined to lead to a delay in her arrival at hospital which possibly contributed to her death.
4	**CIRCUMSTANCES OF THE DEATH** Claire Briggs was first prescribed propranolol from 2008 and had been regularly prescribed daily doses of that medication since 2019. [redacted]. I found, on the evidence, that she had consumed approximately [redacted] propranolol tablets. A friend and the police attended at her home quickly. Ms Briggs was resistant to be taken to hospital until the time at which the effects of the ingestion of drugs became evident. Notwithstanding her stance, the police officers and others at the scene made repeated calls to the ambulance service. In total, 9 calls were made between 4.37pm and 6.12pm, 6 of which were made prior to Ms Briggs relenting and accepting that she should be taken to hospital and a further separate call by the police to the Hear and Treat helpline. The evidence I heard was that calls made by police officers from the

	scene to NWAS are triaged in the same way as other 999 calls. The ambulance service call handlers used the NHS Pathway process in dealing with each of the calls, which prompted a response category under the NHS Pathway system which resulted in a Category 3 response, which was not upgraded to Category 2 until a call made at 17.53 and the incident was prioritised at 18.16 so that the next available ambulance was allocated to respond. There were significant delays within the ambulance service at that time, such that national target response times were significantly breached. Prior to the arrival of the ambulance and in light of Ms Brigg's obviously deteriorating condition and the uncertainty over the arrival time of the ambulance, the police officers decided to transport her to hospital themselves by police vehicle, but she experienced seizures before the police car left the vicinity of her address, which as closely followed by the arrival of the ambulance at 18.32. The police officers at the scene, in the calls they made from the scene and through their control room were unable to convey the seriousness of Ms Brigg's condition to the ambulance service. She went into cardiac arrest at the scene in the back of the ambulance and was subsequently taken to hospital, where, despite care and treatment under guidance from a senior member of the National Poisons Advice Service, she died. The ambulance service accepted that there were failures to undertake timely clinical reviews of the incident.
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 could 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 evidence I heard was that a Joint Operating Protocol between the North West Ambulance Service and the five regional police forces designed to address the issues of which emergency service should take responsibility for incidents involving drug overdoses and the method by which the police officers attending such incidents prior to the arrival of the ambulance service can escalate their concerns over a person suspected to have taken a drug overdose, was in an advanced stage of completion, but was stalled in July 2022. Whilst I heard that discussions have recently recommenced, they now encompass the Right Care, Right Person model, the findings of the Manchester Arena Bombing Enquiry and that additionally, the Fire and Rescue Service and the British Transport Police have now become involved. Pending agreement of a Joint Operating Protocol, there does not appear to be any consistent and reliable understanding in place across the police forces and the North West Ambulance Service to provide clarity as to the roles of the respective services and the method by which concerns about individual patients can be escalated to the ambulance service by police officers dealing with those who are suspected to have taken drug overdoses.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 2nd February 2024. 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 - [redacted] on behalf of Ms Briggs' family, 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	**Adrian Farrow** **HM Assistant Coroner**  **08.12.2023**