	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** The Chief Executive Great Western Hospitals NHS Trust Marlborough Road Swindon SN3 6BB
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, Becky, had previously given birth vaginally and later by caesarean section. During the period before Mabel's birth Becky's 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. Becky 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 Becky's 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 Becky 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 on 10 September 2023 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. – Background The Ockenden Report, which I was directed to in evidence, first published in 2020 a list of immediate and essential actions which included: '*all Trusts must ensure women have ready access to accurate information to enable their informed choice of intended place of birth and mode of birth, including maternal choice for caesarean delivery.*' The externally conducted HSIB report which looked into Mabel's death identified in February 2024 that the Trust's guidance for patients on '*Birth after caesarean*' did not describe what a uterine rupture is. That point was made in the context of Mabel's parents telling the HSIB investigation that they were not informed about the possible consequences of a uterine scar rupture, or that at their most severe those consequences could include the death of their baby. I found at the conclusion of Mabel's inquest that appropriate steps had not been taken to obtain Becky Williams' informed consent to VBAC, and the shortcomings of the Trust's patient information leaflets were part of what informed that finding. In advance of the inquest the Trust's legal representatives found it difficult to provide me with current copies of relevant patient information leaflets. When they were finally disclosed (on day 3 of the inquest) I found it hard to get a clear picture of whether the leaflets were or were not 'in force'. I heard evidence at one point from a member of trust staff that revised leaflets (which did contain a full explanation of uterine rupture) had been drafted but not signed off by the Trust for distribution to patients, much to the frustration of the maternity unit. I was also provided with an Excel spreadsheet after the inquest which contained, among other things, information about the Trust's compliance with various objectives relating to the Ockenden Review. The information in that spreadsheet included an indication that one of the Trust's objective was that "*Change in practice arising from an SI investigation must be seen within 6 months after the incident occurred*". The spreadsheet suggested that this objective was not being achieved. This would accord with my impression (which I would have reached irrespective of having sight of the spreadsheet) that much
	of the change that I was being shown following Mabel's death was coming very late, and as a response to the impending (or active) inquest, not as a result of learning from the tragic events in question. Specific concern That the Trust may not be making appropriate changes within a reasonable timeframe following serious clinical incidents.

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 5 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: Becky and Tom Williams. I have also sent it to the Care Quality Commission who may find it useful or of interest. 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	 10 September 2025