Great Western Hospitals
NHS Foundation Trust

The Great Western Hospital
Marlborough Road
Swindon
SN3 6BB

3rd November 2025

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Private and confidential
Robert Sowersby
Assistant Coroner for the Coroner Area of Avon

Dear Mr Sowersby,

Re: Coroner's Regulation 28 Report – Mabel Olivia Williams

We write in response to the Regulation 28 Prevention of Future Deaths Report, raising concerns about the circumstances which led to the tragic death of Mabel Olivia Williams. I would like to express my deepest condolences to Mabel's family and acknowledge the distress this process has caused.

Thank you for the clarity and detail of your report. We recognise the seriousness of the concerns you have raised and are committed to addressing them with the utmost care and diligence. Please find below a summary of the actions taken to date, alongside the improvements that are currently in progress and those planned for the near future.

In September 2023 a Patient Safety Review into Mabel's case was undertaken which reviewed the entirety of the care Becky and Mabel received to identify opportunities for learning. Mabel's birth was reported to the Maternity and Newborn Safety Investigation (MNSI) team for an external review, and eight safety recommendations were identified in February 2024. An improvement plan was developed based on these recommendations with a focus on addressing the actions identified.

Patient Information and Informed Consent

You identified that the Trust's patient information leaflets did not describe what a uterine rupture is, particularly in the context of VBAC (Vaginal Birth After Caesarean). You have found that this contributed to Becky not having enough information to give informed consent to a VBAC. You further noted that the Trust's processes for updating and distributing these leaflets were unclear.

Actions Taken:

The Trust has undertaken a comprehensive review of the "Birth After Previous Caesarean" patient information leaflet. The revised leaflet now provides a clear, accessible explanation of uterine rupture, including its potential severity and the associated risks to both mother and baby which includes the risk of the death of the baby.

This updated leaflet is now available to all clinical staff and is provided to women considering their birth options in addition to counselling in relation to these options. This is provided to women in the appointment when they meet their named Consultant to discuss the birth of their baby. The Trust places the utmost importance on delivering personalised care, ensuring that women and their families feel genuinely heard, respected, and supported throughout their care. Central to this commitment has been the development of a perinatal education programme, co-produced with our Maternity and Neonatal Voices Partnership, which emphasises the importance of actively listening to women. Through this collaborative approach, we ensure that all women receive clear, accessible, and comprehensible healthcare information as an essential part of the consent process.

As part of our ongoing commitment to quality and patient safety, the Trust has undertaken a comprehensive review of its procedures for the approval, distribution, and audit of all patient information leaflets. This initiative ensures that only the most current and formally approved versions are in circulation, and that these materials are easily accessible to both staff and patients. By strengthening these processes, we aim to support informed decision-making and enhance the overall patient experience. The Trust is prioritising moving to an online hosting system which will ensure that the public have access to all of the Trust patient information leaflets via the hospital website.

Timely changes in clinical practice

You raised concerns regarding the timeliness with which changes in clinical practice are implemented following serious incidents, and you have noted that this objective was not being achieved on the Trust's spreadsheet as to compliance with the Ockenden recommendations.

The Trust has provided a detailed update outlining its current position in relation to the Ockenden review, including the status of all Immediate and Essential Actions and projected completion dates. This was submitted within the designated timeframe following the inquest. It is noted that all the Red actions i.e. the urgent actions arising from the Ockenden report have already been completed by the Trust.

We fully acknowledge the importance of ensuring that learning from serious incidents is translated into practice both promptly and sustainably. To that end, we are undertaking a review of our governance processes to strengthen oversight and accountability for the implementation of learning and improvement actions.

Actions taken

In response to the concerns raised, a full review was undertaken of all outstanding actions from the Trust's serious incident investigations to fully establish the current compliance position and ensure that learning is being translated into meaningful and timely change. To support continued oversight, these actions are reviewed within our monthly Maternity Governance meetings, enabling senior leaders to monitor progress, escalate concerns, and ensure accountability.

To ensure that learning is not only captured but acted upon in a timely and sustained way, we have strengthened our internal systems for tracking and monitoring progress and this revised governance process will be fully embedded by December 2025. Outstanding actions from the Trust's serious incident investigations are now held within a centralised platform that supports teams with timely prompts and clear visibility of responsibilities. Colleagues across the organisation have been asked to contribute evidence of progress, reflecting our shared commitment to transparency and improvement. Weekly meetings with the Patient Quality,

Safety and Assurance team provide a dedicated space to review developments, address any barriers, and maintain collective momentum in delivering meaningful change.

The Trust has reflected deeply on the experience shared by the family, particularly their feeling of not being listened to and their concerns around the process of informed consent. We recognise the profound impact this has had and are committed to ensuring that every individual in our care feels heard, respected, and fully informed. We remain firmly committed to listening in a compassionate and comprehensive manner, ensuring that patients and families fully understand the care being proposed and feel supported throughout their journey.

The Trust is committed to ensuring that the lessons from this tragic case contribute to meaningful and lasting improvements in the safety and quality of our maternity and neonatal services.

Once again, I wish to extend my sincerest condolences to Mabel's family and to apologise unreservedly for the distress experienced.

Yours sincerely

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[redacted]
Chief Executive

Great Western Hospitals NHS Foundation Trust,
Royal United Hospitals Bath NHS Foundation Trust,
Salisbury NHS Foundation Trust

Copy to: Chief Coroner, [redacted] Care Quality Commission