REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive Officer, Central Manchester NHS Foundation Trust.**
1	**CORONER** I am John Pollard, senior coroner, for the coroner area of South Manchester
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 22nd July 2013 I commenced an investigation into the death of Antonio Jerome Allen dob 17th June 2013. The investigation concluded on the 18th June 2014 and the conclusion was one of Natural Causes. The medical cause of death **was 1a Intra-abdominal Haemorrhage 1b Sub-capsular Haematoma (Liver and Spleen)**
4	**CIRCUMSTANCES OF THE DEATH** **On the 26th June 2013 at 07.40 hours, Antonio Allen was admitted to Trafford General Hospital in cardiac arrest with no respiratory effort and no palpable pulse. His mother had breast fed him at 01.00 hours and then found him unresponsive at 06.45 hours. Despite the best efforts of the ambulance and Emergency Department personnel, he could not be revived.**
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. – **It had been arranged that this was to be a home birth and the midwives based at Lostock Medical Centre were aware of this. His expected date of delivery was the 15th June but in fact he was born on the 17th June.** **The mother and grandmother of Antonio tried on four separate occasions to call out a midwife to attend the birth but in fact the delivery had to be carried out by the grandmother and a neighbour. Two midwives eventually arrived, checked the baby and said all was well although he was a bit 'puffy' because it was a 'quick birth'.** **IF A HOME BIRTH IS BOOKED AND EXPECTED OR INDEED OVERDUE, IT SHOULD NOT BE THE CASE THAT THE MIDWIVES ARE NOT CONTACTABLE, NOR THAT THEY ARRIVE AFTER THE BIRTH HAS OCCURRED.**
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 25TH September 2014. 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 [redacted] **(mother)**. 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	**31st July 2014** **John Pollard,Senior Coroner**