REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. [redacted] Executive Director for Professional Practice, Nursing and Midwifery Council, [redacted]**
1	**CORONER** I am R Brittain, Assistant Coroner for Warwickshire.
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** Emilia Watson died on 5 April 2021, shortly after her birth. Signs of life were recognised and, as such, I had jurisdiction to hear an inquest into her death, which concluded on 18 April 2023. I reached a narrative conclusion which read: *'Emilia Watson died from complications of uteroplacental insufficiency. This in itself is a natural cause of death; however, there were missed opportunities to recognise the development of these complications, which contributed to her death.*'
4	**CIRCUMSTANCES OF THE DEATH** Emilia was born at Warwick Hospital after her mother had been admitted from home for what had been planned to be a homebirth. Concerns were raised about fetal wellbeing, which prompted admission to hospital. The timeline of events includes two admissions to hospital over the course of the early morning of the 5 April 2021, after concerns were raised by the two midwives involved in these home attendances. On the second admission concerns were maintained about the fetal heart rate and Emilia was delivered by Caesarean section at approximately 7.22am but she sadly died, despite resuscitation attempts.
5	**<u>CORONER'S CONCERNS</u>** 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 Emilia's death were as follows: 1. I am concerned that the two midwives who attended Emilia's mother at home had limited experience of home births. One was a newly-qualified midwife who actually had

	more experience in home births than the other midwife; despite decades of midwifery experience she had never attended a home birth before. I heard evidence that there is no specific regulatory requirement regarding midwifery experience at home births and that training to become a midwife requires attendance at 40 births of unspecified type. During the inquest it was set out that home births occur relatively infrequently and that it can be difficult to ensure involvement in such births during training. I also heard that some midwives tend to focus on specific areas of practice, such as low-risk or high-risk births and that their experience in other areas can therefore be limited. This is despite the potential need for any midwife to attend low-risk births and the regulatory requirement that midwives ensure competency in all areas of practice. I asked the hospital Trust involved for information as to how they ensure that midwives have appropriate experience in home birthing. They have set out as follows: *The lead midwife has previous experience (gained knowledge and skills through direct observation and participation) of attending and facilitating a home birth or birth in a low risk setting* *The lead midwife normally works in a low risk birth setting i.e Community midwife or Bluebell birth centre midwife* *The lead midwife is competent and up to date with their mandatory training within a home birth or low risk birth setting thus demonstrating the knowledge and skills required.* However, the concern remains that there is seemingly no specific regulatory requirement for training or ongoing exposure to areas of practice that midwives may encounter, in particular the unique issues that can arise during home births.
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 14 July 2023. 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, Emilia Watson's family, the hospital Trust and the HSIB. 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. 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 by the Chief Coroner.

9	19 May 2023  **Assistant Coroner R Brittain**