Regulation 28: REPORT TO PREVENT FUTURE DEATHS

.

REGULATION 28 REPORT TO PREVENT DEATHS

THIS REPORT IS BEING SENT TO:

Dr [redacted]
c/o RadcliffesLeBrasseur
Ref: WRC/KMD/900500.4069
85 Fleet Street
London
EC4Y 1AE

1. CORONER

I am Jacqueline LAKE, Senior Coroner for the area of Norfolk

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 14/08/2019 I commenced an investigation into the death of Kobi David WRIGHT aged Less than 1 day. The investigation concluded at the end of the inquest on 9 July 2020. The medical cause of death was:

1a) Preterm Stillbirth
1b) Complicated Instrumental and Caesarean Delivery
1c) -
2 Prematurity

The conclusion of the inquest was: Stillbirth.

4. CIRCUMSTANCES OF THE DEATH

Maternal membranes ruptured on 1 March 2019 and there was admission to James Paget University Hospital where monitoring was undertaken. On 3 March 2019 examination and reassessment took place. Following an examination at 13:30 and again at 13:50, forceps delivery was attempted. Kobi's head was delivered vaginally but delivery of his body was unsuccessful. An attempt was made to deliver Kobi by caesarean section which was initially unsuccessful, and delivery by forceps re-attempted. This was not successful and delivery by caesarean section was again attempted. Kobi was eventually delivered at 15:28 hours. He showed no signs of life and after attempts at resuscitation and assessment Kobi was declared dead.

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. D [redacted] evidence was that the cervix was almost fully dilated at 12:30 and 13:50 examinations at which point it could be "pushed easily", which was not supported by midwife's evidence of examination at 13:30 (8cm) nor of what transpired at attempted delivery, namely that cervix "retracted" to 6 to 7cm;
2. Dr [redacted] evidence was that during a telephone conversation at 13:57 he did not express concern about the CTG reading and did not give this as the reason to proceed to delivery of Kobi. This was in conflict to the evidence of Dr [redacted] Consultant Obstetrician/Gynaecologist and to his first statement 16.7.2018 para 6.
3. Dr [redacted] evidence at the inquest that he expressed concern about Kobi's mother being pre-

term, high risk with prolonged rupture of membranes was not contained in his first statement nor in his record of the conversation. In any event the evidence of Ms [redacted] and the expert Mr [redacted] who gave evidence was that these would not be reasons in themselves to proceed to an early delivery at that time.

4. Further [redacted] second statement 21.4.2020, refers to some consideration being given to variable decelerations and variabilities contained in the CTG trace when making his decision to proceed to delivery at that time. It was accepted by Dr [redacted] Ms [redacted] consultant and Mr [redacted] expert, that the CTG readings were within normal range and would not be a reason to proceed to delivery at that time. Their evidence was it would be appropriate in light of the full clinical picture and the CTG readings to "wait and see" how matters progressed.
5. Dr [redacted] gave evidence that his arranging to take Kobi's mother to theatre and prepare for delivery, and then carrying out a further vaginal examination at that time, would stand in for a later examination to see how matters were progressing. This was not regarded as good practice by the expert on the basis, it would be better to carry out a further examination after an hour, and then decide how to proceed with the delivery.
6. Dr [redacted] did not accept the Consultant's offer of assistance but regarded himself as fully competent to carry out the procedure.
7. Dr [redacted] proceeded with a forceps delivery of the baby's head. The body did not follow and the cervix "retracted" (which Dr [redacted] had not encountered before. Nor had Mr [redacted] the expert witness). Dr [redacted] cut the cervix and rotated the head and tried unsuccessfully to deliver the shoulders through the incision. Mr [redacted] expert said in evidence the baby's head on its own should never be rotated due to the damage this can cause.
8. Dr [redacted] instructed a midwife to replace the baby's head.
9. Dr [redacted] then attempted to deliver the baby via caesarean section, which was unsuccessful.
10. Ms [redacted] then attended and arranged for the Paediatric Team to be called. She was eventually able to deliver the baby
11. There was a conflict in the evidence as to whether Ms [redacted] applied both forceps blades. The evidence of Ms [redacted] was preferred in that she was the one performing the procedure and would be best placed to know what she was doing and she had throughout been a good and competent witness.
12. There was no evidence that Dr [redacted] had undergone training in emergency obstetrics in the recent period prior 3 March 2019. Dr [redacted] has undergone training since 3 March 2019 but at the instigation of North Devon District Hospital.

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 09 September 2020. 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:

[redacted] parents via Morgan Jones & Pett, Solicitors
Chief Executive, James Paget University Hospital

I have also sent it to

Ethical Guidance Department, General Medical Council, Regents Place, 350 Euston Road, London NW1 3JN
The Chief Executive, North Devon District Hospital, Raleigh Heights, Barnstaple EX31 4JB
Department of Health
Care Quality Commission
Healthcare Safety Investigation Branch (HSIB)
Healthwatch Norfolk
Child Death Overview Panel

who may find it useful or of interest.

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. Dated: 16 July 2020

Jacqueline LAKE
Senior Coroner for Norfolk
Norfolk Coroner Service
Carrow House
301 King Street
Norwich NR1 2TN