THE ROYAL COLLEGE OF MIDWIVES

Promoting · Supporting · Influencing

CEO/CW/MF

893/15 | DH inquest 9/2/17.

06 April 2017

Maxim Karpovich.

Mr D Hinchliff
Senior Coroner
West Yorkshire (Eastern)
71 Northgate
Wakefield
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Dear Mr Hinchliff,

Thank you for your letter of 23 February 2017, and I do apologise for the delay in replying.

The Royal College of Midwives is the professional organisation and trade union dedicated to serving midwifery and the whole midwifery team. We provide workplace advice and support, professional and clinical guidance and information, and learning opportunities with our broad range of events, conferences and online resources.

It is important to note that midwives are specialists in normal pregnancy and birth, and their role is to look after a pregnant woman and her baby throughout the antenatal period, during labour and birth, and after the baby has been born. Where anomalies occur, midwives support their medical colleagues in providing care.

The Nursing and Midwifery Council (NMC) Code Professional Standards of Practice and Behaviour for Nurses and Midwives requires practitioners to maintain the knowledge and skills needed for safe and effective practice and to recognise the limits of their competence.

Point 8 of the NMC Code requires that registrants respect the skills, expertise and contributions of your colleagues, referring matters to them when appropriate and work with colleagues to preserve the safety of those receiving care.

The NMC Midwives Rules and Standards 2012, Rule 5 Scope of Practice was in place at the time of Maxim's birth. The rule stated: 'In an emergency, or where a deviation from the norm, which is outside of your current scope of practice, becomes apparent in a woman or

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baby during childbirth, you must call such health or social care professionals as may reasonably be expected to have the necessary skills and experience to assist you in the provision of care'. A midwife was therefore required to refer to an obstetrician when abnormal findings were detected.

Midwives are expected to work in accordance with their employer's guidelines and national best practice, for example National Institute for Health and Care Excellence (NICE) guidance.

Fetal Heart Rate Monitoring

All NHS trusts will have an evidenced-based guideline or policy on fetal monitoring. The national guidance for fetal heart rate monitoring in labour is NICE guidance Intrapartum care for healthy women and babies Clinical guideline [CG190] Published date: December 2014 Last updated: November 2016.

NHS Trust's mandatory training programmes include interpretation of the fetal heart rate. Trusts also run multidisciplinary practical 'skills and drills' where the maternity team work together to identify and manage obstetric emergencies, which may include CTG interpretation.

The RCM in partnership with the Royal College of Obstetricians and Gynaecologists and Health Education England e-Learning for Healthcare developed a comprehensive web-based resource called eFM: an e-learning resource aimed at improving the interpretation of electronic fetal monitoring and subsequent management. This is a free resource for all employees of the National Health Service and contains knowledge-based interactive tutorials, assessments and case studies.

The RCM also offers multidisciplinary leadership courses for labour ward coordinators and obstetric clinical leads.

Evidence

What I have, I hope, demonstrated said up to this point is that there is an awful lot of work going on to improve the ability of midwives to interpret CTGs and to improve CTG interpretation more generally however it is important to also understand that the evidence as to how far this will get us is equivocal for example:

- When preparing the electronic programme eFM, clinical experts were asked to provide sample CTG case studies for interpretation. Agreement was reached on only 60% of interpretations with variability between practitioners and also over time. Evidence demonstrates that CTG will not, in itself, prevent fetal loss.

- A 2013 meta-analysis of controlled trials of electronic FHR monitoring versus intermittent auscultation showed that the former yielded no significant improvement in overall perinatal death or Cerebral Palsy rates but was associated with a significant increase in caesarean deliveries (RR 1.63, 95% CI 1.29–2.07, N = 18,861, 11 trials).[i]

- In a recent unmasked randomised controlled trial[ii] found that the use of computerised interpretation of CTS in women who have continuous electronic fetal monitoring in labour does not improve clinical outcomes for mothers or babies. Women were randomly assigned to decision support with the INFANT decision-support software system or no decision support via a computer-generated stratified block randomisation schedule. Between Jan 6, 2010, and Aug 31, 2013, 47 062 women were randomly assigned (23 515 in the decision-support group and 23 547 in the no-decision-support group) and 46 042 were analysed (22 987 in the decision-support group and 23 055 in the no-decision-support group). There was no difference in the incidence of poor neonatal outcome between the groups—172 (0·7%) babies in the decision-support group compared with 171 (0·7%) babies in the no-decision-support group (adjusted risk ratio 1·01, 95% CI 0·82–1·25). At 2 years, no significant differences were noted in terms of developmental assessment.

I do hope this information is helpful but please do contact me if you require any further information.

Yours sincerely,

Professor Cathy Warwick, CBE
Chief Executive

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[i] Alfirevic Z, Devane D, Gyte GM. Continuous cardiotocography (CTG) as a form of electronic fetal monitoring (EFM) for fetal assessment during labour. *Cochrane Database Syst Rev*. 2013;5:CD006066. Review.

[ii] The INFANT Collaborative Group. Computerised interpretation of fetal heart rate during labour (INFANT): a randomised controlled trial. Lancet 2017; published online March 21. http://dx.doi.org/10.1016/ S0140-6736(17)30568-8.