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 Theodore Riley Bradley.

We reiterate our apology and condolences to Theo's family, and we hope this response and the implementation of actions reassures HM Coroner and Theo'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 lack of prompt action when a woman presents with an antepartum haemorrhage (APH). This Inquest revealed a culture within the midwifery team of not acting promptly when there is vaginal bleeding in pregnancy. There was an assumption that there was a benign cause for bleeding, rather than assuming, until proven otherwise, that there is a serious cause, such as an abruption, that may require immediate intervention.

The Trust acknowledges that at the time of the incident staff behaviours and the subsequent culture around vaginal bleeding, negatively impacted the care received by Amelia Bradley in September 2023 as staff failed to recognise the urgency of the evolving clinical picture.

<u>Actions taken:</u>

The Trust has reviewed and updated its Antepartum Haemorrhage (APH) 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. 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.

Quality improvement work has been initiated, informed by learning from Amelia and Theo's care, which has resulted in the procurement of a new noticeboard to be fitted on Sherwood Birthing Unit, this will be in addition to our pre-existing Clinical Governance noticeboard. The purpose of the new noticeboard will be to provide up to date and succinct information to all staff relating specifically to new policy and guideline updates. Alongside the noticeboard, there will be the introduction a QR code, allowing an accessible means for staff to scan to acknowledge they have read and understood the updates. Compliance will be monitored by the ward leaders with escalation to the senior leadership team where required.

A training programme has commenced focusing on the key areas of learning. This initially included refresher training for the core triage and Band 7 coordinating midwives on the Birmingham Symptom Specific Obstetric Triage System (BSOTS) BadgerNet (the Trusts Maternity electronic patient record) requirements. Delivered by the Trust's Digital Midwife, the training including how to correctly document triage telephone calls within BadgerNet contemporaneously and how to utilise the 'blood loss' form correctly which in turn ensures any cumulative bleeding throughout pregnancy is captured. In addition, a BSOTS e-learning package has been mandated

for all Midwifery staff to complete, it includes details on the process of reviewing patients in triage under the BSOTS model, highlighting the requirements of an initial review by a Midwife within 15 minutes of arrival and the pathways of care that would follow dependent on the symptoms on arrival and initial review findings. Completion of this training is being monitored closely by the Midwifery practice development team, with escalation to the Head of Midwifery of staff that do not complete the package within the deadline set by the Division. The contents of this training has also been reflected on the PRactical Obstetric Multi-Professional Training (PROMPT) training.

An acronym has been developed within Trust, RED – React, Escalate, Diligent, with guidance next to each point on the expected management of bleeding. This includes reacting to the initial reported blood loss by advising attendance to triage and consideration of calling an ambulance. Escalating to the coordinating midwife, obstetric and triage staff that an attendance with bleeding is anticipated, and being diligent around the assessment of bleeding – preparing for an abnormality until proven otherwise. Prompt cards of the acronym have been disseminated to all clinical areas and shared via email to all staff members, and additional prompt card advising the potential causes of bleeding has been shared alongside this.

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 BSOTS telephone call 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 and setting the time 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).

2) Well established APH Trust guidance was not followed.

The Trust acknowledges that Trust guidance was not followed during Amelia's care.

<u>Actions taken:</u>

In addition to the guideline update highlighted above, the Trust has also reviewed the causes of Antepartum Haemorrhage section within the guideline. This has been amended and now clearly highlights 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.

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.

3) Regional and National theme with APH management.

During the Inquest it was acknowledged by HM Coroner that difficulty in effectively managing and identifying bleeding in pregnancy is a theme from incidents across our region, and potentially nationally in maternity care. Within our Local Maternity and Neonatal System (LMNS) we are actively engaging with colleagues at Nottingham University Hospitals to review both APH and Intrapartum Haemorrhage (IPH). Following a rapid initial meeting we have asked for support from the Regional Midwifery and Obstetric teams and also the Health Innovation Network, noting that the first step is to review the available evidence. This review is expected to be completed by the end of September, with a plan to meet in early October to look at the next steps following this. Both Trusts have shared the Regulation 28 reports received and any immediate subsequent actions taken to ensure that learning has been shared. This has been supported through the LMNS Perinatal Quality Surveillance Group (PQSG).

Additional Information:

In addition to the actions discussed above, it was recognised that wider cultural work was required, this has been undertaken by our Perinatal Quad (four senior leaders from the Trust's Women and Children's Division).

The Perinatal Quad have attended a series of workshops, following the NHS England Culture and Leadership Programme. This is a modular programme and provided the Trust an opportunity to understand our culture using evidence-based tools. The aim of this work is to nurture and grow our safety culture, enable psychologically safe working environments and continue to build compassionate leadership within the service.

This programme has provided dedicated time for the Perinatal Quad to work and learn together and embed a wider culture programme around ensuring staff voices are heard, that issues impacting the delivery of high quality and safe care are addressed openly whilst also ensuring senior leaders are accountable and active in influencing and embedding change. They now form part of the Perinatal Staff Experience Team (PeSET) and are accountable for ensuring co-design of cultural improvement actions identified through the thematic analysis of the Staff Score Survey results for 2023. This identified three key areas of focus for 2024/2025 are Communication, Leadership, and Staff Health and Wellbeing.

The PeSET have begun communicating with clinical staff members during safety walk-arounds on clinical areas, addressing their concerns and opening direct channels of communication to the senior leadership team. Updates are being sent to all staff following a 'You said, We did' format highlighting the changes that are being made. This has supported the Perinatal Quad in improving an open culture amongst

clinical staff members, which will continue to be built upon as the work progresses and evolves with time.