GRAEME HUGHES

HIS MAJESTY'S SENIOR CORONER

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ANNEX A

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

*NOTE: This form is to be used **after** an inquest.*

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** [redacted], **Chief Executive of NICE**
1	**CORONER** I am **Rachel Knight H M Coroner**, for the coroner area of South Wales Central.
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 October 2022 I commenced an investigation into the death of Liliwen Iris THOMAS . The investigation concluded at the end of the inquest on 7th July 2025. The conclusion of the inquest was a narrative as follows: *Box 3:* *Liliwen Thomas's mother was admitted to the University Hospital of Wales for induction of labour on 8th October 2022 at 40+1 weeks. On 9th October she was given analgesia, Entonox and pethidine. Into the early hours of 10th October, Liliwen's mother was not attended to, or subjected to physical checks/examinations, regularly enough for her progress to active labour to be recognised. At 02:14 staff attended and found that Liliwen had been delivered unattended. Liliwen was in a very poor condition. She died at 22:40 the same day. A postmortem examination concluded that she died due to asphyxia around the time of her birth exacerbated by the presence of congenital infection and abnormal perfusion of the placenta of which there were no clinical indications identified before birth.* *Box 4:*

	Liliwen died from a hypoxic brain injury following an unattended delivery in hospital. This was contributed to by: *a. Her mother not being attended to as frequently, or subject to as regular physical checks/examinations, as she should have been and her progress to active labour not being recognised;* *b. The effects of maternal pethidine administered during labour;* *c. Liliwen's mother suffering an exaggerated pharmacological response to therapeutic doses of the drugs codeine and pethidine in combination with Entonox;* *d. The absence of resuscitation at birth;* *e. bacterial infection and malperfusion of the placenta.* Liliwen's cause of death was found to be: **1a Perinatal asphyxia** **1b congenital bacterial infection and maternal vascular malperfusion of the placenta** **1c** **II**
4	**CIRCUMSTANCES OF THE DEATH** The Inquest focused upon:- a. The learning from Liliwen's death, surrounding maternal analgesia during induction and labour; and b. Supervision of mothers being induced and/or labouring under analgesia
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. (1) Liliwen's mother was given unlimited Entonox, as well as routine doses of pethidine and codeine. The result was that she effectively became comatose for a period of time, during which she delivered Liliwen; (2) Cardiff & Vale Health Board have taken significant steps to significantly restrict the use of analgesia during induction and labour, including reductions of prescribed doses, allowing only limited access to analgesia on the wards and increased levels of supervision of mothers under analgesia;

	(3) They have seen an escalation in the numbers of women being transferred from the induction ward to the delivery suite as a consequence of reduced analgesia, which would otherwise have masked the transition to active labour; and (4) The current NICE guidelines on Induction of Labour and Intrapartum Care do not deal explicitly with analgesia levels and supervision.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and your organisation 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 3rd September 2025. 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 family as well as [redacted], Chief Executive of NHS Wales, who may find it useful or of interest, especially in terms of the learning and implications around analgesia use and supervision in induction and labour, and who may wish to consider wider dissemination across other Health Boards within Wales. 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	8 July 2025 **SIGNED:** RKnight Rachel Knight H M Coroner for South Wales Central Coroner Area