Department of Health

*From the Rt Hon Jeremy Hunt MP*
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Mr A Walker
Senior Coroner
North London Coroners Court
29 Wood Street
Barnet
EN5 4BE

29 APR 2014

Dear A. Walker,

Thank you for your letter following the inquest into the death of baby Andrei Ciprian Matei. In your report you conclude that the medical cause of death was peripartum asphixia and abnormal placental maturation.

Andrei Ciprian Matei was born in Barnet Hospital on the 12 December 2010 at 18.58 following an emergency caesarean section and was suffering from progressive intrapartum hypoxia, likely to be related to abnormal placental maturation.

There was a decision to commence oxytocinon and to opt for forceps delivery rather than an emergency caesarean section delivery at 18.35 which you consider were adverse factors that contributed to the development of the foetal hypoxia. There were concerns that the baby's mother, who had trouble speaking and understanding English, did not have an interpreter with her when taken to theatre.

You point out failures to follow the consultant plan and NICE Guidelines in not taking a further foetal blood sample, which was likely to have been abnormal if taken at 18.09, and failure to pick up the abnormality in the CTG trace from 17.20 onwards, which by 18.00 hours was likely to have been pathological.

You consider it likely that a significant hypoxic insult occurred at the time of foetal head rotation and the application of forceps.

You report that there was a lost opportunity between 18.09 hours and 18.20 hours for an emergency delivery which could, depending on the method of delivery chosen, have led to a greater chance of survival.

You therefore raise the following matter of concern:

- *There was no national guidance on the role of interpreters during labour in particular when the interpreter is required in theatre.*

I note firstly that the matter of concern you raise for my attention does not relate to failures around the medical care of mother and baby during labour and birth. These are issues that I agree should be properly addressed by Barnet and Chase Farm Hospital NHS Trust.

I also note that Barnet and Chase Farm Hospital NHS Trust do provide interpreting services to meet the communication needs of patients and their families. They are able to access over 55 languages using the services of freelance interpreters or agencies. Details of how to book an interpreter in both normal hours and in emergency and out-of-hours is available on their website at the following address:

http://www.bcf.nhs.uk/for_patients/interpreting-services/index

However, I cannot comment on why no interpreter was with baby Andrei's mother when she was taken to theatre and advise that this is a matter best addressed by the Trust.

I fully agree that the availability of interpreters when necessary for women giving birth is an important matter. Current National Institute for Clinical Excellence (NICE) guidelines on Antenatal Care advise that:

*"Information should be given in a form that is easy to understand and accessible to pregnant women with additional needs, such as physical, sensory or learning disabilities, and to pregnant women who do not speak or read English."*

These Guidelines can be found at http://www.nice.org.uk/Guidance/CG62

The Royal College of Obstetricians and Gynaecologists (RCOG) also advise in their current Standards for Maternity Care (published 2008) that:

*"There should be provision for translation, interpreting, and advocacy services, based on the assessment of the needs of the local population."*

The provision of such services is however decided, negotiated and commissioned locally by individual NHS and Foundation Trusts.

In addition, a lack of suitable interpreters is one of the key themes running throughout the eighth report on Confidential Enquiries into Maternal Deaths (*Saving Mothers' Lives)*, published in 2011.

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This report recommends that:

*"Commissioners and providers of maternity services should therefore ensure that professional and independent interpretation services are available in both primary-care and secondary-care settings, to ensure that all women can be confident that they can speak freely and in confidence to their maternity-care providers."*

Although this is not in itself a national guideline, it is a widely distributed, influential and highly valued UK report. The full report can be found at:

http://onlinelibrary.wiley.com/doi/10.1111/j.1471-0528.2010.02847.x/pdf

It is open to NICE to incorporate the recommendations of this report into future guidance.

Although the guidance I have detailed does not, and in my view could not reasonably specify the exact roles of interpreters during labour or in theatre, NICE may wish to consider a review of their current guidelines in this respect. I will ensure that the matters you raise are brought to their attention for future consideration.

I hope that this response is helpful and I am grateful to you for bringing the circumstances of baby Andrei's death to my attention.

Yours sincerely

Jeremy Hunt

**JEREMY HUNT**