Thomas Ralph Osborne
Senior Coroner for Milton Keynes

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive of Milton Keynes Hospital**
1	**CORONER** I am Thomas Ralph Osborne, Senior Coroner for Milton Keynes
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 06/01/2015 I commenced an investigation into the death of Ethan Robert Johnson. The investigation concluded at the end of the inquest on 15th September 2015. The conclusion of the inquest was Narrative as follows: The deceased was born on 4th January 2015 at 13.46. Prior to his delivery he suffered perinatal asphyxia and meconium aspiration. The problem with his wellbeing were first identified by an abnormal CTG at 12.15 and the delay in his subsequent delivery by caesarean section resulted in a lost opportunity to deliver him earlier and render further medical treatment. His cause of death was given after a post-mortem examination as 1a) Meconium Aspiration 1b) Perinatal Asphyxia
4	**CIRCUMSTANCES OF THE DEATH** Ethan Johnson was a new born baby. His Mother was admitted to the Maternity Unit for induction of labour at 40+11 weeks. Mum informed midwife on admission that there had not been foetal movements felt since 9pm the night before admission but said that this was her normal pattern of movements. CTG on admission showed a non-reactive trace. Mum spontaneously ruptured membranes and thick meconium was noted. Mum was transferred to Delivery Suite and repeat CTG was deemed pathological. A Category One (Urgent) Caesarean Section was performed under general anaesthetic. There was some difficulty during the delivery and Ethan was born at 1.46pm with no respiratory effort, no heart rate and was floppy and pale. Resuscitation was commenced immediately, his airway was inspected under direct vision by SHO and copious amount of thick meconium aspirated from beneath vocal cords. Resuscitation was carried out and a heart rate was first detected at 35 minutes of age. Ethan was transferred to the Neonatal Unit at 2.44pm. He was still undergoing various treatments and was discussed with a tertiary Neonatal Consultant at the John Radcliffe Hospital. He felt that the situation and outlook was extremely poor and advised discussing withdrawal of intensive care with the parents. A discussion was held with both parents at around 4pm and the decision was made to withdraw treatment. Ethan was extubated at 11.30pm and his death was confirmed at 3.26am on 05/01/2015.
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)That the most junior member of staff (midwife) was left to look after [redacted] even though the CTG trace was deemed abnormal. The midwife felt unsupported. (2) Two further members of staff reviewed the CTG trace and yet it appears that no one was in a position of leadership to require a doctor to attend and review the trace and [redacted] (3)When the consultant on call was requested to attend he indicated that he would do so later. No one on the unit had the leadership role to insist upon his attendance. (4) No one on duty in the unit was able to assume the leadership role and be in a position to offer advice, support and to direct the course of events. (5) There appeared to be a lack of understanding by members of staff as to labour ward management because of the lack of effective leadership. (6) There still appears to be a hierarchical approach to escalation of care within the unit.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 24th November 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 following Interested Persons: • The family of Ethan Johnson and their solicitors • The Local Safeguarding Children Board • The Care Quality Commission 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	Dated 29th September 2015 Signature_____ Mr Tom Osborne Senior Coroner for Milton Keynes

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