	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** **1. University Hospitals Birmingham NHS Foundation Trust**
1	**CORONER** I am Adam Hodson, 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 5 June 2025 I commenced an investigation into the death of Syeda Meerab FATIMA. The investigation concluded at the end of the inquest . The conclusion of the inquest was: natural causes.
4	**CIRCUMSTANCES OF THE DEATH** **Baby Syeda was born premature on 02/06/25 at 31+4 weeks at Good Hope Hospital in Birmingham, after her mother went into premature labour at home. Following arrival at hospital at 01:48, a delay occurred as the team were in a state of unpreparedness and did not have the necessary equipment initially to hand to examine her, and there was a further delay caused by waiting for an ultrasound machine to power up. Mother was identified as being in breech and a Category 1 Caesarean Section (C-Section) was ordered at 01:55. There were then delays in obtaining her mother's informed consent for C-Section due to workplace culture issues and the language barrier, with consent eventually being obtained at 02.04. During this time, Baby Syeda's delivery progressed rapidly, with both feet being delivered by 01:58 with delivery of her hips at 02:10, and torso and shoulder occurring swiftly thereafter in theatre by 02.17 whilst her mother was being readied for a Category 1 C-section. At 02.17, it was identified that Syeda's head was entrapped by the cervix, and efforts were made to release the same including cervical incisions (which was hampered due to an initial pair of blunt scissors), episiotomy extensions, suprapubic pressure, and an unsuccessful forceps attempt. Baby Syeda was eventually born in a poor state with a zero APGAR score at 02:36 on 02/06/25 and required resuscitation before being transferred to Special Care Baby Unit. Sadly, she did not recover, and she died in her mother's arms surrounded by her family a few hours later. An investigation carried out following her death revealed numerous issues in mother's care which meant that there was a lost opportunity for her mother to have been taken to theatre for C-Section earlier, but the evidence suggests this would not have made a difference.** Based on information from the Deceased's treating clinicians the medical cause of death was determined to be: **1a Perinatal asphyxia** **1b Footling breech vaginal delivery** **1c** **1d** **II**

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. Following Syeda's death, a Patient Safety Incident Investigation Report ("PSII") was commissioned by the Trust ([redacted] which revealed a number of issues with the care that was provided to Syeda's mother and to Syeda following her birth (cited at section 4.2 "Summary of Findings" and section 8.5 "Summary of findings, areas for improvement and safety actions" of the PSII).

2. Of those issues, the PSII identified that cultural tensions between the midwifery and obstetric staff at Good Hope Hospital may have played a role in the delay of actioning the category 1 caesarean section and transferring Syeda's mother to theatre (paras 4.2.14 and 8.5.15) with the report indicating that they could not rule the same out as being a factor. In evidence, multiple witnesses for the Trust indicated that the cultural tensions and issues did contribute to events, but minimally. It is clear, therefore, that they played a factor in the timeline of chronology of events.

3. A subsequent report was commissioned by the Trust which was disclosed as part of the inquest proceedings entitled "*Information received on the working and learning environment at Good Hope Hospital Maternity Unit"* which was referred to during proceedings as "the Workplace Culture Report". That report clearly highlighted that the cultural tensions experienced during Syeda and her mother's care were not a one-off and, worryingly, demonstrate that there is a wider and more systemic problem with the workplace culture within the maternity department at Good Hope Hospital.

4. Whilst it was advocated that there are nationally reported issues of workplace cultural problems within and maternity services in the NHS (which may be true, when considering past and current maternity investigations into Trusts such as Shropshire and Telford Hospitals NHS Trust and Nottingham University Hospitals NHS Trust, for example), it is clear from the evidence in this inquest there is a specific problem at Good Hope Hospital.

5. The culture is described in the Workplace Culture Report as being "*hierarchical*" both between the obstetrics and midwifery teams, as well as being within those teams as well. The report indicates that lower banding staff and non-maternity staff cannot offer opinions or views; band 7 midwives make any staff below that banding feel unwelcome to set foot in the office; the band 7 midwives are reported to be "*cliquey*" and some have suggested that the culture stems from those band 7s and is top-down.

6. The department is described as "*cold and unwelcoming*" to new starters and outside staff members and has a "*bullying culture"* which is not felt or seen at other hospitals within the Trust.

7. The Delivery Suite/Labour ward is described as being the midwives' "*territory*" with staff encountering considerable anxiety when urgent decision making is concerned. This is particularly shocking – patients' lives should not be put at risk because of workplace culture.

8. What makes the Welfare Culture Report more shocking is that the Trust committed to addressing culture in 2023 following an independent review. The Trust's Response to the 2023 culture review set out a plan and a roadmap to addressing cultural issues within the Trust. At the inquest into Syeda's death, I heard evidence that the Trust has worked hard since 2023 to address culture, and that three monitoring criteria as stipulated by the CQC

	had been reduced from three to one. That is commendable. However, despite all of that work, it is clear that a culture of bullying and harassment has been allowed to persist and fester within the maternity department of Good Hope Hospital, undermining all of that hard work. 9. The PSII report was completed on 30/10/25 with the Workplace Culture report following thereafter. Under those reports, the Maternity department was tasked to explore NHS England's Safe Learning Environment Charter (SLEC) to help to support a positive learning and working environment and for representatives from each MDT team to complete a self-assessment to identify areas of improvement. That Charter is available online (https://www.england.nhs.uk/mat-transformation/safe-learning-environment-charter/). In evidence, I was advised that the Safe Learning Charter has been widely adopted throughout the Trust, which is concerning in itself as it is clear that it was not fully adopted within the maternity department at Good Hope Hospital before this tragic incident. Having considered the Charter however, and the evidence of witnesses at the inquest, I am not confident that this will be the "silver bullet" to the problem, particularly as two years' work by the Trust has failed to address and eradicate the problem already. 10. It is recognised that tackling issues of workplace cultural is not a "sprint to the finish line" as there will never be a proverbial "finish line" - it is an ongoing process and which requires the input and buy-in of all employees to ensure that the workplace is a safe place for all. However, it is clear that more must be done to address this issue so that both staff and patients' lives are not at risk. 11. As coroner, it is not my role to make suggestions on what action should be taken but to bring this matter to your attention. I therefore leave matters in your hands.
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 02/02/2026. 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: 1) Syeda's next of kin 2) The Care Quality Commission ("CQC") 3) NHS England I have also sent it to the Medical Examiner 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	**8 December 2025**  Signature: **Adam Hodson** **Area Coroner**