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 Andrew Walker
North London

25 June 2026

Dear Mr Walker,

Thank you for the Regulation 28 report of 30th April 2026 sent to the Department of Health and Social Care about the death of Poppy Hope Lomas. I am replying as the Minister with responsibility for Women's Health.

Firstly, I would like to say how saddened I was to read of the circumstances of Poppy's death, and I offer my sincere condolences to her family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention.

The report raises concerns about consideration not being given to holding a multi-disciplinary team meeting with the patient to ensure that the patient receives an understanding of the risks to the baby and to themselves, when the patient chooses to have an unsafe birth at home. It also raises concerns over patients not being given consent forms that clearly set out the risks of choosing to have unsafe births at home. The report also raises concerns around the use of the expression 'out of guidance' in these circumstances, as it may not convey that the delivery is against medical advice, and against the Royal College of Obstetricians and Gynaecologists (RCOG) guidance – and is therefore an unsafe delivery.

All women deserve access to safe care during childbirth, and 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 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.

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 responsibility for the specific matters of concern you have raised sits with NHS England, they will be issuing a substantive response addressing each of these concerns.

It is unacceptable that there was a failure to recognise and appropriately manage the risk factors during the delivery, and the subsequent absence and delay in interventions and actions. It is also unacceptable that the decelerations and a decision to return to hospital

were not discussed with Mrs Lomas. I recognise that it is a known difficulty to monitor the foetal heart rate during intermittent auscultation and I am extremely saddened that during the 30 minutes before Poppy's birth, the maternal heart rate was mistakenly thought to be Poppy's.

I recognise that there were a number of factors which impacted the care Mrs Lomas and Poppy received, which is why Baroness Amos is carrying 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 has also set 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.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

Yours sincerely,