REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive, Pennine Acute Hospitals NHS Trust 2. Department of Health, London 3. Royal College of Obstetricians 4. Royal College of Paediatricians 5. National Institute for Health and Clinical Excellence
1	**CORONER** I am Ms L Hashmi, Area Coroner for the Coroner area of Manchester North.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 20th June 2016 I commenced an investigation into the death of baby Dominic Smith.
4	**CIRCUMSTANCES OF DEATH** The deceased's mother had been in the latent phase of labour for approximately 4 days. At inquest I found that she had suffered a pre-labour rupture of membranes (hind waters) on or around the 28th May 2015. She was admitted to the birthing centre on the 1st June. Over the course of the night the CTG trace showed that the baby was in distress and the decision was taken to move mother of theatre for a trial of forceps delivery with a view to proceeding to Caesarean section if necessary. Instrumental delivery was successful and baby was born on the 2nd June 2015 at 04:11. He was in good condition with APGARS of 9/9/9. At 09:00 on the 2nd June baby had a 'dusky episode'. Neonatal observations were not commenced and he was not referred to the paediatrician. By early evening baby was sleepy and reluctant to feed. He was settled into his cot and both mother and baby fell asleep. Mother awoke at around 21:00 and noted that baby's hand was cold. He appeared to be fast asleep at this point. At 21:40 the night HCA attended mother and immediately noticed that baby was cold and blue. She called for help from a more senior HCA who raised the alarm, picked baby up and ran with him towards the resuscitation area. BLS was commenced by the Midwives and a 'crash call' put out. The crash team arrived promptly and ALS commenced. Resuscitation was unsuccessful and the fact of baby's death was confirmed at 22:11 on the 2nd June 2105. The cause of death following post mortem was 1a) Pneumonia. Conclusion at inquest: Narrative with a rider of Neglect: The deceased died at the Royal Oldham Hospital at approximately 18 hours of life (date and time of birth 04:11 on the 2nd June 2015). Staff did not recognise or identify pre-labour rupture of hind water membranes (PROM) in his mother, treatment was not instigated and protocols/guidance were not followed.

Maternal observations were not conducted post-delivery, despite a raise in the mother's temperature at or round the time of baby's birth.

The evidence demonstrated that infection could pass during the course of delivery from mother to baby. Subsequent tests in the mother showed Enterococcal (urine) infection but were negative to Group B Streptococcus (GBS).

When Baby Smith showed notable signs of deterioration at around 09:00 on the 2nd June 2015, neonatal observations were not commenced and he was not escalated to a paediatrician or neonatologist for review.

Timely antibiotic therapy was not instigated.

Baby Smith was found collapsed in his cot at 21:40 on the 2nd June. Basic and advanced life support were commenced but proved unsuccessful. Treatment was withdrawn and the fact of baby's death was confirmed at 22:11.

Neglect more than minimally contributed to Baby Smith's death.

The Root Cause Analysis (RCA) investigation identified a number of other failings that were not causally linked to baby's demise.

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:-

Department of Health, NIHCE and the Royal Colleges:

1. I previously completed a PFD 13 month ago in relation to a neonatal GBS death. At that time I raised the following concerns:

   - That antenatal screening for GBS was not being routinely offered by the NHS to all pregnant women during the final weeks of pregnancy,

   - That prophylaxis intrapartum antibiotics were not routinely offered to all women who test positive for GBS (or have done so in the past)

     &

   - That given the seriousness of the illness, in the absence of a national screening and prophylactic treatment programme, babies were potentially being put at risk of harm/death.

     During the course of the inquest into Baby Smith's death the evidence suggested that no further action has been taken in this regard, despite the responses received in relation to the last PFD Form.

     I therefore raise the issues again as a concern.

Pennine Acute Hospitals NHS Trust:

1. During the course of the inquest into Baby Smith's death, the following concerns arose:

	- Inadequate communication, handover and record keeping; - Staff did not follow the Trust's protocols/guidance and did not document their rationale where they exercised clinical discretion; - Midwives did not carry out a speculum examination, on two separate occasions, in order to establish whether there had been a rupture of membranes. The time between rupture and delivery was, more likely than not, miscalculated as a result of this; - Early warning scores were i) miscalculated, ii) not acted upon; - Neonatal observations were not carried out when it became apparent that there had been a material change in baby's condition. Signs and symptoms relating to the deterioration were also missed; - Maternal observations were not carried out after delivery, despite a spike in temperature; - Midwives did not escalate to or consult with the Obstetrician/Paediatrician/Neonatologist & - Inadequate preceptorship for newly qualified (and particularly part-time) Midwives.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 the 24th August 2016. 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:- - Baby's parents - CQC - GBS Support - [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 from. 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	Date: 30th June 2016 Signed: