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:** **John Woolley - Chief Executive** **University Hospitals Bristol NHS Foundation Trust** **Trust Headquarters** **Marlborough Street** **Bristol** **BS1 3NG**
1	**CORONER** I am Maria Voisin, Senior Coroner, for the area of Maria Voisin
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 24th January 2012 I commenced an investigation into the death of **Jared William MCDOWALL**, aged **48 hours**. The investigation concluded at the end of the inquest on 26th September 2013. The conclusion of the inquest was Ia Unexpected death of a neonate with raised insulin level, anisonucleosus in islets, focal pulmonary haemorrhage with low birth weight **CONCLUSION – Jared William McDowall died from natural causes. At the time of his death he had a number of medical conditions which had not been diagnosed**
4	**CIRCUMSTANCES OF THE DEATH** Jared was born on 15th January 2012 at St. Michaels Hospital and died there unexpectedly at 02.45 hours on 17th January 2012.
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. – During the inquest I heard evidence of a cut off weight for babies to go into a transitional area where they will receive more careful monitoring. Currently the guideline is babies weighing over 2.5kg do not need to go into this unit. [redacted], a Consultant Neonatologist from the hospital gave evidence about this and indicated that there should be different weights for gestation and different guides for boys and girls. He also said that the presentation of the evidence would be better if it was graphically done and that by referring to a graph it would give a better understanding of a baby being at risk to the staff. In addition [redacted] said that there was a need to synthesize joint working with doctors and midwives. That there should be educational packages for hypoglycaemia and for recognising an unwell baby for both doctors and midwives with a measurement of competency.
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 Friday 22nd November 2013 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] and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18). 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	**27th September 2013** **[SIGNED BY CORONER]**