REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted] Chief Executive Officer, Chelsea and Westminster NHS Foundation Trust, Chelsea and Westminster Hospital, 369, Fulham Road, London. SW10 9NH [redacted], Medical Director NHS England By email: [redacted] [redacted], Chief Medical Examiner for England and Wales, By email: [redacted]
1	**CORONER** I am Professor Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West 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.
3	**INVESTIGATION and INQUEST** On the 18th, 19th and 20th November 2024, evidence was heard touching the death of Master Elton Michael Deutekom. He had died on the 12th January 2022, thirty seven minutes after he had been born on labour ward at Chelsea and Westminster Hospital. **Medical Cause of Death** 1 a. Acute perinatal hypoxia/ischaemia ("perinatal asphyxia") b. Placental abruption II Placental delayed chorionic villous maturation **How, when, where the deceased came by his death:**

	Elton's mother was transferred to labour ward at Chelsea and Westminster Hospital from the community at 01:25 on 12th January 2022. Her labour initially progressed well. At approximately 0320- 0330 she suffered an abrupted placenta. As a result, Elton suffered an acute hypoxic ischaemic injury. This was undiagnosed by those caring for Elton's mother despite a sharp change in her clinical presentation manifesting as severe pain, strong contractions and rapid progression to push and CTG (Cardiotachograph) changes consistent with hypoxia from 0334, when his mother was reattached to the monitor. Elton's baseline heart rate had gone up significantly, increasing by 30 beats per minute, followed by decelerations. There was no heart rate detected after 0414. This change in base rate followed by decelerations was unrecognised by the obstetric registrar, despite her being in the room with Elton's mother from about 0335 to at least 0348. The registrar relied on the historic CTG trace, rather than the trace at the time of her assessment. This was a serious failure that contributed to Elton's death. The midwife caring for Elton and his mother did not seek assistance from the obstetric team nor the senior midwifery team, despite recognising that the CTG trace was abnormal from 0355 hours at the latest. This was against training and guidance. This was a gross failure that contributed to Elton's death. The labour ward co-ordinator responded to hearing Elton's mother screaming at approximately 0420 and allocated a senior midwife to assist. Neither recognised how long Elton had had an abnormal CTG. The emergency bell was not activated until 0430. The emergency team responded promptly, and Elton was delivered by forceps at 04:35. Despite resuscitation his life could not be saved, and he was recognised as life extinct at 05:12. If Elton had been recognised as suffering with hypoxia and delivered before 04:05 on the balance of probabilities, he would have survived. **Conclusion of the Coroner as to the death:** Natural Causes contributed to by neglect.
4	**Evidence relevant to the matters of concern.** Extensive evidence was taken and exhibited and some potential regulation 28 matters explored. Of relevance to this report: 1. The midwife caring for Elton's mother who took over from the community midwife was very newly qualified and had only been managing women in labour independently for a couple of weeks. This midwife appeared to be distracted by administration tasks and TED stockings when she should have been prioritising the abnormal CTG. She made no contemporaneous notes in the medical records and entered information into the notes retrospectively some four- five hours later with the help of a midwife supervisor advising her. The supernumery time spent by a newly qualified mid-wife has not changed since this incident, but there is more training provided now post qualification than at the time of Elton's death. 2. A finding of fact was made that had the community midwife remained to care for Elton's mother whilst in labour, it is likely that she would have recognised the abnormal CTG and acute change in Elton's mother in terms of pain and summoned help appropriately and Elton would have had an expedited delivery and survived.

3. The labour ward has nine rooms all of which were full, but only 8 midwives including the Labour Ward Co-ordinator who should be just assisting not managing women in labour on a 1:1 basis. This was and is currently the usual number. The labour ward was busy with all rooms occupied. This meant that some midwives were caring for 2 women even without covering breaks. It was so busy that the community midwife who had accompanied Elton's mother to the ward was asked to remain with her until 0315. It was so busy that no practitioner picked up on Elton having an abnormal CTG at the CTG central monitoring station, nor was able to provide ad hoc support to the newly qualified midwife caring for Elton's mother until the Labour Ward Co-ordinator responded after hearing Elton's mother screaming. The evidence was that this level of business is usual on the labour ward. The labour ward was effectively 2 midwives short. This may have contributed to his death.

4. Elton's death occurred on 12th January 2022 but was not referred to the coroner until 17th June 2022, and then the evidence presented suggested a still birth since he had only had a heart rate for a couple of minutes after 23 minutes of resuscitation, and did not highlight labour management issues. This understanding of the court came from information supplied by the hospital and resulted in a PIRH on 12th July 2022 to determine whether Elton was a stillbirth. He had never been treated as such by the hospital and had been treated as a neonatal death. Following this hearing, and review of the HSIB report, the court opened an inquest. Elton had been subject to a consented PM, but evidence in relation to the management of labour and the abrupted placenta was not given to the pathologist. When further evidence gathered as part of the inquest was passed to the pathologist, he changed the medical cause of death.

5. Issues in relation to management of labour that may have contributed to the death and thus render the death as reportable to the coroner under the Notification of Deaths Regulations (the Regulations) were noted on 17th January 2022 on a Datix report, in statements gathered in January and February 2022 and at the Perinatal Mortality Review meeting in early March 2022. On 11th April 2022, HSIB advised Chelsea and Westminster to report the death to the coroner based on issues they identified in relation to management of Elton's mother's labour. Despite this the death went unreported until 17th June 2022.

6. Explanation from the hospital was sought as to why the death was not reported in line with Regulations and a letter was received from the Lead for Neonatal mortality. This provided no clear explanation to many of the questions raised and demonstrated a lack of understanding of the Regulations and the obligation they place upon doctors to report deaths to coroners, and that these legal obligations continue after the death may have been registered as natural.

7. Statements that had been requested at PIRHs on multiple occasions were not produced until after the hearing had started. Notes given by the Labour Ward Co-ordinator to the Hospital legal team that were relevant to the inquest were not disclosed until the Labour Ward Co-ordinator referred to them in evidence, and the court asked for them to be produced. Handwritten notes apparently written contemporaneously by the midwife caring for Elton's mother on the labour ward were destroyed by that midwife after she updated the electronic medical record with the assistance of a midwife supervisor.

	8. This court also has heard a recent jury inquest into two baby deaths at Chelsea and Westminster where the full medical records were not received until two thirds the way through the evidence. 9. The court was also informed that the apparent confusion as to when to report neonatal deaths to the coroner is not confined to Chelsea and Westminster. 10. That in some hospitals medical examiners do not routinely have access to obstetric records when assessing neonatal deaths. In Chelsea and Westminster, they do.
5	**Matters of Concern** 1. That Chelsea and Westminster Hospital are not appropriately referring neonatal deaths to coroner- either late or not at all, and this raises the possibly that lessons may not be learned from the investigation of these deaths that may save the lives of others. 2. That Chelsea and Westminster hospital may not be complying with the duty of candour to disclose evidence relevant to a death to the coroner until forced to by court directions made in public, which thus raises the same concern as above. 3. That following neonatal deaths assistance is given to midwifery staff as to how to write records in retrospect and contemporaneous handwritten notes are destroyed possibly reducing the accuracy of the records and thus risking that lessons may not be learned that may save the lives of others. 4. That the labour ward is understaffed. 5. That newly qualified midwives should have more supervision whilst they are managing women in labour. 6. That there is no regular review system for CTGs on the central CTG monitoring board. 7. That in some hospitals the Medical Examiners do not have access to obstetric records when reviewing deaths. 8. That the neonatologists at Chelsea and Westminster are not passing sufficient and appropriate information to the pathologists when consented post- mortem examinations occur such that the cause of death found by the pathologist may be inaccurate. 9. That neonatologists in other hospitals may not be appropriately reporting deaths to the coroner.
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. It is for each addressee to respond to matters relevant to them.

7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report. 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: Parents of Elton Deutekom: [redacted] Via their legal representative's email. [redacted] Consultant neonatologist and lead for Neonatal Mortality, Chelsea and Westminster NHS Foundation Trust Via Trust legal team email [redacted] Lead Medical Examiner, Chelsea and Westminster Hospital NHS Foundation Trust Via Trust legal team email. 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	**2nd December 2024**  **Professor Fiona J Wilcox** **HM Senior Coroner Inner West London** **Westminster Coroner's Court** **65, Horseferry Road** **London** **SW1P 2ED** **Inner West London Coroner's Court,** **33, Tachbrook Street,** **London.** **SW1V 2JR** **Telephone:** [redacted]