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22 December 2025

Ms Joanne Kearsley
HM Coroner's Officer
HM Coroner's Court
Floors 2 & 3, Newgate House, Newgate,
Rochdale,
OL16 1AT

[redacted]

[redacted]

Dear Ms Kearsley

Re: Regulation 28 Prevention of Future Deaths Report (Jennifer and Agnes Cahill)

I write in response to your regulation 28 report dated 5 November 2025 regarding the very sad death of Jennifer and Agnes Cahill. I would like to express my sincere condolences to Jennifer's and Agnes's family.

I asked the patient safety leads at NICE to carefully consider your report with respect to the areas for which NICE is responsible, and I address each point in turn.

1.There is no national guidance in respect of home births

Home birth is covered in NICE's guideline on intrapartum care (NG235). The risks and benefits of home birth compared to birth in an alongside midwifery unit, freestanding midwifery unit and hospital are covered, with information for counselling detailed in tables 6-9. The guideline provides comprehensive guidance on intrapartum care, including (but not limited to) home births. The guideline covers:

- Eligibility - home birth might be considered for women with low-risk, uncomplicated pregnancies. This includes those without medical or obstetric complications and differentiates in terms of risk factors between nulliparous and multiparous women (recommendation 1.3.1).
- Informed Choice: Women should be supported to make informed decisions about their place of birth. This includes discussing risks, benefits, and available support (recommendation1.3.3-5).
- Midwife Support: Care during home birth should be provided by trained midwives, with access to emergency transfer protocols if complications arise.

Within the guideline, medical conditions and other factors that may affect the choice of planned place of birth are not given as *contraindications* to home birth but indicate where care in an obstetric unit would be expected to reduce risk to the mother or the baby. There are also recommendations that support further discussion with an appropriately trained senior or consultant midwife and/or a senior or consultant obstetrician (if there are obstetric issues) if such a discussion is wanted by the midwife or the woman. See recommendations 1.3.9 to 1.3.11 and tables 6-9.

Intrapartum care (NG235) covers assessment in the first stage of labour in any setting, including the observations of the mother and the unborn baby that should led to the transfer of the woman to obstetric-led care, noting also that multiple risk factors may increase the urgency of the transfer, particularly if they have a cumulative effect. The guideline notes the more frequent observations of the mother and the unborn baby that should be undertaken in the second stage.

We therefore conclude that the subject of home births is appropriately covered in the current guidelines. The recommendations guide clinical practice and support women to make an information choice about their care based on discussions with trained staff about the risks and benefits. There is insufficient evidence to suggest that a change to the current recommendations is justified.

2. 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.

As noted above, our guidance on intrapartum care (NG235) lists medical conditions and other factors that may influence the choice of planned place of birth (tables 6-9). These are not given as *contraindications* to home birth but indicate where care in an obstetric unit would be expected to reduce risk to the mother or her baby.

Further discussion with an appropriately trained senior or consultant midwife and/or a senior or consultant obstetrician (if there are obstetric issues) is recommended (recommendation 1.3.10).

It is not possible for us to list all the potential scenarios that might occur, nor to define what is ‘too high risk’ as this will depend upon many local and individual factors. Local transfer times, staffing, and the ability to escalate care quickly are key determinants of whether planned home birth is appropriate for an individual.

We note that the coroner dislikes the term 'birth outside of guidance' but the language associated with this term has been carefully chosen to reflect the sensitivities around discussions where women have felt in the past that their care has been paternalistic and choice has been removed from their care.

There is no national guidance to support women or their care providers in this setting. We would suggest that advice from the Royal College of Obstetricians and Gynaecologists (RCOG) would be most appropriate to address this point, perhaps in a practice paper with a consent advice document.

3.There is no national guidance considering the ethical responsibility and proportionality of offering a home birth model under the NHS framework.

The ethics of service delivery for an individual health care worker are covered by the relevant regulator. For example, the Nursing and Midwifery Council (NMC) and the General Medical Council (GMC) along with the Department of Health and Social Care (DHSC) and NHS England (NHSE).

4.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.

NICE provides a number of tools and resources to support our guidelines. For intrapartum care (NG235), these include a tabulated comparison of the different places of birth containing an estimate of the risks to the mother and the baby. There is also a link to endorsed resources produced by NHS England that support the implementation of the recommendations in this guideline.

Our patient safety leads note that maternal death is a rare event in modern UK maternity care; population surveillance (MBRRACE-UK) reports maternal mortality at the level of ~9–13 deaths per 100,000 maternities in recent periods, which reflects deaths across all settings and risk groups and

cannot be disaggregated reliably by planned place of birth in most studies. The absolute number of maternal deaths is extremely small, so studies are not able to compare maternal death rates specifically by planned place of birth.

We are aware that The Birthplace Study found that for multiparous women home births are as safe as hospital births. For first-time mothers, there is a slightly increased risk of adverse outcomes for the baby. Our patient safety leads are not aware if home births, as currently practised in the UK, are any more or less safe for women. This is supported by a meta-analysis published in 2019 Perinatal or neonatal mortality among women who intend at the onset of labour to give birth at home compared to women of low obstetrical risk who intend to give birth in hospital: A systematic review and meta-analyses - ScienceDirect.

Furthermore, as most home births are in low-risk pregnancies (as per the guidance) determining a risk of mortality for those at greater risk is not possible from observational studies. Our view is that further research is needed by the appropriate bodies to quantify the risk in an individual.

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.

For healthy, low risk women the absolute risk of maternal death during or soon after labour is extremely low and too small for robust direct comparison between planned home birth, midwifery unit birth, and obstetric unit birth in the UK. High quality population evidence (the Birthplace programme and related evidence reviews) finds no clear increase in serious maternal outcomes for low risk women planning birth in midwifery units or at home, but maternal death is so rare that studies are underpowered to detect small differences in that specific outcome.

For clinically low risk women, national evidence supports offering a choice of home birth or midwifery unit birth with careful antenatal assessment and tested transfer arrangements; obstetric units remain the recommended setting for women with identified clinical risk factors because they provide immediate access to higher level interventions should rare but serious complications (including those that might lead to maternal death) occur.

NICE guidance on intrapartum care (NG235) includes a recommendation for research into the effect of information-giving on place of birth. Such research may be used to restructure the way in which information is provided, so that it is presented in a more accurate, less risk-based way in order to support women's choices.

The NICE guideline, as detailed earlier in this response, does include recommendations on medical conditions and other factors that may affect planned place of birth. Those recommendations include consideration of risk to the mother.

6.Terminology around pregnancies describes them as ‘high’ or ‘low risk pregnancy’.

We note your suggestion that as terminology around pregnancies describes them as ‘high’ or ‘low risk pregnancy’, this leads women to consider that pregnancy encompasses all stages through to delivery of a child, and that this does not allow people to differentiate between the level of risk for them in being pregnant and the risk of labour and birth itself.

We do not define the use of the term ‘low-risk pregnancy’, that is ‘one where both mother and baby are expected to remain healthy throughout pregnancy and birth. The term explicitly covers risks to both the mother and the child, but it signals that the likelihood of complications is low, not non-existent’.

There is a discussion about this in the final scope (the final scope defines what the guideline will and will not cover and to whom it will apply) for intrapartum care for women with existing medical conditions or obstetric complications and their babies (NG121). It defines a high risk pregnancy:
"*A pregnancy is 'high risk' when the likelihood of an adverse outcome for the woman or the baby is greater than that of the 'normal population'. A labour is 'high risk' when adverse outcomes arise in association with labour."*

We will review our guidance to consider the feasibility of defining what is meant by high and low risk pregnancy and making the differentiation clear between the risks of pregnancy and the risks of labour.

Points 7-9 do not relate to the role of NICE.

10.The no [sic] national guidance on the model of staffing, training and experience for midwives providing home birth care.

Our guideline on safe midwifery staffing for maternity settings (NG4) covers midwifery staffing in all maternity settings, including at home and in the community. It aims to improve maternity care by giving advice on monitoring staffing levels and actions to take if necessary. It provides recommendations on organisational requirements; setting the midwifery establishment; assessing differences in the number and skill mix of midwives needed and the number of midwives available; and monitoring and evaluating midwifery staffing requirements.

The guideline also provides recommendations on assessing the skill mix of available maternity staff against care requirements.

Additionally, there are the tools referred to under point 4 above.

Training of midwives is not the responsibility of NICE and is better addressed by the Nursing and Midwifery Council (NMC), Royal College of Midwives (RCM) and educational bodies who provide such training.

I hope that the information above is helpful in clarifying the guidance that we have published that is of relevance to the circumstances of these very sad events and would like to reiterate my sincere condolences to the family of Jennifer and Agnes.

Yours sincerely,

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[redacted], CBE MD FRCS FRCEM
Chief Executive