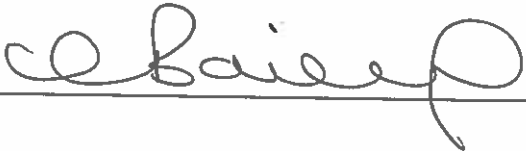
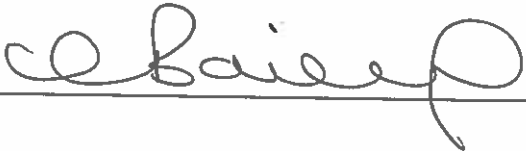


REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>South Tees Hospitals NHS Foundation Trust</p>
1	<p>CORONER</p> <p>I am Clare Bailey, acting senior coroner, for the coroner area of Teesside.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 29 August 2014 I commenced an investigation into the death of Lincoln James BRADY, stillborn. Provisional evidence indicated that Lincoln was alive for forty minutes after he was born. The investigation concluded at the end of the inquest on 21 March 2016. The conclusion of the inquest was STILLBORN.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Lincoln was born at 07.12 on 26 August 2014 by vaginal birth. Originally it was believed that he was alive.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>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.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>At 02.40 on 26 August 2014 whilst in labour Mrs Brady was subjected to an abdominal and a vaginal examination. The results of the examination did not correlate. Despite this fact no further investigations, to include an ultrasound scan, were undertaken to confirm Lincoln's presentation. This resulted in Mrs Brady being considered a low risk delivery and a breach position not being diagnosed. In turn this prevented appropriate planning regarding a preferred method of delivery.</p>
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe your organisation have the power to take such action.</p>

7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 18 May 2016. I, the coroner, may extend the period.</p> <p>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.</p>				
8	<p>COPIES and PUBLICATION</p> <p>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [REDACTED]</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>				
9	<table border="0"> <tr> <td data-bbox="309 815 678 853">DATE</td> <td data-bbox="678 815 1364 853">SIGNED BY CORONER</td> </tr> <tr> <td data-bbox="309 853 678 952">23.3.16</td> <td data-bbox="678 853 1364 952"></td> </tr> </table>	DATE	SIGNED BY CORONER	23.3.16	
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