Sarah Laurie Whitby
Assistant Coroner for Southampton & New Forest

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Isle Of Wight NHS Trust**
1	**CORONER** I am Sarah Laurie Whitby, Assistant Coroner for Southampton & New Forest
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 03/06/2016 I commenced an investigation into the death of Owen Richard Widlake. The investigation concluded at the end of the inquest on 17 November 2017 that Owen Widlake died of natural causes as a result of undiagnosed PPHN. It is not possible to say on the balance of probabilities whether Owen would have survived if his significant respiratory distress had been recognised, investigated and treated at the time. The cause of death was found to be 1a) Acute Intraventricular Haemorrhage 1b) Persistent Pulmonary Hypertension of the Newborn and Meconium Aspiration.
4	**CIRCUMSTANCES OF THE DEATH** Owen Widlake was born on the 30th May 2016 at St Mary's Hospital, Isle of Wight full term and healthy, but had aspirated meconium. He was placed in ambient oxygen and continued to need oxygen at ever increasing levels. The failure of his respiratory function was recognised in part, though the severity was not. Transfer to a tertiary specialist neonatal unit was not sought early enough particularly considering the geographical location at St Mary's. He was diagnosed at a late stage with PPHN and as this was untreated it could not be resolved. He suffered an acute intraventricular haemorrhage which on the balance of probabilities was a result of the PPHN. He died at Southampton General Hospital on the 31st May 2016.
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. – (1a) Staffing levels over the weekend and bank holiday, in particular the use of ANNP and SANNP trained staff to replace junior and registrar level doctors on duty covering NICU. (1b) The need for a dedicated junior level doctor or registrar to be on duty 24 hours covering NICU, and not a limited 3 / 4 hour shift. (1c) The need to clarify as to the role an ANNP or SANNP has, whether in a nursing capacity or medical capacity, and how they are perceived by other staff. 2) The observations for children in transition or admitted to NICU are not recorded seamlessly nor are easily viewable whether on a chart or graph. 3) The nursing staff do not appear able to escalate concerns either i) due to lack of clear care plans and escalation markers ii) poor training particularly the SANNP and ANNP in the recognition of respiratory distress

	and PPHN iii) a lack of empowerment indicating a lack of leadership. 4) The on going training undertaken of nursing staff in relation to PPHN and respiratory distress has been the responsibility of SANNP [redacted] and a consultant, with no indication that they have undertaken training themselves. 5) Concern as to staff deciding whether a child in respiratory distress should be NBM or not and what is the guidance on this. 6) The Transfer policy for this Trust and what would be guidance or indicators as to the seeking of tertiary level assistance and transfer, especially when a crisis point may be reached past 10pm. 7) What is the current system in place for handovers between medical staff and nursing staff, whether written or verbal, and what information must be included as part of that handover.

6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, the Isle Of Wight NHS Trust, 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 22 January 2018, however I am extending this period to the 1st March 2018. 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: [redacted] SANNP [redacted] Isle of Wight NHS Trust and to the IOW Local Safeguarding Board. 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 24 November 2017 Signature_____ Assistant Coroner for Southampton & New Forest