# REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

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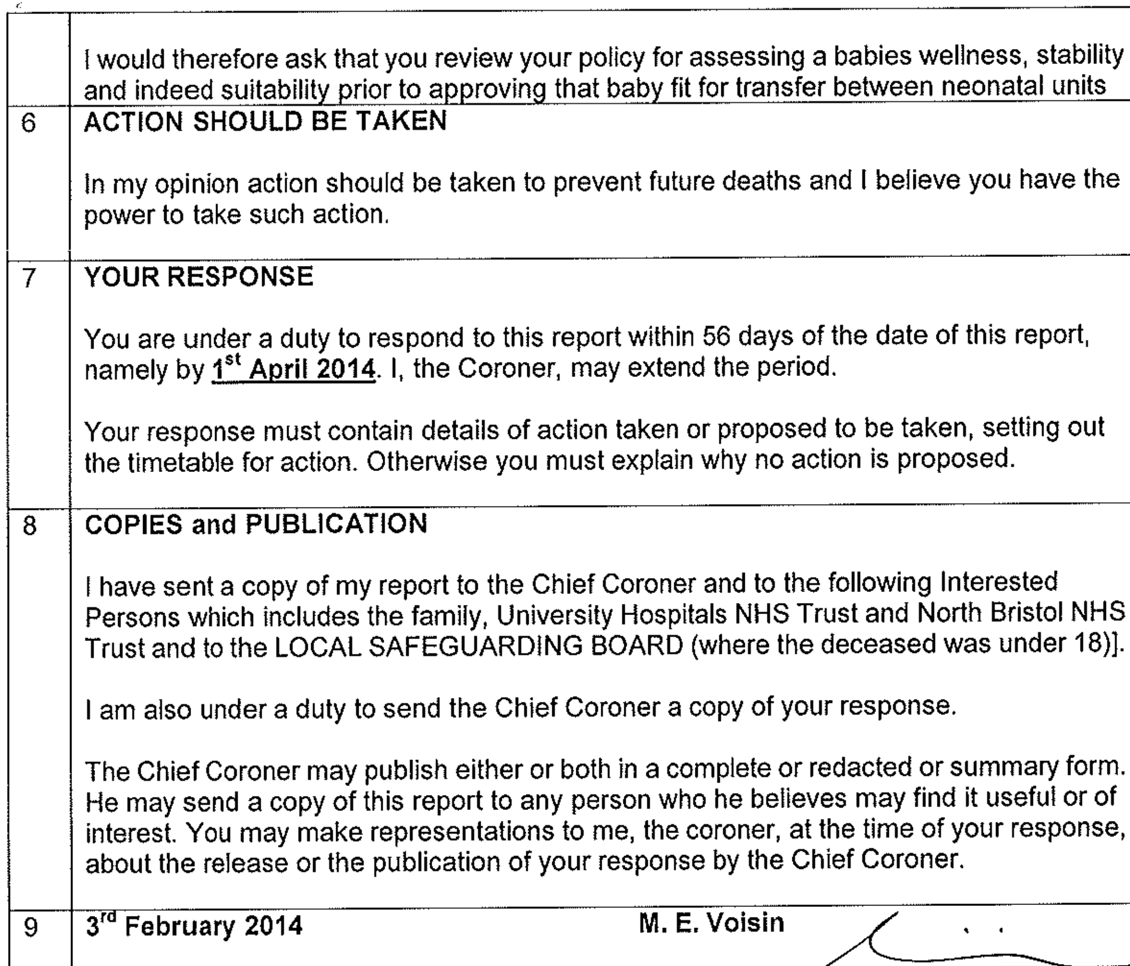
| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>1. **Oxford Universtiy Hospitals NHS Trust** |
| 1 | **CORONER**<br><br>I am Maria Voisin, Senior Coroner, for the Area of Avon |
| 2 | **CORONER'S LEGAL POWERS**<br><br>I make this report under paragraph 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**<br><br>On 15th February 2013 I commenced an investigation into the death of **Scarlett Lucie SINCLAIR**, Aged **25 days**. The investigation concluded at the end of the inquest on 31st January 2014. The conclusion of the inquest was<br><br>Ia Fulminant necrotising enterocolitis<br>II Hypoxic ischaemic encephalopathy and chronic lung disease<br>and history of Twin to Twin transfusion<br><br>**CONCLUSION: Natural Causes** |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Scarlett was born at 28 weeks gestation she one of twin girls who were both initially managed in Oxford.<br><br>The plan was to transfer Scarlett to Bristol as this was nearer to her home and I am told that this is standard practice. She was therefore transferred to the neonatal unit at Southmead Hospital at the age of 23 days on 6th February.<br><br>Within hours of being transferred she became unwell. I was told that around 3-4 a.m. she became more pale and her abdomen was distended. Medical management was commenced with a view to treating necrotising enterocolitis, again I was told during the inquest that this was standard management and an x-ray was taken.<br><br>At 7am there was an acute deterioration which necessitated surgical involvement and Scarlett was transferred for surgical management to another hospital close by. Sadly the surgeon confirmed that there was nothing that could be done due to the extent of the necrosis and Scarlett died a few hours later. |
| 5 | <u>**CORONER'S CONCERNS**</u><br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>During the inquest evidence was given from the Consultant Locum Neonatologist at Oxford as to how a baby is assessed as being suitable for transfer to another neonatal unit. I also heard evidence from a Consultant Neonatologist from Bristol who confirmed that the assessment of suitability for transfer from the United Hospitals Bristol NHS Foundation Trust means that a baby is not transferred to another neonatal unit until they are in a much more stable condition. |



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| | I would therefore ask that you review your policy for assessing a babies wellness, stability and indeed suitability prior to approving that baby fit for transfer between neonatal units |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **<u>1st April 2014</u>**. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons which includes the family, University Hospitals NHS Trust and North Bristol NHS Trust and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)].<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | **3rd February 2014** **M. E. Voisin** |