## REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**1. NHS England**<br>**Cheshire and Merseyside Office**<br>**Regatta Place, Summer Road,**<br>**Brunswick Business Park**<br>**Liverpool**<br>**L3 4BL**<br><br>**2. Rt Hon Jeremy Hunt**<br>**Secretary of State for Health**<br>**Richmond House**<br>**79 Whitehall**<br>**London**<br>**SW1A 2NS** |
| 1 | **CORONER**<br><br>I am André Rebello, Senior Coroner, for the area of Liverpool And Wirral |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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**<br><br>On 15th July 2015 I commenced an investigation into the death of **Amy Rose COOPER** , Aged 153 minutes.<br><br>The investigation concluded at the end of the inquest on 25th February 2016. The cause of death was:<br><br>a Intrauterine growth restriction<br>b Antepartum asphyxia<br>c Maternal vascular underperfusion in the placenta in addition to fetal thrombotic vasculopathy, umbilical vasculitis and acute subchorionitis and low grade villitis of unknown aetiology<br><br>The conclusion was:<br>Natural Causes |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>On the 8th July 2015 at 20.12 Amy was born at 40 weeks gestation by caesarean section at Arrowe Park Hospital, Wirral. Amy was in a poorly state and required immediate resuscitation. At 20.47 (35 minutes of life) it was determined that resuscitation would not be successful and Amy was confirmed as having died at 22.55. It was not evident to community midwives or the hospital maternity unit that Amy had intrauterine growth restriction until after post-mortem investigations.<br><br>Amy and her mother had been under the care of one to one midwives (North West) Limited – St James Children Centre, 334 Laird Street, Birkenhead CH41 7AL which is a community midwifery service. The Maternity where Amy was born at Arrowe Park Hospital which is part of the Wirral University Teaching Hospital Foundation Trust. |
| 5 | **CORONER'S CONCERNS** |

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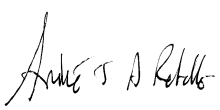
| | During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.<br><br>The **MATTERS OF CONCERN** are as follows. –<br><br>It was clear at the inquest that maternity services which had been commissioned in this region had not been required to have a specification for record keeping, notes and scans which could be digitally available to other maternity services operating in the same area. Such that Arrowe Park Hospital needed to have the paper notes from One to One North West Ltd. to ensure continuity of care.<br><br>This does not appear to be the most efficient system for continuity of patient care and could have been remedied by the commissioners of the services requiring compatible record keeping and medical note systems to ensure the easy sharing of information.<br><br>This would also enable community based midwives to refer a patient to a consultant without the patient necessarily having to attend the maternity unit in the first place.<br><br>Further access to notes would make the admission to the maternity unit safer and seamless, delivering what should be a better patient experience and outcome. |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 22nd April 2016. I, the coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons Amy's parents, Arrowe Park Hospital, One to One Midwives (North West) Ltd and to the LOCAL SAFEGUARDING BOARD. I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 |  <br>**André Rebello**<br>**Senior Coroner for the**<br>**City of Liverpool and the Wirral**<br>**Dated: 25th February 2016** |