REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Secretary of state for health
1	CORONER I am Alison Mutch , Senior Coroner, for the Coroner Area of Greater Manchester South
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 18th May 2020 I commenced an investigation into the death of Violet Leona Jackman .The investigation concluded on the 18th November 2020 and the conclusion was one of Narrative: Sudden and unexpected death of a baby where a Moses basket overturned whilst she was asleep in it. The medical cause of death was 1a) Sudden unexpected death in a child with mild lower respiratory tract infection, associated with an accidental unsafe sleeping position
4	CIRCUMSTANCES OF THE DEATH Violet Jackman was a baby who initially lived with both her parents and then after they separated, care was shared. Following her birth, the initial Health Visitor visit took place in accordance with usual practice. Safe sleeping advice was given to her mother who was present. On 17th May 2020, Violet Jackman was found unresponsive on a bed at her home address, [redacted]. The Moses basket in which she had been sleeping had tipped over.
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. Safe sleeping advice was given to her mother, although it was clear that care would be shared. There was no clear way of ensuring that both parents understood the guidance given or following up that the advice had been shared in detail. 2. The guidance was given as a series of points. The inquest heard that as a general rule, health visitors do not ask parents to explain in a free text style the sleeping arrangements. It is likely if they had asked for

	such a description, then they would have been made aware of how the guidance had been interpreted and the sleeping arrangement in place. If they had then the inquest was told that her parents would have been told that the location of the basket was inconsistent with safe sleeping. 3. The inquest was told that during the first wave of Covid 19, Health Visitors nationally were redeployed into other services. In the area served by this team that meant a 20% reduction decrease in available Health Visitors and stretched services to support new parents significantly. In Trafford, a decision had since been taken that the situation should not continue even in a second wave, given the stretch this put on Health Visitor services and their ability to support parents and young children. However, it was unclear if nationally a similar approach was being taken, or if Health Visitor services were being reduced to support other front line services.
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 Tuesday 26th January 2021. 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 The children's commissioner for England and The Lullaby Trust, 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** **HM Senior Coroner for the Coroner Area of Greater Manchester South** **01/12/2020**