ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Department of Health** **2. Royal College of Obstetricians and Gynaecologists** **3.**
1	**CORONER** I am Philip Barlow, assistant coroner, for the coroner area of Inner London South
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. [HYPERLINKS]
3	**INVESTIGATION and INQUEST** On 29 September 2012 I commenced an investigation into the death of baby Leo Deady, age 1hour. The investigation concluded at the end of the inquest on 19 December 2013. The conclusion of the inquest was given by a narrative conclusion as follows: Leo Deady died at Queen Elizabeth Hospital at one hour of age following an undiagnosed breech presentation.
4	**CIRCUMSTANCES OF THE DEATH** [redacted] was considered to have a normal first pregnancy. She was examined by several experienced midwives after 28 weeks gestation, and in the early stages of labour at hospital, and all diagnosed cephalic presentation. The breech presentation was first noticed at 17.28 on 3.9.2013, when [redacted] was fully dilated, Leo was born at 17.47 by vaginal delivery. Evidence from the consultant obstetrician was that if the diagnosis had been made before labour had commenced, or earlier in labour, plans would have been made to turn Leo in utero or to deliver by caesarean section.
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) The evidence given at the inquest was that there is a small but significant rate of

	breech presentation nationally and that a significant proportion of breech presentations go undiagnosed. The percentage of undiagnosed breech presentations may be as high as 25%. The risks of vaginal breech delivery are very high. Although midwives (especially experienced midwives as in this case) pick up most cases of breech presentation, it is clear that a small but significant number are missed. The only certain way of detecting breech presentation is by scan. The evidence in this case was that there are no national guidelines as to whether hospitals should routinely scan at a late stage of pregnancy to exclude breech. The evidence at this inquest was that some London hospitals do carry out routine scanning in late pregnancy. There was no evidence available at the inquest to say whether the risks and benefits of routine scanning in late pregnancy has been considered nationally in the light of potential funding issues.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken by the Department of Health, if appropriate with advice from RCOG, to consider if any guidance of policy initiative would prevent future deaths. I believe you and your organisation 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 [DATE]. I, the coroner, may extend the period. 13th February 2013 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 [redacted] and South London Hospital NHS Trust [and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. I have also sent it to Royal College of Obstetricians and Gynaecologists who may find it useful or of interest. 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	**[DATE]** 19 xii 2013 **[SIGNED BY CORONER]**