REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. The Chief Executive of NICE
2. Royal College of Midwives

1.	**CORONER** I am Samantha Goward, Assistant Coroner for the coroner area of Cambridgeshire and Peterborough.
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. Coroners and Justice Act 2009 (legislation.gov.uk) The Coroners (Investigations) Regulations 2013 (legislation.gov.uk)
3.	**INVESTIGATION and INQUEST** On 8 July 2021 an investigation in to the death of Muhammad Zayaan ul Hasan was commenced, who died on 21 November 2020 aged 3 days. The investigation concluded at the end of the inquest on 8 July 2022. The conclusion of the inquest was: **Medical Cause of Death** – 1a Meconium aspiration syndrome and patchy acute pneumonia. **Conclusion** – Muhammad Zayaan ul Hasan aspirated meconium prior to his delivery, but there were no signs to alert clinicians to this at birth. After an initial period of close observations due to grunting, he was provided routine care. His reluctance to feed and increasing sleepiness were not detected prior to discharge from hospital. His condition significantly deteriorated at home and he sadly died as a result of meconium aspiration syndrome and patchy acute pneumonia.

4.

CIRCUMSTANCES OF THE DEATH

1. In summary, Muhammad Zayaan ul Hasan (known to his family as Zayaan) was born at 23.40 hours on 18 November 2020. At delivery, Zaayan had APGAR scores of 9, 10 and 10. Umbilical cord gases were within the normal range. There was no sign of meconium at birth.

2. Although there were no concerns and he appeared well at birth, he began to make grunting noises and was kept under neonatal care for the first 15 hours of life, where no further concerns were reported or observed.

3. There was difficulty with breast feeding so bottle feeding was commenced, while attempts were made to establish breast feeding.

4. Zayaan began to show signs of sleepiness and reluctance to feed, but these were not picked up on prior to his discharge home on 20 November and his mother was not given advice of how to recognise reluctance to feed. No feeding assessment was carried out prior to discharge. Had there been, he may have been kept in hospital and received further neonatal care.

5. In the early hours of 21 November, Zayaan's mother called the midwifery helpline to report concerns that Zayaan had abnormal breathing, sleepiness, a nosebleed, jaundice and poor feeding. Her request to bring him in for assessment was denied and she was reassured that a community midwife would assess him the following day. His mother remained concerned and spoke to someone again around 4am, but was again reassured. On both occasions Zaayan was exhibiting signs of an unwell neonate and I heard expert evidence at the Inquest that Zayaan should have received a face to face assessment.

6. At around 5am Zayann was noted to be more floppy, unresponsive and appeared not to be breathing. He was transported by ambulance to PCH but sadly, despite appropriate treatment he died.

7. A post mortem report revealed that he had suffered meconium aspiration syndrome and patchy acute pneumonia. There had been no signs of meconium during labour or at delivery.

8. An investigation carried out by HSIB identified that there is a lack of national guidance on feeding expectation for a formula fed baby in the first 72 hours when the baby is considered to be low risk.

	9. Expert evidence at the Inquest was that if the concerns regarding Zayaan's sleepiness and reluctance to feed had been picked up on at that time, he would have been admitted to the neonatal unit and, on the balance of probabilities, if he had still been in hospital when his condition started to deteriorate, he would have survived after effective treatment. 10. Mother and baby were discharged on 20 November 2020. The written information about formula feeding on discharge did not provide clear guidance on how to recognise reluctance to feed. Had the parents been given more specific advice about signs of reluctance to feed, they are likely to have escalated concerns sooner. 11.The Midwives who gave evidence at the Inquest agreed that national guidance on feeding expectation for a formula fed baby in the first 72 hours when the baby is considered to be low risk, as suggested by HSIB, would be helpful. 12. The independent expert Neonatologist agreed likewise. 13. Following the Inquest I contacted HSIB to see if this was an issue that they had taken further action in relation to. As it is not, I therefore issue this report.

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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. **The MATTER OF CONCERN IS** that there is a lack of national guidance on feeding expectation for a formula fed baby in the first 72 hours when the baby is considered to be low risk. This may lead to babies being prematurely discharged and to families not being provided with appropriate information on signs of concern.

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 15 September 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 to the following Interested Persons: (1) [redacted] (2) North West Anglia NHS Foundation Trust (3) HSIB 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 other 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.

Signature of **Samantha Goward, Assistant Coroner**

21.07.22