



REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS THIS REPORT IS BEING SENT TO: 1. [REDACTED] Secretary of State for Health and Social Care 2. [REDACTED] Chief Executive of the Royal College of Midwives 3. [REDACTED] Chief Executive of the Nursing and Midwifery Council 4. [REDACTED] Chief Executive of the Royal College of Obstetrics 5. [REDACTED] Chief Executive of National Institute for Clinical Excellence 6. [REDACTED] Chief Executive of NHS England
1	CORONER I am Joanne Kearsley, Senior Coroner for the Coroner area of Manchester North
2	CORONER'S LEGAL POWERS I make this report under paragraph 7, Schedule 5, of the Coroner's and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013
3	INVESTIGATION and INQUEST On the 26 th June 2024 I commenced an investigation into the deaths of Jennifer and Agnes Cahill. The Inquests concluded on the 27 th October 2025. The conclusion of the Inquests was: Jennifer Rose Cahill died as a result of complications arising from the delivery of her second child, contributed to by neglect. Agnes Lily Wren Cahill died as a result of complications during birth, such complications contributed to by neglect.
4	CIRCUMSTANCES OF DEATH In 2023, Jennifer Cahill was pregnant with her second child. Her antenatal care was managed by Manchester Foundation Trust ("MFT") community midwives. In 2021 her first pregnancy had resulted in complications at the time of delivery. She had a Post Partum Haemorrhage for which she received an iron and also a blood transfusion. She was also positive for Group B Streptococcal. Due to the complications in her first pregnancy, in her second pregnancy after her first antenatal appointment she was referred to a Consultant Obstetrician. I heard evidence that the advice provided to Jen by the Consultant Obstetrician was for active management of the third stage of labour and intravenous antibiotics in hospital. This was based on the fact it was assumed Jen would deliver her child in hospital. There was no conversation as to whether it was Jen's intention to deliver her child in hospital. This was early in the pregnancy, and no definitive plan had been made. Having heard all the evidence I found that her subsequent antenatal appointments relied heavily on the outcome of this appointment and what was perceived to be a definitive plan. In February 2024 Jen told her community midwife she was considering a home birth. Even though her pregnancy was recorded as low risk on the computer system, given her past history she was referred for a further obstetric appointment to discuss her consideration of a home birth. Jen was seen on the 5 th March 2024 by an ST4 Trainee in Obstetrics. I found this appointment lacked any exploration with Jen as to why she wanted a home birth, there was no consideration as to whether

she had any concerns and how these could be managed. I found Jen's desire for a home birth was linked to trauma from her first pregnancy.

I heard evidence as to the fact that nationally 'high' risk pregnancies are often Consultant led and 'low risk' pregnancies are midwifery led. I heard this can cause confusion to women who are at a higher risk of complication as a result of **delivery** of a child as opposed to any risk of being **pregnant**. In this case Jen believed her pregnancy was 'low risk' as she was midwifery led. Women themselves are likely to deem the term 'pregnancy' to mean all stages through to delivery of their child.

There was a failure in Jen's antenatal care as she was not referred to a senior midwife for completion of an out of guidance care plan. I heard evidence this was a critical plan for women having an out of guidance home birth. The court also heard that the language used with women is delivered in a softer, kinder way and uses phrases such as out of guidance rather than simply 'against medical advice' as would be the norm in other areas of medicine.

This meeting with a senior midwife and subsequent plan, would have meant a detailed discussion with Jen to consider why she did not want to have a hospital birth, consideration of any of her worries, provision of alternatives, clear detailed understanding of her history and any risks and provision of information as to the differences in being able to manage any risks.

This document should have been robust and should have also been continually updated to include the fact that Jen had emerging risk factors. Her haemoglobin level had reduced to 97 by the end of May 2024, despite treatment with iron. In addition, she had a second increased PCR test which should have led to a referral to obstetrics and an offer to induce her labour. These emerging risks were not discussed with Jen in terms of any increased risk around a home birth.

On the 2nd June 2024 two midwives were on call for home births. I heard evidence that intrapartum care is the smallest part of a community Midwife role. The midwives on call had not been involved in Jen's antenatal care. I found the omissions in her antenatal care meant the midwives were placed in a detrimental position. They were also hampered by failing equipment (the Entonox cylinders) and IT connectivity issues whilst they were with Jen.

During the course of her labour Jen received ineffective pain relief due to the issues with the Entonox. She had a raised blood pressure reading at 03:54am which was not repeated. At 4.20am a vaginal examination indicated she was 7cm dilated. The baby was in the OP position. Her labour became increasingly difficult from this point onwards. She was likely in the second stage of labour from approximately 5.30am. During the second stage of labour the fetal heart rate was not monitored every 5 minutes. Any fetal heart rate monitoring was not being conducted in a correct manner. As a result, it was not recognised that decelerations of the fetal heart rate would likely have been occurring for up to an hour before delivery. There was no record of any fetal movement monitoring.

Agnes was born at 06:44am. Resuscitation was not conducted in an effective manner and hampered by a split in the bag valve mask, which had not been noted on arrival when equipment was opened and checked.

A 999 call was made at 06:49am. On arrival of the paramedics' resuscitation of Agnes was conducted effectively by them and her heart rate improved and she was breathing. She was transferred to hospital.

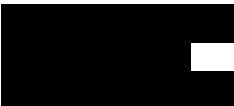
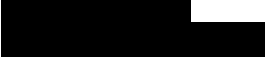
Syntometrine to assist with the risk of a post-partum haemorrhage should have been administered to Jen immediately following the delivery of Agnes but there was a delay of 40 minutes. During this time there was no vaginal examination, and it was not recognised that Jen had sustained a fourth degree perineal tear. It is more likely than not that Jen was bleeding during this period of time. At 07:16am her observations were taken, and her blood pressure was abnormal at 150/122. No further monitoring or observations were conducted. At the time the ambulance service did not use the Maternal early warning score (MEWS) which would have scored Jen as a 6 meaning a risk of serious deterioration. This was not noted by the midwives.

At approximately 07:24am Jen had a post-partum haemorrhage and syntometrine was administered after this, some minutes after she had given birth. During this time there was a lack of clear communication between the midwives and the paramedics.

At around 07:40am whilst attempting to extricate Jen from the property she delivered the placenta and had a second, significant post-partum haemorrhage. She went into cardiac arrest at 08:01am.

She was transferred to North Manchester General Hospital where she died on the 4th June 2024. Agnes was initially taken to North Manchester General hospital but transferred to the neonatal intensive care unit at Royal Oldham Hospital where she died on the 7th June 2024.

	The medical causes of death were recorded as: Jen: 1a) Multiorgan failure with disseminated intravascular coagulation 1b) Cardiac arrest due to post-partum haemorrhage 1c) Perineal tear and atony during term delivery Agnes: 1a Multi-organ insult following hypoxic ischaemic encephalopathy 1b. Cord compression and meconium aspiration syndrome leading to pulmonary hypertension Key findings of fact were: Jen had not made an informed decision to have a home birth and if the out of guidance plan had been completed and all the relevant information provided to her, it is more likely than not she would have given birth in an alternative setting and both Jen and Agnes would have survived. If the fetal heart rate monitoring had been conducted correctly and every 5 minutes, it was more likely than not an abnormal fetal heart rate would have been noted up to an hour before Agnes was born and an urgent transfer to hospital would have occurred. I found emergency services would have been on scene when Agnes was born and effective resuscitation would have been administered which would likely have prolonged her life. Had this call been made it is more likely than not Jen would have survived as the after care delivered to her would have noted a perineal tear and administered syntometrine immediately. I heard evidence that since the deaths MFT have completely overhauled the home birth service provision. The new service became operational in April 2025. In the six month period within the MFT area of GM they have received requests from 34 women for out of guidance home deliveries. Five of these could not be supported due to safety issues. Of the 29 out of guidance home births, 15 (50%) required transfer to hospital for varying degrees of obstetric emergency.
5	<u>CORONER'S CONCERNS</u> During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you. The MATTERS OF CONCERN are 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. 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.
6	ACTION SHOULD BE TAKEN In my opinion action should be taken to prevent future deaths and I believe each of you respectively have the power to take such action.
7	YOUR RESPONSE You are under a duty to respond to this report within 56 days of the date of this report, namely <u>05th January 2026</u>. I, the Coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	COPIES and PUBLICATION I have sent a copy of my report to the Chief Coroner and to the following Interested Persons namely: -  c/o Field Fisher Solicitors  Manchester Foundation Trust

	North West Ambulance Service Legal Representatives for the Midwives who were Interested Persons I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me the coroner at the time of your response, about the release or the publication of your response by the Chief Coroner.	
9	Date: 05th November 2025	Signed: 