REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. Chief Executive, Pennine Acute Hospitals NHS Trust 2. Royal College of Obstetricians & Gynaecologists 3. Department of Health
1	**CORONER** I am Ms L J Hashmi, Area Coroner for the Coroner area of Manchester North
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On the 24th March 2015, I commenced an investigation into the death of infant Thomas Beaty
4	**CIRCUMSTANCES OF DEATH** On the 11th April 2014, the deceased's mother went into spontaneous labour (39 weeks gestation). There was delayed stage II and as a result, the medical team caring for mother and baby proceeded to manually rotate the foetus (he was in malpresentation), to carry out a trial of instrumental delivery (forceps) in theatre with an action plan set in the event that this intervention failed. The instrumental delivery was abandoned, baby's head manually disimpacted and an emergency caesarean section carried out. At birth (00:31), the deceased's APGARS were good and he appeared healthy. A cord blood gas was taken, the result of which was marginally abnormal. At 02:20, the deceased started to bleed and rapidly collapsed. He had suffered a catastrophic head injury (a rare but recognised complication of necessary medical intervention) resulting in hypovolaemic shock and hypoxic brain ischaemia. He developed bleeding complications (disseminating intravascular coagulation), deteriorated rapidly and died 26 hours after birth.
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. **Instrumental Delivery Guidance** – the Court heard how local/national protocols and training programmes are routinely based on guidance issued by the Royal College of Obstetricians and NICE. The guidance in use at the time of Thomas' birth was found to be ambiguous, misleading and potentially open to misinterpretation. A key example was: '...When to abandon the procedure: • No evidence of progressive descent with each pull • No evidence of imminent birth following 3 pulls of a correctly placed instrument by an experienced operator...' The first point by implication must mean that where there is no descent with the first pull, then the procedure ought to be abandoned, yet the second point suggests abandonment after a 3rd traction. 2. **Terminology** - The RCOG Guidance did not provide operational definitions for words such as 'imminent' (*vis a vis* birth) or 'crowning'. This was particularly important in Thomas' case, as it had a bearing on the decision making processes applied during the course of the forceps delivery. 3. **Traction** - The term 'gentle' (traction) forming the 'G' of the algorithm within the Trust's protocol was misleading and not in line with the RCOG Guidance. The clinical evidence suggested that in most (if not all) cases mild to moderate traction is routinely applied by clinicians in order to ensure safe and successful instrumental delivery. Whilst it was accepted that this was often subjective, the term 'gentle' was clinically out with. 4. **Development of Trust Guidance** – it is difficult for Trusts to change their guidance until and unless there is a change/material improvement in the Guidance issued by the RCOG.
6	**ACTION SHOULD BE TAKEN** **In my opinion action should be taken to prevent future deaths and I believe each of you respectively 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 the 27th May 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 and to the following Interested Persons namely:- - Thomas' parents (via their legal representative) - [redacted] (via her legal representative) 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 from. 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: 31 · 3 · 2015 Signed: