The Leeds Teaching Hospitals
NHS Trust

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Date: 4 November 2024
Our Ref: [redacted]

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Kevin McLoughlin
Senior Coroner West Yorkshire (Eastern)
His Majesty's Coroner's Office
The Coroner's Courts
Burgage Square
Wakefield
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Email: [redacted]

Dear Sir

Re: Inquest touching the death of Evelyn Grace March

I write on behalf of Leeds Teaching Hospitals Trust (LTHT) in response to the Regulation 28 report on this matter, issued on 19 September 2024. I am aware of the circumstances of Evelyn's tragic death and take this opportunity to offer my sincere condolences to her family. It is regrettable that a Regulation 28 report was issued in the circumstances whereby LTHT was not an Interested Person at the inquest, and I also note that no LTHT witness was summoned to attend. Due to this, I have no knowledge of the evidence given on the day, beyond that held by LTHT and subsequently the disclosure bundle provided to us at our request to your office following the hearing.

We note that you have also shared a copy of the Regulation 28 report with Maternity and Newborn Safety Investigations (MNSI), it is not clear to us whether you have reviewed a copy of their investigation report into the death of baby Evelyn and the care afforded to her mother Rachel.

I make my comments below against this backdrop.

You raise four matters of concern;

1. The Mother endured a prolonged labour and had little sleep from Sunday (24.9.23) until her baby was born at 04:38 hours on Tuesday (26.9.23). She was exhausted.

2. The baby and her parents were discharged home 4 hours after the birth (08:39 hours).

3. The death of the baby is probably due to the exhausted mother falling asleep whilst trying to breastfeed the unsettled baby in her own bed sometime after 01:45 hours (27.9.23).

4. Consideration should be given to the wisdom of discharging a mother so soon after a prolonged labour and induced delivery. Had she been permitted to sleep in hospital for a few hours knowing that her baby was being monitored, the tragedy may have been avoided.

To address your concerns, I have taken advice from the senior leadership team in Maternity, who inform me as follows.

Evelyn's death was reviewed using the National Perinatal Mortality Review Tool (PMRT), was subject to scrutiny under the Sudden Unexplained Death in Childhood (SUDIC) process and was investigated independently by MNSI.

The MNSI investigation, the SUDIC report and the PMRT into the death of Evelyn did not identify issues in care which impacted on the sad outcome. Additionally, MNSI did not identify any safety recommendations from their investigation.

Evelyn's mother [redacted] and father [redacted] both reported concerns to the Trust as part of the mortality review process and the SUDIC process that [redacted] felt exhausted and that the delay in the induction of labour contributed to this. The Trust has subsequently updated the leaflet it provides to mothers about the induction of labour. This now includes information around bringing isotonic drinks and snacks to the ward, along with other items which may support them, such as eye masks, ear plugs and their own pillows. The leaflet also reiterates that the process of induction can take several days.

I respectfully note that you state that consideration should be given to the wisdom of discharging a mother so soon after a prolonged labour and delivery.

The independent MNSI investigation report documents its findings for the immediate postnatal care and discharge; "The Baby was born in good condition and breast fed well following birth. A discussion took place regarding discharge and the Mother and Father wished to go home the same day.

A full newborn infant physical examination (NIPE) check was completed whilst the Baby was at the Mother's side at 07:59 hours and no concerns were identified. The investigation learned that when mothers and babies are being discharged from the labour ward it is usual practice for the newborn examination to be carried out within 3 to 4 hours of the birth.

The parents decided to return later for the hearing screening as the service did not start until 09:00 hours and they had transport arranged to take them home at that time.

The staff member used the laptop to go through the discharge checklist. They covered the important signs to look for, breast feeding and safe sleeping advice. The Father was packing to go home, and the Mother was listening intently. The Mother was noted to be very tired.

MNSI consider that the immediate postnatal care was carried out within national guidance (National Institute for Health and Care Excellence (2021) Postnatal care)."

I am also advised by the team that post-natal maternity wards are generally not environments conducive to rest and recuperation. Side rooms are generally reserved where there are infection prevention control concerns. This means that the majority of mothers are in bays with other women and their newborn babies, with the associated noise and disturbance. Most mothers will prefer the comfort of their own home.

I hope that my response reassures you that the Trust has considered the concerns you have raised and has also undertaken detailed reviews of the care and treatment provided to Evelyn and her mother [redacted] and that the care has also be scrutinised independently by MNSI.

My thoughts remain with Evelyn's family.

Yours sincerely,

[redacted]
Chief Medical Officer