

RESPONSE TO A REPORT TO PREVENT FUTURE DEATHS

REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013

When a coroner sends a prevention of future deaths (PFD) report to a person or organisation, they must respond within 56 days. Recipients of a PFD report can apply to the coroner for an extension. A response to a PFD report must detail the action taken or to be taken, whether in response to the report or otherwise, or it must explain why no action is proposed.

The purpose of the response template below is to promote clarity, ensure that responses address the coroner's concerns directly and transparently, and support consistency and good practice across organisations and sectors. It does not restrict how a person or organisation formulates their response; recipients remain responsible for determining what action is appropriate and for ensuring that their response accurately reflects the steps taken or planned.

In accordance with the Chief Coroner's [PFD Publication Policy \(2026\)](#) representations regarding publication of a response should be sent to the coroner. These representations should be made at the same time as the response is provided. The coroner will pass any representations received to the Chief Coroner for a decision

	RESPONSE TO A 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)) THIS RESPONSE IS BEING SENT TO: RCOG HM SENIOR/AREA/ASSISTANT Coroner Emma Brown for Birmingham and Solihull in response to a 'REPORT TO PREVENT FUTURE DEATH REGULATION 28' following an inquest into the death of Amelia Nasiadka that concluded on 27 April 2026
1	RESPONDENT In line with our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013, RCOG provides this response within 56 days (plus any extension granted) of the date of the Report to Prevent Future Deaths
2	DATE OF RESPONSE

3	CONFIRMATION OF CORONER'S MATTERS OF CONCERN The MATTERS OF CONCERN were identified in the report as follows: 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
4	DETAILS OF ACTION TAKEN, how has the concern been addressed. (If no action is proposed please explain why here) Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. Thank you for your Regulation 28 Report to Prevent Future deaths following the inquest into the death of Baby Amelia on 21 September 2025. The loss of a baby is a devastating tragedy for parents, the wider family, and healthcare professionals involved. We would like to extend our deepest and heartfelt condolences to Amelia'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 conclusion from the inquest that the medical cause of Amelia's death was a result of oxygen deprivation caused by a delayed delivery arising from prolonged and repeated failures in CTG monitoring, assessment and escalation. We also recognise the matters of concern as outlined in your letter which were 1) a period of loss of contact on a continuous CTG trace can be due to acute fetal bradycardia, distress or demise and 2) 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. Apparent loss of contact on a CTG can be due to several causes. Whilst rarely it is because a fetal heartbeat is no longer present, it is much more frequently associated with fetal movement and fetal position. It is more common at early gestational ages and in women with a high body mass index (BMI). It may also be due to inadvertent recording of maternal heart rate which may be difficult to distinguish from a true bradycardia due to

the lower maternal heart rate. Current national guidance from NICE ¹ suggests that if there is difficulty in obtaining a good signal, the apparent fetal heart rate should be differentiated from maternal heart rate and use of a fetal scalp electrode considered. In practice, even application of a scalp electrode does not always give a clear signal and a clinical decision needs to be made based on the individual situation including the gestational age and both maternal and fetal risk factors. Bedside ultrasound scanning can also help in confirming presence of the fetal heart and optimal position for monitoring.

The RCOG's Avoiding Brain injury in Childbirth (ABC) programme is currently undergoing national rollout. The programme aimed to reduce avoidable brain injury in childbirth by improving care in two high-risk areas, by developing agreed national standards and training, in:

- Recognising and responding to fetal deterioration during labour
- Managing impacted fetal head during caesarean birth

This programme supports maternity teams with evidence-based tools and protocols to ensure consistent, timely, and coordinated care.

The intrapartum toolkit within the programme advises that when there is difficulty auscultating or locating a fetal heart or there is difficulty in establishing the baseline of a CTG, this should result in urgent or immediate escalation. Given the variety of both benign and concerning causes for apparent loss of contact on a CTG, it is difficult to define a set timeframe for escalation. This should be guided by the clinical situation, balancing the need for early recognition of fetal compromise when this does exist, against the potential for unnecessary intervention which can also result in maternal and fetal morbidity and mortality.

Whilst the RCOG do not have any guidance relating to the interpretation of CTGs per se, we note that the guidance from NICE¹, FIGO², and the physiological management³ relating to CTGs do not advocate a particular time for responding to loss of contact. We believe that NICE may wish to explore amending NG229 to emphasise that a period of poor quality CTG may be masking fetal bradycardia, distress or demise, and that escalation should be considered, where this is appropriate to the specific circumstances of the clinical situation.

Thank you for bringing this to our attention. I hope this is a helpful response to this matter.

References

1. [Fetal monitoring in labour](#) NICE guideline NG229 2026.
2. [FIGO Intrapartum Fetal Monitoring Guidelines](#) Oct 2015
3. [Physiological CTG - Guideline](#) Feb 2018

5	DETAILS OF FURTHER ACTION PROPOSED <i>Please note that any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online.</i>

SIGNATURE

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