REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Rt Hon. Sajid Javid, Secretary of state for Health and Social Care.
1	CORONER I am Alison Mutch , Senior Coroner, for the 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 17th December 2020 I commenced an investigation into the death of Jos Tartese-Joy. The investigation concluded on the 30th November 2021 and the conclusion was one of Narrative: Died from the complications of fetal vascular malperfusion, and a small placenta not identified until after death in a high risk pregnancy where an induction of labour had not been arranged before 41 weeks was reached and where the lack of a heart beat was not immediately identified as CTG monitoring was not used because the risk his birth presented at 41 weeks with the low PAPP-A was not recognised. The medical cause of death was 1a Severe hypoxic ischaemic encephalopathy 1b Perinatal asphyxia.
4	CIRCUMSTANCES OF THE DEATH Jos Tartese-Joy's Mother was identified as having a low PAPP-A level on the combined screening test. Her pregnancy was as a consequence a high risk pregnancy. His parents and the community team were not explicitly told that the pregnancy was high risk or that it would be advisable to induce labour if he was not born by 41 weeks. A series of growth scans were undertaken at 28, 32, 36 and 39 weeks. His centile growth dropped from the 97th Centile at 32 weeks to the 75th centile by the 39 week scan. This was not seen as a concern. Applying the national guidance. After the 39 week scan there was no obstetric review. No arrangements were made for an induction and his parents were unaware of the risk. The notes identified low PAPP-A but did not set out that the

	pregnancy was high risk. It was not identified or recognised that an admission CTG would be advisable when his mother went into labour. At 41 weeks his mother went into labour following a sweep at 40+6. She arrived at Stepping Hill Hospital at 21:10. At 21:25 the heart rate was recorded at 118 bpm. A CTG was not used as it was not recognised that her pregnancy was high risk and that she was at the point where an induction would have been advised. As a consequence the heart rate was not continuously monitored. His mother was 5cm dilated. At 21:47 the midwife could not locate his heartbeat. At 21:49 that was escalated to a more experienced midwife who could not find a heartbeat. At about 21:54 it was escalated to the registrar. His mother was transferred to the delivery suite and at 21:56 the registrar scanned for Jos' heart and two flickers were seen. The Registrar moved to a category 1 section. Jos was born by emergency section at 22:10. He was in very poor condition with no heart beat or respiratory effort and significant meconium was present. He was resuscitated and a heart rate was palpable after approximately 18 minutes. He was moved to Royal Oldham Hospital where it was confirmed he had sustained severe brain damage as a consequence of hypoxia. He died at Royal Oldham Hospital on 15th December 2020. Post-mortem examination confirmed that the placenta was small and there was fetal vascular malperfusion of the placenta which significantly impacted placental function
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. 1. The inquest heard evidence that the pregnancy was considered to be a high risk pregnancy .However the inquest heard that there was no nationally recognised way of flagging this within the notes. The trust have taken steps to be more explicit regarding this following Jos's death .The inquest heard that the consequence of it not being explicit in communication or the notes was that his parents, the community midwife and the GP were unaware that the pregnancy was considered to be high risk. 2. The inquest heard evidence that the consultant would not have advised that the pregnancy proceed beyond 41 weeks and that an induction of labour would be offered before his mother reached that date. Disjointed lines of communication with the community midwifery team and poor communication with his parents meant that they were all unaware of that. As a consequence there was no plan for an induction of labour in place. The inquest heard that improvements had been made within the trust but poor lines of communication with community teams increased the risk of

	death of a baby. 3. The evidence before the inquest was that the layout of maternity services at the trust meant that triage and delivery were on different floors. The trust did have steps in place to alleviate the challenges of this but the evidence was that it made it more difficult for full oversight of patients. The inquest was told that this was not unusual across the NHS estate. 4. During the inquest it was accepted that CTG monitoring should have taken place at admission given that the pregnancy had been identified as high risk. If that had been satisfactory then it would have been appropriate to consider moving to regular monitoring. However that was not understood by the midwifery team as it was not explicit within the notes. The evidence was that clearer guidance and understanding nationally of when to use an admission CTG would reduce the risk to a baby during labour. 5. A student midwife was involved in the care. She followed the plan developed with an experienced midwife carefully. There was a lack of clarity regarding the escalation process she needed to follow if she identified problems. The evidence was that to avoid delay it was important that Trusts had clear escalation policies in place to appropriately support trainee midwives. 6. Jos's position on the centile chart had dropped in the last weeks of the pregnancy. The inquest heard that from a clinician's perspective the guidance nationally was not to look at this but to look at the % weight change between the last weight and the new weight. In hindsight the way he tracked on the centile chart appeared to reflect the challenges the placenta was under and it was unclear why the dropping picture on a centile chart was not a trigger for further checks. 7. The antenatal visits occurred during the national lockdown and meant that his father was not at the antenatal visits or present for the initial examination on admission. This meant that Jos's father was not able to offer support and advocate for his mother during the pregnancy or admission.
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 25th February 2022. 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 Family and Stepping Hill Hospital, 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	[signature] 31/12/21