	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Sheffield Teaching Hospitals NHS Foundation Trust**
1	**CORONER** I am Abigail Combes, assistant coroner, for the coroner area of South Yorkshire (West District)
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 22 January 2021 I commenced an investigation into the death of Millie Rae-Needham born on 6 August 2020. The investigation concluded at the end of the inquest on 17 February 2022. The conclusion of the inquest was:- Millie-Rae Needham was born at the Jessop's Wing of Sheffield Teaching Hospitals on 6 August 2020. As a result of clinical decisions there was a 23-minute delay in her delivery and during that time her condition was not adequately monitored. She died in the neonatal unit at the hospital on 9 August 2020. Her death was contributed to by neglect. The medical cause of death was: 1a: Hypoxic-ischaemic encephalopathy 1b: Intra-uterine hypoxia
4	**CIRCUMSTANCES OF THE DEATH** Millie-Rae Needham was born at the Jessop's Wing of Sheffield Teaching Hospitals on 6 August 2020. Her mother (Skinna) had been categorised as a high-risk pregnancy throughout her pregnancy as a result of a previous baby with a very low birth weight. On the last scan [redacted] was switched to midwife led care rather than consultant led care with no consultation and as a result Millie-Rae was born on the midwife led unit at the Jessops. Throughout labour [redacted] was given very high pain relief early in her labour journey with minimal effect. Millie-Rae's heart rate was listened to periodically using auscultation. Once it became apparent that [redacted] labour was not progressing as it had been hoped the midwife determined that an episiotomy would be needed. She did not feel confident in doing this without support and so requested assistance. The midwife that then came into the room encouraged further position changes and this resulted in a 23-minute delay in Millie-Rae being born. During that time there was no adequate monitoring of her heart rate resulting in her being born in a very poor condition and dying on 9 August 2020.
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 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: – 1. A decision was made by the midwife who had been with [redacted] throughout her delivery to move to an episiotomy. Instead, the midwife that came to support encouraged further position changes leading to delay in delivery and inadequate monitoring of the foetal heart rate. Whilst the decision seek support for the episiotomy is not one which I would criticise, people should always be able to ask for help when needed, the fact that the midwife who was with [redacted] was talked out of this so readily resulting in avoidable delay is concerning. 2. The decision to move [redacted] from consultant to midwife led care without consultation, although not contributory to Millie-Rae's death is concerning. 3. The lack of discussion with [redacted] about birthing options prior to labour and therefore the lack of engagement with the pregnant woman is concerning. 4. I have had sight of the new documentation around 'Born in Sheffield' and I am concerned by reference to 'normal birth' on the checklist. Again, this appears as though it is encouraging expectant mothers to be influenced into a natural birth when they may prefer to explore options such as caesarean section. Language is hugely important in terms of the experience individuals have when vulnerable. 5. Evidence was given about fresh eyes on continuous heart rate monitoring but there appear to be no safeguards in place for those not on continuous heart rate monitoring.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action. I would ask that your responses specifically consider the following:- 1. Engagement with families and especially expectant mothers about their preferences for birth. The real pros and cons of consultant led and midwife led care. 2. How the unit will work on culture to ensure that those who have the most knowledge are supported to lead decision making and not be talked out of that decision upon the arrival of someone more senior or more experienced. 3. Guidance for how to make safe decisions. 4. The equivalent safeguard for expectant parents and babies of fresh eyes when they are not on continuous heart rate monitoring 5. How expectant parents know exactly what to expect from a labour and what level of service they should expect. Make the NICE guidelines accessible so that parents are true partners in their care.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 21st June 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 [redacted] and Sheffield Teaching Hospitals NHS Foundation Trust. 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 other person who I believe may find it useful or of interest. In this case I have sent a copy of this report to NHS England and to NHS Sheffield CCG and the South Yorkshire and Bassetlaw ICS as the legacy organisation for CCGs. 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.
9	**25th April 2022**  Abigail Combes **Assistant Coroner**