



Department
of Health &
Social Care

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*Parliamentary Under-Secretary of State for
Women's Health and Mental Health*

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HM Coroner Joanne Kearsley
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5 March 2026

Dear Ms Kearsley,

Thank you for the Regulation 28 report of 5 November 2025 sent to the Secretary of State / the Department of Health and Social Care about the death of Jennifer and Agnes Cahill. I am replying as the Minister with responsibility for Maternity, Women's Health and Mental Health.

Firstly, I would like to say how saddened I was to read of the circumstances of Jennifer and Agnes death. I offer my sincere condolences to their family and loved ones. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention. Thank you for the additional time provided to the department to provide a response to the concerns raised in the report. I recognise the seriousness of the matters raised in your report and the need for urgent action to improve the safety and quality of homebirth services.

The report raises concerns over:

1. There is no national guidance in respect of home births. Specifically, robust evidenced based guidance on home birth care, similar to that which is in place for intrapartum care in a hospital setting.
2. There is an increase in the number of women with 'high risk pregnancies' requesting home births where required interventions cannot take place or would be significantly delayed and there is no robust framework for midwives supporting home birth care. There is no national guidance to support consistent practice across the country including, for example, details of clinical scenarios where women, following robust assessment, have been considered too high risk to safely receive care in a home-setting.
3. The lack of national guidance means there are differing models of care and unlike other specialities home births are not a specialist commissioned service. There is no

national guidance considering the ethical responsibility and proportionality of offering a home birth model under the NHS framework.

4. Even though there is a very small risk of death, this is not something which is discussed with women particularly in relation to maternal death, even if the woman has a recognised risk such as a post-partum haemorrhage. There is no guidance to ensure the risk of death to both mother and baby is discussed with any woman considering a home birth irrespective of being considered high or low risk.
5. NICE guidance on intrapartum care (2023 updated June 2025) Section 1.3.3 only refers to the potential risk of death to a baby. There is no mention in the guidance of risk to the mother.
6. Terminology around pregnancies describes them as 'high' or 'low risk pregnancy' and leads women to consider that pregnancy encompasses all stages through to delivery of a child. Practice does not personalise or individualise risk so women can fully understand what the level of risk is for them in actually being pregnant, or what the level of risk is for them in giving birth.
7. In order to maintain their skills, there is no set number of deliveries a community midwife must conduct following qualification. There is no mandated number of deliveries that any midwife (irrespective of the settings in which they are working) must complete once they have qualified as a midwife in order to maintain their registration. The level of experience of community midwives in conducting deliveries is not information routinely provided to women to inform their decision whether to have a homebirth.
8. No bespoke training needs analysis has been conducted focusing on midwives practicing in home birth teams.
9. The lack of national data collection means there is no data to evidence the number of women who are transferred in during labour or after birth, maternal or neonatal outcomes, number of women who are considered out of guidance.
10. The no national guidance on the model of staffing, training and experience for midwives providing home birth care.

In preparing this response, my officials have made enquiries with NHS England to ensure we adequately address your concerns.

NHS England's letter to Trusts sent on 25 November directed all Trusts to urgently review their homebirth services. This letter directly highlights three matters raised in your report: operational running of services, care planning and risk assessment, governance and oversight. NHS England set a clear expectation for Trusts to report the findings of their review to their local board and to escalate any issues identified for further action to the Regional NHS Team.

I recognise and agree that the guidance relating to intrapartum care does not provide the clarity necessary to support women, staff and services to support home birth requests safely. NHS England have started to develop further resources, and I welcome the

collaboration of the NICE, Royal College of Midwives, Royal College of Obstetrics and Gynaecology, Nursing and Midwifery Council, Maternity and Newborn Safety Investigations, Care Quality Commission and the General Medical Council in this work. These resources will take account of the matters raised in your report and will specifically address the increase in the number of women with “high risk pregnancies” requesting home births and variation in service models.

You have raised an important issue relating to the ethical responsibility and proportionality of offering, and women choosing, a homebirth. It is an incredibly personal choice for women about how they wish to give birth and they have a legal right to choose what healthcare they need. I want to acknowledge that women can choose an unsupported homebirth if they wish which carries a greater risk to the women and the baby. I agree that we need to consider this matter closely and will discuss with NHS England what further guidance is needed to better support Trusts manage these finely balanced situations. My officials will also engage with NICE to amend their intrapartum guidance to reflect the risk of maternal death.

I wholeheartedly agree that all risks throughout pregnancy, particularly the risk of death to both the mother and baby, must be discussed sensitively and fully with women. Whilst this is important for every woman regardless of the level of risk associated with the pregnancy, it is even more critical for women who identified as high risk. I am deeply sorry that for Jennifer, this did not happen, and we must ensure this does not happen again. The Nursing and Midwifery Council has guidance for midwives to support informed decision making, principles for supporting women’s choices throughout their maternity care and for outside of hours care. It is the responsibility of Trusts to ensure care is delivered in line with these standards.

It is critical to the safety of women that they receive a risk assessment at each point of contact throughout their pregnancy. This was a recommendation made by Donna Ockenden, in her independent review of maternity services at Shrewsbury and Telford in 2022. The previous Government accepted all the recommendations in this report and in November 2025 all Trusts were directed to implement this as part of its response. Following Donna’s recommendations in 2022, NHS England carried out regional assurance site visits at Trusts, and all Trusts reported compliance with implementation to their regional teams.

You raised matters relating to the proficiency, training and skills of midwives in homebirths. The Nursing and Midwifery Council are responsible for setting the proficiencies midwives need to practice, ensuring they have the right skills, knowledge and expertise to safely support women and babies. They are mapping these proficiencies against previous maternity reviews and investigations to better understand where standards need to be strengthened. The Department welcomes, and will join, discussions with the Nursing Midwifery Council relating to post registration standards, whilst noting that the number of deliveries is not alone, a reliable criterion for assessing a midwife’s overall fitness to practice.

Last year, the Department of Health and Social Care approved funding for a new neonatal resuscitation training programme. This training will be specific to the roles and responsibilities for clinicians and the out of hospital course includes homebirth scenarios. Whilst NHS England commissioned the Resuscitation Council UK to update their Neonatal Life Support course, the out of hospital course is now available to staff in all Trusts.

I recognise the need to improve the data collection in relation to number of women who transferred during labour and after birth as well as maternal and neonatal outcomes. I support NHS England's proposal to work with the Midwifery Study System to develop a solution to this.

It is vital that lessons are learnt collectively, and changes are made to reflect where things have gone wrong, which is essential to ensure the NHS provides safe, high-quality care.

I hope this response is helpful and we will continue to work closely with NHS England and other partners to bring forward quick action to address your concerns.

All good wishes,

