

Description

Response to Prevention of Future Deaths Report [Ref: 2026-0025]

Katie Fryer-Olliffe, Doula – Doula Training Course Facilitator and Co-Owner at Developing Doulas

She/her

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My name is Katie Fryer-Olliffe. I am a doula of 14 years, a doula preparation course facilitator for Developing Doulas, and a doula mentor.

In January 2025, HM Assistant Coroner Henry Charles published a Prevention of Future Deaths (PFD) report, which was subsequently reported on in the media.

The PFD followed the tragic death of baby Matilda Pomfret-Thomas. My thoughts, and those of the wider doula community, are with Matilda's parents and family, and with all who are grieving her loss.

As both a practising doula and a doula educator, this PFD is of significant professional importance to me, particularly as the family had engaged a doula for antenatal and birth support during the pregnancy and birth of Matilda.

The report raises important considerations regarding working relationships between midwives and doulas, as well as the clarity of roles, communication, professional boundaries, and collaborative practice within maternity care.

It is my hope that the response I have provided – both personally and in representation of the Developing Doulas community – contributes constructively to the wider reflections that doulas, midwives, and healthcare providers must undertake as we continue striving to support families in achieving safe, positive, and trauma-informed maternity care.

Below is a copy of my letter

To: HM Assistant Coroner Henry Charles
Hampshire, Portsmouth and Southampton

Re: Matilda Pomfret-Thomas
Dated 15 January 2026

I write in a personal and professional capacity as a practising doula of fourteen years and as a Doula Training Course Facilitator and Co-Owner of Developing Doulas.

I am not a statutory recipient of the Regulation 28 Report and therefore am not responding under Regulation 29 of the Coroners (Investigations) Regulations 2013. However, given that the report raises concerns regarding the role and

presence of doulas, I consider it important, in the interests of balanced learning and prevention, to provide the following voluntary submission.

This response addresses the Prevention of Future Deaths (PFD) report specifically in relation to its references to the presence and role of a doula during this birth, and the suggestion that this presence “negatively impact[ed] upon the effective provision of midwifery services in terms of building a rapport conducive to effective advice and care being given.”

The PFD records that the doula did not actively discourage midwife access, that she was supporting the parents in accordance with the agreed birth plan, and that she was nonetheless perceived by members of the midwifery team as, “in effect, a buffer.” It further suggests that this support was perceived as grounds for hope that a home birth remained possible.

This description highlights the importance of clearly distinguishing between perception and responsibility. As described in the report, the doula’s actions were consistent with a non-clinical support role: supporting the parents’ stated wishes and birth plan, without restricting access, providing clinical advice, or exercising authority over decision-making. A perception of her presence as a “buffer” reflects the experience of the clinical team, rather than evidence of obstruction or causal action on the part of the doula.

Responsibility for building and maintaining a rapport that enables the delivery of effective clinical advice and care rests with the clinician who holds clinical responsibility. This responsibility is non-delegable and applies regardless of who else is present to support the family. Where clinical concern arises – particularly in the context of deteriorating fetal wellbeing – the duty to communicate risk clearly, to support informed decision-making, and to escalate care appropriately remains with the healthcare professionals involved.

The background of a previous traumatic birth is, I believe, highly relevant in understanding why this family elected for a home birth and chose to engage a doula. Many families who have experienced birth trauma seek additional non-clinical support in order to feel safer and more able to engage with care. The presence of such support should not impede effective communication of clinical concern or timely escalation. Support for a birth plan, or expressions of hope for a particular outcome, should not be understood as a barrier to clinical leadership or decision-making.

If clinicians experience difficulty carrying out their role effectively when a doula is present, this points to a need for improved training, confidence, and support in working alongside non-clinical supporters, rather than indicating an inherent risk associated with the presence of a doula. It is also relevant to consider whether similar perceptions would arise if the supporter present were a partner, parent, sibling, or other family member – all of whom are commonly present at births and are not typically characterised as barriers to care.

Doulas affiliated to Doula UK and other membership organisations operate within established professional guidelines and codes of conduct that emphasise clear boundaries, respect for clinical roles, and support for informed choice. The doula profession is unregulated not because of an absence of standards, but because it is a non-clinical support role. In this respect, it is comparable to other support professions such as counselling and advocacy, where practice is governed by professional ethics rather than statutory regulation.

From a prevention perspective, learning would be better directed toward strengthening clinicians’ skills in trauma?informed care, communication of risk, and the maintenance of clear clinical responsibility in complex and emotionally charged situations. Care should be taken to avoid attributing causal significance to non-clinical supporters in a way that risks obscuring professional responsibility or diverting attention from the systemic and professional learning that PFDRs are intended to promote.

Furthermore, while the MNSI (Maternity and Newborn Safety Investigations) report referenced within the PFD is relevant, it is important to distinguish the nature of the evidence it contains. The twelve references to doulas associated with poor outcomes reflect the perceptions and reporting of healthcare providers only. MNSI has confirmed that, in these cases, neither the families affected by the outcomes nor the doulas involved were invited to provide their perspectives.

It is not appropriate to form conclusions or develop effective or strategic responses on the basis of evidence that is so heavily weighted toward a single source. While it is entirely possible that, in some cases, a doula may have made a mistake or influenced a decision, it is not possible to establish this as fact where information has been collated solely from one professional perspective.

The evidence supporting the benefits of doula care is well established, as is the importance of doulas remaining independent from the maternity system.

In an underfunded, under?resourced, and highly litigated system, this independence can sometimes give rise to resentment, misunderstanding, or projection. These systemic pressures do not negate the value of doula support, but they do highlight the need for improved shared understanding.

The most constructive way forward, in my own well-researched opinion – is through better training for healthcare professionals to understand why families seek doula support, to feel confident and clear about their own roles and responsibilities, and to understand the role, boundaries, and purpose of the doula. This includes recognising where roles differ, where they intersect, and how they can collaborate effectively in the interests of safety and family?centred care.

The MNSI itself has acknowledged the importance of improved shared understanding between healthcare professionals and doulas. Meaningful prevention of future deaths depends on balanced learning, clear accountability, and a commitment to strengthening systems and relationships, rather than attributing undue causal weight to the presence of non-clinical support.

I also wish to add this context from professional experience. I have worked as a doula for fourteen years, and the challenges highlighted in this report are, regrettably, not new. Over that time, I have witnessed many more examples of effective, collaborative working between doulas and healthcare professionals than instances of defensiveness or hostility within birthing environments.

However, I have also experienced situations in which I have been wrongly accused of influencing decision-making or providing clinical advice, particularly where healthcare professionals have felt affronted or insufficiently confident to include a doula as part of the wider care team. There is currently a lack of clear processes for addressing such situations when they arise, within most local trusts, and as a result doulas are often left to live with misunderstanding and misrepresentation without recourse.

These dynamics can have wider consequences. They can further harm what may already be a fragile relationship between a service user and the maternity system, and can contribute to a deepening loss of trust when families experience rejection of a doula they have chosen and employed to support them.

For reports intended to prevent future harm, it is essential that they accurately represent the underlying issues at play. Without doing so, there is a risk that learning is misdirected, and that opportunities to address the real systemic and relational challenges – rather than their symptoms – are missed.

It is also important to acknowledge the context in which midwives practise. Midwives already carry a heavy burden of responsibility and the weight of potential legal recourse. Without appropriate understanding of the doula role, of independent advocacy, and of trauma?aware responses to families who have chosen to employ a doula, it is understandable that some midwives may experience fear or anxiety about a doula’s presence.

Women and birthing people/families arrive in maternity services as whole people, with complex histories, values, and lived experiences long before pregnancy and birth.

The vast majority of doulas support informed decision?making, which may include decisions to decline certain interventions. In many cases, a desire to decline intervention exists prior to the involvement of a doula, rather than being created by it.

When families experience a lack of autonomy within maternity services, this is frequently described as infantilising and disempowering.

Independent support is often sought precisely because families wish to engage more fully, not less, in decision?making about their care. Understanding this motivation is essential if maternity services are to respond in ways that build trust,

rather than deepen fear or division.

In conclusion, meaningful prevention of future harm depends on accurate representation, shared understanding, and clarity of roles and responsibilities. Where difficulties arise in births involving doulas, learning should focus on strengthening trauma-informed communication, confidence in clinical leadership, and collaborative working with non-clinical supporters.

Attributing disproportionate causal weight to the presence of a doula risks obscuring these core issues and diverting attention from the systemic improvements that are necessary to support safe, respectful, and truly family-centred maternity care. These themes are explored further in Michelle Quashie's article Safety: Self-Determined and Human Rights Compliant in The Practising Midwife (available via All4Maternity), and in Milly Morris's dissertation Doulas and Midwives: A Powerful Alliance, both of which offer valuable context for this discussion.

Yours sincerely

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