Senior Coroner Joanne Kearsley
HM Coroner's Court
Floors 2 and 3
Newgate House
Newgate
Rochdale
OL16 1AT

[redacted]

12 January 2026

Dear Coroner

Regulation 28 Prevention of Future Deaths report dated 5 November 2025 in relation to Jennifer and Agnes Cahill

I would like to begin by offering my heartfelt condolences to the family of Jennifer and Agnes for their tragic loss.

As Chief Executive and Registrar of the Nursing and Midwifery Council (NMC), I take the matters of concern set out in your report very seriously. Our vision is to provide safe and effective midwifery education and practice across the four countries of the UK. In line with this, I set out below the steps we will be taking to the address the issues in relation to home births identified as part of your investigations.

First, and by way of background, I thought it would be helpful to set out the NMC's role and to detail some of the work already underway to ensure safe, equitable and person-centred maternity care in the UK.

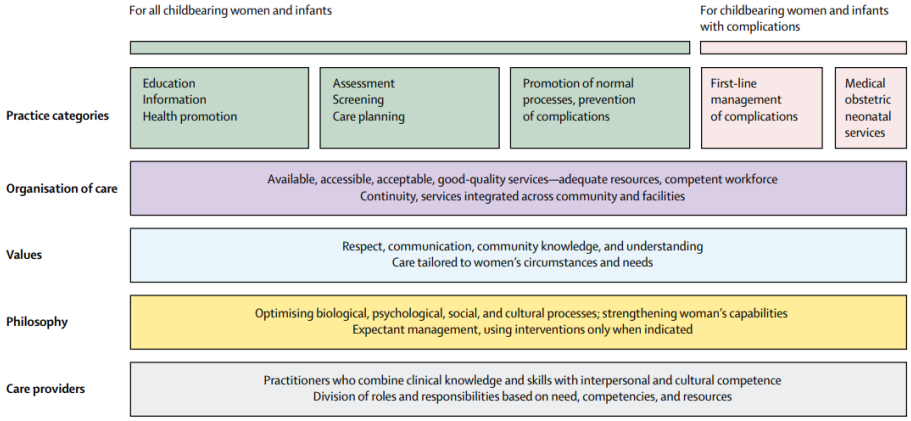
NMC's regulatory role

The NMC is the independent regulator for nurses and midwives in the UK, and nursing associates in England. Our role is to protect the public and maintain confidence in the nursing and midwifery professions.

We support more than 47,400 midwives to deliver safe and effective midwifery care through our regulatory processes. We do this by setting the standards of conduct and performance through the Code and competencies through the standards of proficiencies, which specify the knowledge, understanding and skills that midwives must demonstrate at the point of qualification, when caring for women across the maternity journey, newborn infants, partners and families across all care settings.

The standards of proficiency are in alignment with the International Confederation of Midwives' (ICM) definition of the midwife and the ICM essential competencies for midwives and are based on the Lancet framework for quality maternal and newborn health:

The Framework for Quality Maternal and Newborn Health from The Lancet Series on Midwifery



Renfrew, McFadden, Bastos, Campbell et al The Lancet: 384, 1129-1145, 2014 (used with permission)

The above explains how the proficiency standards are developed and must be read. The different domains are all inter-connected and together demonstrate the expectations from all midwives. Domains 1, 2 and 3 are about universal care for all women and newborn infants whereas domain 4 focuses on additional care for women and newborn infants with complications.

In practice, midwives work across the continuum from pre-pregnancy, pregnancy, labour and birth, postpartum, and the early weeks of newborn infants' life. Midwives are required under our standards to respect and enable the human rights of women and children, and their priority is to ensure that care always focuses on the needs, views, preferences, and decisions of the woman and the needs of the newborn infant.

Our standards also require midwives to provide and evaluate care in partnership with women, and their partners and families if appropriate, referring to and collaborating with other health and social care professionals as needed. Midwives are ideally placed to anticipate and to recognise any changes that may lead to complications and additional care needs. These may be physical, psychological, social, cultural, or spiritual, and include perinatal loss and end of life care. When such situations arise, the midwife is responsible for recognising these and for immediate response, management, and escalation, involving, collaborating with and referring to interdisciplinary and multiagency colleagues. In such circumstances, the midwife has specific responsibility for continuity and coordination of care, providing ongoing

midwifery care as part of the multidisciplinary team, and acting as an advocate to ensure that care always focuses on the needs, views, preferences and decisions of the woman and the needs of the newborn infant.

Our standards recognise that midwives work in a range of roles and settings from women's homes, hospitals, the community, midwifery led units and all other environments where women require care by midwives. As the professional regulator our remit is midwives as professionals. Systems regulators, such as the Care Quality Commission (CQC), have a role in ensuring the safety of maternity and midwifery services settings.

Work underway to ensure safe, equitable and person-centred maternity care in the UK

Failings by certain maternity services across the UK have come under increasing scrutiny over recent months and have been the subject of a number of reviews. Too many women and babies have lost their lives during, or shortly after, childbirth.

While maternity services are delivered by both doctors and midwives, as the regulator of midwives, we have a clear role to play in supporting the improvement of midwifery services.

On 6 November, we published our **Midwifery Action Plan**, which outlines the work we are doing to ensure safe, equitable and person-centred midwifery care. This includes publishing the **Principles for supporting women's choices in maternity care** in August 2025 following extensive coproduction with key UK-wide lay and registrant stakeholders. This document outlines the support women should expect, the care midwives can provide and how employers can support women and midwives to provide safe and effective care.

Alongside this, we are running a joint campaign with the General Medical Council (GMC) around the importance of high-quality multidisciplinary teamwork in maternity care. Good teamwork means better maternity care - The Nursing and Midwifery Council and Maternity care - GMC

Actions we are taking in response to the Prevention of Future Deaths Report

Your report highlights further issues in respect of maternity services, particularly in relation to home births, which we must take action to address.

On 8 December, we participated in a joint safety stakeholder meeting to discuss the specific matters of concerns identified. This meeting was attended by senior maternity and neonatal leaders from NHS England, Maternity and Neonatal transformation programme at NHS England, the Royal College of Midwives (RCM), NHS Resolutions (NHSR), the National Institute for Health and Care Excellence (NICE), the General Medical Council, Maternity and Neonatal Safety Investigations

(MNSI), British Association of Perinatal Medicine (BAPM), the Care Quality Commission (CQC) and Maternity and Neonatal Voices Partnership (MNVP), and involved collaborative working across all key stakeholders whilst maintaining our independent functions. An outcome of the meeting was the development of a task and finish group, led by NHS England, to develop national pathways for homebirth services which will aim to address the matters of concern identified within the report. NHS England have told us that they will contact us to share proposed next steps in the early new year.

As the professional regulator for midwives in the UK, the NMC plans to play an active role in the group in line with our regulatory role. More specifically, we propose to take the following actions in response to the matters of concern detailed in your report as follows:

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**

We propose to feed into the task and finish group to address the concerns about the lack of national guidance in respect of home births.

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.**

We propose to feed into the task and finish group to address the concerns about the lack of a robust framework for midwives supporting home birth care. Our principles for supporting women's choices in maternity care will be used to outline our regulatory function during these discussions.

We will also be strengthening the NMC's midwifery standards to acknowledge homebirth and the differences entailed by adding a definition to the glossary in explanation of all care settings by March 2026.

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.**

We propose to feed into the task and finish group to address concerns about the differing models of care and lack of national guidance considering ethical

responsibility and proportionality of offering a home birth model under the NMC 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.**

We propose to feed into the task and finish group to address concerns around the inconsistency in evidenced based discussions with women to allow them to make informed choices about their birth options.

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.**

We propose to feed into the task and finish group to address concerns around NICE guidance on intrapartum care and the lack of guidance about the risks 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.**

We propose to feed into the task and finish group to address concerns around the terminology used to describe pregnancies as "high" or "low risk".

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.**

Our standards of proficiency for midwives provide that midwives should be equipped to care for women in all settings. Through mandatory training midwives are required to update their skills and competence annually ensuring they are updated within their current scope of practice. This is then reported to the NMC via the Continuing

Professional Development (CPD) section of the revalidation process that all midwives must go through every 3 years to renew their registration with the NMC.

We are not proposing to take action to introduce a mandated number of deliveries post-registration. There is currently no requirement for post registration confirmation of competence in any area of midwifery because midwives work in various areas and can transfer across roles regularly if they choose to do so.

8. **No bespoke training needs analysis has been conducted focusing on midwives practising in home birth teams.**

We propose to feed into the task and finish group to address concerns about bespoke training needs analysis for midwives practising 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.**

The NMC does not hold or mandate the collection of national clinical data and so we are unable to take any action in response to this concern.

10. **There is no national guidance on the model of staffing, training and experience for midwives providing home birth care.**

As the regulator of midwives, we do not contribute to workforce modelling. However, our standards are clear regarding our expectations that midwives should be able to care for women in all birth settings. Midwives, with support from their employers are responsible for ensuring they have the skills, knowledge and capabilities to provide care.

Conclusion

Thank you for sharing the areas of concern that you have identified, during your investigations, with us.

I hope my setting out of our responses with respect of each concern has been helpful.

Once again, I would like to offer my condolences to the family of Jennifer and Agnes Cahill for their tragic loss.

Yours sincerely

Chief Executive and Registrar