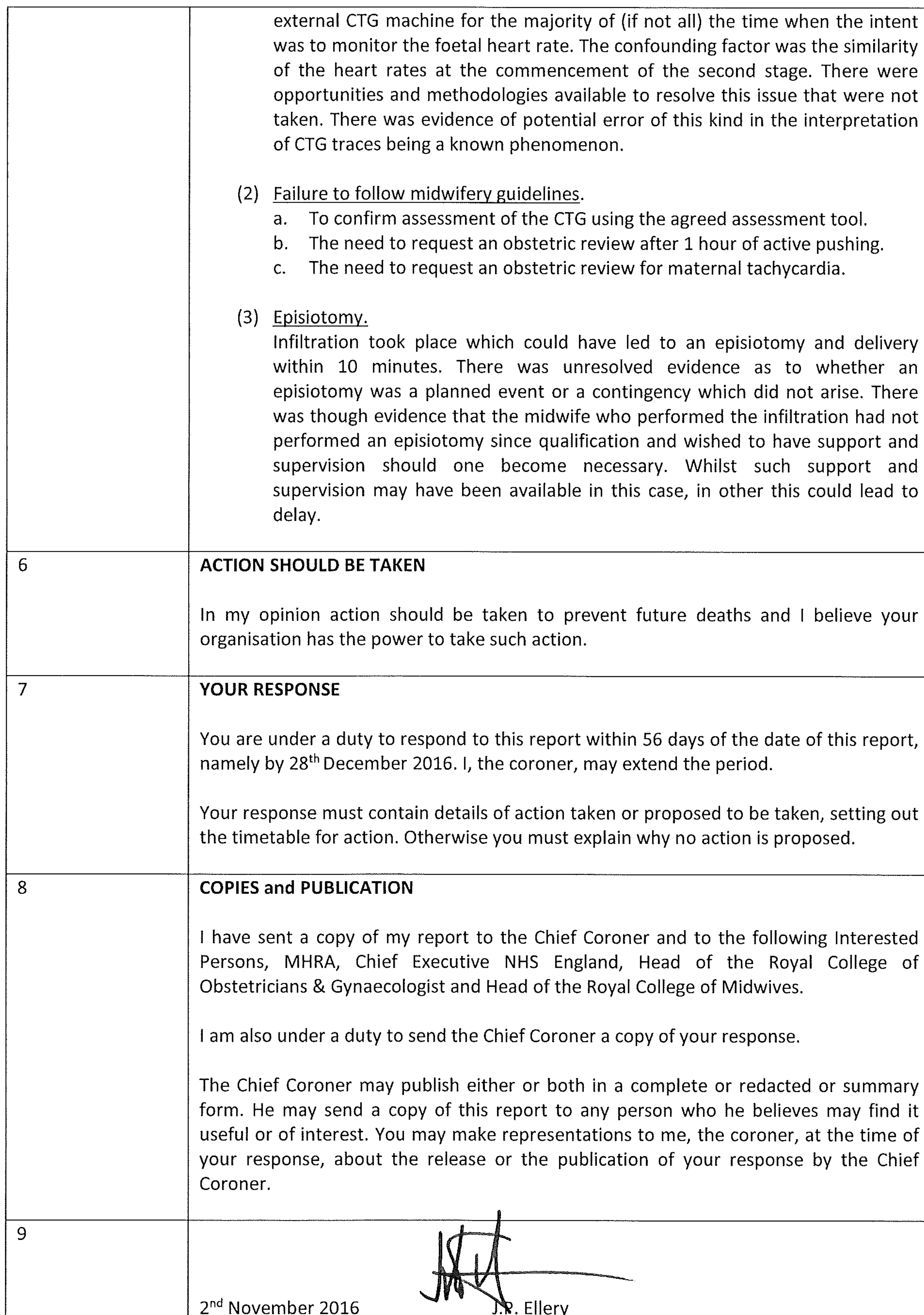
	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Mr Simon Wright Chief Executive Shrewsbury and Telford NHS Trust Royal Shrewsbury Hospital Mytton Oak Road Shrewsbury SY3 8XQ
1	**CORONER** I am John Penhale Ellery, Senior Coroner, for the coroner area of Shropshire, Telford & Wrekin
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 6th May 2016 I commenced an investigation into the death of Ivy Rebecca Morris aged 4 months. The investigation concluded at the end of the inquest on 12th October 2016. The conclusion of the inquest was Ivy Morris died from natural causes where death would have been prevented had appropriate monitoring taken place in the second stage of labour. The second stage of labour was delayed which added to the period of hypoxia and the severity of Ivy's hypoxic ischaemic brain injury at birth. As a result of her avoidable injuries, Ivy was vulnerable to bronchopneumonia, a condition from which she suffered in the months following her birth. On 3 May 2016 Ivy collapsed at home following an episode of bronchopneumonia and did not recover.
4	**CIRCUMSTANCES OF THE DEATH** Ivy was born at the Princess Royal Hospital, Telford on the 15th December 2015 following complications at birth Ivy was born with limiting medical needs including severe perinatal hypoxic ischaemic brain damage. Ivy had a prolonged stay in hospital following her birth and on discharge home she required her feeds through a nasogastric tube. On the 3rd May 2016 Ivy was at home at [redacted] being cared for by her father [redacted] During her feed [redacted] witnessed Ivy becoming unresponsive. He called for an ambulance and commenced resuscitation until the arrival of the ambulance. Resuscitation was continued by the paramedics until arrival at the Royal Shrewsbury Hospital where Ivy was pronounced dead.
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) Foetal heart monitoring. Ivy's foetal heart rate ought to have been monitored and was not monitored. In the second stage of labour the maternal heart rate was recorded on the



	external CTG machine for the majority of (if not all) the time when the intent was to monitor the foetal heart rate. The confounding factor was the similarity of the heart rates at the commencement of the second stage. There were opportunities and methodologies available to resolve this issue that were not taken. There was evidence of potential error of this kind in the interpretation of CTG traces being a known phenomenon. (2) <u>Failure to follow midwifery guidelines</u>. a. To confirm assessment of the CTG using the agreed assessment tool. b. The need to request an obstetric review after 1 hour of active pushing. c. The need to request an obstetric review for maternal tachycardia. (3) <u>Episiotomy.</u> Infiltration took place which could have led to an episiotomy and delivery within 10 minutes. There was unresolved evidence as to whether an episiotomy was a planned event or a contingency which did not arise. There was though evidence that the midwife who performed the infiltration had not performed an episiotomy since qualification and wished to have support and supervision should one become necessary. Whilst such support and supervision may have been available in this case, in other this could lead to delay.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 28th December 2016. 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, MHRA, Chief Executive NHS England, Head of the Royal College of Obstetricians & Gynaecologist and Head of the Royal College of Midwives. 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.
9	2nd November 2016 J.R. Ellery