

Mr. Andrew Walker
Barnet Coroner's Court
29 Wood Street
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National Medical Director
NHS England
Wellington House
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18th June 2026

Dear Mr. Andrew Walker,

Re: Regulation 28 Report to Prevent Future Deaths – Poppy Hope Lomas who died on 26th October 2022.

Thank you for your Report to Prevent Future Deaths (hereafter “Report”) dated 30th April 2026 concerning the death of Poppy Hope Lomas on 26th October 2022. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Poppy’s parents and family. NHS England is keen to assure the family and yourself that the concerns raised about Poppy’s care have been listened to and reflected upon.

Your Report raises the following concerns:

1. That patients who decide to have a home birth and decide to refuse the care recommended by the hospital for the management of the unsafe birth, do not have to sign a consent form clearly setting out the risks.
2. When a patient chooses to have an unsafe birth at home that a Multi-Disciplinary Team meeting is not held with the patient to ensure that the patient understands the risks to the baby and themselves.
3. The use of the term “Out of Guidance”, used nationally, fails to convey the gravity of the decision being taken, and that it is against medical advice.

On 26 November 2025 the Chief Midwifery Officer wrote to all NHS maternity providers in England asking them to urgently review the safety and quality of their homebirth services. NHS Trusts were urged to consider the following issues:

- a) 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.
- b) 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.

- c) Governance and oversight: including how governance is structured to ensure robust oversight of homebirth services by the whole organisation, so the executive board 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.

- d) The National Institute for Health and Care Excellence (NICE) uses evidence-based recommendations to develop clinical guidance to improve health and social care. While not dedicated to homebirths, the [NICE guideline on intrapartum care \(2023\)](#), outlines the care of women and their babies during labour and immediately after birth in all settings and addresses issues around planning place of birth.

We have noted concerns raised by Coroners in previous Prevention of Future Deaths reports relating to homebirths, that this current intrapartum care guidance does not provide sufficient clarity to women, staff and services as to how to safely support requests for and provision of home birth services, particularly when significant risk factors have been identified.

As a result, NHS England has started work with partners including NICE, Royal College of Midwives, Royal College of Obstetrics and Gynaecology, Nursing & Midwifery Council, Maternity & Newborn Safety Investigations, Care Quality Commission, and the General Medical Council to develop further resources to close this gap.

By autumn 2026, we anticipate setting out the minimum standards that providers and commissioners of maternity services will be expected to meet to support the delivery of a safe, effective, equitable and personalised home birth service. The standards will include the use of appropriate and clear language in discussing women's preferences, including review of the term "Out of Guidance". The standards will also include detail on the assessment of safety and risk required, and the need for multi-disciplinary team working in the formulation of care plans and their documentation. This will also include consideration of the use of consent forms which are not currently used in maternity services for any place of birth. It will also include reference to the standardised equipment required for clinical care provided during homebirth.

There are other national guidance and reviews relevant to the concerns you have raised, which I would like to draw to your attention:

The standards of care in relation to sharing information have in part been established through the Montgomery Judgement at 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](#)”. In addition, communication around risk should be personalised ([NICE Shared Decision-Making Guideline, 2021](#) and [NICE Intrapartum care guideline, 2023](#)).

One of the immediate and essential actions that arose from the first report of the Independent Review of Maternity Services at Shrewsbury and Telford Hospitals was that:

All women must be formally risk assessed at every antenatal contact so that they have continued access to care provision by the most appropriately trained professional.

Risk assessment must include ongoing review of the intended place of birth, based on the developing clinical picture.

Following publication of the first report in December 2020, NHS England asked all trusts to assure themselves that this was in place in their services. There then followed two further assurance processes led by the regional teams to assess that this was being undertaken and support any necessary changes to practice.

The [Three year delivery plan for maternity and neonatal services](#) (2023) which states that all women should be “*offered personalised care and support plans*”, where all information is recorded, including “*a risk assessment updated at every contact, including when the woman is in early or established labour.*”

The Royal College of Midwives has also issued guidance on [Informed decision Making](#) (2022). They recommend that midwives “*support women’s informed decision making*” including by not providing “*any care without first receiving consent*”, and document the information given and the discussions had with the woman.

The RCM document on [Care Outside Guidance](#) (2022) discusses Personalised Care and Support Plans and sets out that decisions about care should be “*documented, implemented and shared with the multi-disciplinary team*”. Those decisions should be based on gaining and documenting informed consent from the service user, using evidence and assessments of risks and benefits.

The General Medical Council’s guidance on [Decision Making and Consent](#) (2020), supports healthcare professionals in their conversations with patients and service users ensuring informed consent is given. As a minimum, clinicians, should keep an accurate record of “*information leading to a decision in a patient’s record (which) will inform their future care*”. The guidance states that while a patient can give consent verbally clinicians “*should make sure this is recorded in their notes*”.

The Nursing & Midwifery Council’s [Principles for supporting women's choices in maternity care](#) (2025) includes that midwives should “*document discussion(s) about care in the maternity records and what information has been given to the woman*”. Midwives should provide care that is based on informed consent and adhere to the NMC Code of Conduct (2015).

Trusts are responsible for ensuring midwives and obstetricians practice in line with this guidance and the new homebirth standards will take these documents into account to ensure greater clarity and alignment of advice across all organisations.

Regional Response

NHS England's London regional team have liaised with the Trust regarding this Report. They shared the report on the maternity investigation undertaken by Healthcare Safety Investigation Branch (HSIB) in relation to Poppy's death. As a result of that investigation an action plan has been devised to address the concerns.

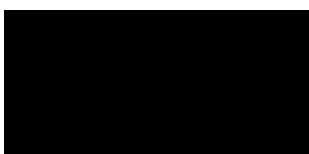
Actions the Trust intend to take include:

- To ensure staff are supported to recognise when to transfer a patient to the hospital from a homebirth or standalone birthing unit.
- To provide training to community midwives on providing care for mothers with a high-risk pregnancy in a low-risk birth setting.
- Updating local guidance regarding the care of Vaginal Birth After Caesarean (VBAC) patients in a low risk setting, including the management of the second stage of labour.
- To establish a pathway for early recognition and escalation to consultant/senior midwife of women requesting to birth outside of guidance.
- To ensure that birth plans for mothers who are birthing outside of guidance at home explicitly detail all aspects of the management of labour and birth and the indications for transferring to the maternity unit.
- To ensure that clinicians are supported to recognise and take timely action on adverse clinical findings when mothers are birthing outside of guidance at home, via specialised training for community midwives.

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 Poppy, 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