ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Mr John Adler, Chief Executive, University Hospitals of Leicester NHS Trust**
1	**CORONER** I am Lydia Brown assistant coroner, for the coroner area of Leicester City and South Leicestershire
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 4th October 2013 I commenced an investigation into the death of Dayani Chauhan-Ahmed, 1 day old. The investigation concluded at the end of the inquest on 25 June 2014. The conclusion of the inquest was "Mrs Chauhan-Ahmed was admitted in labour to Leicester General Hospital for the anticipated and planned delivery of her first baby. She did not receive adequate medical attention due to other concurrent emergencies. Dayani was delivered naturally in very poor condition and died from the consequences of the prolonged labour. Her death was due to natural causes, contributed to by neglect."
4	**CIRCUMSTANCES OF THE DEATH** This was a low risk term (41 weeks) delivery for midwifery care. There was a prolonged second stage of labour, augmented with syntocinon. On the evening in question, additional midwifery assistance would have led to earlier commencement of the syntocinon infusion, and allowed the midwife co-ordinator to continue with her role rather than carry out other clinical tasks. Despite plans for further medical reviews, and requests for medical attendance, these did not happen and Mrs Chauhan-Ahmed eventually progressed to a natural birth after a second stage exceeding 5.5 hours. This management fell well outside NICE and Trust guidelines and protocols. Dayani was born in poor condition and despite intensive care the situation was soon considered to be futile and care was withdrawn with parental consent. The cause of death was considered due to prolonged labour, peripartum asphyxiation and severe hypoxic ischaemic encephalopathy.

5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – (1) Notwithstanding the presence at all material times of a Consultant on the delivery ward, the length of time of the second stage of this labour did not appear to be communicated effectively to either the Consultant or the midwife co-ordinator, due to other events occurring that night. The "white board" system of communication was ineffective as neither of the above had an opportunity to look at this. The Trust should consider a proforma for communication on such occasions that is effective and may include sight of the CTG trace, where applicable, by the most senior clinician available. (2)The Trust escalation policy has been changed since this death, but there seemed to be uncertainly on how well this was known by all relevant midwifery and medical staff, and in particular ensuring knowledge for new staff. Knowledge of the procedures, and adherence to the time limits set out for escalation are key to the effectiveness and the Trust should consider further how this can be robustly incorporated into working practice. (3) The Trust should consider arranging for additional midwifery and medical availability to assist during times of extreme demand on the service. The current informal "SOS" system for midwifery attendance, while promising, should be further explored and confirmed in Trust policy if considered to be effective.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 22nd August 2014. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons [redacted] and to the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	**[DATE]** 30 JUNE 2014 **[SIGNED BY CORONER]**