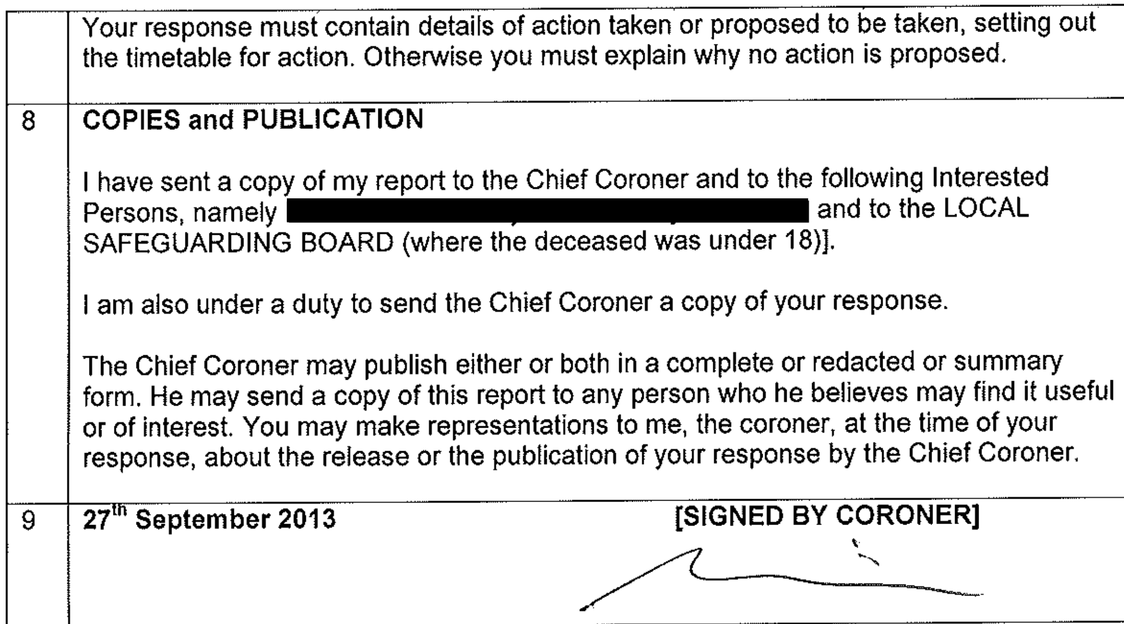
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **John Woolley - Chief Executive** **University Hospitals Bristol NHS Foundation Trust** **Trust Headquarters** **Marlborough Street** **Bristol** **BS1 3NG**
1	**CORONER** I am Maria Voisin, Senior Coroner, for the area of Avon
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 23rd November 2012 I commenced an investigation into the death of **Rose Jean COLES**, Aged **1 month** . The investigation concluded at the end of the inquest on 12th September 2013. The conclusion of the inquest was Ia Congenital heart disease (operated) **CONCLUSION – Rose Jean Coles died due to natural causes. Her death was attributed to the effects of complex congenital heart disease which she had received treatment for.**
4	**CIRCUMSTANCES OF THE DEATH** Rose Coles was born prematurely at 34 weeks gestation on 4th October 2012, she had congenital heart disease and received treatment for this. She died at 09:50 hours on 13th November 2012 at the Bristol Royal Hospital for Children.
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. – Evidence was given about the communication between the neonatal intensive care unit and the cardiac unit. Concerns were raised that the cardiac unit were not suited to caring for premature babies and that a protocol or checklist or better communication between NICU and cardiac unit would be helpful to assist the doctors and indeed the nurses in caring for a premature baby on the cardiac ward.
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 Friday 22nd November. 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 and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. 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	**27th September 2013** **[SIGNED BY CORONER]**