MR G IRVINE
SENIOR CORONER
EAST LONDON
Adult Learning College, 127 Ripple Road, Barking, IG11 7PB
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] CEO, The University College London Hospitals NHS Foundation Trust, 250 Euston Road, London, NW1 2PG [redacted] **2.** RT Honorable Therese Coffey, Secretary of State for Health & Social Care, 39 Victoria Street, Westminster, London, SW1H 0EU [redacted]
1	**CORONER** I am Graeme Irvine, senior coroner, for the coroner area of East London
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 17th February 2021 this Court commenced an investigation into the death of Toby Wilbur Barwick age 2 months (date of birth 24/11/2020). The investigation concluded at the end of the inquest held between the 23rd and 26th January 2023. I arrived at a short form conclusion of open conclusion. The medical cause of death was determined following a post-mortem examination;

	1a Unascertained
4	**CIRCUMSTANCES OF THE DEATH** Toby Barwick was born on 24th November 2020 at University College Hospital in London at 37 weeks gestation with a low birth weight of 2.1kgs. On 12th February 2021 Toby's mother walked to her sister's home carrying her son at her chest in a fabric baby carrier device. On arrival at approximately 13.00hrs, Toby was sleeping. Mrs Barwick allowed Toby to nap in the carrier whilst she spoke to her sister, sitting on a sofa. Just before 14.15 Mrs Barwick found that her son was unresponsive, she shouted for help and removed him from the baby carrier. Emergency services were called and CPR was commenced. The ambulance service arrived and took over conduct of resuscitation, Toby was taken by ambulance to the local hospital. At hospital resuscitation continued until, at 15.43 doctors determined that continued action would be futile and Toby's death was declared.
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 could 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. The inquest heard that infants of low birth weight have a higher chance of dying in circumstances of Sudden Infant Death Syndrome ("SIDS"). Upon discharge from a maternity unit mother should receive advice and documentation upon a number of issues including (but not limited to) SIDS and recommended safe practices to reduce risk. Mr & Mrs Barwick did not receive this material at UCLH. UCLH could not provide clear evidence that the factors that led to this omission had been successfully remedied.
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 **24th March 2023.** 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 the family of Toby Barwick, the Care Quality Commission, the local CDOP and the local Director for Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest.

	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.
9	**[DATE] 27th January 2023 [SIGNED BY CORONER]**