REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. North West Ambulance Service (NWAS)** **2. Secretary of State for Health and Social Care**
	CORONER I am Matthew Cox, Assistant Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	**INVESTIGATION and INQUEST** On the 6th June 2023, I commenced an investigation into the death of Paul Dow, date of birth 26th August 1957 who died on the 3 April 2023 at the Royal Oldham Hospital The medical cause of his death was confirmed as 1a) Combined drug toxicity 2) Ischaemic heart disease, Type 2 diabetes mellitus, urinary tract infection.
4	**CIRCUMSTANCES OF DEATH** On 28th March 2023 Mr Dow was arrested and charged with criminal offences. On 29 March he was bailed subject to conditions not to go within 100 metres of his home address where he lived with his partner as a result of which he started staying at the Travelodge, Rochdale. Mr Dow was on his own in a room at the Travelodge when at 18.35 on 2 April 2023 he made an emergency call to the ambulance service. He made contact with a call handler employed by NWAS. He reported that he was a type 2 diabetic and said "I've taken a pile of tablets and I mean a pile" when asked whether this was an attempt to take his life he replied, "Well yeah, possibly." He was asked what he had taken and he said he had taken [redacted]. When asked whether he had taken a lot, boxes of each he replied "yeah." He said he felt weird. Mr Dow was told there were delays of over an hour and a half in dispatching an ambulance. The call was coded as a category 3 response defined as 9 out 10 responses within 120 minutes. A clinician from the clinical hub attempted to call Mr Dow but received no response to calls at 19.09, 19.22 and 19.26. Mr Dow called the ambulance service again at 19.38 and spoke to the same call handler. He said "I've taken loads of tablets, the ones I have for my diabetes." He was asked again whether this was an attempt to take his life and said "I don't know, could be." This call was also coded as category 3. An ambulance arrived on scene at 20.27. Mr Dow stated to the paramedic that the overdose was intentional as he wanted to take his own life. Mr Dow was transported to hospital arriving at 21.43. Attempts to resuscitate him were unsuccessful and his death was confirmed on 3 April 2023.
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. Despite giving a clear indication that he had taken an overdose of a lot of medication with an indication that he did so to take his own life the calls at 18.35 and 19.38 were both coded as category 3. 2. There was no involvement from a clinician at the time of either call. 3. Mr Dow was on his own in the hotel room. When a clinician called on 3 separate occasions there was no response. During her evidence Ms Lee, the Service Delivery Manager of the Emergency Operations Centre accepted that this could indicate that Mr Dow had lost consciousness but the call made at 18.35 was not escalated
W	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 5 June 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 namely:- The family of Paul Dow North West Ambulance Service 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 from. 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	Date 10 April 2024 Signed: