REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. National Institute for Clinical Excellence ("NICE")
2. British Association of Perinatal Medicine ("BAPM")

1.	**CORONER** I am Miss Lorna Skinner QC, Assistant Coroner for the coroner area of Cambridgeshire and Peterborough.
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. Coroners and Justice Act 2009 (legislation.gov.uk) The Coroners (Investigations) Regulations 2013 (legislation.gov.uk)
3.	**INVESTIGATION and INQUEST** On 9 January 2020 I commenced an investigation into the death of Lola Sheldrake, also known as Lola Clarke, age 13 days. The investigation concluded at the end of the inquest on Wednesday 12 May 2021. The conclusion of the inquest was: **Medical Cause of Death** – 1a severe anaemia 1b haemolytic disease of the newborn 1c maternal anti-c antibodies **Conclusion** – From severe anaemia caused by haemolytic disease o the newborn and which developed untreated following her discharge from hospital on 14 December 2019. Lola's blood count was not checked on or before 20 December 2019, and she was not recalled to hospital for paediatric review on that date after concerns were raised by her health visitor about static weight, despite feeding well.
4.	**CIRCUMSTANCES OF THE DEATH** As noted above, Lola Sheldrake died from severe anaemia caused by haemolytic disease of the newborn and which developed untreated following her discharge from hospital aged 4 days on 14 December 2019. Her haemoglobin levels, tested on 11 December and 14 December 2019 were essentially normal, at 157 and 144. No reticulocyte count was taken. Information about her ongoing risk of developing

	severe anaemia and the signs and symptoms to look for was not conveyed to Lola's parents or to those with responsibility for her care in the community. In consequence it was not relayed back by the health visitor to the on-call paediatric registrar during a call made on 20 December 2019 to express concern about the fact that Lola's weight had remained static, equivalent to birthweight, for 3 days despite apparently feeding well. The facts that, following discharge: (1) Lola's blood count was not checked on or before 20 December 2019; and (2) Lola was not recalled to hospital for paediatric review on 20 December 2019 more than minimally contributed to her death and were therefore causative of it. Had either of these events occurred, Lola would have been diagnosed with significant anaemia, admitted and transfused before her condition became immediately life-threatening. By the time that her parents appreciated that Lola needed medical treatment, and brought her to the emergency department on 22 December 2019, her severe anaemia had caused damage to her organs such that it was not survivable. She died on 23 December 2019 at Hinchingbrooke Hospital, Huntingdon, Cambridgeshire.
5.	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. **The MATTERS OF CONCERN ARE** that there are no national guidelines in respect of the monitoring and treatment of infants at risk of haemolytic disease of the newborn/DCT positive infants and in particular no guidelines as to good practice following acute treatment immediately after birth and/or following discharge.
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 12 July 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, to the Child Death Overview Panel, Cambridgeshire & Peterborough Safeguarding Children Board and to the following Interested Persons: (1) [redacted] (2) [redacted] (3) North West Anglia NHS Foundation Trust (4) Cambridgeshire Community Services NHS Trust I have also sent a copy of my report to the following individuals who provided expert evidence to the inquest, and may find it useful or of interest: (1) Dr [redacted] (2) [redacted] (3) Dr [redacted] I am also under a duty to send a copy of your response to the Chief Coroner and all Interested Persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9.	 17 May 2021