The Inquest Touching the Death of Jesse Samuel Parsons
A Regulation 28 Report – Action to Prevent Future Deaths

THIS REPORT IS BEING SENT TO:

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- **NHS Fetal Anomaly Screening Programme**
- **UK National Screening Committee**
- **Royal College of Obstetricians and Gynaecologists**

CORONER
Dr Karen Henderson, HM Assistant Coroner for Surrey

CORONER'S LEGAL POWERS
I make this report under paragraph 7(1) of Schedule 5 to The Coroners and Justice Act 2009.

INVESTIGATION and INQUEST

On 14th July 2026 I resumed and concluded the inquest into the death of Jesse Samuel Parsons. At the time of his death Jesse was 3 days old.

The medical cause of death given was:

1a. Hypoxic Ischaemic Encephalopathy
1b. Vasa Praevia and Velamentous Cord Insertion

I found:

On the 26th July 2025 at the Royal Surrey County Hospital, Guildford, the mother of Jesse Samuel Parsons had an emergency lower segment caesarean section (LSCS) at 41+2 gestation, having had a low-risk pregnancy. This was due to sudden onset of vaginal bleeding at her home address earlier that morning. This was due to fetal bleeding as a consequence of Vasa Praevia in association with velamentous cord insertion, a rare but naturally occurring anatomical anomaly. Sadly, prior to delivery, Jesse had sustained a severe hypoxic ischaemic encephalopathy. Despite maximal intensive care support, he died at 00:13 hours on 30th July 2025 at St Peters hospital, Chertsey, having been transferred there for ongoing care.

CIRCUMSTANCES OF THE DEATH

Please see my findings above

CORONER'S CONCERNS

1. Placental cord insertion assessment at the routine 20 week anomaly ultrasound scan is not a mandatory requirement.

The mother of Jesse had an uncomplicated first pregnancy which was considered to be 'low-risk'. Her 20 week anomaly scan as well as other scans during the pregnancy did not indicate any difficulty of her wish to spontaneously go into labour and have a normal vaginal delivery.

I heard evidence that whilst Vasa Praevia was a rare but recognised anomaly it is possible to undertake a vaginal doppler ultrasound to confirm placental cord insertion. That this was routine practice in countries such as Australia and New Zealand with significant clinical benefit in terms of fetal survival.

Evidence was heard that it if this had been undertaken, a velamentous cord insertion would have been found. As it is a significant risk factor for Vasa Praevia, steps would have been taken to facilitate Jesse's delivery which would have prevented his death.

The last words of this PFD should go to the parents of Jesse – *'Jesse did not die because medicine lacked the ability to save him. He died because the opportunity to identify that he needed saving was missed'.*

The following references were provided by Jesse's parents:

Gross et al. (2021) - Systematic screening for vasa previa at the 20-week anomaly scan
This is the study demonstrating the 100% infant survival rate when routine screening was implemented. [redacted]

Ward et al. (2023) - Current practice of placental cord insertion documentation in Australia – A sonographer survey. This is the survey proving that roughly 90% of Australian sonographers already check the cord insertion site as standard protocol. [redacted]

Marr et al. (2013) - Vasa praevia: ultrasound diagnosis at the mid-trimester scan. Australasian Society for Ultrasound in Medicine noting that checking the insertion site adds virtually zero time to the 20-week scan and drastically drops mortality rates. [redacted]

Hasegawa et al. (2006) - Ultrasound diagnosis of velamentous umbilical cord insertion (Published as Velamentous cord insertion into the lower third of the uterus is associated with intrapartum fetal heart rate abnormalities).This is the widely cited baseline study proving that sonographers successfully identify the placental cord insertion site in over 97% of cases during the 18–22 week anatomy scan. [redacted]

YOUR RESPONSE
You are under a duty to respond to this report within 56 days of its date; I may extend that period on request.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for such action. Otherwise, you must explain why no action is proposed.

COPIES
I have sent a copy of this report to the following:

1. [redacted]
2. Medical Director, RSCH
3. [redacted] Consultant Obstetrician, RSCH

In addition to this report, I am 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 at the time of your response, about the release or the publication of your response by the Chief Coroner.

Signed:

Karen Henderson

DATED this 27th July 2026