Thomas R. Osborne
Senior Coroner for Bedfordshire and Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: Mr Philip Morley Chief Executive The Princess Alexandra Hospital NHS Trust Hamstel Road Harlow Essex CM20 1QX [redacted]
1	**CORONER** I am Thomas R Osborne, Senior Coroner for Bedfordshire and Luton
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 19 November 2012 I commenced an Investigation into the death of **Isla Peyton LORD,** aged 4 days . The Investigation concluded at the end of the inquest on 28 January 2016. The Conclusion of the Inquest was a 'Narrative Conclusion' that "… Isla Peyton LORD was born on 4 November 2012 at the Princess Alexandra Hospital in Harlow. Following delivery she suffered an inexplicable immediate post-natal collapse; initial attempts at resuscitation were unsuccessful and she suffered a hypoxic ischaemic brain injury. She was transferred to the Luton and Dunstable Hospital where she died on 8 November 2012.
4	**CIRCUMSTANCES OF THE DEATH** Isla was born at Harlow Hospital on the 4th November 2012. During pregnancy, an antenatal scan detected the right leg bent above the knee. There were also concerns over an enlarged heart chamber. She was born by Emergency C Section; she cried upon delivery, however, then collapsed. There was a prolonged period of resuscitation and she was found to have a hypoxic brain injury. She was subsequently transferred to the Luton

	and Dunstable Hospital at 06.00 hours on the 5th November 2012, where she was ventilated. Discussions then took place with Isla's parents when a decision was made to withdraw treatment. She sadly died on the 8th November 2012.
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. During the course of the evidence it became apparent that once the possibility of heart anomalies was identified at University College Hospital in London (UCLH), there was no liaison between Princess Alexandra Hospital in Harlow and UCLH as to the plan for the delivery of the baby. It was simply agreed that UCLH were content for her to be delivered at the local hospital with a referral being made to Great Ormond Street Hospital after delivery. In order to prevent deaths in the future there needs to be a review of the system that exists between the tertiary hospitals and Princess Alexandra Hospital as to how to formulate an Agreed Delivery Plan for both mother and baby.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you as Chief Executive of the Princess Alexandra Hospital 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 **2nd April 2016**. 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 : Parents; Chief Executive, University College London Hospitals (UCLH) NHS Foundation Trust, 235 Euston Rd, Fitzrovia, London NW1 2BU;

	Hertfordshire Safeguarding Children Board Team, Room 147, Postal Point CHO143, County Hall, Hertford. SG13 8DF admin.hscb@hertfordshire.gov.uk 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 5th February 2016** ……. **TOM OSBORNE** **Senior Coroner** **Bedfordshire and Luton**