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. **Jackie Smith, Chief Executive and Registrar, Nursing and Midwifery Council, 23 Portland Place, Marylebone, London, W1B 1PZ**
1	**CORONER** I am David Hinchliff, Senior Coroner for the coroner area of West Yorkshire (Eastern)
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 5th December 2013 I commenced an investigation into the death of Billy Wilson, 3 days old. The investigation concluded at the end of the Inquest on 1st March 2017. The conclusion of the Inquest was that the cause of death was 1(a) Hypoxic-ischaemic brain injury 1(b) Perinatal asphyxia and a Narrative Conclusion was recorded, a copy of which is attached hereto.
4	**CIRCUMSTANCES OF THE DEATH** Billy Wilson was a baby boy born at 0250 hours on 27th November 2013 at Pinderfields Hospital, Wakefield. He survived for 3 days and his death was confirmed on the Paediatric Neonatal Unit at Leeds General Infirmary at 0140 hours on 30th November 2013. The cause of death is as stated above. This was a high risk pregnancy as it was suspected that Billy's mother suffered with polyhydramnios and that Billy was thought to be a large baby. The mother was admitted to Pinderfields Hospital on 21st November 2013 for inducement of labour. She was given a prostaglandin pessary which had little effect. This was repeated on the 22nd November 2013 and a third such pessary was given on the 23rd November 2013. Furthermore a prostin gel was used on 25th November 2013, all of which were without gain. The mother's uterine contractions and the baby's heart rate were monitored with a cardiotocograph (CTG). On one occasion the intermittent CTG tracing showed contractions to be 6 or 7 in 10 minutes – hyperstimulation. Notwithstanding this the mother was started on an oxytocin drip, the dose of which was steadily increased, which obviously increased and strengthened the frequency of the contractions. In Billy's case the monitoring of the CTG on 26th November 2013 showed an abnormality, which should have caused the syntocinon to be stopped. From 1740 hours onwards an expert review identified significant failings in care by both Midwives and Obstetricians, notwithstanding repeated irregularities in both the frequency of contractions and the foetal heart rate, yet the syntocinon was continued and on occasions was increased. Billy suffered from excessive stress and periods of hypoxia caused by the hyperstimulation and the fact that the labour was not progressing. The syntocinon should have been stopped. At 2000 hours the care of the mother was allocated to a newly qualified Midwife. This was only her first night shift and

	only her sixth shift since qualifying in September 2013. This Midwife was not able to interpret the CTG printout as being pathological and she increased the syntocinon. When it was finally realised that the baby was in distress and likely to be brain damaged he was delivered by forceps, in a poor state. He was resuscitated and then transferred to the Neonatal Paediatric Intensive Care Unit at Leeds General Infirmary where, despite all efforts, he deteriorated and his death was confirmed at 0140 hours on 30th November 2013. The newly qualified Midwife referred to in her evidence stated that she had not received appropriate instruction or training during her Midwifery Course at Bradford University and that when she became registered and took up her first appointment she had not completed the second part of an E-learning programme on the interpretation of CTG traces. An expert witness on Midwifery issues stated that this is commonplace and that student Midwives can qualify and become registered without this essential training.
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. – (1) I request that you ensure that training on CTG tracing interpretation is contained in the Undergraduate Syllabus for all Midwifery Degree Courses throughout the country. (2) That this is compulsory and that it has to be assessed on a pass or fail basis, and that a student Midwife cannot seek registration until this vital element in training is undertaken. (3) That Hospital Trusts should not recruit newly qualified Midwives until they can demonstrate their understanding and proficiency in CTG tracing interpretation. (4) There should be formal refresher training for all practising Midwives in CTG tracing and interpretation done on a yearly basis, and that this should be assessed on a pass or fail basis, and not merely left to the responsibility of the individual Midwife to complete an E-learning package without Management Review and assessment.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 Thursday 4th May 2017. 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 – President of The Royal College of Obstetricians and Gynaecologists and [redacted], Ameritus Professor in Obstetrics and Gynaecology. 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	**9 March 2017** **Senior Coroner, West Yorkshire (Eastern)**