REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **1. The Chief Executive, Western Sussex Hospitals NHS Foundation Trust** **2. [redacted] Chief of Service for Women and Children's Division, Western Sussex Hospitals NHS Foundation Trust.** **St Richard's Hospital, Spitalfield Lane, Chichester, West Sussex PO19 6SE**
1	**CORONER** I am Bridget Dolan QC, assistant coroner, for the coroner area of West Sussex
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 6 August 2015 the Senior Coroner commenced an investigation into the death of Miss Leilani Chute. The investigation concluded at the end of the inquest on 30 June 2016. The conclusion of the inquest was that the medical cause of death was: 1a hypoxic brain injury and 1b umbilical cord occlusion. I concluded that Leilani Chute died shortly after her birth from natural causes, however the evidence also led me to find that had the failure to progress earlier in labour been reported to the consultant, the birth plan would have been to go directly to a Caesarean Section with delivery by about 14:20 - thereby avoiding the final cord occlusion and acute hypoxia.
4	**CIRCUMSTANCES OF THE DEATH** 1. On the late evening of 4 August following syntocinon augmentation Leilani's mother, Mrs Chute, was in active labour. From almost the outset a series of assessments with a fetal scalp electrode in place noted, or should have noted, that the CTG tracing was 'suspicious' meaning that there was at least one non-reassuring feature. 2. By 13.40 the following day the cervix was still not fully dilated and had the consultant obstetrician known or been informed of this he would have described this as a 'failure to progress' at the first stage of labour and so advised that a Caesarean Section ('CS') should be carried out. Furthermore, the baby's head was in an unfavourable position deflexed, and the baby was lying in an OP position and still mid cavity. Delivery could have been achieved by CS in around 30 minutes. 3. What the consultant obstetrician was not made aware of, however, was that the

SHO had tried to manually push the cervix back at 12.30 and the registrar had also done this at 13.40 and, on the latter occasion, had thereby achieved 'full' dilation. This is not a technique that was endorsed by the consultant obstetrician. The independent expert obstetrician, [redacted] described it as something not in any textbook and also futile as it did not actually achieve the progression of an arrested labour.

4. It was against this background that a plan was formed to allow [redacted] a further half an hour of pushing and if that did not achieve delivery to then move on to a trial of instrumental delivery in theatre followed by CS if necessary.
5. When the plan including instrumental trial was relayed to [redacted] she said she would prefer not to have forceps used at delivery. There was an ensuing discussion with the registrar which, as he accepted, focussed on the <u>risks</u> of caesarean section and on the <u>benefits</u> of vaginal delivery. [redacted] was not told that her baby was lying in an OP position and that the risks of failure of instrumental delivery were higher with an OP baby. Furthermore, as the registrar accepted, when she had emphasised to him that she "Just wanted what was best for her baby" then, given this clear statement, he should have, but did not, tell her that to go directly to a CS presented less risk to the baby.
6. What [redacted] took from the discussion was that it was too risky to have a CS and it was in this context that she agreed to (and signed the form consenting to) a trial in theatre of instrumental delivery before any CS.
7. The trial of instrumental delivery was not successful and so at around 14.32 the procedure was abandoned and preparations for a CS were made. Leilani was delivered at 14.46. Sadly she was in a moribund condition, in a state of terminal bradycardia and with no other signs of life.

5 **<u>CORONER'S CONCERNS</u>**

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) That the practice of manually pushing back the cervix was one adopted by two junior doctors. This practice was not in accordance with standard training and was conducted without the knowledge of the consultant;
(2) That the manner in which consent was sought from women in labour when there was a choice to be made between attempted instrumental delivery and going straight to a CS did not appear to provide them with the relevant facts in order to come to an informed choice, but presented those facts that favoured the doctor's preferred approach to management.
(3) That neither of the above matters had been identified as a "Care and Service Delivery problem" by the Trust's Root Cause Analysis investigation and hence no steps had been taken by the Trust to address these issues.

ACTION SHOULD BE TAKEN

In my opinion action should be taken to prevent future deaths and I believe your

	organisations 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 16 September 2016. 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: [redacted] (the parents of Leilani Chute) and [redacted] 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.
9	**15 July 2016** pp Bridget Dolan