

Derek Winter Senior Coroner for the City of Sunderland

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS.

THIS REPORT IS BEING SENT TO:

Rt Hon Jeremy Hunt Secretary of State for Health Department of Health Richmond House 79 Whitehall London SW1A 2NS

1 CORONER

I am Derek Winter, Senior Coroner for the City of Sunderland

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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

3 INVESTIGATION and INQUEST

On 06/02/2014 I commenced an investigation into the death of Nathan James Healer, at 2 days of age. Following his death on 05/02/2014, the investigation concluded at the end of the inquest on 24/07/2014. The conclusion of the Inquest was "Although the severity of Nathan's condition was not appreciated and he was not given the opportunity of a more timely blood glucose test he died of a natural cause". Medical cause of death was confirmed as:

1a Neonatal Encephalopathy and Intraventricular Haemorrhage (Grade 4); 2 Poorly Controlled Gestational Diabetes.

4 CIRCUMSTANCES OF THE DEATH

Nathan's mother had gestational diabetes and during the pregnancy had very regular contact with medical professionals.

Nathan was born on 03/02/2014 at 0718 hours without complications and his Apgar scores were good.

However his colour was not all that it ought to have been, he was cold and was slow to feed. It was also reported that his eyes were bulgy, he had jittering arms and excessive startle reflux. When his Blood Glucose was measured for the first time at almost 5 hours from his birth it was 0.2 mmol/L. Despite intervention at this point Nathan died on 05/02/2014.

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. -

I was made aware of: -

- a) the 2008 NICE Clinical Guidance 63 "Diabetes in Pregnancy" which in essence recommended a pre 2nd Feed Blood Glucose test at between 2-4 hours;
- b) the hospital Guidance for "Hypothermia in the newborn Infant" 2014;
- c) the hospital Guidance for "Prevention, detection and management of hypoglycaemia in the newborn 2012 (Blood glucose test at around 4 hours).

Although the severity of Nathans's condition was not appreciated and he was not given the opportunity of a more timely blood glucose test I heard evidence that although new guidance from NICE is in contemplation it has not yet been finalised.

If that is the case then it would be helpful to know what stage this is at and whether any steps can be taken to expedite it's production.

If no new guidance is in contemplation then it may be an opportune moment to revisit the guidance in any event.

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 22 September 2014. 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: -

- Family and their Solicitors
- City Hospitals Sunderland NHS Foundation Trust and their Solicitors
- Care Quality Commission

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 Dated this 25th day of July 2014