

NHS Greater Glasgow and Clyde	Paper No. 25/70
Meeting:	NHSGGC Board Meeting
Meeting Date:	24 June 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 Iain Paterson, Corporate Services Manager

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 the death of Freya Murphy, published 30 May 2025. The Inquiry, led by Sheriff Barry Divers, ran from 28 October 2024 to 8 November 2024 at Glasgow Sheriff Court.

2. Executive Summary

The paper can be summarised as follows:

- There was no accident which resulted in Freya's death
- The cause of Freya's death was Global ischemic brain injury associated with acute chorioamnionitis.
- There were no precautions which could reasonably have been taken and had they been taken might realistically have resulted in Freya's death being avoided

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- There were no defects in any system of working which contributed to Freya's death.

Sheriff Divers made two recommendations following Freya's death:

1. Greater Glasgow Heath Board (GGHB) should review staffing levels across all shifts to ensure that its labour wards, post- natal wards, maternity assessment units and other hospital maternity related areas are adequately staffed at the weekend and in the evening such as to allow, in the case of an emergency where two patients require admission to theatre at the same time, for the opening of a second operating theatre, within a suitably expeditious time and where such a second theatre is available.
2. GGHB should formerly (sp) request that the United Kingdom National Screening Committee (UKNSC) give urgent consideration to a review of whether pregnant women routinely be offered screening for Group B Streptococcus ("GBS"). That if such a review is under way, then a copy of this determination be provided to the UKNSC for consideration in that review.

A response to these recommendations is required to be submitted to the court by 22 July 2025.

3. Recommendations

The NHS Board is asked to consider the following recommendations:

For **Recommendation 1**: NHSGGC proposes to respond as follows:

NHSGGC regularly reviews staffing levels to ensure all maternity services are appropriately staffed. This is managed on a day-to-day basis, including weekends, through site safety huddles and cross-site touch point calls. A key part of each Labour Ward Co-ordinator's role is to manage staff numbers and skills to safely run two emergency Obstetric theatres when required to do so. The Medical resources to do so are built into the Medical Rotas for the specialties of Obstetrics and Anaesthesia.

Our workforce plan prioritises maternity services. This is reflected in the staffing base we recruit to; its focus is to ensure that safe staffing levels in triage, labour ward, theatre and inpatient areas are successfully delivered across our maternity sites. This is subject to annual review.

For **Recommendation 2**, NHSGGC proposes to respond as follows:

In line with the FAI recommendation on this matter, NHSGGC will make the formal request to the UK National Screening Committee (UKNSC) to urgently consider a commissioned review of whether there should be routine screening of pregnant women for Group B Streptococcus (GBS). Our current GBS procedures were not subject to a recommendation however we acknowledge that the issue of universal screening for GBS in pregnancy remains the subject of scientific debate.

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: The responses above have been developed by the Director of Women & Children's Services, Director of Midwifery, the Chief of Medicine for Women & Children's Services and the Clinical Director for Obstetrics.

7. Governance Route

N/A

8. Date Prepared & Issued

Paper prepared on: 13 June 2025

Paper issued on: 16 June 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 the Fatal Accident Inquiry (FAI) into the death of Freya Murphy, published 30 May 2025.

The Inquiry, led by Sheriff Barry Divers, ran from 28 October 2024 to 8 November 2024 at Glasgow Sheriff Court.

Upon publication of the Determination, the Board's Deputy Medical Director for Acute Services extended NHSGGC's sincerest condolences to the family of Freya Murphy, and apologised for the distress they experienced. It was acknowledged that the care Freya received fell below the standards expected.

2. Background

The circumstances of the Inquiry relate to Karen Murphy's care in the QEUH Maternity ward in the lead up to and during her delivery of her daughter Freya, who was born in a poor state and sadly passed away 8 days later under the care of the Neonatal unit in July 2018.

A key issue for the Inquiry was whether staffing levels impacted upon the actions and/or decision-making of staff on 21 July 2018 in light of the high level of clinical activity on the labour ward on that date and, in particular, whether there was any delay to the care and treatment of Mrs Murphy and the birth of Freya as a result of that.

3. Assessment

The Determination established that:

- There was no accident which resulted in Freya's death
- The cause of Freya's death was Global ischemic brain injury associated with acute chorioamnionitis.
- There were no precautions which could reasonably have been taken and had they been taken might realistically have resulted in Freya's death being avoided
- There were no defects in any system of working which contributed to Freya's death.

However, Sheriff Divers made two recommendations following Freya's death:

1. Greater Glasgow Health Board (GGHB) should review staffing levels across all shifts to ensure that its labour wards, post- natal wards, maternity assessment units and other hospital maternity related areas are adequately staffed at the weekend and in the evening such as to allow, in the case of an emergency where two patients require admission to theatre at the same time, for the opening of a second operating theatre, within a suitably expeditious time and where such a second theatre is available.
2. GGHB should formerly (sp) request that the United Kingdom National Screening Committee (UKNSC) give urgent consideration to a review of whether pregnant women routinely be offered screening for Group B Streptococcus ("GBS"). That if such a review is under way, then a copy of this determination be provided to the UKNSC for consideration in that review.

Under the rules of an FAI, 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 22 July 2025 to respond.

Assessment of the recommendations:

For **Recommendation 1**: NHSGGC proposes to respond as follows:

NHSGGC regularly reviews staffing levels to ensure all maternity services are appropriately staffed. This is managed on a day-to-day basis, including weekends, through site safety huddles and cross-site touch point calls. A key part of each Labour Ward Co-ordinator's role is to manage staff numbers and skills to safely run two emergency Obstetric theatres when required to do so. The Medical resources to do so are built into the Medical Rotas for the specialties of Obstetrics and Anaesthesia.

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Our workforce plan prioritises maternity services. This is reflected in the staffing base we recruit to; its focus is to ensure that safe staffing levels in triage, labour ward, theatre and inpatient areas are successfully delivered across our maternity sites. This is subject to annual review.

For **Recommendation 2**, NHSGGC proposes to respond as follows:

In line with the FAI recommendation on this matter, NHSGGC will make the formal request to the UK National Screening Committee (UKNSC) to urgently consider a commissioned review of whether there should be routine screening of pregnant women for Group B Streptococcus (GBS). Our current GBS procedures were not subject to a recommendation however we acknowledge that the issue of universal screening for GBS in pregnancy remains the subject of scientific debate.

4. Conclusions

This was a tragic case. NHSGGC is fully committed to learning from it and implementing the two recommendations from the FAI as described.

5. Recommendations

The Board is asked to note the Determination and recommendations from the FAI, noting where action has been, or is now being taken, to learn and improve services.

6. Evaluation

We will review and evaluate our workforce plan on an annual basis to ensure safe staffing levels throughout maternity service provision.

7. Appendices

Appendix One: Links to the FAI Determination document.

Link to the FAI determination:

[2025fai025-fai-freya-murphy.pdf](#)