	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1) West Midlands Ambulance Service,** **2) NHS Birmingham and Solihull ICB,** **3) NHS Black Country ICB,** **4) NHS Coventry and Warwickshire ICB** **5) NHS Herefordshire and Worcestershire ICB** **6) NHS Shropshire, Telford and Wrekin ICB** **7) NHS Staffordshire and Stoke-on-Trent ICB** **8) The Association of Ambulance Chief Executive**
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 24 February 2025 I commenced an investigation into the death of Mohammed Ismail KHAN. The investigation concluded at the end of the inquest on the 4th September 2025. The conclusion of the inquest was: Death was due to effects of injury sustained during avoidable delay in breech delivery.
4	**CIRCUMSTANCES OF THE DEATH** **Mohammed Ismail Khan died from complications of a catastrophic brain injury sustained during delivery at 35 weeks and 2 days gestation on the 6th September 2022 due to breech presentation. His mother had been discharged from Birmingham Heartlands Hospital earlier that day despite multiple antenatal risk factors which ought to have resulted in her remaining in hospital until delivery. Consequently, the emergency response when spontaneous labour occurred was delayed and suboptimal. This resulted in the hypoxic-ischaemic brain injury which ultimately led to Mohammed death two years later following a respiratory infection.** Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Respiratory Failure** **1b Parainfluenza virus infection** **1c** **1d** **II Hypoxic-ischaemic brain damage**
5	**CORONER'S CONCERNS** 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. [redacted], West Midlands Ambulance Service ('WMAS') Clinical Manager Maternity Lead - gave evidence regarding the findings of WMAS Serious Incident Investigation. She explained : a. At 18:55 on the 06.09.22 the trust received a 999 call for Mohammed's mother, Mrs Khan, who was 36 weeks pregnant and it was reported the baby (Mohammed) was being born feet first. b. A category 1 disposition of "Emergency Ambulance Response for Obstetric Complications" was reached. c. At 18:58, the 1st double crewed ambulance ('DCA') resource was dispatched and arrived at 19:07, a further DCA and Operations Manager also attended. d. The clinicians in attendance had no prior experience of breech deliveries. e. They advised Ms Khan to move from standing to all 4s and this progressed the delivery a little, visible parts of the baby were indicative of hypoxia and the umbilical cord was white and non pulsing. They followed a 'hands off' approach and sought advice from the regional trauma desk who advised rapid transfer to hospital and had pre-alerted Birmingham Heartlands Hospital ('BHH'). f. The crew left at 19:20 and arrived at BHH at 19:24. The patient was admitted to theatre at 19:26 and following Lovsett's manoeuvre Mohammed was born at 19:27 with no heart rate and no respiratory effort. Although he responded to resuscitation, he had suffered profound severe hypoxic ischaemic brain damage. 2. The WMAS investigation concluded that the national, JRCALC guidelines for the clinical assessment and management of breech birth were not adhered by the paramedics and regional trauma desk as the clinicians did not appreciate that the delivery was delayed and that intervention to aid delivery should be attempted. 3. Whilst the JRCALC guidance has since been updated (October 2023) to be clearer and provide much better assistance [redacted] explained that it is not mandatory for paramedics to receive specific training on obstetric emergencies, including breech delivery, either in their foundation training/education or as part of continuing professional development. 4. The clinicians who attended Mrs Khan said they would not have felt confident to attempt the techniques advised by JRCALC even if they had realised they were advised. 5. [redacted] explained that maternity and obstetric care makes up 3 per cent of emergency ambulance responses. 6. Whilst WMAS have purchased specific training equipment and an online course for clinicians on the management of obstetric emergencies in response to the findings of the investigation, resourcing is such that it has not been possible for all paramedics to receive this additional training e.g. less than a third of paramedics with WMAS have completed the online course. 7. [redacted] evidence was that in her opinion the absence of any mandatory training on obstetric emergencies was putting 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 11 November 2025. 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: Mohammed's parents and the University Hospitals of Birmingham NHS Foundation Trust. I have also sent it to the Medical Examiner, ICS, NHS England and the CQC who may find it useful or of interest. 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. She may send a copy of this report to any person who she 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	**16 September 2025** Signature  **Emma Brown** **Area Coroner for Birmingham and Solihull**