REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Secretary of State for Health
1	CORONER I am Alison Mutch, 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 6th November 2017 I commenced an investigation into the death of Carter Isaac Jepson. The investigation concluded on the 18th May 2018 and the conclusion was one of; **Natural Causes** The medical cause of death was; **1a Unascertained**
4	Carter Isaac Jepson was a healthy, well cared for child. On 3rd November 2017 he was put to bed in his Moses basket by his mother. He showed no signs of ill health. At about 04.00 on 4th November 2017, his mother found him not breathing in his Moses basket. An ambulance was called and arrived promptly. Carter was taken to Stepping Hill Hospital where resuscitation attempts continued. He died at Stepping Hill Hospital at 05.40 on 4th November 2017. There were no suspicious circumstances. Post mortem examination confirmed that his death was due to natural causes, although the precise cause of his sudden death could not be ascertained.
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. – The inquest heard that Carter had been breastfed. Following his death, his mother was significantly impacted, psychologically, by his loss. The inquest heard that this was exacerbated because there was no process/protocol in place to prescribe her medication to stop lactation. As a result she continued to lactate whilst dealing with her loss. The inquest heard that the SUDC paediatricians dealing with the case had identified this as a national issue relating to breastfeeding mothers

	dealing with the trauma of the unexpected loss of their child.
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 16th July 2018. 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 of the deceased, 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	**Alison Mutch OBE** **HM Senior Coroner** **21/05/2018**