NHS
Chelsea and Westminster Hospital
NHS Foundation Trust

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FAO the Senior Coroner,
Professor Fiona Wilcox
Inner West London Coroner's Court
33 Tachbrook Street
SW1V 2JR

By Email

11 March 2026

Dear Senior Coroner, Professor Wilcox,

Inquest touching the death of Sidra Ibrahim (Sidra Aliabase) - Response to Prevention of Future Deaths Report issued 21 January 2026.

I am the Chief Executive Officer writing on behalf of the Chelsea and Westminster Hospital NHS Foundation Trust, in response to the Regulation 28 report issued by the court on 21 January 2026, in relation to the death of Sidra Aliabase on 10 May 2024. We thank the Senior Coroner for bringing the concerns to the Trust's attention and aim to address them in this response.

Firstly, on behalf of the Trust, I offer my sincere condolences to Sidra's parents and family. We wish to reassure them that the care and service delivery concerns identified during the inquest process have been reflected upon and learned from.

Matter of Concern

1. ***That communications by the on call paediatric cardiology team at GOSH are not as they should be when they communicate between themselves and hospital teams that contact them for advice.***

The Trust has been in contact with and confirmed that Great Ormond Street Hospital ("GOSH") are intending to address this concern. The Trust therefore defers to GOSH in respect of this point.

2. ***That systems for making plans for diagnosing long QT in newborns at risk need to be put in place early in pregnancy in case of premature delivery.***

The Trust has an established Fetal Medicine Neonatal Pathway when risk factors for either the mother or their baby are identified antenatally, in line with the Trust's Fetal Anomaly Screening Programme Guidelines.

In cases where women continue a pregnancy with a baby that requires multidisciplinary input, a weekly PIMS (Perinatal integrated Multidisciplinary Service) meeting consisting of fetal medicine, neonatal, paediatric surgical, paediatric urology, genetic and fetal cardiology consultants, neonatal nurses and fetal medicine midwives will take place. The multidisciplinary team will review each patient on a case by case basis to consider whether they will benefit from further antenatal screening, appointments, scans and/or monitoring.

In line with routine national schedule of Antenatal care and national screening guidance, the Trust may offer an appointment at 28-30 weeks to discuss implications of antenatal findings and further management, including care planning for delivery and post-natal care. Where appropriate, birth and care plans will be developed and discussed with the patient and a Consultant Neonatologist.

Following receipt of the Regulation 28 report, the Trust has identified that there was a gap in the guidelines for mothers at risk of pre-term labour. Whilst long QT syndrome in a baby is not a precursor to premature delivery, it is recognised that in this case, Sidra's mother had risk factors that ought to have led to earlier care planning for Sidra when she was delivered. Whilst there was a clear care and management plan in place for Sidra's mother, the presence of maternal risk factors highlights the importance of earlier neonatal care planning in similar cases.

The Trust is therefore updating the Guideline to ensure multidisciplinary teams consider cases where appointments prior to 28 weeks may be appropriate. It is considered that this should be on a case by case basis and clinical judgment as to when this appointment should take place will enable treating teams to recognised opportunities for earlier care planning particularly for babies with risk factors, including genetic conditions such as Long QT syndrome.

The Trust has a clear process in place, and babies with a strong family history of inherited arrhythmia syndromes, fetal anomalies, or suspected genetic syndromes should be referred promptly to the PIMS team, where cases are reviewed and a coordinated perinatal and neonatal management plan is agreed. Neonatal management plans are documented on the **neonatal alert within the maternal electronic record** and should be established as early as possible once viable gestation is reached, taking into account the risk of premature delivery.

The Trust is developing and implementing a guideline to be completed within the next 3 months, on the management of Long QT syndrome (LQTS) in pregnancy and the perinatal period, including clear recommendations for neonatal monitoring. The guideline will outline neonatal assessment including monitoring of heart rate and blood glucose at birth, a 12-lead ECG shortly after birth and again at approximately 3 weeks of age (or as advised by the cardiology team), and genetic testing where the familial pathogenic variant is known. It will also clarify the process for sending genetic samples to the Royal Brampton Hospital (RBH) Arrhythmia Centre, where testing is undertaken.

These measures will support earlier multidisciplinary planning and ensure that babies at risk of inherited cardiac conditions have a clearly documented neonatal management plan in place prior to delivery wherever possible.

The Trust will ensure that the updated guideline is disseminated to relevant clinical teams and reinforced through neonatal induction and multidisciplinary practice.

3. ***That Chelsea and Westminster neonatal doctors should take advice primarily from its in house visiting paediatric cardiology team for babies likely to be in hospital for some time, even if care is later transferred to another hospital service for long term follow up.***

As part of the Incident Review into Sidra's care, the Trust identified that whilst there was clear communication and care planning in respect of Sidra's mother with the in-house visiting cardiology team at Royal Brampton Hospital, more input should have been sought regarding Sidra's care planning.

Babies with an abnormal cardiovascular examination or abnormal ECG (including superior QRS axis) should be discussed with the cardiology SpR at the Royal Brampton Hospital (for Chelsea), which is the Trust's designated cardiac referral centre, or with the Paediatric Consultant and Service Director for Neonatology at West Middlesex Hospital, in line with already established Hospital policy.

This is being continually reinforced through the neonatal induction programme for new and locum consultants to ensure awareness of referral pathways, cardiology advice processes, and early multidisciplinary care planning for babies at increased cardiac risk.

4. ***That drop-down menu for prescribing is more likely to lead to errors in drug selection for drugs of similar names.***

The Trust electronic patient system ("Cerner") is provided by Oracle. This is a nationally-distributed electronic system that supports NHS Trusts with appointments, admissions, theatre management, clinical note recording, observations and assessments, ordering procedures, discharging patients and medication administration.

The medication prescribing tool is a contextual search within an overall order catalogue that automatically shows potential medication choices as a clinician continues to type in the search box, gradually decreasing as further text is provided.

Following receipt of the Regulation 28 Report, the Trust escalated this concern internally through the Electronic Patient Record Optimisation Group ("EPROG") and immediately reached out to Oracle who have recorded this on their incident reporting system. Oracle are due to respond to the Trust to confirm whether any system mitigations can be put in place to mitigate this risk in the future. The Trust has also reached out to other local Trusts who utilise Cerner to identify whether their processes are the same and identify further opportunities for adapting the system wherever possible to mitigate mis-selection.

In the meantime, alongside the evidence of action taken during the inquest, the Trust has taken the following steps:

1. Issued further guidance to clinical teams on safer drug search practices in Cerner (e.g., entering more characters before selection) to mitigate mis-selection risk. This is already factored into training and has been updated to reflect the issues identified in Sidra's care. Training took place across the Acute Provider Collaborative (Imperial College Healthcare, Chelsea and Westminster Hospital NHS FT, The Hillingdon Hospitals and London North West University Healthcare) in the week of 02 March 2026, as well as in induction for new doctors.
2. Simulation training is regularly given to the Neonatal team with this scenario for both in-situ and StiNE courses (simulation training in neonatal emergencies)
3. This case has been used as a pharmacy case study for NICU staff induction training in the week commencing 02 March 2026.

The Trust undertakes an ongoing monthly detailed audit within the Neonatal Unit to identify any other prescribing errors. The prescription audit was initiated as an immediate action following Sidra's case, with the aim of monitoring prescription quality within the NICU. The audit's terms of reference currently involve reviewing all prescriptions for babies in the unit on the audit day. This process has facilitated spot checks and provided opportunities for direct learning. Whenever an incomplete prescription was identified—with a focus on omissions of dose per kilogram—the staff involved were promptly notified, and the NICU education team offered targeted training support. This audit found no further medication errors resulting in harm.

This case was also monitored through the Mortality Surveillance Group on 06 March 2026, to ensure learning from deaths is identified promptly and fed across the Organisation. The response to the Regulation 28 report was discussed in the Trust Quality Committee meeting on 02 March 2026.

The Trust is committed to continuing to identify and implement measures to mitigate the risk of human error in prescribing medication across the Organisation and this work is a direct result of the issues identified in Sidra's care, to prevent this happening in the future. This work will remain continuous to reflect changes in prescribing, systems process and/or national guidelines. Any developments are effectively monitored through various internal processes, including the Trust Quality Committee, to ensure learning is widely identified and disseminated across the Organisation.

Yours sincerely

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Chief Executive Officer
Chelsea and Westminster Hospital NHS Foundation Trust