Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

1 Department of Health and Social Care

1 CORONER

I am Professor CE MASON, Senior Coroner for the area of Leicester City and South Leicestershire

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 Ninth April 2019 I commenced an investigation into the death of Harrison Colin Hassall aged 2 Days. The investigation concluded at the end of the inquest on Ninth March 2020. The conclusion of the inquest was:

Natural causes

The cause of death was established as:

I a Hypoxic ischaemic encephalopathy

I b Delayed delivering

I c

II

4 CIRCUMSTANCES OF THE DEATH

Harrison Hassall was born pre-term and breech at the Leicester Royal Infirmary on 12th January 2019 following delayed delivering contributed to by the failings of healthcare professionals upon whom he was dependent. As a result, he sustained brain damage and died peacefully on 14th January 2019 at the hospital with his parents and family present.

5 **CORONER'S CONCERNS**

The MATTERS OF CONCERNS are as follows:

It was highlighted in evidence that midwives may be permitted to work in the community too soon after qualifying and therefore may not have enough experience. The University Hospital of Leicester NHS Trust have indicated that they will be reviewing the appropriate Grade that a midwife should have attained before taking up a community post. This is not a matter that is relevant to only Leicester.

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 8th July 2020. 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] (Mother)
[redacted] (Father)
[redacted]
University Hospitals of Leicester NHS Trust,
East Midlands Ambulance Service

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

Professor Catherine E. Mason
H.M. Senior Coroner
Leicester City & South Leicestershire

Honorary Professor
East Midlands Forensic Pathology Unit
(Leicester Cancer Research Unit)

Tel: 0116 454 1030

Dated: 12 May 2020