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 Chief Executive, Sherwood Forest Hospitals NHS Foundation Trust**
1	**CORONER** I am Laurinda BOWER, Area Coroner for the coroner area of Nottingham City and Nottinghamshire
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 March 2023, I commenced an investigation into the death of Arlo River Phoenix Lambert, aged 5 days. The investigation concluded at the end of an inquest on 3 May 2024. The conclusion of the inquest was that Baby Arlo died on 9 March 2023, at the Queen's Medical Centre, Nottingham, as a result of a hypoxic-ischaemic brain injury, sustained during the intrapartum period, and caused by mismanagement of his medical care at Kingsmill Hospital. His death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Baby Arlo's Mother attended the Kingsmill Hospital for induction of labour due to a diagnosis of suboptimal growth, when in fact, the criteria for such had not been met. Labour was slow to establish and doctors failed to recognise Arlo's compound presentation. The prolonged labour process increased the risk of infection, resulting in a subclinical infection within the membranes with fetal inflammatory response. The infection tiggered a placental abruption, with frank bleeding noted at 03.40 hours. The commencement of the abruption could have occurred at any time from 02.05 hours when CTG monitoring was ceased and Mother was left to rest. The slow progress of labour, distress of compound presentation, infection and abruption all contributed to Arlo's hypoxic brain injury from which he died. There were multiple missed opportunities to have reduced the period of hypoxia by delivering Arlo earlier, and before the final fatal placental abruption, by prioritising progress of labour at 10.40 hours, by following the induction of labour process at 12.40 hours, at the obstetric review at 17.15 hours, or responding to the first episode of blood-stained liquor at 21.18 hours or on ward review at 21.43 hours. These multiple missed opportunities occurred due to systemic failings including discrepancies between local and national clinical guidance, a failure to escalate significant clinical events, a failure in communication to handover salient information or to review the notes at the commencement of care.
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) 1. The Trust's Antepartum Haemorrhage guideline gives no sense of urgency when staff are faced with a bleed – here, staff failed to appreciate the potential for a sinister cause of bleeding both at 21.18 and later at 03.40, and did not appear to appreciate the fact that a volume of the bleeding may well be occult, by the external volume representing only a small proportion of the actual blood loss. Miss Al-Samarrai accepted that further work was likely to be required in this regard. 2. Failure to ensure early reflective accounts were captured from key staff in response to this significant event and others. I consider this to be a Trust wide issue. The Trust cannot begin to rectify patient safety issues, if they do not understand exactly what has happened and why. This analysis can only properly occur with the input of those involved in care, and in circumstances where those individuals have had the opportunity and support of the Trust to capture early written accounts. The Trust currently has no clear system in place to facilitate this early capture of relevant accounts.
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 August 27, 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 **Baby Arlo's family** **Sherwood Forest Hospitals (SFH) – to include King's Mill Hospital, Newark & MCH** I have also sent it to **Care Quality Commission** **Department of Health and Social Care** 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: 02/07/2024**  **Laurinda BOWER** **Area Coroner for** **Nottingham City and Nottinghamshire**