REPORT TO PREVENT FUTURE DEATHS
REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).

1.	**CORONER** I am Martin LANCHESTER, Assistant Coroner, for the coroner area of Gwent.
2.	**DATE OF REPORT** 24 June 2026
3.	**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.
4.	**THIS REPORT IS BEING SENT TO** 1. Chief Executive of ANEURIN BEVAN UNIVERSITY HEALTH BOARD 2. Chief Executive of Health Inspectorate Wales 3. Cabinet Minister for Health and Care 4. Chief Executive of Royal College of Obstetricians and Gynaecologists 5. Chief Executive of Royal College of Midwives 6. Chief Executive of National Institution for Health and Care Excellence You are under a duty to respond to this report within 56 days of the date of this report, namely by August 14, 2026. I, the coroner, may extend the period if an appropriate application is made.
5.	**YOUR RESPONSE** 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.

6.	**SUMMARY OF CORONER'S CONCERN** There is currently no national guidance available concerning antenatal fetal monitoring particularly in cases of suspected chorioamnionitis. Recent guidance provided by the local Health Board for antenatal fetal monitoring does not include reference to suspected chorioamnionitis or continuous fetal monitoring. I have insufficient evidence of the training that has been put in place locally following Nola-Reign's death. There remains a concern over delays in transferring mothers in need of continuous fetal monitoring to the labour ward.
7.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8.	**INVESTIGATION AND INQUEST** Between 11th and 15th May 2026, I held an inquest into the death of Nola-Reign Morgan at Gwent Coroner's court. The conclusion of the inquest was a narrative conclusion that Nola-Reign Morgan died on 08/02/2024 at The Grange University Hospital, Cwmbran, having suffered global hypoxic-ischaemic injury shortly before her birth on 05/02/2024 caused by developing clinical chorioamnionitis. I found that Nola-Reign Morgan's death was contributed to by her mother not being admitted to the labour ward from the triage department following arrival at hospital and a period of 88 minutes when no fetal monitoring was in place whilst Nola-Reign's mother was waiting for transfer to the high dependency unit.
9.	**CIRCUMSTANCES OF DEATH** The mother of Nola-Reign Morgan waters broke on 28 January 2024 when she was 28 weeks pregnant. She attended triage on the morning of the 5 February 2024 with symptoms of fever and was suspected of suffering with chorioamnionitis. The witness evidence was that Nola-Reign's mother was likely to need to deliver her baby that day. Despite this conclusion being reached she was not immediately transferred to the labour ward to administer magnesium sulphate to provide fetal neuroprotection in accordance with local and national guidance. Instead, Nola-Reign's mother was transferred to the antenatal ward and this led to a delay in her starting on magnesium sulphate and having continuous fetal monitoring.

	A decision was taken later in the afternoon to transfer Nola-Reign's mother from the antenatal ward to the High Dependency Unit (HDU) on the labour ward for provision of magnesium sulphate. Whilst waiting for transfer and despite the increased concerns over developing chorioamnionitis, the fetal monitoring was discontinued at 1607hrs and not recommenced until 1735hrs when Nola-Reign's mother arrived on the HDU and by which time Nola-Reign's condition had deteriorated to the extent that the CTG trace was noted to be pathological. Despite attempts to deliver Nola-Reign by emergency Category 1 caesarean section with trial of forceps, the fetal heartbeat was not detected on the CTG after 1801hrs and an ultrasound taken at 1818hrs confirmed she had no fetal heartbeat. Nola Reign was born at 1834hrs with no heartbeat but responded to resuscitation. Sadly, her condition then deteriorated and despite a high level of neonatal care she died 3 days later. During the inquest I heard evidence that once chorioamnionitis was suspected Nola-Reign's mother should have been transferred from triage direct to the labour ward and she should have received continuous fetal monitoring irrespective of where she was in the triage area, the antenatal ward or the labour ward. I also heard evidence that there was not local or national guidance to assist with antenatal fetal monitoring in pre-term mothers or any specific guidance when or how to monitor pre-term mothers when chorioamnionitis is suspected. In my reaching my conclusions in the inquest I found that the decision not to transfer Nola-Reign's mother directly from maternal triage to the labour ward on the morning of the 5 February 2024 was likely to have contributed to Nola-Reign's death. I also found that the decision not to continue to use a CTG to monitor Nola-Reign's heartbeat for a period of 88 minutes whilst awaiting transfer from the antenatal ward to the HDU was also likely to have contributed to Nola-Reign's death.
10.	**CORONER'S CONCERNS** During the course of the inquest I heard evidence 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: 1. National Guidance. There is no national guidance in the antenatal setting to establish when and in what circumstances fetal monitoring should be used especially when chorioamnionitis is suspected. Further there is no specific guidance that has been brought to my attention to identify and treat chorioamnionitis in pre-term mothers. Clear guidance exists for intrapartum

	fetal monitoring but in this case the grey area between Nola-Reign's mother being nearly but not in active labour meant that there was confusion as to whether continuous monitoring should or could have been put in place. 2. Health Board Antenatal Fetal Monitoring Guidance. Following Nola-Reign's death the serious incident review recommended new guidance to address antenatal fetal monitoring. However, the new local guidance for antenatal monitoring does not reference chorioamnionitis, transfer times or the need to consider continuous fetal monitoring. 3. Training. There is insufficient evidence from the Health Board of the nature or degree of training that has taken place since Nola-Reign's death to assist obstetric and midwifery teams to identifying the risk of chorioamnionitis and to ensure adequate monitoring is in place in particular: 4. Delay in transferring between Antenatal and HDU wards. The delay in transferring Nola-Reign's mother from antenatal ward to HDU was over 1 hour in a situation when acuity was not raised. This issue was not identified by the Serious Incident Review yet was a material factor in the period when Nola-Reign's mother remained unmonitored and no steps have been taken to identify causes for delay and to avoid unnecessary delay occurring in the future.
11.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: *[please do not use individual's names, but instead roles/titles]* • **Family members and NEXT OF KIN** I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's PFD Publication Policy (2026). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
12.	**SIGNATURE**  **Martin LANCHESTER**

	Assistant Coroner for Gwent