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:** **University Hospitals Sussex NHS Foundation Trust**
1	**CORONER** I am Joanne ANDREWS, Area Coroner for the coroner area of West Sussex, Brighton and Hove
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 13 July 2022 I commenced an investigation into the death of Alissa Claire NORTON aged 4 Days. The investigation concluded at the end of the inquest on 22 February 2024. The conclusion of the inquest was that: Alissa Claire Norton died on 22 April 2022 at the Royal Sussex County Hospital, Eastern Road, Brighton from a hypoxic ischaemic encephalopathy caused by chorioamnionitis which she was exposed to prior to her birth on 18 April 2022.
4	**CIRCUMSTANCES OF THE DEATH** Alissa Claire Norton died on 22 April 2022 at the Royal Sussex County Hospital, Eastern Road, Brighton from a hypoxic ischaemic encephalopathy caused by chorioamnionitis which she was exposed to prior to her birth on 18 April 2022 at Worthing Hospital, West Sussex.
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:

	1. Alissa Claire Norton was born on 18 April 2022 at 39 + 5 weeks gestation at Worthing Hospital. At the time of and after Alissa's birth there were two midwives present as per Trust Policy. One midwife was primarily looking after Mrs Norton and the other her daughter Alissa. 2. The evidence that I heard was that the majority of the notes which were adduced in evidence as to the events and treatment of Alissa were completed retrospectively on the next day (19 April 2022) by the midwife who cared for Mrs Norton. There were very limited notes completed by the midwife caring for Alissa at the time or at any time thereafter. 3. Therefore, there was limited documented information available to treating clinicians following Alissa's birth as to the events and treatment which had been provided to her. 4. The inquest heard that some of the notes completed retrospectively were based on assumption rather than first hand knowledge. This was not clear in the notes.
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 April 22, 2024. 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] **Maternity and Newborn Safety Investigations Special Health Authority (MSNI)**

	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: 26/02/2024** J. Andrews **Joanne ANDREWS** **Area Coroner for** **West Sussex, Brighton and Hove**