# University Hospitals of Leicester NHS

NHS Trust

HM Coroner for Leicester City and South Leicestershire
The Town Hall
Town Hall Square
Leicester
LE1 9BG



[redacted]

15th August 2014

Dear Mrs Mason

Re Dayani CHAUHAN-AHMED

Thank you for the letter of 30 June 2014 that your Assistant Coroner wrote to me in accordance with Regulation 28 of the Coroner's Rules following the conclusion of the inquest that was held into the death of Dayani Chauhan-Ahmed.

I note the concerns that were raised in your letter namely:-

1. The length of time of the second stage of labour did not appear to be communicated effectively to either the consultant or the midwife co-ordinator;
2. The Trust should consider a proforma for communications on such occasions;
3. Such a pro forma could include ensuring sight of the CTG trace;
4. Ensuring that the escalation policy was known by all relevant midwifery and medical staff and in particular new staff
5. Consider further how knowledge of procedures and adherence to time limits for escalation can be robustly incorporated into working practice
6. Consider arranging for additional midwifery and medical availability to assist during times of extreme demand on the service
7. The current informal 'SOS' system for midwifery attendance should be further explored and confirmed in Trust policy if considered to be effective.

Since the conclusion of the inquest the Senior Management Team of the Women's and Children's Clinical Management Group (CMG) have considered what further actions we can take to improve patient care in connection with

the above points. These actions have also been endorsed by our Medical Director and our Chief Nurse.

Using the above enumeration I am now in a position to respond on the above points as follows:-

1. Our Head of Midwifery has asked the midwife who contacted the consultant to reflect on the importance of clarity when communicating clinical information including being precise in terms of what actions they want to see happen. The importance of clarity particularly in a situation where there is extremely high/intense activity is something that all staff can learn from. In addition our Deputy Clinical Director for Women's and Children's Services has discussed with the consultant the importance of ascertaining accurate information if it is not provided. In addition, our Quality and Safety Manager for Women's and Children's Services has reminded all clinical staff in the CMG of the importance of pulling the emergency buzzer to summon assistance in an emergency situation.

2. We have carefully considered using a pro-forma to aid effective communication as such pro-formas are used in other circumstances to good effect. However, we have decided not to introduce a pro forma in the situation that occurred here. This is because it is felt that completion of a pro forma is not suitable in emergency situations and would be more likely overall to delay effective action. It is the view of the senior management team of the CMG that it would have been appropriate in this case for the midwife to have used the emergency buzzer. Accordingly, the Head of Midwifery will ensure that the guidelines for the management of the second stage of Labour (Intrapartum Care: Healthy Women and their Babies Guideline) will be reviewed by the end of September 2014, and will strengthen the guidance on the need to use the emergency buzzer in emergency situations. We will continue to use the Whiteboard as a communication tool as it is effective in many situations but we accept that it can be of limited use in emergency situations.

3. It would have been helpful for the consultant to have seen the CTG trace so the Head of Midwifery will ensure that this is also fully addressed and guidance strengthened on this aspect when the Guidelines for the Management of Second Stage of Labour undergo review as indicated above.

4. The Head of Midwifery is to ensure that by the end of September 2014 the Escalation Policy (the Transfer of Activity and Closure Policy) will be reviewed and will include guidance on the informal 'SOS' system. Once this has been completed the policy will be disseminated in accordance with normal Trust practice. Additionally, the Head of Midwifery and Deputy Clinical Director between them will ensure that a

copy of the revised policy is sent electronically to all midwifery and medical staff within the CMG.

Moreover, so as to ensure that new staff are aware of the Transfer of Activity and Closure Policy, the Head of Midwifery and the Head of Service will ensure that it forms part of the induction of new midwifery and medical staff, respectively. In addition, staff will be reminded of this policy as part of their annual training.

5. In addition to the above the Head of Midwifery will take further actions namely she will ensure that a laminated flowchart detailing the actions to be taken and time limits for escalation are placed within each of the two delivery suites at the Trust and she will include details of the key actions when transferring activity in the CMG's quarterly Quality and Safety Newsletter.

6. Since this incident occurred the service has advertised two additional consultant posts. It is planned that the maternity service will move toward extended hours of consultant presence on both delivery suites in UHL with a phased increase in consultant numbers. As a first step it is planned that hours of consultant presence at the Leicester General Hospital will increase from its current 60 hours/week to 84 hours/week by the end of September 2014. We also plan to increase hours of cover at the Leicester Royal Infirmary. This will require a reorganisation of consultant job plans and we anticipate that there will be more robust consultant presence with prospective cover at the LRI by end of September 2014. In 2019 it is planned to move to a one-site take and this should better enable the service to manage periods of extremely high demand.

7. As indicated in point 4 above the SOS system, as presently operated, will be included in the strengthened Escalation policy.

8. In addition to these measures it is planned that the service will undertake an annual emergency drill to test the effectiveness of the escalation policy. This will test the robustness of the policy.

I would be happy to share these revised policies with you following their review.

Implementation of all of the actions set out in this letter will be reviewed at the Trust's Executive Quality Board which meets monthly, which I chair and which is attended by the Clinical Director for Women's and Children's Services as well as a number of Executive Directors, including the Chief Nurse and Medical Director.

I hope that this is helpful and addresses the serious issues that you identified in your Regulation 28 Report. This was clearly a very tragic event that we have taken very seriously and tried to respond to as comprehensively and

effectively as possible. If you feel that our response in any way falls short of your expectations, please do come back to me.

Yours sincerely

[redacted]

Chief Executive

cc: [redacted], Medical Director
[redacted], Chief Nurse
[redacted], Consultant Obstetrician
[redacted], Consultant, Neonatal
[redacted], Head of Midwifery/Deputy Head of Nursing
[redacted], Consultant, Obstetrics & Gynaecology
[redacted], Assistant Director (Head of Legal Services)
[redacted], Director of Safety and Risk
[redacted], Director of Clinical Quality