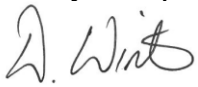
Derek Winter DL
Senior Coroner for the City of Sunderland

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Secretary of State for Health and Social Care**
1	**CORONER** I am Derek Winter DL, Senior Coroner for the City of Sunderland
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/part/7/made
3	**INVESTIGATION and INQUEST** On 7th January 2022 I commenced an Investigation into the death of Charlotte Emma Warkcup, who was born on 21st December 2021 and died at Sunderland Royal Hospital on 23rd December 2021. The Investigation concluded at the end of the Inquest on 29th September 2022. The medical cause of death was confirmed as: - Ia Hypoxic Ischaemic Encephalopathy Ib Perinatal Hypoxia Ic Small placenta with a high grade villitis of unknown aetiology
4	**CIRCUMSTANCES OF THE DEATH** Charlotte Emma Warkcup died at Sunderland Royal Hospital on 23rd December 2021. The severity of her condition had not been recognised at the midwife led birthing centre in South Tyneside despite numerous interactions with her and her mother, all of which were compounded by delays in the decision making to transfer her mother to Sunderland Royal Hospital, and on arrival there not being able to gain immediate entry to the delivery suite. The Coroner recorded a conclusion of Natural causes contributed to by neglect.
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: – 1. Whether standalone midwife led birthing centres are a safe environment for delivery as opposed to those with immediate onsite access to a maternity unit within a hospital 2. The recruitment and retention of midwives to ensure continuity of care 3. The improved detection of babies who are of small gestational age
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 28th November 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: - • Family • South Tyneside and Sunderland NHS Foundation Trust and their Solicitors For information copies will also be forwarded to: • Healthcare Safety Investigation Branch • North East Ambulance Service 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	Dated this 29th day of September 2022 Signature  Senior Coroner for the City of Sunderland