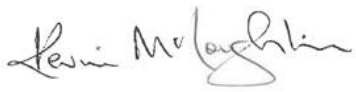
OFFICE OF THE
SENIOR CORONER
for the County of West Yorkshire
(Eastern District)

His Majesty's Coroner's Office
The Coroner's Courts
Burgage Square
Wakefield WF1 2TS

Telephone: [redacted]
Email: [redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Leeds Teaching Hospitals NHS Trust**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East)
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 27.9.23 I commenced an investigation into the death of Evelyn Grace March aged 1 day. The investigation concluded at the end of the Inquest on 18.09.24. The Inquest concluded with a Narrative conclusion including the medical cause of death being recorded as "unascertained". It is likely the death was attributable to overlaying arising from the accidental suffocation of the baby by a sleeping adult.
4	**CIRCUMSTANCES OF THE DEATH** Baby Evelyn Grace March was born on Tuesday 26.9.23 at 04:38 at St James Hospital, following a prolonged labour. She and her parents were discharged home 4 hours after the birth (08:49 hours). Around 01:45 hours the baby was brought into her mother's bed as she was unsettled. As she was being breastfed the mother probably fell asleep. When she awoke around 04:00 hours the baby was under the mothers breast, in an unresponsive condition. Despite emergency treatment she could not be revived and was pronounced dead at 07:50 hours on Wednesday 27 September 2023 at Leeds General Infirmary.
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. The Mother endured a prolonged labour and had little sleep from Sunday (24.9.23) until her baby was born at 04:38 hours on Tuesday (26.9.23). She was exhausted. 2. The baby and her parents were discharged home 4 hours after the birth (08:39 hours) 3. The death of the baby is probably due to the exhausted mother falling asleep whilst trying to breastfeed the unsettled baby in her own bed sometime after 01:45 hours (27.9.23) 4. Consideration should be given to the wisdom of discharging a mother so soon after a prolonged labour and induced delivery. Had she been permitted to sleep in hospital for a few hours knowing that her baby was being monitored, the tragedy may have been avoided.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 11 November 2024. 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 Ms [redacted] (mother) and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. I have also sent it to Maternity and Newborn Safety Investigations and [redacted], Consultant Paediatric Pathologist 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	Signed:  KEVIN McLOUGHLIN Senior Coroner West Yorkshire (E) Date: 19 September 2024