Regulation 28: Prevention of Future Deaths report

Fern-Marie CHOYA (died 25.02.19)

	THIS REPORT IS BEING SENT TO: 1. **Dr Fenella Wrigley** **Executive Medical Director** **London Ambulance Service NHS Trust** **220 Waterloo Road** **London SE1 8SD** 2. **Dr Clare Dollery** **Executive Medical Director** **Whittington Health NHS Trust** **Whittington Hospital** **Magdala Avenue** **London N19 5NF**
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 1 March 2019, I commenced an investigation into the death of Fern-Marie Choya aged 40 years. The investigation concluded at the end of the inquest yesterday. At inquest, I made a narrative determination, a copy of which I now enclose.
4	**CIRCUMSTANCES OF THE DEATH**

	The medical cause of Ms Choya's death was: 1a hypovolaemic shock due to massive intra abdominal bleeding (emergency laparotomy on 25.02.19) 1b rupture of the abnormal gravid uterus 2 monochorionic diamniotic pregnancy (18/40)
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. The London Ambulance Service (LAS) emergency operations centre (EOC) made a pre hospital alert telephone call to the Whittington Hospital emergency department, regarding the expected arrival eight minutes later of a patient in respiratory arrest. This was good practice. However, they failed to include in that alert the information that Ms Choya was pregnant. This was a crucial detail, which had been passed to the LAS at the very outset by her husband, and then again to the EOC by the emergency medical crew on scene. 2. On arrival at the Whittington Hospital, the detail of the pregnancy was not communicated effectively. It is unclear whether the LAS crew did not mention the fact, or whether the emergency staff simply did not hear it. In any event, it took 16 minutes post arrival for the pregnancy to be recognised and the obstetric team to be called. 3. Without the obstetric team, the emergency department team focus was on the potential for a pulmonary embolism, and alteplase was given. Only later was a scan conducted and free fluid noted. By the time of the laparotomy it was too late to save Ms Choya.
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 30 September 2019. 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 • Association of Ambulance Chief Executives (AACE) • National Ambulance Service Medical Directors (NASMeD) • [redacted] husband of Fern-Marie Choya 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** 31.07.19