Department of Health & Social Care

From Baroness Gillian Merron
Parliamentary Under-Secretary of State for
Patient Safety, Women's Health and Mental Health

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Our Ref: [redacted]

Penelope Schofield
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By email: [redacted]

24 July 2024

Dear Penelope,

Thank you for your Regulation 28 report to prevent future deaths dated 26/04/24 about the death of Orlando Nova Davis**.** I am replying as the newly appointed Minister with responsibility for Patient Safety, Women's Health and Mental Health.

Firstly, I would like to say how saddened I was to read of the circumstances of Orlando's death, and I offer my sincere condolences to their family and loved ones. The circumstances your report describes are deeply concerning and I am grateful to you for bringing these matters to my attention.

The report raises concerns about an irreversible brain injury caused to Orlando when his mother suffered a seizure having developed hyponatremia during her labour, and how midwifes (in the community and in the hospital, who had cared for Orlando's mother) were unaware of this potential condition developing in birthing women.

Your report states that due to Orlando developing a tachycardia during labour, Orlando's mother was actively encouraged to take in more fluid, yet there was no accurate record kept of either input or output of fluid. Again, when in hospital, further fluids were given intravenously with no recognition of any potential risk of hyponatremia developing by the midwives or the doctor on duty.

In 2023, NHS Resolution published a report entitled Recognising and avoiding significant maternal and neonatal hyponatraemia. This is a case story which is illustrative but based on recurring themes from real life events, to share insights and support learning from harm. The report highlights the importance of accurate fluid balance monitoring during labour to reduce the chance of a mother experiencing hyponatraemia and asked services to consider their local guidance. There was also a recommendation for trusts to read the Northern Ireland GAIN guideline on hyponatraemia in labour and consider whether it could be implemented in their services.

Current national guidance is informed by The National Institute for Health and Care Excellence (NICE). Hyponatraemia is described in a Clinical Skills Summary (CKS) which provides primary care practitioners with a readily accessible summary of current evidence base and practical advice on best practice, Hyponatraemia NICE (2020). This is largely based on expert opinion in the clinical practice guideline on diagnosis and treatment of hyponatraemia.

Many trusts have developed their adult hyponatremia guidelines as a reference for the management of hyponatraemia in adults, with further guidance for the management of Intravenous fluid therapy in adults in hospital (nice.org.uk) (2017). NICE guidance on hyponatraemia specifically in the peripartum period is embedded within NICE Guidance (NG229) Fetal monitoring in labour (nice.org.uk) (2022) which has been updated and advises not to offer intravenous fluids to treat fetal heart rate abnormalities unless the woman is hypotensive or has signs of sepsis.

NICE Guidance (NG235) Intrapartum care (nice.org.uk) (2023) has also been updated to include the following:-

- 1.8.17 Inform the woman that she can drink during labour when she is thirsty, but there is no benefit to drinking more than normal. Isotonic drinks may be more beneficial than water. **[2007, amended 2023]**
- 1.8.23 Review bladder care for women at least every 4 hours. This should include:
    - Frequency of passing urine and bladder sensation
    - Fluid balance monitoring if sensation is abnormal or absent, if there is an inability to pass urine, or the woman is receiving intravenous fluids (including oxytocin)
    - Offering to insert a catheter if there are any ongoing concerns over the woman's ability to pass urine. **[2023]**
- 1.8.47 When starting intravenous oxytocin in the first stage of labour:
    - Do not start separate intravenous fluids without a clinical indication (for example, the woman is not drinking, is dehydrated, or is hypotensive)
    - Monitor fluid balance **[2023]**

The guidance also advises on the cautious use of intravenous fluids and monitoring of fluid balance every four hours and especially if a woman has altered sensation to urinate or is receiving intravenous fluids. When a woman chooses to have a low-dose epidural for pain relief, she is no longer required to have fluids administered prior to the procedure (known as pre-loading), or any maintenance fluid infusion. This is to limit the likelihood of fluid overload and hyponatraemia. However, the term "hyponatraemia" is not used in either of these national guidelines in maternity and there is no stand-alone guidance specifically for hyponatraemia in maternity services nationally.

Individual trusts may have developed this based on the guidance from GAIN, NHS Resolution's case reviews and local learning. The Core competency framework v2 (2023) was published to guide trusts in developing their training in response to local and national learning.

Reviews of brain injury cases through programmes such as the Royal College of Obstetricians and Gynaecologists (RCOG) Each Baby Counts programme and NHS Resolution's Early Notification programme have identified two clinical areas of practice that contribute to avoidable brain injuries:

1. Failure to identify, escalate and act on signs of foetal deterioration during labour, and
2. Failure to adequately manage an impacted foetal head during caesarean section.

To address these issues and accelerate progress towards achieving the National Maternity Safety Ambition, the Department of Health and Social Care has established a Brain Injury Reduction Programme.

In 2021-22, the Department provided £5 million to the Royal College of Obstetricians and Gynaecologists (RCOG) to lead on Phase 1 and Phase 2 of the Brain Injury Reduction Programme. The RCOG subsequently formed a collaboration with the Royal College of Midwives (RCM) and the Healthcare Improvement Studies (THIS) Institute, which was named the 'Avoiding Brain Injury in Childbirth' (ABC) collaboration.

For phase 1, the ABC has developed consensus-building approaches, standardised tools, and training to reduce the rate of intrapartum brain injuries. For Phase 2, the ABC developed clinical tools and training approaches needed for future implementation to standardise the identification and escalation of a deteriorating baby.

A national pilot for the tools and training approaches commenced in May. The pilot will help inform a full national rollout of the programme. At the 2024 Spring Budget, £9m over three years was committed to roll out the Brain Injury Reduction Programme across maternity units in England following successful completion of the pilot. This will provide maternity services with the tools and training to reduce brain injuries in childbirth.

The Nursing and Midwifery Council's standards of proficiency for midwives represent the knowledge, skills and attributes that all midwives must demonstrate at the point of registration and reflect what the public, women and families can expect midwives to know and be able to do in order to provide the best and safest care possible.

The standards are grouped under six domains, and domain four sets out the midwife's role in first line assessment and management of complications and additional care needs. Standard 6.69 states that midwives must "recognise, assess, plan, and respond to pre-existing and emerging complications and additional care needs for women and newborn infants, collaborating with, consulting and referring to the interdisciplinary and multiagency team as appropriate.

The NHS in England is working in collaboration with national partners and providers of maternity care, towards the national ambition to halve the rates of stillbirth, neonatal and maternal mortality, and intrapartum brain injury by 2025.

Several initiatives are underway including how we learn from incidents with the introduction of the Perinatal Safety Incident Reporting Framework (2020), the ongoing reporting from MBRRACE-UK, and thematical reviews by MNSI, the Maternity and Neonatal Safety Investigations programme. To date, there has not been any thematical reviews pertaining to hyponatraemia in maternity services.

I hope this response is helpful and demonstrates my sincere desire to improve care for patients so we can avoid such tragedies from occurring. Thank you for bringing these important concerns to my attention.

Yours sincerely,

BARONESS GILLIAN MERRON