Department of Health

From Jackie Doyle-Price MP
Parliamentary Under Secretary of State for Mental Health and Inequalities

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18 JAN 2018

Ms Karen Harrold
HM Assistant Coroner –
Portsmouth and South East Hampshire
The Coroner's Court
1 Guildhall Square
Portsmouth PO1 2GJ

Dear Ms Harrold,

Thank you for the Regulation 28 Report to prevent future deaths dated 27 November 2017 following the inquest into the death of baby Rafe Robbie Angelo.

Firstly, I would like to say how extremely saddened I was to read of the circumstances surrounding baby Rafe's death. Please pass my condolences to his family and loved ones. I appreciate this must be a very difficult time for them.

I would like to say that we are committed to making the NHS the safest place in the world to give birth.

In November 2017, we launched *Safer Maternity Care: progress and next steps*[1], which set out progress against the delivery of the national maternity ambition to halve the rates of stillbirths, neonatal and maternal deaths and brain injuries that occur during or soon after birth by 2025. To make sure progress is made quickly, we also set out an expectation of a 20 percent reduction by 2020.

Safer Maternity Care sets out a number of steps to make sure we are doing all we can to prevent serious incidents in maternity services. This includes developing the role of the Healthcare Safety Investigations Branch[2] (HSIB) to standardise investigations of cases of severe brain injury, intrapartum stillbirths, early neonatal deaths and

[1] www.gov.uk/government/uploads/system/uploads/attachment_data/file/662969/Safer_maternity_care_-_progress_and_next_steps.pdf

[2] https://www.hsib.org.uk/

maternal deaths in England so that the NHS learns as quickly as possible from what went wrong and shares this learning as widely as possible to prevent future tragedies.

As well as providing comprehensive final reports for each case it investigates, the HSIB will publish themed reports drawing together overarching themes and points of learning from multiple investigations and making appropriate recommendations for system bodies to act on these findings.

The new investigative approach will begin in a single region from April and will continue to roll out to all areas of England by April 2019. When fully rolled out, the HSIB will investigate around 1,000 cases a year with the expectation that the learning from investigations will spur system improvements leading to fewer deaths and injuries in the future.

I hope this offers assurance that we are committed to learning from deaths and taking action to prevent future tragedies in maternity care.

The Regulation 28 Report details a number of concerns, some of which are for local resolution and some that require consideration at a national level.

My officials have made enquiries with a range of bodies including NHS England, the National Institute for Health and Care Excellence (NICE), and the Royal College of Obstetricians and Gynaecologists (RCOG) in the preparation of this reply and I will address each of the national level concerns in turn.

Antenatal checks carried out to detect small-for-gestational-age (SGA) babies

You raise a matter of concern around maternal weight checks and the effectiveness of GROW charts in identifying cases of fetal growth restriction.

You indicate that in this case, the risk assessment followed NICE guidelines at the time. As you will know, NICE's current guideline on *Antenatal care for uncomplicated pregnancies* (CG62[3]), published in March 2008 and based on best available evidence, includes recommendations regarding smoking, such as the risk of having a baby with low birthweight (section 1.3.10.2), prescribed medicines (section 1.3.4.1), and cannabis (section 1.3.11.1).

I am advised the guideline is currently being updated and the update is due to be published in July 2020.

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[3] www.nice.org.uk/guidance/cg62

I am further advised that NICE is currently in the process of undertaking a review of all its obstetric-related guidelines, which means that NICE has recently considered (or will be considering) new, relevant evidence and how it might impact on existing recommendations. NICE advises that it believes this review will cover all the relevant areas raised within the Regulation 28 Report.

You will be further interested to know that the RCOG published a guideline in March 2013 on *The Investigation and Management of the Small-for-Gestational-Age Fetus*[4]. I am advised that revision of the guideline is currently in the early stages of development.

Furthermore, I am advised that NHS England recommends the use of *Saving Babies' Lives: A Care Bundle for Reducing Stillbirth*[5], which provides interventions for the risk assessment and surveillance for fetal growth restriction during pregnancy. A number of recommendations are made including:

- using a supplied algorithm or RCOG algorithm to aid decision-making on classification of risk, and corresponding screening and surveillance of all pregnancies;
- employing serial ultrasound scans to assess fetal growth for women at high risk of fetal growth restriction and estimating fetal weight derived from ultrasound measurements recorded on a chart;
- using antenatal symphysis fundal height charts to assess fetal growth for low-risk women, by clinicians trained in their use. All staff must be competent in measuring symphysis fundal height with a tape measure, plotting measurements on charts, interpreting appropriately and referring when indicated;
- ongoing audit of SGA birth rates, with reporting of antenatal detection rate, false positive rate and false negative rate on local dashboard (or similar); and
- ongoing case-note audit of selected cases of SGA not detected antenatally to identify barriers.

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[4] *The Investigation and Management of the Small-for-Gestational-Age Fetus* www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg31/

[5] *Saving Babies' Lives: A Care Bundle for Reducing Stillbirth,* www.england.nhs.uk/mat-transformation/saving-babies/

Guidance needed post a bradycardic episode in labour

NICE guidance on *Intrapartum care for healthy women and babies* [CG190][6], was published in December 2014 and updated in February 2017. It includes recommendations relating to post bradycardic episode in labour. This is covered in Table 10 and subsequent recommendations including sections 1.10.15 – 1.10.33. You will wish to note that the fetal monitoring section of the guideline has been extensively updated since baby Rafe's death in 2014.

Availability and use of cardiotocograph (CTG) at birthing centres

Birth centres are accessed by women assessed to be low risk for complications. CTG is not made available in birth centres because NICE guidance clearly states that CTG must not be offered to women at low risk of complications in established labour (*Intrapartum care for healthy women and babies* NICE Guidance, CG190, section 1.10.1). There is no evidence that the use of CTG in low-risk women improves the fetal/neonatal outcome. I am further advised that the evidence base shows that CTGs are not recommended in a low-risk population because they have a high false positive rate, generating much unnecessary interventions such as an instrumental delivery or a caesarean section. The evidence suggests that intermittent auscultation in a low-risk population appears to be equally effective at identifying problems but does not cause as much intervention.

As previously advised, NICE is currently in the process of undertaking a review of all its obstetric-related guidelines, including CG190, which means that NICE has recently considered (or will be considering) new relevant evidence and how it might impact on existing recommendations.

Guidance for midwives about auscultation practice during transfer to hospital

Risk assessment is an integral part of a midwife's role and identified risk will trigger transfer to an obstetric unit as recommended by NICE guidance (*Intrapartum care for healthy women and babies*, CG190, section 1.6).

I am advised by NICE that it has noted the concerns in the Regulation 28 Report about a lack of guidance for midwives about auscultation practice during transfer to hospital and consideration of this concern will be given when next reviewing CG190.

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[6] https://www.nice.org.uk/guidance/cg190

Saving Babies' Lives: A Care Bundle for Reducing Stillbirth includes recommendations for effective fetal monitoring during labour that aim to ensure competency in CTG interpretation and auscultation. These include:

- all staff who care for women in labour to undertake and pass an annual training and competency assessment on CTG interpretation and use of auscultation. No member of staff should care for women in a birth setting without evidence of competence within the last year; and
- a buddy system in place for review of CTG interpretation, with protocol for escalation if concerns are raised. All staff to be trained in a review system and escalation protocol.

Recording all requests to transfer to hospital in notes and active consideration by midwives

NICE guideline CG190 *(Intrapartum care for healthy women and babies, section 1.6)* recommends general principles for the transfer of care during labour, including how care should be given during the transfer. I am advised that clinical observations are implied to continue despite no specific reference.

As before, NICE is currently in the process of undertaking a review of all its obstetric-related guidelines, including CG190.

I hope this information is helpful. You may also wish to know that NICE is currently developing new guidance on intrapartum care for high-risk women[7], which covers intrapartum care for women with an SGA baby (fetal monitoring), interpretation of CTG traces, and transfer of care (for example, via the ambulance service). NICE expects to publish the guidance in March 2019.

In terms of the local response, I am aware that the Portsmouth Hospitals NHS Trust is working to implement an action plan in response to the issues raised by this incident and oversight is being provided by NHS Improvement. I will not repeat the Trust's response here but trust that it answers the concerns you have raised at a local level.

[7] www.nice.org.uk/guidance/indevelopment/gid-cgwave0613

I hope this reply is helpful. Thank you for bringing the circumstances of baby Rafe Angelo's death to our attention. and for your very full report

Jackie

JACKIE DOYLE-PRICE