WORCESTERSHIRE CORONER AREA

PREVENTION OF FUTURE DEATHS REPORT
RHIAN EMMA KATE ROSE

HM ASSISTANT CORONER
NICHOLAS HAYWARD LANE

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1) Chief Executive, Worcestershire Acute Hospitals NHS Trust
1	CORONER I am Nicholas Hayward Lane, HM Assistant Coroner for Worcestershire
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 3 December 2019 an investigation was commenced into the death of Rhian Emma Kate Rose. The investigation concluded at the end of the inquest hearing on 21 October 2021 at Redditch Coroner's Court, in the Worcestershire Coroner Area. The conclusion (a 'narrative' conclusion in Box 4 of the Record of Inquest) was that Ms Rose's death was owing to *'medical complications following feticide.'*
4	CIRCUMSTANCES OF THE DEATH Rhian Rose was 28 weeks pregnant when she underwent genetic testing which discovered trisomy 21. At 31 weeks Rhian underwent feticide (on 22 November 2019 at the Birmingham Women's Hospital) and attended, as planned, the maternity unit of Worcestershire Royal Hospital (run by Worcestershire Acute Hospitals NHS Trust (WAHT)) for the second phase of medical termination of pregnancy on 24 November 2019. Rhian's became unwell during her stay in hospital, evidenced by observations taken between the evening of 24 November 2019 and the afternoon of 25 November 2019. The management plan was for Rhian to progress in labour and deliver vaginally, however Rhian's condition significantly deteriorated in the early evening on 25 November 2019. This resulted in unconsciousness, an emergency caesarean section and hysterectomy, with Rhian later going into cardiac arrest. Despite significant efforts of resuscitation and a number of returns of spontaneous circulation, Rhian could not be saved, and she died in the evening on 25 November 2019 at the Worcestershire Royal Hospital. A post-mortem examination revealed the following cause of death: 1a – multi organ failure 1b – sepsis 1c – feticide for trisomy 21 Box 3 of the Record of Inquest (which answered how, when and where Rhian came by her death) read as follows:

	'Rhian Rose underwent feticide on 22 November 2019 and was admitted to a maternity ward on 24 November 2019 for medical termination of pregnancy. By the evening of her admission, Rhian had clear symptoms of infection, however the sepsis pathway and antibiotics were not commenced until the following morning. Full consideration was not given as to whether an elective caesarean section would be the optimal mode of delivery to attempt infection source control. In the late afternoon on 25 November 2019 Rhian became acutely unwell resulting in unconsciousness, emergency caesarean section and subsequent cardiac arrest. Despite lengthy attempt at resuscitation, Rhian died at 21:06 hours on 25 November 2019 at the Worcestershire Royal Hospital.'
5	CORONER'S CONCERNS During the course of the investigation and 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) **Informed consent and maternal choice regarding mode of delivery –** I am concerned that enough emphasis is not being given to maternal wishes regarding mode of delivery. This issue appears to be a recurring theme in obstetric practice, and I am concerned that the culture in this area appears to still not fully accepting of the principles of informed consent set down in case law of the appeal courts *(Montgomery)* and in NICE guidance (Caesarean Section) and of facilitating the wishes of pregnant women and holding full and frank discussions about the risks and benefits and the pros and cons of the different options. I am concerned that situations might arise, like it appeared happened in Rhian's case, where maternal requests are being made for re-consideration of the mode of delivery owing to feelings of physical weakness, pain or developing ill health. Evidence heard at Rhian's inquest demonstrated that there was very little, if indeed any, recorded (in medical records) discussions held between midwives/obstetricians and Rhian regarding mode of delivery, maternal wishes and risk/benefits of differing management plans. 2) **Infection risk of retained foetus following feticide –** I am concerned that a significant infection risk (retention of a deceased foetus) is not being given due weight in clinical decisions when a mother is attending for delivery (following feticide). There does not appear to be any specific or detailed local, or indeed national, guidance, for obstetricians and midwives which addresses this issue or discusses important considerations such as whether infection can be controlled by antibiotics alone or whether swifter methods of foetal delivery, such as a caesarean section, should be considered, or indeed whether specific microbiology advice needs to be obtained as part of a multi-disciplinary team approach. Cases such as Rhian's may well be rare, however consideration could be given as to whether more detailed and specific guidance should be made available to assist clinicians when treating mothers in maternity units following feticide.
6	ACTION SHOULD BE TAKEN 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 **29 December 2021**. I, the coroner, may extend the period. If any request is to be made for this period to be extended, please ensure this is made in writing at least 7 days prior to the above required response date.

	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 family of Rhian Rose (as Interested Persons), via their legal team. I have also sent it to the following who may find it useful or of interest (although they may wish to confirm receipt or provide a response, they are under no legal obligation to do so): 1) Birmingham Women and Children's Hospital NHS Trust ('BWCH') 2) Royal College of Obstetricians and Gynaecologists ('RCOG') 3) Healthcare Safety Investigation Branch ('HSIB') 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	Date: 3 November 2021 Signature:  **Nicholas Hayward Lane** **HM Assistant Coroner for Worcestershire**