MR G IRVINE
ACTING SENIOR CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], **CEO, BHRUT NHS Trust, Queens Hospital, Rom Valley Way, Romford, RM7 0AG** [redacted] 2. **Department of Health & Social Care** [redacted]
1	**CORONER** I am Graeme Irvine, acting senior coroner, for the coroner area of East London
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 1st May 2020, I commenced an investigation into the death of Louie Neil Johnston, aged 1 week. The investigation concluded at the end of the inquest on 6th October 2021. The conclusion of the inquest was that Louie died from; 1a Diffuse Hypoxic/Ischaemic Encephalopathy 1b Acute chorioamnionitis with fetal inflammatory response 1c Ascending maternal genital tract infection A narrative conclusion was arrived at.

4	**CIRCUMSTANCES OF THE DEATH** Louie Neil Johnston died in hospital on 28th April 2020 as the result of diffuse hypoxic ischaemic encephalopathy, a condition caused by an inadequate supply of oxygen to the brain during his delivery on 17th April 2020. Avoidable delays in that delivery caused or contributed to his death. Factors that produced the delay included; 1. Disregard of part of a cardiotocography (CTG) trace that monitors uterine activity, which led to uterine hyper-stimulation not being considered as the cause for a drop in the baby's heart rate, 2. A prolonged attempt to deliver using a ventouse cup, 3. A sequential decision to proceed to a forceps delivery after the ventouse cup delivery failed, instead of an immediate category 1 caesarean section.
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 could 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. CTG trace monitoring equipment that was in use in the labour ward required staff to switch from a CTG trace screen to a K2 electronic recording screen during delivery. This meant that a graphic representation of the CTG trace was not clearly visible at all times. Instead, midwifery staff were required to crouch down and record numeric data from the CTG displayed on a small LED screen. The Trust identified this as counter-productive and raised the issue with the manufacturer of the system. To date, the system has not been updated. 2. A review of staff training records indicated that an obstetric registrar involved in the delivery was not up to date with mandated annual CTG training. Additionally, the obstetric consultant had not completed annual training which required the session to be repeated following the death of Louie Johnston. Systems in place at the Trust did not ensure that all medical staff had completed requisite training.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] 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 **9th December 2021**. 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, Louie's family and HSIB [and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. I have also sent it to the local Director of Public Health who may find it useful or of interest.

	I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**[DATE] 14/10/2021 [SIGNED BY CORONER]**