REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. West Hertfordshire Hospitals NHS Trust**
1	**CORONER** I am Richard Alexander Hulett Senior Coroner, for the coroner area of Buckinghamshire
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 25th June 2013 I commenced an investigation into the death of Molly Rae Keen a new born baby. The investigation concluded at the end of the inquest on 10th July 2014.The conclusion of the inquest was of natural causes together with a [redacted]
4	**CIRCUMSTANCES OF THE DEATH** At 11.25 hours on 10th June 2013 Molly was delivered by caesarean section. She was in a very poor condition. Resuscitation was stopped at 11.54.
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. – 1a) Buckinghamshire Healthcare NHS Trust (Bucks) employ a customised growth chart as part of their ante natal care. Where ante natal care is provided in West Hertfordshire Hospitals NHS Trust (West Herts) but the birth is intended to happen at Stoke Mandeville Hospital then Bucks supply a growth chart to be kept in the mothers file and utilised. 1b) West Herts do not use customised growth charts for their own deliveries. 1c) An expert witness in midwifery opined that where a chart is supplied, it should be used. 1d) Discussions between Bucks and West Herts to improve this aspect of joint care are currently in abeyance. There is a continuing absence of clarity as to how such joint care should be delivered. 2) Midwives within West Herts estimate fetal growth by measuring fundal height. However:- a) In the immediate case, measurements were variously part recorded on the growth chart, or written on the file, or not recorded at all. As a consequence, an overall assessment of fetal growth is obscured. b) The evidence disclosed that although there was (nevertheless), clear indication

	that the growth of the baby was below normal expectations, no attempt was made to refer the case for further opinion, and a possible scan. 3) Further information given during the inquest did not reassure me that all necessary steps have been taken to remedy the issues outlined in 1 and 2 above.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation has 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 17th September 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] **Buckinghamshire Healthcare NHS Trust,** and to the **Local Safeguarding Board** 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: 22 July 2014** **SIGNED BY CORONER:**