REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive of Tameside Clinical Commissioning Group (CCG), King Street Medical Practice
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 1st October 2018 I commenced an investigation into the death of Kaiya Campbell. The investigation concluded on the 9th September 2019 and the conclusion was one of **Narrative: Died from the complications of extreme prematurity following necessary medical intervention.** The medical cause of death was **1a) Extreme prematurity 19 weeks 6 days gestation**
4	CIRCUMSTANCES OF THE DEATH Kaiya Sonia Campbell's mother had extensive bleeding and early rupture of the membranes. Following medical intervention Kaiya was born at Tameside General Hospital on 28th September 2019. She lived briefly but given her extreme prematurity died soon after the birth.
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 Kaiya's mother was epileptic and prescribed anticonvulsant medication. She had been prescribed this for a number of years and fell within the guidance for management criteria; Her GP practice did not have any records of recent medication being prescribed although there was clear evidence given to the inquest of regular request for repeat prescriptions being requested and dispensed by a local pharmacy. It was not possible to establish at the inquest why this gap in records existed; When Kaiya's mother attended at her GP appointment and her midwifery booking-in appointment, the clinical staff involved did not appreciate the need to seek urgent guidance themselves from the neurology department regarding ongoing prescribing to reduce the risk of foetal abnormalities to the unborn child; Despite her mother falling into the high risk category, a routine consultant appointment was offered. There was no clarity as to how this need was not picked up at the time.
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 25th November 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 [redacted] Kaiya's Mother, 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** **30.09.2019**