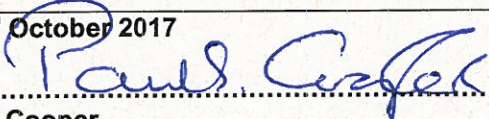




**Stuart P G Fisher
HM Senior Coroner
County of Lincolnshire**

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. Dr. Neill Hepburn, Medical Director, United Lincolnshire Hospital, Lincoln County Hospital</p>
1.	<p>CORONER</p> <p>I am Paul S Cooper, the Assistant Coroner for the area of Lincolnshire, 4 Lindum Road, Lincoln, Lincolnshire, LN2 1NN.</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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made</p>
3.	<p>INVESTIGATION and INQUEST</p> <p>On 19/08/2014 I commenced an investigation into the death of Liam Oldsworth, aged 22 Months. The investigation is currently on going. At post mortem the medical cause of death was reported as</p> <p>1a Aspiration Pneumonia</p> <p>2. Long standing Hypoxic Ischaemic Brain Injury and West Syndrome.</p>
4.	<p>CIRCUMSTANCES OF THE DEATH</p> <p>The child was brought into the Pilgrim Hospital, Fishtoft, Boston with a high temperature, 41.9 and difficulty in breathing. No infection found. Patient treated for Septicaemia and meningitis with antibiotics, condition deteriorated despite all medical support.</p>
5.	<p><u>CORONER'S CONCERNS</u></p> <p>During the course of the investigation the evidence revealed matters giving rise to concern. In the circumstances it is my statutory duty to report to you.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>The Serious Incident Analysis report dated 18/3/2015 has only within the last week been received by this office.</p> <p>Attached are recommendations and shared learning.</p>
6.	<p>ACTION SHOULD BE TAKEN</p>

	<p>In my opinion bearing in mind this report is now over 2 years old but was only delivered to this office in the last week all these recommendations should now have been acted upon and implemented and if not why not and timescale for compliance. Please confirm.</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 15/12/2017. 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</p> <p>(a) Legal Services United Lincolnshire Hospital</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>
	<p>20th October 2017</p> <p></p> <p>.....</p> <p>P S Cooper Assistant Coroner</p>