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| | **REGULATION 28**<br>**REPORT TO PREVENT FUTURE DEATHS** |
| 1. | **CORONER**<br><br>I am Andrew Harris, Senior Coroner, London Inner South |
| 2. | **CORONER'S LEGAL POWERS**<br><br>I make these reports under paragraph 7, Schedule 5, Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. |
| 3. | **INQUEST**<br><br>The inquest touching the death of Baby Isabela Suciu, was opened on 19 April 2022 and heard on 23rd and 24th August 2023 by the Senior Coroner. The coroner's reasons for his judgment were handed down and the Record of Inquest was signed on 31st August 2023, recording thus: The medical cause of death was 1a Sudden unexpected neonatal death. Isabela died from a sudden unexpected neonatal death. In the absence of any identifiable cause, such as airway occlusion, research evidence suggests there is often an underlying infection, but although maternal sepsis was a risk factor for neonatal infection, there is insufficient evidence to conclude the underlying cause here. |
| 4. | **CIRCUMSTANCES OF THE DEATH**<br><br>Isabela was born in hospital at 41 weeks gestation by forceps, weighing 4.3 kg on 2nd November 2020. She received some resuscitation to achieve an Apgar score of 10 at 5 minutes. Her mother was treated for maternal sepsis and Isabella initially had a temperature of 38. This was monitored and she had two low readings of 36.3 at 02.00 and 36.2 at 06.20. These were not escalated for paediatric review and antibiotics were not given. Her temperature stabilised, and she showed no signs of infection before discharge at 12.51 on 4th December. She suffered a cardiac arrest at home about 35 minutes after a 15 minute breast feed. She never recovered consciousness, despite resuscitation by prompt ambulance officers and she died at 16.10 in hospital. |

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| 5. | **THE CORONER'S MATTER OF CONCERN**<br><br>If the Newborn Early Warning Trigger and Track score had been followed the hypothermia would have triggered escalation by the midwife to paediatricians at 02.00 when the temperature was 36.3. Paediatrician [redacted], advised that the KP score would not alter then, but at 06.20, the temperature of 36.2 should have triggered starting antibiotics. There was agreement amongst experts that antibiotics should have been started at 06.20 on 3rd of November. It is accepted by the doctors and Trust that this should have happened and did not because of conflict between the Kaiser Permanente Score and the NICE guidance. Whilst this omission was not shown to have caused Isabela's death, it creates a possible risk for other hospitals using the KP scale.<br><br>Expert microbiologist [redacted] informed the court that it was not that the KP scale was inferior to NICE recommendations, but rather that there is a risk as the threshold for antibiotics is different, that doctors will think the KP score is gospel and not look at the patient as a whole and therefore miss clinical signs which should trigger starting antibiotics.<br><br>[redacted], consultant neonatology expert opined that the evidence for the use of KP pathway was thin, and it was better to follow NICE guidance as KP should only be used as part of an overall assessment. Expert neonatologist [redacted] agreed saying that the use of two guidelines was confusing.<br><br>[redacted] expert opinion was that there was a risk of deaths in other neonatal units and that the expert was not sure how well known the differences and apparent conflict in applying the guidelines was known. The Trust have taken a number of steps to address the risk, but there appears to remain the opportunity for confusion as the revised Newborn Early Warning Trigger and Track score indicates a different response from KP, when late onset symptoms occur after an asymptomatic period, creating a risk of avoidable delay. |

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| 6. | **THE REPORT IS BEING SENT TO:**<br><br>[redacted],<br>Chief Executive of Royal College of Paediatrics and Child Health<br>5-11, Theobalds Road, London, WC1X 8SH<br><br>[redacted]<br>Chief Executive of the British Association Perinatal Medicine<br>5-11, Theobalds Road, London, WC1X 8SH<br><br>[redacted],<br>Chief Executive of NHS England,<br>Skipton House, London, SE1 6LH<br><br>[redacted],<br>Chief Executive of Queen Elizabeth Hospital Trust<br>Stadium Road, London, SE18 4QH |
| 7. | **ACTION SHOULD BE TAKEN**<br><br>In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action. |
| 8. | **YOUR RESPONSE**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by **Tuesday, 7th November 2023**. I, the coroner, may extend the period.<br><br>If you require any further information or assistance about the case, please contact the case officer, [redacted] |

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| 9. | **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] for Novum Law representing the family<br>[redacted] for Clyde&Co representing Queen Elizabeth Hospital<br><br>I have also sent it to:<br>[redacted], Consultant Neonatologist, Northwest Neonatal Ltd<br>[redacted], Consultant Neonatologist, Lewisham and Greenwich Trust<br>[redacted], Consultant Microbiologist, Lewisham and Greenwich Trust<br>[redacted], Consultant Microbiologist, UK Health Security Agency and University College London Hospital NHS Foundation Trust (now retired)<br><br>I am also under a duty to send the Chief Coroner a copy of your response. 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. |
| 10. | **[DATE]** **[SIGNED BY SENIOR CORONER]**<br><br>**Monday, 12th August 2023** **A N G Harris** |