REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: The Chief Executive of Stepping Hill Hospital, the Secretary of State for Health, the Healthcare Safety Investigation Branch (HSIB) and the National Institute for Health and Care Excellence (NICE)**
1	CORONER I am Alison Mutch , Senior Coroner, for the Coroner Area of Greater Manchester 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 17th September 2018 I commenced an investigation into the death of Xander Curran-Pass. The investigation concluded on the 21st June 2019 and the conclusion was one of **Narrative: Died as consequence of the complications of abnormalities of the placenta where his deteriorating condition was not recognised until his condition was irreversible**. The medical cause of death was **1a) Perinatal asphyxia associated with intrauterine growth and abnormalities of the placenta (placenta immaturity, fetal thrombotic vasculopathy, high grade villitis)**
4	CIRCUMSTANCES OF THE DEATH Xander Curran-Pass was identified as being on the 10th Centile on growth scans at 37+ 4 weeks + 39+5 weeks of pregnancy. On the 13th September 2018 his Mother identified a significant reduction in fetal movement. She attended the Triage Unit at Stepping Hill Hospital. As a result, his Mother was booked in for an Induction of labour on 14th September 2018. On the 14th September 2018 the delivery suite was at capacity and could not accommodate his Mother. She was not allocated a time to attend until she telephoned at 18:00pm and was told to make her way in. She had reported continuing reduced fetal movement on each occasion she telephoned the unit. She arrived at the unit at 7pm on 14/09/18. A midwife did not see her until approximately 23:50pm. There was no recorded documentation of a discussion of foetal movement at that time. Induction of labour began. A CTG was commenced after

	induction of labour began. There was no evidence that it was ever reviewed. It was discontinued early and there was no evidence as to who discontinued it. The CTG did not show the expected accelerations. A further CTG did not take place until 07:09am on 15th September 2018. The CTG had abnormal indicators from the early stages of monitoring. The midwife left the room whilst the CTG was underway returning when the call bell was pressed at about 07:20am. The CTG had abnormal features and loss of contact. The midwife called for assistance 07:38. The Registrar attended at 07:50am. Xander's mother had not been reviewed by an Obstetrician prior to that point. He reviewed her and at 08:03am she was consented for a category 1 Caesarean Section. Xander was delivered at 08:22am. His condition was very poor. Resuscitation was unsuccessful and he died. Post-mortem examination showed that his growth was on 0.4th centile and that the placenta had Chorionic Villitis and Thrombotic Vasculopathy. This resulted in poor placental function at the end of pregnancy.
5	<u>CORONER'S CONCERNS</u> 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.The inquest was told that there was a growing challenge to maternity units from the rise in Induction of Labour and the pressure to ensure that timescales set out in NICE guidance were met. In this case and since the death of Xander the trust have taken steps to reconfigure their IOL process to reduce risk but no provision to share such learning nationally existed; 2.In the inquest reference was made to the guidance from the Royal College on reduced fetal movement. The guidance references individual episodes of RFM but does not give clear guidance on the approach to be taken where in effect there is one prolonged episode rather than multiple episodes of RFM; 3. Xander's mother was not told it would be advisable to return to triage for further monitoring in light of the ongoing reduced foetal movement. The inquest was told that this would have been advisable given the prolonged nature and the fact that it was unclear when she would be offered a slot for IOL; 4. A review by an obstetrician did not take place on admission despite RFM and delayed IOL. The trust guidance did not require such a review. Such a review may have identified growing concern about condition of Xander; 5.Xander had his fundal height measured by tape measure by midwives in the community. There was a significant discrepancy between the recorded measurements of two different midwives, which altered where he was on the centile chart significantly;

	6. Xander's mother was given pethidine. There was no guidance on issues to be considered in terms of advisability of pethidine where there was already significant reduced fetal movement; 7. The quality of documentation on admission was poor; 8. The triage and IOL diary were poorly kept and used in different ways by staff. The trust has since changed the way records are kept to ensure consistency and improved its audit process. It is unclear if nationally there is clarity on the way in which IOLs are diarised, prioritised and managed; 9. The CTG at 07.09 was concerning from the early stages but the evidence suggested that it was not closely observed; 10. The second CTG after IOL commenced was not reviewed.
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 18th September 2019. 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 namely Xander's mother, who may find it useful or of interest. 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	**Alison Mutch** **HM Senior Coroner** **24.07.2019**