REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Greater Manchester Combined Authority, Secretary of State for Health
1	CORONER I am Alison Mutch Senior Coroner, for the Coroner Area of South Manchester
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 30th October 2017 I commenced an investigation into the death of Mason Logue. The investigation concluded on the 22nd May 2019 and the conclusion was one of; **Narrative: Died a sudden and unexpected death for reasons that cannot be ascertained** The medical cause of death was **unascertained**
4	CIRCUMSTANCES OF THE DEATH Mason Logue was born prematurely and was in a Neonatal Unit for 11 weeks after his birth. He had a complex medical history. On the 28th October 2017 he was in his mother's bed at their home address of [redacted] Stockport. She awoke and found him unresponsive. A Post-Mortem Examination did not find a clear cause of death. There was no evidence of trauma contributing to the death of Mason.
5	<u>CORONER'S CONCERNS</u> 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 MATTERS OF CONCERN are as follows. – The inquest heard that Mason was discharged directly from the tertiary centre

	into the community after a prolonged period of care in NICU. His mother had previously been known to Family Services .There was limited evidence available of an integrated approach to care from the Local Authority; Tertiary Centre; Local Hospital and Community Health Professionals. As a result, information about his health was not shared between all health professionals. There was no overarching supportive care plan in place on discharge. Furthermore, no one health professional had an overview of his health needs and ensuring that support was put in place and appointments were coordinated. There was no system for an allocated paediatrician to coordinate care where multiple paediatric specialisms were involved. During the course of the inquest, it was clear that the understanding of local health professionals about how information would be disseminated in accordance with MOUs and protocols was different from the tertiary centre. This meant that there were different views held between health professionals as to their roles and responsibilities. There was a lack of understanding about the use and importance of Early Health Assessments amongst community health practitioners. The inquest heard evidence that the lack of a single IT system across NHS trusts meant that information sharing was more difficult. The red book was not utilised as a tool for sharing information other than by the Health Visitor to record standard information e.g. weight. The purpose and value of the red book was unclear amongst the health professionals. It was clear that clinicians in hospitals rarely utilised it.
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 14th August 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 Chief Coroner and to the following Interested Persons namely 1) Mason's family; 2) Stockport Metropolitan Borough Council; 3) Stepping Hill Hospital; 4) Manchester University NHS

	Foundation Trust 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	**Alison Mutch OBE** **HM Senior Coroner** **19/06/2019**