Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

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Mr P Barlow
Assistant Coroner
Southwark Coroner's Court
1 Tennis Street
Southwark
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28 FEB 2014

Dear Mr. Barlow,

Thank you for your letter following the inquest into the death of Baby Leo Deady. In your report you state that Leo died at one hour of age following an undiagnosed breech presentation.

[redacted] was considered to have a normal first pregnancy. She was examined by several experienced midwives after 28 weeks gestation, and in the early stages of labour at hospital, and all diagnosed cephalic presentation.

The breech presentation was first noticed at 17.28 on 3.9.2013, when [redacted] was fully dilated, Leo was born at 17.47 by vaginal delivery. Evidence from the consultant obstetrician was that if the diagnosis had been made before labour had commenced, or earlier in labour, plans would have been made to turn Leo in utero or to deliver by caesarean section.

You raise the following matters of concern:

- There appears to be a small but significant rate of breech presentation nationally. Although midwives pick up most cases, a significant proportion of breech presentations go undiagnosed, possibly as high as 25% and the risks of vaginal breech delivery are very high.

- The only certain way of detecting breech presentation is by scan. Evidence in this case suggested that there are no national guidelines as to whether hospitals should routinely scan at a late stage of pregnancy to exclude breech, although some London hospitals do carry out routine scanning in late pregnancy.

and ask that we consider:

- The risks and benefits of routine scanning in late pregnancy nationally;
- Developing policy or guidance in this area

This is an issue that has been considered and researched in the past.

In October 2008, the Cochrane Review into **The Routine ultrasound in late pregnancy (after 24 weeks' gestation)** concluded that, based on existing evidence, routine late pregnancy ultrasound in low-risk or unselected populations does not confer benefit on mother or baby.

The UK National Screening Committee (UK NSC) advises Ministers and the NHS in all four countries about all aspects of screening policy and supports implementation. Using research evidence, pilot programmes and economic evaluation, it assesses the evidence for programmes against a set of internationally recognised criteria.

The UK NSC has not reviewed the evidence for screening for breech position in late pregnancy against its criteria. However, the UK NSC regularly reviews policy on screening for different conditions in the light of new research evidence becoming available.

The **National Institute for Health and Care Excellence guideline on *Caesarean section* (November 2011)** states that women who have an uncomplicated singleton breech pregnancy at 36 weeks' gestation should be offered external cephalic version. Exceptions include women in labour and women with a uterine scar or abnormality, foetal compromise, ruptured membranes, vaginal bleeding or medical conditions.

It continues to state that pregnant women with a singleton breech presentation at term, for whom external cephalic version is contraindicated or has been unsuccessful, should be offered caesarean section because it reduces perinatal mortality and neonatal morbidity.

Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour (October 2007) states that organisations should have in place robust arrangements to ensure, through clinical governance, that they are providing safe practice and learning lessons both from their own and others' practice. The document continues to state that when incidents have occurred, units need to consider the causes and consequences of the problems highlighted identifying a number of tools, i.e. National Patent Safety Agency *Root Cause Analysis Toolkit*

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and Royal College of Obstetricians and Gynaecologists *Improving Patient Safety: Risk Management for Maternity and Gynaecology*, which can be used to identify the root cause of the adverse events and that all units should have staff trained in the use of these tools.

It also states that there should be a written risk management policy including trigger incidents for risk-averse incident reporting and regular audits of obstetric indicators, such as emergency caesarean section, and neonatal indicators, such as delayed or failed resuscitation.

Officials have contacted the Trust involved, (Lewisham and Greenwich NHS Trust) and they have confirmed that they are aware of the Safer Childbirth standards.

The Trust has a suite of risk management policies and procedures in place which cover the elements quoted in the Safer Childbirth guidance. These include the identification and reporting of adverse events and near misses, and in depth review of serious adverse outcomes using the National Patient Safety Agency (NPSA) framework of root cause analysis. The Trust also implements the Clinical Negligence Scheme for Trusts (CNST) maternity clinical risk management standards. In addition, regular audits of obstetric and neonatal indicators are undertaken and monitored via internal clinical governance processes.

The Royal College of Obstetricians and Gynaecologists Standards for Maternity Care (June 2008) states that clinical governance structures should be implemented in all places of birth and that all health professionals must have a clear understanding of the concept of risk management to improve the quality of care and safety of mothers and babies, while reducing preventable adverse clinical incidents.

It also states that where an incident has occurred, every unit should follow a clear mechanism for managing the situation including investigation, learning, communication and, where necessary, implementing changes to existing systems, training or staffing levels.

I note that you sent a copy of this Regulation 28 report to the Royal College of Obstetricians and Gynaecologists (RCOG) and suggested we might wish to seek advice from them concerning the development of policy or guidance in this area.

Officials in my Department have consulted with the RCOG. They acknowledge that a certain proportion of breech presentations will be undiagnosed until the later stages of labour.

The RCOG has referred me to two of their relevant guidance publications. One is **'The Management of Breech presentation'** (Green-top 20b) which is currently being updated. The revised guidance plans to include a section entitled 'What factors affect the safety of vaginal breech delivery?' in which antenatal assessment and intrapartum assessment of women presenting unplanned with breech presentation in labour, will be considered.

The second is **'External Cephalic Version (ECV) and Reducing the Incidence of Breech Presentation'** (Green-top 20a) which is also currently being updated. Within this guide is a section entitled 'External Cephalic Version - How could the identification of breech presentation be increased?'

The RCOG have confirmed that they will forward your concerns to the developers of these guidelines for their attention and consideration.

In the meantime, taking account of existing research and guidance in this area, I consider that there is no benefit to developing a national system of routine scanning in late pregnancy.

I hope that this response is helpful and I am grateful to you for bringing the circumstances of Baby Leo's death to my attention.

Yours sincerely

Jeremy Hunt

JEREMY HUNT