



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: The Chief Executive at Royal Berkshire Hospital
1	CORONER I am HEIDI 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. The trust's own investigation action plan highlighted a need for training around impacted fetal head scenarios, following the tragic death of Louisa. The trust served a statement from a senior patient safety lead for the maternity department which stated: <i>"Our department has taken this matter very seriously and is committed to learning and changing our practice to avoid recurrence of a similar incident."</i> At the time of the inquest, it was almost 18 months since Louisa's birth and death. The trust was aware that evidence would be required at the inquest regarding their action plan, and that this evidence would be given not just to the coroner, but in the presence of Louisa's parents. Despite this, we heard in evidence that only 17% of obstetricians have undergone this further training. I understand the training is around 30-60 minutes in duration.
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. If the trust is taking this matter very seriously and is committed to learning, I am concerned that 83% of their obstetricians have not undergone this training. For the avoidance of doubt, the training referred to is training arising out of this incident, and not standard obstetric training on this issue, provided before Louisa's death.
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 22 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. 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: 27/10/2025 HEIDI J CONNOR Senior Coroner for Berkshire