Royal College of Obstetricians & Gynaecologists

Miss Nadia Persaud
Her Majesty's Coroner
East London
Walthamstow Coroners Court
Queens Road
Walthamstow, E17 8PQ

4 March 2022

Dear Miss Persaud

Re: Regulation 28 Report into the death of Mrs Hurrun Maksur
[redacted]

Thank you for your Regulation 28 Report to Prevent Future Deaths following the inquest into the death of Mrs Hurrun Maksur dated 15th December 2021. We would like to begin by extending our sincere and heartfelt condolences to Hurrun's family for their deep loss. We recognise and respect the narrative conclusion from the inquest.

In your report you raised two concerns:

1. *Concern was raised during the course of the inquest in relation to the reference to the FAST scan. It was considered that reference should be to a point of care ultrasound scan, as trauma is not necessary a pre-condition for the scan to take place.*
2. *That obstetricians do not receive specific training to identify intra-abdominal bleeding'.*

In order to provide a full response, we have been in touch with colleagues at The Association of Early Pregnancy Units, as well as with Senior College Officers and our Curriculum Committee (responsible for core training in Obstetrics and Gynaecology)

Screening for ectopic pregnancy is a mandatory part of the ultrasound assessment in early pregnancy. Anyone undertaking a scan in early pregnancy must check for a potential ectopic pregnancy. This is specifically stated in our advice regarding ultrasound training: ultrasound-scan--guidance-vfinal.pdf (rcog.org.uk)

Most of the routine scans in early pregnancy within antenatal services are carried out by ultrasonographers rather than consultants or trainees in Obstetrics and Gynaecology (O&G). Excluding ectopic pregnancy is a routine part of the first scan, although the scan is not usually carried out until 11-12 weeks' gestation. In clinical practice, nearly all patients with ectopic pregnancies will have presented to gynaecology emergency services by the time that scan is due to be undertaken and it is rare for an ectopic pregnancy to be diagnosed that late in pregnancy.

Within gynaecology emergency services, scanning is undertaken by a mixture of ultrasonographers trained by and working within radiology departments and O&G doctors; in any case they are all trained to check that the pregnancy they are observing is intrauterine. However, there are very few, if any, Trusts in the UK with emergency gynaecology service provision which relies on ultrasonography being carried out solely by O&G doctors.

The assessments required of trainees within our core curriculum involve transabdominal scanning in early pregnancy. The College has had much discussion about transvaginal scanning as part of the core and basic curriculum, but because most ultrasound examinations are carried out by ultrasonographers we subsequently did not put this into the curriculum as a specialist skill. If a woman presents with a ruptured ectopic pregnancy, the expectation would be that the woman would be seen as an emergency, a clinical assessment made and a decision about urgency taken. The woman can be taken to theatre without a scan if urgent surgery is thought to be life-saving. This is outlined in our Capability in Practice (CiP) 9 where we state that trainees should "*Formulate an appropriate and individualised management plan taking into account a person's preferences and the urgency required.*"

Because of the way that ultrasound services are set up in the UK i.e. there is no clinical need (and sometimes no opportunity) for O&G doctors to routinely perform early pregnancy scans, RCOG educators have not sought to train all our junior doctors to independent competence level and have added the following caveat to the curriculum:

'Completion of the two mandatory transabdominal ultrasound skills does not imply that a trainee is automatically ready for independent practice in diagnostic ultrasound (particularly in out of hours unsupervised clinical settings). Care should be taken in delegating decisions about clinical management of patients to trainees who have completed only the mandatory modules (particularly where management relies on the ultrasound findings). The expected utilisation of ultrasound skills, both within and out of hours should be determined and agreed by the local ultrasound supervisor in the context of local protocols for ultrasound scanning.'

With reference to the second concern, transabdominal ultrasound scan in the first trimester is utilised to confirm the intrauterine site of the pregnancy and the presence of a fetal heartbeat. It is routine and part of the training to note how much free fluid is present in the pelvis, and whether the fluid identified resembles blood or peritoneal fluid. The implications are that if the pregnancy is not intrauterine, you would look for a bleeding ectopic pregnancy. We acknowledge that in the responses raised there was a concern about the timely recognition of intraperitoneal bleeding. Bleeding from a ruptured, or more commonly leaking, ectopic pregnancy is often slow and the blood clots in the peritoneal cavity. This means that there is not much 'free fluid' and the clotted blood looks very similar to loops of bowel. A young fit woman may deteriorate at a late stage and may have an abdomen full of clotted blood that is missed on a portable transabdominal scan looking for fluid. This is a different situation from identifying intra-abdominal bleeding later in pregnancy.

Later in pregnancy, or in the situation where the gestational age is unknown (such as a concealed pregnancy) scans may be undertaken by a variety of personnel but in most cases within an obstetric setting such as on labour ward or a gynaecology setting such as an early pregnancy unit, this would be experienced ultrasonographers trained and working within radiology departments.

RCOG is supportive of the guidance from MBRRACE UK (2019) which states: *Women of reproductive age, presenting to the ED collapsed, in whom a pulmonary embolism is suspected, should have a Focussed Assessment with Sonography in Trauma (FAST) scan to exclude intra-abdominal bleeding from a ruptured ectopic pregnancy especially in the presence of anaemia.*

In A&E, abdominal scanning is usually performed by doctors working within the A&E department who are trained to look for intra-abdominal bleeding; for example in cases of abdominal trauma, ruptured arterial aneurysms etc. It is very rare indeed for an obstetric doctor to be carrying out such a scan within an A&E department and most obstetric doctors would go through their whole hospital career without being asked to perform an ultrasound in these circumstances. Because of the lack of opportunities within routine O&G clinical practice, it would not be feasible to train all our doctors to be able to do this reliably even using simulation. Not only would it be difficult to organise training, they would not be able to retain their skills by regular practice - unlike doctors working in A&E. It would be better to focus training efforts on those doctors who perform this sort of scan (a FAST scan) on a routine basis.

Whilst the O&G doctors should clearly be part of the team making decisions about the care of a collapsed pregnant woman, they are likely to be the least experienced in terms of performing the FAST scan.

[redacted]

It is our intention to engage in discussions with educators from the Faculty of Emergency Medicine and the Royal College of Radiologists to reinforce the need to check for intra-abdominal bleeding before anticoagulating a collapsed patient.

Additional information on training

In addition to the above, the following information provides further clarity on our training in this area:

As above in point 1, competencies are outlined in CiP 9: *The doctor is competent in recognising and managing emergencies in gynaecology and early pregnancy'* (pages 19 and 20 in the Definitive Document for the Core Curriculum).

There are further competencies outlined in CiP 11: *The doctor is competent in recognising, assessing and managing emergencies in gynaecology and early pregnancy'* (pages 23-25 in the Definitive Document for the Core Curriculum).

Royal College of Obstetricians & Gynaecologists

It is expected that O&G trainees are able to independently perform Transabdominal ultrasound examination or early pregnancy, as confirmed by three summative competent OSATS (page 44, Definitive Document for the Core Curriculum).

The detailed knowledge criteria for CiP 9 appears in knowledge areas 3 and 13 in our MRCOG membership examination:
MRCOG knowledge requirements: Area 3 - core surgical skills
MRCOG Knowledge requirements: Area 13 - early pregnancy care
The detailed knowledge criteria for CiP 11 appears in knowledge areas 10, 11, 12, 14 and 15.

We hope that this provides further clarity on the above training queries and demonstrates that the RCOG is committed to improving the standard of care provided for women and working collaboratively with others to prevent tragedies like this in the future.

Yours sincerely,

[redacted]
Vice President, Royal College of Obstetricians and Gynecologists

[redacted]
Vice President for Education, Royal College of Obstetricians and Gynaecologists

[redacted]
Chief Executive, Royal College of Obstetricians and Gynaecologists