Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 NHS England** **2 NHS Improvement** **3 Department of Health and Social Care**
1	**CORONER** I am Anita BHARDWAJ, Area Coroner for the coroner area of Liverpool and Wirral
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 02 August 2022 I commenced an investigation into the death of James CAMPION aged 57. The investigation concluded at the end of the inquest on 19 December 2023. The conclusion of the inquest was that: Narrative Conclusion : The consumption of an excessive amount of prescription medication whilst under the influence of alcohol, contributed to by the delay in medical treatment.
4	**CIRCUMSTANCES OF THE DEATH** James Campion was 57 year old gentleman who had a number of co-morbidities, including a history of depression and previous drug overdoses. Mr Campion was also known to drink alcohol to excess, described by family as a functioning alcoholic. On 1 July 2022 Mr Campion contacted the crisis teams indicated he was going to overdose and then proceeded to overdose on prescription medication. He was conveyed to the Royal Liverpool University Hospital where he was treated for the overdose and seen by the mental health team. A mental health assessment was not carried out and he was discharged with the advice to contact the crisis team if needed. On the evening of 20 July 2022 Mr Campion spoke to a friend who confirms Mr Campion appeared intoxicated but appeared to be his normal self. In the early hours of 21 July 2022, Mr Campion made contact with the Psychiatric Crisis Team threatening to take an overdose of [redacted] and his heart medication, he also stated that he had been drinking vodka. In the light of their concerns the Crisis Team contacted the North West Ambulance Service (NWAS) by 999 at 2.10am. The initial call was allocated a category III classification (attendance within one hour and 90% of calls within two hours). The Service was stated to be very busy at that time. It was four and a half hours from the original call before the case was reviewed by a clinician but there does not appear to have been a welfare check phone call at that time. It was not until six hours after the initial call that an ambulance was allocated and when the crew arrived at his home address at 8:26am they found Mr Campion deceased in the living room. The post mortem and toxicology investigation found the cause of death to be mirtazapine and alcohol toxicity. Mirtazapine is an antidepressant medication and has a number of common side-effects including feeling sleepy and in overdose it can lead to reduced consciousness and coma. The TOXBASE guidance notes that peak plasma concentrations occur approximately two hours after ingestion. It also states that the effects on the central nervous system may be enhanced or prolonged following co-ingestion of other central nervous system

	depressants including alcohol. Though it is unknown as to exactly what time Mr Campion took the overdose of mirtazapine, in the opinion of the expert the delay of over 6 hours from the initial call to the ambulance service to an ambulance crew being allocated and arriving on scene is very significant. It is more likely than not if Mr Campion had been in hospital at a point at least two hours after ingestion he would have survived this event. There were a number of missed opportunities in the care and treatment of Mr Campion. The family contact details noted by the mental health team were incorrect. There was very little evidence of family involvement throughout the mental health interactions, this being a critical and crucial element of the mental heath treatment plan. On 1 July 2022 a full mental health assessment should have been carried out, which is likely to have resulted in immediate support for Mr Campion and measures been put in place for further referrals to the appropriate mental health services. On 21 July 2022 the ambulance call handler did not give the time estimate of the ambulance to the crisis team member; that said the numbers for the family were incorrect and so would not have led to anyone being contacted. The delay in the ambulance dispatch prevented Mr Campion receiving medical treatment and further psychiatric assistance. The outcome for Mr Campion has been adversely impacted due to the demand on the ambulance service . At the time of the 999 call on 21st July 2022 NWAS were operating at Level 4 of the Plan (PSP) experiencing high demand, acute pressures and high numbers of waiting calls. The options for the emergency services were extremely limited and an ambulance was deployed at the earliest opportunity. Mr Campion clearly consumed an excessive amount of prescription medication whilst under the influence of alcohol and as such his state of mind is likely to have been impaired. Taking account of his past actions, particularly that of 1st July 2022, it is more likely than not he carried out the act not with the intention of taking his own life.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) The delay in triaging the call made by Mr Campion threatening to take an overdose resulted in him taking the overdose. The delay in the ambulance dispatch prevented Mr Campion receiving medical treatment and further psychiatric assistance. The outcome for Mr Campion has been adversely impacted due to the demand on the ambulance service . At the time of the 999 call on 21st July 2022 NWAS were operating at Level 4 of the Plan (PSP) experiencing high demand, acute pressures and high numbers of waiting calls. The options for the emergency services were extremely limited and an ambulance was deployed at the earliest opportunity. Consideration be given to how to support the Ambulance and Mental Health Services in fulfilling the NHS long-term plan for Mental Health, in particular Mental Health Practitioners in Ambulance control rooms.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 by February 13, 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] **North West Ambulance Service** **Mersey Care NHS Foundation Trust** I have also sent it to **Merseyside Police** who may find it useful or of interest. 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 person who I believe may find it useful or of interest. 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	**Dated: 20/12/2023**  **Anita BHARDWAJ** **Area Coroner for** **Liverpool and Wirral**