REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: [redacted], President, Royal College of Paediatrics and Child Health

CORONER

I am Chris Morris, Area Coroner for Greater Manchester (South).

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

INVESTIGATION and INQUEST

On 14th July 2022, an inquest was opened into the death of Luca Yates who died at Tameside General Hospital, Ashton-under-Lyne on 24th January 2022 aged 1 day.

A post mortem examination determined Baby Luca died as a consequence of:-

1) a) Hypoxic ischaemic encephalopathy due to;

1) b) Asphyxia around the time of birth.

The investigation concluded with an inquest which I heard between 18th – 22nd September 2023 following which I recorded a Narrative Conclusion as follows:-

'*Luca Yates died as a consequence of complications arising from asphyxia around the time of birth. When his mother was assessed the evening before Luca was born, it was not recognised that she was either in, or transitioning towards established labour. This led to an absence of monitoring in hospital which contributed to death. Luca's death was also contributed to by a period of 14 minutes in the resuscitation phase where 100% oxygen was not utilised as required by protocol. Luca Yates's death was contributed to by neglect'.*

CIRCUMSTANCES OF THE DEATH

Baby Luca was his parents' first child. After an uncomplicated pregnancy, his mother was booked for induction of labour at 41 weeks. On 22nd January 2022 following symptoms suggestive of the onset of labour, Baby Luca's mother contacted her local maternity unit on a number of occasions and was assessed in the unit twice, before being sent home.

When Baby Luca's mother re-presented the following day, it was recognised that she was in established labour, and it was considered birth may be imminent. Following transfer to the delivery suite, the CTG was connected which detected a fetal-bradycardia. Urgent assistance was summoned and the Obstetric Registrar on duty decided to deliver Luca by emergency caesarean section.

Following administration of general anaesthetic, Baby Luca was born at 16:19 on 23rd January 2022 in very poor condition with repeated Apgar scores of 0.

Attempts to resuscitate Luca proved difficult and it was not until 16:42 that the second paediatric registrar called to assist the multi-disciplinary team successfully passed an ET Tube. A heart rate was finally detected when Luca was around 38 minutes' of age. Once stabilised, Baby Luca was transferred to the Neonatal Unit where he sadly died the following day.

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. –

The court heard evidence as to planned changes to paediatric specialist training which will result in a reduction in amount of time specialty trainees are required to spend gaining experience in Level 3 Neonatal units.

The following matters of concern arise from this:-

1) It is a matter of concern that paediatric middle grades may have reduced practical experience in resuscitation of neonates born in poor condition, that will increase the reliance on Consultants (who in some clinical settings may be non-resident on call depending when delivery takes place); and
2) It is a matter of concern that Consultant general paediatricians of the future will have a lower level of experience than is currently the case of complex neonatal resuscitation.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.

YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by **4th January 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

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to Linda Reynolds of Hugh James Solicitors on behalf of the family. I have also sent a copy to Weightmans LLP on behalf of Tameside and Glossop Integrated Care NHS Foundation Trust

I have sent a copy of my report to the Healthcare Safety Investigation Branch, and the Care Quality Commission, 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.

Dated: 9th November 2023

Signature: Chris Morris HM Area Coroner, Manchester South.