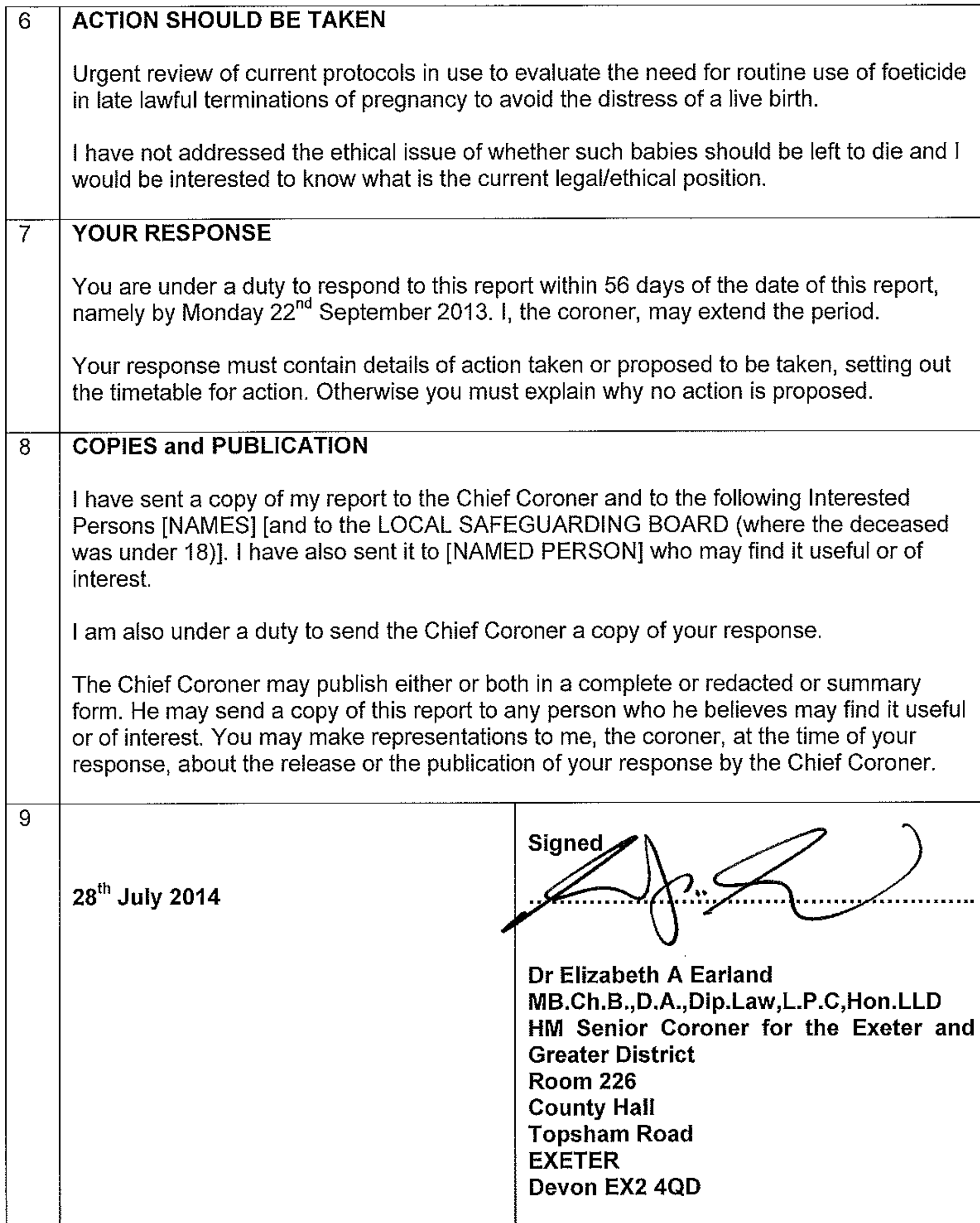
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Chief Executive North Devon District Hospital**
1	**CORONER** I am Dr Elizabeth Ann Earland, Senior Coroner for the Exeter and Greater Devon District
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 19th February 2014 I commenced an investigation into the death of Faye Elizabeth RIPPON, aged 1 day. The investigation concluded at the end of the inquest on 21st July 2014. The conclusion of the inquest was Lawful termination of pregnancy.
4	**CIRCUMSTANCES OF THE DEATH** Baby was delivered prematurely 21/40 gestation on 8th February 2014 at North Devon District Hospital, following medical termination of pregnancy with Mifepristone and Gemeprost on 6th/7th February 2014 in order to save mother's life.
5	**<u>CORONER'S CONCERNS</u>** 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) I write to express concerns that in this case performance of late terminations of pregnancy i.e. 21/40 gestation resulted in a live birth. I am aware your protocols for the use of a foeticide BEFORE induction of labour only allow foeticide to be used after this gestational date. However, I believe the Abortion Act was amended specifically to avoid the problems posed with late terminations resulting in live births. (2)It is extremely distressing for the midwives caring for the mother to be presented with a live baby which is not to receive life-saving medical attention, not to mention the lasting damage to the psyche of the parents. (3)A similar case arose at Inquest in the Royal Devon and Exeter Hospital only six days ago so live birth post induction of labour for termination of pregnancy is not an isolated occurrence.



<table>
<tr><td>6</td><td colspan="2">ACTION SHOULD BE TAKEN

Urgent review of current protocols in use to evaluate the need for routine use of foeticide in late lawful terminations of pregnancy to avoid the distress of a live birth.

I have not addressed the ethical issue of whether such babies should be left to die and I would be interested to know what is the current legal/ethical position.</td></tr>
<tr><td>7</td><td colspan="2">YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report, namely by Monday 22nd September 2013. 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.</td></tr>
<tr><td>8</td><td colspan="2">COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [NAMES] [and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. I have also sent it to [NAMED PERSON] 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.</td></tr>
<tr><td>9</td><td>28th July 2014</td><td>Signed ……………………………………

Dr Elizabeth A Earland
MB.Ch.B.,D.A.,Dip.Law,L.P.C,Hon.LLD
HM Senior Coroner for the Exeter and Greater District
Room 226
County Hall
Topsham Road
EXETER
Devon EX2 4QD</td></tr>
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