REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. The Chief Executive Nottingham University Hospitals NHS Trust ('The Trust')**
1	**CORONER** I am Dr Elizabeth Didcock, Assistant Coroner, for the coroner area of Nottinghamshire
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 the 19th July 2021, I commenced an investigation into the death of Quinn Lias Parker, born on the 14th July 2021, who died on 16th July 2021. The investigation continues and the case will come to Inquest in 2022, dates to be confirmed.
4	**CIRCUMSTANCES OF THE DEATH** Quinn was born in a very poor condition, and it was sadly clear within 1- 2 hours of his birth, that he remained extremely unwell, and there was a high probability that he would not survive. There were concerns raised by his parents at this early point, regarding the care provided by The Trust, in relation to the management of Emmie, his mother, in late pregnancy, and regarding the timing of Quinn's delivery. In the event of Quinn's death, it would therefore require referral to the coroner, and thought needed to be given to the preservation of the placenta, to ensure that it was available for examination as part of the Paediatric post mortem. In this case, the placenta was cut into/dissected after Quinn's death without discussion with the Coroner. This has affected the ability of the Paediatric Pathologist instructed by the Coroner, to determine the likely cause of Emmie's antepartum haemorrhage. Whilst the medical cause of Quinn's death will be explored in full at the Inquest, it is likely that the antepartum haemorrhage, and the underlying pathology causing it, is directly related to Quinn's death. It is not clear to me exactly how the placenta was cut into after Quinn's death without discussion with the Coroner - this will be fully explored at the Inquest, but what is clear is that the outcome has been highly detrimental to the independent investigation by the Coroner and other agencies investigating the circumstances of this case. This death follows a number of similar early neonatal deaths in Nottingham, where the placenta has not been retained, and therefore key information regarding placental pathology has been lost.
5	**CORONER'S CONCERNS** During the course of the investigation the evidence revealed matters giving rise to concern. If the coroner is inhibited from being in a position to confirm the cause of

	death of a baby, 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. The placenta, a key organ required for a full paediatric post mortem in an early neonatal death, has been interfered with such that the Paediatric Pathologist, is limited in his conclusion as to the likely cause of death. In some ways the placenta is akin to an organ for the purposes of a paediatric post mortem- Loss of an organ at any post mortem examination, may well undermine the ability of the pathologist to carry out a full and proper examination. Decisions surrounding interference with, or disposal of, the placenta should be made in a careful and considered manner, with thought given to an early discussion with the coroner as would happen if organ donation is being considered. This did not happen in this case. 2. Unfortunately, there have been a number of cases in Nottingham where the death of a baby shortly after the birth was anticipated, but the placenta was disposed of and/or interfered with prior to the death being reported to the coroner. This undermines the coronial investigation resulting in limited findings and therefore limited conclusions at inquest. This will likely lead to a lack of learning from such deaths, and therefore a risk that similar deaths will occur in the future. It may also deprive the parents of significant information when considering whether future pregnancies may be at greater risk with the consequent need for appropriate management and planning. 3. The Nottinghamshire Coronial service has to date worked collaboratively with all local Trusts, but particularly with NUH NHS Trust, to ensure key staff understand the importance of retaining the placenta in an early neonatal death. This has not led to the actions necessary to achieve a full and proper examination of the placenta in repeated paediatric post mortems in this jurisdiction.
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 the 16th December 2021. 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 of Quinn Parker The Healthcare Safety Investigation Branch The Care Quality Commission The Nottingham and Nottinghamshire Clinical Commissioning Group 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	**21st October 2021** **Dr E A Didcock**