REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: **The Secretary of State for Health, Healthcare Safety Investigation Branch (HSIB)**
1	CORONER I am Alison Mutch, Senior Coroner, for the Coroner Area of Greater Manchester South
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 2nd October 2018 I commenced an investigation into the death of Caspian Thorn. The investigation concluded on the 17th July 2019 and the conclusion was one of **Narrative: Died from the complications of sepsis contributed to by the complications of chronic placental insufficiency where delivery did not take place until 41 weeks and clear signs of developing placental insufficiency were not acted upon at 39 weeks in accordance with Trust guidance.** The medical cause of death was **1a) Gram negative sepsis (Stenotrophomonas maltophilia) and pneumonia in an infant with hypoxic ischaemic encephalopathy resulting from antepartum asphyxia due to chronic placental insufficiency (extensive chronic villitis and fetal thrombotic vasculopathy)**
4	CIRCUMSTANCES OF THE DEATH Caspian Thorn on the growth scan at 28+1 weeks was on the 50th centile. At the scan at 36+3 weeks, Caspian was just above the 10th centile. On 10th September 2018 at 39 weeks, a further growth scan found Caspian was between the 5th and 10th centile. The Trust guidance is that an induction should be considered in such circumstances post-37 weeks. An induction was not offered. A further growth scan was arranged

	for 17th September. Non-attendance at the scan was not picked up and there no follow up by the enhanced midwifery, community midwifery or hospital midwifery service. On 24th September 2018, Caspian's mother attended at Tameside General Hospital. CTG monitoring at 13.47 showed a pathological CTG from the earlier stages of monitoring. The midwife noted the CTG at 14.15 and Caspian's mother was transferred to the delivery suite. She arrived at 14.40 and a doctor was asked to review her at 14.45. She was reviewed at 15.00 and a category 1 section arranged. Caspian was born with significant brain damage. He was transferred to NICU at Royal Oldham Hospital for cooling. Warming began on 27th September 2018. Caspian, from about 18.00 on 27th September, exhibited signs of deterioration consistent with an infection. Blood samples were not taken until 28th September at 07.45. Caspian deteriorated further despite 2nd line antibiotics from 28th September. On 29th September, the microbiologists confirmed a gram-negative infection. Caspian continued to deteriorate and died at Royal Oldham Hospital on 29th September 2018 at 17.10. On 30th September 2018, the infection was identified as Stenotrophomonas maltophilia, which is resistant to antibiotics. Post-mortem examination found that Caspian had died from hospital acquired sepsis to which he was vulnerable as a result of his hypoxic brain injury. The hypoxia arose from chronic placental insufficiency.
5	<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 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:- The two trusts involved gave evidence of detailed action plans to address locally issues identified. However the inquest identified issues that it was clear could be found outside the two trusts where action has been taken. 1. A feature of the evidence was lack of communication between the teams of midwives and social worker. This meant that it was not picked up that his mother had missed a key fetal growth scan and that a small baby was not monitored for the period between 10th September until his birth on 24th September. The inquest heard that contributing to this was a shortage of midwives in the enhanced midwifery team and a shortage of experienced social workers in the Local Authority at the time; 2. Caspian's family had been identified as vulnerable. There was a lack of clarity about how to effectively support and manage the

	situation to ensure that there was effective engagement throughout the pregnancy and during delivery; 3. There had been two undocumented calls to triage on the morning of 24th September 2018. The inquest heard that that when staff were busy on the triage team calls and advice were not always documented; 4. Decision making that was not in accordance with trust guidance on 10th September was not clearly documented in the notes; 5. The 1st CTG on 24th September was a pathological CTG from the very early stages but was not reviewed until half an hour had elapsed despite the history. An expectation that CTG should be observed for a period of time after first starting would have allowed for earlier identification of fetal distress; 6. Early signs of sepsis were not identified by the consultant neonatologist because it was thought the observations reflected a move to warming from cooling. The other experienced staff within the NICU did not appear to recognise a deteriorating position until 12 hours after early signs of deterioration were noted.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you 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 14th November 2019. 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 1) Caspian's mother 2) Tameside General Hospital 3) Royal Oldham Hospital 4) Tameside Metropolitan Borough Council, 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	**Alison Mutch** **HM Senior Coroner** **19.09.2019**