REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **[redacted], Chief Midwifery Officer, NHS England via [redacted];** **[redacted], President, Royal College of Paediatrics and Child Health via [redacted]**
1	**CORONER** I am R Brittain, Assistant Coroner for Inner London North.
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	**INVESTIGATIONS and INQUESTS** An investigation into the death of Alfie Lydon (date of birth 28/2/24) was opened on 26/3/24, following his death on 12/3/24. An inquest was opened on 18/4/24 and concluded on 27/6/25. The conclusion reached was that Alfie died from natural causes.
4	**CIRCUMSTANCES OF THE DEATH** Alfie was admitted to hospital on 6/3/24 after being found profoundly unwell at home. He was subsequently transferred to another hospital for intensive care support but sadly died on 12/3/24 from a then unknown cause. A post mortem examination demonstrated that he died from the consequences of a viral infection. Prior to his admission to hospital, concerns had been raised by Alfie's parents to the community midwife team regarding the adequacy of his feeding and increasing lethargy. On two occasions midwives discussed Alfie with the neonatal team at the local hospital but admission was not felt to be necessary. These discussions were not documented by the hospital doctors who took the calls and, on one occasion, not documented by the midwife who made the call. As such, it was difficult to identify who provided advice to the midwives and the rationale for the decision-making process. Ultimately, given the overwhelming nature of the infection Alfie suffered from, I concluded that it was not likely earlier admission would have prevented his death.
5	**CORONER'S CONCERNS**

	During the course of this 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** following the inquest into Alfie's death were as follows: 1. I heard evidence that the vast majority of hospital Trusts do not have processes in place to document external calls from midwives to hospital teams. Concerns were raised that this can result in a lack of continuity and escalation of care, particularly with regards to parental concerns. The hospital Trust involved has taken steps to document such calls now but this is undertaken on paper, which is subsequently uploaded to the hospital records. They plan to implement an electronic solution but not for some time. There is a concern that a lack of contemporaneous, accurate and immediately available documentation of discussions between community and hospital teams could result in deaths in future similar circumstances. Given that this is not simply a local issue, this concern warrants raising at a national level.
6	**ACTION COULD BE TAKEN** In my opinion action could be taken to prevent future deaths and I believe that the addressees 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 9 September 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, the Lydon family, the hospital Trusts, the Department of Health and Social Care and the CQC. 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. She may send a copy of this report to any person who she 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	15 July 2025  **Assistant Coroner R Brittain**