



Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS THIS REPORT IS BEING SENT TO: Chief Executive Officer, Royal College of Obstetricians and Gynaecologists
1	CORONER I am Mrs H J Connor, Senior Coroner for the coroner area of Berkshire.
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. It is important to note the case of R (Dr Siddiqui and Dr Paepre-Rohricht) v Assistant Coroner for East London. This case clarifies that the issuing and receipt of a Regulation 28 report entails no more than the coroner bringing some information regarding a public safety concern to the attention of the recipient. The report is not punitive in nature and engages no civil or criminal right or obligation on the part of the recipient, other than the obligation to respond to the report in writing within 56 days.
3	INVESTIGATION and INQUEST I conducted an inquest into the death of Louisa Walker which concluded on 23 rd of October 2025. I recorded a narrative conclusion as follows: Louisa's death was the direct result of a resident doctor performing a manoeuvre to try to disimpact her head during a caesarean section, which caused skull fractures and intracranial haemorrhage.
4	CIRCUMSTANCES OF THE DEATH 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. She was born on 25 th May 2024, and died on 28 th June 2024. References were made throughout the inquest to the fact that there is no green top guideline for this obstetric emergency. I understand that the RCOG scientific impact paper number 73 has been retracted (for largely unrelated reasons). The algorithm referred to in that paper had been adopted by the trust in this case – and that may perhaps be the case in other hospitals – but there is currently no national guidance on dealing with impacted fetal head.
5	CORONER'S CONCERNS During the course of the investigation my inquiries revealed matters 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: (brief summary of matters of concern)



	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.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 22nd of December, 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 Louisa's family. I have also sent this report to the following recipients who have an interest in this matter: 1. Legal representative for Royal Berkshire Hospital Trust. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	Dated: 27th of October 2025 Heidi J Connor Senior Coroner for Berkshire