H M Senior Coroner for Gloucestershire
Ms Katy Skerrett

| | |
|---|---|
| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br>**Chief Executive, Ms D Lee, Gloucestershire Hospitals NHS Foundation Trust, Gloucestershire Royal Hospital, Great Western Road, Gloucester, GL1 3NN** |
| 1 | **CORONER**<br><br>I am Katy Skerrett, Senior Coroner for Gloucestershire. |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On the 16th February 2018 I commenced an investigation into the death of Elisa Fuller. The investigation concluded at the end of the inquest on the 10th October 2019. The conclusion of the inquest was a narrative conclusion. The medical cause of death was 1A Cardiac Arrest, 1B Unexplained idiosyncratic reaction to suxamethonium, 2 Prematurity. |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>At 10.46 hours on the 9th February 2018 Elisa Fuller was delivered by elective Caesarean section at 36 weeks gestation due to placenta praevia. Elisa showed no evidence of compromise at delivery. From approximately 12.50 hours she began to display emerging symptoms of respiratory distress. Concerns about these symptoms were not escalated to either a Senior Midwife and / or a Senior Paediatrician. No medical review occurred until approximately 16.25 hours. This resulted in Elisa's admission to the neonatal unit being delayed. However that delay did not contribute to her deteriorating condition. As her condition continued to deteriorate she was intubated. Premedication with morphine and suxamethonium (a muscle relaxant) was prescribed prior to intubation together with atropine. These drugs were administered at approximately 19.27 hours, and immediately thereafter Elisa suffered an idiosyncratic reaction to suxamethonium which triggered a cardiac arrest. Full resuscitation efforts were carried out, to which Elisa did not respond. The underlying cause of her reaction to the relaxant remains unclear. It is likely to be related to a neuromuscular disorder, but no genetic cause has been identified. Resuscitation efforts were ceased at 20.28 hours, and Elisa was pronounced deceased. |
| 5 | **CORONER'S CONCERNS**<br><br>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. Although I acknowledge that the Trust have put in place systems to address the second concern. In relation to the first concern, further training has been put in place. However there remains work to be done. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br>(1) Whether there is appropriate support and systems in place to encourage Junior Midwives and Junior Doctors to escalate any concerns they have to more Senior Colleagues,<br>(2) Whether there is sufficient understanding of the need to retain placentas post delivery |

| | |
|---|---|
| | for a specified time period prior to disposal. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 4pm 12th December 2019. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons<br>(1) [redacted]<br>(2) Clinical Improvements Manager, [redacted], NHS England and Improvements, St Chads Court, 213-215 Hagley Road, Birmingham BI6 9RG (reference point 2 in paragraph 5.)<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 | Dated 17th October 2019<br><br>Signature_____<br><br>Ms K Skerrett<br>Senior Coroner for Gloucestershire |