An open letter from AIMS (Association for Improvements in the Maternity Services), ARM (Association of Radical Midwives) and Birthrights.

To:

Wes Streeting MP, Secretary of State for Health and Social Care

Gill Walton, Chief Executive of the Royal College of Midwives

Paul Rees, Chief Executive of the Nursing and Midwifery Council

Kate Lancaster, Chief Executive of the Royal College of Obstetrics

Professor Jonathan Benger, Chief Executive of National Institute for Clinical Excellence

Sir James Mackey, Chief Executive of NHS England

cc:

Baroness Amos

Michelle Welsh MP

Kate Brintworth, Chief Midwifery Officer for England

We are writing this open letter in response to the Prevention of Future Deaths report written and sent to you by the coroner who investigated the tragic deaths of Jennifer and Agnes Cahill. We offer our condolences to their family who have suffered such a terrible double loss.

We also want to express our sympathy to the two midwives and the ambulance crew who found themselves placed in such a difficult situation.

We hope both the family and the staff are getting the support they need to deal with the psychological impact of these events.

It is clear that with better care Jen and her baby Agnes might not have died, and that there is much learning which needs to happen to avoid other families being put at risk.

It seems to us that there are two distinct issues in this report. One is the standard of care provided and the other is the lack of a personalised care plan to support Jen's decision about place of birth. We were surprised to see that the coroner appeared to focus largely on the latter with little mention of the systemic failures that led to the substandard care. It seems that in this Trust, the homebirth service was not sufficiently valued, resulting in a lack of commitment to ensuring safe care.

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Issues with the care provided

Both of the midwives had already worked a full shift with only a few hours break before being called to attend the birth. This could never be a safe situation. We need models of care that ensure midwives are not expected to work without adequate rest periods.

Neither midwife had previously met Jen or had a chance to discuss a care plan with her. It is clear that they lacked the training and experience, and hence the confidence, to support a homebirth in these circumstances.

As the coroner also notes, "They were also hampered by failing equipment (the Entonox cylinders) and IT connectivity issues whilst they were with Jen" as well as by "a split in the bag valve mask" used in the attempt to resuscitate Agnes.

According to the coroner's report, there was discussion of the risk of postpartum haemorrhage (PPH) at Jen's appointment with Dr El-Adwan, but this was not passed on to the midwives who attended her. Had it been, the midwives could have been prepared to watch out for and deal with the situation. It would also have been appropriate to ensure that an experienced midwife was on call for Jen.

If Jen had had Continuity of Carer then the midwives providing her care in labour would have already been familiar with her risk factors, her concerns and her needs. They would have had time to build a trusting relationship and develop an agreed care plan, and would have been better prepared to deal with the problems that arose. This could have led to a very different outcome.

We are pleased to see that the coroner's list of matters of concern highlights a lack of "national guidance on the model of staffing, training and experience for midwives providing home birth care" and a lack of clarity about the training needs of midwives who may be called on to support homebirths.

We would welcome the development of national standards and guidance for homebirths - including requirements for intrapartum and homebirth experience for all midwives, homebirth-specific emergency drills training with ambulance services, and communication systems to ensure that midwives receive a full handover or briefing before going out to a homebirth. We would urge that these standards are co-produced by midwives experienced in homebirth and familiar with the evidence-base, together with service-user representatives.

In addition, we call for all Trusts to put in place a supportive, specialist team, including both senior midwives and a senior obstetrician, focussed on ensuring safe provision of homebirths in all cases where this is the mother's choice. This would include support to develop a personalised plan, and 24-hour senior midwifery support for more complex homebirth cases.

Decision Making about Place of Birth

We are concerned by the coroner's comment that "There is no national guidance considering the ethical responsibility and proportionality of offering a home birth model under the NHS framework." Homebirth is a human right, and we are concerned by the suggestion that homebirths should not be supported when there are perceived risk factors. This risks women and birthing people being either forced into hospital against their will, or abandoned to birth alone.

"The answer to a system that traumatises women isn't to trap them in it, it's to fix it. If you still believe that hospitals are automatically safe places to give birth, then you're simply not listening." Lucy Hunter Ford[1]

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The coroner seems to have made an implicit assumption that homebirth is less safe than hospital birth, but the evidence does not support this. The coroner also seems to assume that had Jen given birth in hospital there would have been no problem - yet we know that unsafe care is endemic throughout our maternity services.

As Dr Bill Kirkup commented in his review of Maternity and Neonatal services in East Kent "*It is too late to pretend that this is just another one-off, isolated failure, a freak event that "will never happen again. Since the report of the Morecambe Bay Investigation in 2015, maternity services have been the subject of more significant policy initiatives than any other service. Yet, since then, there have been major service failures in Shrewsbury and Telford, in East Kent, and (it seems) in Nottingham. If we do not begin to tackle this differently, there will be more."* [2]

Under Article 8 of the European Convention on Human Rights and the Human Rights Act 1998 all women and birthing people have a legal right to birth at home and cannot be forced to birth in hospital.[3]

As recognised in the NICE Guideline on Intrapartum care[4], there is evidence that, for women and birthing people who are healthy, have had a straightforward pregnancy and are giving birth to a full term baby, planning to birth in a birth centre or at home rather than in an obstetric unit is associated with little or no increased risk to babies and a reduction in the risks of medical interventions and the harm that these may cause to the mother. This conclusion is supported by a number of recent evidence reviews.[5,6,7]

For mothers without complicating factors, the Birthplace study[8] showed that the risk of post-partum haemorrhage is greater for births in hospital than for homebirths.

Even for women identified as 'higher risk', secondary analysis of the Birthplace data[9] showed that a planned homebirth compared with hospital was associated with a significantly reduced risk of death and injury to the mother during birth. Babies were less likely to be admitted to a neonatal unit.

It is known that a great many women are traumatised as a result of how they are treated in hospital[10, 11]. For this reason women and birthing people, whether or not they have previously suffered such trauma themselves, may consider that a homebirth offers greater psychological safety. This means that for many women and birthing people, hospital is not the safest place of birth.

Given this evidence, Jen's informed decision to give birth at home was entirely reasonable. We are appalled by the many comments made in the press that appear to blame her for her own and her baby's deaths.

The decision to give birth at home is a human right and must be supported. What is needed is to make homebirth even safer by ensuring that in all areas of the country:

- There is a properly resourced homebirth service, with trained and experienced midwives effectively supported by their midwifery management team.
- All those who want to plan a homebirth have Continuity of Carer and a personalised care plan that includes consideration of how any problems that arise can be managed.
- All maternity service users are given factual information on the actual risks in their personal circumstances. This should include the risks of hospital as well as homebirth.
- There is adequate ambulance cover to respond rapidly if problems arise at a homebirth or freestanding birth centre.

We hope that all women and birthing people will in future be safely supported wherever they choose to give birth.

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AIMS
We support all maternity service users to navigate the system as it exists, and campaign for a system that truly meets the needs of all.
www.aims.org.uk

The ARM
ARM's vision is for autonomous, empowered midwives to be able to support women's choices in childbirth. We believe that midwifery matters.
www.midwifery.org.uk

Birthrights
We champion human rights in maternity care by supporting women and birthing people, training healthcare professionals, holding systems and institutions to account, and making visible diverse experiences of maternity care.
birthrights.org.uk

References

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4) NICE guideline NG235 "Intrapartum care", published September 2023, updated November 2025
5) Olsen, O. and Clausen J.A. "Planned hospital birth compared with planned home birth for pregnant women at low risk of complications." Cochrane Library, March 2023
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9) Li Y. et al "Perinatal and maternal outcomes in planned home and obstetric unit births in women at 'higher risk' of complications: secondary analysis of the Birthplace national prospective cohort study." BJOG 2015; 122:5, 741-753
10) Thomas, K. Birth Trauma APPG report "Listen to Mums: Ending the Postcode Lottery on Perinatal Care" 2024
11) Cost Action 18211 DEVOTION Recommendations to prevent traumatic birth

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