REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Department of Health (concern 1) 2. Royal College of Obstetricians & Gynaecologists (concern 1) 3. Pennine Acute Hospitals NHS Trust (concern 2)
1	**CORONER** I am Ms L J Hashmi, Area Coroner for the Coroner area of Manchester North
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 the 11th February 2015 I commenced an investigation into the death of infant Rahat Qayyum (otherwise known as Mohammed Rahat Yousaf).
4	**CIRCUMSTANCES OF DEATH** On the 5th July 2013, the deceased's mother was admitted for planned induction of post-term labour. At around 15:50 hours, a CTG demonstrated anomalies. The midwife sought a medical review. The initial CTG demonstrated recovery however by 20:50 hours, a further trace showed evidence of a more marked anomaly. The significance of this CTG was not fully recognised. At 22:00 hours doctors made the decision to proceed to emergency caesarean section. As a consequence, the deceased's mother was transferred to the labour ward at around 22:20. At 22:48 a further examination was carried out by a doctor during the course of which an artificial rupture of membranes was performed. Tenacious, fresh meconium was noted within the liquor. The deceased's mother was transferred to theatre at 22:53 with baby being delivered in a very poor condition at around 23:42. Neonatal resuscitation was commenced immediately and thereafter, the deceased was transferred to the NICU. Over the course of the next few days, tests showed that the deceased was suffering from electrocerebral silence, meconium aspiration syndrome, seizures, hypoxic cardiomyopathy and presumed sepsis. The deceased's condition continued to deteriorate and he died on the 19th July 2013 from hypoxic ischaemic encephalopathy due to or as a consequence of perinatal asphyxia.

	During the course of the treatment and care provided, an official Interpreter was not summoned or utilised.
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:- During the course of the inquest the following concerns were identified: 1. Whilst Pennine Acute Hospitals NHS Trust has now established its own local guidelines based upon recent research conducted in Bristol, there are no national guidelines on how to interpret and/or classify antenatal (as opposed to intra-partum) CTG tracings. 2. The dissemination, application and applicability of the Trust's Interpreting Policy, by its staff, in force at the material time (with particular regard to the obtaining of informed consent).
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 the 14th April 2015. 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 namely:- The Deceased's family 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 from. 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: 16th February 2015 Signed: [redacted]