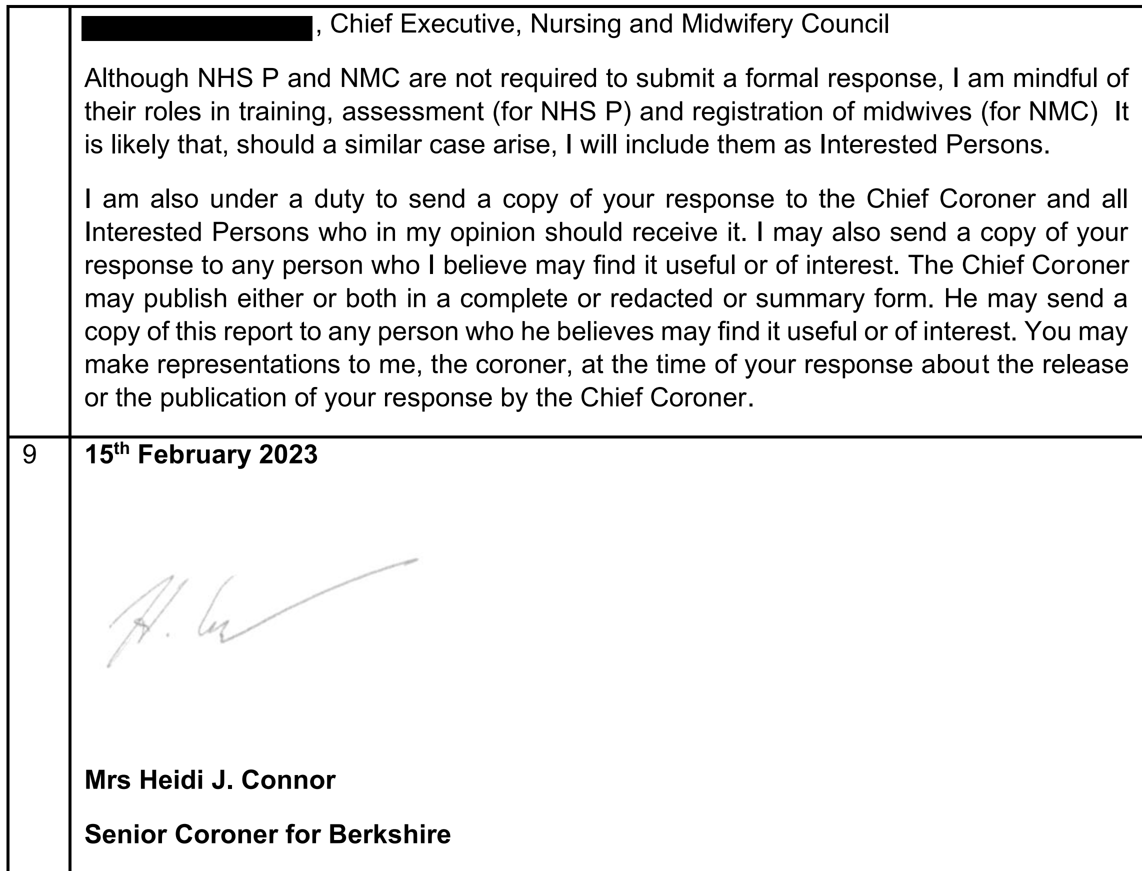
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Acting Chief Executive, Royal Berkshire NHS Foundation Trust
1	**CORONER** I am Mrs Heidi J. Connor, senior coroner for the coroner area of Berkshire.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 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** I conducted an inquest into death of Raniya Rizwan Khan at Reading Town Hall, which concluded on 9th February 2023. I recorded a conclusion of natural causes. Her cause of death was : 1a Multi-organ failure 1b Severe arterial pulmonary hypertension of unknown cause
4	**CIRCUMSTANCES OF THE DEATH** Raniya was born at 07:52 hours on 9th May 2020. Although I heard evidence about her attendance at the day assessment unit ('DAU') the day before the birth, and about her neonatal management, the focus of the inquest was on her labour management from the time of her admission to the labour ward at 03:45 on 9th May. Her care by a band 6 agency midwife from that time until shift change at around 7am was the focus of the investigation. I found in evidence that this midwife: 1. Failed to recognise a pathological trace. Both the trust's internal investigation and the report of an independent expert concluded that it should have been classified as pathological from 06:40 hours. This was largely because of reduced variability. 2. Conducted so called 'fresh eyes' reviews herself for this patient, rather than asking a colleague to do so. The reasons she gave for this significant, repeated and undocumented deviation from policy were inconsistent with the rest of the evidence, and I found them unlikely to be true. 3. Recorded the maternal rather than fetal heart rate for part of the trace. My understanding is that this can happen (briefly) even in experienced hands, but this was not recognised at the time by the midwife. 4. Did nothing to escalate or investigate the mother's high pulse rate. 5. Did not take regular temperature readings, despite spontaneous rupture of membranes happening some hours before, when Mrs Rizwan was admitted to the DAU and was given paracetamol for a raised temperature.

	Raniya was transferred to Great Ormond Street Hospital on 15th May 2020, when her condition deteriorated. Despite extensive consideration and re-consideration of all relevant treatment options, Raniya died at Great Ormond Street Hospital on 28th May 2020. I concluded that earlier delivery was unlikely to have changed the outcome. Despite extensive investigation (including genetic investigations) at a very senior level, it has not been possible to identify the cause of Raniya's pulmonary hypertension.
5	**CORONER'S CONCERNS** I sent a regulation 28 report to this trust on 20th June 2022, in relation to the death of a 6-day old baby born at Royal Berkshire Hospital on 26th June 2020. The circumstances of that case are different from these, but midwifery training and placenta retention are issues common to both cases. Placenta retention In their response to my previous Regulation 28 report, the trust said : *Previously, placentas in uncomplicated cases were being disposed of on a daily basis but I can confirm that the trust have implemented processes to ensure that all placentas are stored for 48 hours from the time of birth. We are advised by the pathology team that retaining placentas beyond this time would not provide reliable histology findings.* *In practical terms, placenta fridges have now been placed in the delivery suite and birth centre, and homebirth placentas will be placed in the birth centre fridge (the homebirth operating procedures have been updated to reflect this). Tutela monitors are operating in the fridges, which provide connected automated monitoring and alerts the clinical areas if there are any concerns with the temperature of the fridge.* *The Standard Operating Procedure (SOP) for placenta retention will be ratified at the Maternity Clinical Governance Meeting in October 2022 and will go live on 10th October 2022; it provides guidance on which placentas need to be sent to histology for pathological examination, as well as storing and retaining all placentas for 48 hours before disposal in uncomplicated cases. In order to disseminate this information, all of the trust's band 7 midwives and unit coordinators will be trained on the new SOP to ensure compliance throughout maternity, and in particular the midwives and community support workers. We are also working with waste management to ensure that their team are fully aware of the new processes, as they now need to request that a member of the midwifery team attends with them to ensure the correct procedures are followed.* *As an additional assurance, the safety huddle templates on our electronic patient system will be updated to prompt the team to ask whether any babies have deteriorated or been admitted from other areas in the last 24 hours to the pediatric wards, who are less than 48 hours of age and require ventilation, cooling or neonatal death. This measure will be introduced to ensure that placentas are not erroneously disposed of due to lack of communication between the maternity unit and pediatric ward.*

	It was surprising in the extreme to be made aware in open court on the final day of this inquest that these undertakings have not in fact been completed – the system referred to above is not in place, there is no SOP, nor has there been any staff training. It was particularly disappointing to hear this in front of a family who had themselves lost a baby and who were being reassured of how committed the trust is to improvement.
	
	<u>Midwifery training and management</u>
	
	I was also advised that there has been no approach made to NHS Professionals about concerns with the midwife in question. Similarly, no approach to the NMC has been made.
	
	It is fair to recognise that this trust is focused on improving obstetric and midwifery care, and they have increased their training and staffing – to include appointing a director of midwifery. Changes have been made regarding induction of agency staff. It seems likely that individual people in these new posts have a clear desire to improve the service and are themselves somewhat frustrated that these changes have not yet been made.
	
	I would ask therefore that the trust respond within the requisite 56 days (at the latest) in relation to the following issues:
	
	1. The current position with regard to :
	    a. Storage of all placentas for 48 hours, and SoP around this
	    b. Review of policies and staff awareness regarding mandatory sending of placentas for pathological examination.
	2. Training and awareness regarding these new policies – to include practical arrangements around ensuring a placenta is retrieved and sent to histology subsequently if needed.
	
	3. The trust should refer concerns about this individual agency midwife as a matter of urgency both NHS Professionals, and to the Nursing and Midwifery Council. This is in addition to raising of the possibility of an individual 'passport' to prevent a midwife moving between agencies to work elsewhere after significant concerns have been raised.

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you (and/or your organization) 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 14th April 2023. I, the coroner, may extend the period, however I have already indicated that an extension is unlikely to be granted in this case, given that these are not new issues. 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 Raniya's family. I have also sent a copy of this to : [redacted], Chief Executive, NHS Professionals



	[redacted], Chief Executive, Nursing and Midwifery Council Although NHS P and NMC are not required to submit a formal response, I am mindful of their roles in training, assessment (for NHS P) and registration of midwives (for NMC) It is likely that, should a similar case arise, I will include them as Interested Persons. 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	**15th February 2023** **Mrs Heidi J. Connor** **Senior Coroner for Berkshire**