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Regulation 28 – Report to Prevent Future Deaths

This Report is being sent to:

Chief Executive, Gateshead Health NHS Foundation Trust
[redacted] Medical Director, Gateshead Health NHS Foundation Trust

1 **Coroner**

I am Terence Carney, Senior Coroner for Gateshead & South Tyneside.

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/ukpga/2009/25/schedule/5/paragraph/7
http://www.legislation.gov.uk/uksi/2013/1629/regulation/28/made
http://www.legislation.gov.uk/uksi/2013/1629/regulation/29/made

3 **Investigation & Inquest**

On 9 June 2017 I commenced an investigation into the death of **ARCHIE RAY GRIEVES,** aged **2 HOURS 20 MINUTES**. The investigation concluded at the end of the inquest on 15TH March 2019. The conclusion of the inquest was :

An avoidable neonatal death following shoulder dystocia, opportunities having been missed both during antenatal care and at time of delivery to identify and implement appropriate and effective plans to provide for a safe and successful delivery of the child

4 **Circumstances of the Death**

The deceased was born on the 24th May 2017. There was a complicated delivery in that shoulder dystocia was identified. He was delivered but showed no sign of life initially. A while after he did show signs of life and was taken to the special care baby unit where he died a very short time after.

5 **Coroners 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 I my statutory duty to report to you.

The matter of concern are as follows:-

This was an avoidable neo-natal death of a macrosomic baby resulting in shoulder dystocia and a consequential 8 minute delay from delivery of the baby's head to the delivery of the body which resulted in significant hypoxia.

The Inquest process identified a number of missed opportunities both ante-natally and at the time of pre delivery assessment and delivery.

1. The mother of this child presented for an initial booking appointment on the 6th October 2016. Discussions at this stage identified the possibility she was about the 12th week of her pregnancy. She was identified as low risk. Routine scans examinations and appointments followed.
2. At the 26th week it was determined that the mother's BMI was above 30 . The fundal height was above the 90th centile and that there was a concern that she may have gestational diabetes.
3. A glucose tolerance test was commissioned. The test request did not identify the patient was pregnant. The result was consequently wrongly interpreted as normal.
4. The mother was not referred to a Consultant lead Obstetric examination and assessment when issues and concerns would have been identified both as to her presentational weight and the potential consequential size of the baby.
5. A subsequent test apparently indicated no diabetes and a determination that the ante natal care should follow a normal pathway
6. At the 34th week fundal size continued to be identify the baby's development as outwith the 95th centile and consequently on the basis of the Trust's own guidelines this mother should have been referred also to Consultant Obstetric care.
7. Fundal size measurements continued into the 40th week of pregnancy outside the curve.
8. No additional planning for pre delivery/delivery was engaged and this mother was continued on a normal pathway towards delivery apparently planned between the 40th and 42nd week.
9. In the absence of Obstetric care effective planning opportunities were missed to consult and counsel this mother on the mode and time of delivery. In particular no consideration was given to the possibility of an induced or caesarean birth or delivery of this child at the 37th/38th week avoiding increases in baby's weight and recognisable risks at the time of delivery of a larger baby.
10. On presentation on the 24th May 2017 in labour this mother was received within the Delivery unit as a low risk delivery and no review was undertaken of her earlier management and care either because of the assumption of the appropriateness of her ante natal care together with a conclusion which identified her as simply low risk and/or because there was no meaningful interrogation of her records. In particular the significance of the Growth Chart present within those records with its all too apparent fundal height measurement was misunderstood/misinterpreted or overlooked as to its relevance.
11. Specifically during the period from 1.30 pm to 6.30 pm, in the absence of any meaningful interrogation of her records the assessment of the mother on presentation in the delivery suite failed to identify any risk she presented in view of her personal bodymass or the size of her baby. It was determined it was appropriate that she deliver in the Birthing Pool. The only considerations as to Pool use were

practical considerations around availability, staffing and an adjacent delivery room.

12. As a consequence of the lack of any alert to the risks that this lady presented no consideration was given to the potential risks identified within the Trusts own protocols relevant in the case of this lady and her child
13. An opportunity was missed to guide the mother away from a pool birth because of those risks and to an alternative method of delivery with appropriate levels of analgaesic support commensurate with her needs and anxiety
14. No risk assessment was made preparatory to the delivery of a macroscopic baby and the heightened risk of shoulder dystocia
15. No plan was prepared guidance or assistance sought to facilitate a safe birth in a safe environment and with the appropriate level of skilled staff on hand or available
16. Further evidence adduced indicated there was an apparent misunderstanding and/or misinterpretation even level of conflict amongst Obstetric Consultants as to the Trust's own guidance on potential large baby development risks and the alternative strategies to be followed and in a timely manner for the safe delivery of such children.
17. Evidence was received that large babies were not identified as such a great concern as small babies, that mothers of the latter would be monitored and advised and quite properly so but larger babies size being more indicative of the healthy presentation and more positive outcome, were accordingly considered less at risk
18. Obstetric approach differed depending on the Consultants personal policy and consequently a more cohesive leadership Departmental approach was potentially missing
19. In addition it was acknowledged that there was a study nationally , currently being undertaken with reference to the management of larger babies and their birth. At the time of this matter and indeed now the outcome of that study was still awaited and no definitive guide appears to exist within the Trust.
20. The consequences of this lack of cohesive policy lends itself to a lack of clear understanding and consistent approach which should be the guideline in all cases and for the benefit of all staff both medical and nursing.
21. There should be no presumption of low risk now and medical/midwifery teams should proactively interrogate records and assess delivery options not simply on the basis of practical consideration – room availability, staff as was the case here but on the requirements of the Protocol and the patients medically identifiable/identified risk profile.
22. A comprehensive Training review involving all staff policies and protocols is clearly indicated. New technology and method should be embraced both in the training process but also as an ongoing aid
23. The missed opportunities in this matter would have been avoided if significant findings had been "red flagged" within mother's records. A significant finding being something which is potentially likely to impact on the management and care of the patient at some stage during their journey and more particularly one identified as factors in the policies and practices of the Trust determined to ensure the safe care of the patient and in this case mother and baby.
24. Such red flags in this matter would and should have highlighted :
    a) A heightened BMI
    b) A Fundal height above and outwith the gestational norm

25. As an added aid to safe management and care such "red flags" should cross reference specific Policies/protocols where such issues contra- indicate certain strategies (birthing pools and increased BMI large baby) or alert for protective planning and preparation

26. The fact that the Growth Chart in this matter :-

a) demonstrated the baby to be large for his gestational age and

b) there was an apparent lack of understanding appreciation /conflict as to the significance of The Chart as well as

c) an inability to interpret The Chart by nursing and medical staff and

d) more importantly a lack of awareness that such a measure should in accordance with established Trust policy have lead to a Obstetric referral and consultation,

together leads to :-

A requirement that that policy be immediately revisited - any contradictions be reconciled and resolved and all staff trained not only as to the validity nature and implication of the policy but an urgent need for Trustwide implementation.

6 **Action Should be Taken**

In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 **7th June 2019**. 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 & Publication**

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons, [redacted], Ward Hadaway {and to the Local Safe-Guarding board (where the deceased was under 18)}.

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.

Date: 12th April 2019 **{Signature}**

Senior Coroner – Gateshead & South Tyneside