



Department  
of Health &  
Social Care

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

39 Victoria Street  
London  
SW1H 0EU

████████████████████  
HM Coroner Victoria Davies  
Area Coroner for Cheshire  
████████████████████

19 March 2026

Dear Ms Davies,

Thank you for the Regulation 28 report of 27 January 2026 sent to the Secretary of State / the Department of Health and Social Care about the death of Pippa Gillibrand. I am replying as the Minister with responsibility for Women's Health and Mental Health.

Firstly, I would like to say how saddened I was to read of the circumstances of Pippa's death, and I offer my sincere condolences to Victoria and her family. The circumstances your report describes are deeply concerning and it is a tragedy that Pippa died from a brain injury sustained due to an avoidable delay in her delivery. This should never have happened.

You raise concerns over the lack of national guidance for home births, particularly the model of care, as well as concerns that there is no national or local collection of data around home births. In preparing this response, my officials have made enquiries with NHS England to ensure we adequately address your concerns, and I understand there is work underway to develop national standards and a clear framework for homebirth services. As operational responsibility for issuing guidance and collecting data around home births sits with NHS England, they will be issuing a substantive response addressing the specific matters of concern raised.

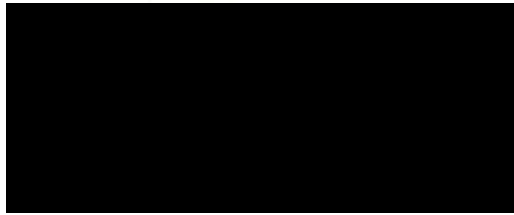
All women deserve access to safe care during childbirth. All staff should receive training that is tailored to their specific setting, including homebirths and how to manage emergencies at point of care. NHS England will speak further to what action is being taken to ensure this is the case, but I want to say how sorry I am that this did not happen for Victoria and Pippa. I understand that NHS England has written to all services and systems asking them to review their service provision, to prevent future tragedies and ensure that women can safely deliver babies across all settings.

It is not acceptable that problems are not always identified effectively or quickly enough such as in the case of Victoria and Pippa, and issues such as these are why the Secretary of State asked Baroness Amos to carry out a national independent investigation in NHS maternity and neonatal care. The investigation will help us understand the systemic issues behind why so many women, babies and families experience unacceptable care, and the final report and recommendations are due to be published in June 2026.

The government is also setting up a National Maternity and Neonatal Taskforce, chaired by the Secretary of State for Health and Social Care. The Taskforce will address the recommendations of the investigation by developing a new national action plan to drive improvements across maternity and neonatal care.

Thank you for bringing these concerns to my attention, and I am sorry again for the failings in care experienced by Victoria which led to the tragic loss of baby Pippa. This is not acceptable and we are taking your concerns very seriously.

Yours sincerely,



**PARLIAMENTARY UNDER-SECRETARY OF STATE FOR  
WOMEN'S HEALTH AND MENTAL HEALTH**