NICE National Institute for Health and Care Excellence

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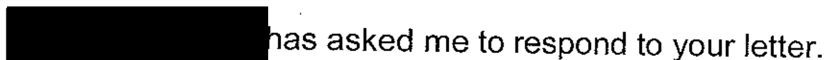
Dr Andrew Harris
Senior Coroner for Inner South District
Southwark Coroners Court
1 Tennis Street
Southwark
London, SE1 1YD

21st March 2014

Your ref: 2648-11

Dear Dr Harris,

Re: William Arthur BROCKETT-DEAKINS (Deceased)
Coroners Regulation 28 Notice


has asked me to respond to your letter.

Although I cannot comment on individual cases, I was sorry to learn of William's death, and I hope the following information helps to explain our guidance, and our process for reviewing and updating recommendations.

As you are aware, the NICE clinical guideline on Intrapartum Care (CG55) states that 40 minutes should elapse if the cardiotocography feature of concern is 'lack of baseline variability'. The guideline also recognises that there are other abnormalities of the cardiotocography which do not require 40 minutes for concerns to be raised, such as, a baseline fetal heat rate that is outside the normal range, or decelerations of the fetal heart rate.

Where there is clear evidence of fetal compromise, for example, prolonged deceleration of the fetal heart rate, greater than 3 minutes, urgent action should be taken and preparations should be made to urgently expedite the birth of the baby.

In relation to fetal monitoring, in the presence of oxytocin, the NICE guideline states, if the fetal heart rate trace is normal, oxytocin may be continued until the woman is experiencing 4 or 5 contractions every 10 minutes. However, oxytocin should be reduced if contractions occur more frequently than 5 contractions in 10 minutes.

If the fetal heart rate trace is classified as suspicious, this should be reviewed by an obstetrician and the oxytocin dose should only continue to increase to achieve 4 or 5 contractions every 10 minutes. If the fetal heart rate trace is classified as

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pathological, oxytocin should be stopped and a full assessment of the fetal condition undertaken by an obstetrician before oxytocin is recommenced. The definition of suspicious and pathological is set out in the NICE clinical guideline (CG55).

The NICE clinical guideline on Intrapartum Care (CG55) also states, that the maternal pulse should be palpated, on initial assessment in labour and during labour, if there is suspected fetal braycardia or any other fetal heart rate anomaly, to differentiate between maternal and fetal heart rate.

We review all of our guidance at regular intervals and also consider feedback and requests for updates where this is appropriate. Our clinical guideline on Intrapartum Care (CG55) is currently being updated. The progress of the update can be monitored via our website (http://guidance.nice.org.uk/CG/WaveR/109).

The team working on updating this guideline have re-examined the evidence on fetal assessment and monitoring during labour. This specifically includes cardiotocography on admission to the labour ward and during labour and the definition and interpretation of the features of fetal heart rate trace. Whilst I am not able to anticipate the outcome of the final guideline, I can report that we have found no evidence to support a significant change in the recommendations but they have been further strengthened where appropriate.

We will consult on the draft recommendations with stakeholders between 13th May – 24th June 2014 and the final guideline will be published in October 2014.

We have confidence that our guidance, correctly implemented, will provide the best outcomes for patients but clinicians retain the responsibility for their decisions. NICE Clinical Guidelines are not mandated and clinical staff can depart from them if there are appropriate and documented clinical reasons for doing so.

With kind regards,

pp

Programme Director,
Centre for Clinical Practice