

HM Coroner's Court
 A Block – Ground Floor
 County Hall
 Victoria Road
 Chelmsford
 CM1 1QH



HM Senior Coroner for Essex

Telephone: 0333 013 5000
coroner@essex.gov.uk

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)

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

| | |
|---|--|
| | <p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>Southend University Hospital</p> |
| 1 | <p>CORONER</p> <p>I am Caroline Beasley-Murray, Senior Coroner for the coroner area of Essex</p> |
| 2 | <p>CORONER'S LEGAL POWERS</p> <p>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.</p> |
| 3 | <p>INVESTIGATION</p> <p>On 12 April 2014 I commenced an investigation into the death of Jessica Hope Bond. The investigation has not yet concluded and the inquest has not yet been heard.</p> |
| 4 | <p>CIRCUMSTANCES OF THE DEATH</p> <p>Jessica Hope Bond was born on 21 May 2013 and she died on 10 December 2013. Jessica's mother had previously given birth by caesarean section and, during the course of her labour with Jessica, she suffered a uterine rupture which necessitated an emergency caesarean section delivery. Jessica's mother had been administered Propress in the course of an induction of labour. Jessica suffered significant brain injury and she died seven months later.</p> |
| 5 | <p><u>CORONER'S CONCERNS</u></p> <p>During the course of the investigation my inquiries 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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> |

| | |
|---|---|
| | <p>[BRIEF SUMMARY OF MATTERS OF CONCERN]</p> <p>(1) Independent expert opinion has drawn attention to the fact that Propess should not be administered to patients with a history of previous caesarean section or uterine surgery given the potential risk for uterine rupture and associated obstetrical complications. Uterine rupture has been reported in association with the use of Propess</p> |
| 6 | <p>ACTION SHOULD BE TAKEN</p> <p>In my opinion urgent action should be taken to prevent future deaths and I believe you have the power to take such action.</p> |
| 7 | <p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 25th August 2014. I, the coroner, may extend the period.</p> <p>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.</p> |
| 8 | <p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons who may find it useful or of interest.</p> <p></p> <p>CQC</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p> |
| 9 | <p>30th June 2014</p> <p>Caroline Beasley-Murray</p> |