REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Sherwood Forest Hospitals NHS Foundation Trust**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of 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 the 16th September 2023, I commenced an investigation into the death of Theodore Riley Bradley The investigation concluded at the end of the inquest on the 5th July 2024 The conclusion of the inquest was a narrative as follows: Theodore Bradley died from hypoxic ischaemic encephalopathy, caused by a placental abruption, secondary to sub clinical acute chorioamnionitis. The abruption led to a major antepartum haemorrhage, which was not recognised as an obstetric emergency that required immediate assessment of maternal and foetal wellbeing. Theo's mother[redacted] was not seen for 37 minutes on arrival at the Triage unit, at Kings Mill Hospital at 01.05 hours, when she was in pain and with significant vaginal bleeding, Had she been seen on arrival as she should have been, Theo would have been delivered by an emergency Category 1 caesarean section, likely by 01.25, certainly by 01.35, instead of at 02.02 hours as occurred. Had he been delivered at either of these earlier times, he would on balance have survived. The delay in Triage assessment made a more than minimal, negligible or trivial contribution to Theos death. Theo's death was contributed to by neglect
4	**CIRCUMSTANCES OF THE DEATH** Theo was born at 02.02 hours on 14.9.23 with no heart rate, and no breathing effort or movement. He had suffered a period of prolonged intra uterine hypoxia, due to a partial placental abruption. His mother, [redacted], reported vaginal bleeding at 41 plus weeks gestation, the severity of which was not recognised during the telephone Triage call, at 00.37 hours on 14.9.23.

	On arrival at the triage unit at 01.05 on that day, [redacted] was not seen as she should have been on arrival, nor thereafter until 00.42 hours, meaning there was a delay of some 37 minutes before she was seen. Whilst delivery thereafter was achieved in 20 minutes, by this time Theo simply could not recover from the acute hypoxic injury caused by the continuing interruption to his blood and oxygen supply, caused by the abruption, evidenced at the time of delivery Both the Trusts Maternity Triage policy and the Antepartum Haemorrhage policy were not followed Detailed Findings as to how he came by his death are provided in a written Determination dated 5.7.24
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will 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, The lack of prompt action when a woman presents with an antepartum haemorrhage (APH). This Inquest revealed a culture within the midwifery team of not acting promptly when there is vaginal bleeding in pregnancy. There was an assumption that there was a benign cause for bleeding, rather than assuming, until proven otherwise that there is a serious cause, such as an abruption, that may require immediate intervention. Well established APH Trust guidance was not followed I set out that difficulty in effectively managing APH is also an accepted issue, for the neighbouring NUH NHS Trust , who are currently reviewing their guidance, and approach to managing APH. It is clearly a regional issue and may be a national one. I am not reassured that necessary actions to address these serious issues identified are in place.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe you 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 the **16th September 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: 1. Theo's family 2. The Regional Lead Obstetrician for the Midlands (NHS England)- [redacted] 3. The National Clinical Director for Maternity- [redacted] 4. The Care Quality Commission 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	**22nd July 2024** **Dr E A Didcock**