NHS England

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24 December 2025

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Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Jennifer Rose Cahill who died on 4 June 2024 and Agnes Lily Wren Cahill who died on 7 June 2024.

Thank you for your Report to Prevent Future Deaths (hereafter "Report") dated 5 November 2025 concerning the sad deaths of Jennifer Rose Cahill on 4 June 2024 and her daughter, Agnes Lily Wren Cahill, on 7 June 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Jennifer's and Agnes' family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Jennifer's and Agnes' care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise for any anguish this delay may have caused Jennifer's and Agnes' family or friends. I realise that responses to Coroners' Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones, and I appreciate this will have been an incredibly difficult time for them.

Your Report raised a number of concerns, which we have considered in full. The concerns that fall within NHS England's role and remit relate to the lack of national guidance in relation to homebirths and associated maternity care, and the current differing models of care and practice across the country. You also raised that there is a lack of national data collection, meaning there is no data to evidence the number of women who are transferred from home to hospital during labour or after birth, maternal or neonatal outcomes, and the number of women considered out of guidance.

We have engaged with colleagues from NHS England's national maternity team as well as our North West regional team in preparing the response to your Report.

On 26 November 2025, NHS England wrote to all NHS maternity providers in England asking them to urgently review the safety and quality of their homebirth services. In particular, we have urged them to consider the following issues which were highlighted in your Report:

- **The operational running of their service**: including how it ensures that prompt midwifery care is available 24 hours a day; that staff are properly equipped, trained, prepared and skilled for providing birth and neonatal care in a home setting; that staff have senior multi-disciplinary support available to them at all times and have sufficient rest periods; and that potential transfer and extraction processes are clear and planned for each birth.

- **Care planning and risk assessment**: including systematic assessment of complexity and risk; how the multidisciplinary team (MDT) ensures a personalised approach to women in planning care in light of any identified issues (particularly when a homebirth is not recommended); how the MDT continues to maintain good communication at all stages of care with women and between all teams including ambulance services; and how dynamic risk assessment is managed and responded to throughout pregnancy, birth and the postnatal period.

- **Governance and oversight**: including how governance is structured to ensure robust oversight of homebirth services by the whole organisation, so the trust board has appropriate oversight; that there is an audit programme that covers outcomes and clinical and operational guidance and leads to continuous improvement; and that there is comprehensive homebirth guidance including standard operating procedures for all stages and aspects of care.

The National Institute for Heath and Care Excellence (NICE) uses available evidence to develop guidance to improve health and social care, including the Guideline on Intrapartum care (published 29 September 2023 and updated on 14 November 2025). While not dedicated to homebirths, the guidance does cover the care of women and their babies during labour and immediately after birth in all settings and addresses issues around planning the place of birth.

We acknowledge that the current intrapartum care guidance does not provide sufficient clarity to women, staff and services as to how to safely support requests for and the provision of homebirth services. NHS England will work with partners including NICE, the Royal College of Midwives, the Royal College of Obstetrics and Gynaecology, the Nursing & Midwifery Council, Maternity & Newborn Safety Investigations, the Care Quality Commission, and the General Medical Council to develop further resources that enable services to consistently support commissioners, providers and women and families.

In December 2025, NHS England convened partners and initiated work to develop resources that rapidly close this gap. This will include how to respond to the increase in the number of women with “high risk pregnancies” requesting homebirths and variation in service models.

In developing these resources, NHS England and its partners will consider the ethical responsibility and proportionality of offering women an NHS homebirth, while taking into account that women have a legal right to choose what healthcare they receive. In

addition, some women who cannot be supported to birth at home due to the level of risk may choose to give birth unassisted, which carries a higher risk. We will build on work already started, looking to clarify whether NHS health professionals providing maternity services may withdraw midwifery services from women birthing at home against professional advice and/or from women making requests with regards to care/treatment that are considered highly unsafe or unreasonable.

We already expect maternity provider Trusts to have operating procedures for planning births at home and pathways for women with high-risk pregnancies requesting home births. We have written to all maternity providers reminding them of those expectations and action to be taken. As a way to escalate where Trusts may not have appropriate operating procedures for planning births at home and managing high-risk pregnancies, the Perinatal Quality Oversight Model (2025) provides a structured approach for identifying and responding to safety concerns across Trusts, Integrated Care Boards (ICBs), and neonatal operational delivery networks.

We agree that patients should be informed about all material risks, and this has been established by case law relating to informed consent. Health professionals must take "reasonable care to ensure that the patient is aware of any material risks involved in any recommended treatment and of any reasonable alternative or variant treatments". With regard to the risk of death, this is better framed in terms of the risk of potential adverse outcomes, such as post-partum haemorrhage, and how mitigations might vary in different settings.

For all women, communication around risk should be personalised. Donna Ockenden, in her review of the maternity services at Shrewsbury and Telford Hospital NHS Trust, made it clear that staff must ensure that women undergo a risk assessment at each contact throughout the pregnancy pathway and that "risk assessment must include ongoing review of the intended place of birth." NHS England asked Trusts to implement this at the time. All pregnant women should also be offered a personalised care and support plan where such information is recorded, alongside the decisions they make about their care.

The Royal College of Midwives (RCM) has separately issued guidance around Informed decision making and Care outside of guidance, and the Nursing & Midwifery Council (NMC) has issued Principles for supporting women's choices in maternity care. Employing Trusts are responsible for ensuring that their midwives practice in line with these principles.

The NMC also maintains standards of proficiency for all midwives, which represent the skills, knowledge and attributes they must demonstrate. While the number of births attended is not alone a reliable indicator of a midwife's fitness to practise, we will work with the NMC to consider the requirements for post-registration standards, that have a specific focus on homebirths, as part of the development of resources mentioned above.

Midwives practicing in homebirth settings require the same level of skills, knowledge and proficiencies and provide the same clinical care as midwives in other settings. However, midwives providing care at home must be able to respond to developing emergencies in these specific settings, sometimes without the support of multi-disciplinary teams and immediate access to hospital facilities and are expected to undergo regular training in this. We will work with other organisations to ensure that multi-disciplinary team training for obstetric emergencies includes at least one scenario starting in a community/homebirth setting.

NHS England has also commissioned the Resuscitation Council UK (RSUK) to design an updated Neonatal Life Support (NLS) course, specific to roles and responsibilities for clinicians, including the out-of-hospital course. Training is available for multi-disciplinary teams, including ambulance crews. Funding is being provided for 6,000 practitioners to have NLS training over a 2-year period. The course build remains to be completed. However, the out-of-hospital course is now available to Trusts and includes homebirth scenarios.

With regard to national data, some is already available. Data drawn from the MBRACE 2009 to 2024 reports, by Professor Marian Knight, Director of the National Perinatal Epidemiology Unit, highlights that over 15 years, there have been 19 women who died who planned to give birth at home, amongst 11.5 million women giving birth, and that, of those 19 women, 6 actually gave birth at home. We acknowledge that this does not provide evidence of the number of women who have been transferred from home to hospital during labour or after birth, or of their and their baby's outcomes. We will work with the UK Midwifery Study System (UKMIDSS) to develop a solution to this.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad deaths of Jennifer and Agnes, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

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National Medical Director
NHS England