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 5th February 2018 I commenced an investigation into the death of Bridget Marie Connell-Graham. The investigation concluded on the 20th August 2018 and the conclusion was one of Narrative: Died from the recognised consequences of premature birth the precise cause of which is unclear. The medical cause of death was Extreme prematurity
4	On 1st February 2018 Bridget Marie Connell-Graham's mother went into premature labour at 20 weeks gestation at her home address [redacted] She was born at her parents address and subsequently transferred alive to Tameside General Hospital, on 1st February 2018 she died there from extreme prematurity.
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 at a scan performed on 31st January 2018 after an attendance the previous day with an episode of bleeding Bridget's mother was found to have a shortened cervix. On 1st February she was born

	prematurely. A history of cervical trauma was contained within the maternal notes. The inquest heard that whilst there is guidance from NICE as to the appropriate action to be taken where there is a history of cervical trauma there is no clear definition of what amounts to cervical trauma. The inquest was told that this means there is an inconsistent approach nationally as to what will be treated as a history of cervical trauma and therefore in what steps are taken in relation to investigating a previous history of cervical trauma and planning clinical treatment during pregnancy.
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 22nd November 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] of Bridget Connell-Graham, 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 26th September 2018