	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Royal College of Obstetrics and Gynaecology The Royal College of Nursing and Midwifery
1	**CORONER** I am Laurinda Bower, HM Assistant Coroner for **Nottingham City and Nottinghamshire**
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/part/7/made
3	**INVESTIGATION and INQUEST** On 20 January 2019, I commenced an investigation into the death of NOAH RICHARD POOLE. The investigation concluded at the end of an inquest heard over 5 days on Monday 14 September 2020 with judgment handed down today, 9 October 2020. The conclusion of the inquest was that NOAH RICHARD POOLE died as a result of a head injury sustained during his delivery by caesarean section 1a. Head Injury 1b 1c II
4	**CIRCUMSTANCES OF DEATH** Noah Richard Poole was born by emergency caesarean section delivery at the Pilgrim Hospital, Boston, Lincolnshire, on 11 January 2019. He was transferred to the Neonatal Tertiary Centre at the City Hospital, Nottingham, on 12 January 2019, and died there on 19 January 2019, aged 8 days. Noah died as a result of complications of a head injury that was sustained during his difficult extraction by caesarean delivery. The Doctor or Nurse attempting to free Noah's head from inside the maternal pelvis caused a depressed fracture to his skull by the force applied from a finger or fingers. The fracture more than minimally contributed to his death. There was a missed opportunity to deliver Noah safely by way of a caesarean section at 36 weeks in accordance with maternal wishes. The Trust failed to expressly inform Noah's Mother of her right to request an elective caesarean section, in accordance with NHS guidance for a twin pregnancy. Furthermore, the medical professionals caring for Mrs Poole, failed to properly take account of her expressed wishes to have a pre-planned caesarean section. The Trust failed on multiple occasions to properly counsel Noah's Mother as to the risks and benefits of the two modes of delivery.

	Senior Obstetric Staff were confused about what guidance ought to be given to Mother's expecting multiple births, and when those conversations ought to happen. This important conversation was repeatedly deferred to the next appointment such that it never happened and there was no agreed birth plan. The Trust's guidance is unclear and excluded any reference to elective caesarean sections, in conflict with national guidance. As a result, Noah's Mother was not in a position to provide properly informed consent to the induction of labour procedure that occurred on 11 January 2019. If Noah's mother had been properly counselled as to the two modes of delivery, she would have chosen a pre-planned caesarean section delivery at around 36 weeks gestation when there is no reason to suggest Noah would not have survived. Therefore, the failings with regards to agreeing a mode of delivery between patient and any doctor, more than minimally contributed to Noah's death.
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) Lack of professional Guidance regarding the use of a vaginal push to disimpact the fetal head Almost all of the Midwives in this case told me that they had been asked perform a 'vaginal push' in theatre at some point in their career, but it is not something that frequently occurs, nor is it something they are trained to do. Furthermore, practice varies between doctors as to whether they ask a fellow doctor to provide the vaginal push, or a midwife, and whether they provide the individual with any guidance on exactly what they should do. The Midwife did exactly what was asked of her to "push" Noah's head. She performed this in the usual way that midwives perform a vaginal examination, that is, with two pointed digits. I have been unable to determine whether it was the Doctor's fingers or the Midwife's fingers that caused the depressed fracture to Noah's head, but both are a possibility, and the issue remains that midwives are asked to perform a manoeuvre in a theatre environment for which they have received no training nor is there any professional guidance. Equally, there is no guidance for the Doctor as to whether and what information they ought to impart to the midwife before they embark on the procedure. (2) Lack of Professional Guidance in relation to the use of fetal pillows The inquest further discovered that the understanding on the use of fetal pillows in this scenario is inconsistent. The manufacturers appear to suggest that the mother's cervix should be at least 8cm dilated, but again, practice and understanding seems to vary. I made enquiries of the Health Sector Investigation Branch. They were not aware of any national guidance either on vaginal pushes in theatre or the use of fetal pillows. Nor could I find any guidance on the RCNM website. The Trust has made enquiries of the RCOG and other Trusts, but again there appears to be an absence of guidance and variation of practice across the Country. While I accept the incidence of traumatic head injury as a result of difficult fetal extraction is, thankfully, rare, and that midwives are only asked to provide a vaginal push 'in extremis', any procedure should be performed by a competent and capable individual who has the support of robust professional guidance to assist them.

	All witnesses in this case said it would be useful to have multidisciplinary guidance and training on this issue.
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 action in relation to the above matters. The Royal College of Obstetrics and Gynaecology The Royal College of Nursing and Midwifery
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by **4 December 2020**. I, the coroner, may extend the period upon consideration of a written request. 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** In addition to the organisations identified in section 6 above, I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: The Poole Family and their Lawyers United Lincolnshire Hospitals NHS Trust and their Lawyers The Care Quality Commission and The Health Sector Investigation Branch I am also under a duty to send the Chief Coroner a copy of the responses received from the organisations listed in section 6 above. 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	9 October 2020 Signature_____ Miss Laurinda Bower, Assistant Coroner, **Nottingham City and Nottinghamshire**