Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **Royal Berkshire NHS Foundation Trust:** **Chief Executive,** [redacted]
1	**CORONER** I am HEIDI J CONNOR, Senior Coroner for Berkshire for the coroner area of Berkshire
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** I conducted an inquest into the death of Adele Angel Massoudi at Reading Town Hall on 25th, 26th, 27th May and 10th June 2022 I recorded a conclusion of natural causes contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Adele Massoudi was born at 0521 on 26th June 2020, as a planned home birth. She was transferred to the Royal Berkshire Hospital at 0542, and then to the John Radcliffe Hospital in Oxford at 1330 hours. She died there on 2nd July 2020. No autopsy was conducted, and the cause of death was recorded as severe hypoxic ischaemic encephalopathy. I handed down written conclusions in this case. This report summarises my key conclusions and concerns. During the course of the inquest, it became clear that there was significant delay in responding to the presence of meconium during labour. The fetal heart rate was inadequately monitored, even after meconium was seen. The unfolding emergency was not adequately communicated to the family. Transfer to hospital should have taken place much sooner, and Adele should have been born in hospital. The placenta appears to have been destroyed without retaining it for examination. An independent expert advised that, had Adele been transferred to hospital at any point up to and including the actual time of her birth at home, then, with the additional monitoring equipment and neonatal resuscitation options there, it is likely she would have survived. Whilst his view was that she may have suffered some compromise had she survived, that was not a matter relevant to a coroner's inquest. I was concerned to hear the midwife in question give evidence that she believed that she called 999 as soon as she could have. She described lots of things happening at once, and that she saw her role as one of communicating with family and calling for help as needed. She accepted under questioning that it would have been a simple thing to call an ambulance and that she should have called an ambulance on arrival at the family home. In fact, she called the delivery suite, and her colleague, a midwifery support worker, and only then did she dial 999, some 30 minutes after arriving.

	Whilst continuous fetal heart rate monitoring is not possible in a home birth setting, the fetal heart rate should have been monitored every five minutes. In the hour before birth, there are only 5 recordings of the fetal heart rate. It was accepted in evidence that monitoring of the fetal heart rate is even more important in the context of meconium, and hence concerns for the baby. There are no recordings of Adele's heart in the ambulance. The evidence was that the midwifery support worker put the placenta in a plastic carrier bag and brought it to hospital, but there was no trace of it after that.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could 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. <u>Midwifery Training</u> The hospital's updated action plan deals with a lot of training and refreshment of training that has taken place since this incident and since the HSIB report. I note in particular that an audit between May 2021 and March 2022 has revealed that, in 12 cases reviewed for women having a home birth with meconium present, 100% of those patients were taken to hospital via emergency ambulance. An escalation flow chart has been added to the home birth standard operating procedure. That has been added to the home birth kit. I am mindful however that transferring a patient to hospital where meconium is seen in a home birth setting was always part of the training. This is not new or particularly complex guidance. At one point in her evidence, the midwife in question said this: *I will say, I believe at the time, faced with the clinical situation I was faced with, there were multiple things to be doing at once and [the mother] was having regular contractions. So I was trying to communicate with the family in between the contractions, the checks that we do on the mum and the baby. Again, I can't perform those while she's having a contraction. So I was waiting for in between those contractions, also setting up my equipment. So I feel that in the moment, time passed very quickly…..* She accepted in her evidence that it was open to her to ask someone else on scene, including a family member, to call for an ambulance. I remain concerned that the response of the key witness appears to be "I did what I could in difficult circumstances, and I had a lot to do". The situation that the midwife was dealing with must indeed have been very stressful, but it is part of a midwife's professional training to assess what is the most urgent thing to do first. That is not setting up equipment, waiting for contractions to finish et cetera. It is, in this scenario, to call an ambulance first and then do everything else afterwards. I remain concerned that, even after all the additional training, and having had this awful experience, this message is not coming through loud and clear from the witness evidence. It is difficult to know whether a need for further training exists in relation to this witness, or more systemically. I am concerned that, having experienced this awful tragedy, and going through the HSIB investigation and the inquest process, anything other than full acceptance of the point was offered in evidence. I invite the trust to consider again the training of their midwives and whether the training provided to date is sufficient and safe, and to respond formally and in a Regulation 28 response. 2. <u>Placenta retention</u> In terms of learning from these cases, examination of the placenta, either as part of a formal autopsy, or even without an autopsy, is absolutely vital. It is akin to asking a pathologist to

	conduct a post-mortem examination without one of the organs, if the placenta is not retained. I am concerned about the response from the hospital trust on this point. I am told that the guideline for placenta examination is being reviewed and I quote from the statement sent by the Director of Midwifery, dated 6 June 2022: *We continue to explore opportunities that may extend placental storage.* It does not go far enough simply to state "we are looking into it" at this stage, or that the trust does not have the space to store placentas for longer. I appreciate that the Human Tissue Act and other considerations have to be taken into account. It is not insurmountable, and I believe the trust must now be given a deadline for responding to this concern, in the format of a Regulation 28 Report, in order to ensure that a decision has been made. There are cases where keeping the placenta is clearly required - such as this case - because Adele was born in a poor condition. The practical realities have to be taken into account, and a line drawn as to when placentas should be kept for longer than usual. Currently, placentas in uncomplicated cases are being disposed of daily. I am happy to liaise with the trust in this respect, and to seek the views of a paediatric pathologist, should that assist. I believe this will be a crucial part of death investigation going forward and improving services as a result of any investigations which flow from those deaths. It is important for bereaved families to have the opportunity to investigate all possible reasons for the death of their child, which may also be vital in considering future pregnancies.
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 August 15, 2022. 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 Adele's family I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 20/06/2022**

	 **HEIDI J CONNOR** **Senior Coroner for Berkshire for Berkshire**