



Heidi J Connor
His Majesty's Senior Coroner for the Coroner area of Berkshire
Reading Museum and Town Hall,
Blagrove Street,
Reading,
RG1 1QH

3 March 2026

Dear Ms Connor

Re: Baby Louisa Walker

Thank you for your Regulation 28 Report to Prevent Future deaths following the inquest into the death of Baby Louisa dated 27 October 2025.

The loss of a baby is a devastating tragedy for parents, the wider family, and healthcare professionals involved. We would like to begin by extending our deepest and heartfelt condolences to Louisa's family for their profound loss.

This response has been developed following input from members of the Royal College of Obstetricians and Gynaecologists (RCOG) Patient Safety Committee and Senior Officers of the College.

We recognise and respect the narrative conclusion from the inquest. Louisa's head was noted to be impacted in her mother's pelvis during a caesarean section. She suffered skull fractures and intracranial bleeding as a result of the manoeuvres used to disimpact her head.

We also recognise the matters of concern as outlined in your letter as follows:

- 1. There is no national guidance (by way of green top guideline or otherwise) dealing with impacted fetal head seen at caesarean section.*
- 2. Whilst the algorithm referred to on RCOG scientific impact paper number 73 may well have been adopted by many trusts, there is a risk of uncertainty and absence of relevant training in respect of this obstetric emergency.*
- 3. I understand that impacted fetal head is becoming increasingly common.*

In response to your concerns, we acknowledge that impacted fetal head at caesarean birth is an increasingly encountered obstetric emergency, potentially complicating one in ten unplanned caesarean births, and around 1.5% of all births. It carries significant maternal and neonatal risk. The rise in reported incidence may be due to better recognition of the emergency and rising caesarean birth rates in the United Kingdom, but the exact reason



remains uncertain. We agree that greater consistency in national guidance is necessary, and variation in training may contribute to risk.

In recognition of this, impacted fetal head at caesarean birth was included as one of the two components of the recently concluded Avoiding Brain Injury in Childbirth (ABC) Programme. The ABC programme was commissioned by the Department of Health and Social Care in 2018, as a national maternity safety initiative, and concluded its pilot phase and third iteration in 2025. It was developed collaboratively by the RCOG, the Royal College of Midwives and The Healthcare Improvement Studies (THIS) Institute at the University of Cambridge, with crucial input from service users and frontline clinicians. It focuses specifically on reducing avoidable intrapartum brain injury, including through the safe management of impacted fetal head at caesarean birth.

The programme combines evidence-based clinical standards with structured multidisciplinary training and practical tools. It uses a “train-the-trainer” cascade model to help embed consistent practice locally. It emphasises both technical and non-technical skills, including communication, teamwork and situational awareness. Following the pilot phase, NHS England is now rolling out the ABC programme nationally across all maternity services in England. This national implementation is intended to reduce unwarranted variation in care and support maternity units in strengthening preparedness for managing impacted fetal head. The training that each unit will receive includes clear step by step guidance for the management of impacted fetal head which will be implemented within all units.

RCOG Scientific Impact Paper No. 73, *Management of Impacted Fetal Head at Caesarean Birth (2025 Second Edition)*, was produced as part of the ABC programme. It provides a working definition of impacted fetal head, reviews the current evidence regarding prediction, prevention and management, and describes the recognised techniques for managing the emergency.

Scientific Impact Papers (SIPs) are used where the evidence base is still evolving and insufficient to support a formal Green-top Guideline. While Green-top Guidelines aim to provide clinical instructions, SIPs give expert analysis on the new scientific findings and highlight the future implications on practice. Although a SIP does not carry the status of a Green-top Guideline, it is a formal, peer-reviewed RCOG publication intended to inform national standards and practice.

The 2025 second edition was developed to reflect current evidence and clarify its strengths and limitations. We will continue to review emerging evidence and consider guideline development when the evidence base permits.

The Scientific Impact Paper explicitly recognises that variation in practice and lack of structured, multi-professional training may contribute to avoidable harm. It sets out detailed descriptions of safe technique, which have contributed to the development of step-by-step guidance to manage the emergency. It emphasises that these techniques require effective training and rehearsal, ideally through simulation, and that clear communication within the theatre team is essential. These elements have been incorporated into the ABC



programme mentioned above and will be taught to maternity units in England as part of the national roll out of the ABC programme, with the explicit aim of reducing poor outcomes for mothers and babies who experience this emergency. There is currently an active programme of national rollout of the ABC programme by NHSE.

Once again, we offer our deepest condolences to Louisa's family, and we thank you for bringing this to our attention. I hope this is a helpful response to this matter.

Yours sincerely,

[Redacted signature]

[Redacted name]

CEO Royal College of Obstetricians and Gynaecologists