REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Coroner
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 March 2021 I commenced an investigation into the death of Oliver Christopher Lindsay. The investigation concluded on the 2nd February 2022 and the conclusion was one of narrative: Died of the recognised complications of an unexpected placental abruption. The medical cause of death was 1a Severe Hypoxic Ischaemic Encephalopathy 1b Placental Abruption on a background of fetal growth restriction
4	CIRCUMSTANCES OF THE DEATH On 4th September 2020 Oliver Christopher Lindsay was identified as having fetal growth restriction following a scan at 38 + 5 weeks. In the early hours of 6th September 2020 whilst at home his mother had a sudden and unexpected placental abruption. Oliver was born at home very quickly with the support of the ambulance service. He was immediately given advanced paediatric life support and was transferred to Stepping Hill Hospital. It was identified that he had suffered a severe hypoxic brain injury as a consequence of the placental abruption. He was transferred to Royal Oldham Hospital where he died on 12th September 2020.
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. At his mother's midwife check-up, it was identified that Oliver may have fetal growth restriction and that a scan was urgently required. A referral was made to the acute trust. However scanning capacity issues meant that there was a delay in an appointment being offered. Oliver's parents were very concerned and felt they had no choice but to pay to have a private scan which did confirm fetal growth restriction and resulted in his mother attending the acute trust to be seen. The inquest heard evidence that there were capacity issues in relation to growth scans nationally particularly after a bank holiday or a weekend. 2. The inquest heard evidence from a number of obstetricians about the very significant risks fetal growth restriction presented to the health of a baby. There was clear evidence that the risks of fetal growth restriction were not widely understood outside experienced obstetric professionals and that greater understanding and clarity of the risks was important in helping all those involved. This was particularly true in relation to parents faced with a sudden change at a difficult time. It was suggested during the inquest that as part of the Saving Babies bundle a FAQ sheet should be developed for parents which set out what fetal growth restriction is ; the risks it presented to a baby at various stages of a pregnancy and the national guidance to reduce risk.
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 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 Next of Kin, Stepping Hill Hospital, Royal Oldham Hospital and North West Ambulance Service 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	 Ms Alison Mutch HM Senior Coroner HM Coroner's Court Manchester South