



BRIEFING PAPER

Number 08167 30 November 2017

The investigation of stillbirth

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Contents:

1. Stillbirth
2. Current investigation of stillbirth in England and Wales
3. Coroners and stillbirth



Contents

| | |
|--|-----------|
| Summary | 3 |
| 1. Stillbirth | 4 |
| 1.1 Definition of “stillborn child” | 4 |
| 1.2 Number of stillbirths | 4 |
| 1.3 Registration of stillbirth | 6 |
| 2. Current investigation of stillbirth in England and Wales | 7 |
| 2.1 England | 7 |
| 2.2 Wales | 9 |
| 3. Coroners and stillbirth | 11 |
| 3.1 Current position | 11 |
| Coroner’s duty to investigate certain deaths | 11 |
| No power for coroner to investigate stillbirth | 11 |
| Cases where there is doubt as to whether child was stillborn | 12 |
| Possibility of inquest in some cases | 12 |
| 3.2 Court of Appeal consideration of coroner’s duty | 13 |
| 3.3 Chief Coroner’s Development Plan | 14 |
| 3.4 Calls for coroners to have power to investigate stillbirths | 15 |
| Sands | 15 |
| Private Member’s Bill | 15 |
| Baby Loss Awareness Week debate | 15 |
| 3.5 Coroners’ investigation of stillbirth in Northern Ireland | 16 |
| 3.6 Government looking at enabling coroners to investigate stillbirths | 17 |

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Summary

This briefing paper deals with the position in England and Wales.

Current investigation of stillbirth in England and Wales

All unexpected or avoidable deaths, including those of mothers or babies, which may have been the result of healthcare failings should currently be investigated as serious incidents, under NHS England and NHS Wales national frameworks.

The Department of Health and the Welsh and Scottish Governments have also jointly commissioned a standard Perinatal Mortality Review Tool, to assist maternity and neonatal units in investigating all stillbirths and perinatal deaths. A pilot was launched in summer 2017, with full rollout planned for the end of the year.

Coroners and stillbirth

At present coroners do not have power to investigate a stillbirth. There has to have been an independent life before the coroner has jurisdiction to investigate a subsequent death. The definition of stillbirth is based on there not having been an independent life, meaning that the coroner does not have jurisdiction to investigate.

There have been a number of calls for the law to be changed, including by Sands, the stillbirth and neonatal death charity, and in Parliamentary debate. A Private Member's Bill, introduced by Tim Loughton (Conservative), would "give coroners the power to investigate stillborn deaths". The Bill is due to have its second reading on 2 February 2018.

In Northern Ireland, which has its own legislation, the position is now different. In 2013, in a landmark decision, the Northern Ireland Court of Appeal held that coroners do have jurisdiction to carry out an inquest on a child that had been capable of being born alive.

Government announcement about independent investigations in future

On 28 November 2017, Health Secretary, Jeremy Hunt, made a statement to the House on the Government's new strategy to improve safety in NHS maternity services. As part of this strategy, from April 2018, the Healthcare Safety Investigation Branch (HSIB) will investigate every case of a stillbirth, neonatal death, suspected brain injury or maternal death notified to the Royal College of Obstetricians and Gynaecologists (RCOG) Every Baby Counts programme, amounting to around 1,000 incidents per year.

Jeremy Hunt also said that he would work with the Ministry of Justice "to look closely into enabling, for the first time, full-term stillbirths to be covered by coronial law, giving due consideration to the impact on the devolved Administration in Wales".

1. Stillbirth

1.1 Definition of “stillborn child”

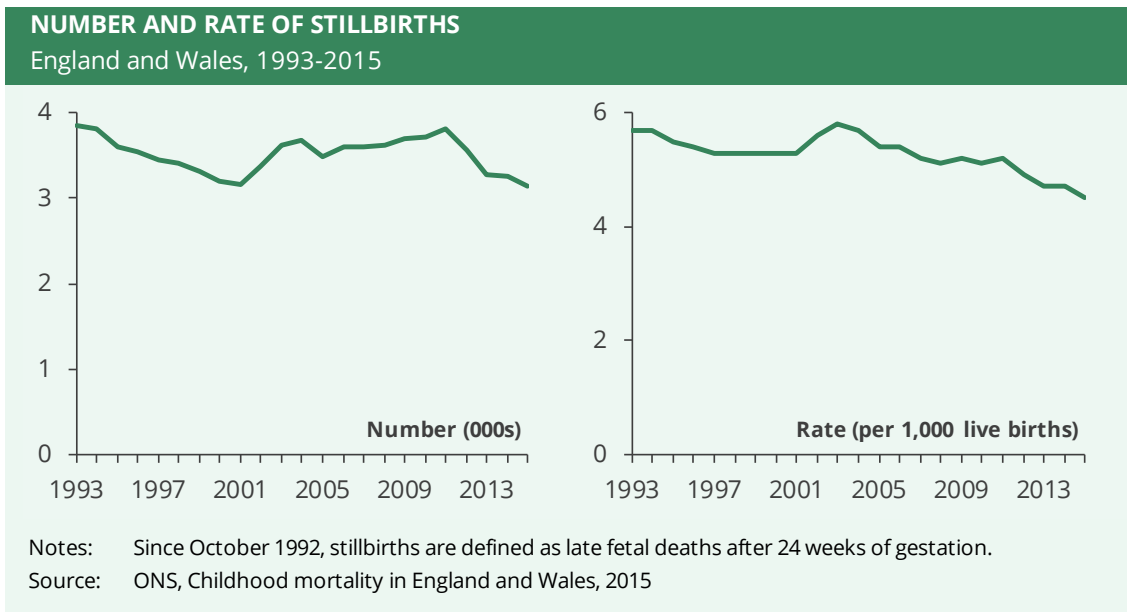
The definition of “stillborn child” in England and Wales is contained in the Births and Deaths Registration Act 1953 section 41, as amended by the Stillbirth (Definition) Act 1992 section 1(1) and is as follows:

“a child which has issued forth from its mother after the 24th week of pregnancy and which did not at any time breathe or show any other signs of life”.¹

A term often used in relation to stillbirths is ‘perinatal mortality’, which refers to a child who has died between the 24th week of pregnancy and the first week of life.















1.2 Number of stillbirths

The charts below show the number of stillbirths, and the rate of stillbirths, in England and Wales in each year from 1993 to 2015.



Between 1993 and 2015, both the number and rate of stillbirths fell in England and Wales. The number of stillbirths fell from 3,855 in 1993 to 3,147 in 2015, which was a fall of 18%; while the number of stillbirths per 1,000 live births fell from 5.7 to 4.5, which was a fall of 21%. There has been a fairly consistent fall in the rate of stillbirths since 2003.

¹ Previously the threshold had been 28 weeks

| NUMBER AND RATE OF STILLBIRTHS BY COUNTRY AND REGION | | | |
|---|--------------|-----------------------|--|
| United Kingdom, 2015 | | | |
| | Number | per 1,000 live births | |
| United Kingdom | 3,434 | 4.4 |  |
| England | 2,952 | 4.4 |  |
| Wales | 158 | 4.7 |  |
| Scotland | 211 | 3.8 |  |
| Northern Ireland | 76 | 3.1 |  |
| London | 646 | 5.0 |  |
| East Midlands | 252 | 4.7 |  |
| West Midlands | 330 | 4.7 |  |
| North West | 392 | 4.5 |  |
| Yorkshire and The Humber | 287 | 4.5 |  |
| East of England | 306 | 4.2 |  |
| South East | 428 | 4.2 |  |
| North East | 103 | 3.6 |  |
| South West | 208 | 3.6 |  |

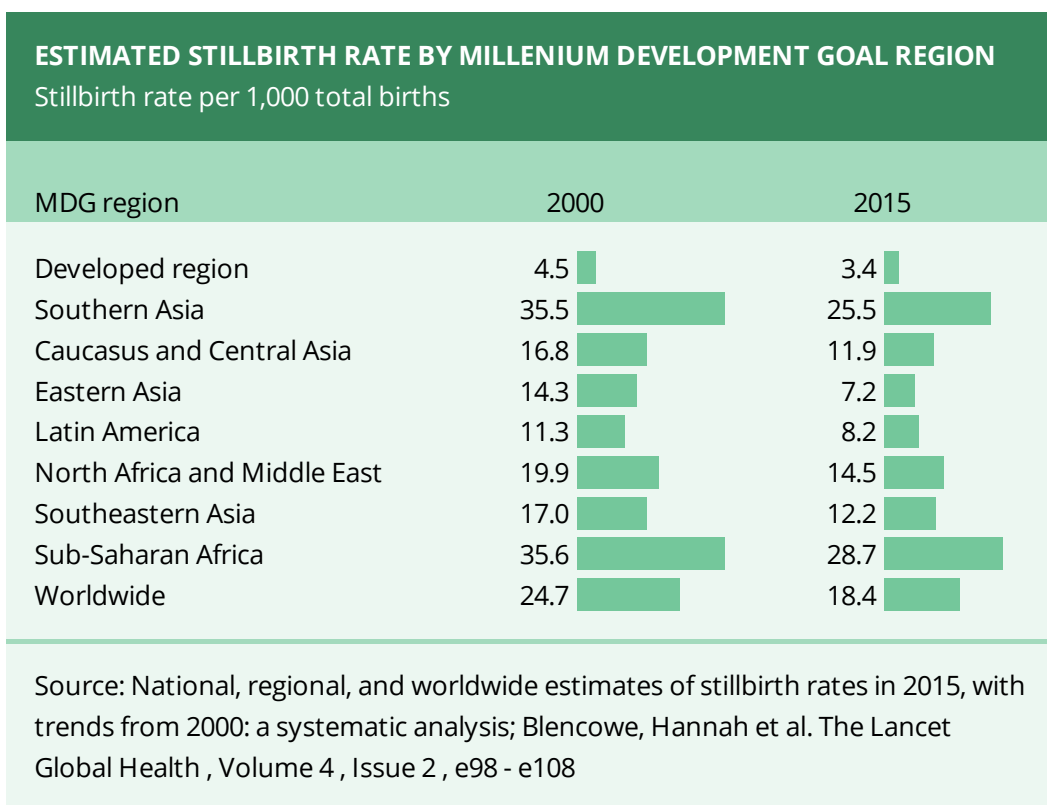
Notes: Since October 1992, stillbirths are defined as late fetal deaths after 24 weeks of gestation.

Source: ONS, Childhood mortality in England and Wales, 2015

The table above compares the number and rate of stillbirths in the countries and regions of the UK. In 2015, the rate of stillbirths across the UK as a whole was 4.4 stillbirths per 1,000 live births. Among the different countries of the UK the rate was highest in Wales (4.7) and lowest in Northern Ireland (3.1).

Comparing both countries and regions of the UK, London had the highest rate of stillbirths (5.0), followed by the East and West Midlands, and Wales (4.7). The North East and South West had the lowest rate of stillbirths in England (3.6). Every other region of England had a higher rate of stillbirths than Scotland (3.8), while Northern Ireland had the lowest rate of any country and region of the UK (3.1).

In January 2016, researchers based at the London School of Tropical Hygiene and Tropical Medicine published estimates of stillbirth rates in different parts of the world in both 2000 and 2015, in order to quantify changes in stillbirth rates over time.



The table above shows the overall estimated stillbirth rate in Millennium Development Goal regions of the world in 2000 and 2015. Between these years the overall global stillbirth rate per 1,000 total births fell from 24.7 to 18.4. The region with the largest percentage reduction was Eastern Asia, where the stillbirth rate almost halved, falling from 14.3 in 2000 to 7.2 in 2015.

1.3 Registration of stillbirth

The birth of a baby who is born alive must be registered, whatever the length of the completed pregnancy. The death of a baby born alive must be registered in the same way as any other death.

When a baby is stillborn after 24 weeks pregnancy, the stillbirth must be registered in the stillbirth register. The process for registering a stillbirth combines features of both birth and death registration.

There is no provision to allow the registration of stillbirths before the 24th week of pregnancy.

A separate Library briefing paper provides further information, [Registration of stillbirth.](#)²

² Number 05595, 4 October 2017

2. Current investigation of stillbirth in England and Wales

2.1 England

In response to failings in maternity and neonatal services at the University Hospitals of Morecambe Bay NHS Foundation Trust between 2004 and 2013, which led to the death of 11 babies and one mother, the Government launched an independent investigation led by Dr Bill Kirkup.

The [report of the Morecambe Bay investigation](#), published in March 2015, proposed a number of recommendations to improve maternity and neonatal services, including a recommendation to improve investigation of stillbirths:

23. Clear standards should be drawn up for incident reporting and investigation in maternity services. These should include the mandatory reporting and investigation as serious incidents of maternal deaths, late and intrapartum stillbirths and unexpected neonatal deaths. We believe that there is a strong case to include a requirement that investigation of these incidents be subject to a standardised process, which includes input from and feedback to families, and independent, multidisciplinary peer review, and should certainly be framed to exclude conflicts of interest between staff. We recommend that this build on national work already begun on how such a process would work. Action: the Care Quality Commission, NHS England, the Department of Health.³

The Government's response to the Kirkup report, [Learning not blaming](#), accepted this recommendation, and highlighted NHS England's recently published [Serious Incident Framework](#) (March 2015). Under the framework, all unexpected or avoidable deaths, including those of mothers or babies, which may have been the result of healthcare failings, should be investigated as serious incidents. Depending on the severity and complexity of the incident, this can either be a concise internal investigation (level 1), a comprehensive internal investigation (level 2) or an independent investigation (level 3).⁴

Learning not blaming also committed to work with health departments across the UK to consider how standardised reviews for all perinatal deaths might be introduced. The 2016 National Maternity Review, [Better Births](#), welcomed this commitment, and called on the Government to consider how such a tool could be expanded to cover neonatal mortality⁵, maternal death and serious morbidity.

Learning not blaming referenced the work of the MBRRACE- UK team at the National Perinatal Epidemiology Unit (NPEU). MBRRACE-UK conducts UK-wide surveillance of perinatal mortality, including all stillbirth and neonatal deaths, and maternal deaths. As part of this

³ [The Report of the Morecambe Bay Investigation](#), March 2015, p188

⁴ NHS England, [Serious Incident Framework: Supporting learning to prevent recurrence](#), March 2015, p41

⁵ This refers to a child which has died before 28 days following birth

8 The investigation of stillbirth

programme, it publishes an [annual perinatal mortality surveillance report](#), which identifies risk factors, causes and trends, and makes recommendations on how stillbirth rates can be reduced.

MBRRACE-UK was chosen to lead a collaboration to deliver a standard Perinatal Mortality Review Tool (PMRT) across England, Scotland and Wales. A pilot was launched in summer 2017, with full rollout planned for the end of the year. The aim of the PMRT is to support:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death;
- Active communication with parents to ensure they are told that a review of their care and that of their baby will be carried out and how they can contribute to the process;
- A structured process of review, learning, reporting and actions to improve future care;
- Coming to a clear understanding of why each baby died, accepting that this may not always be possible even when full clinical investigations have been undertaken; this will involve a grading of the care provided;
- Production of a report for parents which includes a meaningful, plain English explanation of why their baby died and whether, with different actions, the death of their baby might have been prevented;
- Other reports from the tool which will enable organisations providing and commissioning care to identify emerging themes across a number of deaths to support learning and changes in the delivery and commissioning of care to improve future care and prevent the future deaths which are avoidable;
- Production of national reports of the themes and trends associated with perinatal deaths to enable national lessons to be learned from the nation-wide system of reviews.
- Parents whose baby has died have the greatest interest of all in the review of their baby's death. Alongside the national annual reports a lay summary of the main technical report will be written specifically for families and the wider public. This will help local NHS services and baby loss charities to help parents engage with the local review process and improvements in care.⁶

The final commitment from *Learning not blaming* was to establish a new Independent Patient Safety Investigation Service (IPSIS), which would investigate the most serious incidents across the NHS:

It will be selective about the incidents it investigates to ensure optimum effectiveness, and it will focus on incident types that signal systemic or apparently intractable risks within the local health care system. For example, incidents that lead to high cost litigation claims, certain never events and incident types such as

⁶ National Perinatal Epidemiology Unit, [Perinatal Mortality Review Tool](#) (last accessed 21 November 2017)

medication errors. There may be some capacity to examine cross cutting themes from these investigations.⁷

The body was launched in April 2017 as a division of NHS Improvement, although under the name of the Healthcare Safety Investigation Branch (HSIB), rather than IPSIS. In September 2017, the Department of Health published the [Draft Health Service Safety Investigations Bill](#), which would put the HSIB on a statutory footing (operating as the Health Service Safety Investigations Body), and give it independence from the NHS.

The 2016 National Maternity Review, [Better Births](#), recommended a national framework for HSIB to investigate serious incidents in maternity and neonatal care:

There needs to be much greater consistency in the standard of local investigations of perinatal mortality, neonatal mortality, maternal death and serious morbidity. The new Health Safety Investigation Branch (HSIB) should set a common, national standard for high quality serious incident investigations. These should be carried out under the auspices of regional maternity clinical networks... to ensure that they are carried out by experienced experts and that the learning is shared widely.⁸

On 28 November 2017, Health Secretary, Jeremy Hunt, made a statement to the House on the Government's new strategy to improve safety in NHS maternity services. As part of this strategy, from April 2018, HSIB will investigate every case of a stillbirth, neonatal death, suspected brain injury or maternal death notified to the Royal College of Obstetricians and Gynaecologists (RCOG) *Every Baby Counts* programme, amounting to around 1,000 incidents per year:

The new independent maternity safety investigations will involve families from the outset, and they will have an explicit remit not just to get to the bottom of what happened in an individual instance, but to spread knowledge around the system so that mistakes are not repeated. The first investigations will happen in April next year and they will be rolled out nationally throughout the year, meaning that we will have complied with recommendation 23 of the Kirkup report into Morecambe Bay.⁹

2.2 Wales

In 2013, the Welsh Assembly Health and Social Care Committee published the [report of its inquiry into stillbirths in Wales](#). This made a number of recommendations, including a recommendation for improved investigations of stillbirths:

We recommend that a national minimum standard for reviewing perinatal deaths should be developed and rolled out across Wales. We also recommend that a wider, more imaginative approach to

⁷ Department of Health, [Learning not blaming: The government response to the Freedom to Speak Up consultation, the Public Administration Select Committee report 'Investigating Clinical Incidents in the NHS', and the Morecambe Bay Investigation](#), July 2015, p72

⁸ National Maternity Review, [Better Births: Improving outcomes of maternity services in England](#), February 2016, para 4.61

⁹ [HC Deb 28 November 2017, c178-80](#)

10 The investigation of stillbirth

Welsh Government funding for medical research and investigation is adopted, and that the Welsh Government seek detailed costings for a national perinatal audit for Wales from the All Wales Perinatal Survey. We believe that the initial investment in this audit could yield significant benefits in the future detection and prevention of stillbirth.¹⁰

The [Welsh Government's response](#) accepted the recommendation, and stated that a national minimum review standard was being developed as part of the work of the newly established National Stillbirth Working Group. An [update from the then Health Minister](#) Mark Drakeford in September 2014 confirmed that the Welsh Government was working with the Department of Health in England and the charity Sands, in the development of a UK perinatal mortality review tool (see previous section).

As in England, NHS Wales has a framework for investigating serious incidents. The [Putting Things Right](#) guidance sets out a number of serious incident types, including "the unexpected or avoidable death or severe harm of one or more patients, staff or members of the public."

The guidance also sets out a number of serious incident types that must be reported to the Welsh Government, including:

- Intrauterine Fetal deaths if there is early indication that the death it is linked to midwifery/obstetric practice
- Maternal deaths¹¹

The obligation to report to the Welsh Government does not replace the requirement to report to other bodies, including the requirement to report perinatal deaths to MBRRACE-UK.

¹⁰ National Assembly for Wales Health and Social Care Committee, [Inquiry into stillbirths in Wales: Key conclusions and recommendations](#), February 2013

¹¹ NHS Wales/ Welsh Government, [Putting Things Right: Guidance on dealing with concerns about the NHS from 1 April 2011, Version 3](#), November 2013, para 9.3

3. Coroners and stillbirth

Summary

At present coroners do not have power to investigate a stillbirth. There has to have been an independent life before the coroner has jurisdiction to investigate a subsequent death. The definition of stillbirth is based on there not having been an independent life, meaning that the coroner does not have jurisdiction to investigate.

There have been a number of calls for the law to be changed, including by Sands, the stillbirth and neonatal death charity, and in Parliamentary debate. A Private Member's Bill, introduced by Tim Loughton (Conservative), would "give coroners the power to investigate stillborn deaths". The Bill is due to have its second reading on 2 February 2018.

In Northern Ireland, which has its own legislation, the position is now different. In 2013, in a landmark decision, the Northern Ireland Court of Appeal held that coroners do have jurisdiction to carry out an inquest on a child that had been capable of being born alive.

On 28 November 2017, Health Secretary, Jeremy Hunt announced that he would work with the Ministry of Justice "to look closely into enabling, for the first time, full-term stillbirths to be covered by coronial law, giving due consideration to the impact on the devolved Administration in Wales".

3.1 Current position

Coroner's duty to investigate certain deaths

[Section 1 of the Coroners and Justice Act 2009](#) (the 2009 Act) imposes a duty on a senior coroner (coroner) to investigate a death where (s)he is made aware that the body is within that coroner's area and (s)he has reason to suspect that:

- the deceased died a violent or unnatural death,
- the cause of the death is unknown, or
- the deceased died while in custody or state detention.

An inquest may form part of the investigation.

A coroner may make whatever enquiries seem necessary in order to decide whether the duty to investigate the death arises.¹²

No power for coroner to investigate stillbirth

There has to have been an independent life before the coroner has jurisdiction to investigate a subsequent death. The definition of stillbirth is based on there not having been an independent life, meaning that the coroner does not have jurisdiction to investigate.

A leading textbook on coronial law (Jervis on Coroners) provides further detail:

Neither a fetus (that is, a human being still *in utero*) nor a stillborn child can be the subject of an investigation, since in neither case is

A Library briefing paper provides further information, [Coroners' investigations and inquests](#) (Number 03981, 27 June 2017)

¹² Coroners and Justice Act 2009 section 1(7)

12 The investigation of stillbirth

there any independent life and therefore in neither case can there be a subsequent death. For the purposes of death registration, a “stillborn” child is one which has issued forth from its mother after the 24th week of pregnancy but which did not at any time after being completely expelled from its mother breathe nor show any other signs of life. But a child born with signs of life (eg a beating heart) is nonetheless a child, and so may be the subject of an investigation in an appropriate case, even though it suffers from defects (eg missing organs) making it impossible for it to survive.¹³

Cases where there is doubt as to whether child was stillborn

Pre-investigation inquiry

Where there is doubt about whether the child was indeed stillborn, the coroner may conduct a pre-investigation inquiry, treating the question of stillbirth as a preliminary issue.¹⁴

Post mortem examination

[Section 14 of the 2009 Act](#) enables the coroner to commission a post mortem examination. The [Explanatory Note](#) to this section refers specifically to a post mortem examination establishing whether a child was stillborn, in which case the coroner does not have power to investigate further:

Subsection (1) gives a senior coroner power to ask a suitable practitioner to make a postmortem- examination of a body if the senior coroner is either responsible for conducting an investigation into the death or a post-mortem examination will enable the senior coroner to decide if he or she has a duty under section 1 to conduct an investigation. This may be relevant where it is not clear whether a death occurred as a result of a notifiable disease or whether a child was stillborn – where, for example, an infant’s body is found and it is not clear whether it ever had independent life. Where it is known or established that a child was stillborn, the senior coroner will have no further power to carry out an investigation.¹⁵

Possibility of inquest in some cases

If a baby may have been born alive, an inquest might be held. Jervis sets out information about cases where there is doubt:

A coroner might not be sure in a particular case whether a death is or is not a stillbirth, and so the matter goes to inquest. In such a case, if the “death” is found in fact to have been stillbirth, the determination is marked “stillbirth” in para (4) but the rest of the form is not completed,^[16] for the child not having been born had no independent life and cannot properly form the subject of an inquest.¹⁷

¹³ Paul Matthews, Jervis on Coroners, 13th edition, 2014, paragraph 5-04 (footnotes, including those with case references, omitted)

¹⁴ Ibid paragraph 5.05

¹⁵ [Coroners and Justice Act 2009 Explanatory Notes, paragraph 135](#)

¹⁶ Footnote to text: “See Coroners Rules 1984 Sch 4 Form 22, note 4(d) (repealed); the notes to the current form (Coroners (Inquests) Rules 2013 (SI 2013/1616) r.34 Sch Form 2) are silent on the point”

¹⁷ Paul Matthews, Jervis on Coroners, 13th edition, 2014, paragraph 13-66

The table below shows the number of conclusions recorded as stillbirths at coroners' inquests in England and Wales from 1995 to 2016. Since 1995 there have been around nine inquest conclusions recorded as stillbirths on average each year. There were seven recorded in 2016.

| INQUEST CONCLUSIONS RECORDED AS STILLBIRTHS | | | |
|---|------|--------|-------|
| England and Wales | | | |
| Year | Male | Female | Total |
| 1995 | 6 | 2 | 8 |
| 1996 | 2 | 4 | 6 |
| 1997 | 4 | 2 | 6 |
| 1998 | 6 | 6 | 12 |
| 1999 | 2 | 2 | 4 |
| 2000 | 1 | 3 | 4 |
| 2001 | 4 | 4 | 8 |
| 2002 | 2 | 1 | 3 |
| 2003 | 7 | 3 | 10 |
| 2004 | 7 | 4 | 11 |
| 2005 | 5 | 5 | 10 |
| 2006 | 7 | 5 | 12 |
| 2007 | 12 | 9 | 21 |
| 2008 | 10 | 3 | 13 |
| 2009 | 5 | 2 | 7 |
| 2010 | 5 | 3 | 8 |
| 2011 | 9 | 5 | 14 |
| 2012 | 6 | 5 | 11 |
| 2013 | 4 | 8 | 12 |
| 2014 | 3 | 3 | 6 |
| 2015 | 2 | 2 | 4 |
| 2016 | 4 | 3 | 7 |

Source: Ministry of Justice, Coroners statistics 2016, Table 7

3.2 Court of Appeal consideration of coroner's duty

In 2017, the [Court of Appeal](#) considered whether the Senior Coroner for West Yorkshire ("the Coroner") was entitled to conduct an investigation and inquest, pursuant to section 1 of the Coroners and Justice Act 2009, into the question of whether a child was stillborn or survived her birth and died later.¹⁸

The mother argued that the coroner had no jurisdiction to investigate the death, because he was not in a position to conclude, before his

¹⁸ [R on the application of T v HM Senior Coroner for the County of West Yorkshire \(Western Area\) \[2017\] EWCA Civ 318 \(28 April 2017\)](#)

formal investigations started, that the child had probably been born alive. Following a post mortem examination, the cause of death of the baby remained unascertained.

The Court of Appeal was satisfied that the Coroner was correct to conclude that “the 2009 Act enables a coroner to open an investigation into whether a baby was born alive, or still-born, without first having to be satisfied on information gathered before he opens the investigation that the child was probably born alive”.

The Court of Appeal said that the law relating to the investigation of stillbirth had not changed since 1887:

The language used in s.1 of the 2009 Act echoes that found in both the 1988 and 1887 Acts. Whilst the language has varied to reflect the style of legislative drafting over time, the underlying jurisdiction of a coroner in respect to a child that may have been born alive or still-born has not changed since 1887. The 1887 Act was itself an act to consolidate the law relating to coroners. Still-birth is a tragedy that continues to befall many families in advanced societies but it was a phenomenon more common in the past. More such cases would have come to the attention of Victorian coroners than now. The public interest in establishing whether a child was or was not stillborn, and if it was not how it came by its death, is apparent and continuing.

The Court referred to previous editions of Jervis, dating back to 1829, and held that a coroner could investigate whether or not a baby had been stillborn:

A consideration of all the statutory provisions, in the light of the historical position described in successive editions of Jervis on Coroners, leads to the conclusion that a coroner can investigate the death of a baby who may have been born alive or may have been still-born without first being satisfied on balance of probability that it was born alive, so long as he suspects one of the matters set out in s.1(2) is in play. The question whether there was a death is a component of the matters which may be the subject of suspicion.

This case is considered in the following blog post:

- David Hart QC, [Coroner’s conundrums: born alive or still-birth, and mother’s anonymity](#), UK Human Rights Blog, 6 May 2017.¹⁹

3.3 Chief Coroner’s Development Plan

In April 2015, the Chief Coroner formulated a 77 point Development Plan for 2015-2016. This is set out as Annexe 1 to the Chief Coroner’s Third Annual Report, published in September 2016.²⁰ It includes the following information about stillbirth:

| No. | TOPIC | ACTION | TIMESCALE | COMMENTS |
|-----|-------------|---|----------------------|---|
| 14 | STILLBIRTHS | To consider whether stillbirths/near term deaths should be reportable cases | Discussion commenced | Likely to require Parliament to legislate eg in statutory criteria for reporting deaths (see above) |

¹⁹ Accessed 30 November 2017

²⁰ [Report of the Chief Coroner to the Lord Chancellor Third Annual Report: 2015-2016](#), 8 September 2016

3.4 Calls for coroners to have power to investigate stillbirths

Sands

In May 2017, Sands, the stillbirth and neonatal death charity, issued a position statement calling for coroners to be given jurisdiction to investigate stillbirths, should parents believe that the hospital's internal review process does not adequately answer questions around their baby's death:

Sands supports calls to broaden the jurisdiction of the coroner so that they are able, at the request of parents, to investigate a stillbirth. We urge units around the country to conduct a robust local review of care when any baby dies, fostering an open and honest culture, and ensuring it does what it is supposed to – identify preventable deaths and lessons to ensure mistakes are not repeated. We look forward to the standardised perinatal mortality review tool being rolled out in hospitals across the country at the end of the year.²¹

Sands said that the current system of investigation when a baby dies is "wholly inadequate":

Parents want and deserve honest answers about why their baby died, from the hospital who cared for them. If poor care played any part, they need and should receive acknowledgement, an apology, and assurances that lessons will be learned to inform future care of mothers and babies.

However, Sands does not consider that there should be a coroner's investigation in all cases: "The process can be drawn out and complex and is not appropriate in all cases".

Private Member's Bill

Having come fifth in the Private Members' Bill Ballot 2017, Tim Loughton introduced the [Civil Partnerships, Marriages and Deaths \(Registration Etc.\) Bill 2017-19](#) on 19 July 2017.²² The Bill is due to have its second reading on 2 February 2018. Among other things, the Bill would "give coroners the power to investigate stillborn deaths".

Baby Loss Awareness Week debate

Parliamentary debate on this issue includes a House of Commons debate on 10 October 2017 on [Baby Loss Awareness Week](#).²³ Calls were made for coroners to be able to investigate stillbirths. For example, Lilian Greenwood (Labour) supported constituents, whose full-term baby had been stillborn, who were calling for a change in the law to enable coroners to investigate stillbirths and hold inquests into the deaths of babies after 37 weeks' gestation. She said that it appeared that there was cross-party support for such a change:

I welcome the Minister's confirmation that the standardised perinatal mortality review tool is being rolled out across the

²¹ [Sands' position statement. Coroners' inquests into stillbirths](#), May 2017 [accessed 29 November 2017]

²² The [Bill page on the Parliament website](#) states that the Bill is being prepared for publication

²³ [HC Deb 10 October 2017 cc267-300](#)

country, but will he also support calls to broaden coroners' jurisdiction so that they are able, at the request of parents, to investigate a stillbirth? Hospitals' internal review processes should involve parents and should answer their questions about why their baby has died, but when those questions are not answered, the coroner can play a vital role not just in providing answers—important though that is—but in identifying preventable deaths, and ensuring that lessons are learned and mistakes are not repeated. Such a change to coronial law would bring England and Wales in line with Northern Ireland, where a landmark legal ruling in 2013 held that a coroner

“can carry out an inquest into the death of a stillborn child that had been capable of being born alive.”

It is clear from several contributions this evening that there is cross-party support for such a change.²⁴

Shadow Health Minister, Justin Madders, said “I assure [Lilian Greenwood] that the Opposition Front Bench will do what we can to assist in making that campaign a reality”.²⁵

Responding to the debate, Health Minister, Philip Dunne, spoke of the perinatal mortality review tool:

Members have challenged me on a couple of issues, particularly that of coroners' reports. We are introducing a perinatal mortality review tool to allow investigations to be undertaken, with information collated in a manner that can then inform and be learned from. We will watch with interest what happens in Scotland, but at this point I think we need to get the tool working and see how it goes. In my opening speech, I mentioned the health service safety investigations branch on which we are consulting. We envisage it as having a role in looking at some of the more extreme cases, but only if it decides to do so.²⁶

3.5 Coroners' investigation of stillbirth in Northern Ireland

In Northern Ireland, which has its own legislation, the position is now different from that in England and Wales.

In 2013, in the High Court of Northern Ireland, Treacy J said:

...it seems to be the case that for at least the last 50 years, Coroners in this jurisdiction have not been carrying out inquests into stillborn children almost certainly because it is not expressly provided for.²⁷

However, in a landmark decision later that year, the Northern Ireland Court of Appeal held that, under the law applicable in Northern Ireland, the Coroner did have jurisdiction to carry out an inquest on a child that had been capable of being born alive:

We consider that the Attorney was correct in his submission that the effect of section 18(1)(a) of the [Coroners Act (Northern Ireland) 1959] was to extend the definition of "deceased person" in the 1959 Act to include a foetus in utero then capable of being

²⁴ [HC Deb 10 October 2017 cc282-3](#)

²⁵ [HC Deb 10 October 2017 c297](#)

²⁶ [HC Deb 10 October 2017 cc299-300](#)

²⁷ [Attorney General's Application \[2013\] NIQB 52](#) paragraph 34

born alive. In *Rance v Mid-Downs Health Authority* [1991] 1 QB 587 it was held that the words "a child then capable of being born alive" in the [Criminal Justice Act (Northern Ireland) 1945] meant capable of existing as a live child, breathing and living by reason of its breathing through its own lungs alone, without deriving any of its living, or power of living, by or through any connection with its mother. We are satisfied that the effect of section 18 of the 1959 Act as enacted is that the Coroner can carry out an inquest into a foetus in utero falling within that definition.²⁸

A media report sets out information about the circumstances of the case:

- ["Inquest into stillbirth of Axel Desmond in Derry"](#), BBC News, 21 November 2013.²⁹

In April 2015 it was reported that, since the Court of Appeal's decision, 61 stillbirths had been referred to Northern Ireland Coroners' Service.³⁰

In September 2016, the BBC reported an inquest in Northern Ireland which it introduced as follows:

A groundbreaking case, involving the world's first inquest to focus solely on a stillborn baby, has already helped to save lives, a court has heard.³¹

3.6 Government looking at enabling coroners to investigate stillbirths

On 28 November 2017, in his statement to the House on the Government's new strategy to improve safety in NHS maternity services, Health Secretary, Jeremy Hunt, also spoke of extending the jurisdiction of coroners. He said that, following concerns that some neonatal deaths were being wrongly classified as stillbirths, meaning that a coroner's inquest could not take place, he would work with the Ministry of Justice "to look closely into enabling, for the first time, full-term stillbirths to be covered by coronial law, giving due consideration to the impact on the devolved Administration in Wales".³²

Shadow Health Secretary, Jonathan Ashworth, welcomed this move and said that the Opposition would work constructively with the Secretary of State "to ensure the smooth and timely passage of the relevant legislation, should he and the Government choose to bring any before the House".³³

Tim Loughton offered to "sit down with the Secretary of State and his draftsman to decide on the wording of my private Member's Bill, which will be debated on 2 February, as the fastest way to achieve his goals

²⁸ [\[2013\] NICA 68](#) paragraph 34

²⁹ Accessed 29 November 2017

³⁰ Niall McCracken, "[More than 60 stillbirths referred to Northern Ireland's coroner](#)", the detail, 2 April 2015 [accessed 29 November 2017]

³¹ [Cara Rocks inquest: Stillbirth case 'helped to save lives'](#), BBC News, 5 September 2016 [accessed 29 November 2017]

³² [HC Deb 28 November 2017 c179](#)

³³ [HC Deb 28 November 2017 c181](#)

18 The investigation of stillbirth

and get the solution that all Members of the House want".³⁴
Jeremy Hunt said that he was happy to do that.

Victoria Prentis (Conservative) said that not many families would need an inquest to determine what went wrong during the birth of their child. She also asked the Secretary of State to commit to the training of special coroners, as exist for military inquests, "to ensure that those who deal with these very sad cases are the best equipped people to do so". Jeremy Hunt said that he would consider this point.³⁵

³⁴ [HC Deb 28 November 2017 c186](#)

³⁵ [HC Deb 28 November 2017 c187](#)

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