REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **(1) David Behan, Chief Executive, Care Quality Commission (CQC)** **CQCInquestsandCoroners1@cqc.org.uk**
1	**CORONER** I am R Brittain, Assistant Coroner for Inner North London
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** Oliver Asante-Yeboah died on 2 November 2014, aged three weeks. The medical cause of death was *E. coli* sepsis, resulting from mild renal abnormalities and a urinary tract infection. His death was contributed to by a non-therapeutic circumcision which had been performed a few days days prior. An inquest into his death was opened on 7 January 2015 and heard on 15 May 2015, at which I recorded a narrative conclusion (see attached).
4	**CIRCUMSTANCES OF THE DEATH** Oliver was born on 9 October 2014. His parents identified a Rabbi who agreed to perform a non-therapeutic circumcision. The Rabbi gave evidence at the inquest that he had been certified to perform the procedure by the 'Initiation Society of Great Britain' (the organisation which supervises the training of Rabbis to perform circumcisions) and that he has performed two to three circumcisions per week over the past 15 years, without any complications to his knowledge. He set out that his sterilisation procedures include the use of an autoclave (to prepare the necessary surgical instruments) and the application of 'Dettol' to the surgical site. The Rabbi noted his consenting procedure comprised discussion of the risk of infection through use of that term only, without further clarification of what infections could develop following the procedure. I heard evidence that the risk of urinary tract infections is increased after circumcision and that this risk is heightened where the procedure is undertaken in a 'non-medical' setting. On 2 November Oliver's parents took him to their local Emergency Department because he was feeding less well and his sleep pattern had altered. Analysis of his urine demonstrated the presence of an infection. Despite the institution of intravenous antibiotics and attempts to resuscitate him, he rapidly deteriorated and died later on 2 November 2015.
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 Rabbi who performed Oliver's circumcision gave evidence that his practice was not regulated by any official body or organisation. The pathologist who performed the *post mortem* was clear that she considered the circumcision to be a surgical procedure. The consultant paediatrician, who was involved in attempts to resuscitate Oliver, stated that research has demonstrated an increased risk of infection after circumcision in a non-medical setting. It was clear from the evidence adduced at the inquest that the circumcision had contributed to Oliver's death, although it was not possible to conclude that the fact it was performed in a non-medical setting increased the risk of infection in this particular case. I am concerned that future deaths could occur in similar circumstances, owing to the lack of formal regulation of non-medical providers of circumcision.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe that the addressee, 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 22 July 2015. 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, Oliver's family, the NHS Trust and the Rabbi who performed Oliver's circumcision. 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	**27 May 2015** **Assistant Coroner R Brittain**