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 2nd July 2018 into the death of Jenson James Francis. The Investigation concluded at the end of the inquest which I conducted on 16th – 18th May 2019. The conclusion was a narrative conclusion and the medical cause of death was 1 (a) cardio pulmonary failure; 1(b) maternal sepsis, chorioamnionitis, and funisitis; 1(c) prolonged rupture of membranes
4	**CIRCUMSTANCES OF THE DEATH** These were recorded as :- Jenson James Francis was delivered by caesarean section on 21st June 2019. He developed chorioamnionitis and funisitis as a result of maternal sepsis. While the presence of maternal sepsis affecting his mother, [REDACTED] had been identified, there were failures on the part of the clinical care to identify that the CTG was abnormal or pathological from about 22.16 on 20th June 2018 or to arrange for urgent delivery by caesarean section. Thereafter, there was an absence of review by an obstetric doctor from 01.45 – 04.00 on 21st June 2018,

	when the sole available doctor was detained in theatre, and an absence of a jump call. Had [redacted] proceeded to caesarean section it is likely that Jenson James Francis would have been less exposed to maternal sepsis and survived. The narrative conclusion which I returned was: Jenson James Francis died of Cardio pulmonary failure as a result of a failure to deliver him in good time, exposing him to the effects of developing maternal sepsis The Inquest focused upon:- a. The failure of the obstetric and midwife staff properly to classify the CTG trace as abnormal, including deficiencies in their training b. A lack of medical cover on the labour ward while the only available doctor was detained in theatre c. Unclear leadership structure within the clinical team. d. Systemic failures within the maternity unit, with fragmented consultant cover, inadequate support for trainee and middle grade doctors, high usage of locum staff and the lack of awareness of guidelines, protocols, triggers and escalations.
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 root cause analysis characterises the presence of a "dysfunctional team without a clear leader." Evidence at the Inquest and in the report of the Royal College of Obstetricians and Gynaecologists dated 16th April 2019 identified a culture of unclear clinical leadership and a perceived inability on the part of more junior staff to challenge or review decisions. (2) There was a poor standard of CTG interpretation, with insufficient training and review (3) There was unclear communication as to whether a category 1 or 2 caesarean section was required. (4) NEWS charts and partograms were not completed, and there was a poor standard of record keeping. (5) There were insufficient staffing levels, and very high acuity, despite which there was no consultant attendance and the escalation policy was not used. There was evidence that there was no clear line of responsibility for identifying this and ameliorating it. (6) The recent merger of the maternity units of the Prince Charles and the

	Royal Glamorgan 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.
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 18th July 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	**17th May 2019** **SIGNED: D Regan (Electronic Signature)**