Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:
The Rt Hon Robert Jenrick MP
Secretary of State
Ministry of Housing, Communities & Local Government
2 Marsham Street
London
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&

Local Government Association
18 Smith Square
Westminster
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1 CORONER

I am Andre REBELLO, Senior Coroner for the area of Liverpool and Wirral

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

This report is about an infant baby girl, Lucia Jayne Stear who died at 15 hours old.
Lucia's mother, [redacted] had been driving her car outside Arrowe Park on the 10.11.2016 at approximately 7.45 when a bough (large branch) from a large Horse Chestnut tree in Arrowe Park, fell on her moving vehicle and broke the windscreen; landing on her abdomen.
Mrs Stear had to be extricated from the vehicle and paramedics attended. There was communication with the University Hospital Aintree (the regional major trauma centre) and information was exchanged, including information concerning [redacted] pregnancy. [redacted] was taken to Aintree Hospital. Baby Lucia was delivered by emergency C -section at 10:01 hours. She was stabilised at Aintree Hospital and was transferred to the Liverpool Women's Hospital for ongoing care. Her blood tests showed evidence of multi organ failure. The decision was made to withdraw her treatment and she sadly passed away on 11th November 2016 at 01:11.
She died from

1a Multi Organ Failure

1b Antepartum Asphyxia

1c Abdominal trauma with right broad ligament haematoma, sustained in road traffic accident (Maternal condition)

During the course of five days of evidence the court heard that following restructuring and staff

reductions in the last decade. The regular inspection, condition survey and tree maintenance work on parks and countryside trees in the Wirral was affected.

The Court recognised that in spite of austerity statutory services still functioned, however some statutory duties suffered.

Expert evidence was given that there needs to be a strategic management of tree policy, with a written policy system to ensure all trees are checked. There also needs to be effective staff training. The purpose of the policy is to detect trees before they fail, so as to keep the public safe, having regard to the location and occupancy of each tree.

4 CIRCUMSTANCES OF THE DEATH (Jury Findings)

On 10th November 2016, at approximately 07:45, Elizabeth Stear, who was 36 weeks pregnant, was driving along Arrowe Park Road, when a large bough of a Horse Chestnut tree within the boundary of Arrowe Park, adjacent to the highway, fell onto her white Audi A4, piercing the windscreen, and through the driver's window. The bough impacted her pregnant abdomen, and trapped her inside the vehicle. At 07:57 a 999 call was made and fire, police and ambulance emergency services were dispatched. At 08:10, the rapid response vehicle arrived and [redacted] indicated that she had not felt her baby move since the incident. At 08:33 [redacted] left the scene in an ambulance and was conveyed to the Major Trauma Centre at Aintree Hospital, having been categorized as a major trauma, using the North West Ambulance Service (NWAS) paramedic pathfinder major trauma in adults guidelines. At 09:01, [redacted] arrived at Aintree Hospital an was attended by the major trauma team. At 09:07 a midwife could not locate Lucia's heart rate. At 09:10 a fast-scan was performed, which showed that Lucia's heart was beating slowly at approximately 60 beats per minute. At 09:19 it was decided to take [redacted] for an emergency laparotomy and caesarian section. She arrived in theatre at 09:30 and at 10:01 Lucia was born, with no signs of life. Lucia was resuscitated by teams from Aintree Hospital and Liverpool Women's Hospital and then NWAS transferred Lucia to Liverpool Women's Hospital arriving at 12:40. Tests showed that Lucia had multi organ failure and was extubated and died at 01:11 on 11th November 2016.

JURY CONCLUSION

Lucia died as the result of an accident to which the following contributed:
a) Wirral Borough Council (WBC) did not have a proactive, robust tree management system in place for Parks and Countryside up to November 2016. They relied upon external contractors to deal with issues on a reactive basis, without having a detailed managerial overview.
b) The classification of trees into 'Highways' and 'Parks and Countryside' trees, by WBC failed to identify and manage the risk of all trees within falling distance of the highway. There was a complete failure to have a policy in place for tree management in Parks and Countryside, and a complete lack of risk management for trees at risk of falling onto highways. There had been no formal inspection of trees in Arrowe Park for 13 years previously.
c) Inadequate steps were taken to investigate the failed Beech Tree that fell into Arrowe Park Road in January 2015, and rectify mistakes that had been made, including failing to recruit and employ specialist staff for tree management. Had this incident been appropriately investigated, remedial work to the trees along the boundary of Arrowe Park Road would have been carried out. There were missed opportunities to prevent further serious incidents, despite staff concerns and a near-miss event taking place.
d) The Horse Chestnut tree had been affected by Bleeding Canker and disease would have been evident on this tree for at least 4 years.
e) There was inadequate training of Parks and Countryside staff with regard to tree management and identifying tree hazards, There was no programme of mandatory, ongoing training and there was no Arboricultural officer employed by WBC since 2003.
f) There was a systemic lack of accountability and poor communication within and between departments in WBC.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows: (brief summary of matters of concern)

Before the inquest Wirral MBC put in place a “Tree Action Plan”[i] which is address the concerns that had been before the court – This is included as an example of what can be achieved when this problem was highlighted by the death of a 15 hour old resident of the Borough.

How many other public authorities are in a similar plight, not having had a fatal tragic event to prompt action?

The Court asks the Rt. Hon. Secretary of State to address this issue nationally and that he advises the Court as to what steps he has directed to be taken to ensure that there is national learning from Lucia’s short life and her tragic avoidable death.

The Court requests that the LGA brings this matter to the attention of its Local Authority members and that the LGA advises the court as to what steps the organisation has taken to ensure that there is national learning from Lucia’s short life and her tragic avoidable death

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 **08 November 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 and PUBLICATION

I have sent a copy of my report to the **Chief Coroner** and to the following Interested Persons:
Lucia’s family
North West Ambulance Service
University of Aintree Major Trauma Centre
Liverpool Women’s Hospital
Wirral Metropolitan Borough Council
The Health And Safety Executive
and to the Local Safeguarding Board (where the deceased was 18).

I have also sent it to [REDACTED], Barrell Tree Consultancy – Tree Expert Witness 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

Andre REBELLO
Senior Coroner for
Liverpool and Wirral
Dated: 13 September 2019