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. North Bristol NHS Trust**
1	**CORONER** I am Maria Eileen 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 18th July 2016 I commenced an investigation into the death of **Rayan AHMED**, Aged **7 days**. The investigation concluded at the end of the inquest on 28th April 2017. The conclusion of the inquest was: **Natural causes contributed to by neglect.** Section 3 of the Record of Inquest form answering the questions where when and how the deceased came by his death recorded the following: Rayan Ahmed was born on 2nd July 2016 at Southmead Hospital, he was premature, born at 33 weeks and 4 days and he was one of twins. He was cared for in the special care unit and was initially stable. On the 6th July he collapsed, this was unrecognised for 1 hour and 5 mins before resuscitation commenced. Once stable he was transferred into intensive care but had suffered an un-survivable catastrophic brain injury. He died on 9th July 2016. The medical cause of death was recorded as : Ia Post cardiac arrest syndrome Ib Sudden unexpected postnatal collapse (SUPC) II Prematurity
4	**CIRCUMSTANCES OF THE DEATH** On the 6th July 2016 the nurse caring for Rayan had her last hands on contact with him at 8:30am. At 11:00am she went on a break when an assistant practitioner took over Rayan's care along with 7 other babies in the special care unit. At 11:20 that assistant practitioner said in evidence that she noticed Rayan's saturation monitor flashing, she did not remember an alarm sounding, she went over to him and re-sited the probe. At 11:30 the nurse caring for Rayan returned to the ward after her break and was informed what had happened. She said that she could see that the numbers were flashing on and off the screen. It was just before 11:40 that she went into his incubator and noticed that his arm was floppy when she lifted it and that he was pale and had blue lips. She pulled the emergency call bell at 11:40 for assistance. Resuscitation was commenced and once stabilised Rayan was moved to the intensive care unit. The cause of the collapse was unclear but by the 7th July it was confirmed that he had suffered a catastrophic injury to his brain which was unsurvivable and he died on

	9th July. Following his death there was an investigation, including an examination of the monitor which was responsible for monitoring Rayan's heart rate and oxygen saturation levels in special care. That examination showed that the monitor was working as it should have and confirmed that Rayan's condition was deteriorating and went unrecognised for 1 hour and 5 minutes. One of the doctors who had carried out the ward round that morning said that if she had been called she would have assessed Rayan and looking at the charts taken from the monitor said that by 10:45 that his sats. were low and that he needed resuscitation. The consultant who gave evidence confirmed that Rayan's brain was severely affected by the collapse and that if someone had been alerted sooner that he would not have had this period of slow heart rate and low oxygen saturations.
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 **MATTER OF CONCERN** is - I was concerned to note during the evidence that nurses in the special care unit are left caring for babies that they know nothing about when covering a break. I would therefore ask that this matter is reviewed and that there is consideration given to the handover at the start of the shifts to include not only the babies that the nurse is directly caring for but also to include the others that the nurse may have to take responsibility for during her shift when her colleague is say taking a break, alternatively that there is a handover at the break.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 3rd July 2017. 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 – the family of Rayan - 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	**03.05.2017** **M. E. Voisin**