IN THE CORONERS COURT OF THE FALKLAND ISLANDS

CASE NO COR/04/23

27th February 2025

BEFORE

HIS MAJESTY'S CORONER

MALCOLM SIMMONS

In the Inquest Touching the Death of

Aspyn Dottie Hercules

Factual Findings and Conclusion

Foreward

Before I begin my findings and conclusions, I would like to express my sincere condolences on Aspyn's tragic death and I am sure that others in court would want to join me in that regard.

I would also like to acknowledge the dignity of Aspyns mother, Zoe Miller, and her father, Dameon Hercules throughout these proceedings, which I know must have been extraordinarily difficult for them.

I thank counsel for their hard work and assistance, which I have very much appreciated and which has enabled this inquest to run smoothly and effectively.

Interested Persons

Zoe Miller and Dameon Hercules represented by Mr. Daniel Paul, instructed by Waverley Law

Dr. Andrene Hamilton, represented by Mr. David Morris, instructed by Clyde & Co.

Dr. Rosasharn Browne, Mandy Heathman and the Falkland Islands Government, represented by Mr. Joseph Hart, instructed by the Attorney General of the Falkland Islands

Introduction

This was an inquest into the death of Aspyn Dottie Hercules. Aspyn was delivered on 20th October 2023 at the King Edward VII Memorial Hospital in Stanley, Falkland Islands. Aspyn died on 22nd October 2023 at the British Hospital, Montevideo, Uruguay. She was 41 hours old.

I have received and admitted oral and written witness evidence, and documentary evidence. Set out below are my findings and conclusion. My findings have been reached on a balance of probabilities.

In my Findings and Conclusion, I make reference to some of the evidence I have heard but it is not, and is not intended to be, a comprehensive review of all the evidence that was put before me. Rather, my intention is to explain, by reference to parts only of the evidence, why I have reached my findings of fact and conclusion.

In reaching my findings and conclusion, I have taken account of all the evidence I received, both oral, written and documentary. If a piece of evidence is not expressly mentioned, it does not mean that I have not considered and taken full account of it. Unless stated otherwise in my findings, I found the witnesses from whom I heard oral evidence to be truthful and doing their best to assist me. Therefore, my review of the evidence which is set out below can be taken as my findings as to what happened.

At the close of the evidence, I received written and oral legal submissions from the Interested Persons as to what I may or must record in the Record of Inquest. I have taken account of all submissions.

Review of Evidence and Findings of Fact

1. Zoe Miller was a generally fit and healthy 21-year-old. In February 2023, she and her partner, Dameon Hercules, discovered that Zoe was pregnant with their first child, Aspyn. This was her first pregnancy.
2. Zoe had an uncomplicated antenatal course and attended all antenatal appointments and scans at the King Edward VII Memorial Hospital ['KEMH'] in Stanley, Falkland Islands.
3. The KEMH does not employ full-time obstetricians. Pregnancy care is provided by a small team comprising two nurse-midwives supported by the resident medical officers. The team will usually include a GP with additional postgraduate training in obstetrics, certified by a recognised diploma.
4. Zoe's midwife was Mandy Heathman. Zoe saw Mrs. Heathman for the majority of her antenatal appointments.
5. Antenatal care and the local protocol are generally based on NICE Guidance. Women are risk-assessed in early pregnancy. If risk factors are identified, plans are made for delivery in the UK (and elsewhere) with the aim of leaving the Falkland Islands before 36 weeks' gestation.
6. At 7 weeks, as a result of abdominal pain, Zoe had her first ultrasound scan at the KEMH. The scan confirmed a viable intrauterine pregnancy.
7. Zoe's next scan was at 12 weeks and 6 days gestation and was reported as normal. Zoe was offered and accepted a non-invasive pre-natal test for detection of common chromosomal conditions and this was normal.
8. Zoe's estimated due date was 12th October 2023.

9. Zoe had a routine antenatal visit at 15 weeks gestation. She underwent an anomaly scan at 19 weeks and 4 days gestation which was again reported as normal with an anterior placenta noted.
10. She was again seen at 24 weeks and 6 days, 28 weeks, and 30 weeks for antenatal review. On each occasion symphysial fundal height was said to be consistent with gestational age. However, ultrasound reports were incomplete with respect to routine measurements provided and plotted graphs were absent. Importantly, abdominal circumference was not measured. Abdominal circumference is the most sensitive measurement for assessing fetal weight and any intrauterine growth restriction.
11. At 32 weeks gestation, a scan report confirmed normal growth. Zoe and Dameon both said in evidence that, following that scan, they were told Aspyn's estimated weight was 7-8 lbs (3.17kg – 3.63 kg). At that stage, the pregnancy was proceeding normally.
12. Aspyns birth weight was an important issue. A small-for-gestational-age baby may develop placental insufficiency/reduced placental reserve that could become an issue during labour. If detected, labour might be managed differently.
13. When Aspyn was delivered at 41 weeks gestation, her estimated birthweight was 3.28kg. Upon arrival at the British Hospital in Uruguay, her weight was recorded as 2.900kg.
14. If Aspyns birthweight was 3.28kg, that would be normal for her gestational age. If, however, her birthweight was 2.900kg, that would mean she was small for gestational age. Dr. Stone, who co-authored the External Review of the Early Neonatal Death, Significant Event Analysis with Heather Woods, opined that changes in the placenta that were noted in the placental histology report might be suggestive of reduced gestational growth.
15. However, because Aspyn's true birthweight is unclear, any conclusions that might be drawn would be speculative.

16. At 34 weeks and 6 days gestation, birth options were discussed with Zoe at her antenatal appointment, including the options available for pain-relief during labour. She was made aware that an epidural anaesthetic was not available at the KEMH. Zoe wanted a natural birth but would consent to a caesarean if medically required.
17. At 38 weeks and 6 days gestation, Zoe was again reviewed. Fetal movements were noted to be normal.
18. A similar clinical picture was seen at 40 weeks gestation. No abnormalities were noted and the pregnancy was proceeding normally.
19. On 18th October 2023, one week past her estimated due date, abdominal palpation was reported as cephalic with head engaged and back on left. Following that examination, plans were made for labour to be induced the following day.
20. Aspyn was in good condition when Zoe arrived at the KEMH at 0830 on 19th October 2023 for labour to be induced. At that time, she reported contractions at a rate of 1 in 6 minutes. Observations prior to induction were normal.
21. On vaginal examination, the cervix was closed, and 2 cm long. Prostin gel 2mg was inserted vaginally. Although Prostin was prescribed by a doctor, she was not seen and assessed by a doctor at that time. Zoe was allowed home, with a plan to return at 1430 the same day.
22. On her return at 1430, Zoe reported severe period-like pain. She was seen to be contracting irregularly. Although she managed to eat a food bar, she found eating and drinking difficult. Observations were again reported to be normal.
23. Prostin gel1mg was again inserted and Zoe was sent home.
24. At 1900 the same day, Zoe re-presented with painful contractions every 2 minutes. Aspyn was active. Zoe was observed to be in pain. Fetal heart rate was recorded as 140 bpm. On examination, the cervix was now 1cm dilated.

25. When assessing the readiness of the cervix for induction of labor, midwives will often use the Bishop Score.
26. In her evidence, Ms Woods opined an amniotomy could have been performed at 1900 when, on her calculation, the Bishop score was 6. It is not known why the membranes were not ruptured at that stage.
27. I recognise that the Bishop score is but one consideration when deciding whether to perform an amniotomy.
28. At 2030, Zoe was still in pain but the contractions were less frequent. The fetal heart rate was noted to have dropped to 128 bpm.
29. At 2244, a cardiotocograph trace ("CTG") used to monitor and record the unborn babys heart rate pattern in order to assess their wellbeing, was normal, with baseline rate 125 bpm. The tocograph showed irregular contractions at rate of 4-6 in 10.
30. At 2353, a vaginal examination was performed. The fetal heart rate was 130 bpm.
31. Ms. Woods thought an amniotomy could have been performed then. Again, it is not known why it was not done.
32. An amniotomy at 1900 or 2353 on 19th October might have advanced labour.
33. At 0123 on 20th October 2023, 20mg Oramorph was administered to help Zoe with the pain of the contractions.
34. Fetal heart rate was fairly constant at 130 bpm between 2353 on 19th October and 0700 on 20th October.
35. At 0730, the fetal heart rate was 120 bpm, with irregular longer contractions seen on tocograph at a rate of 2-3 in 10.
36. At 0800, a vaginal examination showed a posterior cervix, 0.5cm long, effaced and 1-2cm dilated.
37. Zoe and Dameon both gave evidence that Mrs. Heathman examined Zoe and that it appeared she was preparing to rupture the membrane. Both were surprised when Mrs.

Heathman chose instead to administer a further dose of Prostin. It appears Mrs. Heathman felt 'the head was high and not a good fit'. Ms. Woods said in evidence that it was unclear what was meant by that, although it was accepted that the baby may have moved and that had presented potential difficulties.

38. Dr. Stone said in her evidence that a rupture of the membranes might, nevertheless, have been achievable using a "stabilising induction". However, she accepted that was, ultimately, a decision for the midwife.

39. Following the further dose of Prostin at 0810, the CTG was recommenced until 0910. The fetal heart rate was reported as normal.

40. Zoe progressed to active labour between 0900 and 1040.

41. Dr. Stone opined the membranes should have been ruptured at 0900. Although she thought an amniotomy could have been performed in the evening of 19th October, she acknowledged that might present challenges overnight if, for example, theatre staff were required and not available.

42. At 1000, Zoe reported painful contractions at a rate of 3 in 10. The fetal heart rate was 136 bpm.

43. At 1030, contractions were at a rate of 3 in 10. The fetal heart rate was125 bpm.

44. At 1043, Zoe was standing when Mrs. Heathman noted the fetal heart rate had dropped to 70 bpm, rising to 136 bpm.

45. A further deceleration to 83 bpm at 1045 precipitated a request by Mrs. Heathman for Zoe to move to the bed for a further assessment. While Mrs. Heathman accepted the CTG trace was non-reassuring, she was also of the opinion that it should not be assessed in isolation.

46. At 1049, Mrs. Heathman asked Dr. Rosasharn Browne to review Zoe.

47. At 1051, the CTG showed a 2-minute deceleration of the fetal heart rate to 90 bpm returning to a baseline rate of 130 bpm with ongoing good variability about the baseline.

48. Dr. Browne noted that Zoe was well and observed a further shallow deceleration of the fetal heart rate at 1058, returning to baseline rate of 140 bpm.

49. At approximately 1105, Dr. Browne spoke with Dr. Andrene Hamilton, a visiting consultant gynaecologist/obstetrician who was in the next room performing a colposcopy clinic.

50. Dr. Hamilton attended upon Zoe. Mrs. Heathman was not present, having gone to get pethidine.

51. Dr. Browne gave a clinical summary to Dr. Hamilton.

52. Dr. Hamilton did not think the trace was normal and would require further monitoring. In her opinion, the trace demonstrated the baby was coping well with the stresses of labour. She advised that CTG monitoring should continue, with her reviewing Zoe in one hour, upon completion of her clinic.

53. Dr. Hamilton did not think a caesarean was required at that stage. In her opinion, decelerations of the fetal heart rate do not automatically mean proceeding to a caesarean. She referred to the low threshold on the Falkland Islands for proceeding to do caesarians. As I understood it, hers was a more nuanced approach.

54. Dr. Stone accepted that a caesarean presented significant risks for the mother but the risks for the baby were less serious. In her opinion, if a caesarean is called earlier, it is more likely to be a category 2, than a category 1.

55. Dr. Browne said in evidence that she recounted her conversation with Dr. Hamilton to Mrs. Heathman. Mrs. Heathman said in evidence that Dr. Browne told her CTG's were now interpreted differently and that the fetal heart rate was "within normal limits" and that they had been interpreting the CTG's incorrectly. She said she might

have been told to continue monitoring the CTG but she could not recall. She said she would have continued monitoring in any event.

56. Mrs. Heathman said that she relied upon what she was being told. However, rather than being reassured, she said she continued to have "*enormous concerns*" because she felt they should be proceeding to a caesarean section.

57. Dr. Browne said in evidence that, had Dr. Hamilton not been there, she would have probably advised a caesarean at that time. However, she said she was following the instructions of a senior, and more experienced, colleague.

58. Dr. Browne said it was her understanding that Dr. Hamilton was now involved and that she was overseeing the patient. Dr. Hamilton agreed that she was involved and said she expected more junior doctors to follow her advice.

59. At 1113, there was a more prolonged deceleration of the fetal heart rate to 60 bpm lasting 3-4 minutes. On the evidence, I am in no doubt that deceleration was pathological. Mrs. Heathman was concerned and requested a further review by Dr. Browne.

60. Dr. Stone and Ms Woods said in evidence that the deceleration at 1113 was the time when a caesarean should have been considered.

61. At 1118, Dr. Browne tore off the CTG printout and left the room to discuss with Dr. Hamilton. Dr. Browne said in evidence that at that moment she was expecting a ceasarian to be called.

62. Dr. Browne spoke with Dr. Hamilton in the corridor. Mrs. Heathman was not present.

63. Dr. Hamilton said in evidence the deceleration that was observed at 1113 was completely different to the previous decelerations and was pathological in nature. However, two minutes later, the fetal heart rate had returned to its previous level. She thought this indicated Aspyn had had a significant stress but had coped well. In her view, a pathological deceleration does not automatically mean a caesarian.

64. Dr. Hamilton said that, at that time, she was considering possible explanations for the changes in the fetal heart rate including the possibility the CTG was now picking-up the maternal heart rate, before reverting to the fetal heart rate; that the baby might have pressed on the cord and the possibility the baby was pressing on the cord, that it was trapped and would continue. In her view, if either of the first two possibilities, it would not be reasonable to proceed with a caesarean. If it proved to be the third possibility, that would be revealed by further monitoring the trace.

65. Dr. Hamilton said it was her advice that, if it was the third possibility, that would be significant and necessitate a caesarean. She said that, although the baby was 'coping' and responding to conservative measures, it was an insult she would not want repeated.

66. Dr. Hamilton advised to continue monitoring the CTG and any further deceleration escalated to her. Dr. Hamilton said she was satisfied that Dr. Browne had understood that a further deceleration would require action.

67. Dr. Stone said she thought that was a reasonable approach. However, she thought Dr. Hamilton lacked what she described as 'situational awareness'.

68. In her evidence, Ms Woods agreed that, although the deceleration at 1113 was longer and deeper, Aspyn had recovered well. She agreed that the NICE guidelines suggested adopting a conservative approach. Although Ms Woods opined that best practice is to review a CTG in the room with all those involved in the care of the mother in order to have a more holistic assessment, she did not disagree with the decision of Dr. Hamilton to continue monitoring and report any further decelerations. In her opinion, that advice would have been a "satisfactory" response.

69. I accept that, although Dr. Browne was a GP, she had substantial obstetrics experience and Dr. Hamilton appeared to have confidence in Dr. Browne to ensure her

instructions were carried out, particularly as she was in the middle of a colposcopy clinic.

70. Dr. Browne said in evidence that, in respect of both discussions with Dr. Hamilton, the latter's explanation for the decelerations made sense and that she felt reassured. In her evidence, Dr. Browne said Dr. Hamilton did not say the deceleration was concerning. She said the plan was to continue monitoring and that she would review at the end of the clinic. Dr. Browne added: "…she did reiterate that if anything changes please do come and let me know." Dr. Browne accepted that Dr. Hamilton had told her that if there were any abnormal traces to escalate it to her.

71. Dr. Browne said she relayed to Mrs. Heathman her conversation with Dr. Hamilton. She said she informed Mrs. Heathman that she should continuously monitor the fetal heart rate and to contact her should there be any further abnormalities. In answer to a question from Mr. Hart, Dr. Browne said she could not recall the exact words she had used but that the message she had delivered to Mrs. Heathman was that "if she was concerned about the patient or there were changes in the CTG that she was concerned about…" to contact her and she would immediately return. That is not the same as telling Mrs. Heathman to contact her immediately should there be a further deceleration. While I accept that Mrs. Heathman had contacted Dr. Browne on two previous occasions following decelerations, as accepted by Dr. Browne, on both occasions, Mrs. Heathman had been told the decelerations were not abnormal.

72. In her evidence, Mrs. Heathman said that Dr. Browne told her that they should continue monitoring and that "they were going to come back and review it." She said in evidence that she was not told that if the heart rate dropped that immediate action would be required. She could not recall being told by Dr. Browne to contact her should there be a further deceleration, although she said she knew she could ask for advice.

73. Given the significance of the deceleration at 1113, and the advice of Dr. Hamilton, there should have been no ambiguity about precisely what was expected in the event of a further deceleration.

74. Indeed, Dr. Browne accepted this was a 'high risk' situation. It follows that there was a need for caution.

75. One enduring theme is the apparent failure to communicate in a meaningful way with Zoe and Dameon and to include them in decision-making processes. Zoe and Dameon were unaware of the number of decelerations or their significance. They were not included in the decision-making process. Zoe had stated during the antenatal stages of her pregnancy that, while her preference was for a natural birth, she was willing to have a caesarean, if required for medical reasons. The subsequent management of labour, including the possibility of a caesarean, should have been discussed with them. It was not.

76. At 1123 the CTG showed a further deep prolonged deceleration to a rate of 60 bpm with a slower recovery to a higher baseline rate of 150 bpm with now reduced variability about the baseline.

77. Nine minutes later, at 1132, another deep deceleration occurred with a more prolonged and slower recovery to baseline rate 150 bpm.

78. Mrs. Heathman said she was in the room "for most of the time" and had seen two decelerations. She understood that the purpose of CTG monitoring was to identify potential problems and to act upon them. However, she said she did not alert Dr. Browne because she had been told that "it was not unusual…it was a different way of managing CTG's…and that it was fine". It was her understanding, based upon what she said she had been told by Dr. Browne, that what she was observing was "normal".

79. At 1145, there was a further deceleration to 50 bpm.

80. The neonatologist, Professor Mitchell, believed the most likely explanation for the decelerations was cord compression.

81. Had Dr. Browne been alerted at 1123, the decision would have been made then to perform a caesarean.

82. Mrs. Heathman did alert Dr. Browne at 1151, whereupon Dr. Browne attended and then immediately went to get Dr. Hamilton. It was Dr. Hamiltons recollection that Dr. Browne had a section of the CTG trace in her hand. Dr. Hamilton described Dr. Browne being apologetic and saying words to the effect "*I have only just been called. I am sorry.*"

83. Dr. Hamilton said that she would have expected help would have been sought urgently after a further deceleration lasting 3 minutes. Failing this, she would have expected an emergency call to have been instigated when the second deceleration lasted longer than 3 minutes.

84. On the evidence, there was miscommunication of the instructions of Dr. Hamilton, through Dr. Browne to Mrs. Heathman regarding management of an abnormal CTG and the significance of immediately reporting a deceleration of the fetal heart rate. The advice of Dr. Hamilton was clear and understood by Dr. Browne: further decelerations were to be escalated to Dr. Hamilton. This, perhaps, highlights the importance of midwives being included in discussions between doctors.

85. This miscommunication resulted in Mrs. Heathman not alerting Dr. Browne to the subsequent decelerations. Had Dr. Hamilton been alerted, a caesarean would have been performed at that time and Aspyn would have survived.

86. At 1200, Dr. Hamilton performed an artificial rupturing of the membranes which revealed clear amniotic fluid. However, fetal scalp stimulation did not elicit an accelerated response on the CTG.

87. There is no discernible CTG trace after 1157. Dr. Hamilton did make a retrospective note referring to a continuing fetal heart rate, stating "*some recovery to baseline – 120 bpm but majority of the time at 80 bpm*"

88. At 1202 Dr. Hamilton advised that Aspyn should be delivered by caesarean. Dr. Hamilton said she did not indicate a particular categorization of caesarean. She said she believed the urgency of the situation was understood. In evidence she said she knew the baby needed to be delivered quickly, adding that "*every minute, every second counted.*"

89. Dr. Browne said Dr. Hamilton declined to perform the caesarean and suggested this should be done by the staff surgeon. Dr. Hamilton said a safe Caesarean section would have needed the attendance of the anaesthetist, anaesthetic assistant, scrub nurse and operating doctor before proceeding. In any event, it is clear that Dr. Hamilton could not proceed with the operation without the anaesthetist, who at that time was not at the KEMH.

90. The operating theatre was not immediately ready. The surgical team were not aware of the possibility of a caesarean and had, it appears, gone to lunch.

91. Dr. Hamilton accepted that the theatre should have been put on notice at 1120. I would agree. At 1120 there was at least the possibility of a caesarean becoming necessary.

92. Dr. Browne contacted the surgeon, Dr. Cole and the anaesthetist, Dr. Oliver, neither of whom was in the KEMH.

93. The surgeon, Dr. Cole said he was at home when he was contacted at 1210. Dr. Oliver said he was contacted at about "midday".

94. Dr. Oliver said he was informed it was a Category 1 caesarian. The Operating Department Practitioner, David Ashbridge, said he was informed by Dr. Browne at 1205 of a "*crash*" caesarean. There was no doubt they all understood the urgency of the situation.

95. Dr. Oliver returned to the hospital at about 1215-1220 whereupon Dr. Hamilton had discussed with him the type of anaesthetic.

96. David Ashbridge, the Operating Department Practioner who had been alerted by Dr. Browne, requested Zoe was not brought to the operating theatre until they were ready to start. When he gave evidence, he was asked how the fact the theatre was ready would be communicated to ward staff. He said this was done "based on previous experience."

97. Mrs. Heathman described seeing Mr. Ashbridge on the ward. In evidence she said Mr. Ashbridge had told her "we will come and get her." Mr. Ashbridge could not recall speaking with Mrs. Heathman. Mrs. Heathman expected a member of the theatre team to collect Zoe when the theatre was ready.

98. The theatre manager, Eric Black, said he understood the urgency. He said the theatre was ready within 5-10 minutes. It was standard practice for the Operating Department Technician to go to the ward to get the patient. He said the theatre was ready and waiting for 25 minutes.

99. Mr. Ashbridge said the theatre was ready at 1210 and that he informed ward staff. He said he twice returned to the ward because Zoe had not arrived in theatre. He said that when he went to the ward, the door to the delivery room was closed and he could hear voices inside. He said he did not knock on the door of the delivery room because he thought it might be "distracting" for the doctor. While I accept that patient privacy might be an issue, given the obvious urgency of the situation and the fact Dr. Browne and Mrs Heathman had both been told not to take Zoe to theatre until they were ready to receive her, I do not understand why Mr. Ashbridge did not knock on the door to alert them particularly given that, on his evidence, he had gone to the ward three times.

100. Zoe left the delivery room at about 1223, her bed being wheeled to theatre, a journey Mrs. Heathman estimated would take approximately 1 minute.

101. Had the theatre team be made aware at 1120 of the possibility of a caesarean, critical time would have been saved. That delay was compounded by the delay getting Zoe to theatre.

102. I find that, but for those failures, Aspyn would have been delivered at least 15 minutes earlier, thereby avoiding a significant component of the hypoxic-ischaemic insult and would have survived.

103. It was agreed that Dr. Hamilton would perform the operation. At 1243, following induction of general anaesthesia, the Cesaerian was commenced. Aspyn was delivered at 1245. She was in poor condition with no respiratory effort.

104. Resuscitation of Aspyn was led by Dr. Hayton. Telephone advice was received from the on-call neonatology team of the John Radcliffe Hospital, Oxford. CPR was initiated with a heart rate detected at the 10th minute but without any respiratory effort. Aspyn required endotracheal intubation and assisted ventilation. Failed initial attempts at placing an umbilical catheter prompted intra-osseus access and fluids and antibiotics were administered on advice from the Oxford neonatology team.

105. On balance of probabilities, effective ventilation was given.

106. No obvious cause for the fetal distress was noted during the operation. The placenta was removed and sent for histopathological examination. The caesarian was uncomplicated and completed following closure of uterus, rectus sheath and skin.

107. At 1600 Zoe and Aspyn were prepared for transfer to the British Hospital in Montevideo, Uruguay.

108. During the transfer Aspyn suffered seizures and received two IV bolus injections of midazolam.

109. During the transfer it appears the endotracheal tube had been removed although it is unclear if this was planned or if the tube had been displaced. An umbilical venous catheter was also noted to have been "lost" during transfer.

110. On arrival at the British Hospital in Montevideo at 2310, Aspyn was reintubated. Her weight was recorded as 2.900 kg.

111. A full examination, investigations and subsequent events concluded a clinical diagnosis of severe hypoxic-ischaemic encephalopathy with seizures in the first 12 hours of life.

112. Despite active management, Aspyn developed a worsening severe acidosis with rising lactate, anuria, multi-organ failure, disseminated intravascular coagulopathy, haemorrhages, acute anaemia, and cerebral oedema with bilateral ventricular haemorrhages grade II.

113. A cranial ultrasound was reported to show "severe brain swelling with bilateral [intraventricular haemorrhage] grade 2".

114. Aspyn died at 0545 on 22nd October 2023 in the British Hospital, Montevideo, Uruguay. The cause of death was stated as Birth asphyxia, Hypoxic ischaemic syndrome and multisystemic compromise.

115. Professor Mitchell described Aspyns clinical course during the newborn period being consistent with severe hypoxic-ischaemic encephalopathy following severe hypoxic-ischaemic insult around the time of birth. In his opinion, the more appropriate cause of death was 1a Hypoxic-Ischaemic encephalopathy, 1b Perinatal asphyxia. I agree that is the more appropriate medical cause of death.

116. The placenta showed evidence of low-grade chronic damage, with excess perivillous fibrin and entrapped necrotic villi. While this may have reflected some developing placental insufficiency, I accept the opinion of Professor Mitchell that

there was nothing in the placental histology that would have been likely to give rise to severe, acute hypoxic-ischaemic insult in early labour.

117. Having reviewed all the evidence, I find that Aspyn is likely to have suffered a severe hypoxic-ischaemic injury due to cord compression. This began with episodes of intermittent cord compression and recovery as depicted in the fetal heart rate decelerations that commenced at about 1045, followed by an acute period of cord compression. Those decelerations were heralded by earlier decelerations.

118. Following the pathological deceleration at 1113, there was a failure to provide medical intervention at 1123, that continued until 1151. It was obvious from the CTG trace that Aspyn was in distress and basic medical intervention was required.

119. The theatre team were not put on notice at 1120 of the possibility of a caesarean section. Had they been put on notice, critical time would have been saved.

120. The decision having been made at 1202 to perform a caesarean, there was a further, entirely avoidable delay transferring Zoe to theatre, that constituted a failure to provide medical intervention.

121. In respect of each of the substantial failures to which I refer, there was an opportunity to provide care that would have prevented Aspyns death, such that I find there was a clear and direct causal connection between the conduct described and the cause of Aspyns death.

122. I ask myself whether these failures to provide medical intervention were a gross failure thereby enabling the 'neglect' rider to be added to a narrative conclusion.

123. 'Neglect' is defined in R v HM Coroner for North Humberside and Scunthorpe, exp Jamieson [1995] QB1 in this way:

"Neglect in this context means a gross failure to provide adequate nourishment or liquid or provide or procure basic medical attention or shelter or warmth for someone in a dependent position (because of youth, age, illness or incarceration) who cannot provide it for himself. Failure to provide medical attention for a dependent person whose position is such as to show that he obviously needs it may amount to neglect. "

124. I heard submissions from counsel on 'neglect' that I have carefully considered and taken into account.

125. I accept that 'neglect' is distinct from common law negligence.

126. This was not a case of poor clinical judgement or clinical judgement being badly exercised. This case was about a gross failure to provide *basic* medical attention.

127. There is no doubt that Aspyn was in a position of dependence.

128. It is clear that 'neglect' refers to the grossness of the act or omission in question, rather than the outcome. I have considered very carefully the failures and whether, or to what extent, they might be classified as significant and serious. I have come to the very clear conclusion that they were. The need for basic medical attention was obvious. The failures to provide basic medical attention were so serious and fundamental to Aspyns safety and wellbeing that it is my finding they were 'gross'.

129. Aspyns death was preventable.

Legal Submissions

The applicability of Article 2 of the European Convention of Human Rights was raised by Mr. Paul on behalf of Aspyns parents.

Article 2 of the European Convention of Human Rights (ECHR) provides:

> *"1. Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which the penalty is provided by law."*

The European Court of Human Rights has held, in a series of cases, that Article 2 comprises three distinct obligations:

i. The general obligation to protect by law the right to life (referred to as the positive obligation);
ii. The prohibition of intentional deprivation of life, delimited by a list of exceptions (the negative obligation); and
iii. The procedural obligation to carry out an effective investigation into alleged breaches of either substantive limb (the procedural obligation).

The positive obligation can be distilled into two components:

i. a duty to put in place a legislative and administrative framework to protect the right to life…in the healthcare context having effective administrative and regulatory systems in place. This is the so-called 'systems duty'.
ii. a duty, first articulated in *Osman v UK* [1998] 29 E.H.R.R 245, to take positive measures to protect an individual whose life is at risk in certain circumstances. This is the (positive) operational duty.

The procedural obligation is given domestic effect through coroners' inquests, including via an enhanced investigative duty on coroners in circumstances where the person's death may have resulted from a breach by the state of Article 2.

In terms of both scope and substance, this has been a very broad enquiry that has met the enhanced duty to investigate envisaged under Article 2.

When this matter was before me on 10th May 2024, it was submitted by Mr. Paul that Article 2 may be engaged on the facts of this case. It is correct that, at that hearing, it was my view that, at that stage, I did not think Article 2 was engaged and that I would be willing to hear further submissions as part of the pre-inquest review process. No further submissions were made until 24th February 2025, after the close of evidence at the inquest.

It is also correct that, at the hearing on 10th May 2024, I had stated that, even if Article 2 were not engaged, an inquest is not restricted to the last link in the chain of causation and a coroner must ensure that all relevant facts are the subject of public scrutiny. Therefore, regardless of how we proceeded, the determination of the scope of the inquest would be a matter for the discretion of the coroner and that scope could be quite broad.

In his application, Mr. Paul submits that the evidence presented at this inquest points towards there having been a failure on the part of the Falklands Islands Government to meet its substantive obligation to have in place an appropriate regulatory and administrative system to protect the lives of its citizens.

Mr. Paul refers to the decision of the Grand Chamber in the European Court of Human Rights in *Lopes de Sousa Fernandes v Portugal (app. No. 56080/13)* that enunciates the nature of the systems duty in the field of health care.

Fernandes articulates the law and it is to that case that I shall refer, while acknowledging the summary of Lord Sales in *R (on the Application of Maguire v His Majesty's Senior Coroner for Blackpool & Fylde [2023] UKSC Civ 738*, paragraph 49, wherein is stated:

> *. . . in the context of medical negligence, a state's substantive positive obligations relating to medical treatment are limited to a duty to put in place "an effective regulatory framework compelling hospitals, whether private or public, to adopt appropriate measures for the protection*

of patients' lives". Even where medical negligence is established, it will normally find a substantive violation of article 2 "only if the relevant regulatory framework failed to ensure proper protection of the patient's life"; and it reaffirmed that where the state "has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, matters such as an error of judgment on the part of a health professional or negligent coordination among health professionals in the treatment of a particular patient cannot be considered sufficient of themselves to call [the state] to account from the standpoint of its positive obligations under article 2 . . . to protect life . . . A concrete examination of the facts is required to show that the relevant regulatory framework was deficient and that the deficiency operated to the patient's detriment . . . The state's obligation to regulate is to be understood in a broad sense, which encompasses necessary measures to ensure implementation of the regulatory framework, including supervision and enforcement . . .

It is correct that the Grand Chamber in *Fernandes* found that, only in certain "*very exceptional circumstances*" would the responsibility of the state under the substantive limb of Article 2 be engaged in respect of the acts and omissions of healthcare providers.

The "exceptional circumstances" to which the Chamber referred are:

a. *"a specific situation where an individual's life is knowingly put in danger by denial of access to life-saving emergency treatment…It does not extend to circumstances where a patient is considered to have received deficient, incorrect or delayed treatment.*

b. *where a systemic or structural dysfunction in hospital services results in a patient being deprived of access to life-saving emergency treatment and the authorities knew about that risk and failed to undertake necessary measures to prevent that risk from materialising, thus putting patient's lives, including the life of the particular patient concerned, in danger."*

Mr. Paul relied upon paragraph b.

The court in *Fernandes* observed that it is not always easy to distinguish between cases involving what it described as "*mere medical negligence*" and those where there is a "*denial of*

access to life-saving emergency treatment". In order to meet that test, the following conditions must be met:

i. *"the acts and omissions of the health-care providers must go beyond mere error or medical negligence, in that they, in breach of their professional obligations, deny a patient emergency medical treatment, despite being fully aware that the person's life is at risk if that treatment is not given*
ii. *the dysfunction at issue must be objectively and genuinely identifiable as systemic or structural in order to be attributable to the State authorities and must not merely compromise individual instances where something may have been dysfunctional in the sense of going wrong or functioning badly.*
iii. *There must be a link between the dysfunction complained of and the harm which the patient sustained*
iv. *The dysfunction at issue must have resulted from the failure of the State to meets its obligation in the broader sense. In other words, the State's substantive positive obligations are limited to a duty to regulate, to put in place an effective regulatory framework compelling hospitals to adopt appropriate measures for the protection of patient's lives."*

It is a very high test, particularly in the realm of healthcare.

It is correct that, in their report, Dr. Stone and Ms. Woods make recommendations to improve the provision of maternity care in the Falkland Islands. That, in and of itself, is not determinative of whether Article 2 is engaged.

It is also correct that admissions were made by John Woollacott, the Director of Health and Social Services, in a statement dated 17th February 2025. Those admissions relate to errors of judgement on the part of healthcare professionals and negligent coordination between health care professionals in their treatment of Miss Miller. It would be wrong to elevate individual failings to the level of systemic or structural dysfunctionality.

In short, there is no evidence of a systemic or structural dysfunction in the provision of healthcare on the Falkland Islands such that a patient was deprived of access to life-saving emergency treatment, in circumstances where authorities knew about the risk and failed to

take necessary measures to prevent that risk from materialising, thereby putting paitients lives in danger.

Therefore, on the evidence, and having heard and taken into account the submissions of counsel, I find that Article 2 is not engaged.

Dated this 27th day of February 2025

HHJ Malcolm Simmons

His Majesty's Coroner for the Falkland Islands

RECORD OF INQUEST

The following is the record of the inquest:

1. Name of Deceased: Aspyn Dottie Hercules

2. Medical cause of death:

   1a Hypoxic-Iscaemic encephalopathy

   1b Perinatal asphyxia

3. How, when and where the deceased came by her death. Narrative conclusion - see box 4

4. Conclusion of the Coroner as to the death

   Aspyn was delivered by emergency caesarean at 12.45 pm on 20th October 2023 at the King Edward VII Memorial Hospital, Stanley, Falkland Islands. She died at 5.45 am on 22nd October 2023 at the British Hospital, Montevideo, Uruguay, having suffered intermittent and acute cord compression. There were delays delivering Aspyn. Aspyns death was contributed to by neglect.

Further particulars to be registered concerning the death:

(a) Date and place of birth: 20th October 2023, King Edward VII Memorial Hospital, Stanley, Falkland Islands

(b) Name and surname of Deceased: Aspyn Dottie Hercules

(c) Sex: Female

(d) Date and place of death: 22nd October 2023, British Hospital, Montevideo, Uruguay

(e) Occupation: None