MISS N PERSAUD
HER MAJESTY'S CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

[redacted]

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. [redacted], Director of Clinical & Service Development, Resuscitation Council UK, 5th Floor, Tavistock House North, Tavistock Square, London, WC1H 9HR Email: 2. [redacted], Chief Executive Officer, Royal College of Obstetrics & Gynaecology, 10-18 Union Street, London, SE1 1SZ [redacted]
1	**CORONER** I am Nadia Persaud, H.M coroner for the coroner area of East 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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 17 June 2020, I commenced an investigation into the death of Mrs Hurrun Maksur. The investigation concluded at the end of the inquest on 6 December 2021. The conclusion of the inquest was that she died from natural causes. .
4	**CIRCUMSTANCES OF THE DEATH**

	On the 6 June 2020, the emergency services were called to Hurrun Maksur, as she was suffering from severe abdominal pain. Hurrun was 19 weeks pregnant at the time. Shortly after arriving in the ambulance, Hurrun suffered a seizure followed by a cardiac arrest. Resuscitation was provided promptly. Blood gases taken on arrival into the emergency department showed that Hurrun had suffered a catastrophic event. Difficulties with communication (contributed to by the need for COVID-19 personal protective equipment), led to the clinical team not having the key history of severe abdominal pain. An abdominal scan was carried out by an obstetrician. This did not identify intra-abdominal bleeding. The diagnosis of pulmonary embolism was made, based on the information available to the hospital team and she received thrombolysis treatment. After receiving thrombolysis, an intra-abdominal bleed was discovered. Surgical intervention to stem the bleeding took place, whilst CPR was still ongoing. Surgery identified a ruptured interstitial ectopic pregnancy. Surgical attempts were made to stem the bleeding and multiple blood products were administered. Hurrun continued to deteriorate following surgery, with multiple organ failure, clotting abnormalities and ongoing bleeding. A further surgical attempt was made to stem the bleeding on the morning of the 7 June 2020. Sadly, Hurrun arrested during the surgery and could not be revived. She passed away at Newham University Hospital on the 7 June 2020 as a result of a late gestation rupture of an interstitial ectopic pregnancy. Whilst deficiencies in the care were identified, there is no evidence on the balance of probabilities, that these contributed to her death.
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 could 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 guidance from MBRRACE UK 2019, provides that: *Women of reproductive age, presenting to the ED collapsed, in whom a pulmonary embolism is suspected, should have a Focussed Assessment with Sonography in Trauma (FAST) scan to exclude intra-abdominal bleeding from a ruptured ectopic pregnancy especially in the presence of anaemia.* A FAST scan did not take place before the diagnosis of pulmonary embolism was confirmed. If the MBRRACE guidance had been followed in this case, it is likely to have prevented the administration of Alteplase in a lady who was suffering from intra-abdominal bleeding. The 2019 MBRRACE guidance has now been incorporated into the local Trust's resuscitation policy, but has not been incorporated into the National, Resuscitation Council UK, Obstetric Cardiac Arrest guidance. Concern was raised during the course of the inquest in relation to the reference to the "FAST" scan. It was considered that reference should be to a "Point-of-Care Ultrasound Scan", as trauma is not a necessary pre-condition for the scan to take place. Finally, concern was raised during the course of the inquest, that obstetricians do not receive specific training to identify intra-abdominal bleeding.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe 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 8 February 2022. 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, to the family of [redacted], to the other interested persons to the inquest, the CQC and to the local Director of Public Health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**13 December 2021**