# Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

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| | **REGULATION 28 REPORT TO PREVENT DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1 British Association of Perinatal Medicine**<br>**2 NHS England & NHS Improvement**<br>**3 University Hospitals Sussex NHS Foundation Trust** |
| **1** | **CORONER**<br><br>I am Joanne ANDREWS, Area Coroner for the coroner area of West Sussex, Brighton and Hove |
| **2** | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 15 March 2023 I commenced an investigation into the death of Felix Burton HARTLEY aged 1 Days. The investigation concluded at the end of the inquest on 19 August 2024. The conclusion of the inquest was that:<br><br>Felix Burton Hartley was born at 41+5 days without a heartbeat on 19 February 2023 at the Princess Royal Hospital, Haywards Heath, West Sussex. He was resuscitated after his birth but had been without a heartbeat for around 20 minutes at the time of his birth. He received treatment but sadly could not recover from the hypoxia and chorioamnionitis which was present at his birth. The chorioamnionitis was not known prior to his birth but would have impacted his physiological reserve to withstand the hypoxia. |
| **4** | **CIRCUMSTANCES OF THE DEATH**<br><br>Felix Burton Hartley was born at 41+5 days without a heartbeat on 19 February 2023 at the Princess Royal Hospital, Haywards Heath, West Sussex. He was resuscitated after his birth but had been without a heartbeat for around 20 minutes at the time of his birth. He received treatment but sadly could not recover from the hypoxia and chorioamnionitis which was present at his birth. The chorioamnionitis was not known prior to his birth but would have impacted his physiological reserve to withstand the |

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| | hypoxia. |
| **5** | **CORONER'S CONCERNS**<br><br>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.<br><br>The **MATTERS OF CONCERN** are as follows:<br><br>In this case, I heard that over the weekend and overnight Neonatology Consultants are not available immediately on site at either the Princess Royal Hospital, Haywards Heath or the Royal Sussex County Hospital in Brighton. I heard that on-call Consultants over the weekend are on site at Brighton for some of the period but for the majority they are contactable by telephone in the first instance only. I heard that the Trust position is that this is not unusual in many settings as Consultants are not intended to be the first responders to emergency calls.<br><br>At University Hospitals Sussex NHS Foundation Trust ("the Trust"), the on-call Consultant covers both the Princess Royal Hospital and the Royal Sussex County Hospital. These two sites are not close in proximity, and I heard that the traffic impacts on the time it would take for a Consultant to attend. The on-call Consultant does not always have access to an emergency vehicle and if called to attend either site would use their own vehicle and be subject to the usual road traffic laws. I heard that the Trust practice, as opposed to Policy, is that the on-call Consultant cannot be more than 30 minutes from either Brighton or Haywards Heath. The Trust facilitates accommodation at Brighton for the on-call Consultant so that they are within 30 minutes of Brighton if required.<br><br>I was told that the arrangements for Neonatal care at the Princess Royal are in accordance with the British Association of Perinatal Medicine guidelines and that there is no national guidance as to the time that an on-call Neonatology Consultant should be expected to attend a hospital in the event of an emergency or as to whether multiple sites can be covered by one on-call Consultant. Whilst I did not find the timing of the attendance of the on-call Consultant causative or contributory in relation to Felix's death, I am concerned that the time period in which attendance is made may vary and create a risk of future deaths. |
| **6** | **ACTION SHOULD BE TAKEN**<br><br>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** |

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| | You are under a duty to respond to this report within 56 days of the date of this report, namely by October 25, 2024. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br><br>[redacted]<br>**Maternity and Newborn Safety Investigations Special Health Authority (MSNI)**<br><br>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.<br><br>I may also send a copy of your response to any person who I believe may find it useful or of interest.<br><br>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.<br><br>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: 30/08/2024**<br><br>J. Andrews<br>**Joanne ANDREWS**<br>**Area Coroner for**<br>**West Sussex, Brighton and Hove** |