

NHS Greater Glasgow and Clyde	Paper No. 25/32
Meeting:	NHSGGC Board Meeting
Meeting Date:	29 April 2025
Title:	FAI Update
Sponsoring Director:	Dr Scott Davidson, Executive Medical Director Professor Angela Wallace, Executive Director of Nursing Elaine Vanhagen, Director of Corporate Services and Governance
Report Author:	Jamie Redfern, Director of Women and Children's Services Dr Mary Ross-Davie, Director of Midwifery

1. Purpose

The purpose of the attached paper is to:

Provide the requested briefing for the NHSGGC Board on the determination of the FAI into three neonatal deaths, published 18 March 2025. The FAI was heard by Sheriff Principal Aisha Anwar KC, from February – May 2024 and relates to one case, Leo Lamont, where care was provided by NHS GGC. Care for Ellie McCormick and Mira-Belle Bosch was provided in NHS Lanarkshire only.

2. Executive Summary

The paper can be summarised as follows:

- The Sheriff Principal has made 11 recommendations following the deaths. Some of these require local action and some national action. Some of the recommendations relate to the Lanarkshire cases, but we aim to also address these locally in NHSGGC. The recommendations included:
- The creation of a 'trigger list' to identify and assess preterm (early) labour symptoms and provide guidance on when women should attend for clinical assessment

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- A review of the information held in electronic records of previous preterm births
 - A review of the Electronic Record Keeping Guidance issued by the Royal College of Midwives
 - A system for the exchange of information upon the change of a named midwife
 - The introduction of a direct telephone line to each maternity unit in Scotland solely for the use of Scottish Ambulance Service crews
 - The introduction of hand held scanners to assist in the detection of breech births
- The Sheriff Principal also noted two observations.
- These were:
 - If a neonatal death is reported to the Scottish Fatalities Investigation Unit of the Crown Office and Procurator Fiscal Service, as soon as possible thereafter, the health board should preserve and retain a copy of the mother's electronic records.
 - Health boards should consider storing recordings of triage calls so that, if required, they can be made available to serious adverse event reviews and fatal accident inquiries.

3. Recommendations

- In relation to recommendation one, NHSGGC has updated our preterm labour and birth guidance. This has been published on the Right Decisions platform.
- Recommendations two, three, four and seven are actions required to be completed by System C, the owners and developers of the Badgernet electronic maternity record. A meeting has been requested with System C by Scottish Government and Midwifery Directors of Scotland to ensure implementation.
- NHSGGC Maternity services are in the process of establishing a centralised telephone Triage team, to include recordings of all triage calls and the full implementation of BSOTs (Birmingham Symptom Specific Obstetric Triage system), an evidence based approach to maternity triage, across all sites. This will address the recommendations relating to triage including provision of 'worsening advice', recording and record keeping of telephone triage assessments.
- In relation to the recommendation relating to handheld scanner for identification of presentation, a guideline for standardised training for midwives has been developed and is being finalised in NHSGGC and the handheld scanner hardware is under order.
- The retention of Badgernet records at the time of a perinatal death requiring a report to the PF, an updated Standard operating procedure for the digital and clinical risk midwifery team is in development. The requirement for this facility has also been escalated to System C to address.
- The direct phone line for SAS to each maternity unit is already established across NHSGGC

The NHS Board is asked to consider the following recommendations:

NHSGGC maternity services are committed to:

- Deliver the implementation of the required changes to triage services across GGC at pace over the coming six months, evaluating the implementation and impact on processes and outcomes.
- Provide training for all staff on the new preterm birth pathway and on high quality triage assessment.

- Implement the use of handheld scanners for foetal presentation prior to induction of labour.
- Work proactively at a national level with other Boards and Scottish Government leads to bring about the appropriate changes to the Badgernet maternity record and the processes that lead to required national updates.
- Work at a national level with other Boards, Scottish Government and SAS leads to explore the use of video calls to support paramedic teams in emergency situations.

4. Response Required

This paper is presented for awareness.

5. Impact Assessment

The impact of this paper on NHSGGC's corporate aims, approach to equality and diversity and environmental impact are assessed as follows:

- | | |
|------------------------|------------------------|
| • Better Health | <u>Positive</u> impact |
| • Better Care | <u>Positive</u> impact |
| • Better Value | <u>Neutral</u> impact |
| • Better Workplace | <u>Positive</u> impact |
| • Equality & Diversity | <u>Positive</u> impact |
| • Environment | <u>Positive</u> impact |

6. Engagement & Communications

The issues addressed in this paper were subject to the following engagement and communications activity: This summary will be shared with the Maternity Governance group and will in turn be shared with the Women and Children's maternity governance meeting.

7. Governance Route

This paper has been previously considered by the following groups as part of its development: Maternity Assurance Group, Maternity Governance group.

8. Date Prepared & Issued

Paper prepared on: 10 April 2025

Paper issued on: 17 April 2025

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1. Introduction

The purpose of the attached paper is to provide a briefing for the NHSGGC Board on the determination of this FAI into three neonatal deaths, published 18 March 2025.

The FAI was heard by Sheriff Principal Aisha Anwar KC, from February – May 2024 and relates to one case, Leo Lamont, where care was provided by NHSGGC. Care for Ellie McCormick and Mira-Belle Bosch was provided in NHS Lanarkshire only.

The Determination was published on 18th May 2025. NHSGGC released a press statement extending our sincerest condolences to the family of Leo Lamont, and once again apologising for their loss and the distress they had experienced.

It was noted that the care Leo and his mother received fell below the standards expected. It noted that a number of the recommendations had already been implemented, including preterm guidelines and improvements to electronic record keeping, with others in progress for full implementation by early summer.

Under the rules of a Fatal Accident Inquiry, the respondent to a Determination must set out details of what it has done or proposes to do in response to the recommendations, or set out reasons why it has not done or does not intend to do anything in response to the recommendations. The response is then published on the Scottish Courts and Tribunal Service website. NHSGGC has until 9 May 2025 to respond.

2. Background

The cases of Ellie McCormick and Mira-Belle Bosch were NHS Lanarkshire only.

Leo Lamont's case relates to NHS Greater Glasgow and Clyde.

Leo's mother called the Princess Royal Maternity (PRM) maternity assessment (MAU or Triage) unit for a 15-minute consultation with a midwife in the early hours of 15 February 2019.

Leo was born at home at 27 +3 weeks' gestation. His mother had sought advice from the PRM triage service in the hours before his birth but had not been advised to attend the maternity unit at that time. Baby Leo was transported by ambulance from his home to Monklands hospital, where he sadly died at two hours of age.

3. Assessment

The Sheriff Principal has made 11 recommendations following the deaths. Some of these require local action and some national action. Some of the recommendations relate only to the Lanarkshire cases, but we aim to also address these locally in NHSGGC.

The Sheriff Principal made the following recommendations:

1. Greater Glasgow and Clyde Health Board should develop a 'trigger list' to identify and assess preterm (early) labour symptoms and create guidance on when women should attend for clinical assessment, specifying a low threshold. This should be shared with all health boards in Scotland.
2. All health boards in Scotland should review the information displayed on electronic records relating to previous preterm births and consider the creation of an automatically generated critical alert for previous preterm labour where one does not exist.
3. A procedure should be introduced to ensure appropriate handover when there is a planned change of named midwife. This should be stored electronically and draw attention to any prior complications or risk factors.
4. A system should be developed to allow a note to be added to a patient's electronic records to highlight a further reason for a referral to a pre-existing appointment with a consultant.
5. The Electronic Record Keeping Guidance and Audit Tool issued by the Royal College of Midwives should be reviewed to address situations where midwives may not have access immediately to electronic notes.
6. Health boards should consider acquiring hand-held ultrasound scanners to detect the presentation of a foetus when a woman reports spontaneous rupture of membranes or attends for induction or augmentation.
7. Consideration should be given to how the engagement of the presenting part can be better recorded and, specifically, to whether an assessment of whether the presenting part is 'ballotable' (that is, if it is 'ballotable' it is likely to be cephalic, head, presentation, rather than a breech presentation) should be recorded.

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8. Each maternity unit in Scotland should introduce a telephone line (a red phone) for sole use by Scottish Ambulance Service crews giving them direct access to maternity units.
9. Consideration should be given to the introduction of video facilities to aid communication between paramedics and midwives or obstetricians in emergency situations.
10. Questions posed by healthcare professionals should make it clear that they relate to both the present situation and prior medical history. Health boards should review their electronic record system to ensure that the pre-populated questions ensure this.
11. If “worsening advice” is provided i.e. advice to call back if symptoms do not improve upon taking painkillers, women should be provided with an approximate timeframe in which to do so.

Assessment of NHSGGC actions:

1. **Recommendation 1:** NHSGGC action complete: NHSGGC has already implemented the key recommendation where NHSGGC is identified as the lead, by updating and publishing our new preterm labour and birth guidance (including the ‘trigger list’). This is published on our Right Decisions guidelines platform: [Preterm birth \(1188\) | Right Decisions](#). This has been shared with all health boards in Scotland.
2. **Recommendation 2:** NHSGGC action: complete: A critical alert for preterm birth is already available on the NHSGGC Badgernet system. National action required by the company who are the owners and developers of Badgernet to make this automatically generated.
3. **Recommendation 3:** The recommendation relating to having a procedure to ensure appropriate handover when there is a planned change of named midwife relates to the NHS Lanarkshire case. NHSGGC action: complete. NHSGGC has a process for ensuring that the named midwife is changed on the Badgernet record.
4. **Recommendation 4:** The recommendation relating to the additional reasons for a referral to a pre-existing consultant appointment relates to the NHS Lanarkshire cases. This facility is available on Badgernet, however, the focus in these cases is on the ease with which a practitioner can access information readily on Badgernet during a short appointment.

National action required by the company who are the owners and developers of Badgernet to make key information very readily available. This will be part of the national discussion with the company that owns and manages Badgernet in relation to recommended improvements to Badgernet.

5. **Recommendation 5:** This recommendation is for the Royal College of Midwives. Unclear the timescale for RCM completion of this action. NHSGGC is committed to sharing and encouraging use of the revised RCM guidance and audit tool once completed.

6. **Recommendation 6:** This recommendation relates to the NHS Lanarkshire cases. NHSGGC action: partially complete. NHSGGC has invested in handheld scanners and training for midwives on undertaking presentation scans prior to inductions of labour.
7. **Recommendation 7:** This recommendation relates to the NHS Lanarkshire cases. This relates again to required national changes to Badgernet to be implemented the company that own and manage Badgernet, to enable recording of presenting part in more detail.
8. **Recommendation 8:** NHSGGC action: complete. NHSGGC already has a direct telephone line to each maternity unit solely for the use of SAS crews.
9. **Recommendation 9:** This recommendation is being taken forward at a national level, with NHSGGC contributing to the national work.
10. **Recommendation 10:** This recommendation relates to the quality of documentation during Triage calls and national review of Badgernet records.
11. **Recommendation 11:** Again, this recommendation relates to the quality of documentation during Triage calls and national review of Badgernet records. These will be addressed through the national work and through the implementation of BSOTS (Birmingham Symptom Specific Obstetric Triage System) across all three NHSGGC triage units

Oversight of NHS Actions

NHSGGC has established a task and finish group that is leading on the improvement of triage services. We are now well advanced in implementing BSOTS across all three triage units, with the appropriate midwifery staffing uplift now identified and agreed. Recruitment to the additional posts required has been undertaken and the midwives will be in post by May 2025.

NHSGGC maternity services have also advertised internally in April 2025 for a Triage Project lead midwife post to implement BSOTs in all sites and this will include organising training for all of the teams from the BSOTs team. The postholder will also implement a centralised telephone triage team, to ensure that the midwife who is answering calls is only taking calls and not providing other clinical care. This project will include the implementation of the recording of all Triage calls and will give consideration to the feasibility of video calls. The postholder will commence in May 2025 and will continue until the end of 2025, when all of the key aims of the project will be complete.

In addition, the Sheriff Principal identified two observations relating to access to a full set Badgernet records at the time of a perinatal death and relating to the recording of triage calls:

The first of these observations requires escalation and resolution by the owners of Badgernet. Locally in NHSGGC, the digital team are in the process of developing a Standard operating procedure for staff to guide the process of creating a full Badger record following a perinatal death, which can then be shared. The Triage improvement project

being undertaken in NHSGGC will implement the recording of all triage calls in the next six months.

The recommendations from the FAI relating to changes to Badgernet, require implementation by the owners and developers of the Badgernet maternity record, as all changes to Badgernet records require to be escalated through a national system. The MIDs (Midwifery Directors of Scotland) will work with colleagues from Scottish Government to address these issues with the company and seek a rapid national solution.

4. Conclusions

These were three tragic cases. NHS GGC is fully committed to learning from these cases and for implementing in full the recommendations from the FAI:

- Deliver the implementation of the required changes to triage services across GGC at pace over the coming six months, evaluating the implementation and impact on processes and outcomes.
- Provide training for all staff on the new preterm birth pathway and on high quality triage assessment.
- Implement the use of handheld scanners for foetal presentation prior to induction of labour.
- Work proactively at a national level with other Boards and Scottish Government leads to bring about the appropriate changes to the Badgernet maternity record and the processes that lead to required national updates.
- Work at a national level with other Boards, Scottish Government and SAS leads to explore the use of video calls to support paramedic teams in emergency situations.

5. Recommendations

The Board is asked to note the determination from the FAI into the three cases and actions that have been, and are being taken, to learn and improve services.

6. Evaluation

We will evaluate the impact of the suite of triage changes in terms of process (waiting times), outcomes (women being seen in a timely manner by appropriate professional, appropriate admissions and care), documentation audits, quality assurance of recorded calls and through seeking staff and women's views about the revised model.

We will evaluate the confidence and knowledge of maternity staff about the new preterm birth guidance through a staff survey within the next six months.

The implementation of the new preterm birth guidance and the appropriate use of handheld scanners will be audited also.

7. Appendices

Appendix One: Links to the FAI determination document.

Link to the FAI determinations:

[2025fai015-leo-lamont-ellie-mccormick-mira-belle-bosch.pdf](#)