Her Majesty's Coroner
West London

Coroner's Court
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, St George's University Hospitals NHS Foundation Trust**
1	**CORONER** I am Dr Séan Cummings Assistant Coroner, for the Coroner area of London (West)
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 the 20th February 2019 the Senior Coroner for the Coroner area of London (West) commenced an investigation into the death of Bethan Naomi Harris who was born on the 16th November 2018 at the St George's University Hospitals NHS Foundation Trust. The Investigation concluded at the end of the Inquest on the 19th November 2019. The conclusion of the inquest was that the medical cause of Bethan's death was (1a) Hypoxic Ischaemic Encephalopathy I recorded a narrative conclusion: Bethan Naomi Harris died at Shooting Star Hospice on the 26th November 2018 after delivery at St George's Hospital NHS Foundation Trust on the 16th November 2018. Her mother, [redacted] pregnancy had been uneventful. After admission to labour ward labour progressed very quickly indeed and she sustained severe brain injury during delivery. Despite best efforts by the Neonatal team she succumbed to her injuries.

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CIRCUMSTANCES OF THE DEATH

1. [redacted] was 41 weeks + pregnant when she went into labour at St George's University Hospitals Foundation NHS Trust.

2. She progressed through labour very rapidly – unusually so for a first time mother to be.

3. After she was moved to room four and at around 0450 to 0500 her unbroken membranes possibly containing meconium were visible to [redacted] and she drew this to [redacted] attention and I find that she did make the suggestion that CTG monitoring be undertaken.

4. For whatever reason the CTG was not placed. I find it was incumbent on MW Dunbar as the more senior midwife present – she was the Triage Midwife – to insist on the placing of the CTG.

5. Correct management of descent of membranes with liquor staining in a post dates woman progressing quickly in her first delivery was to rupture the membranes. Indeed [redacted] told me that had she known there was meconium in the liquor she would have ruptured the membranes and started the CTG monitoring.

6. In my view it is likely [redacted] did know and did not act at the time for reasons unknown

7. Had the membranes been ruptured it is more likely than not that delivery would have been expedited and the situation with the plunging fetal heart rate obviated. I consider it more likely than not that Bethan would then have been born in better condition. Unfortunately I cannot say on the balance of probabilities even with this intervention that Bethan would more likely have survived longer term.

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) The Inquest was held one year after Bethan Naomi Harris's death. During the course of the oral evidence it emerged that several, in my mind important, learning issues had not been addressed.

(2) There were issues relating to handover of patients to midwives and at the time of Inquest there had been no further specific training in relation to handover. Indeed it was stated that the process in place at the time of Bethan's delivery still pertained without alteration. This represented a risk to patients.

(3) At the time of Inquest a team debrief, which I consider to be a source of learning to reduce the risk of serious incident in future was still outstanding.

(4) There was little evidence from the oral evidence given that any effective reflection, reflective discussions or learning had taken place subsequent to Bethan's birth and then death. I consider it important that organisations seek to ensure individual and collective reflection to seek to avoid repetition. The evidence for this, one year on, was lacking.

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 August 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 family of Bethan Naomi Harris. 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. [redacted]
9	Dr Séan Cummings Assistant Coroner, London (West) 22ND June 2020