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:** **The Chief Executive of the Cwm Taf University Health Board**
1	**CORONER** I am David Regan, Assistant 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** A Coronial investigation was commenced on 16th January 2018 into the death of Calary Fern Davis. The Investigation concluded at the end of the inquest which I conducted on 6th – 8th February 2019. The conclusion was a narrative conclusion and the medical cause of death was 1a. Hypoxic Ischaemic encephalopathy
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- Calary Davis was delivered by emergency Caesarean Section on 31st December 2017. She had suffered a period of acute fetal bradycardia which caused hypoxic ischaemic encephalopathy resulting in very serious damage to her brain. Her mother, [redacted], had been admitted for induction on 28th December 2017, but that induction had not proceeded normally down the induction clinical pathway. [redacted] had received no planned obstetric review during the course of her admission, and no obstetrician had discussed her care with her. The Cwm Taf University Health Board accept that there were a number of shortcomings in her care. Had [redacted] proceeded to Artificial rupture of membranes in

	accordance with the appropriate clinical pathway, it is likely that Calary would not have suffered hypoxic ischaemic encephalopathy and would have survived. The narrative conclusion which I returned was: Calary Davis died as a result of hypoxic ischaemic encephalopathy which arose from fetal distress and bradycardia to which she was subject within the hour prior to emergency caesarean section. It is likely that she would have survived if, during her admission for induction, her mother had proceeded to Artificial rupture of membranes in good time in accordance with the appropriate clinical pathway. The Inquest focused upon:- a. The fact that [redacted] had received no planned obstetric review during her admission 28 – 31 December 2017 and had no clear care plan b. She spent an unacceptably lengthy period of time awaiting artificial rupture of membranes (ARM) c. There were opportunities for [redacted] to have been progressed down the induction pathway, which were missed. d. Calary Davis was an otherwise healthy baby who would have survived had her mother been treated in accordance with the induction pathway
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 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) The action plan annexed to the root cause analysis remained incomplete. It is understood that this arises in part from the merger of the maternity services of the Royal Glamorgan and the Prince Charles Hospitals. (2) It was accepted at Inquest that the merger of the maternity units of the two hospitals, while potentially creating a future single centre of expertise, does risk causing a period of institutional stress to maternity services which have exhibited some significant shortcomings. (3) There is a review of 43 such cases which was said to be considering them individually rather than analysing common themes and trends. (4) In [redacted]' case, proceeding to ARM would have been possible but there was a culture in the unit not to perform it at night (5) There was a reluctance from mid ranking midwife staff to challenge decisions made by the labour ward coordinators

	(6) Decisions by those coordinators were made without full information as to the clinical needs of the patients awaiting transfer to the labour ward (7) There was a poor standard of safety briefing, provision of information on patient handover and multi-disciplinary team assessment (8) There were insufficient staffing levels, despite which the escalation policy was not used. (9) There was a lack of band 7 midwife and obstetric team leadership.
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 10th April 2019. 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 who may find it useful or of interest. Health inspectorate Wales, Welsh Government, Medical Director of Cwm Taf University Health Board. 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	**11th February 2019** **SIGNED:** **D Regan** **Assistant Coroner** **(Electronic Signature)**