Charlie Mark Jermyn

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Chief Executive of the Royal Cornwall Hospital, Treliske, Truro** 2. **NHS England** 3. **Kernow Clinical Commissioning Group**
1	**CORONER** I am Dr Elizabeth Emma Carlyon, Senior Coroner for the coroner area of Cornwall and the Isles of Scilly
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** **Charlie Mark Jermyn died on 10th May 2015. An investigation was opened on 22nd May 2015 and an inquest was opened on 23rd September 2015. A three day hearing was held between the 9th – 11th February 2016 at Truro Municipal Buildings, Truro.** **The cause of death was recorded as 1a Massive Hypoxic-Ischaemic Brain damage 1b Pneumonia caused by Beta Haemolytic Streptococcus Group A Infection. The Conclusion of the inquest was "Charlie Mark Jermyn died from natural causes contributed by a sequence of failures in the health care system during the first 24 hours of life".**
4	**CIRCUMSTANCES OF THE DEATH** **Charlie Jermyn was born at full term in the bathroom at his home address, [redacted] on 9th May 2015 with a birth weight of 2.820 Kg (5th centile). The birth was attended by his father and no health professionals, as the labour progressed rapidly. A midwife assisted with the delivery of the placenta. The midwife reviewed mother and child between around 5.30 – 9.30 am and found them both healthy and breast feeding was established. They were reviewed by another mid-wife between 18.00 – 19.30 pm where there had been an alteration in Charlie's behaviour. He was sleepy, there was difficulty feeding and possible respiratory distress (grunting), which are all possible signs of sepsis. At around 22.37 pm the parents contacted the Maternity Helpline and were advised further on the feeding difficulties and the grunting was not addressed. A further midwife attended at 10.00 am on the 10th May and during the routine visit Charlie stopped breathing and was transferred by ambulance to the Royal Cornwall Hospital, Treliske, Truro. Despite resuscitation attempts he died at 10.52 am as a result of a Streptococcus Group A Infection. If signs for sepsis had been recognised on the 9th May, he would have been transferred to hospital earlier and provided with the appropriate treatment to prevent death.**
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.

At the inquest the Head of Midwifery at the Royal Cornwall Hospital outlined significant changes that had been introduced to the Trust as a result of learning from this death. These included the implementation of the NEWS chart in the post-natal documentation and there was reassurance that immediate steps had been introduced to reduce risk of future deaths. In addition the Director of Nursing accepted [redacted] – Expert Midwife Consultant offer to share best practice documentation with Trust.

The inquest identified areas where work should be undertaken

The **MATTERS OF CONCERN** are as follows. –

1. The Delay of over 5 hours, in full assessment of [redacted] labour progress in the Day Assessment Unit at Royal Cornwall Hospital on the 8th/9th May 2015 was unacceptable(systemic failing).

2. Routine physiological observations of mother and baby were not undertaken and recorded by the Community Midwives. This practice is not in line with national practice. The accurate temperature, heart rate and other appropriate observations/ recording should be routine and formally recorded with stethoscope and thermometer etc (not just visual and touch). NEWS should be completed on all babies.

3. The Royal Cornwall Hospital Trust core midwifery paperwork does not meet best practice or NICE guidelines and does not prompt midwives to undertake routine physiological assessments.

4. All Community Midwives should be provided with standard equipment to include, ear thermometers, stethoscopes, blood sugar testing and SATS monitors and these should be used as routine practice to make routine observations on mother and baby.

5. There was a recommendation by the Midwife Consultant that centile charts for each baby should be available in all hand held maternity records to assist midwives identify babies who are potentially at risk.

6. The Expert Midwife advised that the use of a single birth weight in the Trusts hypoglycaemic guidance (at risk at 2.5 kg) was not best practice and suggested the use of three weights: pre tern, term, and late weight.

7. The telephone Maternity Helpline was inappropriately triaged by unregistered inappropriately trained and qualified staff, who were unable to identify obvious and significant sepsis markers indicating the seriousness of the deterioration in Charlie's health. No structured note taking or recording of the call was made for future referral. Nor was the call taped/recorded. Helpline triage is a complex task and should only be undertaken after specialist training by an appropriately qualified person and the outcome of the conversations should be recorded formally in line with best practice.

8. The red flag signs for sepsis (in this case sleepy, possible respiratory distress (grunting) and difficulty in feeding) were overlooked resulting in a fatal delay in referral to specialist hospital support/treatment. Identification of sepsis in new born babies is difficult and the staff and Trust should have had in place a systemic, rigorous and regular training in this area. The Trust's own clinical guidelines for the Prevention, Diagnosis and Treatment of Early Onset Neonatal Bacterial Infection, were not known to the midwives at the inquest. The Expert

Midwife gave the opinion that the RCHT Trust guidelines were not consistent with the NICE guidance or best practice on this matter (page 14?). In particular it was noted that capillary re-fill time should be undertaken and recorded in cases of suspected sepsis.

9. The Expert Midwife noted that RCHT SI and SOM were not appropriate and been identified in the most recent LSA report on the Trust.

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.

1. To work with to implement NICE guidance and Good Practice and documentation for the Royal Cornwall Hospital Trust.
2. To review the matters raised in Section 5 above, and ensure Midwifery and Paediatric Practice is in line with NICE guidance and National Best Practice
3. The family welcomed the introduction of the Sepsis Assessment and Management leaflet and expressed a wish that this leaflet should be included in all hand held maternity records.

– Expert Midwife report attached

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 22nd July 2016. 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 Person, (parents), The Chief Executive of the Royal Cornwall Hospital, and to the LOCAL SAFEGUARDING CHILDRENS BOARD. I have also sent it to (Expert Paediatrician), (Expert Midwife) and 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.

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[DATE]	[SIGNED BY CORONER]
27.05.2016	Elizabeth Emma Carlyon