Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 Department for Health and Social Care (PFDs/Reg28)** **2 NICE (National Institute for Health and Care Excellence)** **3 Nursing and Midwifery Council**
1	**CORONER** I am Henry CHARLES, HM Assistant Coroner for the coroner area of Hampshire, Portsmouth and Southampton
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 15 November 2023 I commenced an investigation into the death of Matilda Gwen POMFRET-THOMAS aged 15 Days. The investigation concluded at the end of the inquest on 04 December 2025. The medical cause of death was Hypoxic Ischaemic Encephalopathy. The narrative conclusion of the inquest was as follows: Matilda Pomfret Thomas sadly died on 13th November 2023 at Naomi House and Jacks Place, Stockbridge Roads, Sutton Scotney, Winchester, Hampshire by reason of Hypoxic Ischaemic Encephalopathy. She was 15 days old at the date of her death. She was born on 29th October 2023 at Queen Alexandra Hospital following a difficult labour at home. The Hypoxic Ischaemic Encephalopathy had developed over a period of hours. Meconium had been observed, decelerations were later observed. [redacted] was not taken to hospital following those complications becoming apparent until 12.13 on the 29th October 2023. The background is of a traumatic first birth that impacted upon decision making for this second pregnancy and birth. Matilda's parents had seen a home birth as the best way forward. Labour started in the early hours of 29th October 2023 and there was prompt midwife attendance. An initial and appropriate offer at 7.19 of transfer to hospital upon meconium being found was not accepted, thereafter the implications of a deteriorating situation involving decelerations against a background of the presence of meconium – including further clear signs of it at 10am, requiring hospital transfer, was not communicated in such a way as to lead to a transfer to hospital. An element of what occurred is that the presence and work of a doula did on this occasion negatively impact upon the effective provision of midwifery services in terms of building a rapport conducive to effective advice and care being given.
4	**CIRCUMSTANCES OF THE DEATH** Please see the narrative conclusion. The birth of the family's first child had been traumatic and, for the birth of their second child, they were focussed on achieving a different birth experience and elected to use a doula to provide them with support at a home birth. The hospital's preference was for a hospital delivery, there was discussion as to what circumstances would result in the mother being blue lighted to hospital. Signs of fetal distress developed but the mother was not immediately transferred to hospital. A difficult atmosphere had developed, the midwives felt access was being restricted by the doula: I found that she did not actively discourage

	midwife access but that she was seen as, in effect, a buffer by members of the midwifery team. The doula was following the birth plan. The doula was supporting the parents per the birth plan, and this appears to have been perceived as grounds for hope that a home birth was still possible.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries 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: (brief summary of matters of concern) Doulas provide continuity of care and give emotional, informational and practical support throughout pregnancy, labour and after the birth of a baby: those words come from Doula UK's website. Doula UK is the largest representative body for Doulas, but it is not a regulatory body, it does not represent all doulas, indeed many doulas are not members of Doula UK. Doula UK have put in place membership requirements, training offers and much guidance, but the role of a doula is clearly diffuse in practical terms and capable of multiple understandings not just by doulas but their clients and midwives. It appears that doulas have been increasingly used and increasingly offer services - as here - on a paid basis. As MNSI (Maternity & Newborn Safety Investigations - formerly HSIB) put it in their report into this birth, "MNSI acknowledges that there is no regulation of doula care or any guidance on how the two services interact with each other. MNSI considers the dynamics of a situation, where a third party are involved can provide additional challenges for staff, such as making clinical recommendations against personal recommendations or views and providing usual care that could be viewed as interference rather than surveillance." MNSI have identified 12 cases in which there was evidence that doulas worked outside of the defined boundaries of their role and in which the care or advice provided by the doula was considered to have potentially had an influence on the poor outcome for the family. There was evidence given at the inquest by experienced midwifery professionals highlighting that provision of guidance would be helpful for all involved with a birth at which a doula was present. The issues of doula registration, regulation and training are therefore points of concern I would commend for review.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 March 06, 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

	Queen Alexandra Hospital Legal Department [redacted] **Doula UK** [redacted] **Maternity and Newborn Safety Investigations (MNSI)** 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 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. They may send a copy of this report to any person who they believe 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	**Dated: 15/01/2026** [redacted] **Henry CHARLES** **HM Assistant Coroner for** **Hampshire, Portsmouth and Southampton**