REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Greater Manchester Integrated Care
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 February 2023 I commenced an investigation into the death of Elliott James Harratt. The investigation concluded on the 26th June 2023 and the conclusion was one of Natural causes. The medical cause of death was 1a Extreme Prematurity
4	CIRCUMSTANCES OF THE DEATH Elliott James Harratt's mother went into early labour with him. He was born at the family home and transferred to Tameside General Hospital. He was 20 plus 4 weeks gestation. He died at Tameside General Hospital on 29th January 2023 from extreme prematurity
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. – In the course of the inquest into Elliott's death evidence was heard of a matter that did not contribute to his death but was of concern for the future for other babies. The inquest heard evidence that the rhesus status of Elliott's mum meant that after a sensitising event Anti D needed to be given to prevent Rhesus disease in a newborn baby. The evidence before the inquest was that the type of events that would constitute a sensitising event and what action

	was then required were not made clear to Elliott's mum. In addition, the type of events where a call to maternity triage for advice were not made clear to his mum. This was, the evidence suggested, because there was no readily accessible or consistent list given to expectant mothers at booking in appointments or at follow up signposting them. Such a document in the form of a handout laminate or as a list in the handheld notes would increase awareness of events where a call to maternity triage would be advisable for health of both the mother and baby enabling health professionals to intervene at the earliest possible stage.
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 14th September 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 namely 1) [redacted] on behalf of the Family; 2) Tameside General Hospital, 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** **HM Senior Coroner**  **20.07.2023**