HM CORONER
Central Lincolnshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Ms Jayne Lewington, United Lincolnshire Hospitals NHS Trust, County Hospital, Greetwell Road, Lincoln, LN2 4AX.**
1.	**CORONER** I am Stuart P G Fisher, Senior Coroner, for the coroner area of Central Lincolnshire, Lindum House, 10 Queen Street, Spilsby, Lincolnshire, PE23 5JE.
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 14/10/2013 I commenced an investigation into the death of Thor Harrison Dalhaug. The investigation concluded at the end of the inquest on 05/01/2015. A Narrative Conclusion was returned,, the medical cause of death being: 1a. Birth Related Brain Injury
4.	**CIRCUMSTANCES OF THE DEATH** 1. In January 2013 [redacted] became pregnant with dichorionic diamniotic twins. The pregnancy was the result of in vitro fertilisation. 2. The pregnancy proceeded normally until August 2013 when it was suspected and later confirmed that [redacted] had developed obstetric cholestasis. 3. On 22 September 2013, [redacted] had a spontaneous rupture of the membranes and was admitted to Lincoln County Hospital on 22 September 2013. Medication was administered to commence the induction process. 4. At 12.40pm on 23 September [redacted] was given an epidural infusion. At 1.10pm Thor Dalhaug suffered a bradycardia which lasted for approximately 3 minutes which may have been associated with the epidural infusion. 5. At 2.05pm Thor was observed to have an uncomplicated baseline tachycardia which was defined as "suspicious". Tests established that [redacted] was suffering abnormal renal and liver function. At

	3.20pm a decision was made that [redacted] should undergo a caesarean section (category 2). At 4.00pm [redacted] was taken to theatre. Arrangements had been made for paediatric support to be available in the operating theatre. 6. The caesarean section commenced at 4.25pm with knife to uterus at 4.27pm. Thor's head was found to be deeply engaged . The surgeon who performed the caesarean section attempted on 3 separate occasions to manually lift Thor's head from the pelvis without success. This resulted in considerable pressure being placed upon Thor's head. No attempt was made to release Thor's head by affecting a "vaginal push", which is the orthodox and appropriate way to deliver the head safely. The surgeon then attempted to deliver Thor by utilising Wrigley's Forceps. The surgeon inserted blade 1 without difficulty, however was unable to insert blade 2 properly at which point the use of Wrigley's Forceps was abandoned. The use of forceps in these circumstances was unorthodox and unacceptable. At this point a request was made for the attendance of a consultant, however before the arrival of the consultant. Thor was delivered at 4.30pm. He was found to be in a poor condition and completely hypotonic and was handed to the paediatric team at 40 seconds. Extensive efforts were made to resuscitate Thor and a heartbeat was achieved. His condition then deteriorated. Attempts to resuscitate him then ceased and Thor died approximately 1 hour after his birth on 23rd September 2013. The second twin was successfully delivered shortly after Thor's delivery in a healthy condition. 7. On 26th September 2013 Thor was the subject of a post mortem examination and the cause of death was stated to be "Birth Related Brain Injury". 8. A finding was made that Thor died from a major intercranial haemorrhage secondary to the surgeons manual attempts at disimpaction. 9. The surgeon who performed the caesarean section on 23rd September had only commenced employment at Lincoln County Hospital on that day. Whilst she stated that she had considerable experience of performing caesarean sections in the past the process of her induction at Lincoln County Hospital had been most unsatisfactory, further she was unsupervised whilst performing the caesarean section. 10. The initial internal investigation carried out by United Lincolnshire Hospitals Trust and relating to this death was flawed and was profoundly unsatisfactory.
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. – (I) The failure to supervise the operating surgeon on her first day at work for this complex twin delivery. It was stated in evidence that the policy of inducting new staff had changed but that this had not been enshrined in any formal document. Such a document should be produced and a copy submitted to myself.

	(II) The lack of any steps having been taken to discipline the clinicians involved or limit their practice given their decision to adopt a wholly inappropriate, unacceptable, and unorthodox technique in delivering Thor, resulting in his death. (III) The failure to ensure a full contemporaneous record was kept by doctors involved in a term neonatal death. Such failure has seriously hampered my investigation into the circumstances surrounding Thor's death and has resulted in serious difficulties to Thor's family who clearly struggled and suffered as a result of not being able to understand why their son died shortly after his birth. (IV) The failure to identify in the immediate aftermath of Thor's death that the operating surgeons had neglected to make a full note of the circumstances in which he died and to obligate them to provide the same; in particular [redacted] was advised to amend the Caesarean pro forma, to include the fact that forceps were used in the interests of candour. He was then dissuaded from doing so by senior management as a result of their concerns as to how this would be perceived if the matter was investigated. This raises very serious concerns as to the degree of candour in disclosing the circumstances of this death. What steps have been taken to obviate a repetition of this behaviour in the future? (V) The fact that the consultant ultimately responsible for Thor was also charged with undertaking the SUI Report into his death. Further, that the consultant signed off the original SUI Report without having read any of the statements referred to in that report. Please disclose the policy or means by which it has been made clear that this should not happen in the future. (VI) The fact that the original SUI and the revised version completed after receipt of the post mortem failed to disclose that there was no support for the use of forceps to disimpact the fetal head. (VII) The fact that no steps have been taken to discipline those involved in the production of this wholly inadequate SUI. (VIII) The fact that none of the statements served by the Trust disclosed that there was no support for the use of forceps to disimpact the fetal head. (IX) The fact that there was a failure to recognise the inadequacy of the operating surgeon's original statement and SUI and that these inadequacies were not addressed until I directed the Trust to obtain a full statement and undertake a comprehensive SUI.
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 4 May 2015. 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 (a) Leigh Day, Solicitors for the family (b) Browne Jacobson, Solicitors for ULHT 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.
	6 March 2015 **……** **HM S P G Fisher** **Senior Coroner for Central Lincolnshire**