Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court, 29 Wood Street,
Barnet EN5 4BE

Clerk to H.M. Senior Coroner
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Department of Health and Social Care, 39 Victoria Street, London, SW1H 0EU
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern District of Greater London
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 the 12th March 2018 I opened an inquest touching the death of Alba May Pemberton , 2 days old. The inquest concluded on the 12th June 2018. The conclusion of the inquest was "Consequences of complications during the second stage in childbirth.", the medical case of death was 1a Hypoxia, 1(b) Ischaemic Encephalopathy.
4	**CIRCUMSTANCES OF THE DEATH** On the Tenth of August 2016 Alba was born having suffered a period of hypoxia during the active stage of the second stage of the delivery. It is likely that by 21.45 hrs on the Ninth of August the active second stage had begun and that auscultation of the heart should have taken place every 5 minutes, this level of monitoring did not start until 23.12, This period had a bearing on Alba's death in that there is a possibility that 5 minute monitoring would have lead to the discovery of hypoxia at an earlier stage. If a CTG equipment had been used the trace is likely to have been abnormal for a considerable period and earlier delivery is likely to have resulted in Alba surviving. Alba was born seriously unwell as a consequence of the hypoxia and had only two days of life
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. – The presence of meconium should be classified as meconium, and not graded, and once present should result in the use of CCG equipment. That every patient at a birthing centre should be the subject of obstetric review

	That obstetricians should be more involved in the management of low risk cases There should be MDT meetings with the obstetric staff and midwifery staff and obstetric staff encouraged to work closely together in the management of low risk cases.
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 the 5th November 2018 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;- Representatives for the Trust and the Family. 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	**10-9-2018**