OFFICE OF THE
SENIOR CORONER
for the County of West Yorkshire
(Eastern District)

His Majesty's Coroner's Office
The Coroner's Courts
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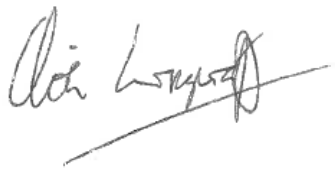
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Secretary of State for Health and Social Care** FAO [redacted] **2. Leeds Teaching Hospitals NHS Trust (LTHT)** FAO [redacted], Chief Medical Officer **3. British Association of Perinatal Medicine (BAPM)** FAO [redacted] (President) **4.Royal College of Paediatrics and Child Health (RCPCH**) FAO [redacted] (President) **5. Resus Council UK (RC UK)** FAO [redacted] (President) **6. Neonatal Network (NN)** FAO [redacted] (Network Manager)
1	**CORONER** I am Oliver Robert Longstaff, Area Coroner for the Coroner Area of West Yorkshire (East).
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 15/06/2022 I commenced an investigation into the death of Benjamin Finch Arnold who was born at 0427 hrs on [redacted] and died 8 hours later. The investigation concluded at the end of the Inquest on 23/05/2025. The medical cause of death was 1a) Respiratory Distress Syndrome and Air Leak Syndrome; 1b) Preterm delivery (34 weeks gestation). In summary, the narrative conclusion to the inquest was that opportunities to identify that Benjamin had a pneumothorax were missed. If the pneumothorax had been discovered and treated before a tension pneumothorax and other complications related to Air Leak Syndrome had developed, he would on the balance of probabilities have survived.
4	**CIRCUMSTANCES OF THE DEATH** It had been intended that Benjamin be born at Leeds General Infirmary (LGI). When his mother went into spontaneous preterm labour [redacted] she was redirected to Saint James' University Hospital (SJUH) because the LGI delivery suite was closed to admissions due to lack of capacity. Benjamin was born by spontaneous vaginal delivery at 0427 hrs. An hour after being born, Benjamin was noted to be breathing with difficulty, and he was supported initially by a positive end expiratory pressure face mask and shortly via a CPAP machine. The Neonatal Registrar decided to perform a "LISA" (Less Invasive Surfactant

	Administration) procedure to prevent his lung alveoli collapsing after each breath due to his prematurity. Shortly into the procedure, Benjamin was recognized to be in peri-arrest with significantly reduced oxygen saturations and respiratory effort. The on-call consultant, who attended SJUH from LGI because she was covering both hospitals, directed the performing of bilateral needle thoracocenteses on Benjamin which showed air on both sides of his chest consistent with pneumothoraces. A chest x-ray carried out almost an hour later, after Benjamin had had chest drains inserted, was indicative of a right-sided tension pneumothorax having developed. At 1030 hrs, Benjamin having suffered a devastating brain injury over two hours with very low oxygen levels and heart rate, his care was refocused on palliation until his death was certified at 1220 hrs.
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. – (1) The provision of maternity services across the Leeds Teaching Hospitals Trust (LTHT) continues to be split unequally between LGI and SJUH, with, for example, no on-site paediatric cover at SJUH. What was described by LTHT witnesses as the "isolation" of the SJUH site, particularly as it related to the limited nursing and medical support that can be called upon, was a recurrent theme in the inquest. The inquest was told that a long held ambition to bring LTHT's maternity services under one roof had been recently frustrated by the announcement that the building of a new hospital for Leeds would not begin until 2030. **Secretary of State for Health and Social Care to respond.** (2) The evidence at the inquest disclosed an ambiguity as to whether the SJUH maternity unit, officially a "Level 1" centre, was operating outside the parameters of that classification. That ambiguity was demonstrated by a witness (whose evidence was admitted in writing under R23 due to her poor health) who described it as a "Level 2" unit, and by a witness in person who described it as a "Level 1 and a half" unit, which last classification does not exist. **LTHT to respond.** (3) The evidence disclosed concerns that guidelines for the performing of a LISA procedure are not standardised across the NHS, particularly with reference to the performing of a chest x-ray to exclude pneumothorax before commencing the procedure, and to the necessity of seeking consultant approval before undertaking the procedure. **BAPM, RCPCH, RCUK and NN all to respond.** (4) The evidence disclosed concerns whether national guidelines on the reversible causes of cardiac arrest ("the 4 H's and 4 T's") were sufficient for the purposes of identifying and treating the potential causes of cardiac arrest in a newborn baby. **BAPM, RCPCH, RCUK and NN all to respond.** (5) The inquest heard oral evidence of amendments and updates to the LTHT risk register in the light of Benjamin's death. The purpose of including this issue as a matter of concern in this report is to give LTHT the opportunity to describe those amendments and updates in a detailed written response so that they may be fully understood. **LTHT to respond.**
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 28/07/2025. 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: Benjamin's parents; LTHT; the CQC. 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	Signed:  OLIVER LONGSTAFF Area Coroner West Yorkshire (E) Date: 03 June 2025