Department of Health & Social Care

[redacted]
Parliamentary Under-Secretary of State
for Health Innovation

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HM Assistant Coroner for Surrey, Dr Karen Henderson
HM Coroner's Court, Station Approach, Woking, GU22 7AP

[redacted]

25 September 2026

Dear Dr Henderson,

Thank you for the Regulation 28 report of 27 July 2026 sent to the Department of Health and Social Care about the death of Jesse Samuel Parsons**.** I am replying as the Minister with responsibility for Health Innovation.

Firstly, I would like to say how saddened I was to read of the circumstances of Jesse's death, and I would like to offer my sincere condolences to his family and loved ones.

The report stated that "whilst Vasa Praevia was a rare but recognised anomaly it is possible to undertake a vaginal doppler ultrasound to confirm placental cord insertion". The concern therefore being that "Placental cord insertion assessment at the routine 20-week anomaly ultrasound scan is not a mandatory requirement of NHS Fetal Anomaly Screening.

Your report request was sent to the UK National Screening Committee (UK NSC), which is hosted by the Department of Health and Social Care. In preparing this response, my officials have made enquiries with the committee secretariat to ensure that we adequately address your concerns.

The UK NSC is an independent scientific advisory committee which is made up of leading medical and screening experts and advises the Government on all screening matters. Where the Committee is confident that there is robust evidence that demonstrates that to offer screening provides more good than harm, they recommend a screening programme. The UK NSC makes its recommendations based on internationally recognised criteria and a rigorous evidence review and consultation process. It is for Ministers in each of the four nations to decide whether to agree to their recommendations, and if so to what timeframe, after considering the evidence and advice on operational, financial and policy issues.

The UK NSC has not been asked to look at screening for vasa praevia at the 20-week scan using placental cord insertion

The UK NSC reviewed the evidence for screening for vasa praevia in pregnancy in 2023. It considered both an evidence map and exploratory modelling work commissioned after the previous review. Having assessed all the available evidence, the Committee concluded at that time that there was still insufficient evidence to recommend a population screening programme.

A screening programme must have a clearly defined condition and a sufficiently accurate test. At present, there is no screening test for vasa praevia itself. Ultrasound can identify features associated with a higher risk - such as a low-lying placenta, a pregnancy following in vitro fertilisation, a multiple pregnancy, or the way blood vessels enter the placenta - but these features do not predict with a good degree of certainty that vasa praevia will be present during labour.

This distinction is important when considering the Australian studies cited in your report. Those studies examine indicators such as where blood vessels enter the placenta. Such findings may be associated with vasa praevia, but they are not a direct test for the condition and do not establish which babies will ultimately be affected. Applying these indicators widely could therefore identify many more pregnancies as potentially at risk than the number in which vasa praevia would occur.

The UK evidence base also does not currently provide a reliable estimate of how many babies are affected by vasa praevia, or sufficiently robust evidence about the accuracy of possible detection approaches. Without that information, it is not possible to be confident that screening would provide more benefit than harm.

Any potential benefit must also be balanced against the harms of identifying pregnancies as high risk when vasa praevia would not in fact occur. This could lead to some women being offered a caesarean birth as early as at 34 weeks gestation, unnecessarily. Although caesarean birth is generally safe, it is major surgery and carries risks for the mother; babies born by caesarean before 39 weeks are also more likely to experience breathing difficulties. Conversely, an inaccurate result which did not identify vasa praevia risk could provide false reassurance and fail to prevent harm during delivery.

The UK NSC nevertheless sought to identify what could reasonably be done within the limits of the current evidence. Its commissioned model compared no screening, targeted approaches based on factors including in vitro fertilisation and low-lying placenta, and a universal approach based on identifying velamentous cord insertion. The modelling suggested that focusing on women with a low-lying placenta could identify a substantial proportion of babies potentially at risk while limiting over-detection and avoiding a large increase in unnecessary caesarean births. However, the model was exploratory and concluded that better-quality data are needed before the clinical and cost effectiveness of any screening strategy can be established.

For this reason, the UK NSC referred its findings to the Royal College of Obstetricians and Gynaecologists (RCOG), which is responsible for the relevant clinical guidance. The RCOG has used the model in its guideline consultation. Taking a targeted clinical approach would enable services to consider recognised risk factors and strengthen the detection and management of pregnancies that may be at higher risk, without introducing a population screening programme that is not supported by robust evidence. The updated clinical guidance is expected in May 2027.

We are also aware that the RCOG have submitted further evidence to the UK NSC open call (which closed on 30th September). The committee will review the submission to determine whether this evidence would change the existing recommendation.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,

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PARLIAMENTARY UNDER-SECRETARY OF STATE
FOR HEALTH INNOVATION