University Hospitals Birmingham
NHS Foundation Trust

Queen Elizabeth Hospital Birmingham
Mindelsohn Way
Edgbaston
Birmingham B15 2GW

[redacted]

30 January 2026

For the attention of HM Area Coroner Mr Adam Hodson
Area Coroner for Birmingham and Solihull

[redacted]

Dear Mr Hodson

Inquest touching the death of Syeda Fatima
Response to Regulation 28 Report to prevent future deaths

I am writing in response to the Regulation 28 Notice issued following the conclusion of the Inquest touching the death of Baby Syeda Fatima on 4 December 2025.

We acknowledge the concerns you have raised regarding cultural and systemic issues within the maternity service at Good Hope Hospital and provide assurance that the Trust takes these matters extremely seriously.

During the Inquest you heard evidence from a number of Trust witnesses who advised that as an organisation a significant amount of work had already been undertaken over the past two years which had resulted in improvements in the culture and environment which was demonstrated in positive feedback from external bodies on the improvements made, together with feedback received from our staff that their experience is improving and that they consider they have a voice and are listened to. You also heard evidence that recent GMC and national education training surveys were showing a trend across the whole Trust of an improvement in culture and that the changes in the structure and in the leadership within Women's and Children's Services had also resulted in positive feedback.

Whilst a significant amount of work has been undertaken, we are aware that further work is required. We have undertaken a comprehensive review of the issues identified within the Regulation 28 notice and have aligned our response with the ongoing Maternity and Neonatal Improvement Programme (MNIP) under the NHS England Maternity Safety Support Programme (MSSP). This programme focuses on leadership, culture, inclusion, communication, and governance to ensure sustainable improvement.

Please find enclosed our Action Plan, which addresses each concern raised within your report. The plan details the specific actions required to mitigate risks, provides details of accountable leads together with the deadlines we are working towards and how assurance of the action taken will be provided.

[redacted] [redacted]

Key initiatives we will be undertaking include:

- Twice-daily multidisciplinary “Team of the Shift” huddles to strengthen communication and escalation
- Enhanced multi-professional leadership development and civility training, including active bystander and cultural humility workshops
- Structured simulation and Practical Obstetric Multi-Professional Training (PROMPT) to embed shared mental models during emergencies
- Completion of the Safe Learning Environment Charter (SLEC) maturity matrix across all maternity areas
- Sustained oversight through Safety Champion walkarounds and Cappuccini checks which are structured senior leader walkarounds that focus on confirming the visibility and identity of senior staff, ensuring teams know who to escalate to, and reinforcing clear, respectful communication during maternity care

The actions will be monitored through divisional governance groups and will be reported to the Women’s and Children’s Board, with external oversight from NHS England.

I would like to assure you that we are committed to creating a safe, respectful, and inclusive environment for staff and families and to ensure that lessons learned translate into measurable improvements in care.

Yours sincerely

[redacted]

[redacted]
Chief Executive Officer

[redacted]

[redacted]