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National Medical Director
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5th March 2026

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Pippa Isobel Waller Gillibrand who died on 5th September 2024.

Thank you for your Report to Prevent Future Deaths (hereafter “Report”) dated 27th January 2026 concerning the death of Pippa Isobel Waller Gillibrand on 5th September 2024. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Pippa’s parents, wider family and loved ones. NHS England is keen to assure the family and yourself that the concerns raised about Pippa’s care have been listened to and reflected upon.

Your Report raised the concerns that there is currently no national guidance in respect of home births and the model of care, nor is there a national or local collection of data around home births, such as the numbers resulting in transfer to hospital, or involving injury to mother or baby. Such information would enable expectant parents to make an informed choice as to the risks of a home birth.

HM Coroner may already be aware that NHS England previously received a Regulation 28 Report dated 5 November 2025 from Joanne Kearsley, Senior Coroner for the Manchester North area. This Report raised very similar concerns to those raised in this case, and NHS England responded to the Report on 24 December 2025. For completeness, and for the benefit of Pippa’s family, NHS England has responded to your Report in full. However, there is an element of duplication in terms of the information which was provided by NHS England on 24 December 2025. No disrespect is intended to the Coroner or family in this regard.

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 urged them to consider the following issues:

- **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 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 executive board of each NHS Trust has appropriate oversight; that there is an audit programme that covers outcomes and clinical and operational guidance and leads to continual improvement; and that there is comprehensive homebirth guidance including standard operating procedures for all stages and aspects of care.

The National Institute for Health 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 continue working 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 partner organisations and their representatives, and initiated work to develop resources that rapidly close this gap in the guidance. We already expect maternity provider Trusts to have operating procedures in place for planning births at home, and this should include potential transfer processes. We have written to all maternity providers on 26th November 2025 reminding them of those expectations and the action to be taken. A copy of this letter has been included with the response to the Coroner. Where Trusts may not have appropriate operating procedures for planning births at home and managing high-risk pregnancies, we would expect this to be identified and escalated using the [Perinatal Quality Oversight Model](#) (2025). This model 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 women should be informed about all material risks, as has been established through the *Montgomery v Lanarkshire Health Board* judgment of the UK Supreme Court. 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](#)”.

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 General Medical Council (GMC) has issued guidance around [decision making and consent](#), to support healthcare professionals in their conversations with patients and service users to help share the information needed to make decisions and to ensure informed consent is given.

The Royal College of Midwives (RCM) has separately issued guidance around [informed decision making](#) and [care outside of guidance](#). The Nursing & Midwifery Council (NMC) has also issued [principles for supporting women's choices in maternity care](#). Employing Trusts are responsible for ensuring that their midwives and obstetricians practice in line with this guidance.

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 practice intrapartum care, 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 providing care at home must be able to respond to developing emergencies on their own, sometimes without the support of multi-disciplinary teams and immediate access to hospital facilities, until additional assistance is provided from the ambulance service. Such midwives are expected to undergo regular training in this. NHS England will work with other organisations to ensure that multi-disciplinary team training simulation for obstetric emergencies includes at least one scenario starting in a community/homebirth setting, in addition to the yearly training competency required by all NHS midwives within the [NHS England » Core competency framework version two](#) (2023).

Following the meeting with national stakeholders in December 2025, ongoing work is taking place to develop resources that will fill the current gap in the guidance. We anticipate that those resources will touch upon all the matters of concern you have raised, including:

- safe working practices.
- midwifery competence, training and education.

- risk assessment and care planning.
- clinical care standards, IT and equipment.
- transfer of care including working with ambulance services, escalation and multi-disciplinary team involvement.
- informed decision making, communication and public information.
- personalised approaches to planning care, particularly when homebirth is not recommended.
- provision of comprehensive homebirth guidance, including standard operating procedures for all stages and aspects of care.

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 explore whether existing data gathering systems can be updated to provide regular reporting on outcomes associated with homebirths and will go out to tender to develop a longer-term solution to this evidence gap.

Local actions

Cheshire and Merseyside Integrated Care Board (ICB) have advised us, via NHS England's North West Regional Team, that the Local Maternity and Neonatal System (LMNS) has contacted Warrington & Halton Hospitals NHS Foundation Trust's Deputy Director of Nursing & Care regarding this case. They have scheduled a meeting with the Chief Nurse at the Trust where they will discuss the actions taken by the Trust since the incident. The LMNS have already raised the Trust's workforce model with them and will be supporting them with further work on this as a result of their own diagnostic report. Should the Coroner require further information regarding the outcome of this meeting, we recommend contacting ICB / LMNS or Trust directly.

As part of the Warrington and Halton Hospitals (WHH) enhanced perinatal surveillance, known locally as 'Joint Oversight and Support' (JOS), the LMNS will review individual guidelines associated with homebirths, including training needs analysis, home birth guidelines, escalation, guidelines in relation to midwifery staffing and management of the homebirth service, including a review of the Whole Time Equivalent midwifery workforce and on call requirements.

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 death of Pippa, 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,



National Medical Director
NHS England