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. Sheffield Teaching Hospitals NHS Foundation Trust**
1	**CORONER** I am Abigail Combes, Assistant Coroner, for the coroner area of South Yorkshire (West District)
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 10 March 2022 I commenced an investigation into the death of Mojeri Adeleye born on 1 March 2022. The investigation concluded at the end of the inquest on 10 January 2023. The conclusion of the inquest was:- Natural Causes The medical cause of death was: 1a: Extreme Prematurity 1b: Pre labour premature rupture of membranes
4	**CIRCUMSTANCES OF THE DEATH** Mojeri's mother was supported throughout most of her pregnancy at her local hospital in Grimsby. Due to concerns and the premature rupture of membranes her care was transferred to the Jessops Wing in Sheffield. Unfortunately, Mojeri's mothers referral notes in respect of her expected due date were not correct. Despite this being brought to the attention of staff multiple times, the staff at the Jessops Wing refused to accept that Mojeri's mother was providing them with the correct information. Mojeri's mother went into labour and due to the policy, guided by national practice, no life saving support was offered to Mojeri because he was under 22 weeks gestation. This was not the subject of discussion with Mojeri's parents due to his gestational age. Unfortunately, the information which the hospital held about Mojeri's gestational age was incorrect and at the time of the premature labour he was just over the 22 weeks gestation mark. I was told in evidence that the single biggest feature in Mojeri's death was the much earlier premature rupture of membranes at 17 weeks gestation and that even if the correct gestational age had been known there would not have been different treatment offered. I was also told in evidence that conversations about whether exceptional measures will be taken to support premature babies take place in the 22nd week of pregnancy rather than in the 21st.
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. – The lack of regard towards Mojeri's mothers knowledge of her own pregnancy and the estimated due date for Mojeri. The lack of discussion with Mojeri's parents about the possible measures that could be taken in the event of premature labour before the 22 week mark.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 6th July 2023. 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: [redacted] and [redacted] I may also send a copy of your response to any other person who I believe may find it useful or of interest. In this case I have sent a copy of this report to NHS England and to the CQC. 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.
9	**10th May 2023**  Abigail Combes **HM Assistant Coroner**