C.G.BUTLER
SENIOR CORONER · BUCKINGHAMSHIRE

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The National Institute for Health and Care Excellence (NICE)**
1	**CORONER** I am CRISPIN GILES BUTLER, senior coroner for the coroner area of Buckinghamshire
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. http://www.legislation.gov/uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/pdfs/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 3rd July 2020, I commenced an Investigation into the death of Mollie Daisy DIMMOCK, who died at 03:11 on 25th June 2020 at Stoke Mandeville Hospital, 34 minutes after being delivered. The Investigation concluded at the end of the Inquest on 14th October 2021. The medical cause of death was confirmed as:

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[redacted]

	1a Perinatal asphyxia
4	**CIRCUMSTANCES OF THE DEATH** Molly's death was confirmed when she was 34 minutes old at 03:11 on 25th June 2020 at Stoke Mandeville Hospital from perinatal asphyxia due to hypoxia caused by umbilical cord compression from shoulder dystocia which lasted for five minutes before Molly was fully delivered. A narrative conclusion was recorded: Molly was a large for gestation age baby. On the balance of probabilities, comparison between the 20 week and 36 week ultrasound scans demonstrate accelerated fetal growth. Retrospective review of the 36 week scan by the Health Safety Investigation Branch clinical panel considered that the abdominal circumference of Molly was under measured and this led to an under estimation of her fetal weight. Molly's mother was not referred for obstetric consultation following the 36 week scan. The first opportunity for an obstetric discussion with Molly's parents about the risks of delivery came late in labour, early on the morning of delivery. On balance, Molly's parents did not have the understanding that shoulder dystocia was a risk. The option of proceeding straight to a caesarean section was not offered to Molly's parents and consent was procured on the basis of a trial delivery with Kielland's forceps, only with caesarean section as an option thereafter. Molly's head was delivered at 02:31 and shoulder dystocia was identified. Molly's body was delivered five minutes thereafter with the umbilical cord wrapped around her neck. Molly was unresponsive, although there was evidence of a heartbeat reported, and, notwithstanding attempts to resuscitate her, she was confirmed to have died 34 minutes after delivery. The risk of shoulder dystocia was heightened by Molly's size.

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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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – NICE Guidance NG121 last updated 25 April 2019 relates to intrapartum care for women with existing medical conditions or obstetric complications and their babies. Within this Guidance, whist there is reference at paragraph 1.17 to guidance in respect mode of birth for large-for-gestational-age babies, there is no definition of a large-for-gestational-age baby in the Guidance. There does not appear to be any national guidance or accepted definition of large-for-gestational-age such that application of the Guidance is open to interpretation and variation depending upon an NHS Trust's own policies and guidance, and, in turn, the interpretation of obstetricians and other clinicians advising potential parents in anticipation of delivery modes. It is clear that NG121 is intended to provide guidance in relation to many potential scenarios which may impact upon care and mode of delivery decisions. The uncertainty surrounding when section 1.17 of the Guidance should be relevant arises through the lack of a definition of a large-for-gestational-age baby. Application of section 1.17 of the Guidance includes consideration of shoulder dystocia and options for continuing labour or caesarean section relevant to both the life of the mother and the baby.
6	**ACTION SHOULD BE TAKEN**

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	In my opinion action should be taken to prevent future deaths and I believe 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 4th January 2022 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 and other agencies: The Family of Molly Dimmock Buckinghamshire Healthcare NHS Trust Healthcare Safety Investigation Branch (HSIB) NHS England (National Maternity Lead) Royal College of Obstetricians and Gynaecologists (RCOG) I am also under a duty to send the Chief Coroner a copy of your response.

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	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	**9th November 2021** **Crispin Giles Butler, Senior Coroner for Buckinghamshire**

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