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 University Hospitals of Derby and Burton NHS Foundation Trust**
1	**CORONER** I am Susan EVANS, Area Coroner for the coroner area of Derby and Derbyshire
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 24 November 2022 I commenced an investigation into the death of Zachary Victor TAYLOR-SMITH aged Less than 1 day. The investigation concluded at the end of the inquest on 12 March 2024. The conclusion of the inquest was that: Zachary Taylor-Smith (Zac) was born and died on the 17th of November 2022 at The Royal Derby Hospital. His birth had been induced preterm due to maternal health complications. During birth Zac contracted an infection. After birth his condition quickly deteriorated and he died at just 14 hours old. His death was contributed to by neglect in that: 1. Despite being clinically indicated Zac's mother was not offered intra partum prophylactic antibiotics at any time during the induction process by either the attending doctors or midwives. 2. The fact that Zac was born more than 18 hours after the rupture of his mother's membranes was not recognised at any time after birth and therefore its significance in relation to the risk of early onset neonatal infection was missed and antibiotics were therefore not considered when they should have been. 3. Despite Zac showing persistent signs of respiratory distress and having feeding difficulties, both clinical indicators of early onset infection, he was not given antibiotics as he should have been in accordance with the hospital's own and national guidance.
4	**CIRCUMSTANCES OF THE DEATH** Zachary Taylor-Smith died on the 17th of November 2022 at Royal Derby Hospital. He was born after a planned induction of labour at 36 weeks. His mother was not given prophylactic antibiotics before birth as she should have been. Both the labour and neonatal wards were busy. Zac was born more than 18 hours after his mother's membranes were artificially ruptured however the significance was not noted by either the midwife supporting the birth, or any professional involved in her care thereafter. Although signs of grunting and respiratory distress, which warranted a review, were escalated to the neonatal team, no neonatal review took place. The requirement for such

	review was not communicated to the incoming neonatology team at the point of handover. Despite Zac showing persistent signs of respiratory distress and having feeding difficulties, both clinical indicators of early onset infection, he was not given antibiotics as he should have been in accordance with the hospital's own and national guidance. There was evidence of confusion about the significance of the four hour period after birth in relation to indicators of a deteriorating baby and the potential over emphasis placed on the possible innocuous explanation for grunting in that period. Evidence was heard at the inquest about the culture that existed between the midwifery team and neonatologists and that their relationship was difficult, albeit it was not thought to have compromised Zac's care. Given that the responsibility for checking and monitoring signs of infection in the newborn was not, from the evidence, placed on either the midwifery team or the neonatologists but was a joint one, the relationship that exists between the teams is of critical importance.
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) I heard evidence that the Trust are committed to improvement and have already made and are planning to make important improvements. However, I remain concerned in relation to the following matters: a. Staff lacking appreciation and proper understanding of the significance of the four hour period after birth in relation to indicators of a deteriorating baby and the potential over emphasis placed on the possible innocuous explanation for grunting in that period. b. Staff lacking appreciation of the significance of the timing between rupture of membranes in a pre-term birth and birth and therefore failing to note or ask to be furnished with that information to inform their assessment of the risks of infection in babies. c. The persisting cultural issues affecting the relationships and communication between maternity and neonatal staff. Given that the responsibility for checking and monitoring signs of infection in the newborn was not, from the evidence, placed on either the midwifery team or the neonatologists but was a joint one, the relationship that exists between the teams is of critical importance. d. Absence of an effective system in place to ensure required reviews remain live until completed. e. Absence of a formal mechanism for reviewing whether it is safe for planned inductions to take place in the context of ward and neonatal units levels of activity and capacity.
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 May 09, 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 [redacted] [redacted] **University Hospitals of Derby and Burton** I have also sent it to 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: 14/03/2024**  **Susan EVANS** **Area Coroner for** **Derby and Derbyshire**