Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Mid Cheshire Hospitals Nhs Foundation Trust**
1	**CORONER** I am Heath WESTERMAN, Assistant Coroner for Cheshire for the coroner area of Cheshire
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 30 November 2018 I commenced an investigation into the death of Remi Nana KODUAH aged 1 Days. The investigation concluded at the end of the inquest on 14 March 2022. The conclusion of the inquest was that: Baby Remi Nana Koduah was born on 22 November 2018 at 23.57. He died on 23 November 2018 at 00.46 at Leighton Hospital. He died as a result of exsanguination due to ruptured vasa praevia. The care and treatment of Remi's mother prior to delivery was appropriate and reasonable, vasa praevia being a rare condition that could not reasonably have been diagnosed before Remi was born. Upon discovery at birth there were a number of missed opportunities during resuscitation but it cannot be said that these caused or contributed to Remi's death.
4	**CIRCUMSTANCES OF THE DEATH** On 22 November 2018 [redacted] Remi's Mother attended the maternity unit at Leighton Hospital for induction of labour. Her pregnancy had been relatively normal and Remi was full term with all scans confirming a healthy baby. Her waters broke at around 7.30pm and blood was noticed shortly afterwards. She was moved to the labour ward and then upon a visit to the toilet suffered a significant show of blood and returned back to the ward. Fetal heartrate monitoring was difficult but when a reading was obtained around 11pm it was of concern and a category 2 C-Section was authorised. This was carried out at and at 11.57pm Baby Remi was delivered. He was pale and floppy and very ill and taken into a resuscitation room. The placenta showed signs of rupture and a message was relayed to the neonatal team that vasa praevia had occurred. During resuscitation no bloods or drugs were administered. Neonatal bloods were not present in the resuscitation room and were located some 10 minutes away. Resuscitation was stopped at 00.46am. Dr [redacted] a Consultant Obstetrician at Bath Hospital was asked by the Trust for an outside opinion. He said in evidence that he had never come across a resuscitation room be separate from the operating theatre as communication between the 2 teams was key and that bloods should have been available.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) 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 the resuscitation area was separate to the operating theatre thus hampering effective communications between the obstetric team and the neonatal team. (2) Neonatal bloods and adult bloods are not kept in the resuscitation room. Since Baby Remi's death bloods have been moved to the labour ward which is 2 mins away but in time critical moments this may still be too far away.
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 May 13, 2022. 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 **Bentley Solicitors Limited** **Mid Cheshire Hospitals Nhs Foundation Trust** I have also sent it to 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 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 by the Chief Coroner.
9	**Dated: 18/03/2022**

	 Heath WESTERMAN **Assistant Coroner for Cheshire for Cheshire**