	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The President Royal College Obstetricians and Gynaecologists (RCOG) 10-18 Union Street London SE1 1SZ
1	**CORONER** I am Robert Sowersby, assistant coroner for the coroner area of Avon
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 19 October 2023 I commenced an investigation into the death of Mabel Olivia Williams, who died when she was 6 days old. The investigation concluded at the end of the inquest on 15 August 2025. The medical cause of Mabel's death was 1a) Severe hypoxic ischaemic encephalopathy, 1b) Undiagnosed uterine rupture. Mabel's mother, [redacted] had previously given birth vaginally and later by caesarean section. During the period before Mabel's birth [redacted] preference was for vaginal birth, but she was particularly anxious about pregnancy and birth, fearful that she might lose Mabel, and keen to pursue the safest option she could for her unborn daughter. [redacted] was warned antenatally that if she trialed vaginal birth after caesarean section (VBAC) she might experience "*uterine rupture*" or "*uterine scar rupture*", but at no point was she told what that phrase actually meant, how severe rupture could be, or that it could carry with it the risk of death for her unborn child (or indeed for her). On 4 September 2023 Becky chose to undergo a trial of VBAC at the Great Western Hospital in Swindon. During VBAC she was induced, and in due course she was started on synthetic oxytocin without being counselled that this *further* increased the risk of uterine rupture. A number of further significant errors were made in [redacted] care and in due course she experienced progressive uterine rupture which caused increasing distress and ultimately a fatal hypoxic episode for Mabel, who was born alive but died 6 days later. My conclusion at the end of the inquest was that *"Mabel died because numerous indicators of her own distress, and of the increasing severity of her mother's clinical condition, went unrecognised by the midwifery staff involved in her care or were not conveyed to the clinical team in time to expedite her birth safely. Neglect contributed to Mabel's tragic death.*"

	I was also very concerned that appropriate steps had not been taken to ensure [redacted] understood the nature of one of the most significant risks of VBAC.
4	**CIRCUMSTANCES OF THE DEATH** The background to Mabel's fatal hypoxic injury is set out above. She sadly died 6 days later in the Neonatal Intensive Care Unit of a hospital in Bristol.

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 as follows. – When [redacted] was advised about VBAC she was referred to internal guidance from the hospital and to the RCOG's information leaflet "*Birth options after previous caesarean section*" (published in July 2016). I reviewed the information leaflet and it does not contain any indication that uterine rupture could potentially prove fatal for mother and / or baby. My concern is that prospective parents may rely on this information leaflet to assist them in making informed choices about their birth options, and that if the risk is not identified then other patients like Becky might pursue VBAC in circumstances where – if they had understood the risk better – they would have chosen otherwise.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you and/or 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 3 November 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 the Chief Coroner and to the following Interested Persons ([redacted], and the Great Western Hospitals NHS Foundation Trust). 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	[redacted] 8 September 2025