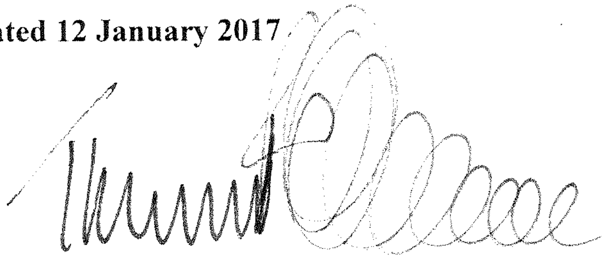
Thomas R Osborne
Senior Coroner for Bedfordshire and Luton

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

	THIS REPORT IS BEING SENT TO: **The Chief Executive** **Watford General Hospital** **Vicarage Road** **Watford** **Hertfordshire** **WD18 0HB**
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 6 October 2014 I commenced an investigation into the death of **Jennifer Elisabeth Lestajo CLARK** aged 18 hours . The Investigation concluded at the end of the Inquest on 10 January 2017. The Conclusion of the inquest was a 'Narrative Conclusion' "…..The deceased was born on 24 September 2014 at 00:54 hours at Watford General Hospital. At the birth there was a failure to carry out a detailed assessment as to her condition and a failure to monitor her continuously until at 01:26 hours it was recognized that she had collapsed; there was a further failure to escalate her case quickly She was transferred to the Luton & Dunstable Hospital and died at 18:25 hours from a massive pulmonary haemorrhage. The failures in the provision of care resulted in lost opportunities to treat her condition prior to her death".
4	**CIRCUMSTANCES OF THE DEATH** Jennifer was born on the 24 September 2014 after a birthing pool delivery. The midwife failed to recognise that baby Jennifer was unwell until the time of her collapse, some thirty minutes after delivery. She was then transferred to the Luton & Dunstable hospital for further treatment where she died.

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. a Consultant Paediatrician from the Hospital, during the course of his evidence, explained that there were over 5,500 births at Watford General Hospital every year, and that the Neonatal Unit only had a limited number of beds and was inadequate for that number of births. Despite having submitted a detailed Proposal for Expansion of the Neonatal Unit, this had been rejected 2. Without adequate neonatal facilities at the Hospital there is a high risk of babies' lives being at risk in the future
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you The Chief Executive of Watford General Hospital 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 **10 March 2017**. 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] - Parents Hertfordshire Safeguarding Children Board Team I have also sent it to the Care Quality Commission and to [redacted] Paediatric Consultant of Watford General Hospital, 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 12 January 2017**  ………………………………………… **THOMAS R. OSBORNE** **Senior Coroner** **Bedfordshire and Luton**