Signed by Geoffrey Sullivan
Title HM Senior Coroner
Jurisdiction Hertfordshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Chief Executive, Medical Director, Clinical Director Paediatrics, East and North Hertfordshire NHS Trust**
1	**CORONER** Geoffrey Sullivan, HM Senior Coroner for **Hertfordshire**
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 10/04/2019 I commenced an investigation into the death of Tillie SPENCER-ADAMS. The investigation concluded at the end of the inquest 3rd September 2019. Medical cause of death: Unascertained Circumstances: On the 18th June 2018 at around 08:45hrs Tillie Spencer-Adams was found unresponsive by her mother next to her in bed. Tillie was lying on her back, on her mother's bed with her arms above her head, her lips were blue. An ambulance was called and paramedics attempted CPR at the scene. Tillie was then taken to Lister Hospital where advanced life support continued for around 30 minutes but Tillie could not be revived and her death was confirmed at 10:15hrs. In the period immediately preceding her death Tillie was co-sleeping with her mother. This is a recognised risk factor in infant death but it is not clear whether this caused the death. Conclusion: Sudden Unexpected Death in Infancy (SUDI)
4	**CIRCUMSTANCES OF THE DEATH** The matters outlined below were not found to have caused or contributed to the death but do give rise to the relevant concern. During the course of the investigation it was discovered that on 04/05/18 the mother was involved in a road traffic collision (no third party) and rolled the car, Tillie was in her car seat at the time. **Tillie was checked at Lister Hospital and no injuries were found apart from small mark on her clavicle from the seatbelt.** She was discharged the same day.

	The post mortem examination on 02/07/19 showed **Tillie had sustained fractures to the distal right radius and ulna.** Given their close proximity it is likely that these occurred together. In dating the fractures it is plausible that they happened as a result of the reported road traffic collision on 04/05/2018. **It is also likely that an old sub-scalp haemorrhage and the old subdural haemorrhage also relate to this road traffic collision.**
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 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) On the 4/5/18 the deceased attended the Lister Hospital following a road traffic collision in which she is likely to have suffered serious injuries (fractures and head injuries) which appear to have been overlooked.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you, Chief Executive, Nick Carver; Medical Director Michael Chilvers and Clinical Director Paediatrics, Amitabh Gite of East and North Hertfordshire NHS Trust 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 31 October 2019. 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: the LOCAL SAFEGUARDING BOARD (where the deceased was under 18)]. 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	05/09/2019 Signature_____ Geoffrey Sullivan HM Senior Coroner **Hertfordshire**