During this inquest, I have heard evidence from the following witnesses :

1. [redacted]
2. [redacted]
3. [redacted]
4. [redacted]
5. [redacted]

We have also referred to the medical records.

I have been assisted by comments and questions from the family, as well as questions put to us in writing before this hearing.

Not every child death requires a coroner's inquest, no matter how sad that death is. This case required an inquest because the cause of death was unknown. There must always be an inquest in those circumstances.

One way to deal with this case would have been to carry out what is called a Rule 23 inquest. Rule 23 relates to the Coroners' (Inquest) Rules 2013. If I had done the inquest that way, I would simply have read a witness statement aloud in court, together with the post mortem evidence, and then have reached my conclusions.

Sadly, it is often the case that we cannot be clear as to the cause of death for some young children and babies. I wanted to give this investigation the best possible chance to have a clear cause of death. That is why I asked a number of very senior witnesses to give evidence, with the pathologist listening to the evidence, and also able to put questions to the witnesses. It was also important for [redacted] family to know that they are at the heart of this investigation, and that their concerns have been taken into account.

Part of every inquest is also considering whether anything should change in the future, to reduce the risk of any other deaths occurring.

I would like to think about the post mortem evidence first. Unfortunately, despite all our best efforts, the pathologist was unable to be any clearer about wh[redacted]died. She found no evidence of trauma, nor evidence of any natural disease which played a part in causing his death. He did have some bruises and grazes, as well as a fracture to his shoulder blade, but these were injuries thought to be caused by his delivery, especially because forceps were used. The doctor who looked at [redacted] brain after death also found evidence of a short period of reduced oxygen to his brain. He could not be certain as to when this occurred, but he said it was likely to have happened in the last 12 hours of his life.

This does not mean that there was direct damage to his brain which caused his death, but that something caused his brain to have less oxygen at some point in the last 12 hours of his life. Unfortunately, we are not in a position to say what that "something" was. Sadly, this happens sometimes in baby cases. We cannot say what the cause of [redacted] death was with any confidence.

Because we cannot be clear about the cause of [redacted] death, we cannot say that, if he had received different treatment, then he would have survived. That is straight forward logic. I have explored many aspects of [redacted] management to see whether we could clarify this further, and we simply have been unable to do so. The hospital has accepted criticism in relation to how the labour was managed, but [redacted] was born well, and the reason for his sudden deterioration remains unclear.

We heard in evidence that it is fairly common for new babies to develop a condition called jaundice, when their skin and eyes become yellow, because they have too much bilirubin in their system. One of the ways that the bilirubin is broken down is by using light, or phototherapy. When a baby is having light therapy, their temperature needs to be checked. This is often because babies can become cold without a lot of clothing on. There was a factual dispute between the family on the one hand, and the hospital evidence on the other. The family said that [redacted] emperature was not taken at 0450, as the hospital evidence suggests. Of course, the only witness for the family whose evidence I can rightly take into account here is that of [redacted] as she was there. This was not an issue raised by the report carried out by the HSIB (health service investigation branch). I have looked at this point, based on the evidence I have heard, but more importantly, based on the records we have looked at today. It seems to me likely that [redacted] temperature was taken shortly before phototherapy began. We know that the light therapy began at around 2045 hours on the 11th of December 2020. The records show that his temperature was recorded after that time at 0054 hours and 0450 hours on the morning of 12th of December. We looked at the very specific times on the recording of his temperature, and heard evidence that these times are automatically generated when a temperature is recorded on the computer. It is not possible to enter an observation for a baby at a later time, but have the computer show it as an earlier time. On that basis, I find that temperature readings were taken at 00.54 and 0450. Both temperatures were normal, at 36.9 degrees centigrade.

We also spent some time looking at the eye mask that was used to protect [redacted] yes whilst he was having phototherapy. We thought about whether it was possible that the eye mask had slipped down and blocked [redacted] nose and mouth. We watched a short video that the family kindly provided us with. It is important to recognise that in that video, [redacted] s crying. The only reason that I mention that is because that shows that he was able to breathe. The mask does look low, but it does not cover his mouth. That of course is just a snapshot and we do not know the position of the mask at all times. We heard that the material used is breathable material, but we cannot be completely sure that this did not play a role.

In this court, I have to deal with what is likely, rather than what is certain. I do not have either a certain or even a likely cause of [redacted] sudden deterioration on the morning of 12th of December.

We heard that [redacted] became very concerned about [redacted] at around 0710 on the 12th of December 2020. Resuscitation efforts were sadly unsuccessful, and he died that morning.

As referred to above, the pathologist can only give us a cause of death which is Sudden Unexpected Death in Infancy.

I hope it was helpful for the family to hear about the hospital's investigation, and the things that they have changed and learned from this investigation. Although the evidence does not suggest

that the care he received caused his death, it is important that any tragedy like this is learned from, and I can see that the trust has taken this seriously and made important changes, so there is no doubt about how labour should be monitored, how staff should raise concerns, and how babies having light therapy should be looked after. I did wonder whether the mask manufacturer is aware of this case. I am aware that a different mask is used now, and I am not suggesting this caused [redacted] death, but the manufacturer may also be able to review the design to reduce the risk of slipping as far as possible. Of course, it is unlikely that all slipping can be prevented in a baby who is moving around. If appropriate, this should also be raised with the MHRA (Medicines and Healthcare products regulatory agency).

I mentioned at the start of the inquest that I have to answer 4 questions in every case. I include my answers to those four questions in a document called a Record of Inquest. I will record my findings as follows :

The name of the deceased is [redacted]

His cause of death is Sudden Unexpected Death in Infancy.

In answering the question of how when and where he died, I will record :

[redacted] died at Royal Berkshire Hospital, London Road, Reading on 12th of December 2020, which was three days after his birth. Despite extensive investigations and post mortem testing, a cause for his sudden deterioration on 12th of December has not been found.

I will record a narrative conclusion as follows :

[redacted] was a much loved baby who was born well, but who, for reasons unknown, deteriorated suddenly in the last few hours of his life.

In drawing this investigation and inquest to a close, I would like to thank those who have assisted as part of this very sad case.

Most importantly, I would like to thank [redacted] family, who have participated in this investigation with great patience and dignity. I am quite sure that the last two days must have been extremely painful for you, and that the wait for this inquest must also have been extremely difficult. Thank you for the dignity which you have shown us, and I end by offering you my sincere condolences.