Regulation 28: Prevention of Future Deaths report

Rifky GROSSBERGER (died 05.08.19)

	THIS REPORT IS BEING SENT TO: **1. Professor Stephen Powis** **National Medical Director** **NHS England & NHS Improvement** **Skipton House** **80 London Road** **London SE1 6LH** **2. Dame Professor Donna Kinnair** **Chief Executive and General Secretary** **Royal College of Nursing** **20 Cavendish Square** **London W1G 0RN**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 6 August 2019, one of my assistant coroners, Sarah Bourke, commenced an investigation into the death of Rifky Grossberger, aged 1 year. The investigation concluded at the end of the inquest on 14 January 2020. I made a determination at inquest that death was the result of an accident. I apologise for the delay in sending this prevention of future deaths report. I had some difficulty in identifying the correct recipients.

	It is my hope that by writing to you both, there is the potential to help parents, carers and their babies across the country, not just locally.
4	**CIRCUMSTANCES OF THE DEATH** Soon after 6pm on Wednesday, 31 July 2019, Rifky Grossberger stood up in her cot and became entangled in a metal blind cord. Her mother found her with it around her neck shortly afterwards and called emergency services. She was resuscitated but died five days later. Her medical cause of death was: 1a hypoxia 1b asphyxia
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. Before Rifky became entangled in the metal blind cord, her parents were unaware of its potential danger. The instruction leaflet provided with the blinds had long since been discarded and so they did not see this. I asked Rifky's mum what would have been the most useful source of warning, and she thought the leaflets she was given after Rifky was born, and also her healthcare professionals. Professor Powis, I have attempted to locate a national leaflet, but so far unsuccessfully. It occurs to me that you may have input into local leaflets. [redacted] the midwives and district nurses who look after new mums and their babies are well placed to offer advice, but may need a reminder to warn of this particular danger. I appreciate that new parents receive a lot of paperwork and a lot of information generally. That can be overwhelming of course, but I am sure that methods could be devised of delivering such safety advice that would make this situation less likely in the future. The NHS website would also be a good place to provide this information, though it might not have assisted in this case, as Orthodox Jewish families do not necessarily access the internet.

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 11 May 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Professor Chris Whitty, Chief Medical Officer for England • Hackney Safeguarding Children Board • Hackney Child Death Overview Panel • Health and Safety Executive • [redacted] and [redacted] Rifky's parents 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 11.03.20