REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The President, Royal College of Paediatrics and Child Health
1	CORONER HM Assistant Coroner Peter Merchant for Greater Manchester South
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 29 April 2024 I commenced an investigation into the death of Yahya Muhammad HAYAT. The investigation concluded at the end of the inquest on 10 February 2025, having been heard on 30 and 31 January 2025. The conclusion of the inquest was: Yahya Muhammad Hayat was born at Tameside Hospital at 05:02 hours on 12 April 2024. He died at Royal Oldham Hospital on 25 April 2024, his death being confirmed at 16:42hours. Yahya's mother had previously given birth by way of a caesarean section and was therefore classified during her pregnancy with Yahya as a high risk pregnancy. Following her attendance at Tameside Hospital at 20:50 hours on 11 April 2024, whilst she was reviewed by a midwife and a plan of care put in place, endorsed by a Registrar, there was no physical examination or personal review by a Doctor until concerns arose regarding the foetal heart rate following a midwifery review at 04:15hours on 12 April 2024. Further, reflecting Yahya's mother being classified as a high risk pregnancy and her reports of pain following admission on 11th April 2024 that required analgesia, Yahya's mother should have been subject to continuous monitoring. At 04:15hours on 12th April 2024 concerns arose regarding locating a foetal heart rate. Whilst Medical assistance was sought, a decision to call a Category 1 caesarean section was not made until 04:50hours. It was not known how long Yahya's foetal heart rate had been abnormal,

	given the previous review before 04:15hours was undertaken at 03:15 hours on 12th April 2024. Yahya was born at 05:02 hours. In the course of undertaking the category I caesarean section, a uterine rupture was identified. It is not known when this occurred. There were missed opportunities to have delivered Yahya sooner. However, on the evidence it is not known whether earlier delivery would have avoided Yahya's death. The medical cause of death was given as: 1a Severe hypoxic ischaemic encephalopathy 1b 1c Maternal uterine rupture at birth of baby II
4	CIRCUMSTANCES OF THE DEATH Term baby born at Tameside Hospital after maternal uterine rupture leading to severe hypoxic ischemic encephalopathy. Baby born in very poor condition with first heart rate detected at 35 minutes of age after receiving resuscitation at birth. There is serious incident investigation at Tameside regarding the events leading to Yahya's birth in poor condition Presenting condition and initial diagnosis Yahya was born at 40+2 weeks of gestation at Tameside Hospital via Em CS due to maternal uterine rupture. Yahya was born in very poor condition, requiring chest compressions and several resuscitation drugs via intraosseous needle line as UVC insertion was unsuccessful. Yahya was successfully intubated at ~30min of life and a heart rate was first detected at ~35minutes of life. A dose of surfactant was given at that time. Yahya was transferred on day 1 of life to Royal Oldham Hospital for ongoing intensive care of severe hypoxic ischaemic encephalopathy (HIE). Yahya remained ventilated from birth, requiring minimal settings but did not demonstrate central drive to breath. Significant cardiovascular support was required, totalling with 4 simultaneous inotropes required to manage hypotension. Hypotension was associated with very high lactates. Inotropes were gradually weaned and stopped on day 4. BP was monitored using a peripheral arterial line. On Day 8 Yahya was again briefly started on adrenaline infusion in view of Low Bp but that was stopped shortly after. Yahya was initially kept nil by mouth and remained on IV fluids. Post re-warming Yahya was started on feeds; and only managed to reach on 1/2 fluids and 1/2 feeds. Yahya was fed by nasogastric tube and never given oral feeds as he did not have safe swallowing. Yahya had no gag or cough reflexes. Yahya's therapeutic hypothermia was commenced within first 6 hours of life, having met criteria A (prolonged resuscitation and very low pH) and criteria B (poor neurological examination) shortly after birth. Yahya went on to develop

	clinical seizures with correlation CFAM changes. These were managed with phenobarbitone, followed by loading and maintenance levetiracetam. Cranial ultrasound suggested features of severe HIE. In addition, there is biochemical evidence of a global hypoxic event including markedly deranged liver enzymes and elevated troponin (cardiac enzymes). Since arrival on the unit, Yahya has examined poorly from a neurological perspective. His pupils have been fixed and dilated throughout his stay with no spontaneous movements, no gag or cough reflex, no primitive reflexes, global hypotonia and areflexia. An in-house cranial ultrasound on day 2 of life showed generalised oedema and features in keeping with severe HIE. Yahya's brain MRI showed severe total intracranial injury. His brain was oedematous with mass effect and central brain herniation and compression of midline structures. Appearances most in keeping with severe hypoxic ischaemic injury. Yahya's brain MRI was discussed with paediatric neurologists at Royal Manchester Children's Hospital who had the same conclusion as above. Yahya's EGG was reported as severe abnormal EEG. He had isoelectric EEG. Yahya's renal function progressively declined since admission. This was associated with hyperkalaemia, requiring calcium gluconate, salbutamol and continuous insulin and dextrose infusion. Additionally, Yahya's biochemistry has shown hypocalcaemia and hypomagnesaemia which have required corrective infusions. Yahya has had hyperglycaemia required insulin infusion. Yahya's haemoglobin has remained acceptable through the NICU stay but he had thrombocytopenia requiring a platelet top up on 19/04/2024. Yahya's clotting profile was also deranged. Yahya received Vitamin K at birth, along with an additional dose of vitamin K later with cryoprecipitate and fresh frozen plasma. Parents were kept up to date throughout their stay in the hospital. Compassionate care was discussed and agreed with parents. Care was then reoriented on 25/04/2024 and after family read the whole Holly Quran to Yahya as they wished, other family members said goodbye, bathed him and dressed him, Yahya was extubated at . Yahya sadly passed away peacefully on 25/04/2024 at 15:09 in his parents' attendance in the parents' bedroom. Serious incident investigation is being carried out at Tameside Hospital to investigate the circumstances leading to maternal uterine rupture and Yahya's birth in very poor condition. Circumstances leading up to and surrounding the death Very abnormal MRI brain, isoelectric EEG, no gag reflex, fixed dilated pupil, no variable heart rate, ventilator dependent. Care was reoriented with parents' agreement to compassionate care. Yahya was then extubated and he did not breath nor show any signs of life after being extubated.

5	**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 of changes to paediatric specialist training that has removed the requirement that paediatric middle grades undergo compulsory direct observed training to be assessed as competent to perform neonatal intubation. The following matters of concern arise from this : (1) The fact training is no longer compulsory, increases the reliance on consultants (who in some clinical settings may be non-resident on call depending when delivery takes place) ; and (2) Consultant general paediatricians of the future will have a lower level of experience than is currently the case of complex neonatal resuscitation
6	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.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely by 7 April 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 Talbots Law on behalf of the family. I have also sent it to Weightmans LLP on behalf of Tameside and Glossop Integrated Care NHS Foundation Trust and to 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.
9	10 February 2025  Signature Peter Merchant HM Assistant Coroner for