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.** [redacted], The Chair of the Royal College of Obstetricians and Gynaecologists, 10-18 Union Street, London Bridge, London, SE1 1SZ **2.** [redacted], The Chair of the Royal College of Paediatrics and Child Health, 5-11 Theobalds Rd, Holborn, London WC1X 8SH **3.** [redacted], The Chair of the National Institute of Clinical Excellence, 10 Spring Gardens, London, SW1A 2BU
1	**CORONER** I am Rachael Clare Griffin, Senior Coroner, for the Coroner Area of Dorset
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 18th June 2019 I commenced an investigation into the death of Brandon-Robert William Collins-Hayward. The investigation concluded at the end of the inquest on the 19th November 2020. The medical cause of death was: 1a Escherichia coli sepsis The conclusion of the inquest was Natural Causes.
4	**CIRCUMSTANCES OF THE DEATH** The deceased was born on the 29th May 2019 following a normal vaginal delivery and presented as a healthy baby boy. When he was 3 days old, he started to reduce his milk intake, developed a shiver of his lip and started to make grumbling noises. Other than that, he displayed no other symptoms until 10.30am on the 7th June 2019 when he was noted to be yellow in colour, had a yellow flemish discharge in his nappy and started to struggle breathing. The emergency services were called and during that call he stopped breathing. Cardio Pulmonary Resuscitation was commenced and he was taken to Poole Hospital, Poole. On arrival he was in a peri-arrest condition and despite

	continued resuscitation attempts and active treatment his condition did not improve, and he died later that day. Of note his mother was admitted to Poole Hospital on the evening of the 6th June 2019 with moderate to severe infection and deemed to be a high risk of developing sepsis.
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. During the inquest evidence was heard that: i. The deceased was assessed at his home address on the 3rd June by the midwifery team at aged 5 days. At this assessment there was a visual check done but no basic observation assessments taken, such as temperature, heart rate and respiration rate, from the deceased or his mother to confirm their wellbeing ii. Evidence was given at the Inquest that there is no guidance nationally for such checks to be undertaken but following a review by University Hospital Dorset NHS Foundation Trust (UHD) who provided the postnatal care to mother and baby, they have reviewed their local policy to ensure these observations are taken in the early days following birth to ensure their wellbeing. iii. The local policy in place at UHD, titled "Postnatal Care Guideline", now provides guidance that at each visit up to day 10 post birth, a full set of baby and maternal observations are to be taken. Evidence was given at the Inquest that there would be great benefit in such guidance being provided nationally to ensure prompt medical care is provided and to prevent future deaths. iv. In addition evidence was given during the Inquest that the deceased's Mother was admitted to hospital on the 6th June 2019, with moderate to severe infection and was noted to be a high risk of developing sepsis. Following this admission, the deceased was not medically assessed for possible infection prior to his cardiac arrest the following morning. v. Evidence was given at the Inquest that there is no guidance nationally for babies to be medically assessed when a mother is admitted to hospital. Following the review by UHD, they have put in place a local policy titled "Caring for Newly Delivered Women and their babies outside the Maternity Unit" which provides guidance to be applied when a women presents at the hospital within 28 days following the birth. vi. This advises that when a mother is admitted to a UHD Hospital, the baby should be medically reviewed either in hospital, or at

	home by the midwifery team, to ensure the medical wellbeing of the baby. Evidence was given at the Inquest that there would be great benefit in such guidance being provided nationally to ensure prompt medical care is provided and to prevent future deaths. 2. I have concerns with regard to the following: i. I am concerned that due to the lack of national guidance regarding close monitoring of mothers and babies following discharge after birth, and the fact that there is no national guidance for a medical assessment of a baby when the mother is admitted to hospital with potential sepsis, there could be a death in the future. ii. I would therefore request there is a review of the guidance in place for post-natal care following the discharge from hospital in the immediate time following the birth, namely 10 days and a review of the national guidance in place when a mother is admitted to hospital within 28 days of birth, especially when diagnosed with infection and at high risk of developing sepsis.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe you and/or 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, 26th January 2021. 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: (1) The family of Brandon-Robert (2) University Hospital Dorset NHS Foundation Trust I have also sent a copy of my report to the following people who I believe have a sufficient interest in the contents of it: (1) Pan Dorset Safeguarding Children Partnership

	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	**Dated** **1st December 2020**	**Signed**  **Rachael C Griffin**