REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Matthew Hopkins, Chief Executive, Queen's Hospital, Rom Valley Way, Romford, Essex, RM7 0AG**
1	**CORONER** I am Nadia Persaud, senior coroner for the coroner area of Eastern District of Greater London
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. http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 12th March 2014 I commenced an investigation into the death of Iana-Liza Chervonenko. The investigation concluded at the end of the inquest on the 20th January 2015. The conclusion of the inquest was a narrative conclusion; [redacted] *attended Queen's Hospital Maternity Unit at 41 weeks gestation with a history of reduced fetal movement. A CTG from 22.47 was noted to be pathological and a decision was made at 00.10 that an emergency caesarean section should be performed. There was a delay in performing the caesarean section due to the level of activity on the labour ward, poor communication and poor clinical decision making. Iana-Liza was born at 02.30 with no heart rate or spontaneous respiration. She died from hypoxic ischaemic encephalopathy caused by intra-partum asphyxia. Her death was contributed to by neglect.*
4	**CIRCUMSTANCES OF THE DEATH** [redacted] attended Queens Hospital at 22.38 with a history of reduced fetal movements. A CTG was commenced at 22.47 and the triage midwife had concerns about the trace. At 23.05 she had difficulties in obtaining a medical review due to the high levels of activity on the maternity unit. At 23.30 the triage midwife took the CTG trace into theatre to show the consultant who was performing another surgical procedure. The consultant confirmed that the trace was pathological and the patient should be moved to the labour ward and prepared for theatre. [redacted] was transferred to the labour ward and prepared for theatre by the midwifery staff. A doctor attended to review her at 00.10 and made a decision for an emergency caesarean section. The doctor documented a grade 2 caesarean section but has given evidence to confirm that this was erroneous and should have been grade 1, (requiring delivery by 00.40). The consultant had anticipated that [redacted] would be taken into theatre when he had finished the case that he had been dealing with. The theatre is likely to have

become free at 00.22 but this fact was not communicated to [redacted] treating team.

The team became aware that the theatre was free at around 00.40 when the labour ward co-ordinator noticed this on her rounds. During the process of transfer to theatre a discussion took place about [redacted] and another case which required emergency intervention. A decision was made to prioritise the other patient. I found that the doctors had failed to take into account all of the relevant information, to allow them to make a fully informed decision. It was considered that it would not be necessary to open a second theatre, as the other case was likely to be completed within around 30 minutes. It was considered that this would be the time that it would take to open a second theatre.

The other case did not finish until 01.45. [redacted] was not taken to theatre until 02.06.

Iana-Liza was delivered at 02.30, following around a period of around 27 minutes of bradycardia. She was delivered in a very poor condition with no heart rate or spontaneous respiration.

Iana-Liza died at twenty-four hours of age from hypoxic ischemic encephalopathy due to intra partum asphyxia.

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 Labour Ward was very busy on the night of 7/8th March 2014. The levels of activity on the ward resulted in the following:

- A delay in obtaining a medical review to the concerning CTG trace.
- A period of 40 minutes before a medical review, following the consultant noting a pathological CTG trace.
- Incorrect documentation in relation to the grading of the caesarean section.
- Due to the activity on the Labour Ward the obstetric registrar was not able to fully record his assessments of the patient.
- The obstetric registrar confirmed that he did not speak to the anaesthetist about the type of anaesthesia to be used due to him being busy with other patients.

2. [redacted] had concerning risk factors of reduced foetal movements and a pathological CTG trace. There were no reassuring reasons for the changes in fetal heart rate. A pathological CTG in an antenatal patient with a history of reduced foetal movements should result in a Grade 1 caesarean section. She should have been delivered by 00.40.

   The theatre is likely to have been free by 00.22. There was however no communication with the treating team of the availability of theatre and this was only noted by the labour ward coordinator whilst conducting her general rounds at around 00.40.

   Had [redacted] been taken to theatre at 00.22, the consultant has confirmed that Iana-Liza would have been delivered by 00.40.

   I am concerned about the level of medical cover on the labour ward. The consultant has confirmed that Queens Hospital Maternity Unit is a very busy unit. The level of activity on the 7/8th March 2014 did result in care being provided which contributed to the death of Iana-Liza. The doctors were under severe

	pressure due to the amount of work and all of the doctors who gave evidence confirmed that further medical support on the maternity unit would improve the care provided to patients. A safe system of care would include the clear and accurate documentation of clinical reviews and clinical decisions; fully informed and thorough discussions with colleagues about prioritisation; fully informed discussions with anaesthetists in relation to the type of anaesthesia required and clear communication between the medical team and midwifery team. The limited number of doctors available on the ward at the time resulted in deficient communication and documentation. I also heard that there is currently no system in place for theatre staff to proactively notify the treating team when the theatre becomes available. I did hear that it would be possible for the Standard Operating Protocol for theatre to be amended to require the Maternity Care Assistant to notify the treating team as soon as theatre becomes free (where a patient is awaiting theatre). No steps had however been taken to address this at the time of the Inquest.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and 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 the 25 March 2015. 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 – [redacted] (father). I am also forwarding a copy of the report to the Care Quality Commission and [redacted] (Director of Public Health). 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]** 28.1.15 **[SIGNED BY CORONER]** [redacted]