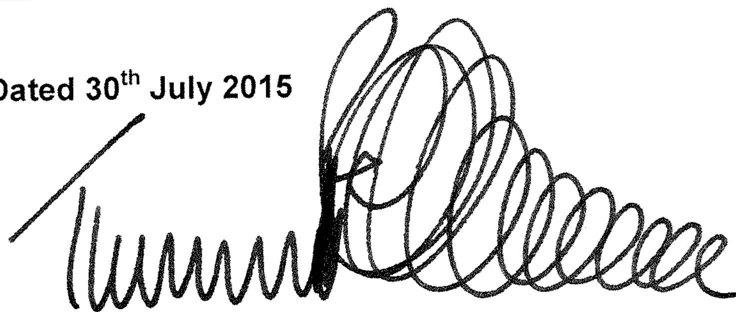
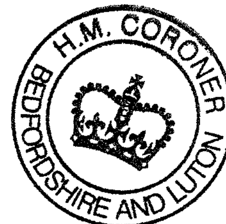
THOMAS R. OSBORNE
Senior Coroner for Bedfordshire and Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **The Chairman** **LET Board** **Health Education East of England** **2-4 Victoria House** **Capital Park** **Cambridge** **CB21 5XB**
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 12th September 2014 I commenced an Investigation into the death of Casey Paul **GARRETT.** The Investigation concluded at the end of the inquest on 21st July 2015. The Conclusion of the Inquest was a Narrative Conclusion: "Casey Garrett was born on 10th September 2014. Prior to his delivery at Bedford Hospital there were a number of failures to recognise that his condition was deteriorating and there was failure to escalate the level of care so as to expedite his delivery. These failures resulted in a lost opportunity to deliver him earlier and avoid his death. He died on the 11th September 2014 at 07:10 hours from Perinatal Asphyxia".
4	**CIRCUMSTANCES OF THE DEATH** Baby Casey Garrett was born with a zero APGAR score at birth - gestation

	38+6. Full CPR was commenced, but his APGAR score remained at zero at 1, 5 and 10 minute intervals after delivery. A heart beat was first noted at 27 minutes of age, after intensive CPR. He was then transferred to the Neonatal Intensive Care Unit for ongoing management. There were serious failings with regard to midwifery care in that : 1. The original Cardiotocography (CTG) was discontinued despite being non-reassuring. 2. There was a failure to carry out intermittent auscultation in accordance with the Trust Policy. 3. When the labour became abnormal at 22.00 hours there was a failure to call for an obstetric review by the doctor on call. 4. There was a failure to recognise that the CTG started at 10.12 hours was recording the maternal pulse. 5. Had the medical staff been alerted to the baby's deteriorating condition, and the deviation from the norm, an instrumental delivery would have been performed by 10.30 hours 6. If delivery had been achieved 20-30 minutes earlier Baby Garrett would have survived.
5	**CORONER'S CONCERNS** My concern was regarding the clinical learning environment, in that a Student Midwife was working with a Midwife and witnessed/carried out entirely inappropriate midwifery care which led to this infant's death, including insufficient fetal monitoring, mis-interpretation of a CTG trace and the failure to escalate the level of care when there was a "deviation from the norm". The **MATTERS OF CONCERN** are as follows : 1. The incident raises questions about the suitability of Bedford Hospital NHS Trust being used as a clinical learning environment for Student Midwives – this needs an urgent review in the interests of safety of mothers and babies to avoid similar deaths in the future.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you as Chairman 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 **25th September 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 Chief Executive of Bedford Hospital Parents' solicitors - Hodge Jones & Allen I have also sent it to : The Chancellor, University of Bedfordshire, Park Square, Luton, LU1 3JU Health Education England, 1st Floor, Blenheim House, Duncombe Street, Leeds LS1 4PL Richard Fuller, MP for Bedford who may find it useful or of interest. 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 30th July 2015**  **THOMAS R. OSBORNE** **Senior Coroner** **for Bedfordshire and Luton** 

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