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 the Department of Health and Social Care.** **2) Greater Manchester Integrated Care.**
1	**CORONER** I am Alison Mutch , senior coroner, for the coroner area of 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.
3	**INVESTIGATION and INQUEST** On 2nd April 2024 I commenced an investigation into the death of Esme Vera Louise ATKINSON. The investigation concluded at the end of the inquest on 8th May 2025. The conclusion of the inquest was narrative: **Died from Complications of a ventricular septal defect not identified until after her death. The medical cause of death was 1a) Ventricular septal defect with cerebral haemorrhage and infarction**.
4	**CIRCUMSTANCES OF THE DEATH** Esme Vera Louise Atkinson was born on 7th February 2024 at Stepping Hill Hospital. Her mother has type 1 diabetes which is known to increase the risk of congenital heart defect. Her mother's identical twin had a congenital heart defect identified at birth. No cardiac defects were noted at her anomaly scan. Following her birth she was admitted to the neonatal unit when she showed signs of infection. She required respiratory support and antibiotics. An echocardiogram was not carried out because she responded to treatment and her requirement for oxygen support decreased. An echocardiogram would have identified the defect. She was discharged home. She was seen by General Practitioners on three occasions and by the community midwifery service. She did gain weight but the trajectory of her weight gain was not recognised as being a concern. Her feeding declined and she had episodes of vomiting. On 17th March 2024 her parents became increasingly concerned about her, due to her overall appearance and an eye twitch they detected. At Stepping Hill Hospital it was identified by the nurse that she was unwell. She was given Oxygen and seen by clinicians. She was diagnosed with Bronchitis and appeared to respond to treatment, although remained very unwell. She suddenly stopped breathing. Attempts to resuscitate her were unsuccessful and she died at Stepping Hill Hospital on 17th March 2024. A post mortem examination found that she had a ventricular septal defect that had led to her death. Earlier identification of the defect would probably have meant she would not have died when she did.
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 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. – 1. 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. 2. 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. 3. 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 significantly and should increase the care taken in relation to presenting symptoms. 4. 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 it would detect a baby with a ventricular septal defect at an early stage 5. 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. 6. 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. 7. 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.
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 **1st August 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: Mother of Esme Vera Louise Atkinson on behalf of the family, Stepping Hill Hospital and GP 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. They may send a copy of this report to any person who they believe 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	**Alison Mutch** **HM Senior Coroner**  **06/06/2025**