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 University Hospitals of Derby and Burton NHS FT
1	**CORONER** I am Peter Nieto, Area Coroner for the coroner area of Derby and Derbyshire.
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 9 August 2022 I commenced an investigation into the death of Rachael Chloe WALKER aged 36. The investigation concluded at the end of the inquest on 3 March 2023. Article 2 of the European Convention on Human Rights was engaged due to the relevance to Chloe's death of hospital Trust policies and systems. The conclusion of the inquest was: - Chloe died of the effects of placental haemorrhage and amniotic fluid embolism at week thirty-seven of her pregnancy due to diagnosed placenta praevia. It is probable that her death would have been avoided if a delivery plan made for her had been recorded in her notes and acted upon, and if the relevant Trust had incorporated national guidance issued in September 2018 which provided for consideration for earlier caesarean delivery.
4	CIRCUMSTANCES OF THE DEATH Rachael Walker, known as Chloe, died in hospital on 19 June 2021 due to experiencing a placental haemorrhage and amniotic fluid embolism at the thirty seventh week of her pregnancy. Chloe had been diagnosed with placenta previa during her antenatal care. Chloe had antepartum haemorrhage at home on the early morning of 19 June 2021 and had to be taken to hospital by ambulance. At the maternity unit she experienced further haemorrhage and was taken for emergency caesarean section. Her baby was delivered but Chloe quickly went into the first of three cardiac arrests. On the evidence it is not apparent that there was a postpartum haemorrhage, but she did develop blood clotting disorder and disseminated bleeding, likely related to the placental haemorrhage and amniotic fluid embolism. Chloe sadly died in the operating theatre despite prolonged resuscitation attempts. Chloe had recognised risk factors in her pregnancy and the consultant obstetrician with lead responsibility for her care decided at an appointment at week thirty-four of Chloe's pregnancy on a plan to review Chloe at an appointment at week thirty-seven, with a view to offering hospital admission and planned caesarean section by week thirty-eight due to the placenta previa. That plan was not recorded in Chloe's notes with the result that the obstetric registrar who saw Chloe at week thirty-seven was unaware of the plan. Furthermore, the relevant hospital Trust had not adopted national guidance issued in September 2018 for consideration of delivery by caesarean section between weeks thirty-six and thirty-seven in Chloe's circumstances. Consequently, Chloe was booked for planned caesarean section at week thirty-eight as per Trust guidance. At inquest the Trust accepted these were missed opportunities to

	avoid Chloe's death and had they not been missed it is likely that Chloe would not have died because delivery would have occurred well before 19 June, or, if antepartum haemorrhage had occurred during admission, it would have been successfully managed. Although not clearly causal or contributory to Chloe's death, I identified the following serious issues from the evidence: - • The maternity unit did not have a system or proforma to note down and pass on to clinicians information provided by the ambulance service via the dedicated phone line to the unit. • Blood for urgent use in maternity unit surgery was not kept on or near to the maternity unit. • There was delay in calling for the on-call consultant anaesthetist to attend once the emergency caesarean section had been called. • There was no robust system in place for a major obstetric haemorrhage to be called and acted upon with resulting delay in the provision and use of blood products. • There was insufficient co-ordination and oversight of the emergency team and roles and tasks in the surgical theatre, in particular in oversight of obtaining and use of blood products. • Certain key equipment was not available for the maternity unit theatre: - - A blood storage fridge. - Warming equipment for women during surgery. - Point of care testing anticoagulation equipment.
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: - My principal concern is that having heard evidence from the Trust as to 'lessons learnt' and its current processes for identifying when Trust clinical policies and guidance needs updating, and where essential equipment needs to be obtained and located, I remain unclear that the Trust now has sufficiently robust processes in place to prevent similarly avoidable deaths to that of Chloe. Indeed, I am unclear that the processes are substantively different to those that existed at the time of Chloe's death. It was of very particular concern to hear that clinicians at the time were aware of revised national pregnancy guidance issued in September 2018 but this had not been incorporated into Trust policy and guidance. I was told that introducing revised guidance was necessarily complex and lengthy and yet the Trust did incorporate the revised guidance just several weeks following Chloe's death and it appears because of her death. It was also very concerning to hear that the Trust had established a regional pregnancy service using out of date guidance. Certain changes relating to the circumstances of Chloe's death have only very recently been addressed or are in process; for example, the procedure to call and respond to a major maternal haemorrhage was to be tested a week or two after the inquest. I therefore consider that the Trust should review its processes for identifying when Trust clinical policies and guidance needs updating, and where essential equipment needs to be obtained

	and located, in the interests of preventing future deaths, and that those processes should ensure timely revisions and associated actions.
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 May 11, 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:- • [redacted] (partner of Rachael Chloe Walker) • University Hospitals of Derby and Burton NHS FT • East Midlands Ambulance Service I have also sent it to: - • Health Service Investigation Branch (maternal deaths) • Care Quality Commission 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: 16 March 2023**  **Peter Nieto**

	Area Coroner **Derby and Derbyshire**