The Portland Hospital
for Women and Children

part of HCAHealthcare UK

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Mrs. Lydia Brown
West London Coroner's Office,
25 Bagleys Lane, Fulham,
West London SW2 2GA

Sent by email to [redacted]

Dear Madam

We write to provide you with our response to the Regulation 28 Report, dated 08 February 2021.

The Regulation 28 Report raises two matters, and we have sought to address these below:

1. **It became apparent during the inquest that although a great deal of positive work, reflection and retraining has taken place and amendments to the Hospital policies and guidelines, the policy does still not reflect practise. This is particularly so in respect of the roles of the primary midwife, the second midwife in support and the anaesthetist when an epidural is being sited.**

   In order for greater clarification and protection of the fetal well-being, further consideration should be given to ensure all attending personnel are aware of their role. The requirements for fetal monitoring during this particular procedure should be highlighted and practise should reflect hospital policy.

Following the sad death of Raphael Kolbe, a Serious Incident (SI) was declared, and the Portland Hospital launched an investigation into the sequence of events that occurred. We have previously provided the Coroner with the SI report, action plan and related audit results.

As a result of the SI investigation, a number of changes were put in place. In relation to the matters referred to above, it was reiterated to all staff that the primary responsibility of the midwife was in relation to the baby's fetal monitoring, and that if this could not be maintained whilst assisting the anaesthetist, then another midwife must support the anaesthetist so that the fetal monitoring is not compromised.

The investigating team created an action plan to address the areas for learning, including the above, and put in place monthly audits to ensure the changes were embedded. These monthly audits can also be used for early identification of any potential issues, and therefore will continue to be an ongoing part of the Hospital's audit process.

Whilst the learning from the SI was properly embedded within the Hospital, we acknowledge that in relation to the 'buddying' system and the role of the anaesthetist, these changes were not properly reflected in the Portland's written policy. We apologise for this, and can confirm that this has now been addressed within the following updated policies, attached for your consideration:

- Fetal Monitoring; and
- Epidural Analgesia in Labour

These policies have been reviewed, and the changes include clarification of the following:

- the role of the midwife;
- the role of the Maternity Coordinator; and
- the role of the Anaesthetist whilst an epidural is being sited.

Specifically, the attached policies set out that:

- it is the role of the anaesthetist to check with the midwife that a CTG has been undertaken prior to commencing the insertion of the epidural.
- It is the role of the primary midwife to monitor the fetal heartbeat
- It is the role of the support midwife to assist the anaesthetist if/when requested. If there are no additional midwives available on the ward to support the Anaesthetist, the Theatre team will be contacted, and Operating Department Assistant support requested.

These clarifications have also been discussed in team meetings, circulated amongst the midwifery multi-disciplinary team (which includes the anaesthetists) and used in the training programme 'skills and drills'.

2. ***The requirement for "fresh eyes" remains under ongoing consideration to encourage and support regular review from another midwife or obstetrician and the hospital are continuing to work on an Action plan to implement best practise. While this is always an area that remains under review, clear guidance from the hospital would best support the staff and facilitate better outcomes.***

At the Portland, all maternity patients admitted to the labour ward are allocated a midwife and are cared for on a 1-2-1 basis. The fresh eyes policy at the Portland Hospital is an additional step for a second midwife to carry out the 'fresh eyes' check on an hourly basis, the practice is that each midwife will 'buddy up' usually with the midwife in the next labour room to undertake the checks. This is agreed with the Labour Co-Ordinator at the beginning of the shift. When the acuity on the ward does not support the above, another midwife, the maternity labour ward co-ordinator / Labour Ward Sister, is contacted to carry out the check.

In addition, one of the requirements of the Labour ward coordinator is to check in with each room at least once every 2 hours, this is to deliver a positive patient experience and to support the midwife. This is another opportunity for the maternity patient or the midwife to seek advice and support, in addition to the call bell system that is present in each room.

The K2 Patient Status system (central monitoring) is situated at the midwives' station. This system aids handovers, ward huddles and discussions outside of the patient's room but is not constantly monitored as the coordinator must be available to attend the midwives in their rooms as required.

The 'fresh eyes' procedure is clearly set out in the attached Fetal Monitoring Policy. All our staff fully understand and utilise the above policies/procedures at the Portland, and this is reviewed within our monthly audit system.

The Portland Hospital for Women and Children introduced the K2 electronic records system within maternity a number of years ago, this system is provided by *K2 Medical Systems* and is used widely throughout the NHS and Independent sector. A function within the K2 system is an hourly pop-up reminder for the midwife to request a 'fresh eyes' review of the fetal heart trace when CTG monitoring is taking place. This reminder is not a 'hard stop' within the system as it would prevent further action and monitoring of the patient that may be clinically indicated.

This is the system used by all NHS and most independent maternity units.

The Head of Midwifery has been in liaison with *K2 Medical Systems* to discuss what additional support may be available to enable the reminder to remain present until the check is carried out. *K2 Medical Systems* have liaised with their technical support team and have put forward a proposal for a new system. The proposed upgrade will provide more information to the patient status board system (also known as the central station) in real time from the bedside. This includes the set task of hourly 'fresh eyes' and will show when the next 'tasks' are due and overdue by highlighting anything overdue in red. The benefits of this includes the 'fresh eyes' request being highlighted in red until complete.

The whole team involved in the care and treatment of Mrs Kolbe are deeply sorry for the events that occurred. The death of Raphael has impacted the team greatly, and the wider team has sought to ensure that his memory lives on in the work that continues to be undertaken within the Portland.

Please do let us know if we can provide you with any further information in relation to the changes implemented since Raphael's tragic death.

Yours faithfully

[redacted]

Chief Executive Officer