Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **The Chief Executive** **Queen Elizabeth Hospital** **Gayton Road** **King's Lynn** **Norfolk** **PE30 4ET**
1	**CORONER** I am JACQUELINE LAKE, Senior Coroner for the coroner area of NORFOLK.
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 17 February 2022 I commenced an investigation into the death of Bonnie Rose WEBSTER aged 1 Days. The investigation concluded at the end of the inquest on 21 November 2022. **The medical cause of death was:** 1a) Severe Hypoxic Ischaemic Encephalopathy 1b) 1c) 2) **The conclusion of the inquest was:** Bonnie died from a placental abruption. The evidence does not reveal the extent to which delays before and after birth contributed to her death
4	**CIRCUMSTANCES OF THE DEATH** Bonnie's mother was admitted to Queen Elizabeth Hospital on 9 February 2022 with a history of spontaneous rupture of membranes with some bleeding. She was assessed as being in early stages of labour Cardiotacograph [CTG] at 06.20 was within normal range. Caesarian section was discussed should bleeding worsen or CTG raise concern At 06.50 the CTG was "suspicious" and Caesarian section was discussed again. It was not recommended or advised. At 07.10 the CTG was more concerning and "remained suspicious" and Caesarian section was to be considered At 07.36 fetal scalp electrodes were fitted (after sourcing a working cord) and this showed a decrease in heartrate. An examination raised further concerns. A Caesarian section was recommended and agreed to and the consent form signed at 07.50 The procedure was deemed a Category 2 (concerns not immediately life threatening) and not a Category 1 (concerns of immediate risk to life). It is accepted this was a Category 1 procedure. The procedure took place in Theatre 2 which staff were unfamiliar with. Mother's records had to be retrieved from the main Theatre. Theatre 2 did not have air in the resuscitaire. On another resuscitaire being brought to Theatre 2, it was found to be three quarters empty. There was no diamorphine in Theatre 2 and this had to

	be brought from the main Theatre. The Paediatrian was alerted on foot rather than by using the emergency beep system The results of blood tests taken at 06.30 hours were not available until after mother was taken to Theatre 2. Only one "group and save" blood sample was available, rather than two. Bonnie was born via emergency caesarean section at 08.46 hours in a poor condition, requiring resuscitation and was admitted to the Neonatal Unit at QEH for ongoing management. A neonatal review took place at 09.35 hours. Antibiotics prescribed during this review were given to Bonnie at 12.30 hours. Umbilical Cord Gas results were not available for 30 minutes. Tests showed low carbon dioxide levels. Bonnie continued to be placed on CPAP and was not intubated and ventilated until after arrival of the Transport team. Bonnie's blood glucose levels were not all checked. Bonnie was not prepared for cooling at the first available opportunity. Due to deterioration in her condition, Bonnie was transferred to NNUH that afternoon. Despite active treatment, Bonnie's condition continued to deteriorate and she died on 10 February 2022 at Norfolk and Norwich University Hospital.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) 1. The evidence of Mr and Mrs Webster is they were unaware of the seriousness of the situation. Caesarian Section was discussed but was not advised or recommended at the meeting at 06.50 hours. This was clearly a traumatic meeting and Mr and Mrs Webster were upset which would have impacted on their ability to understand and take in important information. In such a situation clear language and ensuring an understanding of the whole situation is paramount 2. Antiobiotics were prescribed at the initial review meeting at 09.35 hours. These were not given until 12.30 hours 3. Evidence was heard that staff alerted the paediatric team on foot, rather than using the emergency "bleep" system.
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 January 16, 2023. 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 Mr and Mrs Webster. I have also sent it to Department of Heath Care Quality Commission HSIB

	Healthwatch Norfolk NHS England and NHS Improvement who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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: 25/11/2022**  **Jacqueline LAKE** **Senior Coroner for Norfolk** County Hall Martineau Lane Norwich NR1 2DH