REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. Crown Commercial Services.** **2. NHS England.**
1	**CORONER** I am Sian Reeves, assistant coroner, for the coroner area of South London
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** On 23 February 2023, an inquest was opened, and an investigation commenced, into the death of Evelyn Rae Le Masurier-O'Sullivan ("Evie"), who died 23 hours after she was born. The investigation concluded at the end of the inquest, which was heard over 4 days between 9 and 12 September 2025 and my conclusion was handed down on 16 October 2025. The medical cause of death was: 1a. Disseminated Intravascular Coagulopathy and Persistent Pulmonary Hypertension of the Newborn. 1b. Sepsis. The conclusion was as follows: At around 00:06 on 17 April 2022, when she was less than 10 hours old, Evie became unwell with signs of respiratory distress caused by an infection. A vaginal swab of Evie's mother after her death tested positive for Group B Streptococcus, which was the cause of Evie's infection and the neonatal sepsis which she went on to develop. Evie died as consequence of Disseminated Intravascular Coagulation and Persistent Pulmonary Hypertension of the Newborn, which were secondary to the neonatal sepsis. Although Evie's mother was seen by a member of the midwifery team at around 00:30 and by a midwife at around 02:30, they did not elicit concerns Evie's parents had about Evie's crying and breathing, and nor did they afford an opportunity for these concerns to be shared. This led to an absence of neonatal assessments being carried out and absence of escalation to the hospital's neonatal team, which contributed to the death. Evie's death was also contributed to by the delay between 08:00 and 10:00 in administering antibiotics. Evie's death was contributed to by neglect.
4	**CIRCUMSTANCES OF THE DEATH** Evie was born at 14:17 on 16 April 2022 at Croydon University Hospital by a category 3 emergency caesarean section. Evie was born in good condition with her Apgar scores being normal at 1, 5 and 10 minutes after her birth. There were no known risk factors for Group B Streptococcus or sepsis.

	In the early hours of the following morning, at or around 00:06 on 17 April 2022, whilst on the post-natal ward, Evie was becoming unwell and began to display symptoms of respiratory distress in the form of an abnormal sound known as grunting. These were the first signs that she had an infection. Although Evie's mother was seen by a member of the midwifery team at around 00:30 and a midwife at around 02:30, those staff members did not elicit concerns Evie's parents had about Evie's crying and breathing, and nor did they afford an opportunity for these concerns to be shared. At around 07:00 on 17 April 2022, Evie was observed with signs of respiratory distress, including chest recessions, nasal flaring and some slight grunting. After a neonatal review, she was admitted to the hospital's neonatal unit. The working diagnosis at that time was that Evie was suffering from sepsis. Although antibiotics to treat the suspected sepsis should have been administered within the hour, they were not administered until 10:00. Evie initially stabilised on the neonatal unit. However, she went on to have an acute deterioration with clinical evidence of pulmonary hypertension and became difficult to oxygenate. Thereafter Evie went on to have a pulmonary haemorrhage and disseminated intravascular coagulation and went into cardiac arrest. Advanced life support resuscitation was performed and although return of spontaneous circulation was achieved on three occasions, Evie could not be stabilised and died at 14:06 on 17 April 2022.
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 could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: During the course of the inquest, I heard evidence from an expert midwife that: 1. The NICE Guideline (2021) Postnatal Care (NG194) recommends that at each postnatal contact, a parent or carer should be asked if they have any concerns about the baby's wellbeing, feeding or development; and that the history should be reviewed and the baby's health reviewed including by physical observation. 2. The NICE Guideline on postnatal contact recommends that parental concerns should be treated as an important factor as an indicator for a possible serious illness in their baby. 3. If there are early indicators of possible infection in a baby, including respiratory distress, then immediate clinical assessment should be performed, the maternal and neonatal history should be reviewed and a physical examination of the baby should be carried out. 4. On attending the mother's bedside, the midwife or midwife assistant (also known as maternity assistants or midwifery assistants) should ensure that there are no parental concerns about the baby. Although there are different ways in which this important objective can be achieved, the midwife or midwife assistant should ensure that they ask questions in a way that ensures that the family had an "open space" to share their concerns. In other words, it is important that: (i) the questions asked by the midwife or midwife assistant are asked in a way that can elicit any such concerns; (ii) they afford the parents an adequate opportunity for those concerns to be shared; and (iii) their attitude to, and interactions with, the parents creates an environment in which parents feel able to share concerns. In Evie's case, I concluded that: although Evie's mother was seen by a member of the midwifery team at postnatal contacts at around 00:30 and by a midwife at around 02:30,

	they did not elicit concerns Evie's parents had about Evie's crying and breathing, and nor did they afford an opportunity for these concerns to be shared; and this led to an absence of neonatal assessments being carried out and absence of escalation to the hospital's neonatal team, which contributed to the death. I received evidence from Croydon Health Services NHS Trust about the significant improvements and actions that have been put in place at Croydon University Hospital since Evie's death in relation to eliciting parental concerns about wellbeing during postnatal contacts, including: 1. It has been strengthened through a combination of training, supervision, and wellbeing initiatives. 2. During mandatory training sessions, staff are presented with case studies where there was an unexpected outcome. These discussions focus on the learning from such cases, including how staff attitude and behaviour can directly influence the experience of patients and families. 3. Concerns about communication are closely monitored through complaints, friends and family feedback, and the annual CQC Maternity Survey. Following the survey, an action plan is developed which includes specific measures to address patient concerns about how they were treated whilst in the Trust's care. 4. In 2022 and 2023 the Trust funded unconscious bias training to help staff recognise and address hidden attitudes, stereotypes, and assumptions that may influence behaviour and decision-making. Elements of this training are now included in PROMPT training, either through cultural competency sessions or human factors teaching. 5. Where concerns about staff attitude or behaviour are identified, either directly from patients, through complaints, or from colleagues, senior managers provide immediate feedback and guidance in clinical practice. Reflective sessions are also used to enable staff to learn from experiences and share best practice 6. Since the Ockenden report and the implementation of its actions, there has been a greater emphasis on the importance of listening to parents' concerns. It is reinforced during neonatal doctor induction that parental concerns must be taken seriously. For example, if parents raise concerns about their baby's breathing, this should trigger immediate escalation to a midwife, midwifery team leader, or neonatal team member. A physical examination, enquiry into parental concerns, and a full set of vital signs are then required. This is in addition to the fact that Croydon University Hospital is amongst the first maternity and neonatal units in the country to implement Martha's Rule within their service. However, I also received evidence that: (i) all temporary staffing supplied at Croydon University Hospital including midwives is provided by "On-Framework" suppliers under framework RM6281 (RM6281 is a framework agreement managed under the NHS Workforce Alliance for the procurement of clinical and healthcare staffing across the UK); and (ii) most NHS Trusts, including Croydon Health Services NHS Trust, do not provide in-house training to their agency staff as they are not provided with funding for them to be trained. This means that there is a training gap, in that temporary staff provided by "On-Framework" suppliers under framework RM6281, including those working at Croydon University Hosptial, will not receive the additional training identified above in relation to eliciting parental concerns about a baby's wellbeing at postnatal contacts. In my opinion, this training gap gives rise to a risk that future deaths could occur unless action is taken.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe your organisation has 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 21 January 2026. 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 and to the following Interested Persons: • [redacted] and [redacted]. • Croydon Health Services NHS Trust. • Maternity and Newborn Safety Investigations. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. 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.
9	**26 November 2025** **Sian Reeves**