Trevor H. Kirkman M.A.
H.M. Coroner for Rutland & North Leicestershire

[redacted]

JRCALC
South Central Ambulance Service
NHS Foundation Trust
7 & 8 Talisman Business Centre
Talisman Road
Bicester
Oxfordshire
OX26 6HR

6th August 2013.

Dear Sir,

Re: Lucy Hannah Rose Bailey (deceased)
Inquest Hearing: 10th July 2013 at Loughborough Coroners Court

Report under Regulation 28 of The Coroners (Investigations) Regulations 2013 and paragraph 7(1) of Schedule 5 to the Coroners and Justice Act 2009

Lucy Bailey died at the Leicester Royal Infirmary on the 17th September 2010. I resumed and concluded the inquest into the death of Lucy on the 10th July 2013 and found that the medical cause of death was:

1a Hypoxic ischaemic encephalopathy

I gave a Narrative Verdict and enclosed a copy of the Inquisition.

Report under Regulation 28 of The Coroners (Investigations) Regulations 2013 and paragraph 7(1) of Schedule 5 to the Coroners and Justice Act 2009

I am reporting this matter to you in accordance with Regulation 28 of The Coroners (Investigations) Regulations 2013 and paragraph 7(1) of Schedule 5 to the Coroners and Justice Act 2009

This provides that where the evidence gives rise to a concern that circumstances creating a risk of other deaths will occur or will continue to exist in the future, and in the coroner's opinion action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances, the coroner may report the circumstances to a person who may have power to take such action.

In accordance with Regulation 28 and paragraph 7 (1) a copy of this report is being sent to the Chief Coroner and all the other properly interested persons identified at the Inquest, together with other people I believe may find it useful or of interest. A list of recipients can be found at the end of this report.
Your response to this report will also be shared with those listed.

The Chief Coroner may send a copy of the report and response to any person who the Chief Coroner believes may find it useful or of interest. In addition, the Chief Coroner may publish a full copy or a summary of the report and response.

Regulation 29 of The Coroners (Investigations) Regulations 2013 and paragraph 7(1) of Schedule 5 to the Coroners and Justice Act 2009
requires that you give a written response within 56 days of the day the report is sent. If you are unable to respond within that time, you may apply to me for an extension.

The response must contain:

a. details of any action that has been taken or which it is proposed will be taken whether in response to this report or otherwise, and set out a time table of the action to be taken or proposed to be taken, or
b. an explanation as to why no action is proposed.

Within 56 days you may make written representations to me about:

a. The release of your response; or
b. The publication of your response

The written response will be sent to the Chief Coroner who will decide whether there should be any restrictions on the release or publication of the response

Facts and Circumstances

On the morning of the 16th September 2010 [redacted] Lucy's mother, started her contractions whilst she was at home. An ambulance was called and a paramedic and his colleague who was a qualified technician, arrived at 07.39. They in turn summoned a midwife.

The labour continued and her waters broke. A second ambulance crew arrived staffed by Emergency Care Assistants. The paramedic put [redacted] into the McRoberts position and the baby's head was born but her body did not follow. [redacted] was then put on all fours, but the birth did not continue. At no time was there any gentle traction to the baby's head by the paramedic or any internal manipulation of the baby whilst she was in [redacted]

The midwife arrived at about 8.10. by which time the baby's head had been born for several minutes. The midwife put [redacted] back into the McRoberts position and with some encouragement and internal and external manipulation Lucy was born at 08.14. It appeared to the midwife that Lucy's shoulders were in the transverse position, and that her shoulders semi-rotated as the baby was expelled.

Lucy was not breathing, and CPR was applied. Lucy was placed in the ambulance to be taken to hospital and a heart rhythm and spontaneous circulation was recorded at 08.56.

However at hospital it was clear that Lucy had been starved of oxygen and had suffered irreparable brain damage. She died the following day, on the 17th September 2010.

The evidence given at the Inquest by the paramedic concerned and by an expert in paramedic training, was that shoulder dystocia was a known hazard, and that the training guidelines specifically provided for the paramedic to put the mother into different birthing positions to try to assist a natural birth. The evidence was that the paramedic training process prohibited the paramedic from providing traction to the baby's head, or providing any internal or external manipulation of the baby whilst in the mother's vagina.

The standard training reference documents on paramedic training are provided by the Institute of Health Care Development (IHCD) training manual, and the Joint Royal Colleges Ambulance Liaison Committee (JRCALC) guidelines.

[redacted] Consultant in Obstetrics and Fetal Maternal Medicine, was instructed by HM Coroner to provide an independent report. In his evidence at the Inquest he felt it likely that the baby was large, and that the birth was hindered by soft tissue dystocia rather than shoulder dystocia. He felt that had the paramedic been in a position to provide gentle hands on traction of the baby's head or gentle internal manipulation of the baby whilst in [redacted], then Lucy may have been born without injury.

He went on to suggest that it was appropriate for paramedic training to provide for hands on assistance in giving gentle traction to the baby's head and that the risk to the baby in being injured was likely to be less than the risk of devastating oxygen starvation if such assistance was not provided.

Action which, if taken, may prevent a future fatality or reduce the risk of death created by such circumstances

That consideration should be given to amend the training manuals and guidelines to provide for the training of paramedics to assist a birth by providing gentle traction to the baby's head and/or gentle internal manipulation of the baby whilst in the mothers vagina.

Following the Inquest into Lucy's death there has been some very helpful exchange of e mail correspondence between [redacted] and [redacted], Consultant Obstetrician, who is a reviewer and author of the JRCALC guidance. Copies of the exchange of emails are attached and it appears that [redacted] agrees that it was to be expected that the birth attendant would apply gentle traction outwards and downwards on the baby's head after two contraction had elapsed.

[redacted] in his e mail says: *"In order to know if McRobert's (or any other manoeuvre) has worked, the person delivering MUST apply appropriate gentle traction to the head (with maternal affort) in order to see if the shoulders will deliver. Just applying McRobert's (with or without suprapubic pressure) but not applying gentle traction to the head will not likely lead to completion of delivery."*

Distribution of this Letter

Reply required from:

[redacted] JRCALC Chairman, South Central Ambulance Service NHS Foundation Trust.

East Midlands Ambulance Service, through their solicitors, Brown Jacobson.

For information to:

[redacted]
Leicestershire Safeguarding Children Board

[redacted]
The Chief Coroner

Time for Response

This letter is being sent out on the 6th August 2013. I therefore calculate that the detailed reply should be received by 1st October 2013.

I have power pursuant to Regulation 29 to extend the period of 56 days for the response if application is made by the recipient of this letter and sets out detailed grounds which are sufficient to persuade me that an extension of time is required.

I await hearing from you accordingly.

Yours sincerely,

Robert Chapman
Assistant Deputy Coroner