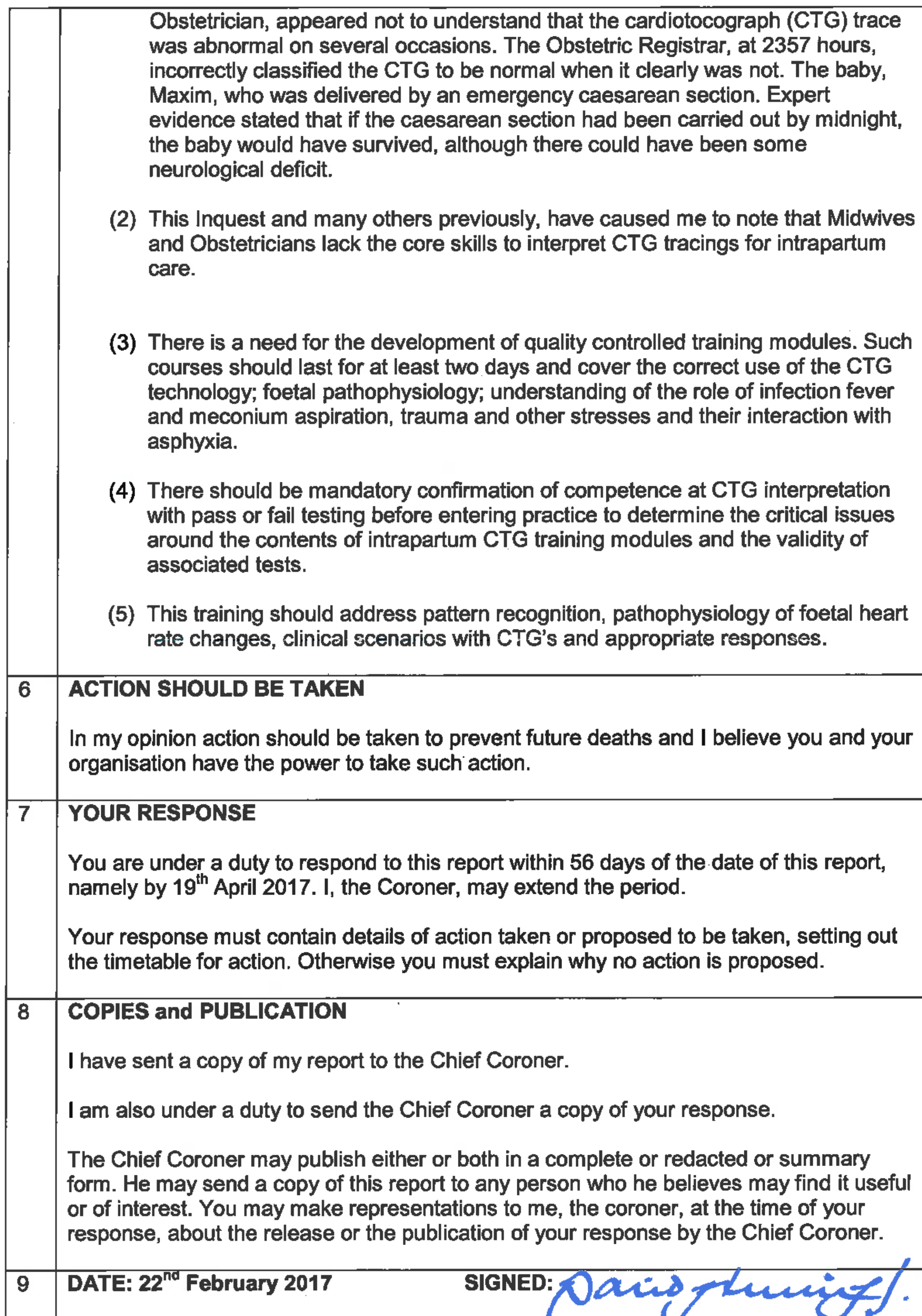
ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted] – President of the Royal College of Obstetricians and Gynaecologists at 27 Sussex Place, Regents Park, London, NW1 4RG 2. Professor Cathy Warwick – Chief Executive of the Royal College of Midwives at 15 Mansfield Street, London, W1G 9NH
1	**CORONER** I am David Hinchliff, Senior Coroner, for West Yorkshire (Eastern) area.
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 9th March 2015 I commenced an Investigation into the death of Maxim Karpovich, who was born on 16th March 2015. The Investigation concluded at the end of the Inquest on 8th February 2017. The conclusion of the Inquest was a Narrative conclusion, a copy of which is attached. The medical cause of death being:- 1(a) Perinatal Asphyxia 1(b) Small Ischaemic Placenta 2 Obstetric Cholestasis
4	**CIRCUMSTANCES OF THE DEATH** Baby Maxim Karpovich was delivered by an emergency caesarean section at Leeds General Infirmary at 0240 hours on 16th March 2015. His mother suffered with obstetric cholestasis. This was her first child. The mother attended the delivery suite at Leeds General Infirmary on 15th March 2015 when she was 38 plus 2 weeks gestation. At 0200 hours on 16th March 2015, the baby was identified as having an abnormal heart rate. He was as stated delivered by caesarean section at 0240 hours, with no signs of life. Immediate resuscitation produced a low heart rate at 0255 hours. He was ultimately treated in the Neonatal Intensive Care Unit and treatment was withdrawn and his death was confirmed at 0730 hours on 16th March 2015.
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) It was apparent that the Midwives involved with Maxim's birth and a Junior



	Obstetrician, appeared not to understand that the cardiotocograph (CTG) trace was abnormal on several occasions. The Obstetric Registrar, at 2357 hours, incorrectly classified the CTG to be normal when it clearly was not. The baby, Maxim, who was delivered by an emergency caesarean section. Expert evidence stated that if the caesarean section had been carried out by midnight, the baby would have survived, although there could have been some neurological deficit. (2) This Inquest and many others previously, have caused me to note that Midwives and Obstetricians lack the core skills to interpret CTG tracings for intrapartum care. (3) There is a need for the development of quality controlled training modules. Such courses should last for at least two days and cover the correct use of the CTG technology; foetal pathophysiology; understanding of the role of infection fever and meconium aspiration, trauma and other stresses and their interaction with asphyxia. (4) There should be mandatory confirmation of competence at CTG interpretation with pass or fail testing before entering practice to determine the critical issues around the contents of intrapartum CTG training modules and the validity of associated tests. (5) This training should address pattern recognition, pathophysiology of foetal heart rate changes, clinical scenarios with CTG's and appropriate responses.
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 19th April 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 Chief Coroner. 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: 22nd February 2017** **SIGNED:**