Regulation 28: Prevention of Future Deaths report

Malyun Habib KARAMA (died 20.02.20)

	THIS REPORT IS BEING SENT TO: **1. Dr [redacted]** **Medical Director** **Royal Free Hospital** **Pond Street** **London NW3 2QG**
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 26 February 2020, I commenced an investigation into the death of Malyun Karama, aged 34 years. The investigation concluded at the end of the inquest on 12 August 2020. I made a narrative determination at inquest, which I attach.
4	**CIRCUMSTANCES OF THE DEATH** Malyun Karama died at the Royal Free Hospital from a uterine rupture caused by the administration of misoprostol prescribed to induce labour following a diagnosis of intrauterine death. The misoprostol was administered at doses in excess of the Royal College of Obstetricians and Gynaecologists national guidelines.

	Abnormal observations were relayed by a midwife to a senior registrar, but the doctor failed to attend Ms Karama and instead ordered fluids. The uterine rupture would have been life threatening whatever the care rendered to Ms Karama, but if the doctor had attended immediately and had reviewed and treated appropriately, the likelihood is that Ms Karama's life would have been saved.
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. I heard evidence of changes in systems at the Royal Free Hospital following the events of 20 February 2020, including changing the misoprostol dose protocol and making a medical review mandatory before each administration to a multi gravida mother. However, the Royal Free has not yet taken any steps to ensure that there is learning at a national level of the increased risk of rupture in a multi gravida mother. The more widely known increased risk is simply of vaginal birth after caesarean. Also, one of the midwives looking after Malyun Karama explained that there was no computer in the delivery suite and so she could not record her observations contemporaneously or without leaving the room. This is sub optimal.
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 19 October 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 following. • HHJ Mark Lucraft QC, the Chief Coroner of England & Wales • Mr [redacted], Malyun Karama's husband 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** 21.08.20 *ME Hassell*