Her Majesty's Coroner for the Northern District of Greater London

(Harrow, Brent, Barnet, Haringey and Enfield)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. AACE Association Ambulance Chief Executives. [redacted] **2.** Department of Health and Social Care, 33 Victoria Street, London SW1H 0EU
1	**CORONER** I am Peter Straker, Assistant Coroner, for the coroner area of Northern District of Greater London
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.

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3	**INVESTIGATION and INQUEST** On the 27th May 2022 I opened an investigation touching the death of O'Shea Medad Dover who was 1 month old when he died. I opened an inquest on the 26th of September 2022, the inquest concluded on the 1st of February 2023. The conclusion of the inquest was the following narrative. [redacted] was 30 weeks pregnant when she experienced abdominal pain and called emergency services. The call was wrongly categorised so paramedics arrived 44 minutes later than should have been the case. Midwifery advice was for the paramedics to bring [redacted] to hospital because pre-term deliveries require full obstetric and neonatal support. They did not follow this advice for three reasons… 1. They thought [redacted] was soon to deliver - a conclusion they'd be less likely to have reached had the call been correctly categorised and they'd been with her 44 minutes earlier; 2. Extrication from the property was challenging. 3. LAS guidance told them not to extricate if delivery is thought to be imminent. Recognising the seriousness of the situation two midwifes came to [redacted]. They deemed her presentation to be more in keeping with placental abruption than imminent delivery and assisted paramedics in extrication [redacted] and taking her to hospital at 22.30. At 22.44, there was no foetal heart rate. At 23.04 O'Shea was delivered, resuscitation was started and caused a return of spontaneous circulation at 23.12. Given these things, it is likely O'Shea was subjected to acute severe hypoxia between 22.14 and 22.19. If the call to emergency services had been correctly categorised, [redacted] would have probably been in hospital by 20.57, Hme enough for CTG monitoring to recognise foetal distress prior to the hypoxia at 22.14 which would have prompted emergency caesarian. Had this happened it's likely O'Shea would have survived.
4	**CIRCUMSTANCES OF THE DEATH** As set out in the above narrative. Since O'Shea's death London Ambulance Service has added "JRCALC Plus" guidance stating where delivery is not progressing the patient should be conveyed to a hospital with obstetric support.
5	**<u>CORONER'S CONCERNS</u>** The **MATTERS OF CONCERN** are as follows. – 1. Consideration to be given for the national JRCALC guidance to include the London Ambulance Service's JRCALC Plus recommendation that where delivery is not progressing the patient should be conveyed to an obstetrics unit;
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has the power to take such action.

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7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by Thursday the Twenty-Fifth of April 2024 I, the assistant 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;- The Family 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.
9	**6-2-2024**