Regulation 28: Prevention of Future Deaths report

Ziggy Dylan MITCHELL-STAGG (died 04.04.21)

	THIS REPORT IS BEING SENT TO: **1. Dr [redacted]** **Medical Director** **Homerton University Hospital NHS Trust** **Homerton Row** **London E9 6SR**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 14 April 2021, I commenced an investigation into the death of Ziggy Mitchell-Stagg, a baby who died a few hours after birth. The investigation concluded at the end of the two day inquest on 15 December 2021. I made a determination of death by natural causes. The medical cause of Ziggy's death was: 1a) perinatal asphyxia 2 chorioamnionitis with funisitis, and macrosomia
4	**CIRCUMSTANCES OF THE DEATH** Ziggy's mum presented to Homerton University Hospital on 3 April 2021. Ziggy was born by emergency Caesarean section at 5.28am in a very compromised state, and died a few hours later.

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. There was not standardisation of the terminology used by the midwives and obstetricians to describe the meconium found, and the information requested by the computer system to record this did not necessarily reflect the verbal descriptions. Sometimes grades I, II & III were used; sometimes significant & insignificant; sometimes thick or thin. There was also inconsistency as to whether grade II was significant, and whether the term significant referred purely to the meconium noted, or to the meconium in the context of other features. 2. The obstetric registrar attending Ziggy's mum did not make any note in the medical records after 3.46am, even retrospectively. 3. I was told that your trust does not have a local policy regarding the use of centralised CTG monitoring, and it seems that such a policy merits consideration. 4. There is national guidance that there should be a fresh eyes review every hour for women in labour, but your trust policy indicates only every two hours. It seems that the trust policy merits reconsideration, either to amend it or to record why there is a departure from national guidance.
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 14 February 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 following. • [redacted] Ziggy's parents • The Healthcare Safety Investigation Branch (HSIB) • Dr [redacted], obstetric consultant, HUH • Dr [redacted], obstetric registrar, HUH • HHJ Thomas Teague QC, the Chief Coroner of England & Wales 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** **SIGNED BY SENIOR CORONER** 17.12.21 *ME Hassell*