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. [redacted] **(Medical Director) and Mr. N. Wood (Chief Executive)** **Weston Area Health NHS Trust** **Grange Road** **Uphill** **Weston-super-Mare** **BS23 4TQ**
	CORONER I am Maria Voisin, Senior Coroner for the area of Avon.
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 15th April 2013 I commenced an investigation into the death of **Chloe Grace FLAVELL**, Aged **3 days**. The investigation concluded at the end of the inquest on 18th December 2013. The conclusion of the inquest was: **CAUSE OF DEATH** **Ia Congenital heart disease (critical aortic valve stenosis with bicuspid aortic valve, small left ventricle and small mitral valve)** **CONCLUSION** **Chloe Grace Flavell died of natural causes contributed to by neglect.**
4	**CIRCUMSTANCES OF THE DEATH** Chloe Flavell became unwell and was taken by her parents to Weston General Hospital on the morning of 3rd April 2013 and died there at 14:30 hours.
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. – It became apparent during the evidence that the management of the reception area, i.e. the stage before triage, could add significant delay when assessing someone who was in need of immediate care and treatment especially a child. I therefore indicated at the conclusion of the inquest that I would write to the Trust about the management of the reception area for them to consider whether there ought to be a better system in place to ensure that those needing immediate care and treatment, especially children, are managed in a more appropriate and efficient way to minimise delay and ensure that immediate care and treatment is given

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 **Monday 3rd March 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner, and the Properly Interested Persons and to the LOCAL SAFEGUARDING BOARD. 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	**[6th January 2014]** **[Maria E. Voisin]**