British Association of Perinatal Medicine

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Sent via email
24th July 2025

Dear Mr Longstaff,

Thank you for contacting the British Association of Perinatal Medicine (BAPM). We respond to numbers 3 and 4 of your matters of concern in your regulation 28 report dated 3rd June 2025 following the sad death of Benjamin Finch Arnold. We are unable to comment on the specifics of a case but we have considered the points in your letter raised in regards to guidance from BAPM.

BAPM is a membership organisation that is here to support all those involved in perinatal care. Our objectives are to optimise their skills and knowledge, deliver and share high-quality safe and innovative practice, undertake research and speak out for babies and their families. We are professional association of neonatologists, paediatricians, obstetricians, nurses, midwives, trainees, network managers, and other health professionals that are dedicated to shaping the delivery and improving the standard of perinatal care in the United Kingdom.

BAPM is an advisory, not an executive body. We have made some relevant recommendations in our frameworks for practice that can form the basis for local guidance. It is the responsibility of individual trusts to implement their own processes in line with national guidelines. The frameworks are published by a multidisciplinary team that deliver neonatal intensive care and after consultation with the whole BAPM membership and relevant associated speciality groups. The two frameworks for practice and one report that are relevant to the care given in this case are "Managing the Difficult Airway in the Neonate" published in October 2020, "Neonatal Airway Safety Standard" published in April 2024 and "Consultant Working Patterns – A BAPM Report" published in November 2023**.** I draw your attention to the fact that the latter two documents were NOT in place at the time of this death.

Neonatal Intensive Care is delivered by a team. This team is composed of trained and competent staff that can and do make decisions about the care of a newborn baby. This care is Consultant led but not Consultant delivered. In the framework **Consultant Working Patterns – A BAPM Report [page 5]**

"Clinical service commitment during daytime clinical shifts and on calls is paramount. Any other service commitments must not prevent 24/7 immediate availability to the neonatal service including the provision of advice and, where required, in person attendance. In person attendance out of hours should always be within 30 minutes. Immediate availability of consultants will be dependent on the experience of resident Tier 2 staff, particularly in relation to airway skills. This may require resident consultant models in some instances. Local solutions for covering additional areas such as general paediatrics and neonatal transport will need to be robustly job-planned and risk assessed."

On this basis, with an appropriate local risk analysis, a consultant does not need to be involved in the decision to administer surfactant or perform LISA as long as it is performed by someone with an appropriate level of experience and competence.

There are no national guidelines, such as guidance from the National Institute for Health and Care Excellence, that mandates the process of performing LISA. On this basis, local delivery of LISA is not standardised. As we have indicated, BAPM does have a checklist to deliver LISA (Appendix F in the Neonatal Airway Safety Standard). This checklist includes a reminder to consider a pneumothorax as the reason for a baby's clinical condition. This framework does not include a recommendation to perform a chest x-ray prior to LISA. A pneumothorax may be diagnosed by other means other than an Xray, including clinical examination, cold light examination or lung ultrasound. The checklist also prompts staff to consider if the consultant is aware (if applicable). This decision

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would be determined locally, dependent on clinical situation and the experience of the on-site team. A universal policy of seeking consultant approval before undertaking this procedure is not necessary and may delay delivery of LISA.

Resuscitation of the newly born infant is guided by the Resuscitation Council of the United Kingdom "Newborn Life support" algorithm. In addition, the Resuscitation Council of the United Kingdom "Paediatric Advanced Life Support Guideline" includes reversible causes of cardiac arrest (4 H's and 5 T's) in its algorithm**.** These algorithms are produced by a multidisciplinary team of experts and updated on a regular basis. They form the National recommendations to deliver neonatal resuscitation in the United Kingdom. Our view is that the list of 4 H's and 5 T's covers the overwhelming majority of reversible causes of cardiac arrest in the newborn infant.

We recognise the importance of addressing the issues raised and suggest that we send out a safety alert to our members and stakeholders drawing attention to the relevant recommendations include in our Frameworks for practice.

Should you require further details on any of the actions outlined or wish to discuss our response in greater detail, please do not hesitate to contact us directly.

Yours sincerely,

[redacted], BAPM Treasurer
[redacted], BAPM President Elect
[redacted], BAPM President
[redacted] BAPM Secretary