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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:** **1 The Directors of Clevermed Limited** **86-90 Paul Street** **3rd Floor** **London** **EC2A 4NE** **2. The Chief Executive Officer of Clevermed Limited** **Clevermed** **Level 6, Edinburgh Quay** **133 Fountainridge** **Edinburgh** **EH3 9QG**
1	**CORONER** I am Crispin OLIVER, Assistant Coroner for the coroner area of County Durham and Darlington
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** On 29/06/2022 13:30an investigation was commenced into the death of Alfie Neil MAINS-FORSTER 13/06/2022. The investigation concluded at the end of the inquest on 09/11/2023 14:51. The conclusion of the inquest was that Alfie died a natural death contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Alfie was born at 38+1 weeks at 01.35 on 13 June 2022 at the Royal Victoria Infirmary, Newcastle Upon Tyne. His mother had risk factors - gestational diabetes, a congenital heart condition and heightened blood pressure. At 4 minutes of age Alfie was noted as "grunting". At 03.55 observations were documented on the NEWTT chart. Two were in the amber category - respiratory rate of 72 rpm and Oxygen saturation of 88%. The Mother was concerned and there was cyanosis around the mouth and nose. Intermittent grunting was noticed. At a review noted up at 5am, having probably occurred at around 04.30, saturation was 89.93%. On re-testing with a monitor from the resusitaire it was found to be 97%. The assessment found that there were no other signs of respiratory distress. The evidence from the Trust has included that given the maternal risk factors, once the two amber category observation at 03.55 had been documented, antibiotics should immediately have been administered to Alfie on a pre-emptive basis. In the event antibiotics were not applied, nor was close monitoring implemented. Alfie's temperature fluctuated. At 05.15 he was 37.5 degrees. By 14.00 he was 37 degrees. The fluctuation was to some extent influenced by environmental factors. He was noted as intermittently groaning at 06.30. There were complications with feeding. He underwent a tongue-tie procedure at 10.20. At 11.30 the complications were persisting. At around 16.45 Alfie was discharged home. He became

	increasingly unsettled, crying consistently. This worsened such that the parents called 999. Pre-alert to the Emergency Department of University Hospital of North Durham at 00.02 on 14 June 2022 stated that Alfie was in cardiac arrest. Despite intensive treatment, and a brief return of cardiac output at 00.40, Alfie declined and died at 01.50. The medical cause of death provided following postmortem was 1)a) severe congenital pneumonia and meningitis, b) suspected acute chorioamnionitis. Reflecting the concession in the evidence of the Trust witnesses, the omission of antibiotics from 03.55 on 13 June 2022 is more likely than not to have contributed directly to Alfie's death and, but for this omission, he would not have died.
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: (brief summary of matters of concern) A) In the badgernet electronic system used at the Royal Victoria Infirmary by the Newcastle Upon Tyne Hospitals NHS Foundation Trust, the current risk assessment (NEWS) does not map the national guidance fully and if would be more user-friendly, and thereby assist towards more effective, and therefore safer, risk assessment for it to map the national guidance completely. B) The current NEWTT2 chart is not yet available and it would assist in the more effective management of risk for it to be on BadgerNet. This was supposed to be implemented in July 2023 but as yet it has not.
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 January 04, 2024. 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 I have also sent it to [redacted] **Consultant Neonatologist** **Royal Victoria Infirmary** **Queen Victoria Road** **Newcastle Upon Tyne** **NE1 4LP** [redacted]

	who may find it useful or of interest. 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: 09/11/2023**  **Crispin OLIVER** **Assistant Coroner for** **County Durham and Darlington**