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IN THE CORONERS COURT FOR NORTHERN IRELAND

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IN THE MATTER OF AN INQUEST INTO THE DEATH OF BABY KARL LEE MORTON

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Before: Coroner Patrick McGurgan

[1] The deceased, Karl Lee Morton, of 8 Heathdale View, Letterbreen, Enniskillen, was stillborn on 16th November 2014.

[2] In her evidence to the Inquest, Miss Sarah Morton, mother of the deceased stated that she had two previous successful pregnancies although she did suffer from pre-eclampsia and had an emergency caesarean section with her first born. Her second child was born two weeks early and Miss Morton had Strep B at that time. Both children were small for gestational age (SGA) with the first child being particularly so.

[3] Miss Morton was booked by Staff Midwife Joan Little on 9th June 2014 and then seen by Dr Salman Kidwai, Consultant Obstetrician, on 26th June 2014. Whilst Miss Morton did not believe that any pathway was discussed with her, I have heard evidence that she was placed on a shared care pathway as opposed to a Consultant led pathway.

[4] Miss Morton found this pregnancy easier than the previous two and she did not suffer from morning sickness or nausea. At her 20 week scan she recalled being informed that everything was fine and that her baby was progressing well.

[5] At around 23 weeks Miss Morton began to experience severe headaches resulting in her attending the A&E department at South West Acute Hospital (SWAH) on the 26th August 2014. She was prescribed paracetamol although she stated that she declined to take it as she generally did not like to take medications while pregnant.

[6] Miss Morton again attended A&E on 4th September 2014 and mentioned no fetal movement. She underwent a scan at the fetal assessment unit where both movement and a heartbeat were confirmed.

[7] On 10th September 2014, Miss Morton attended with Midwife Little. Her urine tested clear and her blood pressure was normal. Fetal heart was heard.

[8] On 26th September 2014 Miss Morton attended for a glucose tolerance test and for other bloods to be taken. The test was normal.

[9] Some two weeks prior to the birth Miss Morton began to feel unwell. She had a severe headache on 4th November 2014 and she believed that she attended the Out of Hours (OOH) GP that night although no record of any such attendance could be located.

[10] Miss Morton then attended A&E on 6th November 2014 complaining of vomiting, headache and blurred vision. Paracetamol was given.

[11] From this point on she recalled attending her GP, A&E and the OOH GP on numerous occasions. She experienced back pain and the headaches never settled. In relation to the back pain, Miss Morton stated that this started on the 8th November and by the 9th November the pain was a 10/10. She drove to her uncle's house as she could not make it the entire way to the hospital and she had to be brought into the hospital in a wheelchair.

[12] Miss Morton in evidence stated that she believed that the last time she felt fetal movement was on the 12th November 2014 and that she had no concerns with the movement on that date. On the 10/11th November Miss Morton attended with Dr Connor GP, followed by an attendance at A&E and then an attendance at OOH GP.

[13] Miss Morton recalled being well enough on 13th November 2014 to go Christmas shopping in Omagh. That afternoon she attended her 36 week appointment with Dr Kidwai. Before meeting with Dr Kidwai another doctor scanned Miss Morton and after that Dr Kidwai informed Miss Morton that her child had passed away. In a note in the records it states that 'Ms Morton

says last time felt movement was last night' which would have been 12th November 2014.

[14] In her evidence to the Inquest, Dr Caroline Gannon, Consultant Paediatric Pathologist, stated that she performed an autopsy on the deceased on 17th November 2014. She explained that the deceased appeared small for gestational age and that there was mild intrauterine growth restriction. Histological examination of the fetal tissues showed that the deceased was chronically stressed. Dr Gannon opined that the deceased was progressing well until the third trimester. At this time the deceased's oxygen requirements increased as would be expected but the placenta could not keep pace with these requirements. Dr Gannon was further of the view that the deceased was stressed for around two weeks prior to death, and in the brain there was global hypoxic-ischaemic change dating to 4-5 days prior to death. There was extensive placental infarction of varying ages and death occurred some 3-4 days prior to delivery. If the deceased had survived once the hypoxic-ischaemic event had occurred he would have been severely brain damaged.

[15] In his evidence to the Inquest, Dr Salman Kidwai stated that at the time he was working as a Consultant Obstetrician and Gynaecologist at the South West Acute Hospital (SWAH) in Enniskillen. This was his first Consultant's role although he had been working in SWAH for some time prior to taking up this post.

[16] He first encountered Miss Morton on 26th June 2014 when she booked under his care. Following examination, he confirmed Miss Morton's Expected Date of Confinement as 18th December 2014. Due to her high BMI an oral glucose tolerance test (OGTT) was arranged for 28 weeks and an anomaly scan at 20 weeks. Miss Morton was booked for shared care and was to be reviewed at the antenatal clinic at 34 weeks.

[17] Dr Kidwai stated that when he was reviewing Miss Morton on 26th June he had access to the booking chart completed by Midwife Joan Little. He was of the opinion that he did know the weights of Miss Morton's previous two children as recorded by the Midwife but that given that the second pregnancy was borderline Intra Uterine Growth Restricted (IUGR), he believed that a 34 week scan was sufficient to pick this up with this pregnancy if it was to occur.

[18] Dr Kidwai next encountered Miss Morton on 13th November 2014 when he was asked by Dr Mohamed Eltom, Obstetric and Gynaecology

Registrar, to repeat her scan as Miss Morton had attended for a routine antenatal visit and expressed feeling no fetal movements. On repeating the scan, Dr Kidwai did not find any fetal movements and no fetal heart activity was seen. By agreement Miss Morton re-attended the hospital the following day where labour was induced and baby Karl Lee was stillborn on 16th November 2014 at 03.45.

[19] In his evidence, Dr Kidwai accepted that Miss Morton should have been placed on a Consultant led pathway in light of her risk factors, in particular the previous birth weights of her two children, one of which Dr Kidwai described as being severely small and the other borderline. This was in addition to Miss Morton's high BMI, her pre-eclampsia with her first pregnancy and the fact that that pregnancy resulted in delivery by an emergency caesarean section. Dr Kidwai stated that the decision not to place Miss Morton on a Consultant led pathway rested with him as Consultant. He explained that if Miss Morton had been on a Consultant led pathway then she would have had her scan at 20 weeks followed by another scan at 26-28 weeks and thereafter a scan every two or four weeks depending on any issues that may have manifested themselves during the pregnancy. He further accepted that if Miss Morton had been on this pathway he would have picked up IUGR but he was unable to state if that would have resulted in an emergency delivery as the guidelines suggest trying to progress the pregnancy to 37 weeks before delivering the baby unless the Doppler readings are grossly abnormal. He did accept however that by not placing Miss Morton on the Consultant led pathway she did not have sufficient scans and that this represented a loss of opportunity in respect of the care and treatment of the deceased.

[20] Dr Kidwai did not believe that the Consultant led pathway would have detected the placental abruption which he believed was the fatal factor in this tragedy.

[21] Dr Kidwai was unable to recall if he had seen or if he was aware of the Western Health & Social Care Trust's "Assessment of Fetal Growth Guidelines" in place at the time but he accepted that he should have been aware.

[22] Dr Kidwai was surprised whenever he reviewed the notes and records following the still birth to find that Miss Morton had seen a number of medical professionals but was not referred to an Obstetrician nor had a CTG performed.

[23] Dr Kidwai agreed with Dr Gannon that the deceased had passed away some 3-4 days prior to delivery.

[24] In her evidence to the Inquest, Midwife Joan Little stated that she completed Miss Morton's booking interview on 9th June 2014 and that she did so from the information provided to her by Miss Morton. She did have sight of the letter of referral from the GP which stated that Miss Morton was for a shared care pathway. Midwife Little stated that at the time Midwives did not have access to Miss Morton's electronic records or GP notes nor did she have the previous paper maternity records as these would rarely be requested by the booking Midwife. As a result the entirety of the information recorded by Midwife Little was gleaned from questioning Miss Morton at the appointment and from the information contained within the GP, Dr Cathcart's, referral letter. Midwife Little explained that on the booking form she recorded the weights of Miss Morton's previous two children which were given to her by Miss Morton. Midwife Little noted in the 'Summary Of Risk Factors' box Miss Morton's high BMI, a previous caesarean section, and previous pre-eclampsia. She stated that she did not know if the weights of the two previous children would have been small for gestational age as that would be worked out by the ante-natal clinic midwife when completing a growth chart in the days that followed this appointment, in this case on the 19th June. According to Midwife Little, Miss Morton was not suitable for midwifery led care on risk assessment and that she would only recommend midwifery care if there were no complicating factors. Midwife Little stated that the final decision regarding the pathway was the Consultant's, in this case, Dr Kidwai.

[25] Midwife Little accepted in her evidence that if the incorrect information was inputted onto the booking form from the outset then there was a danger that this incorrect information could propagate throughout the course of the pregnancy.

[26] Midwife Little next encountered Miss Morton on 10th September 2014. She was aware that Miss Morton had attended A&E complaining of headaches on 4th September. On 10th September 2014 Midwife Little recorded that Miss Morton was:

a. "Well today. No Headache. In good Form. No concerns. 3/52."

[27] Midwife Little could not recall if she had viewed the Growth chart at this appointment but if she had been aware of the two previous SGA weights

then she could have referred Miss Morton back to the Consultant for a scan. Midwife Little did not refer Miss Morton to the Consultant at that time.

[28] In her evidence to the Inquest, Midwife Brenda McCabe stated that when pregnant women are booked in now, midwives have access to electronic records and that information from previous pregnancies and births are readily accessible and the accuracy of information supplied by pregnant mothers can be confirmed by reference to the computerised records. Midwife McCabe confirmed that the final decision regarding which pathway is to be followed rests with the Consultant.

[29] Midwife McCabe reviewed Miss Morton at Dr Cathcart's GP Clinic for a routine planned 28 week appointment. All findings at that review were unremarkable and the fundal height measurement was normal with good fetal movements. As a result Midwife McCabe did not refer Miss Morton in for an earlier Consultant review. At that review Midwife McCabe confirmed that she had access to the growth chart and indeed she entered information onto the chart. On the chart were details of the weights of the two previous children and she accepted that the weights were such that they warranted Miss Morton being referred to a Consultant as they represented SGA babies. Midwife McCabe further accepted that she was the last person who had the opportunity to place Miss Morton on the correct pathway, that is Consultant led pathway, and that by not doing so was a missed opportunity.

[30] In his evidence to the Inquest, admitted under Rule 17, Dr Paul Chan stated that he attended with Miss Morton on 4th September 2014 in A&E at SWAH. She was complaining of headache and no fetal movement since 3rd September. This was her second attendance in two weeks. She had low blood pressure and tension headaches. She was commenced on intravenous fluid and referred to the fetal assessment unit for scanning that day.

[31] I find that Dr Chan acted timely and appropriately in his treatment of Miss Morton.

[32] In his evidence to the Inquest, Dr Mark Cathcart stated that at the time he was Miss Morton's GP. Miss Morton had attended with him on three occasions, in April, May and June 2014. Dr Cathcart saw Miss Morton on 16th May 2014 when he completed a referral letter to SWAH regarding Miss Morton being pregnant. In that referral letter Dr Cathcart ticked a box entitled "shared care". He provided no details on the form regarding Miss Morton's risk factors as he believed that the hospital would hold this information already as it was the same hospital which Miss Morton had

attended in relation to the two previous pregnancies. Dr Cathcart accepted that in retrospect it would have been better to have stated the risk factor information on the referral form and that the form was lacking in this regard. Dr Cathcart further accepted that by ticking shared care and not referencing previous risks then the booking midwife could well be misled and follow on from the lack of information. Dr Cathcart explained that shared care meant that Miss Morton would be looked after between himself and the hospital and that he knew her and her family well and that if the pathway had been Consultant led care then she may well have lost contact with Primary care. He did however accept, again in retrospect, that it may have been beneficial for Consultant led care in this case.

[33] Dr Cathcart further explained that he prescribed Cefalexin on 12th November 2014 for Miss Morton at the request of Miss Morton's mother.

[34] In Dr Mohsin Shahabuddin's statement admitted under Rule 17, as he did not attend the Inquest despite being asked to do so, he recalled that Miss Morton attended A&E on 6th November 2014 at SWAH with 34 weeks pregnancy complaining of headache and vomiting since that morning and also initially blurred vision. He noted a previous history of pre-eclampsia. On examination her observations were stable and bloods and urine were normal. Dr Shahabuddin discussed Miss Morton with Dr Eltom, Gynaecology Registrar, by telephone and he advised that she was not in pre-eclampsia state. Dr Shahabuddin diagnosed Miss Morton with query tension headache and discharged her home with paracetamol.

[35] In his evidence to the Inquest, Dr Mohamed Eltom stated that on 6th November 2014 at around 11.30 he received a call from Dr Shahabuddin in A&E regarding Miss Morton. He was a Registrar in Obstetrics and Gynaecology at that time. He advised bloods be taken and sent for pre-eclampsia screening and that he would review her in due course. At 12.30 he received a further call from Dr Shahabuddin in A&E advising that Miss Morton had been discharged from A&E as her results were normal and her headache settled with a paracetamol.

[36] Dr Eltom was of the view that if he been made aware of the fact that Miss Morton had two previous SGA babies he would have adopted a different approach and organised a scan and CTG monitoring but on the information he had been presented with he was content that Miss Morton had been discharged without him having had the opportunity to have examined her himself. He believed that this was a key piece of information that he had not been told.

[37] Dr Eltom could not say whether or not the outcome would have been different if he had the opportunity to have examined Miss Morton.

[38] In his evidence to the Inquest, Dr Christian Kunze-Davis stated that he saw Miss Morton on 9th November 2014 at 14.52 in the out-of-hours base in Enniskillen. He had no access at that time to her medical notes and records. He could not recall if Miss Morton had taken her maternity file with her to the consultation. Miss Morton was complaining of back pain. He was unaware that the placenta was lying posteriorly and linking the back pain with possible placenta issues was not foremost in his mind. Miss Morton had no signs of pre-eclampsia. Dr Kunze-Davis diagnosed a urinary tract infection and prescribed an anti-biotic. On 10th November 2014 Dr Kunze-Davies spoke by telephone with Miss Morton at 10.58pm after she had seen her GP earlier that day. An appointment was offered as Miss Morton was not improving and she was then seen by Dr McGovern at 00.05am on 11th November 2014. Dr Kunze-Davis was of the opinion that if Miss Morton had been a high risk patient on a Consultant led pathway and that he had been made aware of this then this would have influenced his management of Miss Morton and he would have sought an Obstetric opinion.

[39] I find that Dr Kunze-Davis acted appropriately in his dealings with Miss Morton.

[40] In her evidence to the Inquest, Dr Elaine Connor stated that she was a GP with over 30 years' experience providing antenatal care throughout that time. Dr Connor's first encounter with Miss Morton was on 10th November 2014 when she attended complaining of vomiting. Miss Morton advised that she had attended the OOH GP on 9th November with back pain. Dr Connor also had a copy of the OOH attendance record available to her at the time. Dr Connor stated that she was unaware that Miss Morton had also attended A&E on 6th November 2014. A medical history was taken in addition to a past obstetric history. Miss Morton stated that fetal movements were good. A urine sample was checked and also sent to the laboratory. Dr Connor examined Miss Morton's abdomen. She was not aware that the placenta was lying posteriorly and given that in Dr Connor's experience back pain was a common complaint, particularly in pregnant ladies, a placental abruption was down her list of possible issues.

[41] Dr Connor observed a ripple of fetal movement and although there was no audible heartbeat on the hand held Doppler it did provide an intermittent reading and Miss Morton confirmed movement. In her evidence Dr Connor believed that she could not hear a heart- beat due to the batteries

in the Doppler needing replaced. Dr Connor prescribed medication for vomiting and advised her to stop the antibiotics until the vomiting improved. Miss Morton was advised to return if problems persisted.

[42] Dr Connor was unaware of Miss Morton's previous two children being SGA and if she had thought that there was a risk of IGUR she would have referred Miss Morton to hospital immediately. She would also have referred Miss Morton to hospital if Miss Morton had been deemed a high risk pregnancy and on a Consultant led pathway.

[43] As regards the back pain, Dr Connor conceded in evidence that her notes of the consultation did not mention this complaint. She further accepted that her notes did not reference Miss Morton's previous pregnancies or her use of a Doppler and a blood pressure reading was not recorded.

[44] Whilst I find that Dr Connor acted appropriately in this matter, the evidence suggests that it is imperative that full and detailed notes and records are made of consultations and that any equipment to be used is fully functioning.

[45] In his statement to the Inquest admitted under Rule 17, as he was outside the jurisdiction, Dr M K Krishnamurthy stated that on 10th November 2014 he was working as a staff grade whenever Miss Morton attended A&E at 14.30. She presented with lower back pain, 36 weeks pregnant and that the back pain radiated into the right leg. He diagnosed a query prolapsed disc, reassured Miss Morton and discharged her.

[46] There was no referral to an Obstetrician.

[47] Doctor Geraldine McGovern gave evidence to the Inquest. At the time she was working as a GP and on the night of 10th November 2014 was working in the GP OOH service based at SWAH. Dr McGovern stated that Miss Morton telephoned the service at 10.55pm on 10th November 2014 complaining of vomiting and spoke to Dr Kunze-Davis. Dr McGovern stated that she was to see Miss Morton at the OOH centre but Dr McGovern could not recall if she visited Miss Morton at home or saw her at the centre. Miss Morton stated that it was a home visit and Dr McGovern accepted this was the case in her evidence.

[48] Dr McGovern examined Miss Morton and she suspected that Miss Morton had a urinary tract infection. Dr McGovern was aware that Miss Morton had attended with her own GP earlier that day and she believed that she was being appropriately investigated for an UTI. She was unaware that

there had been an A&E attendance. The absence of ketones reassured Dr McGovern that Miss Morton was not dehydrated. Dr McGovern examined Miss Morton's abdomen and noted that her abdomen size accorded with her expected delivery date. She felt fetal movement. Dr McGovern suggested that Miss Morton attend with her GP in the morning for the urine results so that her GP could assess if there was a UTI.

[49] Dr McGovern accepted in her evidence and I find that she should have checked the fetal heart rate, Miss Morton's blood pressure and should have listened to the fetal heart.

[50] Dr McGovern accepted and I find that she should have referred Miss Morton to maternity services for further assessment. This was Miss Morton's fourth examination by a medical professional since 9th November, and although Dr McGovern was unaware of the A&E attendance, she conceded that the three contacts she was aware of were sufficient to refer Miss Morton to hospital.

[51] Dr Campbell Brown, Consultant in Emergency Medicine, gave evidence to the Inquest. He explained that he carried out an investigation following a complaint by Miss Morton into the roles played by Drs Mohsin Shahabuddin and M K Krishnamurthy in this tragedy. He would have expected Dr Shahabudddin to have palpated Miss Morton's abdomen and to note that and that to discharge Miss Morton prior to Dr Eltom examining her was inappropriate. In relation to Dr Krishnamurthy, Dr Brown believed that he should have palpated the abdomen and have referred Miss Morton to Obstetrics and Gynaecology.

[52] Dr Brown explained in his evidence the revised policy that now operates in A&E as regards pregnant ladies attending that department and I fully commend the said policy.

[53] Dr Brown further explained how all pregnant mothers are provided with their maternity folder which they are to bring with them to all appointments and medical contacts. He acknowledged that there are occasions when pregnant mothers would not bring their notes with them particularly to unplanned medical contacts such as an A&E attendance. He stated that A&E doctors would not normally write in these folders regarding A&E attendances although he believed that this should be happening going so far as to suggest that those pregnant mothers who attend without their folder should be followed up so that the notes can be updated following an A&E attendance.

[54] The evidence suggests that pregnant mothers should be reminded at all times to bring their folders with them to medical contacts be this when being phone triaged by OOH GP service, ambulance contact or at any other relevant opportunity. In addition, the evidence suggests that any attendance with a medical professional should be recorded in those notes together with the outcome of the attendance. Alternatively, a copy of the medical record should be given to the patient on discharge so that they can insert same into the maternity folder. This should be the policy in every Trust.

[55] Professor Kevin Dalton, Consultant Obstetrician and Gynaecologist, was instructed on behalf of the Next of Kin as an expert and he gave evidence to the Inquest. Professor Dalton was of the view that Miss Morton should have been placed on a Consultant led pathway from the outset. This would have meant that Miss Morton would have been scanned more frequently post 24 weeks and given that IUGR takes some time to develop then in all likelihood that could have been identified by serial scanning. In addition he opined that Dr Kidwai should have identified at the 14 week consultation that Midwife Little had not realised the significance of the small weights of the two previous babies. He also stated that Midwife McCabe should have recognised the previous small weights at the 28 week consultation and referred Miss Morton to Dr Kidwai.

[56] Professor Dalton accepted that Dr Kidwai made a human error as opposed to this being a systems failure as Dr Kidwai had all the relevant information to hand at the 14 week consultation with Miss Morton to enable him to decide which pathway was indicated. Professor Dalton stated that the placental abruption could not have been predicted and that this was in effect a new event and one which would cause severe hypoxic brain damage.

[57] Professor Dalton was further of the view that Miss Morton should not have been discharged from hospital on 6th November until Dr Eltom had seen and examined her and that if that had happened it is likely on the balance of probabilities that Dr Eltom would have at least suspected IUGR and set in motion an appropriate treatment plan leading to the deceased being born alive.

[58] Dr Nicholas Kearsley General Practitioner was also instructed on behalf of the Next of Kin as an expert. In his evidence he believed that Dr Davis diagnosis of an UTI was reasonable. As regards Dr Connor, he was of the opinion that she should have listened to the fetal heart beat with a stethoscope in the event that the Doppler was not working properly as it is standard practice to do so. He did accept that if Dr Connor was sure that

there were fetal movements as described by Dr Connor then it was likely that a fetal heart beat was present but he was of the firm view that Dr Connor should still have listened to the heart beat particularly as she went to do so with the Doppler.

[59] As regards Dr McGovern, Dr Kearsley was of the opinion that she should have referred Miss Morton to Obstetrics and Gynaecology due to the number of previous contacts with medical practitioners, a point accepted by Dr McGovern.

[60] Dr Kieran McGlade, General Practitioner, was retained on behalf of Dr Connor as an expert. In his evidence he stated that he believed that:

[61] "… the observation of fetal movement would be reassuring and, in the context of a general practice examination, it would not be unusual to rely on the presence of fetal movements, if observed, in the place of an accurate Doppler reading of the fetal heart…"

[62] Dr McGlade was of the strong opinion that the fetal observations by Dr Connor, the feeling of movement by her and the reported movements by Miss Morton were sufficient to indicate fetal viability without having to listen for a fetal heart- beat.

[63] In relation to pregnant women bringing their maternity notes to medical consultations he was of the opinion that many forget to bring the folder with them to appointments.

[64] I find that whilst nothing turns on it in this matter, good practice would dictate that a General Practitioner listen to the fetal heart-beat at all consultations.

[65] Dr Angela McKinney, Lead Clinician Obstetrics and Gynaecology in the Western Health and Social Care Trust gave evidence to the Inquest. She had been a team member involved with the Serious Adverse Incident investigation which was conducted by the Trust following this tragedy. The team were of the view that Dr Kidwai had made an error and that commencement of ultrasound surveillance at 28weeks would have been more appropriate.

[66] A new algorithm and risk assessment tool is now in operation which I commend.

[67] Dr McKinney stated that she had never come across a set of hand held maternity notes which had attendances at A&E or with the GP completed in

the notes. The evidence suggests that this needs to change as a matter of urgency and that details and outcomes of all medical contacts need to be detailed in the maternity folder.

[68] I find that the referral form completed by Dr Cathcart was deficient. I find that it is incumbent upon those completing such forms to include all relevant information and to make no assumptions about what information others may or may not know.

[69] I find that Midwife Little acted appropriately at the time of booking Miss Morton given the restraints on her as regards accessing computerised notes. However, I find that at the appointment on 24th September 2014, Midwife Little failed to appreciate the significance of the two previous birth weights and that by doing so missed an opportunity to refer Miss Morton to the Consultant with a request for a scan.

[70] This represented a loss of opportunity in respect of the care of the deceased.

[71] I find that Miss Morton should have been placed on a Consultant led pathway by Dr Kidwai on 26th June 2014 in light of her risk factors. I find that the shared care pathway upon which she was placed was inappropriate and by not placing her on a Consultant led pathway represented a loss of opportunity in respect of the care and treatment of the deceased. I find that Dr Kidwai had at the consultation on 26th June with Miss Morton all the necessary information which would have allowed him to have made an informed decision as to which pathway Miss Morton should be placed on.

[72] I find that Midwife McCabe did see the weights which were detailed on the Grow Chart at the appointment on 1st October 2014. I find that she was falsely reassured by the fact that the tests and growth plotting in respect of the deceased were unremarkable and also by the fact that Miss Morton had been placed on a shared care pathway and was due to see the Consultant, Dr Kidwai, at 34 weeks (on 13th November 2014).

[73] I find that not acting upon the significance of the previous weights represented a missed opportunity in respect of the care of the deceased.

[74] I find that Dr Shahabuddin did not take a complete history from Miss Morton and that a key piece of information was not picked up, that is, the weights of the two previous babies. I find that as a result Dr Eltom was not fully aware of all the relevant facts and that if the full facts had have been relayed to Dr Eltom then proper investigations would have ensued. I find

that Dr Shahabuddin having spoken to Dr Eltom should have awaited his attendance before discharging Miss Morton and that his notes of the consultation were deficient.

[75] I find that the failure to take a full and detailed history from Miss Morton and discharging her prior to examination by Dr Eltom represented a loss of opportunity in respect of the care of the deceased.

[76] I find that Dr Eltom acted appropriately throughout his involvement in this matter.

[77] I find that Dr Krishnamurthy should have examined Miss Morton more thoroughly and referred her to Obstetrics and Gynaecology and that by not doing so represented a further missed opportunity in respect of the care and treatment of the deceased.

[78] I find that the placental abruption itself was concealed and therefore unforeseeable.

[79] I find that the deceased became "stressed", as described by Dr Gannon, at approximately two weeks prior to his death, that brain damage occurred some 4-5 days prior to death and that death occurred some 3-4 days prior to delivery. By not being placed on a Consultant led pathway, I find that Miss Morton was deprived of the opportunity for scans and checks to have taken place during the period when the baby was "stressed" and that this represented a loss of opportunity in respect of the care and treatment of the deceased.

[80] Dr Gannon stated in evidence and I find that death was due to:

[81] I(a) Placental Infarction and Retroplacental haemorrhage/placental abruption.