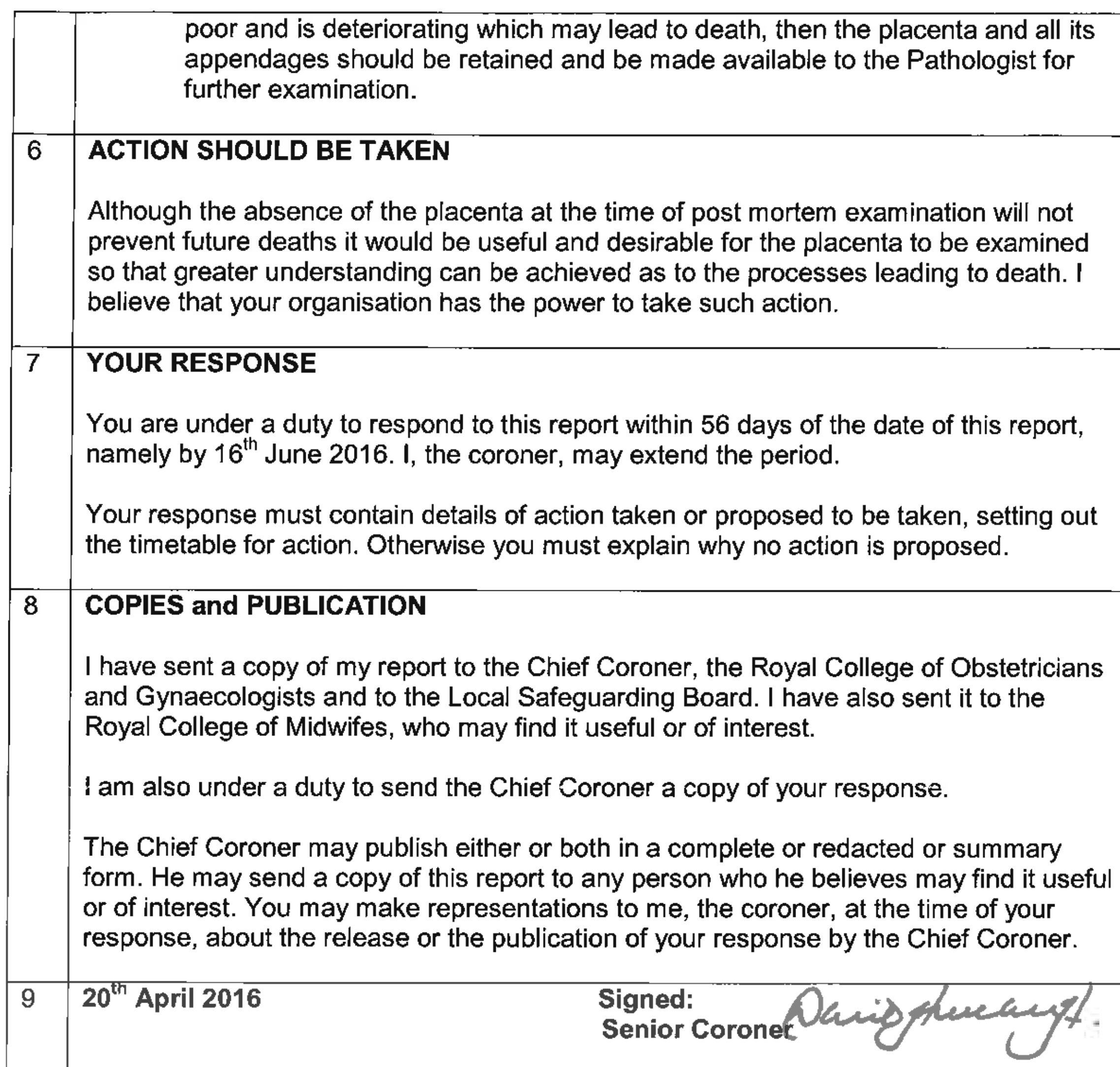
ANNEX A

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:** 1. Medical Director of the York Teaching Hospitals NHS Foundation Trust
1	**CORONER** I am David Hinchliff, Senior Coroner, for the Coroner area of West Yorkshire (Eastern)
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 20th February 2015 I commenced an investigation into the death of Angus Jonathan Labofski WEST aged 27 days. The investigation concluded at the end of the Inquest on 1st April 2016. The conclusion of the Inquest was Natural Causes, the cause of death being 1(a) Hypoxic-ischaemic encephalopathy
4	**CIRCUMSTANCES OF THE DEATH** Angus Jonathan Labofski West was born at York District Hospital on 24th January 2015. It became apparent that he may have brain damage which necessitated him ultimately being transferred to the Neonatal Unit at The General Infirmary, Leeds, where he was noted to be perfect before he became unwell and had no infections and for reasons which are not clear, he became asphyxiated which led to him suffering severe hypoxic-ischaemic encephalopathy which caused his death to be confirmed at Martin House Children's Hospice, Boston Spa, at 1424 hours on 20th February 2015.
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. – [BRIEF SUMMARY OF MATTERS OF CONCERN] (1) After the baby was born the placenta was not retained. Within a short time after his birth he became unwell and despite all efforts his death was confirmed. It was likely that a post mortem examination would be needed to determine the cause of death. It would have been of assistance to the Pathologist to be able to examine the placenta to show the possibility of a toxoplasmosis infection; to establish if relevant the possibility of placental abruption and to establish if the umbilical cord was kinked, trapped or in any way damaged which could have caused or contributed to the death. I therefore recommend and request that when it is foreseeable that at birth or shortly thereafter, the baby's condition is



	poor and is deteriorating which may lead to death, then the placenta and all its appendages should be retained and be made available to the Pathologist for further examination.
6	**ACTION SHOULD BE TAKEN** Although the absence of the placenta at the time of post mortem examination will not prevent future deaths it would be useful and desirable for the placenta to be examined so that greater understanding can be achieved as to the processes leading to death. I believe that your organisation has 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 16th June 2016. 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, the Royal College of Obstetricians and Gynaecologists and to the Local Safeguarding Board. I have also sent it to the Royal College of Midwifes, 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	**20th April 2016** **Signed:** **Senior Coroner**