Regulation 28: Prevention of Future Deaths report

Vasilis KTORAKIS (died 23.05.15)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Executive Medical Director** **The Whittington Hospital NHS Trust** **Magdala Avenue** **London N19 5NF**
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 28 May 2015, I commenced an investigation into the death of Vasilis Ktorakis, who died shortly after birth. The investigation concluded at the end of the inquest on 5 October 2015. (I apologise for the delay in sending this report.) I made an open determination and recorded a medical cause of death of: 1a acute perinatal asphyxia 1b underlying cause unknown.
4	**CIRCUMSTANCES OF THE DEATH** Following a long labour at the Whittington Hospital, [redacted] gave birth on Saturday, 23 May 2015. To the great surprise of the healthcare team, Baby Vasilis was born in an extremely poor condition and died very shortly thereafter.

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.

Errors in Care

1. [redacted] was started on Syntocinon at 7.15pm on Friday, 22 May 2015. Given the circumstances of her presentation (including meconium stained liquor and infrequent contractions at a late stage of labour), her consultant told me in court that when [redacted] 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. The notes recorded by that registrar fell significantly short of what can be expected in terms of recording a management plan.

Learning Lessons

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 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.

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 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.

6	**ACTION SHOULD BE TAKEN** In my opinion, action should be taken to prevent future deaths and I believe that 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 21 December 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 following. • HHJ Peter Thornton QC, the Chief Coroner of England & Wales • [redacted] Vasilis's parents • [redacted], obstetric consultant • [redacted] obstetric registrar • [redacted] obstetric registrar 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 Senior Coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**DATE** **SIGNED BY SENIOR CORONER** 19.10.15