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:** Ms Judith Paget Chief Executive, Aneurin Bevan University Health Board, Headquarters, St. Cadoc's Hospital, Lodge Road, Caerleon, Newport NP18 3XQ
1	**CORONER** I am Wendy Ann James, assistant coroner, for the coroner area of Gwent
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 15.04.13 I commenced an investigation into the death of Rachel Hollister (d.o.b. 17.08.81). The investigation concluded at the end of the inquest on 26.06.15. The conclusion of the inquest was Rachel Hollister died from natural causes as a result of a known but rare complication of pregnancy and childbirth. The medical cause of death being:- Amniotic Fluid Embolism
4	**CIRCUMSTANCES OF THE DEATH** During the early hours of 13th April 2013 Mrs. Hollister presented unannounced to the Maternity Unit at the Royal Gwent Hospital. Mrs. Hollister gave birth to her daughter, [redacted]t 2.40 a.m. She suffered a retained placenta and was transferred to theatre for manual removal where she suffered a cardiac arrest and was pronounced dead at 6.25 a.m.
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. Medical staff and porters either did not follow or were unaware of the Health Board's Protocols 2. The major obstetric haemorrhage protocol does not meet the guidelines published by the Royal College of Obstetricians and Gynecologists

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 15th September 2015. 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 [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	**[DATE]** 21st July 2015 **[SIGNED BY CORONER]** [redacted]