Regulation 28: Prevention of Future Deaths report

Ana Geanina SIRGHI-MARIN (died 29.07.16)

	THIS REPORT IS BEING SENT TO: **1. [redacted]** **Vice President, Clinical Quality** **Royal College of Obstetricians and Gynaecologists** **27 Sussex Place** **Regent's Park** **London NW1 4RG** **2. [redacted]** **President** **British Maternal and Fetal Medicine Society** **27 Sussex Place** **Regent's Park** **London NW1 4RG**
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 2 August 2016, I commenced an investigation into the death of Ana Geanina Sirghi-Marin, who died on 29 July 2016 aged 36 years. The investigation concluded at the end of the inquest on 5 January 2017. I made a determination at inquest as follows.

	Ana Sirghi-Marin died because of a naturally occurring uterine infection, when she was sixteen weeks pregnant. She had become pregnant by in vitro fertilisation (IVF) and had undergone an amniocentesis at approximately 1pm on 27 July 2016. I recorded a medical cause of death of: 1a Escherichia coli sepsis 1b choriamnionitis 1c second trimester pregnancy.
4	**CIRCUMSTANCES OF THE DEATH** It appears that the amniotic E coli pre-dated the amniocentesis, as it was later determined to be present in the amniotic fluid drawn off that day. It is unclear whether conception by IVF played any part in the infective process.
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. The amniotic fluid drawn off at amniocentesis two days before death was neither purulent nor blood stained, but was discoloured dark yellow. Given the rarity of such non blood stained discolouration, I heard evidence that it would be a wise precaution in this situation always to send a sample for immediate microbiological analysis, and quickly to follow up the result. I say always because, at the time of the amniocentesis, there was no fever or other indicator of infection, yet when Ms Sirghi-Marin presented at the emergency unit the following afternoon she was very unwell, and she died the next morning. Such action would not have changed the outcome in this instance, because presentation to the emergency unit took place approximately 26 hours after the amniocentesis. However, it might in another case. And given the rarity of such non blood stained discoloured amniotic fluid, a guideline that this action is necessary does not seem onerous.

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 13 March 2017. 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 Mark Lucraft QC, the Chief Coroner of England & Wales • Care Quality Commission for England • [redacted], Chief Medical Officer for England • [redacted] Director, Homerton University Hospital • [redacted], husband of Ana Sirghi-Marin 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** 09.01.16