REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Portland Hospital**
1	**CORONER** I am Lydia Brown area coroner, for the coroner area of West London
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 5 November 2019 I commenced an investigation into the death of Raphael Maximilian Kolbe. The investigation concluded at the end of the inquest on 5 January 2021. The conclusion of the inquest was:- Medical Cause of Death 1a Respiratory failure 1b Severe neonatal hypoxic ischaemic encephalopathy Conclusion (narrative) Raphael was delivered in Portland Hospital, London, following an uneventful pregnancy. During the induced labour his condition was not monitored appropriately from 1500 hours and not at all during the re-siting of the epidural. A cord prolapse occurred causing compression of the cord and spasm and leading to a hypoxic brain injury which was unsurvivable. Earlier recognition of this obstetric emergency would have allowed for immediate delivery and probably a different outcome.
4	**CIRCUMSTANCES OF THE DEATH** Raphael was delivered following an uneventful pregnancy at term. His delivery was complicated by a cord prolapse which was not recognised until fetal compromise had occurred. He died 6 weeks later in Kingston Hospital, having been transferred for palliative care.

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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – 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. 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 6th April 2021. 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 [redacted] and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18). I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**8 February 2021** **[SIGNED BY CORONER]**