Regulation 28: REPORT TO PREVENT FUTURE DEATHS

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

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Joint Royal Colleges Ambulance Liaison Committee (JRCALC)** **2 CEO Association of Ambulance Chief Executives**
1	**CORONER** I am Karen Henderson, Assistant Coroner, for the 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 02 June 2021 I commenced an investigation into the death of Arthur Ronnie TROTT aged 4 Days. The investigation concluded at the end of the inquest on 17 November 2022. The conclusion of the inquest was that: [redacted] went into spontaneous labour at home with her son Arthur Ronnie Trott at 0300 hours on 24th May 2021 at 37+2 weeks gestation. Having sought advice from labour ward at Princess Royal Hospital, Haywards Heath, she remained at home. At or around 0535 hours it was recognised Arthur was an unanticipated footling breech and as an acute obstetric emergency a 999 call was made to facilitate urgent admission into the labour ward. The first paramedics attended at or around 05.50 hours and Mrs Trott and Arthur arrived at the hospital at or around 0635. Arthur was delivered at 06.38 hours on 24th May 2021 in a very poor condition. Active resuscitation was undertaken with transfer of Arthur for ongoing care to the neonatal unit of RSCH but sadly died there 4 days later on 28th May 2021 from complications from severe hypoxic ischaemic encephalopathy.
4	**CIRCUMSTANCES OF THE DEATH** Arthur died following an unexpected breech delivery at home where the delay in transfer to hospital materially contributed to hypoxic ischaemic encephalopathy
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) The initial advice from the labour ward and the consultant midwife employed by the ambulance service was to bring the mother into hospital as an acute obstetric emergency but on arrival at the mother's home a decision was made to attempt delivery from JRCALC guidelines indicating that it may be possible for breech presentation babies to be delivered at home. Whilst this was recognised as possible in different breech (bottom first) presentations it was not advisable nor should an attempted delivery be made for footling breech presentations. This resulted in a delay in transferring mother and baby to the

	nearest obstetric unit which played a material contribution to the baby's death. 1.The JRCALC guidance on the emergency management of footling breech presentation by the emergency services is insufficiently robust in that it should be recognised as different from other breech presentations and considered an acute obstetric emergency requiring immediate transfer to the nearest hospital obstetric unit. That is, no attempts should be made to attempt a home delivery due to difficulties with the baby's head not being able to be delivered. 2. On evidence heard in court there are only two consultant midwives employed by the Ambulance services despite there being 11 Ambulance organisations within England. This leaves the majority of ambulances services having no obstetric support, guidance or ongoing teaching and training. As a matter of urgency there is a need to provide resources to employ more consultant midwives - at least one to two per service - throughout all the Ambulance organisations.
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 January 24, 2023. 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 **South East Coast Ambulance Service - Sussex HQ** **HSIB** [redacted] **Brighton and Sussex University Hospital NHS Trust** I have also sent it to **President of Royal College of Obstetrics and Gynaecologists** who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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.
	Dated: 29/11/2022  **Karen HENDERSON** **Assistant Coroner for** **West Sussex Coroners Service**