Summary of Regulation 28 Report to Prevent Future death: Remi Koduah (*died 23/11/2018*)

RCPCH Royal College of Paediatrics and Child Health
Leading the way in Children's Health

This is a brief summary of the regulation 28 coroners report into the death of *Remi Koduah* from which you can review the coroner recommendations to health care and consider whether there are changes you could implement in your local NHS trust to address them

Clinical summary

Cause of Death: Ruptured vasa previa.

Events leading to HIE:

- Mum had a significant show of blood shortly after the waters broke on labour ward.
- CTG at 23:00 showed abnormal tracing with Cat- 2 c-section performed at 23:57.
- Vasa previa seen at placental review & neonatal team informed
- Resus occurred in a different room to delivery
- No blood or drugs were administered during resuscitation and it was stopped at 00:46.

Coroner's Recommendations

- The neonatal resuscitation room should not be separated from the operating theatre as it is a barrier to good communication.
- Blood products should not be located away from the resuscitation room.

Key Themes

- Failure in **effective communication** among different teams.
- Logistics about **storage of blood components** for theatres and delivery areas.

Local Improvement suggestions from this report

- Review & improve logistics & location for neonatal resuscitation to ensure that communication between neonatal, the midwifery, and the obstetric teams is maximised

- Review your local blood product storage for obstetric theatre: Is it readily accessible? Do all relevant staff know how to access it?

For full information visit:
www.judiciary.uk/prevention-of-future-death-reports/remi-koduah-prevention-of-future-deaths-report/
or follow the QR code