GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

SOUTH WALES CENTRAL CORONER AREA

CORONER'S OFFICE
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ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

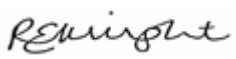
*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive Cardiff & Vale University Health Board**
1	**CORONER** I am Rachel Knight Assistant Coroner for the coroner area of South Wales Central.
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 29 December 2021 I commenced an investigation into the death of Ocean-Leigh Pauline Jean Hayes. The investigation concluded at the end of the inquest on 15th November 2023. The conclusion of the inquest was Sudden Unexplained Death in Infancy, as there was insufficient evidence of any other natural or unnatural factor. **1a Sudden Unexplained Death in Infancy** **1b** **1c** **II**
4	**CIRCUMSTANCES OF THE DEATH**

[redacted] [redacted]

	These were recorded as :- Ocean-Leigh Pauline Jean Hayes was aged 4 months when on 22nd December 2021, she died at her home address of 58 Snowden Road, Ely, Cardiff. Ocean had been co-sleeping with her mother in the hours and minutes before she died. The Inquest focused upon:- a. The arrangements for sleeping with a newborn infant and the pathology evidence. .
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. (1) Guidance requires health visitors to physically review sleeping arrangements before the baby is 6 weeks old. (2) I heard evidence that this was not always being done. (3) There may be missed opportunities to physically risk assess sleeping arrangements including *inter alia* bedding, blankets, pillows, mattress and positioning, particularly where co-sleeping is a factor, and missed opportunities to advise parents on risks they may be taking.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 10th January 2024. or if 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 family members, and the Nursing and Midwifery Council who may find it useful or of interest.

[redacted] [redacted]

	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	15 November 2023 **SIGNED:**  Assistant Coroner for South Wales Central Coroner Area