NHS
University Hospitals Birmingham
NHS Foundation Trust

Trust Headquarters
Level 1
Queen Elizabeth Hospital Birmingham
Mindelsohn Way
Edgbaston
Birmingham
B15 2GW

[redacted]

30 August 2023

For the attention of Miss Emma Brown
Area Coroner for Birmingham and Solihull
Birmingham Coroner's Court
50 Newton Street
Birmingham

[redacted]

Dear Miss Brown

Inquest touching the death of Sinon Masha

Response to Regulation 28 Report to prevent future deaths

I write in response to the Regulation 28 Report made by you following the Inquest touching the death of Baby Masha which concluded on 29 June 2023.

University Hospitals Birmingham NHS Foundation Trust (the Trust) has carefully considered the concerns raised within your report to prevent future deaths, which relate to the Trust's Birth Choices Guidance, specifically section 5 and that 'patients may not be making fully informed decisions resulting in birth choices that put lives at risk'.

At the time Ms Masha (mother) was under the care of the Trust there was a Consultant midwife vacancy on-going for 2 months and normally they would be responsible for developing the birth plans. In their absence the responsibility for developing the birth plans was the Matron for Community. Matron Adams (Matron for Community) developed the birth plan for Ms Masha, which was complicated because she was a late transfer from another Trust.

At the time Ms Masha was under the care of the Trust, the Trust's Birth Choice Guidelines states under 5.9 *'Where there are complexities that require the input of other professionals and if the woman remains undecided or voices a decisive choice to pursue a plan outside of Trust guidance a joint multi-professional appointment must be arranged'.*

The process for MDT discussion was in place although due to the pandemic this was sometimes held as separate discussions. The birth choices guideline does give flexibility for this to occur in section 5.11 it states '*there may be occasions when the multi professional team cannot meet. In these circumstances it is acceptable for the multi professional team to see the woman separately. However, the team members must still agree a plan together and document this on the woman's records."*

Due to her late transfer of care, and having missed her initial consultant appointment, the birth plan was sent to the initial booking consultant for agreement via email. Ms Masha had a subsequent telephone appointment with another consultant but delivered the following day before the telephone appointment could take place.

Following Baby Masha's death the following actions have been taken:

- There are now two consultant midwives in post who share the birth choices discussion and planning for women requesting homebirth outside of guidance.
- A Bi-weekly MDT meeting is in place with joint discussion and planning separately with the named consultant.
- To ensure compliance with the standards an audit is in place to evidence multidisciplinary input for high-risk home births. The initial audit has demonstrated that for those women who had requested birth outside of guidance, there was always consultant input into their birth plan.
- There is a plan to agree allocated Consultant (either Delivery suite lead or Antenatal clinic lead) to regular MDT meetings. This is contingent on the current consultant job planning (due for completion by 31 August 2023). Following job planning this action will be completed before the 31 October 2023.
- A review of the Birth Choices Guidelines (CG1200) and the home birth guidance (CG1143) is being undertaken and will be completed by 31 October 2023. Currently there are discrepancies in relation to the referral pathway, roles and responsibilities of members of the multi-professional team (including Consultant Midwife), and inclusion of the woman in birth planning discussions. Alignment of these guidelines will provide a clear and standardised pathway for referral and management for women/birthing people requesting birth outside of guidance including homebirth, and clarity of Roles and responsibilities of each member for the Multi professional team.

I would like to reassure you that the concerns raised within the Regulation 28 Report have been taken extremely seriously which I hope is demonstrated by our response above.

Yours sincerely

[redacted]

[redacted]
Chief Executive Officer

CC [redacted], Chief Nurse
[redacted] Head of Clinical Governance and Patient Safety
[redacted] Director of Midwifery