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.** Jackie Bene, Chief Executive, Royal Bolton Hospitals NHS Trust, Minerva Road, Farnworth, Bolton BL4 0JR **2.**
1	**CORONER** I am John S Pollard, Assistant Coroner for the Coroner Area of Manchester West.
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 the 31st August 2017 I commenced an investigation into the death of Louie Francis Bradley, aged 1 day. The investigation concluded at the end of the inquest on the 15th August 2018. The conclusion of the inquest was that he died from Sudden and Unexpected Neo-Natal Death of an Infant born at 42 weeks with widespread pneumonia. The narrative conclusion was as follows:- On the 27th August 2017 Louis Francis Bradley died as a result of a combination of Natural Disease (undiagnosed Bronchopneumonia and the symptoms of the common cold) and an accidental obstruction of his airways whilst in bed following a breastfeed.
4	**CIRCUMSTANCES OF THE DEATH** He died following breast feeding in bed with his mother when mother fell asleep.
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. The midwives at your Hospital gave evidence that they still advise breastfeeding in bed whilst lying side-by-side with the baby even if no-one else is present and the mother is obviously fatigued, this leads to

	inadvertent co-sleeping and as in this case can lead to death. 2. The standard Trust issue documentation was not (properly) completed with the omission of vital information such as mother's name, GP Practice, address etc.; similarly advice allegedly given to patient was not documented.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 17th October 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:- 1. [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.

	Dated **21st August 2018**	**Signed** **John S Pollard** **HM Assistant Coroner, Manchester West**