

Inquest Touching the Deaths of

Jennifer Rose Cahill

and

Agnes Lily Wren Cahill

Ms Joanne Kearsley H.M. Senior Coroner for Manchester North

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## **Findings and Conclusion**

### **Introduction**

1. This has been the inquests into the deaths of Jennifer Rose Cahill ("Jen") and her daughter Agnes Lily Wren Cahill ("Agnes"). The Interested Persons ("IPs") are (i) Mr Robert Cahill ("Rob"), represented by Cara Gutherie of counsel, (ii) Jen's family who were supported by Ms Gutherie during the Inquest (iii) Manchester Foundation Trust ("MFT") represented by Ms Rebecca Sharrock (iv) Midwife Andrea Walmsley represented by Mr Matthew Stanbury of counsel (v) Midwife Julie Turner represented by Mr Ben Turner of counsel and (vi) North West Ambulance Service ("NWAS") represented by Ms Sadie O'Reilly.
2. The purpose of this inquest is laid out in section 5 (1) of the Coroners and Justice Act 2009 which provides that a coroner must ascertain who the Deceased person was and when, where and how the person came by their death. It is unusual to hear the Inquests of two persons at the same time however the circumstances of the deaths of Jen and Agnes led me to consider it was entirely appropriate in this case for the Inquest to hear all the evidence pertaining to the deaths of each of them.
3. In order to answer the statutory questions I have received and admitted oral and written evidence from Jen and Agnes's family, from their medical records, from the post mortem investigation, from community midwives, doctors and NWAS professionals.
4. Set out below are my findings and conclusion as to the deaths of Jen and Agnes. All of my findings have been reached on the balance of probabilities. In the course of this document I make reference to some of the evidence I

have heard but it is not intended to be, and is not, a comprehensive review of all the evidence before me. Rather, my intention is to explain, by reference to parts of the evidence, why I have reached my findings of fact and conclusion. However, in reaching my findings and conclusion I have taken account of all the evidence I received, both oral and written. If a piece of evidence is not expressly mentioned, it does not mean that I have not considered and taken full account of it.

5. I will say at the outset I am acutely aware I have the benefit of hindsight and knowing the tragic outcomes which occurred. I have no doubt for all those involved this was a deeply distressing and traumatising event, it was clear for the majority of witnesses it remains such.
6. In any case, recollections can vary and timings may differ. There can be legitimate reasons for this, people can genuinely be mistaken. My role has been to put aside hindsight and to reach my findings of fact on the basis of what was known or could have been known by individuals at the time. Likewise, where there may be conflicting evidence my role is to assess all of the evidence and to consider from any documents or records whether evidence corroborates or supports what a witness may have said in their verbal account.

### Jen

7. I am satisfied that the person who died was Jennifer Rose Cahill (nee Howick) and that she was born on the 2<sup>1st</sup> June 1989 in Worcester. Jen was the third of four children. Warmly described by her family as a “driving force”, there is no doubt Jen was an intelligent and gifted individual. Not only was she musically talented, in the family string quartet and with a grade 8 distinction in singing, she had a flair for languages. Her academic ability taking her to University in Manchester.
8. It was here she met Rob. “It was so easy to like her” was how Rob described Jen and in Rob’s words, “fortunately she liked me.” In 2018 they married in an idyllic wedding in the local village church with a reception at Jen’s parents home. This happy family occasion highlighting Jen’s ability to be perfectly organised and unflappable despite the torrential downpour.
9. Further joy ensued, when in 2021 Jen became pregnant and delivered their first child, their son. Jen was described as, “an amazing and attentive mother” and it was motherhood which brought out the very best of her, “full of patience, love and fun”. Mrs Howick (Jen’s mother) told the court that later in 2021 the family suffered the sudden death of Jen’s father. She spoke

movingly of the support Jen provided during this difficult time and later when she herself moved home.

10. In 2023, Jen and Rob are expecting their second child. I heard that early on in this second pregnancy Jen was considering a home birth. A facebook post dated the 8<sup>th</sup> December 2023 made by Jen shows she has joined a facebook group titled Home Birth Support UK. Rob explained to the court that there had been issues during Jen's first delivery and there were two main reasons for her considering a home birth for this pregnancy, one being that she would have two midwives in attendance and also the fact that she would be in the comfort of her own home.
11. Rob explained Jen was the sort of person who would educate herself, she would have done research and he understood she read articles and listened to podcasts however he was clear Jen had not reached a fixed decision at the outset of her pregnancy she was considering all her options and would have made a decision following her scans later and later into her pregnancy.
12. **It seems to me, therefore, that Jen and Rob had started their married life with plans and ambitions like so many young couples. They had a child and shared plans to grow their family. Jen was bright, she was talented, loving and kind. An individual who was educated and more than capable of informing herself and undertaking her own research. Whilst her initial thinking for her second pregnancy was to have a home birth I am satisfied that was not a rigid fixed view at the start of her pregnancy it was something she was exploring and learning more about.**

### Agnes

13. Agnes Lily Wren Cahill was the much loved and much longed for second child of Jen and Rob. Her presence very much felt by them as she appeared to enjoy having a good kick and wriggle in the early hours of the morning. Her entry into this world was challenging and she needed immediate support. Despite the efforts of all the medical professionals Agnes died in the Royal Oldham hospital four days after her birth.

### Community Midwives and Home Births

14. At the outset of this ruling I think it is important to set out the evidence I heard in respect of Community Midwives and home births. The role of the community midwife historically was to support home births but this was in respect of low risk pregnancies.

15. All of the professional witnesses I heard from explained to the court that the overall percentage of women choosing to have a home birth is low. I heard an average of approximately 2% of births nationally take place at home. Nevertheless, what was also evidenced was the fact that whilst the numbers remain low there has been a subtle yet definite increase in the number of women requesting home births and perhaps more importantly, an increase in women who have a greater degree of risk requesting a home birth.
16. The lack of a national data collection means it is difficult if not impossible to accurately evidence the reasons for this increase. Both Professor Johnstone Clinical Head of the Maternity Division at MFT and the court appointed expert Ms Abigail Holmes Director of Midwifery and Neonatal Services at Cardiff and Vale University Health Board, talked about concerns for women following the findings of recent national inquiries into maternity services which have highlighted issues within hospital services. This comes at a time when there have been positive steps taken by Royal Colleges and regulatory bodies (Nursing and Midwifery Council) to encourage providers to support a women's choice as to where they wish to give birth.
17. It is not an increasing number of women, who choose to give birth at home, which raises any concerns, but the evidence I heard strongly suggests that more women who have complex pregnancies or various risks around delivery, those who are deemed as "high" risk are requesting home births. I have no doubt in my mind from the evidence I heard that there are very real concerns held by midwives of the increase in the complexity of cases which they are now being asked to attend in a home setting.
18. In addition to the historical role of the community midwife supporting low risk women at a home birth the evidence also explored the number of deliveries attended by community midwives. It became very apparent during the course of the evidence that in general, intrapartum care is the smallest part of a community midwife's role. Most of their role is with antenatal and postnatal care.
19. Ms Holmes explained to the court that there is nothing which determines how many births a midwife should undertake. In order to qualify a midwife has to attain 40 births (at any location but more likely reached through hospital deliveries). After registration, this requirement ceases and there is no national guidance around the number of births a community midwife should attend each year in order to maintain their competency levels.
20. I heard from four community midwives during the course of the inquest hearing and three of them described on average that they would be on call

several times a month but in reality were only ever called out to attend approximately two births a year. Midwife Turner had slightly more experience as she had experience of working in the birth centres when she was in a different role.

21. There is no standard model for the provision of a home birth service. The extent to which a community midwife is involved in births will depend on the model in each individual area or trust. Nevertheless, I am satisfied that it is likely to be surprising to women in general, to learn how few deliveries community midwives attend. It is not national practice to inform women as to the experience of the midwives attending home births. Whilst care would need to be taken not to scare women if a midwife had limited experience, I can see this may be something women would want to know in order to make an informed choice as to the location of their own delivery and to understand what is yet another difference between a hospital and a home birth.
22. For midwives themselves, Ms Holmes accepted it can be very difficult for a community midwife to maintain their skills if they are only doing a small number of deliveries. For example cannulation is a skill which if midwives only use once or twice a year can be challenging, similarly suturing and neonatal resuscitation.

### **Jen's First Delivery**

23. Jen suffered a number of complications during the delivery of her first child. She gave birth to him in North Manchester General Hospital when the impact of the covid-19 pandemic remained ongoing. Rob explained to the court Jen had found the experience difficult not only due to the fact it was a complicated delivery but also the environment. Jen had been transferred to the labour ward from the hospital birth centre. The labour ward was understandably a less calm environment. There were different midwives who would be involved with her care. There were times when it felt to Jen and Rob that they were left alone for long periods of time, having to repeat information to different professionals.
24. Professor Johnstone Clinical Head of Division (Maternity) told the court that during the delivery of her son, Jen had suffered a post partum haemorrhage ("PPH"). PPHs are not rare. Professor Johnstone explained blood loss of over 500mls is classed as a PPH. Loss of around 500 mls occurs in 30-40% of pregnancies. This amount of blood loss would be a slight warning flag for subsequent pregnancies. More severe PPHs would be levels of over 1000 mls or 2000 mls.

25. I heard there are four main reasons why any woman may have a PPH, (i) Atony where the uterus fails to contract leading to blood loss (ii) Trauma either as a result of an episiotomy or a tear (iii) Tissue such as retained placenta or (iv) Blood clotting factors. Any of these alone or in combination can be a cause of a PPH.
26. To try and prevent a PPH clinicians recommend Active Management of the Third Stage of Labour ("AMTSL"). This is the delivery of the placenta and active management is the administration of drugs to help the uterus contract and also to reduce bleeding. The alternative approach being a physiological approach where the woman delivers the placenta with no assistance.
27. At the time of Jen's first delivery it was documented that she had suffered a PPH with blood loss of 890mls. Professor Johnstone explained that she had had a long second stage of labour, an extended episiotomy (cut and tear) and a Kielland's forceps delivery. Her son was on the 90<sup>th</sup> centile so a larger baby and this increased the risk of atony. Having lost blood during the PPH it was noted that Jen's haemoglobin levels had dropped the following day to 74 and she was given an iron infusion. Subsequent checks when she was in hospital noted that she remained tired, her haemoglobin remained low and as a result she had a blood transfusion.
- 28. The cause of Jen's first PPH could not be determined definitively. Professor Johnstone noted from the records that she had suffered from a tear as well as having an episiotomy. On balance he felt and I would agree, that it was likely to be as a result of trauma with an element of atony although to what extent atony contributed cannot be precisely determined.**
29. In addition to the PPH Jen was also administered intravenous antibiotics during the delivery as she was positive for Group B streptococcal infection ("GBS"). Some hours after his birth her son showed signs of a developing infection and was given antibiotics. At the time it could not be established where the source of any potential infection had come from.
30. Professor Johnstone explained to the court there are some significant differences as to treatment which can be provided during delivery depending on whether an individual chooses a home birth or a hospital birth:
- a. For the AMTSL only two doses of syntemetrine can be given at a home.
  - b. Intravenous antibiotics can only be given in hospital during the delivery
  - c. In hospital, most women will have full blood counts so their haemoglobin levels can be checked

31. During the course of the Inquest I also heard of other critical differences between a home birth and one taking place in a birth centre (near hospital) or hospital. Namely the timely availability of neonatologist, obstetricians, the timeliness of any transfer for Mum and baby, the equipment available to manage bleeding and resuscitation being amongst some of the differences.
32. Abigail Holmes provided expert evidence and told the court that unresolved birth trauma from a first pregnancy can often present itself for women at the time of a second pregnancy. Understanding a woman's experience is important not only to frame the conversation around any current risks but also to ensure the woman feels listened to and their experiences validated. It is important in trying to resolve some of their trauma and ongoing concerns.
33. **In summary, the evidence paints a picture, which I find was the case with Jen of a first time mum having had a very challenging delivery, who required treatment for post natal complications. The records and evidence indicates that both Jennifer and her son received appropriate treatment as a result of their respective separate complications.**
34. **I am satisfied this experience is likely to have had a lasting impact on Jen which would have more likely than not contributed to her decision making and the planning in her second pregnancy.**

### Jen's Second Pregnancy Antenatal Care

#### Identification of Risks and First Consultant Appointment

35. Jen's first appointment with the antenatal midwife Caroline Nixon was on the 11<sup>th</sup> October 2023. Ms Nixon had not been able to access Jen's first pregnancy records due to the change from Pennine Acute NHS Foundation Trust to Manchester Foundation Trust and the introduction of the HIVE computer system. I am satisfied that Ms Nixon was made aware by Jen of all the significant information pertaining to her pregnancy risks. It was this information which prompted Ms Nixon to make a referral to a Consultant.
36. The consultant appointment takes place on the 24<sup>th</sup> November 2023 with Dr Caroline Rice Consultant in Obstetrics and Gynaecology. Both Jen and Rob attend this appointment. At this stage Jen was 14 weeks pregnant. I heard from Dr Rice that this appointment was approximately 20 minutes. The purpose of the appointment was to, "hopefully allay any worries from the family as to the chances of any reoccurrence of risks, explain how we can minimise those risks and how we would manage them when the lady goes into hospital."

37. When questioned, Dr Rice explained a definitive plan as to the delivery is not made. This appointment is providing information, providing medical advice and also a chance for the family to ask any questions they may have. Dr Rice had correctly identified there were two risks with Jen's second delivery: PPH and GBS.
38. Her management advice was that Jen should have a hospital delivery, AMTSL and intravenous antibiotics for any potential GBS risk. She was satisfied that there was no risk from the fact of Jen being pregnant. She did not consider this a high risk pregnancy and felt it entirely appropriate that the management of Jen's pregnancy could be managed by midwifery led care.
39. When asked about whether "risk of delivery" is directly discussed with a woman Dr Rice stated that she probably assumed that the patient understands whilst her pregnancy could be a low risk, she may be at a "high risk" in terms of the delivery.
40. In line with other evidence I heard, Dr Rice did not discuss a potential risk of death with Jen in respect of the risk of a PPH. She thought she would have discussed the potential small chance of death to baby if baby was infected from GBS.
41. In respect of location of where a woman may choose to give birth, Dr Rice said she would not open a conversation with a woman in respect of the location of delivery. Unless the woman raised the issue she would simply work on the basis that it would be a hospital delivery. She did confirm at this stage she did not think many families will have formulated a plan and should a home birth be requested later in the pregnancy she was aware the woman would be referred back by the midwives for a further discussion.
- 42. I find from the evidence that at this stage there was appropriate recognition of the potential risks for Jen and her baby. The advice given by Dr Rice did detail what would occur if Jen gave birth in hospital and advised AMTSL and Intravenous antibiotics for GBS. However, I am equally satisfied that at the end of this appointment there was no set formalised plan. I consider it more likely than not that Jen was still considering her options. The fact Jen and Rob had not raised any questions was not a guarantee they had reached a firm opinion as to the location of the birth or importantly whether Jen was in agreement with AMTSL or intravenous antibiotic treatment. It was early in the pregnancy. Dr Rice correctly**

**identified Jen could be referred back for further discussion and the return of Jen to midwifery led care was appropriate.**

### Describing Pregnancy as a High or Low Risk

43. Dr Rice had correctly identified that there was no risk from the actual pregnancy to Jen. As a result Jen was correctly referred for midwifery led care. I heard and explored with a number of witnesses including Ms Abigail Holmes, Mrs Esme Polshaw Head of Midwifery MFT and Professor Johnstone Head of Clinical Division MFT, the use of the terms high and low risk pregnancy. Consideration was also given to the current National Institute Clinical Excellence (NICE) guidance for Intrapartum care published 2023 (updated 18<sup>th</sup> June 2025). The phrases “high and low risk pregnancy” are used nationally in obstetric and midwifery care, this was not something unique to Manchester.
44. I heard that there is a common misconception amongst women that if they are under a Consultant then the pregnancy is high risk. Alternatively, if they are under midwifery led care the pregnancy must, by the very fact they are not under a consultant, be low risk. One can see why this misunderstanding arises since many women may understand the term ‘pregnancy’ to incorporate the entire process from pregnancy through to labour and delivery of a child. However this is incorrect. Pregnancy and labour are distinct processes and carry different risks. In Jen’s case there was no risk attached to her being pregnant, the risk to Jen was in respect of the delivery of her child.
45. My attention was drawn to Section 1.3 of the National Institute Clinical Excellence (“NICE”) Intrapartum Care Guidance. In addition to the risks set out in Section 1.3.3, the guidance also advises professionals to, “advise a women (giving birth at home) of the small increase in the risk of an adverse outcome for the baby.” Nowhere does it advise what the level of risk of an adverse outcome is for the mother.
46. In Jen’s case, the MFT after visit summary which was the documented generated on HIVE after all of Jen’s appointment and to which she would have had access, suggests a confused position. It fluctuated between describing her pregnancy as a high risk or a low risk at different times. I heard from both Rob and also Jen’s friend Katherine Kershaw as to how Jen viewed the described risk of her pregnancy.

47. I am satisfied from all of the evidence that Jen believed that the description being given to her, in general terms, was that she had a low risk pregnancy.
48. I am satisfied that Jen was aware of a described risk of infection to her baby as she was a GBS carrier that she was also aware of Dr Rice's advice for AMTSL due to her previous PPH but beyond these risks I do not consider Jen viewed her pregnancy or more importantly the delivery of a child as one where there was an overtly increased risk.

#### Antenatal Care 6<sup>th</sup> December 2023 – 7<sup>th</sup> February 2024

49. Jen's next appointment with Midwife Caroline Nixon is on the 6<sup>th</sup> December 2023. Ms Nixon told the court that she would have discussed the plan which Jen had made with Dr Rice. Ms Nixon told the court her expectation was that after the appointment with Dr Rice a plan would have been set.
50. As such she said she would have discussed the plan with Jen and she recalled going through it. She did not recall Jen raising any thoughts about a home birth or any questions or concerns about the plan to have AMTSL. She told the court she did not think Jen had any doubts about a hospital birth.
51. On the 8<sup>th</sup> December 2023 Jen posts an entry onto a facebook page which certainly indicates she is strongly considering a home birth. In this post Jen states that she is not due to see her midwife now until February, she had recently started to think about a home birth and is trying to "*find out if it's possible to receive IV antibiotics at home..*" She also indicates she wants to arm herself with as much information as possible.
52. At her next appointment with Midwife Nixon on the 7<sup>th</sup> February 2024 Jen expresses her wish for a home birth. As a result, she is referred for a further Consultant appointment to discuss this decision. Ms Nixon told the court that she would have expected the consultant to fully discuss all the risks of a home birth with Jen.
53. I heard that this would be considered an Out of Guidance ("OOG") home birth. Ms Nixon was of the view that she fell into the category of OOG as Jen was a high risk pregnancy and was requesting a home birth. In fact by this stage, the after visit summary sent to Jen following her appointment with Dr Rice had the level of risk for her pregnancy set to low and Dr Rice confirmed she considered Jen a low risk pregnancy.

#### Appointment 5<sup>th</sup> March 2024

54. On the 5<sup>th</sup> March 2024 Jen had an appointment with Dr El-Adwan a ST4 Trainee in Obstetrics. I heard evidence it would not be unusual for the appointment not to be with a Consultant. Dr El-Adwan had some experience of seeing women who were considering a home birth out of guidance however given the small number of home births across the trust in her four years of training she felt this would only have been approximately 10 women.
55. Dr El Adwan told the court this appointment was to discuss the risks and advise against a home birth. She recalled discussing with Jen her two risk factors. In respect of Jen's risk of PPH she told the court her normal conversation with a woman would be to advise a woman that if bleeding occurred in hospital it would be dealt with as an emergency, whereas from home the woman would need to be transferred. In respect of the GBS risk she recollects her advice would have been to have intravenous antibiotics regardless of whether her swab was positive or negative. Her advice also remained for Jen to have a hospital birth.
56. In respect of AMTSL Dr El Adwan said, she considered that from the medical records a plan had been made with Dr Rice. She recalled discussing oxytocin and cannulation and "didn't think Jen objected to that." Whilst Dr El-Adwan discussed with Jen what she considered was an already made plan, Dr El-Adwan accepted when questioned that she did not discuss Jen's view on AMTSL. She said she assumed Jen was going with the advice given.
57. Dr El-Adwan was not aware of certain aspects of Jen's first pregnancy, she did know Jen had a forceps delivery and that she had had an episiotomy.
58. At end of this conversation Dr El Adwan's recollection was that Jen indicated she was more likely to go for a home birth but that she would wait to have the GBS swab and consider matters further at that time. There is no record from this discussion that the reasons why Jen wanted a home birth were ever discussed or queried.
59. Dr El-Adwan recalled that Jen did not have many questions and she was satisfied Jen understood the risks and at the end of the conversation understood that Jen indicated that she was "more likely to go for a home birth but would have the swab for GBS and then finalise her decision."
60. The record made by Dr El-Adwan at the conclusion of this consultation makes no mention of any plan in respect of the third stage of labour and whether Jen was receptive to active management or may have been considering a physiological approach. In questioning from Ms Gutherie, Dr El-Adwan felt she should have escalated this consultation to a Consultant.

61. Mr Malcolm Griffiths Consultant Obstetrician and Gynaecologist and Medical Examiner was appointed by the court as an expert. He told the court that it would have been important for Dr EL-Adwan to discuss with Jen why she was considering a home birth. He explained there would be various alternative options to explore with a woman, such as a half-way house such a birthing centre, a different hospital or the possibility of having consistency of care with particular midwives.
62. He also confirmed he would have explored with Jen the fact that in her first pregnancy the birth centre notes indicate on the vaginal examination the fact that at 6cm dilated the baby was in the Occiput Posterior (OP) position. This position can lead to a longer more painful labour with back pain a common symptom. This together with the fact that she had a forceps delivery due to slow progress of her labour would have led him to ask Jen if she was aware that there was a risk of another OP position and of a difficult labour. His evidence was that he would have tried harder to persuade her not to have a home birth ensuring she was aware of these risks.
63. Mr Griffiths agreed with the court that there is nothing in the medical record of this appointment to indicate what the plan was in respect of the third stage of labour and whether Jen agreed with active management.
64. In addition to this he said he would also have expected to see a plan as to what would happen in respect of GBS if Jen had a home birth. I heard evidence Jen and Rob should have been provided with information as to what to look for should early onset of GBS occur after any midwives leave a property.
65. Dr El-Adwan told the court she had never referred a woman to a senior midwife for an OOG plan. Her assumption was the community midwives would do this. Whilst I consider the referral to a senior midwife was more likely an action for the community midwives it would be a helpful reminder for any community midwife for the doctor to add an action onto a woman's plan, that a referral was required.

#### 5<sup>th</sup> March – 2<sup>nd</sup> June 2024

66. On the 13<sup>th</sup> March 2024 Jen had a routine 28 week antenatal appointment with Midwife Rachel Wadkins. I heard that this was a routine appointment but also an opportunity to discuss the recent obstetric appointment and to make sure Jen had understood it. Ms Wadkins told the court that before meeting

Jen she reviewed her antenatal records, she was aware she had seen the Dr a week earlier and she discussed this appointment with Jen.

67. Her recollection was that she went over the plan formed with Dr El-Adwan and whilst Rachel Wadkins has not documented that Jen agreed to active management of the third stage of labour she told the court that she would have referred Jen back to the consultant if Jen had indicated she wanted a physiological third stage.
68. Jen attended a further antenatal appointment on the 10<sup>th</sup> April 2024 with Caroline Nixon. On the 27<sup>th</sup> April 2024 Midwife Nixon carried out a home birth risk assessment.
69. The home birth risk assessment document has limited personalised information or details of any discussions. It is in essence, a yes/no tick sheet. This assessment completed at 36+2 weeks should have occurred around the same time as Jen should have been referred to a senior midwife for an out of guidance care plan. Ms Nixon accepted she should have referred to Jen a senior for her personalised OOG care plan to be completed.
70. Ms Holmes told the court that the home risk assessment should be informed by a womans OOG care plan. She told the court that an appointment to put together an OOG plan would be expected to be over an hour. I heard in the trust now it could be in the region of two hours.
71. Having heard and considered all of the evidence it is clear an OOG care plan is crucial for not only the woman but also the midwives who would be attending. An OOG care plan would have discussed and considered in detail some of the issues which were later set out by Jen in her birth plan, preferences for vaginal examinations, fetal heart rate monitoring, the third stage of labour. However this appointment and plan is far more than simply detailing a woman's preferences. It should be an opportunity to explore fully with a woman what has happened in any previous pregnancies, to explain why certain advice was being given and to explore options on all topics as well as any worries or concerns a woman has.
72. On the 3<sup>rd</sup> May 2024 Jen emailed her husband Rob a copy of her birth plan. I cannot reconcile from the evidence why this was not provided to the community midwife. We cannot check to ascertain whether Jen did try and email the same. No evidence has been found on a trust review of the systems that any email was received. I heard evidence that Jen was highly organised and it is the detail in the plan itself which makes me question whether in her mind she thought it had been sent. She sets out detailed instructions as to

how to get to the home, she indicates she would have no objections to a student midwife attending. This suggests she had an expectation that this document would be read before midwives arrived at her home for the birth.

73. At her antenatal appointment on the 8<sup>th</sup> May 2024 it was documented by midwife Nixon that Jen had decided to decline the GBS swab test. There is no indication as to why, or whether her reasoning was explored. In addition prior to this appointment Jen had recently been seen at maternity triage with proteinuria and a raised PCR. In addition her hsemoglobin (“HB”) level had recently found to be 101g/L and she had been commenced on iron.
74. On the 29<sup>th</sup> May 2024 Jen had a further episode of proteinuria and her PCR value was 191. Mr Griffiths told the court that in his opinion this increased protein level is not normal. In his view this should have led to a review by obstetrics. He said he did not think a PCR of 191 was indicative of a urinary tract infection and it may have indicated a problem with Jen’s renal function.
75. He was of the opinion that as a result of the PCR levels on the 29<sup>th</sup> May 2024 an induction of labour should have been discussed with Jen. He went onto say that an induction could have been initiated and Jen could have returned home before coming back into hospital. This is not uncommon. A referral to obstetrics would have meant another opportunity to discuss with Jen the change in her presentation and risks and to go over the care plan. Or in this case, to recognise that a OOG care plan had not been done.
76. There was also no recognition or consideration that Jen’s HB levels had dropped to 97g/L which showed a decrease despite several weeks of iron treatment. The court heard that the required level of HB for a home birth was 90g/L. So whilst this level would not in itself have precluded Jen from having a home birth, national guidance does indicate an individual assessment of a woman is required for women with HB level of 85g/L to 105g/L. There is no evidence the risks of anaemia and the potential increased risks this could bring should she have a PPH were ever discussed with Jen.
77. **My findings of fact in relation to Jen’s antenatal care from the 6<sup>th</sup> December 2023 – 2<sup>nd</sup> June 2024 are as follows:**
78. **Even though Jen appears to have been categorised as a low risk pregnancy immediately after her appointment with Dr Rice, I find it was correct that once Jen indicated she was considering a home birth that she was treated as being OOG given the medical advice provided by Dr Rice for a hospital birth.**

79. Following the appointment with Dr Rice I find the community midwives placed undue reliance on the fact Jen had been seen by Dr Rice in her clinic on the 24<sup>th</sup> November 2023. They assumed Jen had agreed to a definitive plan for active management of the third stage of labour. They did not explore this further with her throughout her pregnancy and were not alert to the fact that she was considering a physiological approach.
80. The referral to obstetrics in February 2024 following Jen's indication she was planning a home birth, was appropriate. That appointment did not require the involvement of a Consultant Obstetrician. However, it did require with Jen a discussion of her reasons for wanting a home-birth; of other venues that were available for labour and delivery in addition to option of hospital; an exploration of any fears that she had which were influencing her decision-making around a home-birth. These matters were not discussed at the obstetric appointment on the 5<sup>th</sup> March 2024. Subsequent antenatal appointments did not explore such matters and were deficient. This meant that the personalised risks associated with Jen having a home-birth were not fully explored.
81. Jen should have been referred to a senior midwife for the completion of an OOG care plan. This did not happen. Whilst the subtle differences between the Trust's antenatal care guidance was not helpful, this was not the reason why the referral was not made.
82. I accept there is no evidence to indicate the birth plan document produced by Jen could have been available to the community midwives who attended the delivery, prior to their arrival.
83. When Jen indicated she had made the decision not to have a GBS swab a further conversation as to the risks and signs to watch for postnatally should have occurred. No such discussion took place.
84. By the 29<sup>th</sup> May 2024 when Jen had her second increased PCR she should have been referred for an obstetric review and induction of labour should have been offered.
85. At this time her low declining HB level should have resulted in a further conversation with Jen in respect of the increased risk of her moderate anaemia should she have a PPH.
86. Overall, I find as a matter of fact that from the time Jen indicated she was considering a home-birth in February 2024 her antenatal care lacked any active inquiries, was based on assumptions made by midwives and was

**perfunctory. The most critical of appointments with a senior midwife to complete THE MOST important guidance document, an out of guidance care plan was simply overlooked and forgotten. In my view, this was a catastrophic error and a gross failure to provide basic medical care.**

**2-3<sup>rd</sup> June 2024**

**23:00 – 03:54am**

87. On the 2<sup>nd</sup> June 2024 two Midwives were on call for home births, Andrea Walmsley and Julie Turner. Neither of these midwives had met Jen before. Both attended the Inquest to provide evidence. Before I turn to their evidence, I want to say I have no doubt at all, that this was a deeply distressing and traumatic experience for both of them. I have viewed their evidence with this fact in mind. Considering the impact this evening has evidently had on both of them I have to take into account it is perhaps not surprising to some degree that recollections may differ and timings may not always be accurate.
88. Both Midwives had worked a full shift during the day on the 2<sup>nd</sup> June 2024. I heard this was common national practice albeit with slight variations. This was Midwife Walmsley's third delivery since 2022. It was her first 'high risk' home birth. Midwife Turner was a team leader and due to previous roles she had more experience of home deliveries, although the vast majority would have been with low risk.
89. HIVE introduced 2022 trust wide, although it was not rolled out immediately for intrapartum care. From the evidence I heard neither midwife appeared confident in the use of the HIVE system. Midwife Walmsley less so. The intrapartum section on the system would not have been something she had likely accessed often. She had not been on the training day in 2023 and was due to attend training on the 6<sup>th</sup> June 2024.
90. HIVE was known to have connectivity issues when off site and on the night it also attempting to complete various updates. However, whilst I find this was likely distracting and frustrating, the fact is, the appropriate paperwork was available in the home-birth kit bag and both midwives should have known this. Given the technical issues they faced a decision should have been made to simply use the paperwork which would have included a partogram.
91. I have considered the reliability of the computer records available in these cases. The records provided show that entries were made into the system on

the 3<sup>rd</sup> June 2024. The time entries are made is recorded. I would acknowledge that there is going to be some time between something taking place ie monitoring or examinations and when they are input into a computer. Having considered the records very carefully I think the timings of entries made up until 03:54am are more than likely to be close to accurate in terms of their time of events.

92. The midwives met at NMG in order to collect all the equipment which is required for a home-birth. They then attended together to Jen's home. I heard evidence as to some challenges in locating the property, but they arrive on scene at around 23.30 hours.
93. Neither of the midwives had attempted to read any records pertaining to Jen or any of the women on the home birth on-call list prior to being called out. They did not know that there was no OOG care plan. This is only fully realised when they arrive at the home and manage to log onto the computer system.
94. What they do become aware of when setting up within the property is Jen's birth plan. From her evidence to the court, Midwife Walmsley clearly found aspects of this document surprising and concerning. She said it was concerning that Jen did not want vaginal examinations or sytemetrine to be administered. Midwife Turner told the court she considered it was organised and was surprised no-one had seen it given the helpful information in respect of directions to the property.
95. Having read Jen's birth plan it includes the following:
  - a. **No periodic Ves.** (Her emphasis) If it is deemed medically necessary then please provide a full explanation for this and gain clear consent from Jen.
  - b. Would like monitoring of the baby to be kept to a minimum unless there is any cause for concern.
  - c. No syntemerine injection unless there are concerns about heavy blood loss. If there are concerns about how long t is taking to birth placenta then please encourage Jen to use the toilet and use peppermint aromatherapy oil.
  - d. If transfer to hospital is required then please discuss with Jen and Rob.
96. I heard evidence as to the impact on the Midwives of being in a situation where there was no OOG care plan and seeing Jen's birth plan for the first time. **I am satisfied that this placed them in an disadvantaged position in**

**that it is not ideal at the point in time when a woman is in labour for a midwife to start having detailed conversations about a woman's choices.**

97. Midwife Turner said she did speak to Jen to try and understand about her first birth and how much blood she had lost. At this stage Jen mentioned about wanting to wait 30 minutes before the administration of syntemetrine. Midwife Turner did not feel that was the time to explore with Jen why she wanted to wait 30 minutes as she said Jen was in labour, focused and in the zone.
98. A resuscitation area was set up in the room which I heard was standard practice. At this stage syntemetrine was drawn up. Ms Holmes told the court that the resuscitation area should not include adult medications and syntemetrine should be drawn up when required.
99. At the time of setting up the resuscitation area I heard the equipment was checked however later in time when Agnes required resuscitation the bag valve mask could not be used as the mask had split. I heard evidence from Ms Polshaw and Ms Holmes that at the point of setting up, the mask should have been taken out of the packet and checked and another one obtained when found to be faulty.
100. During the early hours of the 3<sup>rd</sup> June, Jen requests the use of Entonox. At a home birth this is the only pain relief available to a woman except for TENS machine. For several hours the midwives had difficulties with the tubing fitting correctly onto the cannisters. This meant the gas was hissing as it was leaking out. Not only did this mean that Entonox was being wasted and used up more quickly, I heard that this would likely have meant the effect for Jen was reduced.
101. As a result of the faulty equipment Midwife Turner made the decision to return to NMGH to obtain more cylinders and tubing. **From consideration of the records and evidence I find Midwife Tuner is likely to have been away from the property for approximately an hour.** She is back at the property around 3.30am.
102. During the time Midwife Tuner was away from the property, I heard evidence that the Entonox ran out meaning Jen had no pain relief. Rob explained that she became distressed and struggled to control her breathing. At this time he considered her contractions were increasing in intensity.
103. At no stage during Jen's labour did the midwives obtain a urine sample. I heard evidence that Jen was asked on at least two occasions, firstly near to

the time of the midwives having arrived when she indicates she has just been to the toilet, secondly at a later stage when Jen is in the birthing pool she indicates she again cannot give a sample as she has urinated in the pool. Midwife Walmsley told the court she felt Jen was reluctant to give a sample but accepted that she would not routinely explain to a woman why a sample is required. At no stage did she ask Rob to speak to Jen about obtaining a sample.

**03:54am – 06:49am**

104. At 03:54am Jen's blood pressure is recorded as 150/70mmHg. This is raised. I heard evidence from the Midwife Tuner, Mr Griffiths and Ms Holmes that this blood pressure reading should have been re-taken. Midwife Walmsley told the court 03:54 was not the last time Jen's blood pressure was taken but she could not evidence it as it was not documented. Her evidence was it was done and it would not have been high.
105. Mr Griffiths said he would wanted Jen's blood pressure repeating preferably sooner at around 15 minutes. He would want to know if it had gone up or down and acknowledged 150/70 is worrying.
106. Ms Holmes told the court it would have been helpful to know if this blood pressure reading was taken during a contraction, is so she would discredit it, however if it was outside a contraction then she would agree it is abnormal and needed to be repeated. At this stage she also said that further attempts should have been made to request a urine sample.
107. Midwife Turner gave evidence that around 4am she started to see a change in Jen's presentation. She felt this was the first signs of her going into the second stage of labour. She recalled Jen struggling and saying things like she could not do it. Midwife Turner did acknowledge this not uncommon and many women began to say things and present in such a way. It was this presentation which led Midwife Tuner to commence a conversation with Jen about a vaginal examination as she had no way of knowing how far along she was.
108. Midwife Turner spoke to Jen about conducting a vaginal examination. During this conversation she learnt what Jen's worries were and provided reassurance. Jen consented to an examination. This is the first time anyone had tried to understand why Jen had any concerns about an examination. During this examination Midwife Turner was able to note that the baby was in the OP position like her first pregnancy. There is no evidence that this was communicated to Jen.

109. Ms Holmes gave evidence that in her opinion by 04:30 a repeat blood pressure reading should have been taken. Ms Holmes went on to say that on the balance of probabilities she was of the opinion a further reading is likely to have been abnormal. She was also of the opinion that if a urine sample had been taken this might have shown proteinuria.
110. Ms Holmes told the court in her opinion Jen should have been approached about a *possible* transfer to hospital and the conversation started with her. From the notes and the evidence of the Midwives it is clear some thought was being given, certainly by Midwife Turner, to a transfer to hospital at this time. There is no evidence any conversation was commenced with Jen or Rob.
111. The midwives were not aware as they should have been if there had been an OOG Care Plan of the increased PCR rate of 191 on the 29<sup>th</sup> May 2024 or that Jen's HB levels had been last recorded at 97.
112. At 04:51 Jen's waters break, clear liquor is seen, this is documented in a handwritten note on Jen's birth plan.
113. It is not clearly documented as to when it was understood by the Midwives that Jen was in the second stage of labour. Midwife Turner confirmed it would be good practice to note this and have a conversation with the woman so that it gives them an understanding of where they are up to.
114. There were differing opinions given by Midwife Walmsley and Midwife Turner as to when the second stage of Jen's labour commenced. Midwife Turner said she would be thinking about it from about 05:30am. Ms Holmes agreed from her reading of the evidence she would have said around this time also. Midwife Walmsley considered it may have been earlier than this.
115. Both Midwives accepted that there is no evidence documented of any fetal movement monitoring. Midwife Turner accepted in her evidence that this should have been done to understand if the baby's movement had reduced. Midwife Walmsley told the court that she was doing this.
116. Midwife Turner and Midwife Walmsley recognised that Fetal Heart Rate monitoring ("FHR") should take place every 15 minutes during stage 1 of labour and every 5 minutes during stage 2 of labour. I heard evidence that the majority of the fetal heart rate monitoring was being undertaken by Midwife Walmsley who would then tell Midwife Turner who would input it into the computer albeit from around 04:30am Midwife Turner was more

involved with Jen's care and more likely alongside her. Certainly, as we heard there was a period of time when only Midwife Walmsley was in the property. She recalled writing down the observations onto an incontinence pad which was near her. This contemporaneous evidence was disposed of and was never seen.

117. Prior to 04:23am the computer records suggest that FHR was undertaken approximately every 15 minutes with some slight variations. This would indicate that despite what is documented in Jen's birth plan, "*would like monitoring of the baby kept to a minimum unless there is any cause for concern*" she was entirely agreeable to fetal heart rate monitoring. All of these entries and one at 04:44 were entered into the computer whilst Midwives were still on scene. There is no evidence to indicate there were any concerns during this period.
118. All the computer records around the period of time from 05:00am onwards are input retrospectively. More importantly and not a criticism of the Midwives, they are entered around 1-1.30pm after they have been awake for an extremely long time, by now over 30 hours and have experienced an extremely traumatic incident and I heard no evidence as to any post critical incident support for them. It is recognised there are clear errors in these records as the time of Agnes's birth is input as 06:30am. This cannot be correct.
119. Midwife Walmsley told the court that she was monitoring the fetal heart rate and between herself and Midwife Turner they were counting it aloud. When questioned Midwife Walmsley described how she would monitor the FHR and said that she would use a hand held doppler and count in 15 second blocks over 1 minute and then add them up to obtain the number of beats per minute. Normal FHR would be between 120-160.
120. Ms Holmes gave evidence to the court that Intelligent Intermittent Auscultation which is the monitoring and counting of the FHR rate using a complex clinical assessment. It involves counting every 15 seconds for at least 60 seconds. The Royal College of Midwives advises six 15 second intervals. She explained, you then look at the blocks and find the four numbers which are most similar and that is your baseline. You would discredit the highest. This must commence immediately after a contraction. It should be plotted on partogram and would show any changes in the increase of a baby's heart rate back to its baseline.

121. Whilst unreliable, the computer records do input some FHR at 05:12, 05:26, 05:45, 05:59, 06:13, 06:16, 06:20 and 06:24. They are not documented as being completed every 5 minutes.
122. Jen reaches a stage in her labour at approximately 06:00am, when Agnes' head can be seen and it is then retracting. Midwife Turner described the fact that the head was advancing slowly. Midwife Walmsley told the court, that from when Jen was on the couch she felt this was becoming a difficult labour.

### **Birth of Agnes**

123. At the point of delivery of Agnes Midwife Turner immediately recognised her poor condition. She noted the cord was around her neck and she removed this and she also saw meconium. She told the court that Agnes had at the point of delivery sustained hypoxia.
124. Agnes's apgar scores were done at 1 minute and 5 minutes before Rob was asked to call 999. At 06.49 an emergency 999 telephone call was made by Rob from his mobile phone requesting the ambulance service. The timing of this call is recorded on Robs phone and corroborated by the time on the NWAS contact centre log.
125. Mr Rehman Consultant Neonatologist, Mr Griffiths and Ms Holmes all gave evidence to the court that in their opinion fatal hypoxia would have occurred for a period of time prior to the delivery of Agnes. In the opinion of Mr Rehman and Mr Griffiths they believed this could be up to an hour. The evidence indicated decelerations of the FHR should have been noted during this period.
126. Midwife Turner took the lead in resuscitating Agnes. She accepted the findings of the Maternity Safety Newborn Investigation report which found the resuscitation was not in line with neonatal resuscitation guidance. I acknowledge the attempts made by Midwife Turner and I also recognise the evidence I heard as to the experience of both Midwives of neonatal resuscitation. This was the second time Midwife Turner had faced such a situation in her career, the first being 10 years ago, Midwife Walmsley had never been in such a position.
127. No amount of training can take account of the very real human factors which present themselves in times of crisis. I have no doubt that by this stage Midwife Walmsley was, as she described in a blind panic. Midwife Turner was hampered by issues with the mask but I do find was attempting to take control of the developing situation.

128. Whilst understanding of human factors and the differences in how people respond in a crisis, given the fact that Midwife Turner was conducting the resuscitation of Agnes, more assistance should have been provided to her by Midwife Walmsley such as recognising this was now an emergency situation and turning the lights on.
129. One of the decisions taken by Midwife Turner was not to cut the cord. This split second decision was to try and allow Agnes to receive some oxygen. I heard evidence the cord should have been cut and whilst I agree with that evidence, I think it is important to again acknowledge this was a very difficult situation for Midwife Turner who I accept took this decision with the best of intentions for Agnes.
130. **In respect of the labour and delivery of Agnes on the balance of probabilities I have reached the following findings of fact:**
131. **The lack of an OOG Care plan meant the midwives who attended Jen were in disadvantaged position by the lack of an OOG care plan however its absence does not account for shortcomings in the care provided to Jen and Agnes.**
132. **Jen's birth plan was entirely reasonable and does not account for weaknesses in the delivery of care to Jen or Agnes.**
133. **The HIVE computer system provided additional challenges for the Midwives due to connectivity and upgrade issues. In addition, there was a lack of understanding as to how to use the system and a lack of confidence. Nevertheless, both midwives should have known the kit bag contained paperwork and resorted to using this. This would have include the use of partograms for Fetal Heart Rate monitoring.**
134. **The problem with the Entonox equipment could not have been known by the Midwives before attending at the property. As a result of the Entonox not working correctly, it is likely that until a replacement was obtained Jen would have received ineffective pain relief. It was appropriate for Midwife Turner to obtain a replacement. Whilst escalation of this to a bleep holder was, in theory available, I find it would not have been clear to midwives if the bleep holder could assist with this type of issue.**
135. **On arrival at the property the setting up of the resuscitation area should have included a check of the bag valve mask. If a check had been**

carried out it would have identified the problem and a replacement mask should have been obtained.

136. I find Jen's high blood pressure was not managed appropriately and was not re-checked after 03:54 hours.
137. At no stage was a urine sample obtained. More attempts to obtain a urine sample should have been made. This became more important after the recorded increase in Jen's blood pressure and a clear explanation provided to Jen and Rob as to why one was necessary should have been provided.
138. I find as a fact that Jen's waters broke at 04:51 and it is more likely that not that between then and 05:30am Jen entered the second stage of labour.
139. During the second stage of labour the fetal heart was not monitored every 5 minutes. I find that any monitoring which did take place was likely to have been conducted ineffectively and none of the FHR recorded observations in the computer records are reliable.
140. There was a lack of fetal movement monitoring.
141. I find on the balance of probabilities that after the vaginal examination at approximately 04:20, given the ineffective pain relief, the raised blood pressure reading, the fact she was 7cm dilated, the baby was in the OP position, conversations should have been commenced with Jen and Rob as to the *possibility of a transfer to hospital at some stage*.
142. Agnes was born at 06:44am with the cord around her neck and I find by this time she had sustained a severe hypoxia. On balance it is more likely than not that she would have been showing signs of fetal distress through decelerations for around an hour prior to her birth. These were not noted by the midwives and therefore no action was taken prior to her birth. These should have been recognised and a call to emergency services places immediately.
143. Following her birth the cord should have been cut and the resuscitation of Agnes should have been conducted in line with local and national neonatal guidelines.
144. Overall, I find that there was a gross failure to provide basic medical care in that FHR was not completed every 5 minutes in the second stage of

**labour and was not conducted in a correct manner. It is more likely than not that Agne's heart rate would have shown signs of deceleration for up to an hour prior to her birth.**

### **NWAS on scene**

#### **Resuscitation of Agnes**

145. The call to NWAS was correctly triaged and managed as a category 1 incident of a newborn at home not breathing. As a result, numerous crews were allocated to attend the incident.
146. At 06:50am hours Mr Sean Scroop senior paramedic was allocated to the incident and arrived on scene at 06:58am He was in his vehicle with a student paramedic Sinead Hirst. At the same time, 06:50am, Adrian George paramedic working alongside Brendan Greener and arrived on scene at 06:55 am.
147. Brendan Greener recalls as himself and Adrian George had parked up Mr Scroops vehicle arrived and parked up behind them. This was also the recollection of Mr Scroop. All, then gather their equipment and enter the house. By the time Mr Greener gets into the property after spending a very short time locating a vascular access device in the vehicle he could see that Mr Sean Scroop had started to attend to Agnes.
148. **Whilst there is a small difference in the times the crews are recorded as being on scene I am satisfied that in real terms they arrived so very shortly after each other that the practical effect was they entered the house together.**
149. I heard the evidence from Mr Scroop who I found to be an impressive and compelling witness. Given his seniority and experience and the medical emergency he was faced with he quite rightly, took control of the situation. I am satisfied that he was the first NWAS individual to get to Agnes.
150. On entering the room Mr Scroop told the court he instructed the curtains to be open and the light to be put on as it was dark. He said Agnes was on the floor and the midwife (JT) was doing chest compressions. He repositioned Agnes into a more suitable position by placing a pad underneath her so that he could better open her airway at which point she took a breathe and as he said "started to pink up nicely." Before this he had noted that she was cyanosed (blue).

151. Defibrillator pads were attached to Agnes front and back which confirmed a low heart rate. As Agnes was still connected to the placenta he instructed for the cord to be cut. At this point Mr Scroop clearly communicates a 2 minute warning that they will be leaving. He does this to allow his crews the ability to warm up the ambulance and to be ready to leave. He directs a towel to be provided and instructs the midwife that he will lift Agnes, for her to be wrapped in a towel and he would in effect then carry her out continuing chest compressions. Until this stage he said Agnes was not wrapped in anything.
152. Agnes was carried to the ambulance by Mr Scroop where an i-gel was then inserted to maintain her airway and there was a further assessment of her. At this stage her heart beat was recorded as 104, she had good circulation and she was oxygenated. The ambulance departed the scene with Agnes at 07:09.
153. **I find the resuscitation and management of Agnes by the North West Ambulance Service to have been appropriate and a good standard of care was afforded to her.**
154. Whilst all of the above was ongoing other crews were being allocated to this incident at 06:57 Leah Brannan and Thomas Rudd allocated incident as back up arriving on scene at 07:02.

#### **Care of Jen after departure of Agnes**

155. The chronology of events in respect of the care of Jen after paramedics left with Agnes, has not been easy to reconcile from the differing accounts and evidence I heard. I set out here some of the key evidence including, the fixed points which may assist in corroborating other evidence. I was also assisted by the evidence of Mr Faulkner Associate Clinical Director of London Ambulance Service who provided expert evidence to the court.
156. Prior to leaving the room with Agnes, Mr Scroop said he looked over at Jen. He could see she was a good colour, she was not sweating, she was not agitated. She appeared to be in some discomfort but that was it and not unexpected as she had just given birth. He did not see any signs of her bleeding. Mr Scroop was asked whether anything was said to him in respect of Jen being at risk of a PPH. He was very clear that nothing was said to him. Of note, he also said he did not see any signs of blood on the floor where he was kneeling to treat Agnes.

157. He went on to say to the court he was focused on Agnes however if he was aware Jen was a risk of PPH, he would have asked what observations had been undertaken on Jen. Plus, he would have told the crew remaining on scene that Jen was a high risk, to keep monitoring and extricate when they could.
158. The crew remaining on scene were Adrian George a Paramedic of less than 1 year qualification and Leah Brennan an apprentice emergency medical technician. I accept the evidence from Mr Faulkner, the decision as to which crew remain is a split second decision at a time when the medical emergency is the resuscitation of Agnes.
159. The court received a statement from Natalie Ashcroft Advanced Paramedic. Her evidence was accepted by all Interested persons as evidence which could be read pursuant to R 23 Coroners (Inquest) Rules 2013, on the basis the evidence was unlikely to be disputed.
160. At 07:08am Natalie Ashcroft an Advanced Paramedic arrived on scene. At this stage Agnes was in the back of the ambulance being treated. Natalie Ashcroft is only at the scene for a short time as she goes in the ambulance to assist with the care of Agnes. Within this minute, she enters the property and speaks to the crew and midwives remaining. Natalie Ashcroft said she recalled being advised Jen had had a small blood loss after the birth which had stopped, that she had had a previous PPH and that she was due to have syntometrine. This information had to have been provided by at least one of the midwives.
161. As a result of this information, Ms Ashcroft indicated she advised to *give* syntometrine and *rapidly extricate* to the Emergency Department. She said no-one was raising any concerns with her and there was no indication of active bleeding. She was also advised Jen's observations were stable. As her skills were required with Agnes, she left.
162. In her statement Ms Ashcroft stated that she also requested another Advanced Paramedic to attend and support the crew who remained on scene. **Consideration of the NWS transmissions, both calls and radio have identified that there was no request for a further crew or advanced paramedic made by Ms Ashcroft.**
163. In addition to the remaining NWS crew there remained two trained midwives at the house and I would agree with the evidence I heard that whilst **there is a collective responsibility for care and teamwork with other**

**agencies is important, it would be reasonable to consider that the maternity care of Jen would predominantly be lead by the midwives.**

164. After the crews leave with Agnes, Leah Brennan described how she was in and out of the property, she brought the ambulance nearer to the house, she spoke to the NWS control centre who wanted to know the time of Agnes's birth she was advised that this was 06:30 and relayed this back, she realised the wheelchair was unlikely to be able to be used and went back to the ambulance to obtain the carry chair and bring this into the property.
165. Ms Brennan recalled that Jen was on the sofa with her back to the door initially and this is where she was when the observations were taken at 07:16am. Later she confirmed Jen repositioned herself on floor against sofa on her knees and then went from on knees to sitting on her bottom her knees bent upright.
166. It was at this point in time when Jen moved to her bottom that Leah Brennan said she was supporting Jen with a midwife and Jen delivered the placenta. Leah Brennan considered Jen had a bleed just before the placenta was delivered. Ms Brennan said a bleed occurred as Jen sat on her bottom and it seemed to her like the bleed had been concealed and was released when Jen moved.
167. Ms Brennan did not recall any discussion around why Jen may have had a bleed and she did not know when sytemetrine was administered. She said the first time she heard mention of that drug was in the debrief.
168. Ms Brennan told the court after delivery of the placenta the track chair was not suitable and the plan changed to use a scoop for extrication.
169. Paramedic Adrian George told the court he recalled Natalie Ashcroft asking him to stay at the house. He was aware of Jen's previous PPH, the fact Jen had not delivered the placenta and his understanding was that Jen had received sytemetrine.
170. His recollection was that Jen appeared agitated and uncomfortable in that she could not settle in a position. He recalled that she was still having Entonox. He did find this concerning as he said Jen was still in the third stage of labour and having contractions.
171. Mr George explained that he had not witnessed Jen bleeding. He said he had conducted an 'assessment' of Jen, in that he had noticed that he could see blood on her vagina but no active bleeding. The coverage of blood meant

he could not see whether there was any trauma. Mr George accepted this was not a vaginal examination, simply his own assessment from a distance.

172. Midwife Walmsley gave evidence to the court that when Mr Scroop entered the room he took her position and she moved. She did not move onto the couch where Jen was and was not therefore able to get to her. She could see her. She went onto say that as soon as Agnes had been taken out of the house she went to Jen. The earliest this could have been is 07:07am.
173. Midwife Walmsley told the court ,she recalled moving a blanket when there was a "gush of blood." She said blood went onto her and onto the incontinence sheets. Midwife Walmsley said it was *after* this blood loss that she administered syntemetrine to Jen. Midwife Walmsley told the court her recollection was this bleed occurred at around 07:07 and Jen lost approximately 500mls of blood. After this she said she administered syntemetrine.
174. Following the administration of syntemetrine Midwife Walmsley told the court that Jen was very quiet she was not really talking, Midwife Walmsley could not recall what was going on around her. She described it as absolute chaos. She said she was waiting to deliver the placenta, Midwife Turer was in and out and at one point made an attempt to get the placenta out, then she believed Midwife Turner went upstairs to get Jen some clothes.
175. She said she noticed Jen was becoming sweaty and clammy. At some point she described Jen went onto her knees and the placenta just fell out. She recalled , Midwife Turner noticed this and remembered her saying, "there is the placenta." Midwife Walmsley said she did not see any further bleeding and was not aware of a second bleed.
176. When questioned, Midwife Walmsley accepted that maternal observations should have been undertaken on Jen and that an inspection to see if Jen had had a tear should have been carried out. She explained at the time she was in shock.
177. At 07:12 Midwife Turner called the bleep holder to arrange transfer of Jen to the labour ward. She also made a call to Hayley Duthie the team leader. Midwife Turner indicated if she had been aware Jen had had a bleed at this time then she would have arranged transfer to A&E not the labour ward. After her conversation with the bleep holder Midwife Turner said she then spoke to the paramedics to ask them to remain at the house and transfer Jen to hospital after the third stage of labour had been completed. Her recollection was that the paramedics had been packing up to leave prior to

her making these calls. **I am satisfied there is no evidence to indicate NWS ever had any intention of leaving without Jen.**

178. At 07:16 the NWS electronic records show that observations were carried out on Jen. Mr George and Ms Brennan recalled conducting these. At this time Jen's blood pressure was recorded as 151/129. This was abnormal. I heard that in June 2024, ambulance services nationally did not use the Maternity Early Warning score ("MEWS"). This would have given a score of 6 on a MEWS score meaning there was a high risk of deterioration. Instead, they used the National Early Warning Score (NEWS) scoring which gave a score of 0 which indicated no concerns.
179. Paramedic Mr George said, he recognised the blood pressure was high but did not consider this was due to her bleeding. Mr Faulkner the expert, told the court having reviewed this reading he was of the opinion the narrow pulse rate was an indication for acute blood loss however, he acknowledged this would not necessarily be known by a paramedic and would be something covered in an Advanced paramedic course.
180. Paramedic George also recalled that Jen was giving an indication she wanted to be left alone which he took to be because she was agitated and still in labour and using pain relief. He confirmed that ideally should have had more observations but at the time he respected her wishes.
181. He said he did recognise Jen had had a traumatic birth and given her past medical history he wanted to get her out. He later said himself and a Midwife were attempting to get Jen on the carry chair when she lost strength in her legs, her blood pressure had gone lower and at some point around this time the placenta was assisted to be delivered followed by blood loss. Her blood pressure at this point he said was 91/72 and he requested back up.
182. The recollection of Midwife Turner was that at around 07:24 she noted blood loss from Jen who was sitting on the couch next to Midwife Walmsley. She estimated this to be around 500mls. Her evidence was it was at this stage that Jen was administered the syntemetrine by Midwife Walmsley. Midwife Turner in questions accepted syntemetrine should have been administered to Jen at the point the cord was cut.
183. Midwife Tuner told the court that she tried to deliver the placenta by cord traction but she said the cord felt friable. Her recollection was at this point the paramedics were getting the carry chair.

184. As I have already stated at 07:33 the computer system shows Midwife Turner was accessing and recording on the HIVE system.
185. The recollection of Midwife Turner was that she walked into the room when Jen was attempting to get up and she saw the placenta come out. She said she did not see Jen actively bleeding but there was blood on the floor. She also noted a change in Jen's condition when she was tying her hair back and she noted she was sweating. She acknowledged at this point she knew Jen was unwell as she was pale, she had had blood loss, she was clammy and sweating and she said she was getting annoyed with the paramedics as she just wanted Jen in hospital. She assumed at some point Jen had been examined to see if she had a tear.
186. Late evidence from NWAS came from the transcripts of the radio transmissions. At 07:36am there is a transmission by Natalie Ashcroft to dispatch to check if the crew remain at the house or if they have left. Dispatch make contact with the crew at scene at 07:38am the information given to dispatch at this point in time is, *"mum is going to be travelling, yeh we're just having a bit of trouble actually getting her out and off the ambulance at the minute, she's really , really weak and she's bleeding a little bit so we're just trying to like sort out the logistics of getting her out the room and not the ambulance as she's struggling to get herself up at the minute."*
187. At 07:41am there is further radio transmission between dispatch and the crew on scene as follows, *"..i think we're going to need an extra pair of hands for extrication at the moment if that's possible."* No reason is provided and there is no mention of any further deterioration of Jen.
188. At 07:44 Paramedic James Morgan and Tracy Reilly are diverted to this call and arrive on scene at 07:50am.
189. At 07:46 a third radio transmission takes place following an enquiry by dispatch for an update. The response at this stage is, *"we're with the mum, her condition has deteriorated, resp rate reduced and she's unconscious at the moment, we're waiting on another crew to help us get her out...."*
190. At 8:01am it is confirmed Jen is in cardiac arrest.
191. Advanced paramedic Scott Garritty arrives on scene and assists in the transportation of Jen to hospital. In his statement he says the history given to him was, Jen had given birth and was initially doing ok but had then begun to bleed. He was told she had lost 2 litres of blood which was estimated by the midwife. He was told there was lots of blood soaking through

incontinence pads. He verified the placenta had been delivered and that she was still externally bleeding. He says, "*I was told that the placenta had been delivered and this had slowed the bleeding initially.*"

192. Ms Holmes told the court that at the point Agnes was delivered in a critical condition the whole situation had changed and any previous plans are essentially gone. From the point of Agnes's delivery this was a critical situation, if only as you want mum to be with baby.

193. As well as the cord being cut Ms Holmes told the court you would then immediately move to the third stage of labour and administer syntocinon. She said this should have been administered over syntemetrine given the last recorded blood pressure for Jen. **Whilst I acknowledge that point I will continue to refer to syntemetrine as that was what was ultimately given.** The reasons for syntocinon was that it does not case the risk of hypertension.

194. In the opinion of Ms Holmes she was of the view that the blood pressure reading at 07:16, which was likely to be accurate as it was completed by the paramedics was likely showing the effect of the administration of syntemetrine. She said the diastolic reading is very high, life impactingly high but she has seen those types of responses from administration of syntemetrine.

195. Ms Holmes also told the court that a vaginal examination should have been conducted by a midwife and should have looked for signs of trauma. If blood was obscuring your view on an examination she said this should have been a concern and you would swab and remove the same to see if bleeding was occurring. She would have expected a midwife to be able to see a fourth degree tear.

196. The evidence from Ms Holmes was that she would have expected the midwives to be conducting observations on Jen

197. **In respect of the care of Jen following the departure of Agnes to hospital I have reached the following findings of fact:**

198. **This was a chaotic and distressing situation for the midwives and human factors came into play particularly with Midwife Walmsley who I find was more likely in shock. However, this meant Midwife Walmsley did not contribute in any meaningful way and this impacted the care provided to Jen.**

199. Syntemetrine should have been administered to Jen before at the point when the cord should have been cut. Whilst consent would have been required the reason for the emergency situation should have been explained to Jen and Rob (who would have still been on scene as this should have been before Agnes was removed).
200. As syntemetrine had not been administered before the paramedics left the scene I find it should have been administered at 07:08 on the instruction from Advanced paramedic Natalie Ashcroft.
201. I find there was a lack of communication between the Midwives themselves and a lack of clear communication between the Midwives and the paramedics which meant there was a lack of understanding roles, responsibilities for the care of Jen, the plan of action meaning there was a lack of situational awareness.
202. The midwives should have taken charge of caring for Jen with support from the paramedics when requested, allowing the paramedics to both swiftly formulate a plan for extrication and obtain the necessary equipment.
203. An examination of Jen should have taken place with her consent but again the urgency and reason for this should have been explained to her, such an examination more likely than not would have identified she had suffered a tear.
204. I find it is more likely than not that the cause of Jen's bleeding was from both a fourth degree perineal tear and probably from uterine bleeding. The extent to each of these contributed cannot be determined.
205. I heard evidence that the only way to prevent bleeding from a perineal tear would be for the tear to be repaired, albeit in the meantime you would put pressure on the area, use swabs and administer fluids. Whilst limited if a tear had been noted some steps could have been taken to assist Jen including the administration of misoprostol which would have within the NWAS equipment.
206. No request for another paramedic crew was made at 07:08 by Natalie Ashcroft and this should have been done given the level of experience of the crew left, the instruction for a rapid extrication and with the knowledge of the risk of a PPH.
207. A request for assistance with extrication was made at 07:41 and Paramedics Morgan and Riley were on scene at 07:50am I find it is more

likely than not if a request had been made at 07:08 more NWS support would likely have been on scene before Jen delivered the placenta.

208. On the balance of probabilities I find Jen had two bleeds, one on the sofa and one onto the floor. Whilst blood loss is hard to determine from photographs I accept these were two separate PPHs, the blood loss on the sofa less but probably still in the region of 500mls.
209. The time of the first bleed is very difficult to reconcile with the evidence I heard. Both Midwives describe witnessing an initial bleed. The paramedics have no recollection of witnessing any bleed other than the bleed when the placenta is delivered. There were clearly times when different people were in and out of the room with Jen. There are several scenarios which I have considered:
- a. Either the bleed occurred before 07:16am and the blood pressure reading was impacted by the administration of syntemetrine which had taken place. In this case Midwife Turner is mistaken and Midwife Walmsley is more accurate in her recollection.
  - b. The bleed occurred after 07:16 and Midwife Walmsley is mistaken as to the time. This would mean Jen's blood pressure was not affected by the syntemetrine. It would also mean that shortly after witnessing Jen have a bleed Midwife Tuner is on the computer system rather than with Jen.
210. Whilst Midwife Tuner told the court she believed the initial blood loss occurred at 07:24 am she also said it was just after she came off the call to the team leader which she said was made at 07.12am. Of note in her statement this was in fact three telephone calls, one to the bleep holder, one to the team leader and a further call from the team leader approximately 5 minutes later. After these calls she said she had a conversation with the paramedics about transferring Jen after she had delivered the placenta. Up until this stage she said she had had no involvement with Jen's care as she had been speaking to the neighbours in respect of childcare and also making calls. Neither in her statement nor in her evidence did Midwife Turner give any indication she was present when the observations were taken with Jen at 07:16am.
211. Ms Holmes was asked of the impact of syntemetrine in terms of delivery of the placenta and she said it could be around 5- 10 minutes if done with cord traction. This would also be more in keeping with subsequent events after any administration of syntemetrine at 07:24am.

212. On balance I find it is more likely than not that the initial bleed of around 500mls occurred when Jen was on the sofa after 07:16am. I therefore find it is more likely than not to have been closer to 07:24am. It follows that I also find :
- a. Syntemetrine was not administered to Jen until approximately 07:24am, some 40 minutes after she had given birth.
  - b. Syntemetrine did not contribute to her raised blood pressure.
213. Jen's blood pressure reading at 07:16 am should have been recognised by the Midwives as meaning on MEWS there was a high risk of deterioration and communicated to the paramedics.
214. I find that after Jen had the initial bleed and before 07:33am Midwife Tuner attempted cord traction to deliver the placenta.
215. During the period of 07:09 until approximately 07:41am as well as conducting Jen's observations, paramedics were obtaining equipment to attempt an extrication of Jen via carry chair. I heard evidence that the ambulance had to be moved from further down the road and that the wheelchair was initially obtained and then found to be unsuitable and a carry chair obtained. I also heard evidence from Mr Falkner as to the reality of how long it can take to extricate a person from a home. Whilst understanding of these challenges I do consider there was a short delay and a lack of urgency between 07:08 and 07:41 by the paramedics, albeit I do not consider they were properly briefed by the Midwives in order to fully understand the deteriorating situation.
216. At approximately 07:38am it is likely the carry chair was in the property. The delivery of the placenta and a second significant loss of blood, likely occurred around 07:41am, shortly after the radio transmission requesting assistance and before the transmission at 07:46am.
217. Overall I find on the balance of probabilities it is more likely than not,
- a. There was a delay of approximately 40 minutes in the delivery of syntemetrine.
  - b. Jen had sustained a fourth degree tear during labour. The fact of a tear should have been seen on an examination. I find it would have been challenging in the environment to complete this examination whilst paramedics were resuscitating Agnes but this should have been

undertaken at the point Agnes was removed by which time syntemetrine should already have been given.

- c. At 07:16am Jen's blood pressure was abnormal and whilst it may have been a sign of active bleeding I would not expect this to be recognised by anyone on the fact of a narrow pulse alone.
- d. The Midwives should have noted this blood pressure reading was a concern on a MEWS score and clearly indicated this.
- e. I consider it is more likely than not that if there had been a vaginal examination and a swab to clean and assess for active bleeding then it would have been noted that Jen was bleeding before 07:24am.
- f. If syntemetrine had been administered shortly after Agnes had been born then it is more likely than not the placenta would have been delivered earlier.
- g. If extra assistance had been requested by NWS at 07:08 it is more likely than not they would have been on scene before Jen delivered the placenta at approximately 07:41am, but I cannot say they would have been on scene at the time of the first loss of blood.
- h. The evidence does NOT reach the standard required for me to find that had extra assistance been called at 07:08am and more NWS crews been on scene at around 07:41am that this would have made a difference to the outcome, as I find Jen would have not been extricated from the property any sooner and would have delivered the placenta and suffered further blood loss.

218. I have considered carefully when any of the care of Jen or omissions can be considered a gross failure to provide medical care. On balance I consider the lack of an examination in a woman with a known history of PPH who has had a difficult and traumatic delivery, the lack of administration of syntemetrine for approximately 40 minutes in these circumstances, the lack of recognition of a MEOWS score of 6 and a lack of ongoing maternal observations do lead me to conclude there was a gross failure in the care of Jen.

219. Whilst I consider the urgency of the situation with Jen was recognised by the NWS crew on scene I find this is more likely than not due to the lack of communication and observations by the midwives. I do find the extrication plan by the NWS crew on scene could have been managed with a degree more urgency, however I do not find this contributed to Jen's deterioration and I find it would not have made a material difference to the outcome.

### Medical Causes of Death

220. Dr Barker conducted a post mortem examination on Jennifer Cahill. Dr Barker was asked by myself to conduct this examination as she had an experience of maternal deaths. Dr Barker confirmed the presence of a 3 cm sutured area in the posterior vaginal wall in keeping with a perineal tear occurring during the course of the delivery.
221. The fact that the placenta was not available for her to examine did hamper the post mortem examination to some degree. This was the first time she had not had a placenta to examine. Dr Barker explained it would have been helpful to examine the placenta for any evidence to indicate there had been placental adherence to the uterus wall. This can itself be a cause of severe haemorrhage.
222. Dr Barker sought guidance from other colleagues to review her findings. Without the placenta she told the court it was difficult to be certain that the tear was the only source of a haemorrhage without being able to rule out placental adherence. However, she went on to explain that a tear, which Jen definitely had, can bleed copiously and in her view if the court was to determine that a bleed occurred at the time of delivery of the placenta then she felt both the tear and fact of the placenta coming away are both likely to be causes of the PPH.
223. In her opinion despite the lack of a placenta she was entirely satisfied that 1a) Multiorgan failure with disseminated intravascular coagulation due to 1b) Cardiac arrest due to postpartum haemorrhage accurately reflect the immediate cause of Jen's death.
224. She was asked whether there was any pathological evidence to indicate haemorrhagic shock however she could not see any changes on her examination albeit she told the court it may be that they did not have time to appear or were disguised by the multi-organ failure
225. Similarly she did not find any reason for the disseminated intravascular coagulation such as an amniotic fluid embolism. In her view this was a result of the PPH and not a cause of the PPH.
226. Dr Barker was also asked as to whether she could assist the court with the amount of blood loss required to cause a cardiac arrest. Other than being able to say, "the larger the bleed the greater the more likely a cardiac arrest" Dr Barker could not assist with specific amounts.

227. I have considered carefully whether the evidence I have heard supports an amendment to 1c of the medical cause of death and whether I can add placenta haemorrhage as an additional factor to the perineal tear as a cause of the PPH. Dr Barker reviewed the first pregnancy notes to ensure she was satisfied there was nothing in those records which might provide an indication Jen may have had placental adherence, she found nothing. I do not therefore consider the evidence reaches the required standard for me to add placenta haemorrhage to the medical cause of death. However, I do think it would be correct to amend it slightly to add atony within the medical cause of death. The medical cause of Jennifer Cahills death will be recorded as:

- 1a) Multiorgan failure with disseminated intravascular coagulation
- 1b) Cardiac arrest due to post partum haemorrhage
- 1c) Perineal tear and atony during term time delivery

### Agnes

228. Dr Rehman Consultant Neonatologist at the Royal Oldham Hospital described to the court Agnes' critical presentation when she arrived at NMGH prior to being transferred to the neonatal intensive care unit at Oldham. It was clear that despite full medical support and treatment Agnes' had suffered a severe hypoxic ischaemic encephalopathy. By the 6<sup>th</sup> June 2024 it was clear that her chances of survival were very low and a decision was made to cease active management and move to compassionate care. Agnes died at 05:47 on the 7<sup>th</sup> June 2024.

229. Dr Rehman was able to confirm the medical cause of Agnes's death as being due to :

- 1a. Multi-organ insult following hypoxic ischaemic encephalopathy
- 1b. Meconium aspiration syndrome leading to pulmonary hypertension

230. Dr Rehman also confirmed to the court that cord being around the neck of a baby is the leading cause of hypoxia. In these circumstances I propose to reflect that on the cause of death for Agnes as I am satisfied it is more likely than not that this did contribute to her hypoxia. I will therefore alter 1b to read: 1b. Cord compression and meconium aspiration leading to pulmonary hypertension

### Conclusions

231. In completing the Record of Inquest I have reminded myself of the guidance contained in the Chief Coroners Guidance for Coroners on the Bench (the “benchbook”) 1<sup>st</sup> January 2025, Chapter 15 para 32 and 33. The function of an inquest is to ‘seek out and record as many of the facts concerning the death as the public interest requires.’ [para 32]. Relevant acts or omissions that were probably causative of the death should be recorded using a neutral form of words.[para 33]. I must not use language that appears to amount to a finding of civil liability or criminal liability on the part of a named person [para 33].
232. At the end of the evidence I received legal submissions from counsel for the IPs as to the conclusions available to me. All Interested Persons agreed a finding of neglect was open to me for consideration alongside either a short form conclusion of Natural Causes or a short narrative conclusion.
233. No-one made submissions that neglect was not available to me in respect of Jen on the basis that she was not a dependant person. However, I have considered this point very carefully. The test for neglect is not only was there a gross failure to provide basic medical care but also whether there was a gross failure to provide such care to someone in a **dependant position** (because of age, illness or incarceration), who cannot provide it for himself. [80]
234. **I have considered this point and in my opinion Jen (and similarly Agnes) was a dependant person during her labour but not, in my opinion, during her antenatal care. There is no evidence she lacked capacity or understanding.**
235. Paragraph 45 of the benchbook states, whilst all of my findings of fact have been reached on the balance of probabilities the threshold that must be reached for causation of death to be established, is that the event or conduct said to have caused the death must have more than minimally, negligibly or trivially contributed to the death – put simply did the action or omission probably contribute to the death in a more than minimal way?
236. In order to return a finding of neglect I would have to be satisfied from the evidence that a gross failure to provide basic medical care or attention has caused or contributed to the death. There must be a clear and direct causal connection between the conduct described as neglectful and the cause of death. It is sufficient to establish that the conduct made only a material contribution to the death, it need not be the sole cause. [para 81-82]

237. When considering omissions, it must be established that had adequate care been given it would probably have saved or prolonged life. [para 83].

### Causation

238. Having reached findings of fact I have now have to consider whether causation is established. I have already found there was a gross failure to provide basic medical care in that Jen did not have an appointment with a senior midwife and an out of care guidance plan.

239. When considering whether, if such an appointment had been provided and an out of care guidance plan it would probably have saved or prolonged Jen's life I have considered the following:

240. Did Jen make an informed decision to have a home birth? The answer is categorically no. I do not consider Jen had all of the information to make an informed choice to have a home birth. As such I need to consider if she had had all the information whether the evidence allows me to make a finding that she would have made a different choice.

241. I have given very careful thought to this aspect of the evidence. The question is whether Jen was aware of the all the risks, benefits and consequences and ultimately made the decision for a home birth with all the facts available to her. I have guarded against hindsight bias by considering only what was available or could have been available to Jen at the time she was making her decision.

242. I heard in evidence there were several pieces of information which would have been available but that it would not be practice nationally to discuss such issues with women, this includes :

- a. The risk of death – even though remote no advice or information is provided to a woman of the risk of death from the difference in treatment at home as opposed to hospital of a PPH.
- b. The difference between a risk as a result of being pregnant as opposed to any specific risks to an individual of them delivering a child.
- c. The intrapartum experience of community midwives of delivery.
- d. I also heard evidence that professionals are now encouraged to use softer, kinder language with women such as 'out of guidance' rather than being direct and describing it as 'against medical advice'.

243. As such, I have not included those above factors as set out above in reaching my decision on causation.

244. I heard evidence the out of guidance care plan was a live document it should have been updated from the point it was created at 36 weeks. If this had occurred it is reasonable to consider it would have included ;
- a. Detailed exploration with Jen as to why she was making certain choices
  - b. Discussion and recognition of any trauma and fears as a result of her first pregnancy
  - c. Consideration of alternative options
  - d. Clear consideration and exploration of all her risks
  - e. A clear understanding of her plan for the third stage of labour and if physiological this would have prompted another referral to a Consultant Obstetrician.
  - f. Jen would have had a clear understanding that she had a high risk pregnancy
  - g. Consideration of the fact her HB level was 97 and what this meant in terms of increased risk of complications should she have a PPH.
  - h. Consideration of her elevated PCR test on the 29<sup>th</sup> May and the fact that this required a further Consultant Obstetric appointment, this should have resulted in a discussion in respect of induction of labour.
245. I would agree with Mr Griffiths and Ms Holmes that the evidence does not indicate Jen was inflexible and there is no suggestion that she was reckless. There is evidence which shows flexibility in Jen's thinking. She had indicated a willingness to go into hospital in the event that she went into labour on a night when the home delivery service was not available, she was taking a maternity bag out with her when she was not at home in case she went into labour.
246. I also consider that the OOG care plan and the referrals which should have occurred to obstetrics would have meant there would have been further discussions between Jen and Rob. Jen shared with Rob her birth plan, I can see no reason to consider she would not have shared an out of guidance care plan.
247. I do acknowledge from the evidence that Jen was prepared to accept a certain level of risk. For example, she knew she could be positive for Group B Streptococcus, she knew her son had been born and developed an infection and required treatment, she knew being GBS positive may mean her new born would require treatment and she knew the advice being given to her was to be tested for GBS. Ultimately, she made the decision not to be tested for GBS.

248. Likewise, I am satisfied that Jen understood that the advice being given in this pregnancy was for her to have active management of the third stage of labour *regardless of where* she gave birth. She knew she had had a previous PPH. She knew she had required iron and a blood transfusion. I am also satisfied that she understood there was a risk of her potentially having another bleed yet as can be seen from her birth plan she decided to try a physiological approach before administration of syntemetrine. Of note this birth plan appears to have been developed by Jen on the 3<sup>rd</sup> May prior to her emerging risk factors were known.
249. But as I have already stated I do not consider Jen was immovable, nor do I consider her an individual who would have recklessly endangered the life of her child or her own.
250. **I therefore find as a matter of fact that if the referral to a senior midwife and an OOG care plan had occurred by the 2<sup>nd</sup> June 2024 I find it is more likely than not that Jen would have given birth in a setting other than her home.**
251. I heard evidence from Mr Griffiths the Consultant Obstetric expert who explained that if Jen had been in a birthing Centre or hospital it is more than likely that Jen would have avoided the extensive perineal injury, she would have been attended to more quickly, there would have been effective monitoring of the FHR, she would have had active management of the third stage of labour and in his opinion the outcome for Agnes and Jen would have been different.
252. **I agree and accept this evidence. As such, I find that if Jen had received an appointment with senior midwife and an out of care guidance plan it is more likely than not that she would have given birth in setting other than her home and on balance both Jen and Agnes would have not died at the time they did. Therefore, the gross failure to provide basic medical care probably contributed to the deaths more than minimally, trivially and negligibly.**
253. **However, for the reasons I have stated earlier I do not consider Jen was a dependant person for the purposes of antenatal advice and therefore neglect is not open to me on this causative issue.**
254. I have therefore considered whether neglect is available to me for the gross failures I found during her intrapartum care, when I do consider she was a dependant person.

255. In respect of the gross failure to provide basic medical care in respect of the FHR monitoring. I have found this was not completed every 5 minutes in the second stage of labour, that it was not conducted in a correct manner and the fact this would more likely than not have shown that Agne's heart rate was showing signs of deceleration for up to an hour prior to her birth. I also find this would have led to NWS being on scene before Agnes was born.
256. Whilst I am satisfied there are likely to have been more NWS crews on scene before 06:44am I am not satisfied that the evidence leads me to find it more likely than not that Jen would have been IN hospital at the time of Agnes's birth. I find this due to the timings of NWS crews being on scene and extrication.
257. However, I am satisfied that the gross failure in respect of the FHR monitoring probably contributed more than minimally to the death of Agnes, in that effective resuscitation from the moment she was born was not given and had NWS been on scene it would have been effective and would likely have at least prolonged her life.
258. I am also satisfied this gross failure likely made more than minimal contribution to the death of Jen. I find it is more likely than not, Jen would have been in a hospital setting much sooner than 08:01am when she went into cardiac arrest, almost certainly by the time of the delivery of her placenta at 07:41am. The tear to her perineum would have been noted, she would have had active management of labour and delivered the placenta in hospital.
259. For the sake of completeness, the gross failure to monitor Jen appropriately at home after delivery of Agnes would not have led me to conclude that this probably more than minimally contributed to her death. (Given the timings and challenges on extrication and the limited options available at a home for a fourth degree tear.)

### Record of Inquest 1

I shall, therefore, record the following on the first Record of Inquest :

Box 1 :

Jennifer Rose Cahill

Box 2 :

- 1a) Multiorgan failure with disseminated intravascular coagulation
- 1b) Cardiac arrest due to post partum haemorrhage
- 1c) Perineal tear and atony during term delivery

Box 3 :

Jennifer died on the 4<sup>th</sup> June 2024 at North Manchester General Hospital. She had been admitted as an obstetric emergency on the 3<sup>rd</sup> June 2024 following the delivery of her daughter following a home birth.

Jen had been identified as being at risk of a post partum haemorrhage. During her antenatal care Jen was not provided with complete information in order to make an informed decision as to her place of birth or the management of her risks. She should have had an appointment with a senior midwife and a personalised out of guidance care plan should have been completed. In addition, she should have had two further referrals to a Consultant Obstetrician to discuss her consideration of a physiological approach to the third stage of labour and also following her PCR test on the 29<sup>th</sup> May 2024. If Jen had received appropriate antenatal care it is more likely than not she would have chosen an alternative venue for her delivery.

Jen went into labour on the evening of the 2<sup>nd</sup> June 2024. Two community midwives were present at the delivery. Jen delivered her daughter at 06:44am on the 3<sup>rd</sup> June 2024. During the labour and delivery there was inappropriate monitoring of the foetal heart rate. If this had been conducted in the correct way it is more likely than not that from 05:44am onwards decelerations and signs of foetal distress would have been recognised and the ambulance service contacted due to the obstetric emergency. If the ambulance service had been called before delivery of her daughter it is more likely than not that Jen would have been in hospital for the management of the third stage of her labour, the perineal tear would have been noted and Jen would have survived.

Immediately at her birth her daughter required emergency medical attention and resuscitation. She was transferred to hospital by paramedics at 07:09am. During this period of time there was a lack of monitoring and examination of Jennifer. An examination would have revealed that she had sustained a perineal tear. Due to the medical emergency with her daughter syntemetrine should have been administered as soon as the umbilical cord was cut, to assist with the delivery of the placenta and to reduce further bleeding. Syntemetrine was not administered for 40 minutes until

Jen had a post partum haemorrhage at approximately 07:24am. It is likely Jen had been actively bleeding until this time. Her blood pressure taken at 07:16 had been abnormal but this was not acted upon. At approximately 07:40 Jen delivered the placenta and had a second significant post partum haemorrhage. Shortly after this she went into cardiac arrest. Despite appropriate treatment at hospital she died at 23:55 hours.

Box 4 :

Died as a result of complications arising following the delivery of her second child, contributed to by neglect.

### **Record of Inquest 2**

I shall record the following on the Record of Inquest :

Box 1:

Agnes Lily Wren Cahill

Box 2:

1a Multi-organ insult following hypoxic ischaemic encephalopathy

1b. Cord compression and meconium aspiration syndrome leading to pulmonary hypertension

Box 3

Agnes was born at 06:44am following a delivery at home. Prior to her delivery her Mother had not received appropriate antenatal care and had been unable to make an informed decision about the risks of a home birth. If appropriate information had been available to her it is likely she would have attended hospital for the delivery. If this had occurred it is more than likely that Agnes would have been born without the complications which ensued and would have likely survived.

Agnes was born suffering from severe hypoxia as a result of cord compression. During the delivery of Agnes there was a lack of appropriate foetal heart monitoring which would likely have indicated signs of foetal distress from approximately 05:4pm

onwards. Once this was noted a call to emergency services should have been made. It is likely paramedics would have been on scene prior to the delivery of Agne. The evidence does not allow a finding as to whether Agnes would have been born in hospital however appropriate resuscitation would have occurred and it is more likely than not her death would not have occurred at the time it did.

Agnes was transported as an emergency to the North Manchester General Hospital before being transferred to the Royal Oldham Hospital where despite appropriate treatment she died on the 7<sup>th</sup> June 2024.

Box 4

Died as a result of complications during birth, such complications contributed to by neglect.

**Ms Joanne Kearsley**

**Senior Coroner for Manchester North**

**27<sup>th</sup> October 2025**