REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

This report is made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

Recipients

This report is being sent to:

- North West Ambulance Service
- [redacted] - Brother and Next of Kin
- Chief Coroner
- [redacted], Counsel

Coroner

I am Jean Harkin, H.M. Assistant Coroner for the area of Manchester City.

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.

Investigation and Inquest

On the 7th January 2014 I commenced an investigation into the death of Terence Norbert Dooley, aged 45 years. The investigation concluded at the end of the inquest on 7th January 2014.

The cause of death was found to be:

1a Ingestion of excessive amounts of Citalopram, Mirtazapine and Propanalol

The conclusion of the inquest was as follows:

Narrative conclusion: Terence Norbert Dooley was found deceased on 29th October 2013, having taken a fatal dose of medication. Due to a heavy demand on the Ambulance Service, attendance to him was delayed by 2 hours 38 minutes.

Circumstances of death

Mr Dooley had taken an overdose of tablets and he telephoned 999 for an ambulance, informing the call handler that he had taken a mixture of 40 tablets. He complained of feeling hot and said that he could not feel his legs. He gave his location as being on a bench next to Butler Bridge by the canal. He was able to name the tablets he had taken and was informed that a response car would be with him in 20 minutes. However, it was 2 hours 38 minutes later when a response vehicle was dispatched. By the time the response vehicle arrived Mr Dooley had wandered off. On the evidence heard in court, he most likely entered the water to cool down. He was found on the bank by the canal, wet with wrinkled skin and unresponsive at 0800hrs. He had called the service at 0151hrs.

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 the fact that each different tablet could be fatal on its own, let alone together, this call was given a code green.
2. This was an emergency and a delay of 2 hours and 38 minutes is totally unacceptable regardless of pressures on the service due to Halloween.
3. There appears to have been a lack of communication. The call handler believed that a response vehicle would be dispatched in 20 minutes.
4. The computer generated codes are misleading. One death is one too many when it should have, and could have been avoided.

Action should be taken

In my opinion action should be taken to prevent future deaths and I believe that your organisation has the power to take such action.

Your response

You are under a duty to respond to this report within 56 days of the date of this report, namely by 6th Jun 2014. 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.

Copies and publication

I have sent a copy of my report to the following Interested Persons: [redacted] the brother of the deceased, and [redacted], Counsel to the 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 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.

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Mrs Jean Harkin **Date: 10th April 2014**
H.M. Assistant Coroner – Manchester City area