NHS
Greater Manchester
Integrated Care

[redacted]

Date: 29 August 2025

Private & Confidential
Ms Alison Mutch
Senior Coroner for the area of Manchester South
Manchester City Coroner's Office & Court
Exchange Floor
The Royal Exchange Building
Cross Street
Manchester M2 7EF

[redacted]

Dear Ms Mutch

Re: Regulation 28 Report to Prevent Future Deaths – Esme Vera Louise Atkinson

Thank you for your Regulation 28 Report dated 6 June 2025 regarding the sad death of Esme Vera Louise Atkinson. On behalf of NHS Greater Manchester Integrated Care (NHS GM), We would like to begin by offering our sincere condolences to Esme's family for their loss.

Thank you for highlighting your concerns during the inquest which concluded on the 8 May 2025. On behalf of NHS GM, I apologise that you have had to bring these matters of concern to our attention. I recognise it is very important to ensure we make the necessary improvements to the quality and safety of future services.

During the inquest you identified the following cause for concern: -

> **The inquest heard evidence that health visitors / midwives and GPs play a key role in the early identification of a heart defect such as Esme's at an early stage. Such a defect will rarely be apparent at the 72 hour check on the evidence given at the inquest but symptoms will manifest subsequently. Such symptoms can be subtle and the inquest was told that for there to be early suspicion, of a heart defect, training for community midwives/health visitors and GPs needed to be improved and good quality information sharing was also essential. This should include concerns around feeding and weight loss.**
>
> **The GP check at 6- 8 weeks was a key checking point but needed to be informed by asking all of the right questions and a good understanding of how to listen for such a heart defect.**
>
> **The inquest was told that it was important that it was understood by health professionals involved in the care of a baby that the mother being diabetic increased the risk of a defect**

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significantly and should increase the care taken in relation to presenting symptoms.

There was no routine echocardiogram of a baby born of a mother with diabetes nationally although their risk of a defect was significantly higher than other babies and such a test would detect a baby with a ventricular septal defect at an early stage.

In Esme's case although her mum's identical twin had a heart defect this did not in the North West, trigger the protocol for a routine echocardiogram. A heart defect in her mother would have. It was unclear why this was excluded given the genetic link.

Esme had the usual abnormality scan which the inquest was told did not detect the defect on her heart. The inquest was told that the cardiac part of the abnormality scan was not audited in England under national guidance and the cardiac images were not stored. This meant they were not available for subsequent examination.

The evidence of the paediatricians at the inquest was that tracking weight on the centile chart even from an early point assisted in understanding if there was a significant issue in relation to feeding triggering professional curiosity. However the evidence from the Health Visitor appeared to suggest that centile tracking was not seen as useful before 1 month and the red book was not used to look at weight centile tracking in the early stages.

I have liaised with colleagues in the division of Women and Children at Stockport NHS Foundation Trust (SFT) and understand that there is nothing specific regarding training for early suspicions relating to heart defects within regular / mandatory training that we are aware of for the midwifery staff. It does not appear that there is anything within student training but will make enquires with the university syllabuses.

All midwives are trained to escalate to a senior medical professional if they have any concerns or there are any deviations from the normal throughout the perinatal period, such as concerns based on failure to thrive, feeding issues or weight loss.

I understand that:

- All providers have clear guidelines on escalation pathways
- All providers have clear guidelines on appropriate escalation of any abnormalities detected on scan during the pregnancy
- All midwives complete an initial APGAR (Appearance, Pulse, Grimace response, Activity, Respiration) review & top to toe examination – this would include escalation to the neonatal team for any colour, respiratory or tone concerns
- All babies receive a Neonatal Examination of the Newborn (NIPE) examination within 72 hours of birth. This includes auscultation of the heart, checking the femoral pulses & completing Oxygen Saturations. Any deviations from normal findings requires escalation to the Neonatal team for further review
- All providers are required to monitor weight gain in newborn infants and will have a policy in place to support escalation & referral if this is outside of normal limits
- All providers have an infant feeding guidance in place to support 'reluctant feeders' and ensure appropriate onward escalation where deviations from the norm occur
- All midwives follow a postnatal visit schedule prior to transfer of care to the Health Visitor which includes full examination of the newborn infant and direct links back into the neonatal pathways should there be any deviations from the normal

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All of the above guide staff to escalate with any concerns around heart defects. Additionally, the specialist NIPE training does detail specific training around heart defects, and is now included in all student midwives training, historically this was seen as specialist training completed by some midwives.

Learning

NHS GM is committed to learning from Prevention of Future Death reports. In response to this report, I will initiate the following actions:

- Develop with NHS GM clinical leadership and share a briefing for primary care providers to be distributed through the NHS GM primary care newsletter to remind primary care colleagues, especially GPs, of their role in the early identification of heart defects.
- Share your report and our response through the NHS GM Clinical Effectiveness Group (CEG) for wider system learning.
- Share your report and our response through the NHS GM Provider Oversight Meeting (POM) with Stockport NHS Foundation Trust.

I will share the evidence of the above actions with you.

I hope that my response addresses your concerns. Please contact me should you have any further enquiries.

Best wishes

[redacted]

Interim Deputy Chief Executive Officer and Chief Nursing Officer
NHS Greater Manchester

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