

Sian Reeves
Assistant Coroner
South London
Southwark Coroner's Court
1 Tennis Street
London
SE1 1YD

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

[REDACTED]

5th January 2026

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Evelyn Rae Le Masurier-O'Sullivan who died on 17th April 2022.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 26th November 2025 concerning the tragic death of Evelyn Rae Le Masurier-O'Sullivan ("Evie") on 17th April 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Evie's family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Evie's care have been listened to and reflected upon.

Your Report raised the concern that most NHS Trusts do not provide in-house training to their agency staff as they are not provided with funding to train them. You were concerned that there is a training gap for temporary / agency staff provided by "On-Framework" suppliers, particularly in relation to eliciting parental concerns about a baby's wellbeing at postnatal contacts.

The training of agency staff is a local Trust level issue and not something that NHS England mandates nationally. The [Maternity Incentive Scheme](#) (MIS) safety action 8 states 'It is the responsibility of the employing agency to provide training for staff, it is the responsibility of the Trust to ensure that all agency staff have met minimum training requirements before working in the Trust. The [Safe, Sustainable and Productive Staffing](#) resource highlights that "*All temporary staff should receive local training and induction, so they are familiar with how the organisation works.*"

The specifics of eliciting parental concerns about a baby's wellbeing at postnatal contacts falls under fitness to practise and regulation, as all midwives should have these skills. A number of standards within the [Standards of Proficiency for Midwives guidance](#), published by the Nursing & Midwifery Council (NMC), relate to eliciting parental concerns regarding neonatal wellbeing during postnatal contacts. Specifically, the following two standards reflect what a midwife should be competent

to do at the point of registration and must maintain as a requirement of the regulator (NMC):

- 6.15 when assessing, planning, and providing care include the woman's own self-assessment and assessment of her newborn infant's health and wellbeing, and her own ability and confidence in regard to self-care and care for her newborn infant
- 6.59 conduct ongoing assessments of the health and wellbeing of the newborn infant, involving the mother and partner as appropriate and providing a full explanation.

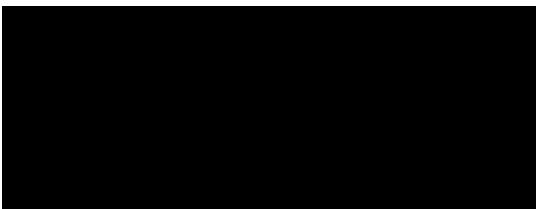
Through the process of regulatory revalidation, each registrant (midwife) must meet specific requirements to ensure they remain fit to practice, to maintain their registration.

Croydon Health Services NHS Trust has provided NHS England's London regional team with details of the action plan they have completed as a result of this Report and the improvements they have made as a result. The Trust has advised that key message would be sent to all staff including NICE sepsis management guideline and audits will be completed regarding antibiotics compliance, reviewing the quality of resuscitation documentation, as well as audits to ensure that new starters attend PROMPT training within one month of recruitment.

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 Evie, 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,



National Medical Director
NHS England