REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1.** The Right Honourable Matt Hancock MP, Secretary of State for Health, 39 Victoria Street, London SW1H 0EU **2.** Manchester University NHS Foundation Trust, Cobbett House, Manchester Royal Infirmary, Oxford Road, Manchester M13 9WL **3.** Royal College of Obstetricians and Gynaecologists, 27 Sussex Place, Regents Park, London NW1 4RG
1	**CORONER** I am Simon Nelson, HM Assistant Coroner for the Coroner Area of Manchester West.
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 2018 I commenced an Investigation into the death of Mohammed Rehman Ahmed. The Investigation concluded at the end of the Inquest on the 6th June 2018. The conclusion of the Inquest was Mohammed Rehman Ahmed died of Natural Causes precipitated by the compassionate termination of pregnancy.
4	**CIRCUMSTANCES OF THE DEATH** The mother of baby Mohammed Rehman Ahmed was referred to St Mary's Hospital Fetal Medicine Unit due to the diagnosis of a spina bifida defect on the routine fetal anomaly scan. Arrangements were made for her to attend for an elective feticide procedure on the 16th February 2018. The procedure went smoothly and without complications with the Consultant Obstetrician noting an immediate response of cardiac cessation following the administration of potassium chloride via the umbilical cord vein. After 10-15 seconds of watching the fetal heart the needle was removed. The Consultant subsequently returned to the Scan Room to confirm fetal asystole and noted no heartbeat. Both mother and professionals were under the impression that fetal death had occurred following which mother presented at the Royal Bolton Hospital for induction of labour to deliver the baby. Baby Mohammed Rehman Ahmed was born at 01:45 hours on 17th February with spontaneous breathing and movement. Compassionate care was provided prior to the fact of his death being confirmed at 02:48 that day.

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. 1. Mother in particular but also the experienced professionals involved were wholly unprepared both emotionally and technically for a live birth. "Stunned" "shocked" and "distressed" were amongst the epithets given in evidence to describe their reaction to the birth. The Neonatal Team were not present and would not have expected to be present and had to be called urgently to review baby Mohammed. 2. However well-intentioned - the attempt to reduce the time that a patient waits in the Department after feticide has been performed by minimising the scan time when confirming fetal death contributed to this unintended case of a live birth after termination of the pregnancy. The Consultant Obstetrician giving evidence confirmed the need to formally record the exact time of the injection as well as confirmation of fetal demise at the "interval scan" which should be at least 20 minutes later with the interval fetal heart check for a full minute to avoid more transient changes than permanent asystole. Following the case involving baby Mohammed written Feticide Guidelines have been implemented (copy attached). The Consultant Obstetrician agreed that it would be good practice to contemporaneously record the medication infused, the time of infusion; the time of insertion and withdrawal of needle and the time at which the fetal heartbeat was monitored on ultrasound. 3. Without intending to be prescriptive I am of the opinion that other Departments nationally which carry out feticide procedures should be aware of the tragic sequence of events which took place in Greater Manchester and should consider the implementation of similar written guidance with documented procedures to facilitate unequivocal confirmation of fetal demise. 4. Consideration should also be given to the desirability of a leaflet for parents which fully explains the feticide process using appropriately sensitive and lay terminology.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent action should be taken to prevent future deaths and I believe that 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 Wednesday the 12th 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:- 1. [redacted] (baby Mohammed's mother) 2. The Chief Executive, Bolton NHS Foundation Trust 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	**Dated** **18 July 2018**	**Signed** **Simon Nelson, HM Assistant Coroner, Manchester West**