Signed by **Geoffrey Sullivan**
Title **Senior Coroner**
Jurisdiction **Hertfordshire**

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Maternity Quality & Safety Group Watford General Hospital (WGH)
Clinical Director WGH:

1 CORONER

I am Geoffrey Sullivan Senior Coroner for **Hertfordshire**

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

The Chief Coroner directed that an investigation should take place into the death of Jack Postle, a baby aged 6 days. Jack was delivered at WGH on the 29th September 2017 and died on 5/10/17 at Luton and Dunstable Hospital specialist neonatal unit.

A hospital post-mortem was carried out and the cause of death was given as 1a) Severe Hypoxic Ischaemic Encephalopathy & Multi Organ Failure. A Form 100A was issued by Bedfordshire Coroner's Service and registration and cremation then took place.

Subsequently the family raised concerns with Bedfordshire and a Root Cause Analysis Investigation Report produced by West Herts Hospitals.

On 25/04/2019 I commenced an investigation into the death of Jack POSTLE. The investigation concluded at the end of the inquest 18th- 19th February 2020.

The cause of death provided by the pathologist:
1a) Severe Brain Hypoxic Ischaemic Encephalopathy
1b) Delayed Placental Maturation and Acute Chorioamnionitis and Foetal Chronic Vasculitis.

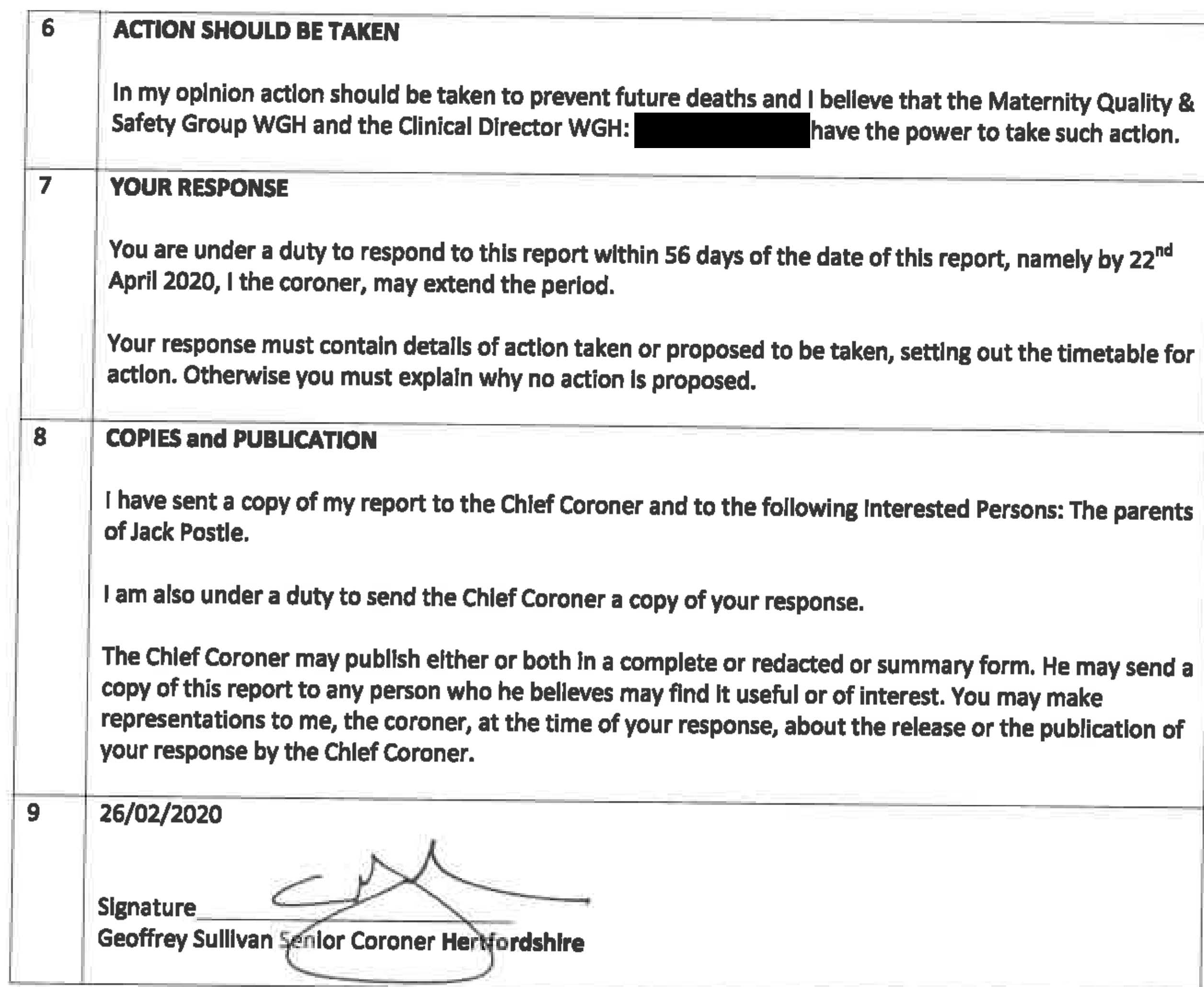
The conclusion: Jack Postle died as a result of an avoidable natural cause.

The death was avoidable as there were two missed opportunities to provide care to Jack which if taken would likely have saved his life.

During the course of the inquest, evidence was heard from multiple witnesses that the maternity unit did not have the capacity to care for the number of patients on the unit at that time. The delivery suite was consistently unavailable during Mrs Postle's stay at the hospital which meant that the ARM (artificial rupture of membrane) procedure could not be performed.

The evidence of (consultant obstetrician) that Mrs Postle was offered a caesarean section and that she declined was not accepted by the court. It was confirmed that at the time of the inquest was on suspension and had been referred to the GMC.

4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death recorded at the Inquest: Jack Postle was to be delivered by induced labour at 40 weeks due to reduced foetal movements. On 23 September 2017 Jack Postle's mother was admitted to Watford General Hospital for induced labour. She remained there until the 26 September 2017. When she was discharged on 26 September 2017 she was not given the option of a caesarean section and had this procedure been performed that day it is likely that Jack would have survived. Jack Postle's mother returned to Watford General Hospital on 28 September 2017 with strong contractions. She was suitable for delivery by artificial rupture of the membrane (ARM) but the delivery suite was not available. Had Jack been delivered on 28 September 2017 it is likely he would have survived. On 29 September 2017 the delivery suite was still not available for ARM. Jack Postle's heart rate was monitored during the day and was essentially normal until 09:58hrs when it dropped to unrecordable. The reading was noted by a mid-wife at 10:08hrs and an alarm call put out. The decision was made for an emergency caesarean section and Jack Postle was delivered at 10:36hrs. He was in a poor condition and was transferred to the specialist neo-natal unit at Luton and Dunstable Hospital. Despite treatment he died there on 5 October 2017. There were two missed opportunities to provide care to Jack which if taken would likely have saved his life.
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 there is insufficient capacity at the WGH maternity unit to provide a safe level of care to patients. (2) That the guidance provided to consultants, for outlining options to an expectant mother, seek to limit the availability of caesarean section, even following failed induction. Of the three options, LSCS is the only one to include the caveat 'but not as first choice'. This caveat is included without reference to any other clinical considerations which might affect the appropriateness of the options. (Para. 10 *Induction of labour including out-patient and use of intrapartum oxytocin*, 1st September 2016, Version 3.1)



6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the Maternity Quality & Safety Group WGH and the Clinical Director WGH: [redacted] 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 22nd April 2020, 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 parents of Jack Postle. 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	26/02/2020 Signature____________________ Geoffrey Sullivan Senior Coroner Hertfordshire