REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **Chief Executive** **James Paget University Hospital NHS Trust** **Lowestoft Road** **Gorleston** **Great Yarmouth** **NR31 6LA** **Ethical Guidance Department** **General Medical Council** **Regents Place** **350 Euston Road** **London** **NW1 3JN**
1	**CORONER** I am YVONNE BLAKE, area coroner, for the coroner 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 May 2018, I commenced an investigation into the death of Ifeoma Onwuka, 37years. The investigation concluded at the end of the inquest on 20 December 2019. The conclusion of the inquest was a narrative, copy attached. including medical cause of death.
4	**CIRCUMSTANCES OF THE DEATH** Mrs Onwuka was admitted to hospital for induction of labour. She was a high-risk labour due to induction, previous intra-uterine death of twins, age and ethnicity. Her labour progressed very quickly after 21:06 and she went from 7 centimetres to fully dilated in a matter of minutes. The baby was in distress, so an alarm was sent out and plans made to take her to theatre for a category 1 caesarean section. However, the baby was delivered in the recovery room. Mrs Onwuka began to bleed so she was taken to theatre for examination under a general anaesthetic. Just before induction of anaesthesia she had burning epigastric pain and before delivery had complained of difficulty in breathing. The anaesthetic care was excellent. The registrar could find no obvious source of the bleeding so called in the on-call consultant. He arrived and inserted a bakri balloon and conservative treatment was used until just after 01:00hrs when she eventually had a hysterectomy which stopped the bleeding. She developed disseminated intravascular coagulopathy about 30 minutes after the anaesthetic. Blood and blood products were given as well as inotropes and vasopressors.

	The consultant asked for a second consultant. **He had not performed an emergency total abdominal hysterectomy before**. He had assisted at elective surgery. He had three registrars present, one a general surgeon but did not choose to operate. It appears that the first consultant who was called could not attend **but that consultant then performed a ring around to find someone else to assist the original consultant. There did not appear to be a formal method of getting assistance.** [redacted] Eventually, someone was found but he had to drive in from Norwich. At no time did [redacted] (on call Consultant) speak to the doctor who was coming in which could have been facilitated as he was not performing any surgery. **He said in evidence** that it is not his normal practice to discuss cases with anaesthetists when he comes into theatre, he expects his registrar to give him information. **He does not, he says**, ask for updates on the patient's condition, he relies upon the anaesthetist to inform him of any problem. He was unaware or couldn't remember he said if he knew Mrs Onwuka was requiring adrenaline and vasopressors. His evidence from the witness box was that it was normal practice at the James Paget, Norfolk and Norwich and Addenbrookes hospitals to have 2 obstetric consultants to perform an emergency hysterectomy. Upon my checking this is not the practice at these hospitals and I therefore have additional concerns that he gave this evidence on oath/affirmation in a court of law. Of concern is that on the anaesthetist's evidence [redacted] **did not appear to know Mrs Onwuka had DIC, he made regular enquiries about her condition (contrary to his evidence) indicating a degree of worry or concern and that he did not agree with their repeated suggestions to proceed to an emergency hysterectomy much sooner. It was clear from the evidence that there was no leadership in the care of Mrs Onwuka, the anaesthetists were supply organ support, but no-one took control of the overall situation.** An expert instructed to assist the court has concluded that a delay in surgery to control the bleeding contributed to Mrs Onwuka's death. She was 37 years old and leaves 3 children.
5	**CORONER'S CONCERNS** During 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.Apparent lack of confidence/ability on part of on-call consultant to perform an emergency total abdominal hysterectomy without another consultant present. 2. Lack of professional curiosity about cause of DIC, the haemorrhage was not enough to cause this. 3. Lack of leadership and overview of Mrs Onwuka's care. Reluctance on the part of the on-call consultant to consider anything other than conservative measures until another obstetric consultant was present. That pregnant women in the area served by this hospital may be at risk if emergency surgery is needed and this consultant has these apparent difficulties, continues with an apparent lack of professional curiosity and displays no evidence of the ability to work in a team or head a team.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation has 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 18 February 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] – Husband I have also sent it to: [redacted] (expert witness) The Royal College of Obstetricians and Gynaecologists Department of Health Care Quality Commission HSIB Healthwatch Norfolk 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	**24 December 2019** ..... **Norfolk Coroner Service** **301, King Street, Norwich** **NR1 2TN**