Department of Health & Social Care

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

Department of Health and Social Care
39 Victoria Street
London
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Your reference: 6847/CLB
Our reference: PFD 1143208

Ms Alison Mutch OBE
HM Senior Coroner, Manchester South
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

13 September 2018

Dear Ms Mutch

Thank you for your letter of 25 July to the Secretary of State for Health and Social Care about the death of baby Aniyah Jasmine Winston. I am responding as Minister with portfolio responsibility for maternity care.

I have noted carefully the matters of concern raised in your report. My officials have sought the advice of the National Director for Maternity and Women's Health at NHS England, as well as the National Clinical Lead and Clinical Director for Maternity and Children at NHS Improvement in the preparation of this response.

On the first matter of concern, I can confirm that it is not the case that a lack of equipment or training accounts for a lack of pre-delivery scans to detect fetal malpresentation. Rather, it is that there is currently no evidence base to recommend routine third trimester scanning.

The National Institute for Health and Clinical Excellence (NICE) has issued a clinical guideline on Antenatal care for uncomplicated pregnancies[1] that was last updated in January 2017. The guideline recommends the following:

- *1.10.4 Fetal presentation should be assessed by abdominal palpation at 36 weeks or later, when presentation is likely to influence the plans for the birth. Routine assessment of presentation by abdominal palpation should not be offered before 36 weeks because it is not always accurate and may be uncomfortable.*

- *1.10.5 Suspected fetal malpresentation should be confirmed by an ultrasound assessment.*

- *1.10.9 The evidence does not support the routine use of ultrasound scanning after 24 weeks of gestation and therefore it should not be offered.*

I am advised that it is recognised that there will be situations where breech presentation is first diagnosed in labour. The key issue is the response and actions following the diagnosis. NHS maternity service providers should have a breech guideline in place and this should include a section on undiagnosed breech in labour.

It will be helpful to note that the Royal College of Obstetricians and Gynaecologists (RCOG) Green-top Guideline No. 20b – on the Management of Breech Presentation[2] was updated in March 2017 (shortly after this incident). The guidance states that:

- *Where a woman presents with an unplanned vaginal breech labour, management should depend on the stage of labour, whether factors associated with increased complications are found, availability of appropriate clinical expertise and informed consent. [New 2017]*

[1] https://www.nice.org.uk/guidance/cg62

[2] https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg20b/

- *Women near or in active second stage of labour should not be routinely offered caesarean section. [New 2017]*

- *Where time and circumstances permit, the position of the fetal neck and legs, and the fetal weight should be estimated using ultrasound, and the woman counselled as with planned vaginal breech birth. [New 2017]*

- *All maternity units must be able to provide skilled supervision for vaginal breech birth where a woman is admitted in advanced labour and protocols for this eventuality should be developed. [New 2017]*

The RCOG guidance also states that:

- *Augmentation of slow progress with oxytocin should only be considered if the contraction frequency is low in the presence of epidural analgesia. [New 2017] As a means to treat dystocia, augmentation should usually be avoided as adequate progress may be the best evidence for adequate fetopelvic proportions. However, if epidural analgesia has been used and the contraction frequency is low, its use should not be excluded. Notably, labour augmentation is not supported by many experienced advocates of vaginal breech birth who favour a less interventionist approach.*

I hope this information offers some assurance that there are guidelines available to providers of maternity services on how to manage undetected breech presentations.

Turning to your second matter of concern about staff having the confidence to challenge decision-making in a multi-disciplinary environment, I can confirm that this is recognised as an important area in ensuring patient safety and there is much work underway at a national level to support the NHS to strengthen multi-professional team working.

The Maternity Safety Strategy[3] sets out the Government's vision and an action plan to achieve the national ambition to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur during or soon after birth by 2030, now brought forward to 2025. The action plan was structured around five key drivers for delivering safer maternity care, one of which is a focus on teams: prioritising and

[3] https://www.gov.uk/government/publications/safer-maternity-care-progress-and-next-steps

investing in the capability and skills of the maternity workforce and promoting effective multi-professional team working.

A major element of the Safer Maternity Care Action Plan was the distribution of the £8.1 million Maternity Safety Training Fund by Health Education England to 136 NHS trusts throughout England, including all 134 NHS trusts with maternity units. The funding is supporting multi-disciplinary teams to train together and further develop skills and experience in leadership, multi-professional team communication, human factors and situational awareness, cardiotocography (CTG), as well as midwifery and obstetric emergency skills and drills.

The Department is also providing additional funding over the next three years to provide support for the RCOG and the Royal College of Midwives to launch 'Each Baby Counts Learn and Support[4] - a programme of work to enable greater collaboration between the Royal Colleges and the NHS via the Maternal and Neonatal Health Safety Collaborative - this aims to align quality and safety improvement, multi-professional learning and clinical leadership into a consistent and sustainable safety strategy across the system.

I hope this information is helpful. Thank you for bringing your concerns to our attention.

JACKIE DOYLE-PRICE

[4] https://improvement.nhs.uk/resources/each-baby-counts/