Regulation 28: Prevention of Future Deaths report

Jannat ABBKER (died 19.08.24)

	THIS REPORT IS BEING SENT TO: **1. The President** **Royal College Obstetricians and Gynaecologists (RCOG)** **10-18 Union Street** **London SE1 1SZ**
1	**CORONER** I am: Coroner ME Hassell Senior Coroner Inner North London St Pancras Coroner's Court Camley Street London N1C 4PP
2	**CORONER'S LEGAL POWERS** I make this report under the Coroners and Justice Act 2009, paragraph 7, Schedule 5, and The Coroners (Investigations) Regulations 2013, regulations 28 and 29.
3	**INVESTIGATION and INQUEST** On 23 August 2024, one of my assistant coroners, Edwin Buckett, commenced an investigation into the death of Jannat Abbker, a baby who died shortly after birth. The investigation concluded at the end of the inquest yesterday. I made a determination at inquest that Jannat died as a consequence of trauma suffered during birth as a result of shoulder dystocia.
4	**CIRCUMSTANCES OF THE DEATH** Jannat was a big baby and her mother had a history of shoulder dystocia with two out of her three previous pregnancies. Her mum received midwifery and obstetric care for the two pregnancies at University College London Hospital (UCLH), and Jannat was delivered there.

	Unfortunately, the fact of the shoulder dystocia was not communicated to Jannat's parents after the earlier births, and was not recognised by the staff at UCLH during this pregnancy. If it had been, Jannat's mother would have been offered a Caesarean section for Jannat's delivery. A Caesarean section would have avoided the shoulder dystocia that caused Jannat's death.
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. With the benefit of a maternity and newborn safety investigation (MNSI), UCLH is undertaking a significant piece of work to improve its systems. However, there remains one outstanding point. When all else had failed, Jannat was finally delivered by use of a manoeuvre called a shoulder shrug. I heard at inquest that this is not a manoeuvre included within the NICE (National Institute for Health and Care Excellence) guidelines, but it is used abroad. One of the obstetric registrars looking after Jannat's mother had seen it in a training video. I wonder if there is merit in considering this for inclusion in the next set of relevant NICE guidelines, whenever these are updated?
6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 23 June 2025. 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. • Jannat's parents • HHJ Alexia Durran, the Chief Coroner of England & Wales 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 other 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. She may send a copy of this report to any person who she 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.
9	**DATE** **SIGNED BY SENIOR CORONER** 25.04.25 *ME Hassell*