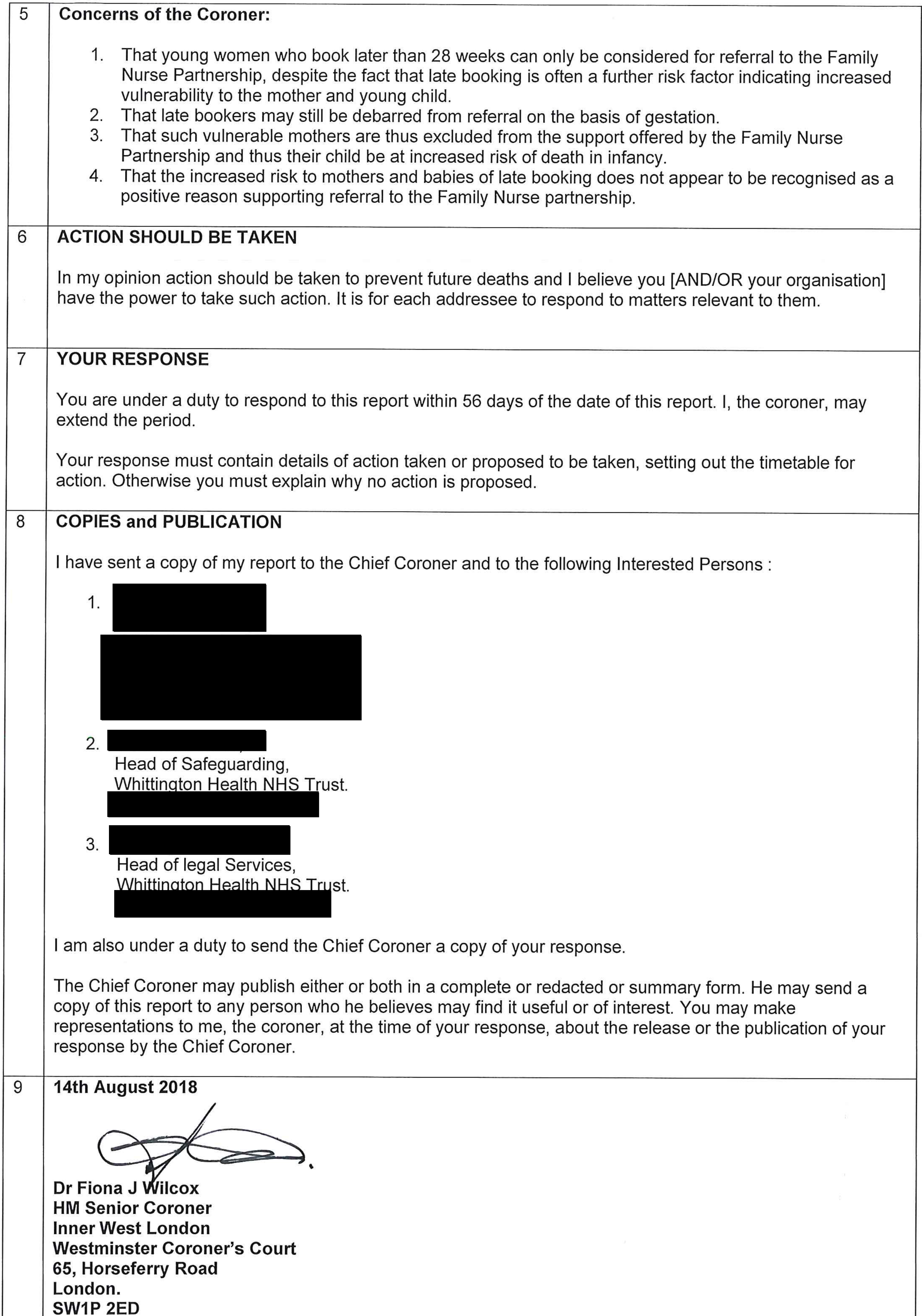
REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Ms Siobhan Harrington, Chief Executive, Whittington Health NHS Trust Magdala Avenue London N19 5NF [redacted]
1	**CORONER** I am Dr Fiona J Wilcox, HM Senior Coroner, for the Coroner Area of Inner West London
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 18th July 2018, evidence was heard touching the death of **Enric Albert Alejandro Elliott.** Enric had died on the 24th November 2017 in St Mary's Hospital after being found collapsed and then resuscitated at his home address on the 20th November 2018. He was just 5 months old at the time of his death. The findings of the court were as follows: **Medical Cause of Death** 1 (a) Diffuse hypoxic- ischaemic brain injury (aka hypoxic-ischaemic encephalopathy) (b) Sudden unexpected death in infancy **How, when and where the deceased came by his death:** On 20/11/2017, Enric was found not breathing by his mother at his home address. LAS was called and he was resuscitated at the scene. Return of spontaneous circulation was achieved and he was transferred to hospital. Despite all treatment he died on 24/11/2017 at St Mary's Hospital of brain injury due to the cardiac arrest. The cause of the initial arrest is unknown. He was well cared for and there were no suspicious circumstances. **Conclusion of the Coroner as to the death:** Natural Causes
4	**Circumstances of the Death.** Evidence taken at the inquest from Head of Safeguarding at Whittington Health was that Enric's mother had not been referred to Family Nurse Partnership because she had booked one week too late at 29 weeks gestation, referrals only being accepted until 28 weeks gestation, despite Enric's mother's young age and psychosocial vulnerabilities. If such a referral had been made it is likely that Enric's mother would have agreed and accepted the extensive support provided by the Family Nurse partnership. It could not be said that such support would have changed the outcome in this case and in fact Enric's mother was caring well for her child, despite her difficult circumstances. Since Enric's death the rules around gestation and referral have become more flexible and some mothers who book after 28 weeks may be referred.



5 Concerns of the Coroner:

1. That young women who book later than 28 weeks can only be considered for referral to the Family Nurse Partnership, despite the fact that late booking is often a further risk factor indicating increased vulnerability to the mother and young child.
2. That late bookers may still be debarred from referral on the basis of gestation.
3. That such vulnerable mothers are thus excluded from the support offered by the Family Nurse Partnership and thus their child be at increased risk of death in infancy.
4. That the increased risk to mothers and babies of late booking does not appear to be recognised as a positive reason supporting referral to the Family Nurse partnership.

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. It is for each addressee to respond to matters relevant to them.

7 YOUR RESPONSE

You are under a duty to respond to this report within 56 days of the date of this report. 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 :

1. [redacted]

2. [redacted]
Head of Safeguarding,
Whittington Health NHS Trust.

3. [redacted]
Head of legal Services,
Whittington Health 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 14th August 2018

Dr Fiona J Wilcox
HM Senior Coroner
Inner West London
Westminster Coroner's Court
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SW1P 2ED