Her Majesty's Coroner for the
Northern District of Greater London
(Harrow, Brent, Barnet, Haringey and Enfield)

North London Coroners Court,
29 Wood Street,
Barnet EN5 4BE

Telephone [redacted]
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO** Department of Health, Health and Wellbeing Richmond House, 79 Whitehall, London, SW1A 2NS
1	**CORONER** I am Andrew Walker, senior coroner, for the coroner area of Northern 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.
3	**INVESTIGATION and INQUEST** On the 9st July 2015 I opened an investigation touching the death of Kristian Andrew Jaworski , 5 days old. The inquest concluded on the 21st March 2016 The conclusion of the inquest was "Complications of delivery", the medical case of death was 1a Asphixia as a consequence of prolonged and extended instrumental delivery.
4	**CIRCUMSTANCES OF THE DEATH** On the 20th September 2012 [redacted] at 16.18 was delivered of a son by forceps. [redacted] was told that she had a narrow birth canal at the time that her first child was born and was told to ask for a caesarian section were she to have a further child it is likely that this was said. It is likely that the obstetrician who delivered the first child did tell [redacted] firstly that the birth canal was narrow and secondly that [redacted] was told to ask for a caesarian section on the next occasion. [redacted] medical notes made no reference to these matters. On the 18th May 2015 [redacted] when planning for the delivery of her next child raised with a Consultant Obstetrician that during her first birth she had been described as having a narrow birth canal and that the birth had been traumatic for

her ,she had some decelerations and then episiotomy and a 2nd degree tear and was concerned about a similar problem and [redacted] added that she was told to ask for a caesarean section .

A plan was made for vaginal delivery with the option of an emergency caesarian section and there matters rested.

On the 27th June 2015 [redacted] attended North Middlesex Hospital Triage following the spontaneous rupture of her membranes at 16.30. [redacted] was examined and discharged home.

At 23.45 [redacted] returned and was again discharged home. At 1.40 hrs on the 28th June 2015 [redacted] returned to the Triage at North Middlesex Hospital and was transferred to the labour ward at 2.10 hrs.

At 4.30 the Registrar was summoned to review fetal heart rate and decelerations. At 4.43 a fetal blood sample was taken and was borderline abnormal.

At 5.00 the progress was discussed with the Registrar and the Consultant Obstetrician agreed with the plan to take [redacted] to theatre. The Consultant Obstetrician believed that the purpose of taking [redacted] to theatre was to deliver the child by caesarean section.

During this period there continued to be an abnormal CTG trace but given the normal fetal blood samples this was reassuring.

In theatre the Registrar made an assessment of [redacted] birth canal and reached the conclusion trial of instruments would be appropriate.

At 5.55 delivery was attempted by Ventouse and there was descent with each of 3 pulls.
At 6.12 a decision was taken by Registrar to switch to forceps and a fourth pull resulted in no descent. A more junior doctor present was asked to give a 5th pull again with no decent. A fetal bradycardia with a heart rate below 100 was noted and the decision taken to abandon instrumental delivery.

A category 1 caesarean section was then necessary and was started using an epidural and then a general anaesthetic.

Kristian was born at 6.39 with poor Apgar scores and was soon transferred to University College Hospital where he died on the 3rd July 2015.

The cause of death is likely to have been Asphyxia as a consequence of prolonged and extended instrumental delivery.

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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. – To the Department of Health That there was a presumption in favour of vaginal delivery based partly of cost that needed to be rebutted.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR 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 Tuesday 31st May 2016. 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;- Representatives of the family 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	**4th April 2016.**