Royal College of Obstetricians & Gynaecologists

Sonya Hayes
His Majesty's Coroner Area of Essex
Essex Coroners Service
Seax House
Victoria Road South,
Chelmsford,
CM1 1QH

6 February 2025

Dear Ms Hayes,

Re: Laura Jane Kirsten Nicole Seaman- deceased

Thank you for your Regulation 28 Report to Prevent Future deaths following the inquest into the death of Laura-Jane Seaman dated 18 December 2024.

This loss is a devastating tragedy for the immediate and the wider family, and healthcare professionals involved. We would like to begin by extending our deepest and heartfelt condolences to Laura-Jane's family for their profound loss.

This response has been developed following input from members of the RCOG Patient Safety Committee and Senior Officers of the College.

We recognise and respect the narrative conclusion from the inquest that Laura Jane died as a consequence of lack of timely recognition and appropriate escalation of her clinical deterioration by healthcare professionals.

We also recognise the matters of concern as outlined in your letter as follows,

(1) The acute Trust 72-hour investigation did not identify:

a. The absence of a contemporaneous Labour Ward medication chart for a patient that was administered medications on the ward

b. Significant omissions in the medical record-keeping and some medications administered were entered into a medication chart from a previous admission in November 2023

c. Vital signs for patients on the labour ward being annotated on a piece of cardiotocograph paper and the absence of required MEOWS charts

d. Communication issues with Trust staff and sharing of information

e. Lack of compliance with national guidance and training

f. Absence of contemporaneous blood testing results for Laura-Jane as a patient at high risk of post-partum haemorrhage in labour taken at

i. 00:40 hours for cross matching, and

ii. urgent blood tests taken at approximately 04:45 for a deteriorating patient

g. Lack of compliance with the triggering of the major haemorrhage protocol

(2) Laura-Jane was not escalated for hours as a deteriorating patient in accordance with training and national guidance including PROMPT training, or the Royal College of Obstetricians and Gynaecologists Maternal Collapse in Pregnancy and Puerperium (RCOG) Green-top Guideline No.56. The maternal collapse was categorised as a "faint" by Trust staff and Laura-Jane was treated for potential dehydration (with no apparent risk factors) and administered medication that had only a transient effect.

(3) The administration of Metaraminol on the labour ward is rare for a mother who had an uneventful delivery and did not prompt a critical care review with a background of deranged vital signs.

(4) There was a focus by midwifery staff on per vaginal bleeding and the hypovolemia was not recognised. The PROMPT training guidance contains illustrations by way of photographs to assist with the assessment of blood loss that focuses on per vaginal bleeding. Covert bleeding is referred to in the context of hypovolemia in a separate place on one line. Covert bleeding is not referred to in the Trust Drills & Skills Booklet.

(5) Laura-Jane informed clinical professionals she thought she was haemorrhaging and that she was going to die in a background picture of maternal collapse and prolonged deranged vital signs. This did not trigger Consultant obstetric review, 2222 alert or referral to the critical care outreach team.

(6) The Trust Executive Review Group ("ERG") Report was not shared with the Trust Director of Midwifery or the Head of Midwifery at Broomfield Hospital who did not agree with the ERG conclusions that:

> *'The absence of escalation to an obstetric consultant was discussed and noted that the team escalated to an anaesthetist, which is usual practice in an obstetric emergency (putting out a call to the medical emergency team would not be common practice).'*
>
> *'The possible reasons why the bleeding was not identified were discussed and it was noted that in maternity cases the absence of vaginal bleeding and with no signs of uterine rupture it would be unlikely that the team would have considered bleeding as a cause of deterioration.'*

and gave evidence that this is not in accordance with good clinical practice or national guidelines and training.

(9) Staff skill mix for doctors on the Labour Ward for the night of 20/21 December was staffed with a junior obstetric registrar with a newly qualified colleague in his first week and a junior anaesthetist, all with limited experience of working on the Labour Ward.

(10) Quality of communication and handovers between Trust staff key information was omitted in handovers between staff at all levels including when Laura-Jane was taken to theatre as a medical emergency.

(11) Therapeutic anticoagulation was administered without consultant obstetric input, further medical review or imaging where there had been hours of deranged vital signs that were inconsistent potential complications for pulmonary embolism.

(12) No accounts were taken from Haematology, or the blood lab team involved with this massive haemorrhage by the Trust or the HSIB (who investigated this case) where massive amounts of blood products were prepared, dispensed and then administered where the timings and sharing of information were important to understand.

The Royal College of Obstetricians and Gynaecologists (RCOG) plays a vital role in supporting health care professionals with appropriate clinical care provision through its various initiatives around clinical guidance and education and training.

There are clear clinical evidence-based guidelines for the management of obstetric emergencies which involves, recognition, escalation and multidisciplinary team (MDT) management with a helicopter view of the situation.

The core competency framework[1] has been developed by the maternity transformation programme, in collaboration with other national maternity and neonatal organisations. This framework aims to promote consistencies in training and competency assessments. It also ensures that essential training addressing key areas of harm, is implemented as a standard requirement across all maternity and neonatal services, fostering safer and consistent care delivery.

The framework contains a module (3) on **Medical emergencies and multiprofessional training** specifically for maternal collapse, escalation and resuscitation. It includes the use of maternal critical care observation charts, structured review proformas with deterioration and escalation thresholds. NHS Trusts have to demonstrate that the requirement for MDT training has been met to comply with Action 8 of the maternity incentive scheme[2] overseen by NHS resolution.

The RCOG's clinical guidance in this context includes the following:

1. **Prevention and Management of Postpartum Haemorrhage[3] (PPH) (Green-top Guideline No. 52).** It clearly states that: "*Clinicians should be aware that the visual estimation of peripartum blood loss is inaccurate, and that clinical signs and symptoms should be included in the assessment of PPH.***"**

The guideline outlines a full protocol for monitoring and investigation in major PPH (blood loss greater than 1000 ml) and ongoing haemorrhage **or** clinical shock. This includes that: "*Relevant staff with an appropriate level of expertise should be alerted of PPH."* And*: "The management of PPH requires a multidisciplinary approach: the anaesthetist plays a crucial role in maintaining haemodynamic stability and, if necessary, in determining and administering the most appropriate method of anaesthesia."*

The guideline also advises*: "recording of parameters on a modified early obstetric warning score (MEOWS) chart (and) acting and escalating promptly when abnormal scores from a MEOWS chart are observed*." The guideline also recommends that: "*all staff involved in maternity care should receive training in the management of obstetric emergencies, including the management of PPH and that the training for PPH should be multiprofessional and include team rehearsals".*

2. **Maternal Collapse in Pregnancy and the Puerperium[4] (Green-top Guideline No. 56).** Clearly states that: *"An obstetric modified early warning score chart should be used for all women undergoing*

observation, to allow early recognition of the woman who is becoming critically ill." And that: *"Maternal collapse can result from a number of causes. A systematic approach should be taken to identify the cause."* It advises that the cause of the maternal collapse should be rapidly identified and treated to prevent potential progression to maternal cardio-respiratory arrest. Ongoing regular ABCDE assessment should be performed as the risk of progression to cardiac arrest remains until the cause of the collapse is treated. "*Abdominal ultrasound by a skilled operator can assist in the diagnosis of concealed haemorrhage.***"**

The **NICE guideline [NG235] on Intrapartum care 2023**[5] also states: *"continuously assess blood loss and the woman's condition and identify the source of the bleeding."*

3. **Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium**[6] **(Green-top Guideline No. 37a April 2015)** states that*: "Low molecular weight heparin (LMWH) should be avoided, discontinued or postponed in women at risk of bleeding after careful consideration of the balance of risks of bleeding and thrombosis.***"**

Metaraminol causes mainly systemic vasoconstriction. The use of metaraminol to treat hypotension due to distributive shock caused by anaesthetic agents is well known in the operating theatre setting. However, guidance for its use outside of this environment in critically ill patients with shock in the intensive care unit (ICU) is limited[7]. None of the RCOG guidelines advocate the use of metaraminol in treatment of shock or PPH.

4. **Improving patient handover**[8] **(Good Practice Paper No. 12).** States that it is important to optimise communication of critical information as an essential component of risk management and patient safety. It goes on to describe two structured tools to use for effective communication between teams to improve the efficiency of communication. The two structured tools described by the RCOG are **SBAR** (situation – background – assessment – recommendation) and **SHARING** (Staff, High risk, Awaiting theatre, Recovery ward, Inductions, NICU, Gynaecology). These act as an aide memoir to provide appropriate team updates during handovers.

5. **Good Practice Paper on Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology**[9] states that one of the general situations in which the consultant must attend is any return to theatre for obstetrics or gynaecology. Some of the other obstetrics reasons for attendance are early warning score protocol or sepsis screening tool that suggests critical deterioration where HDU / ITU care is likely to become necessary or maternal collapse or where '*major obstetric haemorrhage'* call has been instigated.

The College supports the training run by the PROMPT Foundation which is a multi-professional skills and drills training programme for maternity units helping midwives, obstetricians, anaesthetists and other maternity team members be safer and more effective. This should be undertaken to instil the importance of clear leadership, communication within the wider team and the ability to lead and provide a helicopter view in such scenarios.

The College's commitment firmly lies in improving maternity safety. This encompasses elevating care standards through clinical guidance and multidisciplinary training. It is imperative that the Trust's

guidelines are in line with the national guidelines. The College strongly advocates the importance of the Trust's guidelines being aligned with national guidelines.

I hope this is a helpful response in this matter.

Yours sincerely,

[redacted]

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CEO, Royal College of Obstetricians and Gynaecologists

References:

1. NHS England Core competency framework v2: Minimum standards and stretch targets NHSE
2. NHS Resolution Maternity incentive Scheme
3. Prevention and Management of Postpartum Haemorrhage (PPH) (Green-top Guideline No. 52 - 2016).
4. Maternal Collapse in Pregnancy and the Puerperium. (Green-top Guideline No. 56-2019).
5. NICE guideline [NG235] on Intrapartum care 2023
6. Reducing the Risk of Venous Thromboembolism during Pregnancy and the Puerperium (Green-top Guideline No. 37a -2015)
7. Gamper G et al. Vasopressors for hypotensive shock. Cochrane Database Syst Rev 2016; 15: CD003709).
8. Improving patient handover (Good Practice Paper No. 12 2010).
9. Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology (2021)