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

North London Coroners Court,
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	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **Department of Health** Department of Health 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 6th January 2011 I opened an inquest touching the death of ,Andrei Ciprian Matei aged 65 minutes. The investigation concluded at the end of the inquest on the 4th December 2013. The conclusion of the inquest was "Narrative Conclusion", the medical case of death was ;1a Peripartum asphixia , 2 Abnormal placental maturation.
4	**CIRCUMSTANCES OF THE DEATH** On the 12th December 2010 at 18.58 Andrei Ciprian Matei born in Hospital following an emergency caesarean section. Andrei was suffering with progressive intrapartum hypoxia that is likely to be related abnormal placental maturation. The decision to commence oxytocinon and to opt for forceps delivery rather than an emergency caesarean section delivery at 18.35 hrs were adverse factors that contributed to the development of the foetal hypoxia. There were concerns raised that the baby Matei's mother, who had trouble speaking and understanding English, did not have an interpreter with her when taken to theatre There was a failure to follow the consultant plan and NICE Guidelines in not taking a further foetal blood sample which was likely to have been abnormal if taken at 18.09 There was a failure to pick up the abnormality in the CTG trace from 17.20 onwards which by 18.00 hrs was likely to have been pathological. It is likely that a significant hypoxic insult occurred at the time of foetal head rotation and the application of forceps.

	There was a lost opportunity between 18.09 hrs and 18 20 hrs for an emergency delivery which if taken is likely, depending on the method of delivery chosen, to have led to a greater chance of survival.
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) There was no national guidance on the role of interpreters during labour in particular when the interpreter is required in theatre.
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 Thursday 1st May 2014. 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 parties The trust and solicitors representing the members 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	**25th February 2014 amended 6th March 2014**