Summary of Regulation 28 Report to Prevent Future death: **Bonnie Webster** (died 10/02/22)

RCPCH Royal College of Paediatrics and Child Health
Leading the way in Children's Health

This is a brief summary of the regulation 28 coroners report into the death of Bonnie Webster from which you can review the coroner recommendations to health care and consider whether there are changes you could implement in your local NHS trust to address them

Clinical summary

Mother presented with bleeding in labour

<u>Events surrounding Death:</u>

- CTG concerns and foetal bradycardia-> decision for Category 2 C-section (not category 1). Parents unaware of seriousness of concerns .
- Paediatric team alerted on foot instead of via bleep system.
- Delays in treatment postnatally (intubation, cooling, antibiotics)
- Death due to hypoxic ischaemic encephalopathy following deterioration post-tertiary transfer.

Coroner's Recommendations

- Clearer communication in emergency situations
- Ensure parental understanding if concerns about a patient
- Antibiotics should be given promptly when prescribed
- Ensure staff are aware of how to activate emergency calls

Key Themes

- Poor communication with parents
- Emergency protocols not followed
- Delays in administration of antibiotics
- Delay in treatment (cooling and intubation)

Local Improvement suggestions from this report:

- Improve patient/parent communication in emergencies & work to ensure information is understood-> co-produce improvement work with families.
- Review local sepsis guidelines & improve adherence to sepsis 'golden hour': antibiotics should be given within 1 hour
- Ensure robust staff training on emergency protocols e.g. how to activate '2222' emergency calls-> consider PDSA cycles of simulation training.

For full information visit: Bonnie Webster - Prevention of future deaths report - 2022-0378 (judiciary.uk)
or follow the QR code