ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Chief Executive, Portsmouth Hospitals Trust** 2. **The Director of Midwifery and Maternity, Portsmouth Hospitals Trust**
1	**CORONER** I am Samantha Marsh, Assistant Coroner for the Coroner area of Portsmouth and South East Hampshire.
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 21st May 2018 I commenced an investigation into the death of Ezra James BOULTON aged 2 months. The investigation concluded at the end of the inquest on 21st June 2019. The conclusion of the inquest was "At about 1am on the 20th May 2018 Ezra James BOULTON was removed from his mother where they had been co-sleeping together on the sofa. Ezra was found to not be breathing. Paramedics attended and commenced CPR and Ezra was subject to a 'scoop and run' and was conveyed immediately to the Accident and Emergency Department at the Queen Alexandra Hospital where a full team were waiting to receive him. Despite the full range of medical interventions and resuscitation attempts being given it became apparent that his presentation was incompatible with life and further resuscitation attempts would be futile. Ezra was pronounced dead at 02:05am. On the balance of probabilities the suboptimal sleeping position on the sofa, which may have been influenced by alcohol consumption, and the missed opportunities to remove him to a safe sleeping environment caused or contributed to his death."
4	**CIRCUMSTANCES OF THE DEATH** Somewhere between 22.00 and 23.30 hours on the 19th of May 2018 Ezra and his mother fell asleep on the sofa, co-sleeping. Ezra's mother had been consuming alcohol throughout the day. At around 01.00 hours on the 20th of May 2018 Ezra's father removed him from under his mother's arm and tried to wake him for his night-time bottle and discovered Ezra to be cold and lifeless. Paramedics attended, performed a scoop and run, and conveyed Ezra to the ED at QAH. Despite the full range of medical treatment being given it was not possible to revive Ezra and he was pronounced dead at 02.05 that morning.
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 **MATTERS OF CONCERN** are as follows. –

(1) At Ezra's Inquest I was told in evidence that throughout her pregnancy (this being her first pregnancy) (Ezra's mother) did not see the same midwife twice. I believe that there should be some level of continuity of care in antenatal appointments to ensure that all of the necessary checks are preformed and appropriate antenatal advice is shared with the mother.

(2) I was also heard that own personal pregnancy was uneventful but I am concerned that the distinct lack of continuity of care appears to expose a risk that should there be any abnormalities and/or risk factors to either mother or baby as the pregnancy develops, that these have the potential to be missed; either entirely misses or not properly communicated to whichever midwife conducts the next antenatal appointment, causing significant risk to both mother and baby. I believe that there is a serious risk of future death posed by this lack of continuity of care.

(3) At Ezra's inquest I was told that as baby had been delivered safely with no significant injuries to mum (i.e. no significant tearing or blood loss) that the family were encouraged to leave fairly rapidly. On discharge, the focus of information sharing and care was distinctly focused on after-care for the mother. The family did not recall being given any information directly on safe-sleeping; either at antenatal appointments or at a post-natal stage from any midwife or Health Visitor. Any information they were given was provided almost as an after-thought and given in the form of a leaflet which it was suggested that they read. I was told that the first HV appointment the family received was approximately seven weeks after Ezra had been born. I believe that making safe sleeping information readily available to all parents at an early stage may significantly reduce the risk of future infant deaths due to co-sleeping.

(4) I also heard that midwives are unaware that causing the death of an infant due to co-sleeping becomes an automatic criminal offence of "overlay" (under section 1(2) of the Children and Young Persons Act 1933) if alcohol and/or drugs are involved. I believe that making this information readily available to midwifery practitioners may reduce the risk of future infant deaths due to co-sleeping but may also reduce the need for Police involvement (with a view to prosecution) in what is already a tragic time for a family who have lost their child.

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**

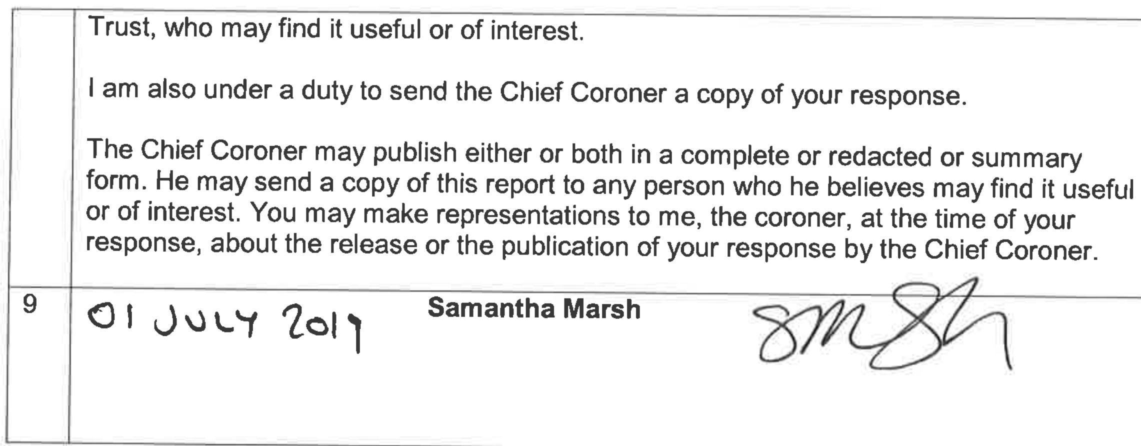
You are under a duty to respond to this report within 56 days of the date of this report, namely by 26 August 2019. I, the Coroner, may extend the period.

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;
NOK, Hampshire Police, Detective Chief Inspector head of Child Abuse Investigation Team, Southampton Police Station, SO15 1AN and to the Portsmouth MASH, Civic Offices, Portsmouth, PO1 2BG.

I have also sent it to , of Child and Adolescent Services Portsmouth NHS



	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	01 JULY 2019 **Samantha Marsh**