Please find below the organisational response from Sherwood Forest Hospitals NHS Foundation Trust to the Regulation 28 Report to Prevent Future Deaths issued by HM Area Coroner for Nottingham City and Nottinghamshire following the inquest into the death of Arlo River Phoenix Lambert.

We reiterate our apology and condolences to Arlo's family, and we hope this response and the implementation of actions reassures HM Coroner and Arlo's family that the necessary changes have been implemented.

Matters of concern raised within the report and responses for each are as follows:

1. The Trust's Antepartum Haemorrhage guideline gives no sense of urgency when staff are faced with a bleed – here, staff failed to appreciate the potential for a sinister cause of bleeding both at 21.18 and later at 03.40, and did not appear to appreciate the fact that a volume of the bleeding may well be occult, by the external volume representing only a small proportion of the actual blood loss. Miss Al-Samarrai accepted that further work was likely to be required in this regard.

The Trust acknowledges that at the time of the incident, the Antepartum Haemorrhage guideline did not support staff in assessing the urgency of the evolving clinical picture when bleeding was identified on both occasions, which delayed emergency treatment.

Actions taken:

The Trust has reviewed and updated its Antepartum Haemorrhage guideline to emphasise the clinical importance of bleeding in pregnancy, and the requirement for an immediate assessment of fetal and maternal condition with any degree of bleeding. The guideline now informs staff that best practice is to treat bleeding with an expectation of a worse-case scenario and then de-escalate if appropriate, rather than treating it as benign. The causes of Antepartum Haemorrhage section within the guideline has been amended to highlight that bleeding in pregnancy is not normal and can be unpredictable, and the expectation around quantifying and documenting repeated episodes of bleeding within the patient record has been added to support the ongoing risk assessments.

The amended guideline received a multidisciplinary review including the obstetric service leads, midwifery matrons, and midwifery staff prior to ratification through the Maternity and Gynaecology Clinical Governance Meeting.

Following ratification of the guideline, the updates have been shared with all staff members. The guideline updates have been shared via email and in person on shift handovers, and all staff have been asked to sign a registration sheet as evidence that they have read and understood the amendments. Additional support and training will be provided on an individualised basis to staff that do not understand the changes, this will be supported by their line manager and the practice development midwives.

2. Failure to ensure early reflective accounts were captured from key staff in response to this significant event and others. I consider this to be a Trust wide issue. The Trust cannot begin to rectify patient safety issues, if they do not understand exactly what has happened and why. This analysis can only properly occur with the input of those involved in care, and in circumstances where those individuals have had the opportunity and support of the Trust to capture early written accounts. The Trust currently has no clear system in place to facilitate this early capture of relevant accounts.

The Trust acknowledges the importance of capturing the early recollection of events from staff involved in incidents / significant events and also acknowledges that at the time of this incident, a Trust wide process was not in place. The Trust also agree that the implementation of a process to capture early accounts need not conflict with any MNSI or Patient Safety Incident Response Framework.

Actions taken:

The Trust have put in place a system of capturing early Factual Recollection of Events, which are a description of involvement in an incident at the time it occurred but are not a replacement for the medical record.

We have designed a template to capture these recollections and a guidance document that provides useful information and support to staff when completing the template. The guidance requires staff to review the patient's notes when writing the Factual Recollection of Events, ensuring the report is based on factual evidence as documented and reminding them that they should also describe things that are not in the notes that might help the investigators understand what happened and what can be learned. The guidance also describes how to store and share completed Factual Recollection of Events templates ensuring that staff understand that they will form part of the disclosure bundle as required.

Robust governance processes around implementation of this new system have been followed and include consulting with Divisional Clinical Chairs, Divisional Leadership teams and Clinical Governance colleagues, discussion at Patient Safety and Quality Committees and a pilot of the process with real time incidents. We have implemented an ongoing programme of engagement with staff to ensure that they understand when they should complete a Factual Recollection of Events template, the reason behind the request for capturing early accounts, and how to access additional support available to assist in the writing of the recollection. We have added an additional question into our Rapid Review and After Action Review templates, to ensure we are sighted to the need to consider the capture of early recollection of event at the time a review of the incident is conducted.

Additional information:

The Trust's Maternity department, supported by the Professional Midwifery Advocates, are reviewing the immediate responses taken following an incident as defined within the Trusts Incident Reporting Policy and are planning to introduce the Edinburgh Emergency Medicine 'STOP 5' moments for 'Hot Debriefs'. This will enable clinicians involved in an incident to have a 5-minute team debrief immediately following an incident. During this team debrief, the need to complete a Factual Recollection of Events will be highlighted to relevant staff and will provide the clinicians with a space to discuss what went well and the opportunities to improve. The debrief will be documented and saved on the Incident reporting system,

In addition to the Trust guideline changes explained above, a telephone assessment section has been included within the Antepartum Haemorrhage guideline. This includes the need to consider transfer into hospital by ambulance and highlights the need to prepare the midwifery coordinator and obstetric staff in preparation for an incoming admission.

Antepartum Haemorrhage cases will continue to be reviewed through our 'triggers' incident review meeting, to ensure that the recommendations within the updated guideline are being followed. 'Triggers' is a weekly multidisciplinary case review meeting where there are set criteria for cases to be reviewed and membership includes Obstetricians, Matron for Maternity Governance, specialist midwives including the Fetal Monitoring Lead, Audit Lead and Clinical Governance Midwives, incidents are then escalated in line with the Incident Reporting Policy. The Triggers meeting is an open forum for staff members to attend for their own learning, and aims to identify learning from incidents, along with identification of cases further escalation and investigation. Cases will also be escalated into regional and national conversations as appropriate.

The Maternity team are currently developing an Antepartum Haemorrhage scenario video that includes role play of a phone call in progress whilst a midwife completes the Birmingham Symptom Specific Obstetric Triage System (BSOTS) telephone proforma. This consists of a prompt and brief assessment (triage) of women when they present with unexpected problems or concerns, and then a standardised way of determining the clinical urgency in which they need to be seen. This will be available for staff members to access anytime and has been included within our BSOTS Training Needs Analysis (TNA).

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