**REGULATION 28: REPORT TO PREVENT FUTURE DEATHS**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>Chief Executive<br>London North West University Healthcare NHS Trust,<br>Watford Road,<br>Harrow.<br>HA1 3UJ |
| 1 | **CORONER**<br><br>I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London |
| 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 1st and 2nd March 2022, evidence was heard touching the death of **Manhareen Kaur.** This baby was born at Northwick Park Hospital on 21st July 2020 at 09:39. At 11:35 she was found by the midwife unresponsive. She was resuscitated and transferred to St Mary's Hospital for therapeutic hypothermia but died on 23rd July 2020. She was 2 days old at the time of her death.<br><br>**Medical Cause of Death**<br><br>1 (a) Sudden Unexpected postnatal collapse<br><br>11 Kiwi assisted vaginal delivery at term<br><br>**How, when, where the deceased came by her death:**<br><br>Manhareen was born by kiwi assisted delivery at 09:39 on 21st July 2020 at Northwick Park Hospital. She was well at birth. She was noted to be feeding at 11:00 by the midwife who then left the room. At 11:33, on the midwife's return she was found to be cold and floppy. She had arrested at some time between 11:00 and 11:33. Despite all active resuscitation and transfer to St Mary's Hospital for cooling and ventilation, she had suffered overwhelming brain damage and died in her mother's arms at 11:39 on 23rd July 2020, in the neonatal unit at St Mary's Hospital.<br><br>**Conclusion of the Coroner as to the death:**<br><br>Sudden unexpected postnatal collapse of cause unknown |
| 4 | **Circumstances of the death.** |

Extensive evidence was taken and accepted by the court. In summary:

Manhareen had had an assisted delivery by the consultant obstetrician in theatre due to foetal tachycardia following her mother requiring antibiotics during the night for tachycardia and pyrexia in labour.
The baby was passed to the paediatrician. There was some thin meconium from the nose but she was well at birth. At 8 mins she had developed intermittent grunting which settled with two periods of PEEP.
At 30mins of life she was well and fit to be transferred to the ward with recommended observations at 1hr, 2hrs and 4hrs of life according to the Kaiser Permanente calculation, to be performed by the midwife.

She was transferred with her parents to the ward.

Her first set of observation at 10:30 of life were normal. At 11:00 observations recorded were normal but there was no record of the respiratory rate.

She was found arrested at 11:33.

It was clear from the evidence that the parents had concerns about their daughter having a floppy arm before 11:00 am and that the midwife left them alone for long periods as she performed other duties.

By the time Manhareen had been discovered collapsed at 11:33 she had suffered irreversible brain damage.

Expert evidence was consistent that she was a normally developed baby and not died as a result of sepsis.

Questions remain as to whether if she had been noted to have collapsed earlier she would have survived.

There is currently no system for monitoring of babies who have discharged to the postnatal ward, even if they required assisted delivery and/or some resuscitation before transfer to the ward.

It was discussed in evidence with the independent expert neonatologist that monitoring via pulse oximeter, or heart and respiratory monitors may be beneficial for babies that have not required admission to PICU but have had deliveries complicated by assistance or early resuscitation, such as Manhareen, as this may allow arrests in the early postnatal period to be detected earlier, and appropriate treatment given, which may prevent death.

In the view of the expert, for appropriate cases, this would represent a middle ground of enhanced non-invasive monitoring for babies who have had a complicated delivery and are thus at increased risk of collapse whilst not interfering with bonding with the parents.

5 **Matters of Concern**

That babies at relative increased risk of early neonatal collapse due to deliveries complicated by factors such as assisted delivery, meconium staining, or early resuscitation assistance, are discharged back to the postnatal ward with no enhanced monitoring of their breathing, heart rate or oxygen saturations, unless they require admission to PICU or neonatal wards. In short that there is no “middle ground” which may allow early detection of collapse and thus increased chance of successful resuscitation should collapse occur.

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| 6 | **ACTION SHOULD BE TAKEN**<br><br>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. It is for each addressee to respond to matters relevant to them. |
| 7 | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report. 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><br>[redacted],<br>94A, the Broadway,<br>Southhall.<br>UB1 1 QF<br><br>[redacted],<br>Northwick Park Hospital,<br>London North West University Healthcare NHS Trust,<br>A404 Watford Road,<br>Harrow.<br>HA1 3UJ<br><br>Dr [redacted]<br>Consultant Paediatrician, Northwick Park Hospital,<br>London North West University Healthcare NHS Trust,<br>A404 Watford Road,<br>Harrow.<br>HA1 3UJ<br><br>Dr [redacted],<br>Consultant Paediatrician,<br>Department of Paediatrics,<br>Jenner Building,<br>Whittington Hospital,<br>Magdala Avenue,<br>London.<br>N19 5NF<br><br>Chair of Independent Review of Perinatal Death at London North West University Healthcare NHS Trust,<br>Northwick Park Hospital,<br>London North West University Healthcare NHS Trust,<br>A404 Watford Road,<br>Harrow.<br>HA1 3UJ |

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| | | HSIB<br>www.HSIB.ORG.Uk<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 | **8th April 2022**<br><br>**Professor Fiona J Wilcox**<br><br>**HM Senior Coroner Inner West London**<br><br>**Westminster Coroner's Court**<br>**65, Horseferry Road**<br>**London**<br>**SW1P 2ED**<br><br>**Inner West London Coroner's Court,**<br>**33, Tachbrook Street,**<br>**London.**<br>**SW1V 2JR**<br>[redacted]. |