REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive NICE**
1	**CORONER** I am Lydia Brown, Acting senior coroner, for the coroner area of West 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.
3	**INVESTIGATION and INQUEST** On 24 September 2019 I commenced an investigation into the death of Thomas Hoskin, newborn. The investigation concluded at the end of the inquest on 21 March 2022. The conclusion of the inquest was Medical cause of death 1a Congenital pneumonia 1b Placental acute chorioamnionitis with fetal inflammatory response 1c Maternal ascending genital tract infection due to Group B Streptococcus Conclusion Natural causes
4	**CIRCUMSTANCES OF THE DEATH** Thomas' mother presented to West Middlesex University Hospital in labour at term on 8 April 2019. During the course of her labour, there were clear signs of Thomas having an acute infection. Obstetric input was not requested as early as it could have been as the 2 clinicians were known to be in theatre, but other staff were working within the hospital and earlier senior input could have been obtained. There was no clear evidence that this would have led to an earlier delivery of Thomas, due to the number of factors presenting at the time that all had to be balanced and no one course of action was risk free. Thomas was delivered by forceps and his condition at birth was unexpectedly extremely poor and despite active resuscitation with all appropriate staff, he did not survive but died in hospital on 9 April 2019 shortly after his birth.

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. – It was brought to the Court's attention that the focus of guidelines relate to maternal infection, which is rarely life-threatening, but not to the optimal management of fetal infection which can be fatal or life changing. For Thomas, the evolving infection caused fetal circulatory collapse at birth and he could not be resuscitated. There appear to be no specific guidelines available to assist clinicians in this difficult situation and it was agreed by the independently instructed expert and the clinicians who gave evidence that this would be a helpful development.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 17th June 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 Chelsea and Westminster Hospital NHS Foundation Trust, Parents of Thomas and to the LOCAL SAFEGUARDING BOARD (as the deceased was under 18). I have also sent it to [redacted] (the independent instructed Consultant obstetrician 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	**22/04/2022** **Acting Senior Coroner, Mrs Lydia Brown**