	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Nottingham University Hospitals NHS Trust**
1	**CORONER** I am Laurinda Bower, HM Assistant Coroner for **Nottingham City and Nottinghamshire**
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 15 September 2019, I commenced an investigation into the death of WYNTER SOPHIA ANDREWS. The investigation concluded at the end of an inquest heard over 3 days on 24 September 2020, with Judgment handed down on 7 October 2020. The conclusion of the inquest was that WYNTER SOPHIA ANDREWS died as a result of: 1a. Hypoxic Ischaemic Encephalopathy 1b. Fetal inflammatory response and Fetal Vascular Malperfusion 1c. Acute Chorioamnionitis and Umbilical Cord Compression during labour And that her death was contributed to by Neglect.
4	**CIRCUMSTANCES OF DEATH** Sarah Andrews was admitted to the Birth Centre at the Queen's Medical Centre, Nottingham, on 14 September 2019. On that day, and the following day, the Unit operated in a fundamentally unsafe manner. There was an insufficient staff to patient ratio, such that Sarah Andrews did not receive the care and attention that she clinically required. Custom and practice replaced adherence to the National and Local Guidelines. Decisions about clinical care were made without recourse to the patient, the patient's notes, and at times without consideration of individualised risk. Decisions that ought to have involved multidisciplinary professionals, were made unilaterally, and without having considered all of the available patient information. As a result, there were multiple missed opportunities to provide additional monitoring of baby Wynter's wellbeing, and to have taken action if that monitoring had shown that baby Wynter was in distress. On 15 September 2019, when baby Wynter was first afforded continuous CTG monitoring, the trace ought to have been classified as Pathological from at least 12.20 hours when considered in the context of delayed

	labour and other obstetric risk factors, and Wynter ought to have been delivered by caesarean section well before 14.06 hours when she was in fact delivered. If baby Wynter had been delivered earlier, it is likely that her death would have been avoided. Her death was contributed to by Neglect.
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. – 1. Lack of robust initial critical analysis of deaths Prior to 1 October 2019, when the Notification of Deaths Regulations 2019 came into force, the Trust were mandated by local agreement to refer every child death (even expected deaths) to HM Coroner. However, the implementation of the Regulations, removed the discretion of coroners to set local referral criteria. Wynter's death occurred just two weeks prior to the implementation of the Regulations, and was therefore referred to HM Coroner as 'standard procedure'. The referral itself expressed that Wynter's death was 'Expected' and as a result, there had been no review performed by the Rapid Response Clinician for Unexpected Paediatric Deaths. The checklist on the reverse of the referral to HM Coroner indicated that the only trigger for referral was the "Deceased's Age". The boxes for neglect, unnatural death, allegations of negligence, and death associated with a clinical incident were all left unticked. The detail within the body of the report made no reference to any of the failings that have become apparent throughout the inquest, and indeed, would have been apparent upon robust scrutiny of the CTG trace and medical records available at the time. The referral explained that the reporting doctor was happy to propose a cause of death, and happy to complete the Medical Certificate of Cause of Death. The effect of this, would have meant Wynter's death being registered as a natural death and without investigation by the Coroner. As is usual practice, before the Coroner reaches a decision, the Coroner's officer makes contact with the family to see if they have any concerns. Understandably, this is a shocking and upsetting time for the family, but they had the clarity of thought at that stage to express some concerns about the events leading up to labour, which were sufficient for the Coroner to direct an independent post mortem examination. The full picture then unfolded through the coronial investigation and the separate Health Sector Investigation Branch inquiry. I am concerned that the lack of robust initial critical analysis of deaths has the potential to lead to missed opportunities to learn lessons that are vital to improving patient safety. Mrs [redacted] agreed that one of the recommendations to come out of this inquest is a review of the current 72-hour table top review of care. This risk goes beyond obstetric deaths and has the ability to prevent learning from deaths within other Divisions of the Trust. For that reason, I am informing the Trust's Chief Executive of my concerns through a PFD report.

2. The unsafe culture prevailing within Midwifery Services

(a) Failure to listen to and respond to staff safety concerns

I have made findings that the Maternity Services were operated in an unsafe manner on 14 – 15 September 2019. Staff told me this was not the first time, nor the last time, that they have been asked to care for multiple families simultaneously, meaning that those families cannot receive the time, focus and dedication they require. Staff further told me that they have repeatedly raised their concerns about patient safety, but their concerns have been met with silence. I saw evidence that staff were repeatedly raising their concerns through the Datix system, but they told me they would receive no feedback in reply nor would anything change.

(b) Failure to promote and facilitate professional challenge

Midwives spoke of their inability to professionally challenge plans made by medical staff, even in circumstances where they felt the plan might harm mother or baby. The culture failed to promote professional challenge and multi-disciplinary care of women. Decisions were often made in isolation, without understanding the full background and patient wishes.

(c) Failure to reach decisions based on individualised patient risk

It was custom and practice that critical decisions, such as which patient to transfer to the labour suite when demand outstripped supply, were made in isolation without reading the patient notes, speaking with the midwife caring for the patient, without seeing the patient, without seeking medical input and, crucially, without assessing individualised patient risk at the point the patient was unable to receive the care on the labour ward that they required.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take action in relation to the above matters (1) Nottingham University Hospitals NHS Trust
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **4 December 2020**. I, the coroner, may extend the period upon receipt of written request. 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** In addition to the organisations identified in section 6 above, I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: The Andrews Family and their lawyers The Health Sector Investigation Branch The Care Quality Commission I am also under a duty to send the Chief Coroner a copy of the responses received from the organisations listed in section 6 above. 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	9 October 2020 Signature_____ Laurinda Bower, Assistant Coroner, **Nottingham City and Nottinghamshire**