**Derek Winter DL**
**Senior Coroner for the City of Sunderland**

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| | **REGULATION 28 REPORT TO PREVENT FUTURE DEATHS**<br><br>**THIS REPORT IS BEING SENT TO:**<br><br>**Secretary of State for Health and Social Care** |
| 1 | **CORONER**<br><br>I am Derek Winter DL, Senior Coroner for the City of Sunderland |
| 2 | **CORONER'S LEGAL POWERS**<br><br>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.<br>http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7<br>http://www.legislation.gov.uk/uksi/2013/1629/part/7/made |
| 3 | **INVESTIGATION and INQUEST**<br><br>On 20th August 2020 I commenced an Investigation into the death of Master Vinnie William Ord Dodds (Vinnie), who was born on 14th April 2020 and died in Sunderland Royal Hospital on the same day.<br>The Investigation concluded at the end of the Inquest on 1st July 2021. The medical cause of death was confirmed as: -<br>Ia Hypoxic Ischaemic Encephalopathy<br>Ib Shoulder Dystocia |
| 4 | **CIRCUMSTANCES OF THE DEATH**<br><br>Vinnie William Ord Dodds died at Sunderland Royal Hospital on 14th April 2020 when a major shoulder dystocia was recognised following a forceps delivery of his head. Appropriate manoeuvres were undertaken, and the birth was completed, but Vinnie could not be successfully resuscitated.<br>I recorded a narrative conclusion Complications of childbirth. |
| 5 | **CORONER'S CONCERNS**<br><br>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.<br>The **MATTERS OF CONCERN** are as follows: –<br>Although shoulder dystocia is a medical emergency for which staff are trained, it was the elements of the mother's antenatal care which gave rise to concerns notwithstanding the obvious impact of the pandemic.<br>The Trust carried out and acted on a full review. However, there are concerns of wider |

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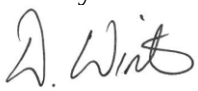
| | significance: -<br>1. There is no national guidance for the management of large babies in pregnancy, unless diabetes is present, so it may not be possible to produce a safety recommendation to advise mothers with a suspected large baby.<br>a) should counselling/management be based on 'macrosomia' (i.e. weight estimated >4500g for diabetes and >5000g for non-diabetic) or alternatively should it now be applied to all babies estimated to be >90th centile by scan >34 weeks?<br>b) in counselling women about risk of shoulder dystocia in LGA, should this include formal mention of the rare risk of foetal death and if women are to be fully informed should this be balanced by the rare risk of maternal death with an elective Caesarean section (the only other mode of delivery to be considered)?<br>c) in fact, point b is highly relevant to counselling ALL women about the risks associated with shoulder dystocia and would be very useful to rationalise.<br>2. NICE in 2015 indicated a glucose tolerance test at 24-28 weeks. Should the optimum be at 26 weeks?<br>3. The risk of death from shoulder dystocia was not discussed and is not included in the current RCOG shoulder dystocia patient information leaflet (RCOG 2013). |
| 6 | **ACTION SHOULD BE TAKEN**<br><br>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**<br><br>You are under a duty to respond to this report within 56 days of the date of this report, namely by 14th September 2021. I, the Coroner, may extend the period.<br><br>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**<br><br>I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: -<br>• Family<br>• Care Quality Commission (CQC)<br>• Healthcare Safety Investigation Branch (HSIB)<br>• South Tyneside and Sunderland NHS Foundation Trust and their Solicitors<br>• Risk and Inquest Manager, South Tyneside and Sunderland NHS Foundation Trust<br><br>I am also under a duty to send the Chief Coroner a copy of your response.<br><br>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 this 20th July 2021<br><br>Signature  <br>Senior Coroner for the City of Sunderland |