HM Assistant Coroner R Brittain
Inner North London
St Pancras Coroner's Court
Camley Street
London
N1C 4PP

[redacted]

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

[redacted]

4th September 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Alfie Lydon who died on 12 March 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 15 July 2025 concerning the death of Alfie Lydon on 12 March 2024, sent to NHS England's Chief Midwifery Officer. I am responding on behalf of the organisation in my capacity as National Medical Director but would like to assure you that the Chief Midwifery Officer has also been sighted on this response and reviewed your Report.

In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Alfie's parents and wider family. NHS England is keen to assure the family and yourself that the concerns raised about Alfie's care have been listened to and reflected upon.

Your Report raised the concern that the vast majority of hospital trusts do not have processes in place to document external calls from community midwives to hospital teams, and that this can result in a lack of continuity and escalation of care, particularly regarding parental concerns.

With regard to documenting communication between community midwives and staff working on acute sites, this would be a standard expectation in the provision of care for both those making and those receiving the calls. Both staff groups will typically utilise the relevant Trust's Electronic Patient Record (EPR) system for either community midwifery services or hospital maternity / neonatal services, depending on which staff groups on the acute site are involved. This should allow them to record information directly within the patient's record, which should be accessible to all system users regardless of setting. This is on the provision that the maternity service has the necessary digital infrastructure, including capabilities for offline working when in the community. Should this not be the case, Trusts should still ensure that they have effective processes and procedures in place for the recording of key information within the EPR and access for those caring for the patient.

Regardless of the EPR system in use, community midwives are expected to document any conversation that they have with other healthcare professionals in the patient notes, with the requirement for accurate documentation being a basic, core aspect of clinical care. This is made clear in both the Nursing and Midwifery Council Standards of proficiency for midwives and The Code, which describes professional standards of

practice for nurses, midwives and nursing associates. It would also be expected that each organisation has a process to ensure that any community midwife notes are brought together with the hospital maternity / neonatal notes, if this is not an automatic feature of the digital system employed. In addition, the person receiving any call from a health care professional should have a means of documenting any advice given in the patient record.

Alfie's case will be raised with the Neonatal Operational Delivery Networks and Regional maternity teams, with the expectation that they subsequently cascade to all maternity and neonatal units the importance of documenting such consultations.

The new Fit for the future 10 year health plan for England will also help address the issues raised in your Report through its commitment to the introduction of a new Single Patient Record (SPR), which will bring together all of a patient's medical records into one place. It is intended that the SPR will be rolled out in maternity care first, ensuring that maternity teams have all of the information they need about previous consultations, medical history and stated preferences, helping them to provide high quality and personalised care.

NHS England's National teams have also engaged with the East of England's Regional Chief Midwife on the concerns raised in your Report. They advise that:

- Currently, 46% of maternity units in the region have digital care records and the expectation is that any discussions regarding clinical care are recorded in the EPR.
- The remainder of maternity units are expected to have digital records in place within the next 12 months.
- Some trusts within the region also use digital devices such as mobile phones to record clinical care conversations.
- The concerns raised in your Report have been shared with maternity and neonatal units across the region, with a reminder to staff to record discussions on electronic records where available. Where not currently available, staff have been asked to join up hand-held records with clinical records at the earliest available opportunity.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Alfie, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]

[redacted]
National Medical Director
NHS England