Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Chief Executive Milton Keynes University Hospital

1 CORONER

I am Tom OSBORNE, Senior Coroner for the area of Milton Keynes

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 01/04/2021 I commenced an investigation into the death of Poppy HARRIS aged 4 Months. The investigation concluded at the end of the inquest on 15 October 2021. The conclusion of the inquest was:

Cause of death

I a Respiratory Failure

I b Spinal Cord Injury (Cervical, Level 1 & 2)

I c Birth Injury

Narrative Conclusion - Poppy Harris died as a result of a spinal cord injury (Cervical level 1 & 2) caused by the inappropriate use of Kielland's forceps during delivery for which her mother had not given informed consent.

4 CIRCUMSTANCES OF THE DEATH

Poppy Harris was born at Milton Keynes University hospital on 23rd November 2020 following a protracted labour, she was delivered by the use of Kielland's forceps. She was transferred to John Radcliffe Hospital in Oxford where it was discovered that she had suffered a spinal cord injury and despite all efforts and care she died on 24th March 2021.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

1. I am concerned that when [redacted], Poppy's Mum, came into the hospital she did not have a birth plan and the midwives did not attempt to complete one. There was therefore no indication as to her preferences for treatment and care throughout her labour.
2. Poppy was delivered by the use of Kielland's forceps that resulted in a catastrophic spinal cord injury. I believe the Hospital should carry out an urgent review of the use of Kielland's forceps and decide that they should no longer be used.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 15th December 2021. 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]
2 CQC
3 **GMC**

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.

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Tom OSBORNE
Senior Coroner for
Milton Keynes
Dated: 20 October 2021

RCOG
Regulation 28: REPORT TO PREVENT FUTURE DEATHS (1)

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REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO: [redacted], Chief Executive Officer of the Royal College of Obstetricians and Gynaecologists

1 CORONER

I am Tom OSBORNE, Senior Coroner for the area of Milton Keynes

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 01/04/2021 I commenced an investigation into the death of Poppy HARRIS aged 4 Months. The investigation concluded at the end of the inquest on 15 October 2021. The conclusion of the inquest was:

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Narrative Conclusion - Poppy Harris died as a result of a spinal cord injury (Cervical level 1 & 2) caused by the inappropriate use of Kielland's forceps during delivery for which her mother had not given informed consent.

4 CIRCUMSTANCES OF THE DEATH

Poppy Harris was born at Milton Keynes University hospital on 23rd November 2020 following a protracted labour, she was delivered by the use of Kielland's forceps. She was transferred to John Radcliffe Hospital in Oxford where it was discovered that she had suffered a spinal cord injury and despite all efforts and care she died on 24th March 2021.

5 CORONER'S CONCERNS

The MATTERS OF CONCERNS are as follows:

My concern is that this baby died as a result of the use of Kielland's forceps and there should now be a thorough review of the use of Kielland's by the college and consideration given to whether it should be used in the future.

6 ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe you (and/or your

organisation) have the power to take such action.

8 COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons

1 **Milton Keynes University Hospital**
2 [redacted]
3 CQC

who may find it useful or of interest.

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Tom OSBORNE
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Dated: 20 October 2021