Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 The Chief Executive of Calderdale And Huddersfield Foundation Trust**
1	**CORONER** I am Mary T. BURKEfor the coroner area of West Yorkshire Western Coroner Area
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 13 February 2018 I commenced an investigation into the death of Edward Arthur AKROYD aged 4 Days. The investigation concluded at the end of the inquest on 13 December 2021. The Narrative conclusion of the inquest was that: Edward Arthur Akroyd was born at Calderdale Royal Hospital at 19.44 hours on 13th January 2018 by forceps delivery. It is likely that if during labour his mother s elevated blood pressure had been more closely monitored and treated and closer monitoring and correct interpretation of CTG tracing during labour had been made , it is likely that steps would have been taken to ensure his earlier delivery. If this had occurred, it is likely that his death at 20.45 hours on the 17th January 2018 at Leeds General Infirmary from severe Hypoxic Ischaemic Encephalopathy would have been prevented
4	**CIRCUMSTANCES OF THE DEATH** In 2018 Edwards mother was booked to deliver her first child at the midwifery led Huddersfield Birthing Centre. At 7.00am on the morning of the 13th January 2018 , she attended the Centre after developing contractions. She was later transferred at 17.15 hours to Calderdale Royal Hospital following a diagnosis of Pre-elampsia with symptoms of elevated maternal hypertension. She was placed under the care of both a midwife and registrar doctor who both undertook various reviews and assessments in the ensuing hours. At 19.20 hours, the attendant registrar detected abnormalities in the CTG tracing and determined that the delivery should be expedited and directed that Mrs Akroyd should undergo a forceps delivery. Edward was delivered at 19.44 hours on 13th January 2018, he was in a critical condition . Following initial review and treatment at Calderdale Royal Hospital, Edward was transferred to Leeds General Infirmary for further intensive review and treatment. Despite this provision , his condition continued to give rise for concern and did not improve . Sadly his death was confirmed at 20.45 hours on 17th January 2018 at Leeds General Infirmary
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

	The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) please see attached sheet
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.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by April 28, 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 **«[redacted] and Minton morrill solicitors»** I have also sent it to who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 04/03/2022**  **Mary T. BURKE** **HM Assistant Coroner for** **West Yorkshire Western Coroner Area**

1. Whilst Mrs Akroyd was being cared for at Huddersfield Birthing Centre, her blood pressure was not checked and fresh eyes review was not undertaken at the appropriate time in accordance with the trust guidance. I am concerned that if this were to reoccur there is a real risk of missed opportunities to identify significant changes which could impact upon both the mother and unborn baby's wellbeing.
2. At the time of transfer of care between midwives, following arrival at Calderdale Royal hospital, the attendant midwife did not enter a complete handover record in Mrs Akroyds notes, as she understood that it was the duty of the receiving midwife to make a record within the notes. At the inquest, the same midwife who continues to practise, gave evidence that she remained of the view that that was trust policy. The lack of entry in the notes led to confusion and a lack of clarity of previously prescribed medication I heard evidence at the inquest, that the practise undertaken by the midwife was not trust policy at the time nor subsequently and it is the role of the midwife handing over care to complete a medical record within the patients notes . I am concerned that if complete and effective medical notes and records are not made, this may impact on decision making and treatment and in turn to the wellbeing of expectant mothers and their unborn child.
3. After a diagnosis of pre-eclampsia was made at Huddersfield birthing centre and Prior to transfer, various samples were obtained and sent for laboratory analysis, some of the results were received at Huddersfield Birthing Centre and phoned through to the labour ward at Calderdale Royal Hospital. From the evidence presented, the results were not passed to Mrs Akroyds attendant midwife or treating registrar. The subsequent internal review did not appear to investigate and determine the reason why this did not occur.
   I am concerned that if this were to reoccur, important information may not be provided which could pose a risk to the wellbeing of an expectant mother and or their unborn child
4. In evidence, Mrs Akroyd attendant midwife at Calderdale Royal Hospital did not appear to acknowledge that there was a need for her to continue to undertake regular monitoring of Mrs Akroyds Blood pressure in light of earlier readings and to escalate to either a doctor or labour ward co-ordinator, I am concerned that if similar circumstances were to re-occur, this poses a risk to the wellbeing of expectant mother and her unborn child. The same midwife also in evidence appeared to state that there was no need to review Mrs Akroyds earlier records as a verbal handover had been made, once again I am concerned that if this were to reoccur, it may pose a risk to the wellbeing to expectant mother and child.
5. The registrar who was seized of Mrs Akroyds care following transfer to Calderdale Royal hospital, in evidence stated that both at the time and also from the position of hindsight, considered Mrs Akroyds blood pressure both prior to and post transfer was only marginally elevated and he based his treatment plan on this view. I heard evidence from various consultants, that Mrs Akroyds blood pressure was significantly elevated, which required urgent treatment and careful review. I am concerned that if similar circumstances were to reoccur, and the same clinician were to hold similar views this may pose a risk to the wellbeing of the expectant mother and unborn child.
6. The same registrar in evidence stated that he was not aware of the recommended treatment for elevated blood pressure at this stage of labour and that he had recognised that Mrs Akroyd had pre-eclampsia and that he understood that the appropriate treatment of pre-eclampsia was the delivery of the baby. I am concerned that if the same facts were to reoccur, and the same registrar were to adopt the same treatment plan within similar time scales, it may present a risk to the wellbeing of the expectant mother and her unborn child.
7. The same registrar in evidence stated that it was his view at the time and also from the position of hindsight, that the ctg trace showed no significant cause for concern until shortly before he made the decision that Mrs Akroyd Should undergo a forceps delivery. I heard evidence from a number of consultants that the ctg trace from shortly after its commencement was showing non reassuring signs which should together with other facts

have resulted in an earlier delivery of Edward and if this had occurred it is likely he would have survived.

I am concerned that if the same facts were to reoccur, and a similar interpretation of a ctg trace was to be made, it poses a risk to the expectant mother and her unborn child.

8. The same registrar in evidence stated that at the time he initially assessed Mrs Akroyd he expected the attendant midwife to provide to him a full verbal update and that there was no necessity for him to have undertaken a review of Mrs Akroyds Medical notes and records. The attendant midwife did not provide a comprehensive summary of Mrs Akroyds medical notes and records. I am concerned that if the same circumstances were to reoccur, there presents a risk to the expectant mother and unborn child.
9. The same registrar stated in evidence that he was aware that samples had been taken at Huddersfield Birthing Centre but didn't think there was a need to obtain the results to assist in determining an appropriate treatment plan. I am concerned that if similar circumstances were to reoccur it may pose a risk to the wellbeing of the expectant mother and their unborn child.
10. From the evidence presented, and in accordance with trust guidelines, a second midwife should have undertaken a fresh pair of eyes review at 18.40 hours. this did not occur. I understand that such guidelines are put in place so as to ensure that key features are not missed and appropriate treatment plans are put in place. I am concerned that if such reviews do not occur it presents a risk to the wellbeing of expectant mothers and their unborn child