Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
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Barnet EN5 4BE

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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Department of Health Richmond House 79 Whitehall London SW1A 2NS
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
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 15 Day of April 2014 I opened an investigation touching the death of Carla London , 12 days old. The inquest concluded on the 21st November 2014. The conclusion of the inquest was "Natural Causes", the medical case of death was 1a E Coli septicaemia 1b Extreme Prematurity
4	**CIRCUMSTANCES OF THE DEATH** Carla was born on the 14th April 2011 weighing 970 gms in hospital. On the 20th April Carla was given a course of antibiotics for a suspected sepsis. The antibiotics were stopped on the 24th April 2011. During the afternoon of the 25th April 2011 Carla was noticed to be unwell by her mother and was reassured by a nurse. Carla was recognised to be unwell by the staff on the morning of the 26th April 2011 and rapidly deteriorated and died in hospital at 14.30 hrs on the same day. Expert evidence heard at the inquest suggested that there should be NICE guidance on late onset sepsis in under 1500 gms babies and that and for research in to HeRO or other infection monitoring systems.
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.

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	The **MATTERS OF CONCERN** are as follows. – That coroner shares the concerns expressed by the independent expert that consideration should be given to NICE guidance on late onset sepsis in under 1500 gms babies and that and for research in to HeRO or other infection monitoring systems.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 30th February 2015. 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;- Representatives of 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	**6th January 2015**