REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: Chief Executive of Stepping Hill Hospital, Chief Executive of East Midlands Ambulance Service, Chief Investigating Officer of Healthcare Safety Investigation Branch and the Secretary of State for Health
1	CORONER I am Alison Mutch, Senior Coroner, for the coroner area of South Manchester
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 1st February 2017 I commenced an investigation into the death of George French Russell. The investigation concluded on the8th February 2018 and the conclusion was one of: Narrative: Died from the recognised complications of a breech birth contributed to by the absence of expert input during delivery The medical cause of death was 1a Hypoxic ischaemic encephalopathy b Preterm prolonged footling breech birth c II
4	CIRCUMSTANCES OF THE DEATH On 11th January 2017, [redacted] was 35 weeks plus 1 pregnant with George Edward French-Russell. At about 11:30am she rang triage at Stepping Hill Hospital and was advised by an unqualified maternity assistant to take paracetamol, rest and ring back in an hour if required. At about 12:30pm she rang the High Peak Community Midwife Team and the call taker agreed a midwife would call her back. At about 1:00pm she spoke with a midwife and described her symptoms. A face-to-face appointment was arranged for 2:20pm that day. At 1:20pm, she rang 999 and spoke to East Midlands Ambulance Service control (EOC). A crew was dispatched as a red 1 at 1:21:56pm. The target response time was 8 minutes. The call handler remained on the line with [redacted] who told her that her waters had broken; she was 35 weeks pregnant and wanted to push. At 1:28:18pm, EOC updated the crew that her waters had broken. No contact was made with

	the midwifery team at Stepping Hill Hospital for advice. The position remained that the crew were to assess. The crew asked if a midwife was on the way. At 1:38:28pm, the ambulance arrived on scene. [redacted] wanted to push. At 2:42pm, EOC rang Stepping Hill Hospital triage. Triage was not given all the information known by East Midlands Ambulance Service. They asked if she wanted to push. It was confirmed she did. East Midlands Ambulance Service was advised to transfer as an emergency to Stepping Hill Hospital. The transfer time was 30 minutes plus and the crew at 1:44pm did not believe there was time to transfer. At about 1:55pm the crew rang Stepping Hill Hospital triage direct after being given the number by EOC. Stepping Hill Hospital triage was told that George was a footling breech. The paramedic had not dealt with a breech birth before. A doctor spoke to the ambulance crew who wanted advice. The call between the crew and the doctor terminated before George was born. No further expert advice was sought by the crew to inform how they managed George's delivery. The doctor did not do anything further. George had not delivered when the second crew arrived at 2:06pm. The second crew assisted with George's delivery. He was born at 2:15pm in a poor condition. Midwives arrived on the scene shortly after his birth. An airway was established and he was transferred to an ambulance and then to Stepping Hill Hospital. After assessment, he was transferred to Bolton Hospital for neonatal care. His prognosis was poor due to the severe brain damage at birth. On 23rd January 2017, he died at Royal Bolton Hospital after he was extubated.
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. During the inquest it became clear that during the telephone conversation between EMAS and George's mother her labour was rapidly developing. There was no evidence of the call taker seeking guidance on how to deal with a rapidly evolving situation other than to update the ambulance crew who were on route.(EMAS) 2. The way in which information was exchanged between Stepping Hill Hospital and EMAS meant that all those involved in making decisions were not in possession of key facts. There was no structure to how information was shared and it was passed 3rd hand. 3. During labour EMAS were present. The paramedics did not have the experience to deal with a footling breech delivery. Expert input was given for a brief period by a registrar but when that conversation

	terminated there was no further support given or sought.
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 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 26th April 2018. 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 namely 1 [redacted] father of the deceased 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.
9	Alison Mutch OBE HM Senior Coroner 01/03/2018