

REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

If during an investigation, a coroner becomes concerned about circumstances that create a risk of future deaths, Paragraph 7 of Schedule 5, Coroners and Justice Act 2009, provides coroners with the duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths. That report is called a Prevention of Future Deaths Report (PFD report).

The Chief Coroner provides this template to support coroners in the effective and consistent exercise of their statutory duties under the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

The purpose of the template is to provide a clear and structured framework for setting out the matters of concern identified during an investigation which, in the coroner's opinion, give rise to a risk of future deaths. It is designed to promote clarity, ensure that reports are formulated in a way that enables recipients to understand and address the concerns raised, and to support good practice across jurisdictions.

The template does not fetter judicial independence: coroners remain responsible for determining the facts, identifying the matters of concern, and drafting reports that accurately reflect the circumstances of each individual case. The template may be adapted as necessary to ensure that the report properly and precisely records the coroner's views.

In accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#) any applications for redactions to content or general publication of the report must be sent to the coroner. The coroner will provide the representations to the Chief Coroner for a decision.

	REPORT TO PREVENT FUTURE DEATHS REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013 (Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026))
1	CORONER I am Emma Brown HM Area Coroner for the coroner area of Birmingham and Solihull
2	DATE OF REPORT 27 July 2026

3	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.
4	THIS REPORT IS BEING SENT TO 1.National Institute for Health and Care Excellence 2.The Royal College of Obstetricians and Gynaecologists 3. 4. You are under a duty to respond to this report within 56 days of the date of this report, namely by 21 September 2026. I, the coroner, may extend the period if an appropriate application is made.
5	YOUR RESPONSE 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. I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding the publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
6	SUMMARY OF THE CORONER'S CONCERN The evidence in this investigation identified that there is a risk to life arising from the absence of specific national guidance for intrapartum care professionals identifying that 1) a period of loss of contact on a continuous CTG trace can be due to acute fetal bradycardia, distress or demise and b) a specific period after which loss of contact, despite actions to improve contact, should be escalated as an emergency or, at least, considered for escalation.

7	ACTION SHOULD BE TAKEN In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
8	INVESTIGATION and INQUEST On 27 April 2026, I commenced an investigation into the death of Amelia Nasiadka, aged 68 hours The medical cause of death was 1a Hypoxic-ischaemic encephalopathy 1b 1c 1d II How, when and where - see below Conclusion The investigation concluded at the end of the inquest. The conclusion of the inquest was: "Death was a result of oxygen deprivation caused by a delayed delivery arising from prolonged and repeated failures in CTG monitoring, assessment and escalation."
9	CIRCUMSTANCES OF DEATH <i>[Please explain the relevant circumstances of the individual's death, ideally this should be in no more than 500 words]</i> Amelia died at Birmingham Heartlands Hospital on the 24th September 2025 due to a catastrophic brain injury resulting from lack of oxygen during her delivery at Birmingham Heartlands Hospital on the 21st September 2025. Amelia's mother had been admitted to the delivery suite shortly after 2am on the 21st September 2025 in active first stage labour. She required constant CTG monitoring due to her high-risk status. A continuous CTG was in place from 02:30. The CTG trace started showing abnormalities, including periods of loss of contact, after 03:04. It should have been identified from 03:30 onwards that the situation required emergency escalation which would have been likely to result in delivery by 04:30. However, escalation did not take place and whilst some efforts were made to improve contact and at times a trace returned it never reached an interpretable level and the delay in escalation and delivery continued. Ameilia was eventually delivered by a ventouse instrumental delivery at 05:41.

CORONER'S CONCERNS

During the course of the inquest I heard evidence giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows:

[250-word statement addressing what circumstances of the death have led to the coroner's concern, and why the coroner thinks the person to whom the report is directed is responsible for taking action to prevent future deaths. This statement must not propose what action should be taken, as coroners cannot make recommendations].

On 21st September 2025 the University Hospitals of Birmingham NHS Foundation Trust had a local guidance on fetal monitoring that included a section on loss of contact highlighting that, amongst other things, loss of contact could be due to acute fetal bradycardia or demise and that after allowing a timeframe of 3 minutes to relocate the fetal heart rate ('FHR') if unable to do so, assume potential fetal bradycardia and commence emergency procedures. The Trust had introduced this guidance due to common themes relating to lack of oversight of potential acute causes of loss of FHR contact during constant fetal monitoring. The 3-minute period derived from the "3, 6, 9, 12" emergency obstetric training mnemonic for ensuring rapid escalation and timely delivery.

In Amelia's case between 03:02 and delivery there were several periods where contact was lost for over 3 minutes, including one of 21 minutes, without emergency escalation. The Trust guidance was not known to 3 of the practitioners involved (a band 6 midwife, a band 7 midwife and a specialist trainee 4), 2 of whom had only recently started working at the Trust. Evidence was that the absence of similar guidance in NG22 hampered awareness. The evidence was that this local policy is not reflected at all other maternity units nationally.

Whilst action has occurred and is ongoing to raise awareness of the Trust guidance this is not a local issue and life is at risk if maternity practitioners are not aware of the need to escalate promptly when the FHR remains undetected after a reasonable period of action to relocate it. It is my belief that you are able to raise awareness.

COPIES AND PUBLICATION OF THIS REPORT

I have a duty to send a copy of my report to every interested person who in my opinion should receive it.

I also may send a copy of the report to any other person who I believe may find it useful or of interest.

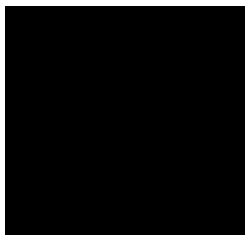
I can confirm I have sent the report to: *(please do not use individual's names, but instead roles/titles)*

1. The parents of Amelia
2. The University Hospitals of Birmingham NHS Foundation Trust
3. The MNSI
4. The nursing and midwifery council

I also have a duty to send a copy of the report to the Chief Coroner.

You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner's [PFD Publication Policy \(2026\)](#). Any representations will be sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.

SIGNATURE



Emma Brown

Area Coroner for Birmingham and Solihull