ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Chief Executive of the Welsh Ambulance Service NHS Trust** 2. **Chief Executive of the Royal Gwent Hospital** 3. **Chief Executive of Neville Hall Hospital** 4. **Minister of Health, Welsh Government**
1	**CORONER** I am Andrew Barkley, Senior Coroner, for the coroner area of South Wales Central.
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 the 17th August 2016 I commenced an investigation into the death of Ceriann Richards. Investigation concluded at the end of the inquest on the 28th February 2017. The conclusion of the inquest was that of a "Narrative" conclusion which was *Ceriann Richards died from the effects of Venlafaxine Toxicity, but the circumstances in which she came to be affected by it, remains unclear.*
4	**CIRCUMSTANCES OF THE DEATH** The deceased was found by her husband acutely unwell and suffering fits at their home address in the early hours of the 14th August 2016. The deceased's husband telephoned for an ambulance at 03:52 hrs on the 14th August and despite further contact with the emergency services the first rapid response vehicle arrived on the scene at 06:21 hrs followed by an ambulance arriving at 06:52 hrs – a delay of 2½ hours to be at the patients side and 3 hours to convey the patient from the scene to an acute hospital. During the period of time between the initial call and the arrival of assistance the deceased suffered 5 fits/seizures Upon admission to hospital at the Prince Charles Hospital she passed away within several hours being declared deceased at 10:10 hrs on the 14th August 2016. A subsequent post mortem examination revealed that she had toxic levels of prescribed anti-depressant medication Venlafaxine in her post mortem blood at a concentration of greater than 50mg per litre which was termed by the Toxicologist as being "very high and consistent with a significant overdose of this drug". The generally accepted toxic effects of this drug are usually noted in concentrations greater than 1 mg per litre and associated with fatalities of greater than 7mg per litre. The evidence revealed that the delay in the ambulance arriving at the scene did not cause or contribute to the death as the evidence showed that she was likely to have

	been suffering with the toxic effects of the drug prior to the ambulance being called.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) The delay in an ambulance being despatched to the home address of the deceased who was clearly experiencing seizures/fits. The evidence showed that the main reason for the delay was the significant hand over delays being experienced at the 2 district general hospitals within the Aneurin Bevan University Health Board Areas which on that day for the Royal Gwent Hospital were of an average of 107 minutes up to a maximum of 279 minutes and for the Neville Hall Hospital with an average delay of 43 minutes and the longest delay of 93 minutes. The evidence revealed that the agreed "handover time" is 15 minutes. The evidence further revealed that since guidance was issued in the spring of 2016 in relation to the handover from ambulance crews to hospital staff the position has worsened and in the order of 140 to 200 hours are lost each day equating to 10 to 20 vehicles being off road for the whole day across the Welsh Ambulance Trusts Area.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 25th April 2017. 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 the 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	**1st March 2017** **SIGNED:** **Mr Andrew Barkley** **HM Senior Coroner**