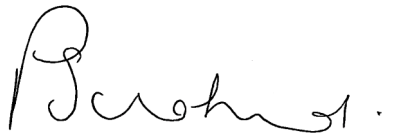
Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1.** [redacted] **Chief Executive** **Nursing and Midwifery Council** **23 Portland Place** **London** **W1B 1PZ** **2.** [redacted] **Chief Executive** **Royal College of Obstetricians and Gynaecologists** **10 – 18 Union Street** **London** **SE1 1GH** **3. Rt Hon Victoria Atkins** **Department of Health and Social Security** **39 Victoria Street** **London** **SW1H 0EU** **4.** [redacted] **Chief Executive** **NHS Sussex Integrated Care Board** **NHS Sussex** **Wicker House** **High Street** **Worthing** **BN11 1DU**
1	**CORONER** I am Penelope SCHOFIELD, Senior 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 08 October 2021 I commenced an investigation into the death of Orlando Nova DAVIS aged 14 Days. The investigation concluded at the end of the inquest on 14 March 2024. The conclusion of the inquest was a Narrative Conclusion namely:- On 9th September 2021 [redacted] (Orlando's mother) developed hyponatremia during her labour while having a home birth. [redacted]'s condition went completely unrecognised during the period of her labour and therefore she did not receive the care and attention that

	she and her son, Orlando, clinically required. There was a lack of understanding of this rare medical condition by midwives and clinicians and as such there were lost opportunities to treat [redacted] both at home and or during her subsequent admission to Worthing hospital. Sadly the failure to recognise this condition resulted in [redacted] suffering a number of seizures which led to a restriction of oxygen to Orlando before birth and this resulted in him suffering an irreversible brain injury. Orlando sadly died from this injury on 24th September 2021 at the Royal Sussex County Hospital at the age of just 14 days. Orlando's death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances of Orlando's death are set out in the narrative conclusion above.
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: (brief summary of matters of concern) Orlando was caused an irreverseable brain injury when his mother suffered a seizure having developed hyponatremia during her labour. The concern is that the midwifes (in the community and in the hosptial, who had cared for Orlando's mother) were completely unaware of this potential condition developing in birthing women. In this case due to Orlando developing a tachicardia during labour Orlando's mothers was actively encouraged to take in more fluid yet there was no accurate record kept of either input or output of fluid. Again when in hospital further fluids were given intravenously with no recognition of any potential risk of hyponatremia developing by the midwives or the Doctor on duty.
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 21st June , 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] **University Hosptial Sussex NHS Trust** [redacted]

	Maternity and Newborn Safety Investigations I have also sent it to **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: 26/04/2024**  **Penelope SCHOFIELD** **Senior Coroner for** **West Sussex, Brighton and Hove**