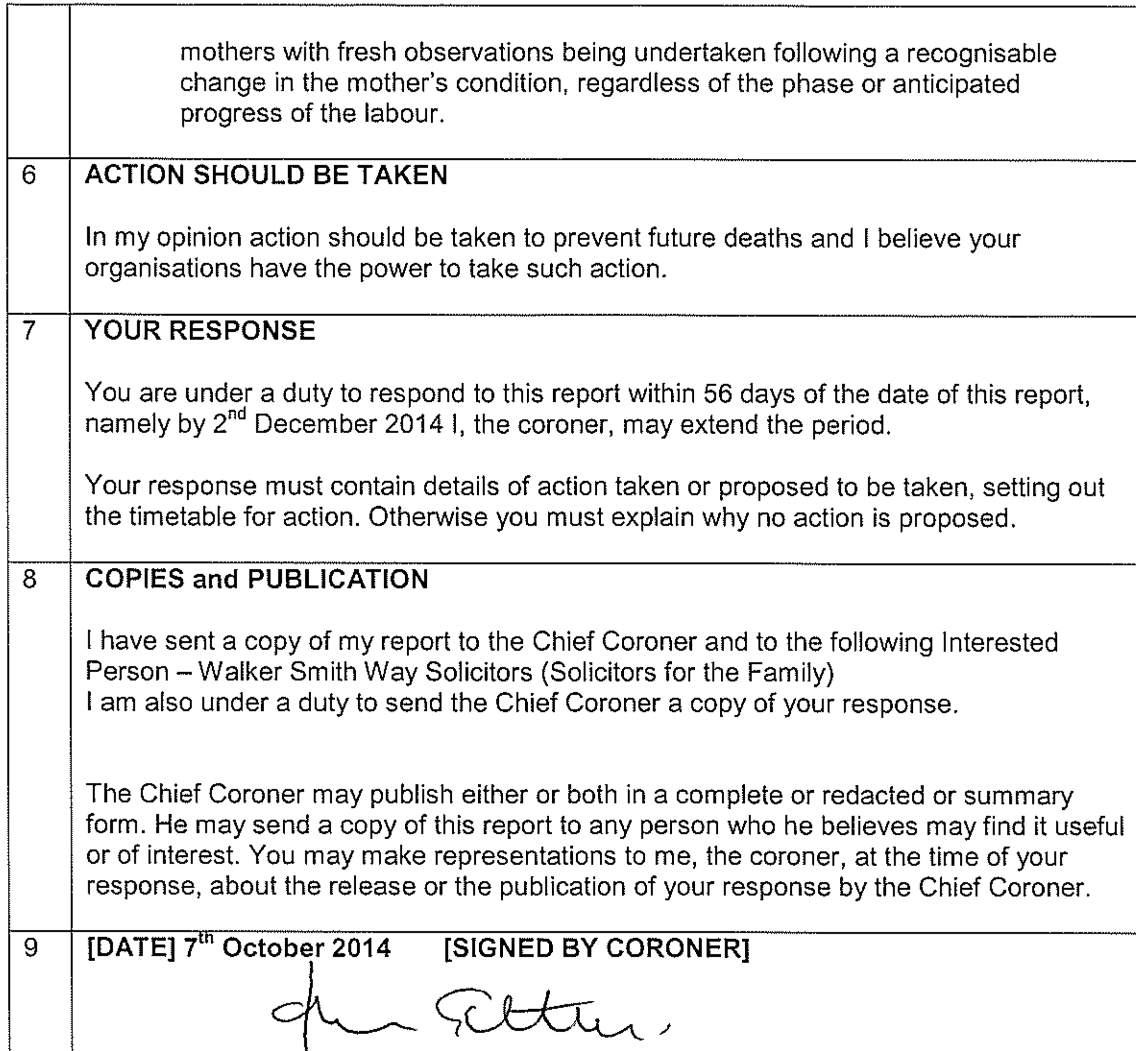
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** BCUHB, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd LL57 2PW
1	**CORONER** I am JOHN ADRIAN GITTINS, senior coroner, for the coroner area of North Wales (East and 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 21st of March 2011 I commenced an investigation into the death of Elouise Winship (DOB 11.3.11, DOD 12.3.11). The investigation concluded at the end of the inquest on the 3rd of October 2014 and I recorded a conclusion of a death from natural causes, the cause of death being 1(a) Massive Aspiration of Amniotic Fluid and Meconium due to 1(b) Severe Intrauterine/intrapartal Asphyxia due to 1(c) Umbilical Cord Wrapped around the Baby.
4	**CIRCUMSTANCES OF THE DEATH** The Circumstances of the death are that Elouise was resuscitated after being delivered unresponsive on the 11th of March 2011 but failed to survive beyond thirteen hours.
5	**<u>CORONER'S CONCERNS</u>** 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. That although a Local Serious Review was undertaken following Elouise's death in which it was agreed that the fetal heart should have been auscultated on a regular basis following administration of opiates to the mother, there is no documented regime by which this has been adopted into standard practice. 2. That it should be considered a good practice (which should if possible be incorporated into the care pathway) that there should be a further examination of



	mothers with fresh observations being undertaken following a recognisable change in the mother's condition, regardless of the phase or anticipated progress of the labour.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisations 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 2nd December 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 to the following Interested Person – Walker Smith Way Solicitors (Solicitors for the Family) 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	**[DATE] 7th October 2014 [SIGNED BY CORONER]**