Summary of Regulation 28 Report to Prevent Future death: Manhareen Kaur (died 23/07/2020)

Royal College of Paediatrics and Child Health
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This is a brief summary of the regulation 28 coroners report into the death of *Manhareen Kaur* from which you can review the coroner recommendations to health care and consider whether there are changes you could implement in your local NHS trust to address them

Clinical summary

Cause of death: Sudden unexpected postnatal collapse.

Events around time of death:

- Born in good condition via Kiwi delivery at 09:39.
- PEEP @8 minutes of life for grunting-> resolved
- Ongoing observations for ?maternal sepsis
- Normal observations @ 10:30am & 11:00am
- Found cold and floppy at 11:33.
- Resuscitated and transferred for cooling
- Died on day 2 from severe HIE

Coroner's Recommendations

- Establish a monitoring system for neonatal collapse in those with risk factors (such as assisted delivery, brief resuscitation, meconium etc), but not unwell enough to need neonatal unit care
- To occur on postnatal ward & to not interfering with mother and baby bonding.

Key Themes

- Need to improve risk stratification so patients are cared from in the appropriate clinical area with adequate monitoring
- Difficulties in recognising deterioration in health.

Local Improvement suggestions from this report

- **Review of local criteria for admission to neonatal care post-delivery to ensure that it is appropriate**
- **Consider improvement project to institute enhanced monitoring of neonates with increased risk of neonatal collapse on the post-natal ward**
- **Co-produce improvement project with parents to help to facilitate real time escalation of concerns on the postnatal ward.**

For full information visit:
https://www.judiciary.uk/prevention-of-future-death-reports/manhareen-kaur-prevention-of-future-deaths-report/
or follow the QR code