1/ For the purpose of this judgement I make it clear that all findings are done so on the basis of the balance of probabilities, ie more likely than not, unless I specifically state otherwise.

2/ Harry Richford was born at the QEQM hospital on 2/11/17 he died on 9/11/17 at the William Harvey Hospital, Ashford to where he had been transferred. He was a much desired and much loved baby. His parents are both teachers who were enormously excited when they discovered they were to be first time parents and they did everything recommended to them so that their child should be born in the best possible condition. Neither smokes, both are fit, young and active and Sarah Richford avoided any alcohol. They also attended NCT classes.

3/ The poet John Donne wrote 'any man's death diminishes me'.. If that is true how much more are we all diminished by the death of a new born baby. Today Harry should be almost 2 years and 3 months old. He should be a bundle of energy causing no end of mischief as a happy active young child. Instead his family are still grieving, and will no doubt for the rest of their lives. What makes it worse is that they are grieving for a child they do not believe should have died. I agree with them. Harry's death was in my judgement wholly avoidable. Mr and Mrs Richford were failed by the hospital, but more importantly Harry was failed.

4/ During the course of the last 3 weeks I have heard a very substantial quantity of evidence from Harry's parents, the midwives who looked after Sarah Richford, from doctors at the trust varying in seniority from consultants through the registrars to junior doctors, from nurses and from experts who have been asked to review the case and advise upon it. I do not intend to review each and every piece of evidence but only those which are, in my opinion, central to the issues which I have to decide, namely who was it who died, how, where and when did that occur. Importantly in this inquest the word how is defined as meaning by what means and in what circumstances. I also bear in mind S 5 of the Coroners and Criminal Justice Act 2009. A coroner's inquest is a fact finding enquiry. It is not a trial. No-one is on trial. By S 5 of the Act the coroner is prevented from expressing an opinion in

the conclusion on any matter other than those four questions, namely who is the person who died, when where and how did the death occur. That determination may not be framed in such a way as to appear to determine any question of criminal liability on the part of a named person or civil liability. This inquest is not an enquiry into the running of the East Kent Trust or into other deaths at the Trust. Any such investigation if there is one is for other authorities such as the Care Quality Commission. As I said at the beginning of this inquest the CQC were not attending but indicated that they would be taking an interest in the hearing and the conclusions. This has been an enquiry into Harry Richford's death. At a pre inquest review I made it clear that this was to be a very full, frank and fearless inquiry with all the relevant and available evidence taken into account.

5/ In all of this evidence what stands out are two very stark opinions from two experts instructed by the court, Mr Taylor (Myles) and Dr Kendall (Riles). Mr Taylor, a consultant obstetrician and gynaecologist who is President of the British Maternal and Foetal Medicine Society, said 'but for the failure to deliver at 2.00am and expedite delivery in competent hands, I believe Harry would have been born in good condition and would have survived'. Even after that failure Dr Kendall, clinical lead for neonatology at UCH and a specialist in perinatal hypoxic ischemic brain injuries, wrote 'had the resuscitation afforded to Harry Richford been of an appropriate standard he would have almost certainly survived and, on the balance of probabilities, had a normal neurological outcome'.

6/ It is with that background of a baby failed on those two occasions there was a seemingly incomprehensible decision by the trust after Harry's death to describe his death as 'expected'. Even more remarkable was that that position was maintained when a moment's quiet reflection should have made the hospital realise that although his death itself may have been expected on the 9th there was no reason at all to expect his death when his mother came into hospital to give birth. The effect of that error was that the Coroner was not informed of Harry's death. It is only due to the hard work and persistence of Mr and Mrs Richford and their family members that eventually the national Chief Coroner ordered that an inquest should be held. Without a full inquest such as this the family would never

have had the opportunity to see and hear from those involved in the care of their son, let alone to question them in detail through counsel or to give evidence themselves. The trust has undertaken that such a mistake will not happen again. Immensely difficult though going into a witness box and giving evidence about the birth and death of their child must have been the opportunity to do so and be heard and for their pain to be recognised was a moment they had waited two years for. They have remained during these three weeks calm and dignified. That has probably been hard in the face of the evidence.

7/ On the day the inquest began the trust put out a press release apologising to the family for what had occurred. That was not brought to my attention by the trust and I only found out through the good auspices of the BBC. I am unclear whether that apology was given to the family beforehand. If it wasn't it should have been. During the course of this inquest admissions of error and apologies have been made by both registrars who looked after Harry, Dr Spyroulis and Dr Ratmanathan, the consultant obstetrician Miss Goumenou and by the senior management of the trust. Had that happened two years ago the sense of loss and bereavement would not have eased but the sense of frustration that no-one was taking responsibility may have been less.

8/ The inquest began with the reading of the Coroner's Officer's statement, Mrs Helen Jenkins. Identification of Harry had been made by Dr Sean Mun, a consultant neonatologist who had the care of Harry at the William Harvey Hospital. A certificate had been provided issuing the medical cause of death as 1a – Hypoxic Ischaemic encephalopathy. Hypoxic Ischaemic Encephalopathy is a type of brain damage. That is consistent with the post mortem examination, the MRI scan examined by Professor Rutherford and the expert evidence heard during the course of the inquest. It has been undisputed and for the purpose of this inquest I so find.

9/ Harry was Sarah and Tom Richford's first child. Sarah was assessed as being a low risk pregnancy and the plan was for her to be delivered on the midwifery led unit. She

presented at QEQM on 31/10/17 where she was seen by a midwife, Poppy Erasmi. After an examination and a CTG she was discharged home. A CTG is a cardiotocaphy. It records the fetal heartbeat and the uterine contractions during pregnancy. She was at that stage in early labour. She returned to the hospital in the evening at 18.55 as her contractions had become stronger and more frequent. She was placed in the midwifery led unit where she stayed until 11.20 on the 1/11/17. Jacqueline Foad, a band 6 midwife, had taken over her care at 7.45. When Mrs Foad assessed Sarah at 10.30 she noted that there had not been any progress since an earlier examination four hours before. She therefore arranged for Sarah's transfer to the labour ward where Sister Michelle Kiting was happy to accept her. The day registrar, Dr Ogunyanwo, was informed. There were decelerations on the CTG so that at 11.57 the emergency buzzer was pressed. Both sister and doctor attended. Dr Ogunyanwo requested that intravenous fluids should be given, that the CTG should be continued to be monitored and that syntocinon should be given by infusion. Syntocinon is a drug which can be used to induce labour. The midwives were not happy to commence syntocinon as there were some decelerations on the CTG. It should be noted that the form which should be detailing the quantity of syntocinon given to Sarah cannot be relied upon as it conflicts with the evidence of the midwives. Dr Ogunyanwo handed over his duties to the night registrar, Dr Spyroulis, at 20.00.

10/ Susan Barnes, midwife, took over Sarah's care at 14.05. She remained in that position until 20.30 when she handed over care to Mrs Katy O'Shea who remained with her until after Harry's birth at 3.32 am the following day. When Mrs Barnes handed over care at 20.30 she told Sarah that she would see her the following day and was looking forward to meeting Sarah's new born baby. It is clear to me that there was no inkling at that time of the tragedy that was going to take place. During the course of this inquest Mrs O'Shea became quite emotional. It is important to note that a tragedy such as Harry's death affects many people, especially those perhaps who are trying to deliver new life. One must not overlook the effect that an unexpected death such as this affects many people. In this case there were also two very young doctors involved. One of them thought Harry was dead when she first saw him after birth and was clearly very upset in court.

11/ I do not intend to go through the CTG readings in detail. I heard a great deal of evidence about them from numerous sources. Even when looking at the same figures there were almost as many different interpretations as there were people giving them. Miss Julia Parvia, a band 7 midwife, (band 7 being a more senior position than band 6) who gave a specialist expert report for the court, was highly critical of the interpretation of the CTGs. In particular she said that up to 18.00 hours the midwife failed to recognise that Sarah Richford was hyper stimulating and failed to recognise the seriousness of it. She said that the midwife failed to decrease the syntocinon and in fact increased it causing further hyperstimulating. At a later stage she said that the midwife failed to recognise that the CTG was pathological from 1.30 for 26 minutes. She described the care given by the midwives was very much below the standard expected.

12/ It must be pointed out that the midwives concerned strongly disputed Ms Parvia's opinion. Not all the doctors agreed with her either and I therefore treat this evidence with some caution. Her opinion concerning the period leading up to 2 am is however of some importance and is supported by Mr Taylor, if not necessarily by others. Mr Taylor stated that between 1.30 – 2.00 am the CTG was pathological. CTGs he said are described as reassuring, suspect or pathological. With a suspicious CTG corrective measures such as adjusting the maternal position or reducing the rate of syntocinon may suffice. With a pathological CTG there is a need either to perform a fetal blood sample (that is a small sample obtained from the fetal scalp) to see if the baby is acidotic, or to expedite delivery. That, he said, required either a fetal blood sample to be taken or for delivery to be expedited. A fetal blood sample could take 20 minutes to be analysed. Between 2.00 and 2.47 there were recurrent decelerations but the variability diminished significantly to being abnormal at around 2.25. This was, he said, a vital moment. Harry should have been delivered urgently at 2.00 am and at most within 30 minutes. He wasn't in fact delivered until 3.32. Dr P Forbes made an earlier report than Mr Taylor in January 2019 instructed by the Medical defence Union. He disagreed with Mr Taylor in two important areas, both relating to timing. His opinion was that when looking at the timing as a whole he said it did

not suggest that Harry was suffering from hypoxia and secondly he did not agree that the 2.00 time was crucial. He said that the timing was not a necessary element and that Harry would have been born in any event in a poor condition but capable of being resuscitated. The evidence in my judgement amounted to the following - CTGs are a very useful tool. They are not, however, definitive. The readings need to be put in context with all the available information and experience, skill and judgement applied to them.

13/ Dr Mark Waterstone, a consultant obstetrician of great experience, instructed by the head of midwifery at the Trust also disagreed with Mr Taylor in that, in his opinion, there was nothing before 23.55 which was relevant to the outcome. The CTG interpretation was inaccurate he said for the most part with the trace being interpreted as normal when in fact it should have been suspicious and then pathological. However in his opinion this did not have a material impact on the outcome as the fetal condition was good and there was no evidence of significant hypoxia. He also disagreed strongly with Ms Parvia who was, he said, simply wrong. His view was that Dr Spyroulis had found himself in a horrendous position for a very junior level. In that latter comment he was backed up by Mr Taylor who described the position Dr Spyroulis was in like this – " you know you're out of your depth. If you do nothing the baby could be harmed. If you do anything then you might fracture the baby. You are out of your depth and floundering".

14/ To the extent that I have to resolve the issue between the experts I accept Mr Taylor's opinion. One must be wary in doing so as all of these doctors are eminent experts in their field. I do so because I found him to be the clearer and more authoritative voice and also that it was consistent with Ms Parvia's evidence. I also found that it was more consistent with what actually happened at Harry's birth. By the time of Harry's birth a very long time had elapsed with little or no progress. Mr Taylor gave as his opinion that by the time of the CS Harry was vulnerable having been challenged by hyperstimulation over a period of time. The passage of time would appear to be important. That is also supported by Dr Spyroulis who said that in his opinion the CTG became pathological at 2.00 am and that as a result the delivery should have been within 30 minutes, not at 3.32 which was 92 minutes later.

15/ Mr Taylor's overall interpretation of the CTG was that Harry had been put under stress due to the excessive use of syntocinon and the resulting hyperstimulation which occurred frequently between 17.20 on the 1st to delivery 10 hours later. This was potentially an important first factor as Mr Taylor's opinion was that there were three important factors present, the first being the hyperstimulation which made Harry more susceptible to problems at delivery, the second factor, and then a delay in resuscitation, the third factor.

16/ Harry was delivered by Dr Christos Spyroulis, a locum registrar on his third night at the hospital. Dr Spyroulis assessed and confirmed that Harry was lying in an OP position. An OP position is when the back of the baby's head is against the mother's back. He intended to attempt to deliver by the use of non rotational forceps. This was, in Mr Taylor's opinion, unacceptable and substandard. Had he actually used the forceps there was a risk of traumatising both mother and baby. Fortunately the blades did not lock and no attempt was made to use them. What the actions did do, however, was to indicate to the expert that Dr Spyroulis was inexperienced.. That view was re-inforced by the registrar's actions during the caesarean section. He asked Mrs O-Shea, the midwife, to push Harry's head up vaginally. He should, according to the expert, have briefed Mrs O'Shea how to do this as the head needed to be de-flexed as well as pushed. He should also have requested the anaesthetist to have the drug tocolysis available to relax the uterus. Dr Spyroulis accepted to us that he overlooked tocolysis.

17/ Mrs O'Shea had only twice pushed a baby's head up in 11 years as a midwife. The last time was some years before. Ms Parvia said she had never done it although Mrs Burgess who assisted Mrs O'Shea, a band 7 midwife, said she had done it numerous times. When Mrs O'Shea tried to push Harry's head upwards she had a difficulty in that Dr Spyroulis's fingers were in the way. Dr Spyroulis also asked Dr Kayzia Ballantyne, a GP trainee to extend the uterine incision. That request was, according to Mr Taylor, completely inappropriate.

The incision should have been larger to begin with and, if not, then the registrar should have extended it. In the event Dr Ballantyne did not know how to do it.

18/ This was a difficult CS and it was clear that it was going to be in advance. Dr Spyroulis telephoned Ms Goumenou, the consultant on call that night. Dr Spyroulis times the call at 2.12, Ms Goumenou at 2.20. Ms Goumenou says she asked the registrar if he wanted her to come to the labour ward. He replied that he wanted to try an instrumental delivery or to deliver the baby by way of a CS. Importantly he told Ms Goumenou that the mother had been fully dilated since 23.55. He said he was happy to deliver the baby himself. Dr Spyroulis said that Ms Goumenou did not ask him about his experience and nor did anyone else. He said he should have asked her to come in, that was, he said a misjudgement, he should have done so. In her evidence to the inquest Ms Goumenou said she thought there had been another call about a different mother during which she asked after Sarah Richford. That call does not appear in her statement, made a few weeks later. No-one else recalls it.

19/ One of the significant questions in this inquest into to the death of Harry Richford is whether Dr Spyroulis should have attempted to conduct Harry's birth without the presence of his consultant, Ms Goumenou. In my judgment Ms Goumenou should have been present and should have conducted Harry's birth herself. To her credit she accepted in her evidence that she should have come in earlier. The failure to do so played an important part in the events of that night. The Royal College guidelines also make it clear that the consultant should attend with a CS at full dilatation or for an instrumental delivery.

20/ Whether Dr Spyroulis should have been in the hospital as the senior obstetrician at all is also an important question. He was a relatively inexperienced doctor. No-one seems to have taken responsibility for hiring him. Dr Stevens, the medical director of the trust, said that he had not been able to establish who employed Dr Spyroulis. Nor had he been able to establish who assessed him. There should be a record. The logical assumption therefore is that there is no record and it may be that no-one assessed him. That was Dr Spyroulis's

evidence. No consultant assessed him. No-one, including Ms Goumenou, asked him about his experience. He had previously done 3 such OP deliveries, only one of them unsupervised. That had been earlier in 2017 and was not as difficult as Sarah Richford's.

21/ The specialist evidence from the doctors called in this inquest is that they would never allow an unassessed locum to be in charge unsupervised. They would also have seen the locum's CV and also the references. This was in my judgement a serious failing by the trust. Ms Goumenou said that she hadn't seen Dr Spyroulis working before but she had been told that he'd worked at the trust before. Later on she was told that that had been a mistake. She said she hadn't seen his CV at the time but that later, when she had, she agreed that he should not have been on the ward that night on his own. The information that it was believed Dr Spyroulis had worked at the trust before was a new piece of evidence which was not contained in her statement. However there is some support for it in Dr Redfearn's evidence. Even if Ms Goumenou was told that without finding out a great deal more about the locum it is clearly insufficient information to allow him to work unsupervised. Nor is it, in my judgment, sufficient to be aware that this was his third night without knowing what type of problems he had encountered and dealt with on the previous two.

22/ Staff Nurse Laura Guest answered a telephone call for help at about 3.30. She ran to the labour suite. She had recently completed a course in neo natal care. She went to assist. Her description of the situation was that it was chaotic. She didn't feel that it was being strongly led. Mrs O'Shea said that the atmosphere in the theatre changed when Dr Spyroulis asked for the consultant to be called at 3.24 because he couldn't deliver Harry. The atmosphere she said was one of panic. Mrs Burgess, a band 7 midwife, phoned Ms Goumenou. The consultant suggested that Dr Spyroulis should use an assistant to push vaginally whilst a second person gently pushed the shoulder, while he attempted a direct extraction of the fetal head. Alternatively he should try to perform a reverse brech extraction. That message never got through to Dr Spyroulis or to his junior doctor. Mr Taylor in his evidence pointed out that Dr Spyroulis did not have the requisite skill or experience to perform a reverse breech extraction.

23/ When Harry was eventually born at 3.32 he appeared to all intents and purposes lifeless. The neonatology evidence from Dr Kendall, was that time was of the essence. It took 28 minutes to resuscitate Harry by which time the damage was done. At Harry's birth the cord gas analysis suggested a period of hypoxic ischemia but not of a severity expected to result in irreversible brain injury. Dr Kendall reported that the documentation of the resuscitation to Harry was poor. No-one was making notes, no-one was keeping a log and time passed. He concluded that -

a) There was an unacceptable delay in requesting consultant support
b) An unsecured airway was handed over from the only trained member of the neonatal resuscitation team to an inexperienced and untrained junior doctor without the skills required to support the airway and maintain ventilation
c) Due to the failure to secure an airway and achieve effective ventilation there was a prolonged period of postnatal hypoxia. This continued up to the point that Harry was successfully intubated by the anaesthetist at around 28 minutes of life
d) The prolonged period of postnatal hypoxia compounded Harry's condition at birth and directly resulted in hypoxic ischaemic encephalopathy , irreversible brain injury and Harry's subsequent death

24/ Dr Kendall described Harry's condition at birth as being within the normal range taken from the cord gases. They were not consistent at that time with a prolonged ischemic insult at that stage. He was at that time likely to have been in terminal apnoeia (apnoeia being the cessation of breath) meaning that if there was no intervention then the heart rate would progressively drop, the blood pressure would drop and the baby would die. The initial stage would have occurred during the delivery but there was a period of up to about 10 – 15 minutes after birth when if properly ventilated Harry would not only have survived but would have been likely to have had no irreversible brain injury. In Dr Kendall's opinion some limited oxygen did on occasions get through to Harry thereby extending life but in his view by the time Dr Gurung, the anaesthetist looking after Sarah Richford, came on the scene Harry was near to death. Dr Kendall's description of the attempted resuscitation was

that if he had been presented with this scenario in a training exercise he would have failed them on a life support course.

25/ Dr. Ratnaranjith Ratnanathan was the paediatric registrar that night. He gave evidence from abroad by way of skype. He was a relatively junior doctor. He sensibly told the court that he had read Dr Kendall's expert opinion and had learnt lessons from it. He accepted that he could have called his consultant, Dr Abigail Price, earlier once the position became problematic once the intubation had failed. He couldn't remember why he hadn't used a carbon monoxide detector. He finally agreed that he had lost control and situational awareness. It was Mrs Burgess, the band 7 midwife, who had suggested calling Dr Price.

26/ The consultant paediatrician , Dr Price, was supposedly on call at up to 30 minutes away. She, however, as a habit slept in her office rather than take the risk of not being readily available if need be. She attended within 10 minutes of a call and arrived at 3.57. She should in my opinion have been called much earlier. When the first effort to call her was made the hospital switchboard had the wrong consultant listed and it was only on the third call that she was contacted. This is clearly unacceptable. There is, I was told, a problem with small maternity units such as this. Babies, of course, don't come just Mondays to Fridays during working hours. Many such hospitals according to the experts have only 40 hours obstetric consultant cover a week. QEQM had 60 now increased to 70. In the circumstances because Dr Price was very sensibly on site she was able to get to the theatre far faster than if she had been at home as she was quite entitled to be under her contract. Consultant's contracts only required that they should be within 30 minutes of the hospital when on call. Dr Price arranged for Harry to be taken to the special care baby unit in an incubator from where in due course he was transferred to the William Harvey Hospital. There have been no criticisms made as to his care and treatment at that hospital. Unfortunately one of the effects of Harry's immediate transfer in an attempt to save his life was that neither parent was able to hold their son until the day of his death.

27/ For much of the time the resuscitation was being attempted upon Harry both his parents were in the theatre. Exactly how many people were present is unclear as no proper note or log was kept. The highest estimate I heard was 20-25 while Tom Richford thought there were about 20. Not one of them was deputed to keep the team aware of the time passing, something fundamentally important to attempted resuscitation.

28/ This must have been totally terrifying for Sarah Richford. Her husband was trying to get between her and Harry so she couldn't see what was happening. The anaesthetist, one person who comes out of this sad occasion with his reputation intact if not enhanced, then stepped in by putting Sarah under a general anaesthetic and then going across and successfully intubating Harry. Dr Gurung who comes originally from Nepal said that although leaving a patient to help another was unusual in this country it was something he had done a number of times in Nepal where there are a limited number of anaesthetists. It was in fact too late as became clear over time. What it did do however was to give the family a few precious days with Harry. Assuming therefore that Mrs O'Shea is correct, from 3.24 onwards until she was anaesthetised by Dr Gurung about 30 minutes later, Sarah Richford either in the middle of a CS or soon afterwards with an epidural in place, must have been conscious of the air of panic and chaos around her. This is not one's normal idea of a calm professional hospital environment.

29/ It is with that factual background that submissions were made to me on Wednesday. I am very grateful to all counsel for their full and helpful submissions. It is common ground that in a complicated article 2 inquest such as this a narrative conclusion is appropriate in accordance with the Chief Coroners guidance number 17. Where there is substantial divergence is that the family submits that the narrative should include either a finding of unlawful killing, in this case essentially corporate rather than individual, or neglect. That is disputed by counsel for Ms Goumenou, Dr Spyroulis and the Trust. There is common ground that I should include those failings, if I find there to be any, in my conclusion, and this would include any defects in the systems which contributed to death.

30/ The law in relation to unlawful killing is set out in the Chief Coroner's guidance, in law sheet 1. I was also referred to the ruling at the Inner London Crown Court in the case of Cornish and others by Mr Justice Coulson. That related to the inquest of Mrs Frances Capuccini who died following a CS at Pembury Hospital. Mr Justice Coulson set out the law in paragraphs 6, 7 and 8 of that judgement. He said that a jury must be convinced that 'the negligence was bad enough to be condemned as the grave crime of manslaughter...that the shortfall from a reasonable standard was so flagrant, so atrocious, that it can properly be categorised as a serious criminal offence, namely manslaughter' . He referred to the cases of Adamaco, Jessey, Lion Steel Equipment, Misra and Prentice. In Misra the Court of Appeal stressed that mistakes, even serious mistakes and errors of judgment are nowhere near enough for a crime as serious as manslaughter to be committed. The Recorder of Manchester in Lion Steel Equipment said 'there are many circumstances in life where mistakes or poor judgment can lead to the death of another ...any death caused thus is tragic and one must do what one can to reduce the risks. But that does not mean that the law brings the full weight of criminal sanction for a very serious offence – manslaughter-to bear on any but very few such deaths.'

31/ In relation to neglect the law is set out in the well known case of Jamieson. 'Neglect in this context means a gross failure to provide adequate nourishment or liquid, or provide or procure basic medical attention, or shelter or warmth for someone in a dependent position (because of youth, age, illness, or incarceration) who cannot provide it for himself. Failure to provide medical attention for a dependent person whose physical condition is such as to show that he obviously needs it may amount to neglect. That judgement has been supplemented by later cases which include R (Clegg) v HM Coroner for Wiltshire 1997. In that case it was said that 'failure to provide appropriate medical attention to a dependent patient in hospital is capable of constituting neglect.'

32/ Both of these potential findings are serious conclusions. Mr Christopher Dorries in his text book, Coroners Courts 3rd edition, describes a finding of neglect as follows;- a conclusion incorporating neglect will have far reaching consequences; such a conclusion brings some element of censure , often of an organisation or person in authority. One fundamental distinction between them is that unlawful killing has to be upon a criminal standard , namely that I would have to satisfied so that I was sure, in other words beyond reasonable doubt. Neglect is upon the balance of probabilities. It should be noted that this inquest comes over two years after Harry's death. At no stage in a number of pre inquest reviews held either before my late involvement in this inquest or before my predecessor, HH Alan Blunsdon, a highly experienced former circuit judge, was any submission made that this inquest should be halted for any potential prosecution. The family were represented for a long time by a very experienced inquest practitioner. Had such a submission been made then consideration would have to have been taken as to whether to exercise to suspend the inquest investigation under paragraph 5 of schedule 1. Given the long passage of time since Harry's death no such decision would be taken lightly with the prospect of yet another long delay. The second distinction between unlawful killing and neglect is that with neglect it is possible to consider the position in the round rather than look at individuals or corporate bodies.

33/ The grounds upon which the submissions were made to me were much the same in both scenarios. In addition to the CTG interpretations, the delivery and the resuscitation they included complaints about the misuse, or otherwise, of guidelines and training. There was, said Ms McCleod, on behalf of the family, an underlying theme that guidelines were either incorrect or had not been properly followed in a number of important areas. There were also areas where training should have been carried out but had not been. There were also important periods in which the record keeping and time keeping were either inadequate or non existent. Guidelines are just that. They are in the words of one expert aspirations. They are not meant to be followed religiously. They are dependent upon the facts in each case. However if one strays from them one would expect to see an explanation why the guidelines has not been followed. An example of the problem with guidelines was that of Dr Waterstone who made it clear that he, as a very senior doctor, didn't like some of

the NICE guidelines and hoped the UK would move to the international guidelines. The NICE guidelines were he said widely open to interpretation. Dr Bokhari described simulation training as being an emerging field. Simulation training involves everyone practising together. Considerably more needs to be done by way of simulation training and team working to ensure that deaths such as Harry's are avoided in future. I note that now there are opportunities for doctors to obtain more specialised training at the William Harvey.

34/ I have considered the submissions made by Miss McCleod very carefully together with those of Miss Petts, Miss Misra and Mr Fortune. Ms McCleod set out a series of matters which she said, put together, are sufficient for me to be sure that the threshold for unlawful killing has been passed. Ms Misra referred to her namesake case of R v Misra where in another passage the court noted 'mistakes, even very serious mistakes, and errors of judgment, even very serious errors of judgment, are nowhere near enough for a crime as serious as manslaughter to be committed'. She submitted that there was no proper basis for a conclusion of unlawful killing. Mr Fortune went further and submitted that, certainly in respect of his client Ms Goumenou, that there was no basis for such a finding. Miss Petts for the Trust submitted that there is simply not enough evidence to consider such a conclusion.

35/ In respect of neglect Miss Petts for the Trust submitted that the failings in this inquest were not gross failings and/or that they were not causative of death.

36/ I have come to the conclusion that I do find, on the balance of probabilities, that there were such failures in Harry's case as to be categorised as gross for the meaning of neglect. He was in an almost acute position of dependency. There were a series of errors and failings made by a number of different people over a period of time. I do not, however, conclude so that I am sure to a criminal standard of proof that the shortfalls were so flagrant and so atrocious as to fall within the definition of unlawful killing as defined in the case law. If I had at any stage reached the conclusion that such a serious threshold had

been, or may have been passed, I would have considered suspending the inquest. A very high threshold is required. There is a substantial difference between the two standards of proof required. I do so having listened carefully to all the evidence over a 3 week period. There were clearly a number of failings in Harry's care and a number of errors of judgment, some of them serious errors, made by a number of different people some of whom lacked the requisite degree of experience for the position they were in. There were also failures in the manner of the recruitment of locums or the following of local or national guidelines, which were not always the same. One must, however, be very careful before reaching a conclusion of unlawful killing for all the reasons set out by Mr Justice Coulson in Cornish. This case in my judgment falls within the category set out by the Court of Appeal in Misra. I intend to set out the failings I regard as important in my formal conclusion.

CONCLUSION

Harry Richford was born by caesarean section at Queen Elizabeth the Queen Mother Hospital, Margate at 3.32 am on 2/11/17. He died on 9/11/17 at the William Harvey Hospital, Ashford. At the time of his birth he had been put under stress for some 10 hours due to the excessive use of syntocinon and the resulting hyperstimulation. It was a difficult caesarean section which followed preparations for a forceps delivery which didn't in fact take place. When born Harry was pale, floppy and apparently lifeless. There then followed a lengthy and unsuccessful attempt at resuscitation by a paediatric registrar and a team which only ended after 28 minutes when the anaesthetist left his mother to come to Harry's aid. Harry was taken to the William Harvey Hospital, Ashford where his condition deteriorated. Following an MRI scan and expert advice from an expert radiologist he died on the 9/11/17.

I find there were the following failures in the care of Harry Richford-

a) He was hyperstimulated by an excessive use of syntocinon over a period of approximately 10 hours

b) Once the CTG reading had become pathological by 2.00am Harry should have been delivered within 30 minutes and not 92 minutes later

c) The delivery itself was a difficult one. It should have been carried out by the consultant who should have attended considerably earlier than she did.

d) The locum on duty that night was relatively inexperienced. He was not properly assessed, if at all and should not have been put in the position of being in charge unsupervised.

e) There was a failure to secure an airway and achieve effective ventilation during the resuscitation attempts after birth leading to a prolonged period of postnatal hypoxia. The resuscitation afforded to Harry Richford failed to be of an appropriate standard.

f) There was a failure in not requesting consultant support earlier enough during the resuscitation attempts.

g) There was a failure to keep proper account of the time elapsing during the resuscitation attempts with the effect that control was lost.

Harry Richford's death was contributed to by neglect.
~~A rider of neglect is added in this inquest.~~

C J SUTTON-MATTOCKS

Assistant Coroner for the County of Kent