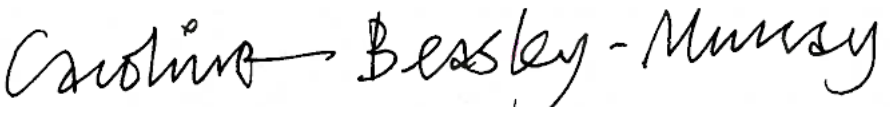
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (2)

*NOTE: This form is to be used **before** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Mid and South Essex NHS Foundation Trust**
1	**CORONER** I am Caroline Beasley-Murray, senior coroner for the coroner area of Essex
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** On 16 November 2019 I commenced an investigation into the death of baby Frederick Joseph Terry. I decided to make this report during the investigation stage prior to reopening the inquest touching upon baby Terry's death. On 4 September 2020 I reopened the inquest and I heard evidence relating to the specific issue as to whether or not baby Freddie was stillborn. I found as a fact that baby Freddie was stillborn, I called no further evidence and I concluded in box 4 on the Record of Inquest that Frederick Joseph Terry was stillborn.
4	**CIRCUMSTANCES OF THE DEATH** Baby Frederick Joseph Terry was delivered by caesarean section, after a failed forceps attempted delivery on 16 November 2019 and death was confirmed after 40 minutes of resuscitation attempts. The cause of death at post mortem examination has been given as:- 1a) hypovolaemic shock 1b) skull fracture and scalp laceration and haemorrhage 1c) birth trauma The evidence showed that baby Freddie's very serious scalp and brain injuries were sustained during the failed forceps attempted delivery and, but for these, baby Freddie would have survived as a perfectly formed, healthy baby.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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. Continued ….

	The **MATTERS OF CONCERN** are as follows. – [BRIEF SUMMARY OF MATTERS OF CONCERN] Independent expert opinion has drawn attention to the following areas of concern • Lack of risk assessment leading to the options available to mothers as to delivery • Forceps delivery was attempted without recognising an occipito-posterior position. More training in this respect is required and the use of scans developed. • The injuries imply an excessive degree of force in the application of the forceps and the traction • Concerns about the engagement and induction of locum staff and management of staff levels on the maternity ward • The need for a bleep in the neonatal unit • Accuracy of record keeping • Training and procedures in respect of how communications should occur between all clinical personnel in the delivery theatre • Training and procedures in respect of how communications with the family should be carried out. This should cover the duty of candour. • Availability and suitability of resuscitation equipment and procedures on the maternity ward. The Trust's Neonatal Resuscitation Policy may need to be revisited • The Trust's Action Plan must be rigorously carried out • It would have been helpful for there to have been, during the course of the inquest, an exploration, in the course of evidence, of the treatment and care provided to baby Freddie and his parents at the time of delivery. Currently there is no legislation to cover the holding of a coroner's inquest into a stillbirth. In March 2019, HM Government issued a *Consultation on coronial investigations of stillbirths* It would be helpful for this important topic to be progressed, whatever the ultimate jurisdictional decisions.
6	**ACTION SHOULD BE TAKEN** In my opinion urgent 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 4th November 2020. 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 who may find it useful or of interest. Mr [redacted] The Ministry of Justice The Medical Defence Union Continued….

	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	**[DATE] 9 September 2020**  **SIGNED BY HM Senior Coroner Mrs Caroline Beasley-Murray**