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:** **The Chief Executive, Princess Alexandra Hospital NHS Foundation Trust**
1	**CORONER** I am Thea Wilson, assistant coroner for the coroner area of Essex
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 9th July 2024 I commenced an investigation into the death of Emmy Russo, aged 3 days. The investigation concluded at the end of the inquest on the 7th May 2025, having been heard on 24th, 25th and the 26th March and the 6th and 7th May 2025. Emmy Russo was delivered by category 1 caesarean section at Princess Alexandra Hospital at 21:30 on the 9th January 2024. Emmy's mother had arrived at the hospital in labour earlier that day, having been booked in for an induction at 41+4 weeks. Her evidence was that she had refused earlier induction having not been provided with full information on the risks of proceeding with pregnancy and having been encouraged by the midwives to labour naturally. At 13:45 Emmy's mother's membranes ruptured. Meconium was suspected but no speculum examination was done to confirm. At 15:10 meconium was confirmed. Emmy's mother was started on a CTG trace and transferred to the labour ward, but no doctor's review took place although the witnesses agreed that one was indicated at this time. The CTG which started at 15:36 was never normal, with indications of hypoxia throughout (showing a lack of cycling and no accelerations throughout, and a shallow deceleration at 16:31). No full holistic review with a doctor took place although Emmy's mother's midwife believed she had requested one shortly after 17:10. Prolonged decelerations occurred at 18:12, 19:47 and from 20:55 onwards. Doctors' reviews occurred at 18:30 and 18:55, but confirmed that labour should proceed. Reviews by a doctor were indicated at 19:30 and at 19:47, but no review was requested (although there was a senior midwife review following the 19:47 deceleration). A doctor's review was requested at around 21:00 and a decision to proceed to category 1 caesarean section was made at 21:13. Emmy Russo was born in a very poor condition at 21:30. There were a number of missed opportunities to have delivered Emmy sooner, particularly at the review at 18:30. The evidence was that had a decision been made to deliver her at or before 19:30, her death would probably have been avoidable and had a decision been made to deliver her between 19:30 and 20:55, it is possible that her death would have been

	avoidable. The conclusion of the inquest was a narrative as follows: The deceased died as a result of an acute hypoxic brain injury sustained shortly before birth. The medical cause of death was given as: 1(a) Severe Hypoxic Ischaemic Encephalopathy 1(b) Placental Dysfunction
4	**CIRCUMSTANCES OF THE DEATH** Post-dates baby born at Princess Alexandra Hospital following a hypoxic injury in the period shortly prior to birth, leading to severe hypoxic ischaemic encephalopathy. Emmy was born in a very poor condition. She was resuscitated and transferred to Addenbrookes' Hospital for ongoing intensive care on 10th January, at less than 12 hours of life. At Addenbrookes', treatment was carried out to support Emmy's organs, including treatment for meconium aspiration syndrome. Her organs recovered quickly, however scans indicated a severe hypoxic ischaemic brain injury. Emmy's care was reoriented towards palliative care and she was extubated at 21:55 on the 12th January 2024. Her death was confirmed within an hour.
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 evidence of the current information given to patients at 40 weeks' pregnant on the decision over whether to accept the offer of an induction from 41 weeks does not reflect NICE guidance on the information needed by patients to make an informed choice on induction. Whilst it provides details of the risks associated with induction, it does not provide information on the risks of continuing with pregnancy beyond 41 weeks. (2) The evidence given at inquest indicated a lack of understanding and/or consistency over when concerns about labouring mothers and/or the CTG trace should be escalated for doctor review. Evidence was given on the measures put in place to address issues with escalation, including "Teach or Treat" and "AID" tools, however, there was limited evidence that these are understood by the working midwives and/or advertised to them by way of regular reminders.
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 July 14th 2025. 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: the legal representatives of the Family. I have also sent it to Kennedys LLP on behalf of the Princess Alexandra Hospital NHS Foundation Trust, and to the Care Quality Commission who may find It useful or of interest. I am under a duty to send a copy of your response to the Chief Coroner. The Chief Coroner may publish either or both in a complete or redacted or summary form. She 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.
9	**Dated: 19/05/2025** Thea Wilson **Thea WILSON** **HM Assistant Coroner for** **ESSEX**