	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **University Hospitals of Birmingham NHS Foundation Trust**
1	**CORONER** I am Emma Brown, Area Coroner for Birmingham and Solihull
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 30 December 2021 I commenced an investigation into the death of Sinon MASHA. The investigation concluded at the end of the inquest. The conclusion of the inquest was: Natural causes.
4	**CIRCUMSTANCES OF THE DEATH** **Sinon Masha was born following a home birth at 13:41 on the 17th December 2021. For a variety of reasons, a home birth was against medical advice, this had been explained on a number of occasions throughout the pregnancy. On the 17th December 2021 advice to transfer to hospital had been given by midwives during early labour due to concerns that Sinon's mother was showing signs of pre-eclampsia and due to findings of light meconium staining on rupture of membranes which could indicate fetal distress. This advice was not accepted. At 12:47 it was identified that Sinon maybe an undiagnosed breech presentation, transfer to hospital was recommended and declined. Up to that time presentation based on abdominal palpitation and vaginal examinations had been assessed as cephalic. A frank breech presentation was confirmed during a 999 call commencing at 13:00. Paramedics arrived at scene at 13:07 and transfer to hospital was again advised and not accepted. The presenting part delivered at 13:14, there was then a 27 minute period before delivery of Sinon's head causing a catastrophic hypoxic brain injury. He received resuscitation and was transferred to Birmingham Heartlands Hospital arriving at 49 minutes of age. At 57 minutes Sinon was found to have a heartbeat, he was ventilated and cooled but remained comatose and subsequently developed signs of encephalopathy and multi organ failure, a decision was made to provide palliative care on the 20th December and Sinon died at 05:15 on the 21st December 2021.** Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Hypoxic ischaemic encephalopathy** **1b Undiagnosed breech presentation during home delivery** **1c** **II**
5	**<u>CORONER'S CONCERNS</u>** During the course of the 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** are as follows. – 1. The University Hospitals of Birmingham NHS Foundations Trust ('UHB') has specific guidance covering home birth against medical advice in the form of 'Birth Choices Guidance, CG1200, June 2021' and 'Homebirth Including Risk Assessment, CG1143, August 2021'. 2. Specifically, Section 5 of the Birth Choices Guidance includes: *"5.1 All women requesting birth outside of guidance must be referred for discussion to the consultant midwife via BadgerNet for decision-making regarding their birth choices.* *….* *5.7. 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 multiprofessional appointment must be arranged.* *5.8. This appointment should include the consultant midwife; the woman's named obstetric consultant and other relevant professionals/clinicians as needed. The consultant midwife will convene the multiprofessional team meeting with the purpose of ensuring that a comprehensive multiprofessional pregnancy and birth plan is formulated.* *5.9. There may be occasions when the multiprofessional team cannot meet. In these circumstances it is acceptable for the multiprofessional team to see the woman separately. However, the team members must still agree a plan together and document this on the woman's records."* 3. Evidence given at the inquest pertaining to the current situation was that the system outlined in section 5.8 of the Birth Choices Guidance is not in operation at all. Evidence was given by UHB's Community Matron that without the input of a Consultant Obstetrician at the multiprofessional appointment, things might be missed in the birth plan, and the information given by the Consultant Midwife and Community Midwives may not carry the same weight with the patient as hearing the opinion of the Consultant Obstetrician. It was stated in evidence by the Community Matron that this could put the lives of Mums and babies at risk. 4. Evidence was given by the Director of Midwifery that although patient's named Consultants are not involved in multiprofessional appointments with the patient there is a bi-weekly meeting of the other professionals who discuss all high risk patients and then the Consultant midwife meets with the patient's named Consultant (who will have reviewed the patient in clinic) and discusses the individual cases and the birth plans. This system is felt to be working satisfactorily by the Consultant midwife. 5. I remain concerned that the current approach has evolved from necessity rather than being a carefully considered and planned amendment to the Trust's guidance. Furthermore, the approach appears fragmented increasing the risk of mis-communication or mis-understanding. This system also deprives the patient of the benefit of hearing the perspectives of all the relevant professionals together in a setting where they, the patient, can witness the discussion and be satisfied that everyone has considered all the relevant factors and answered any queries or concerns they may have relevant to their decision. Consequently, I am concerned that patients may not be making fully informed decisions resulting in birth choices that put lives at risk.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you 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 30 August 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 and to the following Interested Persons: [redacted] West Midlands Ambulance Service 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	**30 June 2023**  Signature: **Miss Emma Brown** **HM Area Coroner** **for Birmingham and Solihull**