REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)
*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS [redacted] **THIS REPORT IS BEING SENT TO:** 1. **Mr Tim Higginson, Chief Executive, University Hospital Lewisham** 2. [redacted] **Managing Director, NHS Lewisham Commissioning Group**
1	**CORONER** I am Andrew Harris, Senior Coroner, London Inner South
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 14th April 2011, an inquest was opened into the death of Luna Lesko, aged 26 days. The inquest concluded at Southwark Coroner's Court on 16th August 2013. The conclusion of the inquest was a narrative (see section 4 below).
4	**CIRCUMSTANCES OF THE DEATH** Baby Luna Lesko died at University Lewisham Hospital at 16.40 on 20th March 2011, after discontinuing intensive care, due to unsurvivable brain damage. Her mother was 41+4 weeks pregnant on 22nd February, became fully dilated at 14.30, with meconium liquor at 15.30. Syntocinon was begun at 19.00, increased at 19.48 and stopped at 20.20 as failure to progress with OP position. CTG remained normal. The baby was delivered by LSCS at 21.45 with Apgar 9 and normal blood gases. She was put to the breast at 22.30 until 22.49. The paediatric doctor attending birth asked for meconium observations to be done as per Trust Protocol. Although there were records of two readings of pulse, resps and temperature, it was concluded that the full range of observations were not done by the attending midwife, in particular at around 23.15, when the baby was lying wrapped on the mother's chest. It was found that neither the prenatal events nor breast feeding contributed to death. Contributory causes were the position of the baby since there was at some time an occlusion of the airway and the failure to perform the required observations, in particular observation of skin colour. This failure amounted to neglect. She was found collapsed with no respirations, pale and floppy at about 23.28, was resuscitated, required intubation and ventilation after 7 minutes and was transferred to NICU. There was a prolonged period of hypoxia from before she was found until intubation and persistent acidosis after, this being found to be a further contributory cause of the death. The resuscitation did not contribute to death. She had extensive investigations and treatments for all possible causes. The cause of the collapse was not found.

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed a matter giving rise to concern, namely the limited access to theatres for mothers requiring lower segment Caesarean section (LSCS) out of hours. Whilst in this inquest this did not contribute to death, 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 **MATTER OF CONCERN** can be described as follows. – (1) There was a delay in securing a cardiotocograph (CTG) which she needed after she had meconium liquor at 15.30. [redacted] was in the birthing suite and needed to access a labour ward room to have this foetal monitoring. The delay was due to the labour suite being very busy, but she was transferred and monitoring began at 17.02. I accepted expert evidence that what was best in the local context was not to site a CTG machine in the birthing centre, but to ensure access to the labour ward. Evidence was given that there is now another labour room. Whilst I did not conclude that there was now a risk to future babies from this arrangement, it establishes an on going increased capacity of the labour ward, which is relevant to the concern below. (2) LSCS was required to deliver the baby, due to lack of progression despite augmentation, adverse position and prolonged rupture of membranes with meconium. The decision was taken at 20.00 hours, but delivery was not possible until 21.40 hours, as theatres were busy. This delay of 1 hour 40 minutes for a category 2 section was 40 minutes outside the Trust's own guidelines. (3) The consultant obstetrician reported that this delay, which occurred out of hours, in a unit with over 4000 births per year was unacceptable. It worsens the potential impact, carrying a higher risk of brain damage or death of babies, if there were several emergencies at one time. Staff were reluctant to use the second out of hours (non obstetric) theatre as they cannot then respond to a category 1 emergency. My expert obstetric witness, [redacted] of Kings College Hospital, gave an opinion that the out of hours theatre access created a real risk of preventable death, especially with the increasing rate of performing LSCSs. He advised me that I should be concerned and bring the matter to the attention of the Trust. (4) Whilst the Head of Midwifery reported management changes and compliance with CNST assessment, she did not provide assurance that the theatre capacity had been increased out of hours. Furthermore it was reported that the Trust is shortly to be disbanded and a new Trust is being formed by merger with another. This may lead to service configuration changes. She reported that the future obstetric services were under review. (5) I concluded that a real risk existed that I should report to the Trust and the commissioning body, to ensure that it was fully appreciated and given appropriate priority in the service reconfiguration planning.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organization(s) 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 17th of October 2013. 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 and legal representatives: [redacted] next of kin [redacted] Leigh Day & Co, solicitor for family [redacted] Bevan Brittan, solicitor for Trust I have also sent it to the following, who may find it useful or of interest: [redacted] consultant obstetrician, Kings College Hospital. [redacted] consultant obstetrician, University Hospital Lewisham [redacted] Head of Midwifery, University Hospital, Lewisham [redacted] Director of Clinical Quality, The Royal College of Obstetricians and Gynaecologists Rt. Hon Jeremy Hunt, Secretary of State for Health 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	**[DATE]** 23rd August 2013 **[SIGNED BY CORONER]**