Regulation 28: REPORT TO PREVENT FUTURE DEATHS

NOTE: This form is to be used **after** an inquest.

	REGULATION 28 REPORT TO PREVENT DEATHS **THIS REPORT IS BEING SENT TO:** **1 NHS England** **2 National institute for health and care excellence (NICE)** **3 Secretary of State for Health & Social Care**
1	**CORONER** I am Victoria DAVIES, Area Coroner for the coroner area of Cheshire
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 22 July 2025 I commenced an investigation into the death of Pippa Isobel Waller GILLIBRAND aged 11 Days. The investigation concluded at the end of the inquest on 27 January 2026. The conclusion of the inquest was that: Narrative Conclusion - Pippa Gillibrand died as a result of a brain injury sustained due to an avoidable delay in her delivery.
4	**CIRCUMSTANCES OF THE DEATH** [redacted] [Pippa's mother] was pregnant with her first child and was receiving antenatal care from Warrington Hospital. She decided to opt for a home birth as her preferred choice for delivery and this was agreed by the team. On Friday 23 August, a discussion took place between senior members of the midwifery team about staffing for the community teams going into the bank holiday weekend, as they were short staffed. Changes were made to the rota to include moving a member of staff from the hospital team to community on Sunday 25th, to ease the pressure on the team. There was no discussion about suspending the homebirth service, and there were no midwives from the home birth team on the on call rota that weekend, which was unusual. On 25 August 2024, a bank holiday weekend, [redacted] [her mother] went into labour and called the birth suite to notify them. Her and her husband were told that the home birth team were out with another birth, and that they could come into hospital if they wanted to. Pippa's parents decided to wait. They were not told that there was only one home birth team, or that there was only the equipment for one team. Having heard the evidence, I found that at this point, there should have been an assessment and discussion as whether it was appropriate for [redacted] [Pippa's mother] to continue as a home birth, or whether she should have been told that the team were unavailable, and she should come into hospital. One balance, given the staffing and that the allocated team were already engaged in another birth, with the equipment, her mother should have been told to come into hospital, and the home birth service suspended. Approximately 2 hours later, the parents made a further call to the birth suite informing them that [redacted] waters had broken and requesting assistance. A decision was made for one of the community midwives, not part of the home birth team but with home birth

experience, to attend to assess. Having heard the evidence as to the options available at this time and the risks/ consequences of each option, I found that [redacted] should have been asked to come into hospital.

An hour later, a community midwife attended at [redacted] home and assessed her, followed shortly after by the arrival of a second midwife. Neither of these midwives were part of the home birth team. Both were team leaders for two of the other community teams. They would be on call for home births as the second midwife to support the home birth team, but this was not their day to day role. As community midwives, their only involvement in labour and delivery as a general rule would be when on call for the home births, and this was roughly around 3 a year per home birth midwife. Midwife 2 had more experience in previous roles as she had previously worked with the home birth service, and had more experience than a 'standard' community midwife. Midwife 1's experience was significantly less and she said she had worked as a community midwife since 2016, with an average of 1-2 births a year.

A decision was made that care for [redacted] would continue at home as the safest option, as she was now fully dilated. In the next 30 mins, Pippa's heart rate was recorded at 9am, 9.15 and 9.30, not at 5 minute intervals as mandated by the guidance. The reason given for this was that the midwives were involved in setting up equipment, trying to get their laptops to work and discussing the staffing issues for the day and plan for that. Laptop connectivity was an issue and affected the recording of notes. Due to issues getting on the system, the fetal heart rate was not plotted on a partogram as it should have been, which would have assisted in monitoring and looking at trends. No paper notes/ partogram was available to the midwives, them having been removed when the Trust switched to electronic recording. Connectivity issues had been raised in the past.

A third midwife arrived to bring tubing for entonox and the plan was for her to stay to replace midwife 1. She expressed her concern about this to both of the other midwives, on the basis she had no home birth experience and was worried that, if something went wrong, there was no immediate assistance available outside the door. I found that midwife 3 did in fact have more frequent and recent experience of intrapartum care than her 2 colleagues, as she worked in the hospital on a regular basis, and as such it was a reasonable decision for her to stay once the plan was for the home birth to continue, but she should not have been put in the position she was in, given her concerns.

At 9.36 the fetal heart rate was heard again and felt to be normal, but was not heard for the full minute as a contraction started. Between 9.40 and 9.49 midwife 2 listened to the heart rate 3 times, after each contraction. Each time she was not able to listen for a full minute and she felt this was due to the time it was taking to allow [redacted] to move between contractions and then find the heart rate. She did not hear any concerning features but could not rule them out as she was not able to hear for the required time. From 9.50 onwards, midwife 2 was struggling to listen to the heart rate for more than 20-30 seconds a time, which was much less than previously. What she could hear was still around 130bpm, but again she could not rule out any concerning features in the period that she could not hear. At 10am a decision was made to transfer to hospital and an ambulance was called. On arrival at hospital, [redacted] was taken to theatre and baby Pippa was delivered by forceps in a poor condition. She was taken to the neonatal unit and later transferred to the Liverpool Women's Hospital for ongoing care. Despite treatment efforts, scans identified that Pippa had suffered a severe irreversible brain injury and her care was re-oriented to comfort care. She died in hospital on 5 September 2024.

The evidence, which I accepted, was that had [redacted] been brought to hospital sooner, in line with the issues in care identified, issues in identifying Pippa's heart rate would have been acted upon and, on balance, Pippa would have been delivered earlier. The delay in delivery more than minimally, trivially or negligibly caused or contributed to her death.

I heard evidence that the home birth team within the Trust is made up of 5 community midwives. They would each have a case load of patients who they would see ante-natally and post natally, and during labour and delivery. On average there are around 15-20

	homebirths per year at the Trust, and so as a crude average, each home birth midwife will assist with around 3 home deliveries a year, plus occasionally assisting on the MLU if needed but this is not often. The second on call midwife is from the community team and may have less exposure to labour and delivery. Since Pippa's death, Warrington Hospital have re-modelled their home birth service such that it is now staffed by midwives from the midwifery led unit, who have far more recent experience and exposure to labour and delivery. They have a clear guideline that only one home birth can be safely managed at a time.
5	**CORONER'S CONCERNS** During the course of the investigation my inquiries revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows: (brief summary of matters of concern) 1. There is no national guidance in respect of home births and in particular the model of care. Linked to this, there is therefore no guidance on: a. The training that a midwife should undergo to ensure they are competent to manage a home birth, given the inherent risks involved when there is no hospital team behind you in an emergency. b. The number of deliveries a midwife should have done in a hospital setting before being able to safely manage a home birth and/ or the number of deliveries a community midwife should be involved in to maintain their skills. c. The threshold for transfer to hospital. d. Safe staffing and equipment levels, without which the service should be suspended. e. The supervision which should be provided during a home birth, for example through a midwife in the hospital accessing the notes. f. A system for back-up should electronic systems fail i.e. whether paper notes should be provided as a routine. g. Information which should be provided to expectant parents around the risks of home birth/ the experience of the team to enable them to make an informed choice. 2. There is no national or local collection of data around home births such as number resulting in transfer to hospital, number involving injury to mother or baby. Such data would allow expectant parents to make an informed choice as to the risks of a home birth.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you (and/or your organisation) 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 by March 24, 2026. 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 **Pippa's parents,** [redacted] **Warrington & Halton Hospitals NHS Foundation Trust**

	and to the Child Death Overview Panel. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any person who I believe may find it useful or of interest. 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	**Dated: 27/01/2026** [redacted] **Victoria DAVIES** **Area Coroner for** **Cheshire**