Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

NOTE: This from is to be used **after** an inquest.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 Staffordshire, Shropshire and Black Country Newborn and Maternity Network

1 CORONER

I am Mrs D HOCKING, Assistant Coroner for the area of Leicester City and South Leicestershire

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 Twenty-Sixth February 2019 I commenced an investigation into the death of Marley Hope Slack aged 2 Months. The investigation concluded at the end of the inquest on Twenty-Eighth January 2020. The conclusion of the inquest was:

Narrative Conclusion - Whilst the cause of death remains 'Unascertained' evidence has been heard that the sleeping environment of Marley on the night of her death presented a more than minimal risk of sudden infant death.

The cause of death was established as:

I a Unascertained

I b

I c

II

4 CIRCUMSTANCES OF THE DEATH

Baby Marley Slack was born on the 22 November 2018 at 31+6 weeks gestation weighing 870 gms. She was the smaller baby of twins. She progressed very slowly and was discharged from hospital on the 06 January 2019 weighing 1550 gms. On the night of the 19 February 2019 Marley was unsettled and was taken into her parents bed beside her father. He woke early in the morning to find Marley not breathing and unresponsive. Cardiopulmonary resuscitation was commenced by dad and continued by paramedics until Marley reached hospital. She was unable to be resuscitated and was declared deceased at Leicester Royal Infirmary on the 20 February 2019.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

The Red Book for your Trust contains in its inside cover a colourful list of `Do's' and' Don'ts' regarding co-sleeping which is obviously meant to be eye catching and for quick reference. You

have accredited the information to the Lullaby Trust. I am concerned as the `Don't section on co-sleeping does not include that premature or low birth weight babies should not be co-slept with whereas the rest of the Lullaby Trust's advice about not co-sleeping if you smoke, drink or take drugs is quoted. I acknowledge that the advice is repeated in full in `The Safe Sleep Assessment section inside the booklet at page 15. However, if you are providing information that appears to be designed for immediate impact it should contain the appropriate correct information and advice.

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 10 April 2020. 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 [redacted] University Hospitals Of Leicester Nhs Trust, Leicestershire Partnership Nhs Trust, and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18).

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.

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Mrs D HOCKING
Assistant Coroner for
Leicester City and South Leicestershire
Dated: 14 February 2020