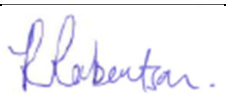
Kate Robertson
Senior Coroner for North West Wales

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** Betsi Cadwaladr University Health Board (BCUHB)
1	**CORONER** I am Kate Robertson, HM Senior Coroner for North West Wales
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 20 May 2024 I commenced an investigation into the death of Etta-Lili Stockwell-Parry (DOB 3/7/23) who passed away on 7 July 2023 (having received a transfer from the Coronial jurisdiction where Etta passed away). The investigation concluded at the end of the inquest on 20 May 2025. A narrative conclusion was recorded with the cause of death as:- 1a Hypoxic ischaemic encephalopathy Etta Lili Stockwell-Parry was born at 40+13 gestational weeks on 3 July 2023 at 00:51 at Ysbyty Gwynedd in poor condition following an instrumental assisted birth. Etta was transferred later that day to Arrowe Park Hospital, Liverpool for specialist neonatal support where she passed away on 7 July 2023 as a result of inutero compromise which led to the condition from which she died. There were several opportunities not taken by those caring for Etta's mother antenatally including at 40+1 gestational weeks and at 40+5 gestational weeks and at 40+12 gestational weeks to escalate from a midwife to a registrar due to static growth which would have led to induction of labour and likely safe delivery of Etta. There were opportunities to identify concerns with Etta through her mother on the midwifery led unit on 2 July 2023 including properly conducting holistic assessments, properly completing partogram and manual palpation of maternal pulse which would also likely have resulted in earlier detection of distress and successful delivery. Etta's death was contributed to by neglect.

4	**CIRCUMSTANCES OF THE DEATH** The circumstances of the death are as follows :- Etta was born in poor condition at Ysbyty Gwynedd on 3 July 2023 where her Mother's pregnancy was uneventful up until 21 June 2023 (40+1 gestational weeks). Static growth had not been identified by the community midwife at this time and therefore there was no referral to obstetrics. The static growth was not identified for a second time at 40+5 gestational weeks on 25 June 2023. Again, there was no referral to obstetrics. When Etta's mother was 40+12, on 2 July, she arrived at the Maternity Outpatient Assessment Unit for induction of labour. It was not noted that there was static growth. She ought to have been referred to the labour ward for close monitoring. Instead, she was induced. She received intermittent monitoring. The holistic assessments were not always completed and not entirely complete, the partogram did not note baseline fetal heart rate only as required, the maternal pulse was not always taken and recorded and there was no recognition that Etta's mother's pulse was being recorded as opposed to the fetal heart rate. There were several gross failures identified in Etta's mother's care which resulted in opportunities not taken to deliver Etta before she became distressed. Etta was transferred to Arrowe Park Hospital for specialist neonatal care where she passed away 4 days later. There were many incidences of learning from a neonatal perspective relating to Etta's resuscitation at Ysbyty Gwynedd.
5	**<u>CORONER'S CONCERNS</u>** 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 – The maternity and neonatal departments undertook an investigation into Etta's mother's care antenatally and after Etta's delivery. The concerns are as follows:- a. The neonatal investigation was not thorough. The investigator did not obtain or request statements from doctors directly involved in Etta's resuscitation, nor did they meet with them to understand what had occurred. The investigation was based on records alone. The records themselves, identified as part of the investigation, were often incomplete or included retrospective entries. Despite this, the investigator nor the panel involved considered speaking to or obtaining statements from crucial individuals.

	b. There was no sufficiently full contextual sharing of the investigation or its findings from a neonatal or maternity perspective. Some witnesses had only received and read the report several weeks prior to the Inquest. c. The memoranda sent to staff highlighting the learning did not include context or narrative around the circumstances of investigation. Therefore, those not directly involved would not have been fully aware of the context of what had occurred. Having issued Reports to the Health Board regarding quality of investigation previously, this concern remains. Specifically, I have concerns that the neonatal element of the investigation was not thorough enough such that without this genuine learning and change will not and cannot occur. Even where learning has been shared, I am concerned that this is not contextualised sufficiently. I am also concerned that staff not involved in the incident will not learn fully enough from events where there is inadequate sharing of learning from an incident.
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 16 July 2025. I, Kate Robertson, 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 Etta's family and to the Chief Coroner. 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	Dated 21 May 2025

	 Signature Kate Robertson HM Senior Coroner for North West Wales