ANNEX A

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 **THIS REPORT IS BEING SENT TO:** **1. Mr Tim Higginson, Chief Executive, Lewisham and Greenwich NHS Trust, Queen Elizabeth Hospital, Stadium Road, London SE18 4QH**
1	**CORONER** I am Philip Barlow, assistant coroner, for the coroner area of Inner London 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 10 April 2013 I commenced an investigation into the death of Archie Haxell, age 5 days. The investigation concluded at the end of the inquest on 27 February 2015. The conclusion of the inquest was that the medical cause of death was extensive brain haemorrhage and hypoxic ischaemic encephalopathy. The narrative verdict was as follows: About 2 hours after his birth at Queen Elizabeth Hospital, Archie Haxell suffered a respiratory arrest. He was found to have had extensive brain haemorrhage and hypoxic ischaemic encephalopathy although the underlying cause of these remains unknown. He was transferred to St Thomas' Hospital where he died on 29 March 2013. Breakdowns in communication between healthcare professionals and with Archie's parents contributed to the delay in recognising Archie's deteriorating condition.
4	**CIRCUMSTANCES OF THE DEATH** The circumstances are also set out in the Trust's serious incident investigation report dated 12 August 2013. Briefly, Archie was the eldest of twins and was born in seemingly good condition in theatre by forceps delivery on 24 March 2013. About 2 hours after his birth Archie suffered a respiratory arrest. He was transferred to SCBU and then to St Thomas' where he died at the age of 5 days.
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) About 25 minutes after his birth Archie was noted to be grunting and he then developed nasal flaring, both of which are potential signs of respiratory distress. He was

	midwife [redacted] performed a set of observations, including oxygen saturations, and she also noticed vomiting, grunting and nasal flaring. The evidence at the inquest was that [redacted] wrote the observations on a piece of paper because the medical records were not immediately available (her observations were performed shortly after the birth of Archie's brother who required resuscitation). Midwife [redacted] later transcribed these results into the medical records. However, the evidence was that midwife [redacted] was not aware of the vomiting, grunting and nasal flaring noticed by midwife [redacted] although midwife [redacted] believes she did pass this information on verbally. During this period attention may understandably have been focussed on Archie's brother. However, I am concerned that the important information about further possible signs of respiratory distress was somehow lost in the communication between the two midwives. Also, the piece of paper on which the observations were recorded was not retained. I am concerned that this should have been retained in the medical records. (2) No-one informed Archie's parents of the concerns about Archie's breathing. After returning to delivery suite [redacted] was left alone with Archie for a period of between 7 and 10 minutes. During this period [redacted] noted that Archie's breathing was irregular. My finding at the inquest was that if he had known of the midwives' concerns he would have raised the alarm sooner, although it was not possible to say from the evidence whether this would have altered the outcome. I do of course understand that a balance needs to be maintained between sharing relevant information with parents and causing unnecessary alarm. However sharing relevant information potentially enables parents to make important contributions to their child's care and my concern is that this opportunity was lost in this case.
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 1 May 2015. 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 solicitors of Archie's parents as Interested Persons and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. 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	**5 March 2015** **Philip Barlow** [redacted]