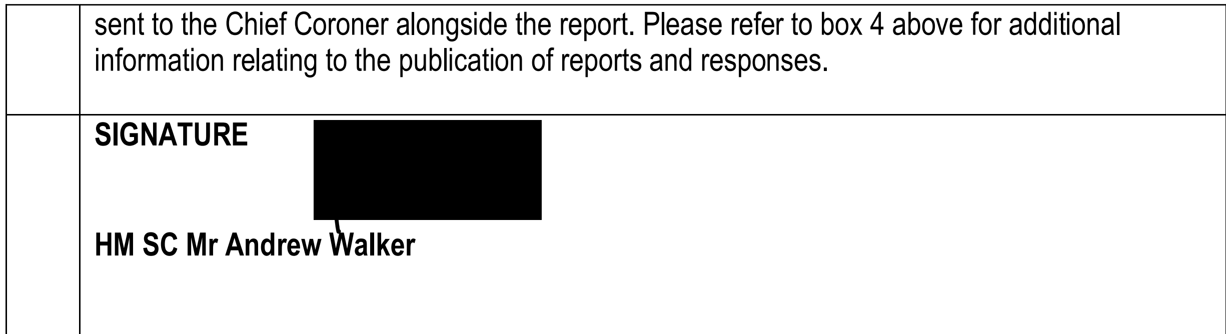
REPORT TO PREVENT FUTURE DEATHS REGULATION 28 OF THE CORONERS (INVESTIGATIONS) REGULATIONS 2013 Please do not include any living persons' names in this document, in accordance with the Chief Coroner's PFD Publication Policy (2026).	
1.	**CORONER** I am Mr Andrew Walker, HM Senior Coroner for the coroner area of North London.
2.	**DATE OF REPORT** 30th April 2026
3.	**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.	**THIS REPORT IS BEING SENT TO** 1. NHS England 2. Department of Health and Social Care 3. National Institute for Health and Care Excellence You are under a duty to respond to this report within 56 days of the date of this report, namely by **25 June 2026**. I, the coroner, may extend the period if an appropriate application is made.
4.	**YOUR RESPONSE** I have a duty to send a copy of your response to the Chief Coroner. In accordance with the Chief Coroner's Publication Policy, you should send me any representations regarding publication of your response. These representations should be made at the same time as the response is provided. I will pass any representations received to the Chief Coroner for a decision. Please note any links to webpages included in the response will not be checked for sensitive information prior to publication, as the information is already online. The names of those who do not respond to PFD reports are regularly published on the Chief Coroner's webpages Non-responses to Prevention of Future Death (PFD) reports - Courts and Tribunals Judiciary.
5.	**SUMMARY OF CORONER'S CONCERN:-**

	The use of expressions that may minimise the detail of the risks taken by patients who elect, following a caesarean birth, to have a vaginal birth at home. The support that can be provided by the Trust to the patient in these circumstances. The absence of a consent process when such a patient chooses not to follow medical advice and the Royal College of Obstetricians and Gynaecologists guidance, and chooses an unsafe birth. The contents of the Home Delivery kit used by midwives in these circumstances.
6.	**ACTION SHOULD BE TAKEN** In my opinion unless action is taken to address the above concerns then there is a significant risk of future deaths and I believe each of you have the power to take such action.
7.	**INVESTIGATION AND INQUEST** On 03 March 2025, I commenced an investigation into the death of Poppy Hope LOMAS aged 7 days. **The medical cause of death was:-** Cause of death 1a - Hypoxic- Ischaemic Encephalopathy Cause of death 1b - Peripartum Hypoxic Ischaemic Episode **How, when and where:-** Poppy Hope LOMAS died in University College hospital on the 26th October 2022 aged 7 days. **Conclusion:-** Poppy died when an accumulation of risk factors were not recognised during a high risk delivery at home.
8.	**CIRCUMSTANCES OF DEATH** Poppy Hope LOMAS died in University College hospital on the 26th October 2022 aged 7 days. The Trust agreed to support Mrs Lomas with an unsafe home delivery that was against medical advice and the guidance provided by the Royal College of Obstetricians and Gynaecologists. The home delivery midwives worked against a background of an accumulation of risk factors including:- a prolonged rupture of the membranes without antibiotic cover, two episodes of deceleration at around one and a half hours before delivery, the slow delivery and poor condition at birth.

	There was a failure to recognise and appropriately manage these risk factors:- The prolonged rupture of membranes without intravenous antibiotic cover, two episodes of deceleration heard around one and a half hours before delivery, the slow delivery of Poppy's head, the fresh bleeding from her nose and mouth, the slow delivery of her body and her poor condition at birth. This resulted in a lack of recognition of these multiple deviations from the normal position during this time and subsequent absence or delay in interventions and actions. It is likely that the cause of Poppy's death was caused by a severe hypoxic ischaemic event suffered in the 30 minutes before her birth, most likely an acute foetal bradycardia. It is likely that during the period of approximately 30 minutes prior to Poppy's birth, the maternal heart rate was thought to be Poppy's when the foetal heart was checked, and this is a known difficulty when monitoring foetal heart-rate during intermittent auscultation. To not discuss with Mrs Lomas the decelerations and a decision to return to hospital is likely to be a really serious failure to provide basic medical care to Mrs Lomas. Poppy was taken to hospital in a poor condition following delivery in a pool at her home and despite medical attention could not recover from the consequences of the hypoxic ischaemic event.
9.	**CORONER'S CONCERNS** During the course of the inquest, I heard evidence 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: The below matters all fall within the purview of NHS England and the Department of health and Social Care and the National Institute for Health and Care Excellence. It is a matter of concern that where the patient has chosen to have an unsafe birth at home and has decided to refuse to consent to the care the hospital recommend for the management of the unsafe birth, that consideration is not given to the patient signing a consent form that clearly sets out the risks. It is a matter of concern that where the patient has chosen to have an unsafe birth at home consideration is not given to holding a Multi-Disciplinary Team Meeting with the consultant obstetrician, hospital midwives & community midwives and the patient, to ensure that the patient receives an understanding of the risks to the baby and to themselves.. It is a matter of concern that the nationally used expression “Out of Guidance” is used in these circumstances, which may fail to convey the gravity of the decisions being taken, rather than an expression that captures all elements:- in particular that the delivery is against medical advice, the Royal College of Obstetricians and Gynaecologists guidance and that as a consequence it is an unsafe delivery. It is a matter of concern that the Home Delivery kit does not include a pulse oximeter for maternal heart rate.
10.	**COPIES AND PUBLICATION OF THIS REPORT** I have a duty to send a copy of my report to every Interested Person who in my opinion should receive it. I also may send a copy of the report to any other person who I believe may find it useful or of interest. I can confirm I have sent the report to: 1. NHS England 2. Department of Health and Social Care 3. National Institute for Health and Care Excellence 4. Royal Free NHS Trust 5. University College London Hospitals NHS Foundation Trust 6. Princess Alexandra Hospital NHS Trust 7. The Family I also have a duty to send a copy of the report to the Chief Coroner. You may make representations to me, the coroner, about the publication of the contents of this report in line with Chief Coroner’s PFD Publication Policy (2026). Any representations will be



	sent to the Chief Coroner alongside the report. Please refer to box 4 above for additional information relating to the publication of reports and responses.
	SIGNATURE **HM SC Mr Andrew Walker**