THOMAS R. OSBORNE
for Bedfordshire and Luton

	THIS REPORT IS BEING SENT TO: **Mr Stephen Conroy** **Chief Executive** **Bedford Hospital NHS Trust** **Kempston Road** **Bedford** **MK42 9DJ**
1	**CORONER** I am **Thomas R. Osborne** Senior Coroner for Bedfordshire and Luton
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 14th February 2014 I commenced an Investigation into the death of **Willow Davies**, aged 2 hours 42 minutes . The Investigation concluded at the end of the Inquest on 27th March 2015. The Conclusion of the Inquest was 'Birth Trauma following a Precipitate Labour'.
4	**CIRCUMSTANCES OF THE DEATH** Mother had a normal pregnancy, other than detecting a heart murmur. Willow was born at 05.32 hours on the 8th February 2014 at Bedford Hospital. There were no complications and Willow was given to dad at 06.05hours; at o6.10 hours she was pale and floppy at which point CPR was commenced. Her death was subsequently confirmed at 08.14 hours.
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. That a newly qualified Midwife was allocated to deliver a baby when, during the course of her training and her practice since qualifying, she had never assisted with the resuscitation of a new born baby. The Midwife had no further support. 2. That the allocation of women to midwives on a shift by shift basis did not, and does not, take into account the experience of the individual midwife 3. That system of 'Supervisors of Midwives', as it operates at Bedford Hospital, is in urgent need of review to ensure that it is working to support pregnant women and midwives in the Trust.
6	**ACTION SHOULD BE TAKE** In my opinion action should be taken to prevent future deaths and I believe you 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 **16th JUNE 2015**. 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 : The Parents The Care Quality Commission (CQC) The Local Safeguarding Children's Board (LSCB) 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	**Dated 21 April 2015** ..... **THOMAS R. OSBORNE** **Senior Coroner** **Bedfordshire and Luton**

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