NHS
Somerset
NHS Foundation Trust

Yeovil District Hospital
Higher Kingston
Yeovil
BA21 4AT

Date : 30 September 2025

Ms Deborah Archer
Area Coroner for the County of Devon, Plymouth and Torbay

[redacted]

[redacted]

Dear Ms Archer

REGULATION 28 REPORT – PREVENTION OF FUTURE DEATHS – Daisy May McCoy

I am writing in response to your correspondence dated 5 August 2025 regarding the Regulation 28 Notice of the Coroner's (investigations) Regulations 2013 following the inquest regarding the death of Daisy May McCoy which concluded on 25 July 2025.

We are deeply saddened by the tragic loss of Daisy May McCoy. This letter outlines the actions Somerset NHS Foundation Trust has taken in response to this event, the recent changes in our service provision in maternity and to the Regulation 28 report. We are committed to ensuring that the lessons learned from this case lead to meaningful and lasting improvements in maternity care and patient safety.

We have set out the matters of concern as raised in the report below and our response to them.

MATTERS OF CONCERN

1. **Lack of training to recognise unusual foetal movements/ compromise and implementation of such training:**

   Following the sad passing of Daisy May, the completion of the PMRT (Perinatal Mortality Review Tool) review that was undertaken by North Bristol NHS Trust and the Trust level 2 STEIS investigation, the Trust implemented a series of improvements. Details of these were provided to the Inquest by the Head of Midwifery Stephanie Larcombe and included:

   - Implementation of the Labour Ward Co-Ordinator Framework
   - Implementation of twice daily Consultant led ward rounds (as mandated by Ockenden)
   - A review of the Antenatal foetal Monitoring Guideline
   - Introduction of insights gathered from CTG cases review in CTG training
   - Implementation of Centralised CTG monitoring

[redacted]

As an update to this improvement work:

- An initial review of the Antenatal Foetal Monitoring Guideline was conducted to facilitate appropriate classification, timely decision-making, and escalation for abnormal antenatal CTGs. As part of our continued maternity improvement work to align systems and processes across SFT, a new cross site foetal monitoring guideline is being developed to support equity and alignment in care across SFT maternity services. This is due for ratification via a new robust guideline ratification process in October 2025.
- Insights from local CTG cases are now embedded into mandatory CTG training and align with the recommendations of the Saving Babies' Lives V3 care bundle.
- Centralised intrapartum CTG monitoring and formal SBAR handover information was implemented at the YDH site. Work is ongoing to provide equity across both SFT acute maternity sites and to include Antenatal CTG centralised monitoring.

Compliance for all staff for foetal monitoring training is closely monitored and reported monthly via the maternity governance group, this is then reported quarterly to the board via internal governance routes or before by escalation. To date compliance for both midwives and obstetricians is above 90%.

2. A lack of familiarity with the processes and polices by midwives to understand foetal compromise.

Following the concerns raised by the coroner in Daisy May's inquest, the senior Maternity team have reviewed the foetal monitoring guidance and training for midwives. New dedicated foetal monitoring lead midwives and Obstetricians have been put in place across Somerset FT maternity services with the role of improving the quality and safety of foetal monitoring practices within maternity services by providing leadership in education and practice development for midwives and obstetricians. Key duties include developing and implementing effective foetal monitoring and CTG interpretation training, auditing clinical practice to ensure new processes and learning are embedded to drive continual improvements, and establishing a strong safety culture to enhance patient outcomes by ensuring the identification and timely management of foetal compromise.

3. A lack of training and policies on rapid escalation of emergency events

As part of the maternity and neonatal improvement work following the CQC Maternity inspections, SFT Maternity have launched and implemented a Maternity Operational Pressures Escalation Levels (OPEL) Framework including the embedding of a new Escalating Clinical Concerns Charter. This charter supports all members of staff with a framework of escalation in the event of any clinical concern. The charter provides clear communication and escalation routes based on the "Each Baby Counts" Learn and Support escalation toolkit (RCOG, RCM) and aims to:

- Reduce delays in escalation by improving the response escalation and action taken
- Standardise the use of safety critical language
- Reduce feelings of hierarchy, creating a supportive environment which empowers staff of all levels to speak up when they identify deterioration or a potential mistake
- Promote a culture of respect, kindness and civility amongst staff members, normalising positive feedback and saying thank you to each other
- Improve the ways in which we listen to women

To support embedding of the charter, a launch month was held where senior staff attended handovers and team meetings to support full understanding and operationalisation of the tools and to share further information, to take real time feedback and develop training and information sharing amendments in response. To monitor the impact and ensure these are embedded, the senior team and board level safety champions conduct bi-monthly safety walkabouts where the impact of the charter is discussed with frontline staff and any escalation of concern can be made.

The service has also implemented the South West Labour Ward framework which is a regional strategy for improving services across the South West. The framework provides a structured approach for the safe and high-quality management of a labour ward, focusing on workforce development for roles like labour ward coordinators, leadership, and maternity support workers, many of which we already have in place as part of our service development. The framework outlines key goals and domains, such as education and training, clinical practice, and leadership, to ensure consistent and compassionate care for women and babies, improve outcomes, and support the ongoing professional growth of staff within the maternity setting.

4. A gap in policy to provide for both Consultants and or midwives to attend in person where understaffing may lead to patient safety being compromised outside of the recognised situations where this is required under the FIGO guidelines.

Daisy May was born in the early hours of 9 February 2022. Out of hours Consultant Obstetric cover is provided by On Call Consultants, who support the Resident (formally Junior) Doctors who are working clinically on site, remotely and attend the unit when called for additional support. To ensure that all staff feel able to escalate and communicate clinical concerns out of hours, including asking the on-call consultant to attend, the Trust has undertaken a number of additional actions including:

- Implementing the South West OPEL framework to support effective escalation regarding high acuity, and to support implementation of the South West Labour Ward Framework.
- Supporting the Labour Ward Coordinators to attend an education programme of work to support advanced decision-making, learning through training in human factors, situational awareness and psychological safety, to tackle behaviours in the workforce. 76% of all Labour Ward Co-Ordinator's attended this training (13 of 17) as well as ward leads, the Inpatient Matron and a labour ward midwife undertaking a development programme to become a Co-Ordinator. The Trust is working with the regional team and other Trusts across the region to continue this work with the development of further leadership development for Labour Ward co-ordinators.
- Continuing ongoing development for labour ward coordinators. This includes protected time to engage with local and regional workstreams relating to the Labour Ward Co-ordinator Education and Development Framework, providing a pathway of continuous development and support to progress their skills and proficiencies to provide high-quality care.
- The Trust has implemented enhanced Obstetric led twice daily ward rounds as per Ockenden requirements to improve patient safety by ensuring that all women with complex pregnancies and those who are unwell are identified and receive prompt, senior-level review as well as to support staff with escalation pathways. These ward rounds are now written into all Obstetric job plans and embedded into practice. Compliance and attendance is captured and monitored by the Labour Ward Forum with breeches in meeting this standard escalated to Trust board via Maternity & Neonatal Governance reporting. For Q1 2025 compliance was at 100%.

To support effective leadership and oversight of staffing, service activity and acuity, the labour ward co-ordinator is supernumerary for all shifts and any event where this is not possible is recorded via a workforce activity app (BirthRate Plus acuity App) as a “red flag”. All Red Flag events are investigated by maternity leaders and compliance is reported via Trust governance processes. To date, over the past 12 months, there have been no red flag incident reported where the labour ward co-ordinator has not been supernumerary.

In line with the Maternity (and perinatal) Incentive Scheme (MIS), the Trust monitors and reports on Obstetric attendance at RCOG defined scenarios for obstetric attendance involving situations requiring a consultant's direct presence or involvement as set out by RCOG such as life-threatening maternal conditions like eclampsia or maternal collapse, significant postpartum haemorrhage (PPH), or complex instrumental or caesarean births. Any event where a consultant does not attend is incident reported, investigated and escalated via governance routes.

As mandated by the Ockenden report, the Trust has developed a conflict of clinical opinion policy to support all staff members in being able to escalate their clinical concerns regarding a woman’s care in case of disagreement between healthcare professionals. This has been presented to the MDT as the ‘Escalating Clinical Concerns Charter’ and clearly outlines roles and responsibilities of the Senior on-call midwife, obstetric consultant on-call and others that play a clear role with regards escalation, including supporting clinical staff to escalate to senior clinicians for support and attendance in the event of unusual presentation or any uncertainty in relation to management of care; the RCOG escalation toolkit; and principles pertaining to human factors and safety science. The Consultant body are clear on the RCOG recommendations for attendance out of hours (and we are monitoring this as part of our MIS compliance) as well as attending when concern is escalated from the labour ward.

5. A lack of understanding and implementation of the policies that additional staffing in times of high acuity or other emergency situations which if left unaddressed may leave patient safety compromised.

As well as the implementations described above, the trust has introduced a “Flow” Midwife 7 days per week. The Flow midwife’s role is to provide a helicopter view of services both within the acute unit and in the community to ensure effective use of staff and to support mitigation of any risk in the event of high acuity or activity. Out of hours, the service is supported by a Senior Midwife On Call rota to provide senior advice, support and escalation to the wider trust where necessary.

Following a full maternity staffing review (November 2024) the midwifery and maternity support worker staffing establishment has been increased to support effective workforce rota cover for all maternity areas. Since the temporary closure of YDH services, this staffing template has been reviewed and refreshed to support effective deployment of staff across all areas to mitigate the impact of the additional activity on the MPH acute site.

6. No culture of appropriate professional challenge.

SFT Maternity senior leaders have been actively working to understand the culture across both YDH and MPH sites. A number of listening events were held in 2023/24 and a programme of cultural improvement efforts rolled out in response. To support improvements, the Trust launched a professional disagreement policy and utilises the RCOG tools for professional challenge. The trust also utilises Freedom to Speak Up Guardians (FTSU) who provide regular support to staff and conduct regular walkarounds for staff to raise any concerns.

7. A lack of adequate communication between different health care professionals on the maternity unit.

In addition to efforts described above, the Trust has introduced the use of standardised handover and safety huddle “SBAR”’s (Situation, Background, Assessment, Recommendation tool for structured handover information sharing) to provide an infrastructure for communication events between different health care professionals. The Trust has also recently engaged the national Equity Diversity and Inclusion lead to undertake a culture review diagnostic. The results of this review are pending, and the Trust will work with the national team to inform continued efforts to improve culture across SFT maternity services.

Since the temporary closure of the YDH neonatal and inpatient maternity services, the Trust has been actively monitoring the impact of the closure on service activity, clinical quality, patient safety, staff wellbeing and service user experience as well as wider effects on neighbouring NHS organisations.

To date, there have been no reported incidents where the outcome has been directly attributed to the temporary closure.

During the temporary closure, the YDH site continues to run Obstetric led antenatal clinics with follow on care being provided by either Dorset County Hospital (DCH) or Musgrove Park Hospital (MPH). This highlighted a need to undertake urgent work to accelerate the review and development of care pathways to ensure alignment and reduce duplication or fragmentation of care. Work was completed with DCH, MPH and YDH multiprofessional teams and is subject to ongoing monitoring via joint pathway review meetings.

The temporary closure has generated a complex risk landscape, which is being actively managed through robust governance processes. A total of 16 risks are currently recorded on the risk register in relation to the affected services. Spanning key domains: Staffing, Governance, Estates and Facilities, Operational Challenges, reputational Risk and Patient Safety.

The risks associated with patient safety centre on risk of fragmented care pathways with care delivery spanning 2 or 3 organisational boundaries. There are mitigations in place for these risks, and the Trust continues to monitor, evaluate and respond to emerging risk. The Trust is working closely with each organisation to respond to risks as they emerge and to amend and align pathways to support effective care planning and improve safety.

There have been both achievements and ongoing challenges as a result of the closure and the Trust continues to work towards service restoration. This work is informed by the development of a set of criteria to support the safe re-opening of the SCBU and inpatient maternity services at YDH. These criteria are being co-produced with clinical colleagues, the Somerset Maternity and Neonatal Voices Partnership (MNVP), and system partners to ensure they reflect both clinical safety standards and service user perspectives.

The criteria will be formally agreed between Somerset NHS Foundation Trust and Somerset ICB in September 2025 and will be incorporated into a criteria-based timeline for re-opening.

The Trust has been onboarded onto the National Maternity Safety Support Programme (MSSP) and is working with a lead Midwifery advisor who has reviewed this response in line with the developing re-opening criteria to ensure that all concerns within this notice are include in the re-opening criteria.

As essential safety criteria to support safe re-opening, the service has included a set of team building actions to support effective team working, support safe psychological spaces and encouraging staff to speak up in the event of any clinical concerns. Ongoing cultural development action plans are in place and are monitored and delivered by the multiprofessional Perinatal Leadership Teams. Progress on delivery of these action plans is monitored and reported monthly via the maternity and neonatal governance group and quarterly by the Safety Champions Board both of which report into the Trust board.

The criteria for these are taken from national guidance, input from regional and local partners and stakeholder sessions within the trust. This enables a structured and transparent approach to determining the timing and conditions for safe service restoration. The aim is to ensure that there is a stable core paediatric service, including the development of a paediatric assessment unit, with senior clinical decision making, up and running. The Trust is also considering whether the paediatric and neonatal services at YDH need to be co-located.

On 19 August 2025, the trust provided a public update on the impact of the temporary closures and our progress to reopen services. The trust confirmed that a three-month review between the trust and our commissioner, NHS Somerset, was taking place and we would update further when the process is concluded. Further communications from the trust and Somerset ICB are planned in September 2025.

This approach reflects the trust's commitment to evidence-based decision-making, robust governance, and meaningful engagement with stakeholders. The next phase will focus on finalising the safety criteria, operationalising the decision-making framework, and continuing preparations for the phased and safe re-opening of services at YDH.

The Trust has considered all matters of concern raised in the Regulation 28 notice to ensure that reopening plans provide assurance of embedded change made in response to learning from Daisy May's death.

Key criterion included in the reopening decision making tool that relate to the matters of concern:

- Obstetric Consultant rota at 1:8 with twice daily Ockenden compliant ward rounds, hand overs and time allocation
- The presence of a full neonatal team at all neonatal resuscitations, reducing the risk of poor outcomes
- Obstetric middle grade rota of 1:7 (minimum) to provide sufficient middle grade resilience supported by a framework for introduction of middle grade trainees (rotational from SFT)
- BirthRate+ standards achieved for midwifery staffing numbers
- Appropriate cross site governance and specialist midwifery roles to support services
- Rotational midwifery workforce model for labour ward leads (+/- Band 6 midwives between YDH and MPH)
- Plan developed to deliver regular multi-disciplinary team simulation training
- Cross site PROMPT (Practical Obstetric Multiprofessional training) and foetal monitoring training established
- Robust MDT Simulation training programme in place
- Obstetric leads in place in line with ockenden recommendations (cross county)

- Framework for cross-county departmental medical leadership for obstetrics
- Cross site leadership and participation from obstetrics in training
- Cross-county governance structure that underpins robust governance between paediatric, neonatal and maternity services
- Established cross site obstetric leads for prenatal medicine and foetal monitoring.
- Multi-disciplinary team cohesion for safe re-opening of services
- Perinatal Leadership Team owned action plan around cultural change
- Obstetricians to have engaged with Organisational Development programme around teamworking
- Action plan and framework for cultural change program with Labour ward leads and Obstetricians colleagues to be established and underway
- Launch OPEL framework with YDH teams, with integration into Trust operations

We remain fully committed to embedding the learning from Daisy May's death into every aspect of our maternity services. Our actions reflect a Trust-wide commitment to safety, transparency, and continuous improvement. Should you require any further information or clarification, please do not hesitate to contact me directly.

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

Yours sincerely

Chief Executive
Somerset NHS Foundation Trust