The Princess Alexandra Hospital
NHS Trust

The Princess Alexandra Hospital
Hamstel Road
Harlow
Essex
CM20 1QX

22 July 2025

Assistant Coroner Thea Wilson
Essex Coroner's Court
Chelmsford County Hall
Victoria Road
Chelmsford
CM1 1QH

Dear Ms Wilson,

Thank you for providing us the opportunity to respond to your Regulation report dated 19 May 2025.

Firstly, we would like to convey our sincere condolences to Baby Emmy's family. The maternity service agrees that there were missed opportunities to have delivered Baby Emmy sooner for which it is truly sorry.

We note that two areas of concern which you raised, and will respond to these in turn.

The evidence of the current information given to patients at 40 weeks' pregnant on the decision over whether to accept the offer of an induction from 41 weeks does not reflect NICE guidance on the information needed by patients to make an informed choice on induction. Whilst it provides details of the risks associated with induction, it does not provide information on the risks of continuing with pregnancy beyond 41 weeks.

01 As discussed at Inquest, the Maternity Service developed a new patient Information Leaflet in November 2024 concerning Induction of Labour. It was, however, recognised through the course of the Inquest that the leaflet required more specific details of the risks of continuing pregnancy beyond 41 weeks (including stillbirth, neonatal death and increase risk of admission to Neonatal Unit (NNU)) in order to allow informed decision making. It was also recognised

that there needed to be a move from overemphasis that inductions can be prolonged and painful.

02 A multidisciplinary task group was subsequently established to complete these amendments. This group consisted of Obstetricians, Midwives, Governance Leads and representatives from the Maternity and Neonatal Voices Partnership in order to ensure that language was clinically accurate and accessible to service users.

03 The final version was published on 16 June 2025 and is appended to this letter. This updated leaflet explicitly sets out the risks as set out at paragraph 1 of this statement.

04 In addition to the above, and whilst the above leaflet was being developed, the Maternity Leadership held a meeting immediately following the conclusion of the Inquest to inform all witnesses and the senior leadership (including the Director of Quality and Assurance for the Trust) to address the concerns raised.

05 Immediate action also consisted of persistent and consistent messaging in daily staff huddles and discussion at the Maternity Unit Meeting held on 29 May 2025.

06 In regards to future plans, the Trust plans to implement regular audits of antenatal records of Induction of Labour discussions. It is anticipated that these audits will take place from October 2025, once the new Patient Information Leaflet has fully been embedded. In the interim, snap Audits will take place to monitor compliance.

07 Audit findings will be shared with the Divisional Board and Service User Forums for assurance and transparency.

08 Feedback will also be collected via the Maternity and Neonatal Voices Partnership and antenatal clinic surveys to further monitor implementation.

10 Whilst we understand that the above concern was directed at ensuring that patients are informed the risks of prolonged gestation in particular, the Trust continues to work with Birthrights to provide training to clinicians. As discussed at Inquest, Birthrights is an organisation focused on supporting patients right to choose and enabling individuals to make informed decisions about their care. The Trust plans to make this training mandatory for all Consultants, resident doctors and Midwives, with a view to start in January 2026, having been optional to this point.

The evidence given at inquest indicated a lack of understanding and/or consistency over when concerns about labouring mothers and/or the CTG trace should be escalated for doctor review. Evidence was given on the measures put in place to address issues with escalation, including "Teach or Treat" and "AID" tools, however, there was limited evidence that these are understood by the working midwives and/or advertised to them by way of regular reminders.

11 The work to continue embedding the appropriate and consistent use of escalation tools continues with a commitment from Senior Leadership Team (SLT) to champion these and emphasise their importance to patient safety.

12 This has including a relaunch of the 'Teach or Treat' and AID tools with posters and quick reference messages being distributed across clinical areas including the labour ward, handover room and staff areas.

13 In regards to training, this is not only provided to new starters in the form of dedicated escalation training but also is regularly revisited by existing staff. These tools form part of the mandatory fetal monitoring teaching days which take place annually. Refreshers are also provided post incidents and when applicable, form part of the weekly case based learning reviews which are led by the Fetal Monitoring team every Monday. Learning points from these meetings are displayed on the Fetal Monitoring noticeboard and shared electronically.

14 In addition to this, the Trust is currently hiring a *Labour Ward, Obstetric and Simulation Lead.* As part of this role, the Consultant Obstetrician appointed will be responsible for providing simulations to the team which will include issues of both CTG interpretation and escalation.

15 On a day-to-day basis, these escalation criteria are routinely and regularly reinforced in daily safety huddles and actively encouraged in Labour Ward Obstetric Consultant rounds.

16 The Trust recognises the cultural and psychological factors in implementing these tools. In order to embed this practice, SLT has committed some Continuous Professional Development (CPD) funding towards "Active Bystander" training and embedding the "Civility Saves Lives" campaign at the Trust.

17 Further to this, the Trust is actively participating in the Labour Ward Coordinator Education and Development Framework. This is a national programme, focused on strengthening the leadership of Labour Ward Coordinators. The framework aims to enhance the quality of care provided in Labour Wards and will strengthen clinicians skills to escalate care appropriately.

Whilst we acknowledge that completion of these actions will take time and are a continuous process, we are pleased to confirm that the wheels are already in motion and would be keen to provide further updates to the Coroners Service in due course.

Please do not hesitate to contact me if you require any further details.

Your sincerely,

[redacted]

[redacted]
Chief Medical Officer Designate