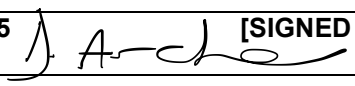
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], Associate Medical Director, Musgrove Park Hospital, Somerset.**
1	**CORONER** I am Deborah Archer, Area Coroner for the County of Devon, Plymouth and Torbay.
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 16th March 2022 I commenced an investigation into the death of Daisy May McCoy aged 13 weeks. The investigation concluded at the end of a 6-day inquest on 25th July 2025. The conclusion of the inquest was a narrative one namely: **Narrative** The deceased died as a result of an interruption in the blood flow to the brain which ultimately caused significant damage to her brain and peri natal asphyxia some time before her delivery by Caesarean section on 9th February 2022.
4	**CIRCUMSTANCES OF THE DEATH** Daisy was born by Caesarean Section at the Yeovil Maternity Unit on 9th February 2022 after her mother reported feeling reduced foetal movement and unusual movement. Expert evidence revealed that Daisy had sustained at least one hypoxic / ischaemic insult to her brain in the form of an interruption of blood supply or oxygen which on the balance of probabilities had occurred before delivery. The cause of this interruption was not determined on the balance of probabilities but was potentially due to a problem with the umbilical cord / placenta. There was a delay in Daisy's caesarean being performed due to a combination of factors which involved a failure to communicate appropriately between staff and a lack of training on recognising the significance of abnormal foetal movements and foetal compromise generally. Daisy was moved to Southmead Hospital Bristol on 9th February 2022 and died in a Children's hospice in Barnstaple on 22nd February 2022 .

	Although the inquest ultimately determined that the brain injury to Daisy was already present when she attended Yeovil maternity unit and that an earlier delivery would not have made a difference to her survival the following findings of fact were made as the timing of the injury was an issue at inquest and the delivery process raised a number of concerns . (a) The Consultant who was working remotely, was not fully aware of the staffing issues on the ward, and this meant that she did not fully consider with all the information whether she should have come onto the unit to assist in person. (b) The Guidance at the time did not include asking a Consultant to attend where there was a presentation outside of the staff's experience and /or skill set and /or where a significant hypoxic insult was suspected to have already happened. (c) Because of the high acuity on the ward, no one had the time to escalate matters for help or make an accurate note which directly led to no one apart from the Registrar knowing that the Consultant required a call back on Daisy's abnormal scan within 30 minutes. (d) The Consultant failed to telephone the ward back after 30 minutes which led to a further delay in the caesarean being commenced. (e) No professional telephoned the Consultant back as they were not aware of the plan to initiate a call (f) There was no open discussion between professionals or challenge about whether the initial view of the Registrar that Mrs Mccoy needed a Caesarean was correct. (g) No one looked at the Dawes Redman criteria at 0028 and no one escalated this and the CTG generally to the Consultant who said that if she had been aware of this at 0028, she would have come onto the ward to assist. (h) Multiple communication issues as set out above resulted in the parents being left on their own for about an hour with no action being taken and the likely seriousness of the insult being left unexplained (i) A midwife who gave evidence about the new processes for seeing patients with reduced foetal movements had an incorrect understanding of what the new process was . Although certain issues were addressed during the inquest I still remained concerned about the prosect of Yeovil Maternity Unit (which is currently closed) reopening in November 2025 without the below matters being considered
Consultant	**<u>CORONER'S CONCERNS</u>** 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. A lack of training to recognise unusual foetal movements / compromise and implementation of such training. 2. A lack of familiarity with the processes and polices by midwives to understand foetal compromise. 3. A lack of training and policies on rapid escalation of emergency events 4. A gap in policy to provide for both Consultants and or midwives to attend in person where understaffing may lead to patient safety being

	compromised outside of the recognised situations where this is required under the FIGO guidelines. 5. A lack of understanding and implementation of the polices that additional staffing in times of high acuity or other emergency situations which if left unaddressed may leave patient safety compromised. 6. No culture of appropriate professional challenge. 7. A lack of adequate communication between different health care professionals on the maternity unit.
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 4pm on 30th September 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 Somerset NHS Trust, Mr and Mrs Mccoy [and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. I have also sent it to Somerset Integrated Care Board and 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	**[DATE] 5th August 2025**  **[SIGNED BY CORONER]**