REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: The Secretary of State for Health and the Healthcare Safety Investigation Branch
1	CORONER I am Alison Mutch ,Senior Coroner, for the coroner area of South Manchester
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 9th March 2017 I commenced an investigation into the death of Aniyah Jasmine Winston. The investigation concluded on the 20th July 2018 and the conclusion was one of died as a recognised complications of a breech delivery contributed to by neglect. The medical cause of death Osteo-diastasis of the occipital bone on a background of hypoxia
4	Aniyah Jasmine Winston was a full term baby with no complications antenatally. Her Mother arrived at Tameside General Hospital on 8th March 2017 at about 7am. Her waters had broken. At about 7:25am she was examined and was fully dilated. Aniyah's presentation did not appear to be head down. A registrar examined and concluded Aniyah was a breech presentation. A decision was made to try for vaginal delivery. From about 8:15am for approximately 30 minutes there were strong, regular expulsive contractions. The contractions reduced at about 8:45am. Examination showed Aniyah had not moved. At the handover meeting at about 9am an undocumented decision was taken to administer Syntocinon without further review, examination or counselling of her mother. No prescription was written for the Syntocinon that was then administered. At 09.43 Aniyah's foot was delivered. After manipulation and intervention by the medical team led to Aniyah being fully delivered at 10:28am in poor condition. She had sustained damage

	to the occiput likely to have been caused as the head was manipulated. A heart beat was present as the head was being manipulated. Neo natal life support was commenced . At 10:59am the decision was made to cease resuscitation.
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 inquest heard that Aniyah was an undetected breech birth. By the time it was identified she was breech her mother was fully dilated. The inquest heard that there are undetected breech births are not uncommon and present particular challenges for those involved in care during labour. The inquest was told that it is the case that pre delivery scans are not routinely carried out to try and reduce the number of undetected breeches and midwives/doctors rely on external examination. The inquest was told that this is due to availability of scanning facilities and training to utilise the scanners. 2. The inquest was told by a number of medical professionals involved in Aniyah's birth that they whilst they felt the decision to give Syntocinon was incorrect they did not feel comfortable challenging the decision. The expert instructed was clear that at the time it was given it should not have been. The Trust has since the death of Aninyah put in place a detailed programme to improve confidence in challenging decision-making within a MDT setting. However the extent of recognition of the issue and steps to counter it nationally were unclear.
6	ACTION SHOULD BE TAKEN In my opinion, action should be taken to prevent future deaths and I believe you 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 19th September 2018 . 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 [redacted] (Father), [redacted] (Mother), Tameside General Hospital and [redacted] 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	Alison Mutch OBE HM Senior Coroner 25/07/2018