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Scottish Government
Riaghaltas na h-Alba

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Dear Members,

FATAL ACCIDENT INQUIRY LEO LAMONT, ELLIE McCORMICK AND MIRA-BELLE BOSCH

I want to alert you to the findings of a Fatal Accident Inquiry into the neonatal deaths of three babies in NHS Lanarkshire and the action underway within Health Boards and the Scottish Government. As I know you will agree, the loss of a baby is devastating for any family, and the Fatal Accident Inquiry report makes for very difficult reading. All women in Scotland should receive high quality, safe maternity care and have the very best experience of our maternity services.

NHS Lanarkshire and NHS Greater Glasgow and Clyde have provided me with an initial outline of work that is already underway to respond to the findings of the FAI Determination issued by Sherif Principal Anwar. I have attached the summary of this at Annex A.

In addition, as noted in the Parliament in response to an urgent question from Megan Gallacher on Wednesday this week, I have written to the Chief Executives of NHS Lanarkshire and NHS GGC asking for more detailed assurance that the Board has taken full account of the Sheriff's recommendations, and have asked them to provide details of the work in place and ongoing programme of work to deliver the safest care for mothers and babies. I have also asked that they provide regular updates on progress with delivery.

I recognise that a number of the recommendations will require action at a national level as well as local action, for example those relating to changes to Badgernet, the clinical system that is used by the majority of maternity units in Scotland. The Chief Midwife, Justine Craig, our Senior Medical Officer Tony Nicoll, and officials in the Maternal and Infant Health team will work with the Scottish maternity community to develop collective solutions to these national level actions.

I have given my sincere apologies to the families for any failures in the system that led to the tragic deaths of babies Leo, Ellie and Mira-Belle and thanked them for their participating in the Fatal Accident Inquiry. I would like to assure you that I am determined to ensure we learn from their deaths and improve care for mothers and babies in Scotland.

Yours Sincerely,

NEIL GRAY

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Annex A: FAI Determination: Recommendations and Actions Underway

Recommendation	Actions undertaken by NHS Lanarkshire	Actions undertaken by NHS GG&C
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.	In Place. In Maternity Triage NHSL have fully implemented Birmingham Symptom Specific Obstetric Triage System (BSOTS) in in both badgernet and triage clinical area. This system allows Midwives to continue to use their clinical judgement whilst using the BSOT algorithms which includes triggers for preterm labour and immediate care guidance required. The Midwife conducting the initial assessment must categorise the clinical status of the woman as per BSOTS algorithm which then enables clinical prioritisation of care. Core midwives working in maternity Triage have received the full training package for the use of the BSOTS and the associated documentation.	In Progress GG&C have agreed maternity services will implement Birmingham Symptom Specific Obstetric Triage System (BSOTS) across three main acute sites and in doing this key points of this action will be completed. Target for implementation of BSOTS across sites – June 2025 Pre-term birth guideline implemented. NICE guidance followed.
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.	Critical alerts are now documented in BadgerNet, the maternity electronic information system, to help all clinical staff to identify pregnancy risks. All Boards needs to review what critical alerts they can see and then manually 'switch on' critical alerts they need in Badgernet system. NHS Lanarkshire are progressing this, for completion 20 March. Discussions with System C (Badgernet provider) required to request changes to critical alerts as mandatory fields.	In progress Improvements made to electronic record keeping. Request with IT Supplier put forward Target implementation June 2025 Prior to implementation can populate manually.
3. **All Health Boards** should introduce a procedure to ensure appropriate handover when there is a planned change of named midwife. This	There is an SBAR handover function in Badger net that is used by NHSL to handover care if a midwives caseload changes or she moves to another area. Midwives highlight risk factors as part of the SBAR handover. NHSL will continue to audit against the recommendations and are considering a	Standard Operational Plan (SOP) supporting roll out of this recommendation drafted Implemented April 25

should be stored electronically and draw attention to any prior complications or risk factors.	SOP for community care to reduce variation of handovers. Action: NHSL ask to System C: when a change of primary midwife occurs this is pulled through onto the mandatory risk assessment page as a visual for all to see. This will alert all clinicians of a change of midwife and at what gestation on the pregnancy summary page.	
4. **All health boards** should have a system 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.	New antenatal care pathway introduced supporting referrals between midwives and obstetricians when risk factors emerge. As part of the new model for antenatal care pathways implementation, NHS Lanarkshire will discuss with System C and digital midwives how this note can be made mandatory on the risk assessment banner and easy to access via a colour code for example to ensure this is easily accessible for all practitioners	Implemented
5. **Royal College of Midwives**: The RCMs Electronic Record Keeping Guidance and Audit Tool should be reviewed to address situations where midwives may not have access immediately to electronic notes.	NHS Lanarkshire utilise this tool as part of assurance of care delivery. The RCM are aware of this recommendation and changes required to the tool for midwives who take calls and cant access badgernet immediately.	Implemented
6**. All Health Boards** should consider acquiring hand held ultrasound scanners to detect the presentation of a fetus when a women reports spontaneous rupture of membranes or attends for	NHSL have developed pathways and guidance for midwives, with initial testing in Day Bed Unit. Procurement of hand held scanners has been delayed due to internal systems however other scanners have been used for teaching. NHS have linked with another health board who have implemented similar pathways and expect full roll out once the devices are procured and further discussions with midwifery staff in DBU and triage are hosted.	In progress Midwifery training being extended on all sites Equipment supplied - RAH local IT site issue; expect to be resolved. Target implementation June 25

induction or augmentation.		
7. **System C:** Consideration should be given to improving recording on badgernet of presenting part and assessment of ballotability	This needs considered nationally and discussed with System C and a ballotability selection added to Badgernet in line with the recommendation. At this time, professional judgement is applied to documenting this component and interim actions are beign considered in maternity triage and DBU to ensure balottability is documented as mandatory field.	Needs further consideration as not part of national guidance
8. **All Health Boards**: 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.	A dedicated telephone is now in place within the Maternity Unit for Scottish Ambulance Service crews to use in an emergency.	Implemented Red phone lines are in place across acute sites Scottish Ambulance Service (SAS) can use a dedicated line between them and each of the maternity units to alert a woman is in transit and they are bringing her to the relevant site.
9. **All Health Boards**: Consideration should be given to the introduction of video facilities to aid communication between paramedics and midwives or obstetricians in emergency situations.	NHSL do not use these facilities at the moment and will consider how to take this forward in line with information governance, confidentiality, systems and process	In progress SLWG to scope delivery and cost of this recommendation set up under Associate Chief Midwife and Clinical Service Manager supporting Completed by June 2025 This would link to Recommendation 8
10. **All Health Boards**: Questions posed by healthcare professionals should make it clear that they relate to both the present situation and prior medical history. Health boards	NHS Lanarkshire are considering an SOP to progress this action and discuss with System C how this function could be switched on within Badgernet. NHSL will seek advice from Digital midwives as to how this can be achieved within the current system. All actions concluded within 12 weeks	In progress Request to IT supplier for change put forward Target date for completion June 2025

should review their electronic record system to ensure that the pre-populated questions are clear on this.		
11. **All Health Boards**: 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.	BSOTS enables this function. During the triage call, the practitioner uses algorithms, which also includes call back. BSOTS asks questions that must be completed (compared to the triage section in Badgernet). Consider national work with System C to review if any further action is required for develop mandatory fields.	The terminology 'worsening advice' is no longer used Not applicable