NHS
Royal Free London
NHS Foundation Trust

Royal Free Hospital
Pond Street
London
NW3 2QG

Tel: 020 7794 0500

8 October 2020

BY EMAIL ONLY

HM Coroner ME Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London N1C 4PP

Dear Madam,

Response to Regulation 28 Prevention of Future Deaths Report – Malyun KARAMA

I have set out within this letter and in the action plan and documents attached, the Trust's responses to the Matters of Concern that you have brought to our attention in your Regulation 28 Prevention of Future Deaths Report dated 21 August 2020. I have been assisted in compiling the Trust's responses by:

- Dr [redacted], Clinical Director of Obstetrics and Gynaecology
- [redacted], Head of Midwifery
- Dr [redacted], Consultant Obstetrician & Service Line Lead for Obstetrics
- [redacted], Head of Quality Governance

I have set out below each of the Matters of Concern followed by the Trust's responses:

1. Evidence was heard at the inquest of changes in systems at the Royal Free Hospital following the events of 20 February 2020, including changing the misoprostol dose protocol and making a medical review mandatory before each administration to a multi gravida mother. However, the Royal Free had not yet taken any steps to ensure that there was learning at a national level of the increased risk of rupture in a multi gravida mother. The more widely known increased risk is simply in vaginal birth after caesarean.

2. Evidence was heard at the inquest that there was no computer in the delivery suite and so the midwife could not record her observations contemporaneously or without leaving the room which was found to be sub-optimal.

1. <u>Learning at a national level of the increased risk of rupture in a multi gravida mother</u>

Please refer to the attached action plan item (1d) and documents, which can be summarised as follows:

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The Actions required are:

- For the case to be presented at the NCL (North Central London) Local Maternity System Quality and Safety Meeting. This is set to take place on 6 November 2020.

- Learning in relation to the increased risk of rupture in relation to multigravida women to be shared with the national maternity risk/governance managers email distribution forum. This was completed on 2 October 2020 and the email that was distributed has been embedded into the attached action plan.

- Learning from the incident to be shared with the Project Manager for the Maternity Clinical Network – NHS England and NHS Improvement – London Region. This was completed on 2 October 2020 and the email that was distributed has been embedded into the attached action plan.

2. <u>Ensure a computer is in the delivery suite to enable contemporaneous note-keeping</u>

Please refer to the attached action plan item 2 and document, which can be summarised as follows:

The Action required is for a review to take place of the workstations on wheels (WOW) on the Labour Ward to ensure that all Labour rooms possess a computer for staff use.

This review was completed on 2 September 2020 and it identified that there were the appropriate number of workstation on wheels for the Labour rooms. However it was identified that staff were removing the Wow carts from the Labour rooms. This gave rise to recommendations being sent out via email on 2 September 2020 that:

1. The Wow carts should not be removed from the delivery room;
2. If the Wow carts are not working, the staff member: should
   - speak to the labour ward co-ordinator in order to check this and to check that the cables are correctly placed;
   - reported it to the IT helpdesk.
   - Log an incident on our Datix system to ensure the issue is investigated.

Thank you for bringing these matters to the Trust's attention and providing us with an opportunity to further review and improve our processes. The Trust is continuously seeking to improve the quality and safety of the care that it provides to its patients and your Preventing Future Deaths Report has been a helpful contribution to this ongoing and extremely important process.

Yours sincerely,

[redacted]

Dr [redacted],
Medical Director, Barnet Hospital

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Royal Free London NHS Foundation Trust – Response To Prevention of Future Deaths Report: Action Plan

Report from:	Medical Director (Barnet Hospital Business Unit) Clinical Director of Obstetric and Gynaecology (Royal Free Hospital) Head of Midwifery (Royal Free Hospital) Obstetric Lead (Royal Free Hospital)
Author(s)	Head of Quality Governance
Date	02/10/2020

Background

The purpose of this report is to summarise the actions the Royal Free London NHS Foundation Trust has taken and intend to take in order to address the Regulation 28: Prevention of Deaths report issued against the Trust on 21 August 2020 following the inquest into the death of Mrs MK (MRN 20055715) at the Royal Free Hospital on 26 Februaruy 2020.

The Prevention of Death report highlighted the following Matters of Concern:
'I heard evidence of changes in systems at the Royal Free Hospital following the events of 20 February 2020, including changing the misoprostol dose protocol and making a medical review mandatory before each administration to a multi gravida mother.
However, the Royal Free has not yet taken any steps to ensure that there is learning at a national level of the increased risk of rupture in a multi gravida mother. The more widely known increased risk is simply of vaginal birth after caesarean.
Also, one of the midwives looking after MK explained that there was no computer in the delivery suite and so she could not record her observations contemporaneously or without leaving the room. This is sub optimal.'

Action plan

No.	Matters of Concern	Action (required to address the Matter of Concern)	Responsibility (Person who has agreed to take action forward: job title)	Action Deadline	Evidence (that will prove action is completed)	Status of the Action
1.	'I heard evidence of changes in systems at the Royal Free Hospital following the events of 20 February 2020, including changing the misoprostol dose protocol and making a medical review mandatory before each administration to a multi gravida mother. However, the Royal Free has not yet taken any steps to ensure that there is learning at a national level of the increased risk of rupture in a multi gravida mother. The more widely known increased risk is simply of vaginal birth after caesarean.	a. The Bereavement/Pregnancy Loss guideline updated to include the following and disseminated via the Trust intranet: - The regimen for Misoprostol to be in line with national guidance - Clear guidance on the dosage for women receiving misoprostol for induction of an intrauterine death depending on their parity. The change should be as follows: If a woman is administered vaginal misoprostol after 26 weeks the dosing needs to be every 6 hours rather than every 4 hours. Once the woman begins to contract after having been given misoprostol, she should have an obstetric review prior to any further dose of misoprostol being given. - New guidance outlining the medication dosages for termination of pregnancy which are different to those for intrauterine death. - To develop an e-learning package to reflect the changes to the guideline. - To share the learning at the	Obstetric Lead	Bereavement/Pregnancy Loss guideline updated and approved by the Women Services Guideline Group – **Action completed April 2020** Further amendments made to the Bereavement/Pregnancy Loss following the inquest on 12 August 2020 – revised guideline uploaded to the intranet – **Action completed 30 September 2020.** E-learning package - **Deadline for completion of action 5 October 2020.** Junior doctor teaching – **Deadline for completion of action 30 October 2020.**	Revised Bereavement/ Pregnancy Loss guideline – April version Revised Bereavement/ Pregnancy Loss guideline – September version Screenshot of the updated guideline on the intranet Attendance log of junior doctor teaching as evidence Email communication of the e-learning package.	New guidance to be disseminated as part of junior doctor teaching and an e-learning package for all midwifery and obstetric staff currently under development.

		Junior doctor teaching.				
		b. A memo to be sent to staff of the changes to the Bereavement/Pregnancy Loss guideline.	Obstetric Lead	Action completed - 28 August 2020	Memos sent to staff	Initial memos sent to staff on at the time of the incident and the initial revision of the guideline on the 30 March 2020 and 29 May 2020. A further memo was sent to staff with the additional amendments to the guideline on 28 August 2020.
		c. Spot check of compliance with the new regimen for Misoprostol to be undertaken by the Bereavement midwives for a three-month period to ensure this practice is embedded. This will be performed over two months due to the small numbers of cases.	Bereavement Midwives	31 December 2020	Results from the spot checks of compliance with the new regimen for Misoprostol	
		d. Learning from the incident to be shared on a national basis via the following: - The case to be presented at the NCL Quality Safety meeting on 6 November 2020. - Learning in relation to the increased risk of rupture in relation to multigravid women to be shared with the national maternity risk/governance managers email distribution forum. - Learning from the incident to be shared with the Project Manager for the Maternity Clinical Network - NHS England and NHS Improvement – London	Head of Quality Governance Barnet Hospital Business Unit	NCL Quality and Safety meeting presentation of the case - 6 November 2020 Email communication to the national maternity risk/governance managers - Action completed 2 October 2020 Email communication to the Project Manager for the Maternity Clinical Network - NHS England and NHS Improvement - London Region - Action completed 2 October	Minutes from the NCL Quality and Safety meeting Powerpoint Presentation of the case Email communication to the national maternity risk/governance managers email distribution forum. Email communication to the Project Manager for the Maternity Clinical Network - NHS England and NHS Improvement – London Region	

		Region.		2020		
2.	Also, one of the midwives looking after MK explained that there was no computer in the delivery suite and so she could not record her observations contemporaneously or without leaving the room. This is sub optimal.'	To review the workstations on wheels available on the Labour ward to ensure that all Labour rooms possess a computer for staff use. The review to inform the actions to be taken. Review completed – The review identified that there were the appropriate number of workstation on wheels for the Labour rooms – however it was identified that staff were removing the WOW carts from the Labour rooms.	Head of Midwifery	Action completed - 2 September 2020	Memo to staff	Review completed – The review identified that there were the appropriate number of workstations on wheels (WOW) for the Labour rooms – however it was identified that staff were removing the WOW carts from the Labour rooms. A memo sent to staff on 2 September 2020.