Department of Health

From Ben Gummer MP
Parliamentary Under Secretary of State for Care Quality

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

POC 1028108

Mr Andrew Walker
Senior Coroner
North London Coroner's Court
29 Wood Street
Barnet
EN5 4BE

24 May 2016

Dear Mr Walker

Thank you for your letter of 4th April 2016 following the inquest into the death of Kristian Jaworski. I was extremely sorry to hear of Kristian's death and wish to extend my sincere condolences to his family.

You are concerned that, in this case, there was a presumption in favour of vaginal delivery based partly on cost.

In addition, I note that there appears to have been a failure of several doctors involved in the care of Kristian's mother to make a recorded note of her biological condition (i.e. narrow birth canal), the problems this had caused with a previous delivery and the advice for her to request a caesarean for any future births.

You have also raised concern about doctors giving a fifth pull with forceps rather than switching to a caesarean section for delivery of the baby.

My officials have contacted the Royal College of Obstetrics and Gynaecology (RCOG) for advice about the use of instruments during vaginal delivery.

RCOG advise that it's Green Top Guideline No. 26 on Operative Vaginal Delivery (published in 2011 and reviewed in 2014) states that one of the prerequisites for operative vaginal delivery is that the 'pelvis is deemed adequate'.

The guideline also covers when operative vaginal delivery should be abandoned. Section 5.4 says that 'operative vaginal delivery should not be attempted unless the criteria for safe delivery have been met. Operative vaginal delivery should be abandoned where there is no evidence of progressive descent with moderate traction during each contraction or where delivery is not imminent following three contractions of a correctly applied instrument by an experienced operator'.

I note that, in this case, a fourth and fifth pull using forceps was attempted – this was clearly not in line with the RCOG guidance.

There is a sound basis for the RCOG advice. It is known that the sequential use of instruments is associated with an increased risk of trauma to the infant. Nevertheless, the operator still needs to weigh up the risks of a caesarean section following failed vacuum extraction with the risks of forceps delivery following failed vacuum extraction.

Obstetricians should also be aware of increased neonatal morbidity with failed operative vaginal delivery and/or sequential use of instruments and should inform the neonatologist when this occurs to ensure appropriate management of the baby. The RCOG guidance is also clear that 'the sequential use of instruments should not be attempted by an inexperienced operator without direct supervision and should be avoided if possible'.

The full RCOG guidance is available at:

https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_26.pdf

I am unable to comment on why a caesarean delivery was not attempted at an earlier opportunity in this case or whether that decision was based in any way on cost – this is clearly something that the North Middlesex University Hospital NHS Trust needs to consider. I will ensure that a copy of your letter and this reply are sent to the Trust to give them the opportunity to respond to your concern.

I can advise however, that there is clinical guidance for health professionals around the use of caesarean section (CS) which has been produced by the National Institute for Clinical Excellence (NICE).

Treatment decisions in maternity care should always be made by clinicians in full consultation with women and should be based on a woman's individual clinical needs, in line with these guidelines.

You may wish to note that part of the guideline covers the economic issues relating to CS and includes an analysis of the costs of different methods of birth (both planned and unplanned) and care options. The issue of cost-effectiveness is discussed and recommendations are made that represent a cost–effective use of healthcare resources.

The full guidance is available at:

https://www.nice.org.uk/guidance/cg132/evidence/full-guideline-184810861

Department
of Health

I will now turn to the issue of clinical record keeping, as there appears to have been a failure of several doctors to make adequate recorded notes relating to the biological condition of Kristian's mother, the problems this had caused with a previous delivery and the advice for her to request a caesarean for any future births.

Whilst I cannot comment personally on the reasons behind this lack of note taking, I would like to point out that the General Medical Council (GMC) has issued clear guidance about record keeping as part of their Good Medical Practice guidance. I've pasted relevant paragraphs 19 -21 below which include advice concerning clinical records:

Record your work clearly, accurately and legibly

19. Documents you make (including clinical records) to formally record your work must be clear, accurate and legible. You should make records at the same time as the events you are recording or as soon as possible afterwards.

20. You must keep records that contain personal information about patients, colleagues or others securely, and in line with any data protection requirements.

21. Clinical records should include:

a. relevant clinical findings

b. the decisions made and actions agreed, and who is making the decisions and agreeing the actions

c. the information given to patients

d. any drugs prescribed or other investigation or treatment

e. who is making the record and when.

I hope that this reply is helpful and I am grateful to you for bringing the circumstances of Kristian's death to our attention.

BEN GUMMER

[redacted]