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 Airedale NHS Foundation Trust**
1	**CORONER** I am Charlotte KEIGHLEY, Assistant Coroner for the coroner area of West Yorkshire Western Coroner Area
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 21 May 2019 I commenced an investigation into the death of Alfie HINTON aged 23 minutes. The investigation concluded at the end of the inquest on 13 November 2024. The conclusion of the inquest was that: Baby Alfie Hinton died as a consequence of hypoxic ischemic brain injury sustained during the intrapartum period arising from delays in the management of his medical care. His death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Baby Alfie Hinton died at Airedale Hospital on the 10th May 2019 as a consequence of complete umbilical cord occlusion leading to hypoxic ischemic brain injury. In the days leading up to his death and whilst in utero, Alfie experienced a period of chronic hypoxia arising from placental insufficiency which made him more vulnerable to any further hypoxic events. On the 8th May 2019, Alfie's mum was admitted to hospital through the Maternity Assessment Centre for Induction of Labour as a consequence of extremely high levels of bile acids, which were recorded at 149, with anything over 100 increasing the risk of stillbirth tenfold. Induction of labour was requested 'as soon as possible', the expectation being that the induction would commence, at the latest, the following morning, but induction was in fact commenced at 2250 hours on the 9th May 2019, following a significant delay arising from the unavailability of beds on the Labour Ward. Once Induction of Labour commenced, the plan was for six hourly fetal monitoring with additional monitoring at the point when contractions commenced. At some point between 0700 hours and 0904 hours on the morning of the 10th May 2019, Alfie experienced an acute hypoxic event from which he recovered, the effects of this event would have been recognised earlier had monitoring taken place on time or alternatively at the point when contractions commenced. At the time contractions commenced, staff on the ward were engaged with other patients, consequently, there was no one to inform. The scheduled six hourly monitoring was delayed by 39 minutes with bradycardia being identified soon after the commencement of the trace. The bradycardia was not acted upon immediately and therefore preparations for birth were delayed. There were further delays once preparations commenced and at some point during the 12 minutes prior to Alfie's delivery at 1441, a

	complete cord occlusion occurred from which Alfie was unable to recover. Upon delivery his heart was slow and despite resuscitation attempts Alfie did not survive. Alfie's death was confirmed at 1504 hours the same day.
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) (1) During the course of the Inquest, I could find no evidence of how or if the maternal risks were assessed following her admission, nor how the level of risk posed by the level of bile acids was communicated to those tasked with prioritising those patients awaiting induction of labour and therefore the allocation of staffing and resources. This is further reflected in the 39 minute delay in CTG monitoring and the fact that at the point Bradycardia was noted, the initial assumption from staff was that there was an issue with the monitoring equipment, there being little awareness of the risks already present, which contributed to delays in expediting delivery. These facts gives rise to concerns in respect of the way in which information is gathered and shared within the Maternity Unit and in particular how risk is recorded and communicated between all of those involved in providing intrapartum care. (2) During the course of the Inquest, I heard evidence about the difficulties in communication between the Consultant Obstetrician and Consultant Anaesthetist, with delays being caused by several attempts being made at siting spinal anaesthetic, against the advice of the Obstetrician and the wishes of the patient, causing distress to staff and patient alike. I heard no evidence of any policy that provided direction or guidance in circumstances such as this. This gives rise to concerns in respect of communication, ongoing risk assessment and an absence of local policy in respect of the approach to be taken in such time critical situations.
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 27, 2025. 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] I have also sent it to

	CQC Leeds 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: 02/12/2024**  **Charlotte KEIGHLEY** **Assistant Coroner for** **West Yorkshire Western Coroner Area**