Regulation 28: Prevention of Future Deaths report

Phoenix Grace CHAPMAN (died 15.07.22)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Chief Executive** **Homerton Healthcare NHS Foundation Trust** **Homerton Row** **London E9 6SR**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 3 August 2022, I commenced an investigation into the death of Phoenix Chapman, a baby who died less than six weeks after he was born. The investigation concluded at the end of the inquest on 7 July 2023. I made a determination at inquest of death by natural causes. I recorded the medical cause of death as: 1a) hypoxic ischaemic encephalopathy and bronchopneumonia 1b) peripartum asphyxia 1c) cord compression 2 vaginal breech delivery and unplanned home delivery
4	**CIRCUMSTANCES OF THE DEATH**

	Phoenix was born unexpectedly at home and died as a consequence of a cord compression during the second stage of labour. His mother was attended by paramedics, but really what she needed was early hospital obstetric care.
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. That Phoenix' death was and remains utterly devastating for his parents is unsurprising. However, it was clear at inquest that it was also deeply shocking for those trying to care for him and his mum. Events were outside the experience of several of the healthcare professionals involved. I heard at inquest that new national maternity guidance is to be published at the end of the month. This will include within it revised advice for paramedics faced with an unplanned home delivery such as this one to transport to hospital even if birth is imminent. I was assured at inquest that the advice will quickly be disseminated. Had I not been given this information, I would have made a prevention of future deaths report to the ambulance service. It is of course of the utmost importance that hospital clinicians and ambulance clinicians have the same understanding of how a patient in any given situation should be treated, and I have copied this report to the London Ambulance Service (LAS). The reason I make a report to the Homerton, is because it seemed to me at inquest that there were two matters that had not yet been resolved. i) At inquest, there was not a shared understanding among the clinicians *within* the trust about how such a situation should be approached. The obstetricians were clear that, given her very high risk status, Phoenix' mum needed to come in to hospital as soon as she showed the first signs of labour. And even if she had started to deliver, she could still only be treated effectively and Phoenix given the best chance of a good outcome in hospital.

	However, some of the midwives felt strongly that, when Phoenix' dad could see the baby's leg emerge, they should have been allowed to go out to the home to give whatever assistance they could. All the clinicians need have the same understanding of the correct protocol. ii) A related point is that, before Phoenix was born, some of the midwives felt that their views of what should happen in the event of precipitous labour had not been taken seriously. If they are to be effective in their role, and if necessary to understand why a protocol does fully reflect their feelings and views, the midwives' ability to communicate with senior management needs to be enhanced. If the team as a whole is to move forward in a way that provides the best possible care for women in labour and their babies, questions and differing opinions need to be in some way acknowledged and dealt with before the correct protocol can be embedded.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that you 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 11 September 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 following. • [redacted], parents of Phoenix Chapman • [redacted], chief executive, LAS

	• [redacted], paramedic, LAS • [redacted], paramedic, LAS • [redacted], paramedic, LAS • [redacted], midwife, Homerton • [redacted], midwife, Homerton • [redacted], obstetrician, Homerton • [redacted], obstetrician, Homerton • HHJ Thomas Teague QC, the Chief Coroner of England & Wales 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 other 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 14.07.23 *ME Hassell*