ANNEX A

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. Cwm Taf Health Board 2. General Medical Council
1	**CORONER** I am Rachel Knight, Assistant Coroner for the coroner area of South Wales 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 11th October 2017 an inquest was opened in to the death of Miss Jennifer Louise Handy. The investigation concluded at the end of the inquest on 4th April 2019. The conclusion of the inquest was a narrative.
4	**CIRCUMSTANCES OF THE DEATH** • Jennifer Louise Handy was born at 26 weeks plus 4 days gestation. Her mother had spontaneously delivered Jennifer at home on 10th April 2017. The pregnancy had been complicated and high risk, and the evidence leads me to find that the Registrar did not seek blood tests to check for infection markers, he did not escalate the mother's care to a Consultant when she had presented in hospital with pains in the hours before Jennifer was ultimately born, nor did he decide to admit the mother under observation. When she was born at home, Jennifer was simply too premature to survive.
5	**CORONER'S CONCERNS** During the course of the inquest, and the investigation leading up to it, the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

	The **MATTERS OF CONCERN** are as follows. – • No account in any format was ever provided by Dr A, the Registrar who treated Mrs Handy on 9th April 2017 and sent her home with laxatives and paracetamol. He left the UK in April 2017 to return to his native Sri Lanka to work and thereafter could not be traced. • It is unacceptable that any doctor who has worked in the UK should not be easily traceable and held to account where their conduct is in question. • The risk of future deaths arises as the quality of this investigation/inquest was diminished because it was incomplete, and the doctor in question has been unable to learn from the issues raised.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action. You may wish to consider the following points: • The recording of, updating of and accuracy of contact details for doctors who are licenced to work in the UK, especially if they are from overseas and may travel around for work in different countries. • There should be a legal/contractual requirement of doctors who leave this jurisdiction to provide personal contact details for a period of time post-departure, and to ensure that the same remain updated. • There should be a legal/contractual requirement of doctors who leave this jurisdiction to comply with reasonable requests of investigators/coroners to provide evidence. • Every doctor who leaves this jurisdiction to work overseas should provide the name of every country they practice in thereafter, together with the contact details of the relevant regulatory body (akin to the GMC) for those countries. • Consider whether a register akin to the Criminal Records Bureau should be established to flag up matters of concern with doctors, so that prospective employers could identify any issues of clinical governance that have arisen.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 31st May 2019. 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: 1. Family who may find it useful or of interest.

	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	**5th April 2019**	**SIGNED:** R Knight **Miss Rachel Knight** **Assistant Coroner**