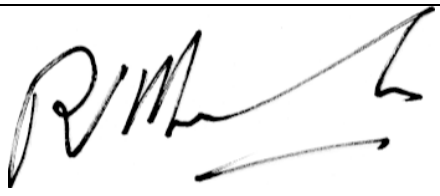
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)
*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted], President, Royal College of Obstetricians & Gynaecologists** **2. [redacted], Chief Executive of NHS England**
1	**CORONER** I am Professor Paul Marks, Senior Coroner, for the Coroner Area of City of Kingston Upon Hull and the County of the East Riding of Yorkshire.
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 24th May 2021 I commenced an investigation into the death of Finley Austin May, aged 28 days. The investigation concluded at the end of the inquest on 30th June 2023. The narrative conclusion of the inquest was: *Finley Austin May was born the 16th of February 2021 having been delivered by use of Keilland's rotational forceps. He was floppy, bradycardic, and blue at the time of delivery, and underwent resuscitation according to the neonatal life support algorithm. He was treated as a case of hypoxic ischaemic encephalopathy, but his clinical picture was at variance with this condition and he was investigated for other disorders. A MRI scan showed the presence of a high cervical spinal cord injury, which was caused by the use of Keilland's obstetric forceps. He died at Hull Royal Infirmary, Anlaby Road, Kingston Upon Hull, on the 16th of March 2021 as a result of his spinal cord injury.* The medical cause of death was determined as follows: 1(a): High Spinal Cord Injury due to Keilland's Forceps Delivery 1(b): Malposition and Prolonged Labour II: Hypoxic Ischaemic Encephalopathy
4	**CIRCUMSTANCES OF THE DEATH** These are set out in my summary and findings of facts which are attached.

5	**CORONER'S CONCERNS** 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) The Hull and East Yorkshire NHS Trust has abandoned the use of Keilland's forceps since Finley's death and evidence was heard that other NHS trusts have also done so, Nevertheless, some have retained them. (2) Evidence was heard that the use of these obstetric forceps can facilitate delivery from the mid-pelvis in cases of malrotation, asynclitism and where the lie is occipito-transverse or occipito-posterior, and this is a well-accepted practice. (3) Evidence was heard that such malpositions can be corrected manually, or by the use of the Ventouse suction apparatus, but the evidence adduced was that these alternative techniques *may* be inferior to the use of Keilland's forceps in *skilled and practiced hands; this might mean increased risk to both mother and baby.* *(4) Continued use of Keilland's forceps may be the most appropriate way to manage this obstetric problem but there should be increased awareness of complications associated with its use and guidance issued about the minimum number of cases per annum needed to maintain skill levels coupled with guidance for training.* *(5) If NHS trusts have abandoned the use of Keilland's forceps, clear guidance should exist about alternative methods of managing malrotation and asynclitism.*
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation has 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 Thursday, the 21st day of September 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 following Interested Persons: • [redacted], Family Counsel • [redacted], Capsticks, Counsel for Humber NHS Trust I have also sent it to the local child safeguarding officer, [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	 **26th July 2023**