ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Hull University Teaching Hospitals NHS Trust, Hull Royal Infirmary, Anlaby Road, Hull, HU3 2JZ, For the Attention of [redacted] Chief Medical Officer, Trust Headquarters**
1	**CORONER** I am Kevin McLoughlin, Senior Coroner, for the Coroner area of West Yorkshire (East).
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 5th September 2017 an investigation was commenced into the death of Serena Jane Nicholas, a new born baby. The investigation concluded at the end of the Inquest on Monday 11th November 2019. The conclusion of the Inquest was a narrative conclusion based upon the cause of death: 1(a) Intrauterine hypoxia, 1(b) Infant of a diabetic mother.
4	**CIRCUMSTANCES OF THE DEATH** Serena Jane Nicholas died on Wednesday 30th August 2017 at 0010 hours at Leeds General Infirmary, shortly after she was born by a category 1 emergency Caesarean section performed at 2224 hours on 29th August 2017. The pregnancy was complicated by virtue of (1) the mother's type 1 diabetic condition which was poorly controlled and (2) a truncus arteriosus fetal heart abnormality identified on a 20 week scan. When the mother attended the maternity unit at the tertiary centre the evening before the planned C-section the following day, the fetal heart was found to be bradycardic, necessitating an immediate C-section. The baby was born in poor condition and died shortly afterwards.
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 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 antenatal surveillance was largely carried out in Hull where the mother lived. She was seen by a variety of clinicians and at a late stage by a community midwife, despite the recognition that this was a pregnancy accompanied by clear risk factors. The absence of identified consultants responsible for the oversight of mother and baby's care in relation to diabetic and gynaecological aspects resulted in disjointed management.

	(2) The tertiary centre where the C-section (and the subsequent open heart surgery envisaged) were to take place, were not aware that the baby had been inactive for some days before the planned C-section (because the mother had not reported this and had not had contact with clinicians since the clinical appointment with a community midwife on 24/08/17). In consequence, a serious adverse development went unheeded until stumbled across on the eve of the C-section. In view of the history of the pregnancy continuity of care and close monitoring of a high risk pregnancy led to a situation in which the desirability of advancing the C-section by say, a week, was not recognised.
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 no later than 5pm on Friday 17th January 2019. 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: 1) [redacted] 2) [redacted] Clinical Lead for Obstetrics, Leeds Teaching Hospitals; and to the Local Safeguarding Board. I have also sent it to: 1) [redacted] Leeds Teaching Hospitals; 2) [redacted] Capsticks Solicitors; 3) [redacted] Consultant in Obstetrics and Gynaecology – Hull; 4) [redacted] Consultant in Diabetes and Endocrinology – Hull; 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	**14th November 2019** **Signed:** Kevin McLoughlin **Kevin McLoughlin** **Senior Coroner** **West Yorkshire (E)**