Whittington Health NHS

Regulation 28: Prevention of Future Deaths

Action plan following the report of:

Coroner ME Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London N1C 4PP

Into the death of:

Vasilis Ktorakis

Identified MATTERS OF CONCERN for Whittington Health:

No.	Matters of concern	Key Actions	Completion Date	Responsible Lead(s)	Progress on actions and dates:	Evidence of implementation and date of implementation (to be completed once actions are completed)
1	Ms Ktorakis was started on Syntocinon at 7.15pm on Friday, 22 May 2015. Given the circumstances of her presentation	1) Educational supervisor to meet with the registrar (KA) and discuss the learning from this case.	29th January 2016	[redacted], Consultant Obstetrician	[redacted] met with the registrar shortly after the inquest and went through the learning from this case.	

	(including meconium stained liquor and infrequent contractions at a late stage of labour), her consultant told me in court that when Ms Ktorakis was seen by a registrar at 2.40pm that afternoon, the registrar should have conducted a full review and started Syntocinon then, some four and a half hours before. Having spoken to the registrar since, the consultant is unable to explain why that full review and medication commencement did not take place. It is therefore unclear whether this particular registrar, and indeed others on the unit, might be likely to make the same mistake again another time.	2) Registrar to complete a reflective statement which will be added to their training and appraisal portfolio. 3) Provide a summary of the case and all the learning points and share with staff via the maternity newsletter, maternity clinical governance committee, the weekly maternity teaching sessions and the trust intranet (the trust intranet includes a section for sharing learning from complaints and incidents).	29th January 2016 (these actions will take place throughout January and will be completed by the end of January)	[redacted] Clinical Risk Midwife and [redacted], Consultant Obstetrician	VR to ensure the reflective statement has been completed and added to the portfolio as outlined. This case was originally shared with the maternity unit in August 2015 via the maternity newsletter	

2	The notes recorded by that registrar fell significantly short of what can be expected in terms of recording a management plan.	4) As per action points 1 and 2 above. 5) A regular audit of maternity records is undertaken (40 sets of notes a year) and includes a review of 69 standards. Consultants and trainee doctors to be actively involved in the completion of the audit, presentation of the results and action planning. Results of the most recent audit and learning regarding record keeping in this case will be presented at the next clinical audit day (this is a trust wide multidisciplinary learning event).	21st January 2016	[redacted] Matron and [redacted], Consultant Obstetrician and [redacted] Consultant Obstetrician		
3	At ten past midnight on Saturday, 23 May, a different registrar took the decision to allow two hours passive descent before pushing. This was	6) Educational supervisor to meet with the registrar (SA) and discuss the learning from this case. 7) Registrar to complete a reflective statement which	29th January 2016	[redacted] Consultant Obstetrician and Divisional Director [redacted],	[redacted] met with the registrar shortly after the inquest and went through the learning from this case. CB to ensure the reflective statement	

	an error of judgement that the registrar had not appreciated even by the time of the inquest, over four months after death, indicating that she had not received appropriate feedback. It is therefore unclear whether this particular registrar, and others on the unit, might be likely to make this same mistake again.	will be added to their training and appraisal portfolio. 8) As per action 3 above.		Consultant Gynaecologist and Director of Research and Innovation	has been completed and added to the portfolio as outlined.	
4	The first registrar was not asked to contribute to the hospital's untoward incident investigation, so there was a systemic failure to understand the value of her input, resulting in a loss of learning for the organisation and for	9) A meeting will take place with at the start of every maternity serious incident investigation that includes all the staff involved in the incident and the investigating team. It will be agreed in this meeting who needs to provide a statement and contribute to the process.	COMPLETED	[redacted], Maternity Clinical Governance Manager	This was put in place immediately following the outcome of the inquest.	

	the registrar.					
5	Neither the first nor the second registrar was notified of the untoward incident investigation findings, even by the time of inquest, and so the opportunity for them to learn and to improve was lost. This seems to demonstrate a lack of a robust system for learning lessons.	10) A multidisciplinary meeting (MDT) will take place at the conclusion of every serious incident investigation that includes all the staff involved in the incident and the investigating team. A wider MDT will take place involving other staff on the unit as relevant. 11) The serious incident action plan template will include a preset recommendation for completion that stipulates feedback must be given to each individual involved who requires feedback. The action will need to include who will provide the feedback and when this will	31st December 2015 Arrangments for this to be in place by 29th January 2016 31st December 2015	[redacted], Maternity Clinical Governance Manager [redacted] Consultant Obstetrician and Divisional Director [redacted] Head of Integrated Risk Management		

		be done. 12) Medical Director to write to all Divisional Directors regarding the importance of robust record keeping and for this to be cascaded to all staff within their clinical services.	29th January 2016	[redacted] [redacted] Medical Director		