Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

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POC1_846082

Mr A Harris
Senior Coroner
Southwark Coroners Court
1 Tennis Street
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9 MAY 2014

Dear Mr. Harris,

Thank you for your letter following the inquest into the death of baby William Arthur Brockett-Deakins. In your report you conclude that William died from respiratory failure, chest infection and perinatal hypoxic ischaemic encephalopathy (HIE).

William died in October 2011 from respiratory problems. These problems and his disabilities were a direct result of acute profound perinatal HIE, which was not due to any inherent condition of the baby or mother or any antenatal factors.

William had been born in a poor condition on 16 December 2007. He initially required resuscitation and ventilation. He survived but was brain damaged, severely disabled with seizures, spasms, visual and hearing impairments, feeding and respiratory difficulties requiring constant medical and parental support. His condition was incurable and he received all the treatment that was in his best interests.

You describe the management of the mother's labour by the midwives involved and detail failures of care and neglect, including a failure to refer issues relating to cardiotocograph (CTG) tracings to an obstetrician and a consecutive midwife attendance of 15 hours. You also accepted the expert evidence that there was an opportunity to render care, which if taken by a certain time, on the balance of probabilities would have prevented the tragedy from occurring. William would not therefore have died of HIE when he did.

I note that you have sent your letter to several organisations and have asked each to consider specific concerns. I am aware that the National Institute of Health and Care Excellence (NICE) has already responded on its clinical guideline on Intrapartum Care (CG55) and the issues relating to CTG interpretation. The Nursing and

Midwifery Council (NMC) has also replied, addressing the training of one of the midwives in CTG interpretation and explaining the current system of midwife statutory supervision.

You raise the following matter of concern both for my attention and that of the Nursing and Midwifery Council:

- *Models of private midwifery led services for low risk pregnancy. Expert advice considered that the model of service created a risk of deaths. It is not clear how the risks are best identified and managed across a mixed health economy, which is why the Secretary of State is an addressee of my report.*

As the NMC has already suggested, this is more appropriately addressed by my department. The model of midwifery provision described in this case was and is unacceptable and, for the reasons cited in the Regulation 28 Report, unsustainable. When this incident occurred in 2007 the Trust had a system of two midwives providing care to private patients who requested midwifery-led care. This system was discontinued in July 2010 and no longer operates. The model is not known to exist elsewhere in England.

The issue of statutory supervision of midwives is, as the Report points out, important but needs some clarification. All midwives are registered with the Nursing and Midwifery Council (NMC) and are required, by law, to have a statutory supervisor. All practising midwives are required to meet their statutory supervisor at least once a year (or more frequently, if either party wishes to discuss issues of concern - caseload and practice for example). This annual discussion ensures the midwife is up-to-date in his or her sphere of practice and results in the supervisor of each midwife making a decision about the midwife's continuing fitness to practice.

Provided the midwife is fit to continue practising the statutory supervisor enters the annual review on the NMC database and confirms that the registrant has undergone supervision and is fit to practice. The consequence of this is that the midwife's name has a statement next to it which confirms that the midwife is entitled to provide midwifery care until a certain date (limited to one year from the date of statutory supervision – most run until 31st March each year). This is not however a performance review or appraisal in the managerial sense. Statutory supervisors of midwives are not usually the managers of the midwives they are supervising.

Your report states that "not all midwives are members of the College that runs supervision". While it is true that not all midwives are members of the Royal College of Midwives (RCM), the RCM does not regulate the profession. The RCM is a union and there is no requirement for midwives to join.

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This disconnection between statutory supervision and performance management of midwives was of concern to the Parliamentary and Health Service Ombudsman in her report on maternity care in Morecambe Bay. She published her report - *Midwifery supervision and regulation: recommendations for change* - in December 2013 which has initiated a national review of statutory supervision which is being led by the NMC.

In order to practise midwifery all midwives must, by law, be registered with the NMC. This applies regardless of where they practise, including the NHS, the private sector, in a social enterprise or as an independent self-employed practitioner. Every midwife registered with the NMC is subject to statutory supervision regardless of where they practise.

As the regulator of the profession, the NMC has the authority to place conditions on or suspend the ability to practise or remove a midwife from the register. The midwives involved in this case were referred to the NMC in 2009 by the family. The case was reviewed and was not taken to a full hearing by the NMC.

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

Yours sincerely

Jeremy Hunt

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