REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. Medical Director, Doncaster & Bassetlaw NHS Foundation Trust 2. [redacted] 3. Switalskis Solicitors 4. HSIB 5. Chief Coroner
1	CORONER I am Ms NJ Mundy, Senior Coroner, for the coroner area of South Yorkshire (East)
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. [HYPERLINKS]
3	INVESTIGATION and INQUEST On 24 July 2020 commenced an investigation into the death of Clay Daniel Wanckiewicz. The investigation concluded at the end of the inquest on 9 September 2021. The conclusion of the inquest was 1a Skull Fracture (in the context of both failed instrumental delivery and caesarean delivery) II Failure to progress in 2nd stage of labour and acute chorioamnionitis. I recorded the following Narrative conclusion: *Clay Daniel Wanckiewicz died on 15 July 2020 from skull fractures caused by both attempted forceps delivery and release of a deeply impacted head at caesarean section. Continued pushing when the head was at the spines and the attempted instrumental delivery contributed to the degree of impaction. Despite extensive resuscitation attempts Clay survived for only a matters of minutes before succumbing to his injuries.*
4	CIRCUMSTANCES OF THE DEATH [redacted] became pregnant with her first child and was managed by both the community midwifery team and a private midwife. During the course of her pregnancy, some scans revealed the possibility of this being a large baby leading to tests for gestational diabetes (negative) and consultant review to determine whether the desired home birth was a safe option in the circumstances. One consultant felt that the birth should be in a hospital setting but wished the treating consultant to have full dialogue with [redacted] before a final decision was

reached. Following that further consultation, it was deemed appropriate for the home delivery to proceed.

On the 11th July 2020, [redacted] went into labour. On the 14th July, contractions were strong and regular and the private midwife attended to manage the home birth. Due to failure to progress and a diagnosis of labour dystocia, in the early afternoon of the 14th arrangements were made for [redacted] to be admitted to Doncaster Royal Infirmary. There was no evidence that the head descended beneath the spines but by 19.50 [redacted] was fully dilated. A passive hour was to be allowed before active pushing commenced. After an hour and a half of active pushing there had been little progress but a decision had been reached that [redacted] would push for the full 2 hours. This did not achieve delivery and thus instrumental delivery was attempted with 2 attempts of traction by forceps, which failed to deliver Clay. [redacted] was then conveyed to theatre where a caesarean section was performed. There was difficulty in delivering the head, which was deeply impacted. Clay was born in a very poorly condition and death was confirmed at 22 minutes of age. During the latter stages of the labour there had CTG features warranting obstetric review particularly in light of the overall picture of a large baby, slow progress in second phase, the mid cavity position, elevated maternal temperature, pulse and heart rate and episodes of tachycardia. There had also been no progress below the spines and the reason for admission was slow progress and a belief that this was a case of labour dystocia.

I concluded that the attempts at forceps delivery fractured Clay's skull and attempts to release the head at caesarean section led to to further fractures of the skull.

HSIB investigated, 3 recommendations were made including the need for awareness of confirmation bias. I found there had been a failure to attach sufficient weight to factors which should have called into question the appropriateness of advice encouraging any continuation of the efforts to push and a failure to engage obstetric input at an earlier stage.

The Trust accepted that there had been confirmation bias in this case. Certain steps have been taken in response to this finding which included newsletters and training programs. Unfortunately, a number of the members of staff who gave oral evidence during the inquest failed to appreciate the meaning and significance of confirmation bias, and the importance of being open minded. There appeared to be a lack of awareness of the importance of viewing all clinical parameters etc objectively, and also the importance of looking at the overall clinical picture and wider circumstances in determining the best care pathway. It was my finding at inquest that had all relevant factors been taken into account and given sufficient weight Clay's management would have been different. If the obstetric staff do not change their practices to ensure that confirmation bias is no longer a feature in any care provided there is a

	significant risk that situations such as this will continue to occur in the future. I also heard evidence that when the draft HSIB report was discussed with those involved a number of them simply restated their position and appeared not to accept the HSIB findings, which were in fact on all fours with my own conclusions. This approach reinforced my concerns.
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) Failure of members of staff to understand the concept of confirmation bias. (2) A reluctance on the part of staff to accept situations of confirmation bias and be open to altering practices. (3) I am not satisfied the Newsletters had been considered and digested by all staff. (4) The training program in place is delivered over a 12-month period thus many staff members will not have had that training and there is a risk that confirmation bias situations will continue placing mothers and their babies at risk. Furthermore, some staff members who were involved in Clay's management were not prioritised to have that training. These are the reasons for my belief that there continues to be a risk.
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 18th November 2021. 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, to the following Interested Persons Switalskis Solicitors, DAB Beachcroft Solicitors, HSIB and to the Doncaster Safeguarding Board.

	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	 24 September 2021