	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. East & North Hertfordshire NHS Trust 2. Secretary of State for Health and Social Care
1	CORONER I am JONATHAN STEVENS, assistant coroner, for the coroner area of Hertfordshire
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 14th March 2019 Senior Coroner Geoffrey Sullivan commenced an investigation into the death of EDDIE JOHN COFFEY [age 1 day]. The investigation concluded at tie end of the inquest on 11th November 2020. The conclusion of the inquest was that Eddie Coffey died on 14th January 2019 at the Luton & Dunstable Hospital as a result of birth asphyxia during labour which was not property managed constituting neglect contributing to the cause of death. The medical cause of death was perinatal asphyxia.
4	CIRCUMSTANCES OF THE DEATH Eddie Coffey was born at 23.27 on 19 January 2019 at Lister Hospital. On delivery he was in a poor state with a low heart rate and symptoms of hypoxia. He required resuscitation at birth. He was transferred to the Luton & Dunstable Hospital NICU for ongoing care. He died the next day on 14th January 2019.
5	<u>CORONER'S CONCERNS</u> During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. MATTERS OF CONCERN are as follows. - (1) The Serious Incident Report prepared on behalf of East and North Hertfordshire NHS Trust concluded that the Investigation was unable to determine the factors that were directly responsible for the death of baby Eddie Coffey. This conclusion was directly contradicted by evidence at the inquest. (2) Evidence was given at the inquest by a Consultant Obstetrician from Lister Hospital that there was a gross failure in the basic medical care provided in the monitoring and management of the foetal heart rate during the labour, and that but for that failure Eddie Coffey might have survived.

	(3) Evidence was given at the inquest by an independent Consultant Obstetrician that there was a gross failure in the basic medical care provided in the monitoring and management of the foetal heart rate during the labour, and that but for that failure Eddie Coffey would more than likely have survived. (4) It was not clear from the inquest that, despite training implemented by the Trust since the death, that the same situation would not arise again. (5) The Evidence was given at the inquest by an independent Consultant Obstetrician that 100 maternity units in the country are following the wrong guidelines in relation to managing foetal heart rate monitoring in labour.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you AND/OR your organisation 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 9th February 2020. 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 (parents of the deceased) and the East & North Hertfordshire NHS Trust. 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	15th December 2020 SIGNED