REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive, Doncaster and Bassetlaw Teaching Hospitals NHS Foundation Trust**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 10th July 2018, I commenced an investigation into the death of Jade Michelle Hart, aged thirty three years. The investigation concluded at the end of the inquest on the 1st June 2022. The conclusion of the inquest was a Narrative Conclusion as follows: Jade Hart died on the 9th July 2018 at Bassetlaw Hospital, Worksop, Nottinghamshire at the age of thirty three. She gave birth to her son, [redacted], and then suffered a uterine inversion. The uterine inversion occurred between 22.35 and 22.45 hours and was caused by inappropriate umbilical cord traction applied repeatedly when the placenta had not separated, and there was resistance. The uterine inversion, although promptly reversed at 23.00 hours, led to neurogenic shock, and then to a prolonged cardiac arrest of unclear cause. Massive uterine haemorrhage followed the uterine inversion, and this was not recognised, until approximately 00.23 hours on the 9th July 2018. From the onset of the uterine reversion, the management of the uterine haemorrhage was not undertaken as per guidelines, with no uterotonic drugs given until 00.37 hours, and no definitive management of the bleeding source achieved until 02.10 when a hysterectomy was performed. By this time, Jade had lost at least 5.5 litres of blood from the uterus. This uncontrolled bleeding, together with the effects on the heart, brain and other tissues, of the acidosis and high potassium level, following multiple cardiac arrests, led to multiple organ failure and ischaemic brain damage, and to Jade's death. Her death was contributed to by neglect
4	**CIRCUMSTANCES OF THE DEATH** In brief, Jade died following the birth of her first child, from the complications of a uterine inversion, caused by inappropriate management of the third stage of labour. Following the uterine inversion, and rapid reversion, she had a prolonged cardiac arrest, then further cardiac arrests, with massive uterine haemorrhage, that was not managed urgently or effectively, with delayed use of necessary uterotonics to control bleeding.

	Her death was the subject of a lengthy Police Investigation, with charges of both Gross Negligence and Corporate manslaughter considered by the Crown Prosecution Service (CPS). The final CPS advice received in February 2022, was that there were likely to be considerable difficulties in establishing the basis for a prosecution in respect of either offence. The Inquest identified a number of serious care and treatment issues, set out in the full Determination, attached, and there is an ongoing GMC Investigation in relation to the doctor responsible for the inappropriate management of the third stage of labour.
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 conduct of the Trust Serious Incident Investigation** – there are outstanding concerns regarding the methodology, findings and conclusions in this case. The Investigation in my view was flawed in a number of serious ways as follows: • It was undertaken without including, nor giving due weight to, the family evidence, in the analysis and conclusions of the report • It was undertaken without any immediate written accounts taken of what had happened, and very limited and delayed interviews of key staff involved • The Trust commissioned an expert to assist with the Investigation. This was provided by a well respected Royal College of Obstetrics and Gynaecology recommended expert, and was then ignored, simply because there were aspects of the expert report that the Trust did not accept. All of these omissions in the Investigation process, led to serious omissions in the analysis, conclusions, recommendations and actions that followed in the report, in my view. Also, the Trust, on the evidence of Dr [redacted], Executive Medical Director, likely did not share with either the CCG or the CQC, the fact that they had received a detailed, but critical, expert report, that they had not included, nor referred to in the final Investigation report. At the Hearing, there was no reflection on this latter issue by senior Trust staff, no acceptance that the inadequacies of the report had caused huge distress to the family, and more importantly insufficient learning. If there is insufficient learning from a tragic and avoidable death such as this, what reassurance is there that there will be sufficient learning by the Trust in the future. In my mind this poses a continuing risk of similar deaths occurring in the future if the Investigation process does not change. 2. **Insufficient support for newly appointed Obstetric Consultants.** The Obstetric Consultant who was on call when Jade died, was newly appointed. She was dealing with an extremely complex and challenging situation, yet did not call for help at an early point, when Jade had had a prolonged cardiac arrest, following the uterine inversion. Whilst I accept that it is unrealistic to expect there to be a second Consultant on call every night or weekend to provide additional support, there does need to be a robust system of mentoring, and access to a

	senior consultant for prompt advice out of hours for at least one year post consultant appointment, and beyond, when serious emergencies such as this arise.
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 the **15th September 2022**. 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: 1. [redacted], Jade's husband 2. [redacted], via his legal representative 3. Nottinghamshire (previously Bassetlaw) Clinical Commissioning Group 4. The Care Quality Commission 5. The GMC 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	**20th July 2022** **Dr E A Didcock**