IN THE SURREY CORONER'S COURT
IN THE MATTER OF:

The Inquest Touching the Death of Theo Benjamin Young
A Regulation 28 Report – Action to Prevent Future Deaths

	THIS REPORT IS BEING SENT TO: • HSIB • Secretary State for Health • Chief Executive, NHS England • Chief Executive, East Surrey Hospital
1	**CORONER** Dr Karen Henderson, HM Assistant Coroner for Surrey
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.
3	**INVESTIGATION and INQUEST** The inquest into the death of **Theo Benjamin Young** was opened on 28th November 2018. It was resumed on 9th March 2020 and was concluded on 10th March 2020 The medical cause of death was found to be: 1a. Hypoxic ischaemic injury and hyaline membrane disease 1b. Perinatal hypoxia Conclusion: **perinatal hypoxia contributed to by neglect**
4	**CIRCUMSTANCES OF THE DEATH** Theo's mother was admitted to East Surrey Hospital on the 24th May 2018

RT4563

for induction of labour, due to pre-eclampsia, when 40+3 days pregnant.

On the 25th May 2018, a CTG (cardiotocograph) recording prior to induction of labour to assess Theo's well-being in utero was found to be normal. Before induction, Theo's mothers 'waters' broke and was found to contain a significant amount of meconium. As a consequence, she was promptly transferred to the labour ward at or around 12.30 to have 1:1 care, continuous CTG monitoring and if necessary, facilitate delivery.

On admission to the labour ward a midwife facilitator recognised the CTG showed 'reduced variability' which could indicate baby Theo was compromised in utero. The obstetric senior trainee was informed, and Theo's mother was prepared for a possible caesarean section (LSCS).

Labour ward was busy at that time. At or around 1430, maternal care was allocated to a newly qualified midwife (NQM), who was also new to the Trust and in her first week of a two-week supernumerary induction period, supervised by 'her buddy', who was a senior midwife.

The senior specialist registrar obstetrician attended at or around 1440 to assess the CTG trace. He attempted but failed to attach a fetal scalp electrode (FSE). An emergency LSCS was put on hold as steps taken to improve the CTG trace (fluids, stimulation of the baby, mother changing position) were effective. The SpR advised continuous CTG monitoring and augmentation with oxytocin to progress labour.

From around 1430 until 1840 the NQM was left to care for the 'high risk' mother for more than 50% of the time on her own or in association with the supervising midwife. During that time failures in the care included:

1. The labour ward co-ordinator did not inform the supervising matron of staffing and poor skill mix issues on labour ward thereby allowing the NQM to care for a 'high-risk' delivery despite not expected to do so during her supernumerary induction.

2. Failure of NQM and supervisor to obtain or maintain a consistent and continuous CTG recording with frequent loss of contact on a background of a high BMI (41.3).

3. Failure to recognise the presence of any persistent abnormalities in the CTG including reduced variability, artifacts and decelerations indicating baby Theo was distressed and becoming increasingly so throughout the afternoon.

	4. Failure to recognise the CTG trace had been pathological for 50 minutes at or around 1550 and at no time thereafter when it was progressively more so and was not recognised as such until a routine review by the on call consultant obstetrician at 1840. 5. Failure to ensure an independent 'fresh eyes' hourly review of the CTG trace throughout the afternoon as was expected practice, with the NQM and supervising senior midwife reviewing the CTG trace themselves, thereby losing the opportunity to pick up a concerning CTG trace earlier. 6. Oxytoxcin was commenced and increased incrementally without an adequate CTG trace to be able to assess Theo's wellbeing on a background of maternal distress from poor pain relief. 7. Maintaining and increasing oxytocin infusion despite poor progression in labour and whilst waiting for analgesia in the presence of unrecognised inadequate CTG trace. 8. Failure to inform a more senior midwife or obstetrician to assist in the assessment and management of labour at any time, including after a failed attempt by the NQM at attaching a FSE. An immediate lower segment caesarean section (LSCS) was carried out shortly after the on-call consultant obstetrician recognised the severity of the pathological CTG trace. Theo was born at 19.12 hours in a very poor condition. Despite full and active resuscitation and transfer to a tertiary neonatal unit, it was recognised that Theo had suffered non-survivable injuries from intrapartum hypoxia and he died three days after delivery on the 28th May 2018. The Court heard evidence that the CTG should have been recognised as pathological at or around 1600, which would have led to a LSCS no more than 30 minutes later and if so, it was more likely than not that Theo would not have died when he did.
5	**CORONER'S CONCERNS** The **MATTERS OF CONCERN** are in relation to the role of the HSIB in their conduct, investigation and conclusion:

	1. The HSIB specifically requested the Trust not to undertake their own investigation effectively preventing the recognition of causes of concern and therefore being unable to undertake any immediate and necessary remedial action at the earliest opportunity to prevent future deaths. 2. HSIB indicated to the Trust at the outset that their investigation would take approximately six months which is highly likely to delay the introduction of any immediate necessary measures by the Trust to prevent further deaths. 3. The initial draft report contained factual errors and inaccuracies requiring considerable input by the Trust to resolve. The final report is insufficiently detailed and was completed 18 months after the death, during which time further deaths could have resulted. Consideration should be given to whether any steps can be taken to address the above concerns. Other matters were brought to the attention of the court outside of PFD matters which raise considerable concern as to the role and actions of HSIB which I will deal with in a letter to them in due course and will be shared with other relevant bodies.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the people listed in paragraph one above have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of its date; I may extend that period on request. Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise you must explain why no action is proposed.
8	**COPIES** I have sent a copy of this report to the following: 1. See names in paragraph 1 above

	2. [redacted] 3. President, Royal College of Obstetrics and Gynaecology 4. Care Quality Commission 5. Chief executive, Nursing and Midwifery Council In addition to this report, I am 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 at the time of your response, about the release or the publication of your response by the Chief Coroner.
	Signed: **Karen Henderson** **DATED this 20th day of April 2020**