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Investigation of stillbirth

Summary

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Summary

This briefing deals with the position in England and Wales except where stated otherwise.

The investigation of stillbirths in the UK

The Department of Health and Social Care and the Welsh and Scottish Governments have jointly commissioned a standard Perinatal Mortality Review Tool (PMRT), to assist hospitals in investigating all baby deaths, from 22 weeks' gestation onwards, including late miscarriages, stillbirths and neonatal deaths.

All stillbirths should be reviewed by the hospital providing maternity care. The review should be carried out by a multi-disciplinary team to understand the events that led up to the death of the baby. It aims to find out why the death of a baby has occurred, to provide bereaved parents with as much information as possible, and to allow the hospital to learn lessons and improve future care.

The hospital review is different from a coroner's investigation or inquest. For about 90% of parents the PMRT review process is likely to be the only hospital review of their baby's death that will take place.

In England, all cases of intrapartum stillbirth, where the baby was thought to be alive at the start of labour and was born with no signs of life, are investigated by the Maternity and Newborn Safety Investigations (MNSI) programme.

For information on measures to reduce stillbirth, and to improve the quality of care for bereaved parents, please refer to the Library briefing Quality and safety of maternity care (England).

Coroners and stillbirth

At present, coroners do not have power to investigate stillbirths. 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.

Where there is doubt about whether a child was born alive or stillborn, the coroner can make preliminary enquiries to try to establish the position or can start an investigation.

In Northern Ireland, which has its own legislation relating to coroners, the position is different. In 2013, in a landmark decision (PDF), the Northern Ireland Court of Appeal ruled that coroners do have jurisdiction to carry out an inquest into a stillborn baby that had been capable of being born alive.

Civil Partnerships, Marriages and Deaths (Registration etc) Act 2019

Section 4 of the Civil Partnerships, Marriages and Deaths (Registration etc) Act 2019 requires the Secretary of State to "make arrangements for the preparation of a report on whether, and if so how, the law ought to be changed to enable or require coroners to investigate stillbirths". The Secretary of State must publish the report and then the Lord Chancellor may make regulations to amend Part 1 of the Coroners and Justice Act 2009 for specified purposes.

Government consultation 2019

In March 2019, the Government launched a consultation on coronial investigations of stillbirths in England and Wales. This was prepared jointly by the Ministry of Justice and the Department of Health and Social Care.

One of the matters on which the Government sought views was a proposal that stillbirths occurring at or after the 37th week of pregnancy should be in scope of an inquest. The Government said its proposals aimed to:

- bring greater independence to the way stillbirths are investigated
- ensure transparency and enhance the involvement of bereaved parents in stillbirth investigation processes, including in the development of recommendations aimed at improving maternity care
- effectively disseminate learning from investigations across the health system to help prevent future avoidable stillbirths.

The Government confirmed it was not seeking to replace the role of the NHS in investigating stillbirths (PDF). Instead, coronial investigations would supplement and support those investigations and ensure that coroners could contribute to learning and play a role in reducing the stillbirth rate.

The consultation closed on 18 June 2019. As of 12 October 2023 the Government is still analysing feedback.

In May 2021, the House of Commons Justice Committee recommended that the Ministry of Justice should revive the consultation and publish proposals for reform. The Government's response, published in September 2021, said the delay in responding to the 2019 consultation was due to the impact of Covid-19 on work programmes. However, the Government accepted the Committee's recommendation and said the Department of Health and Social Care and the Ministry of Justice planned to publish a joint response as soon as possible.

On 12 September 2023, in answer to a parliamentary question from Tim Loughton (Conservative) asking when there would be progress, Mike Freer, Parliamentary Under-Secretary of State for Justice, said "Both the Health Minister and I are pushing this as fast as we possibly can".

1 Stillbirth

1.1 Definition of "stillborn child"

The definition of "still-born child" in England and Wales is contained in the Births and Deaths Registration Act 1953 section 41 (as amended) and is as follows:

> a child which has issued forth from its mother after the twenty-fourth week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other signs of life, and the expression "still-birth" shall be construed accordingly.

Until 1992, the threshold was 28 weeks.

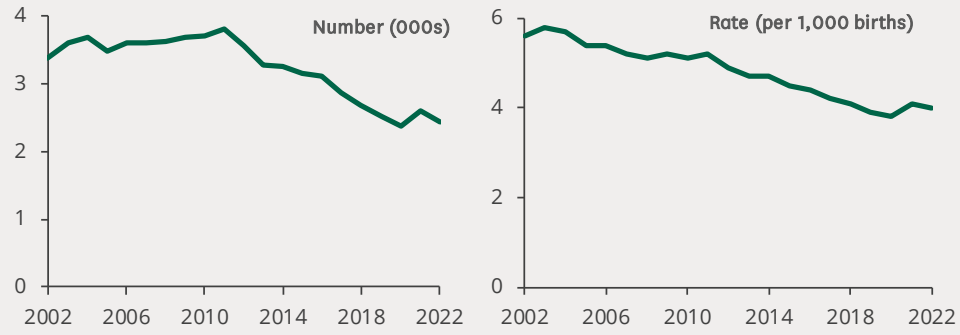
A term sometimes used in relation to stillbirths is 'perinatal mortality', which refers to a child who has died between the 24th week of pregnancy and the first week of life.

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 2002 to 2022.

Number and rate of stillbirths

England and Wales, 2002–2022



Source: Office for National Statistics Births in England and Wales: summary tables

In 2022, there were 2,433 stillbirths recorded in England and Wales, a 28% reduction on the 2002 figure of 3,372. When stillbirths are expressed as a rate

per 1,000 births, the 2022 rate of 4.0 per 1,000 births was 29% lower than the 2002 rate of 5.6.

Both the number and rate of stillbirths increased in 2021, before falling again in 2022.

The table below compares the number and rate of stillbirths in the countries and regions of the UK in 2022. The rate of stillbirths across the UK as a whole was 3.9 stillbirths per 1,000 births. Among the different countries of the UK the rate was highest in Wales (4.5) and lowest in Northern Ireland (3.4).

The West Midlands and the North East had the highest rate of stillbirths (4.3 per 1,000 births) out of the regions of England, followed by London and the East of England (4.2 per 1,000 births) The South West had the lowest rate of stillbirths in 2019 (2.9 per 1,000 births).

Number and rate of stillbirths by country and region

United Kingdom, 2022

	Number	Rate per 1,000 births
United Kingdom	**2,649**	**3.9**
England	2,276	3.9
Wales	126	4.5
Scotland	176	3.7
Northern Ireland	71	3.4
West Midlands	271	4.3
North East	126	4.3
London	450	4.2
East of England	268	4.2
Yorkshire and the Humber	223	4.0
North West	307	4.0
East Midlands	177	3.8
South East	331	3.6
South West	143	2.9

2 Investigation of stillbirths in the UK

2.1 Recommendations to improve the investigation of perinatal deaths

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 UK Government launched an independent investigation led by Dr Bill Kirkup.

The report of the Morecambe Bay investigation (PDF), published in March 2015, proposed a number of recommendations to improve maternity and neonatal services, including a recommendation to improve investigation of late and intrapartum 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.[1]

The UK Government's response to the Kirkup report, Learning not blaming (PDF) (July 2015), accepted this recommendation and committed to work with health departments across the UK to consider how standardised reviews for all perinatal deaths might be introduced.[2]

The 2016 National Maternity Review, Better Births (PDF), also said there needed to be "...much greater consistency in the standard of local investigations of perinatal mortality, neonatal mortality, maternal death and serious morbidity."[3]

1 The Report of the Morecambe Bay Investigation (PDF), March 2015, p188
2 Department of Health, Learning not blaming (PDF), Cm 9113, July 2015
3 National Maternity Review, Better Births: Improving outcomes of maternity services in England (PDF), February 2016, para 4.61

2.2 The Perinatal Mortality Review Tool programme

The UK Government, along with its counterparts in Scotland and Wales, commissioned the MBRRACE-UK team at the University of Oxford's National Perinatal Epidemiology Unit (NPEU) to deliver a standard Perinatal Mortality Review Tool (PMRT), across England, Scotland and Wales.[4] The PMRT was launched in 2018 to support NHS hospitals to undertake systematic reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death.

The Perinatal Mortality Review Tool (PMRT) is intended to assist hospitals in investigating all baby deaths, from 22 weeks' gestation onwards, including late miscarriages, stillbirths and neonatal deaths.

The PMRT supports reviews across NHS maternity and neonatal units in England, Scotland and Wales to carry out:

- Systematic, multidisciplinary, high quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care
- 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

[4] MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK) provides surveillance of all maternal deaths, stillbirths and infant deaths in the UK. It delivers the Maternal, Newborn and Infant clinical Outcome Review Programme (MNI-CORP), which continues the national programme of work conducting surveillance and investigating the causes of maternal deaths, stillbirths and infant deaths. As part of this 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.

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.[5]

Alongside the national annual reports, a lay summary of the main technical report should be written specifically for families and the wider public. Local NHS services and baby loss charities can also help parents engage with the local review process and improvements in care.

Implementation support materials are available to support the conduct of reviews and the use of the PMRT. Further details of the programme are available on the PMRT programme page, including information for bereaved parents.

The hospital review is different from a coroner's investigation or inquest. For about 90% of parents the PMRT review process is likely to be the only hospital review of their baby's death that will take place.

Perinatal Mortality Review Tool annual reports

The Perinatal Mortality Review Tool (PMRT) programme publishes an annual report based on analysis of reviews. Its fourth annual report was published in September 2022, and based on analysis of reviews completed from March 2021 to February 2022. It focuses on quality in terms of parent engagement, the review process and subsequent action plans.

The report found that there have been continued improvements in the use of the tool, despite it being based on reviews carried out during the COVID-19 pandemic. In particular the report found improvements in the multi-disciplinary nature of reviews.[6]

The report goes on to make a number of recommendations, including a call for the local PMRT summary reports and the national annual report "to be used as a basis to prioritise resources for key aspects of care and quality improvement activities identified as requiring action."[7]

5 University of Oxford NPEU, Perinatal Mortality Review Tool (accessed 12 October 2023)

6 Perinatal Mortality Review Tool, Fourth Annual Report, 30 September 2022 (accessed 12 October 2023)

7 See above

2.3 Other measures to improve maternity safety and the quality of care for bereaved parents

The Pregnancy Loss Review, was set up in March 2018 to consider the:

- registration and certification of pregnancy loss occurring before 24 weeks' gestation and
- quality of NHS care.

The review published its report on 22 July 2023. It made 73 recommendations, which are intended to support the Government and the NHS to improve the safety and care experience for all those who have a pre-24-week baby loss.

The Government response to the independent Pregnancy Loss Review, also published on 22 July 2023, set out the immediate actions in response to 20 of the recommendations made in the review. The Government agreed with the recommendations that pregnancy loss needs to include plans for ongoing care after every loss. The Government also stated that all parents experiencing a loss should be provided with safe and compassionate bereavement support, and highlighted the National Bereavement Care Pathway (NBCP) for Pregnancy and Baby Loss.

In England, all cases of intrapartum stillbirth, where a baby is thought to be alive at the start of labour and is born with no signs of life, are investigated by the Maternity and Newborn Safety Investigations (MNSI) programme.

Further information on this, and other measures to reduce stillbirth and baby loss, and to improve the quality of care for bereaved parents, is provided in the Library briefing Quality and safety of maternity care (England).[8]

2.4 Further information

The NHS website provides information on what should happen after a baby is stillborn, including finding the cause, follow-up care, and bereavement support. The NHS also provides information on other sources of support:

> Sands, the stillbirth and neonatal death charity, provides support for anyone affected by the death of a baby. You can:
>
> - call the Sands confidential helpline on 0808 164 3332 – 10am to 3pm Monday to Friday, plus 6pm to 9pm Tuesday, Wednesday and Thursday
> - email helpline@uk-sands.org

[8] Commons Library research briefing CBP-9815, Quality and safety of maternity care (England)

There are many other self-help groups in the UK for bereaved parents and their families. You can search for bereavement support services in your area.[9]

[9] NHS, Stillbirth - What happens if your unborn baby dies (accessed 12 October 2023)

3 Coroners and stillbirth: current position

3.1 England and Wales

Coroner's duty to investigate some 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 they are made aware that the body is within that coroner's area, and they have 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, and in some cases must, 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.[10]

Another Library briefing provides further information, Coroners' investigations and inquests.[11]

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.

Cases where there is doubt as to whether child was stillborn

Chief Coroner guidance

In February 2023, the Chief Coroner issued guidance, Stillbirth, and Live Birth Following Termination of Pregnancy.[12] The guidance sets out, among other

10 Coroners and Justice Act 2009 section 1(7)
11 Commons Library briefing SN-03981, Coroners' investigations and inquests
12 Courts and Tribunals Judiciary, Chief Coroner's Guidance No.45 Stillbirth, and Live Birth Following Termination of Pregnancy, 3 February 2023 (accessed 12 October 2023)

things, how it might be established whether there has been a live birth. It says where there is doubt about this, the coroner can make preliminary enquiries to try to establish the position or start an investigation:

> If a child has been born alive (no matter how brief that child's life is, and whatever the extent of any physical defects the child might have), the coroner will have a duty to investigate the child's death if section 1 Coroners and Justice Act 2009 applies. However, it can be difficult to establish whether a child showed signs of life after birth … Parents and medical professionals might also have opposing views as to whether signs of life were observed.
>
> Where there is doubt about whether a child was born alive or was stillborn, a coroner can either make preliminary inquiries to try to establish the position, or can begin an investigation. A coroner does not have to be satisfied on the balance of probabilities that the child was born alive before an investigation can be commenced.[13]

The Chief Coroner considers that, where there is any dispute over whether a child was born alive, and section 1 of the Coroners and Justice Act 2009 would be engaged if there had been a live birth, there should always be an investigation, and this issue should be determined at inquest.[14]

The guidance sets out how the coroner should notify the registrar if it transpires before an inquest that a child was stillborn. Where the finding at an inquest is that a child was stillborn, the short-form conclusion of 'stillbirth', should usually be used.[15]

Post-mortem examination

Section 14 of the 2009 Act enables the coroner to commission a post-mortem examination, either as part of their preliminary inquiries, or as part of an investigation.[16] The explanatory note to this section refers specifically to a post-mortem examination establishing whether a child was stillborn, in which case the coroner would not have power to investigate further:

> Subsection (1) gives a senior coroner power to ask a suitable practitioner to make a post-mortem 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 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.[17]

13 As above, paras 13-14 (footnote omitted)
14 As above, para 16
15 As above, paras 17-18
16 As above, para 15
17 Explanatory Notes to the Coroners and Justice Act 2009, para 135

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 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 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 concluded the coroner did have jurisdiction to investigate without first having to be satisfied that it was more likely than not that the child was born alive:

> A consideration of all the statutory provisions, in the light of the historical position described in successive editions of Jervis on Coroners[19], 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) [of the 2009 Act] is in play. The question whether there was a death is a component of the matters which may be the subject of suspicion.[20]

Possibility of inquest in some cases

If a coroner is not sure whether or not the baby was born alive, an inquest might be held but this tends to apply only in a minimal number of cases, representing a very small proportion of overall stillbirth figures. There were 5 inquest conclusions recorded as stillbirths in 2022 and an average of 9 per year over the past 20 years.[21]

3.2 Northern Ireland

In Northern Ireland, which has its own legislation dealing with coroners, the position differs from that in England and Wales.

In 2013, in a landmark decision (PDF), the Northern Ireland Court of Appeal ruled that, under the law applicable in Northern Ireland, the coroner did have

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)

19 A leading textbook on coronial law

20 *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) , para 54

21 Coroners' statistics 2022, Table 7

jurisdiction to carry out an inquest on a stillborn child that had been capable of being born alive.[22]

A previous case[23] had decided, in a different context, that the words "a child then capable of being born alive" 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. The Northern Ireland Court of Appeal said it was satisfied that the effect of section 18 of the Coroners Act (Northern Ireland) 1959 was that the coroner could carry out an inquest into an unborn child falling within that definition.[24]

22 *Attorney General for Northern Ireland and Siobhan Desmond v The Senior Coroner for Northern Ireland* [2013] NICA 68 (PDF)

23 *Rance v Mid-Downs Health Authority* [1991] 1 QB 587

24 *Attorney General for Northern Ireland and Siobhan Desmond v The Senior Coroner for Northern Ireland* [2013] NICA 68 (PDF), para 34

4 Calls for coroners to have power to investigate stillbirths

There have been calls for the law to be changed, both inside and outside of Parliament.

4.1 Sands

In May 2017, the charity Sands, issued a position statement (PDF) supporting calls "to broaden the jurisdiction of the coroner so that they are able, at the request of parents, to investigate a stillbirth".[25]

Sands does not consider 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".[26]

4.2 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.[27] Lilian Greenwood (Labour) supported constituents, whose full-term baby was stillborn, and 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' pregnancy. She said it appeared 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 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

25 Sands' position statement, Coroners' inquests into stillbirths (PDF) May 2017 (accessed 12 October 2023)

26 As above

27 HC Deb 10 October 2017 cc267-300

> "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.[28]

Justin Madders, who was then Shadow Health Minister, said "I assure [Lilian Greenwood] that the Opposition Front Bench will do what we can to assist in making that campaign a reality".[29]

Responding to the debate, the then-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.[30]

28 HC Deb 10 October 2017 cc282-3
29 HC Deb 10 October 2017 c296
30 HC Deb 10 October 2017 cc299-300

5 Civil Partnerships, Marriages and Deaths (Registration etc) Act 2019

5.1 The Act

Section 4 of the Civil Partnerships, Marriages and Deaths (Registration etc) Act 2019 (the Act) requires the Secretary of State to "make arrangements for the preparation of a report on whether, and if so how, the law ought to be changed to enable or require coroners to investigate stillbirths". The Secretary of State must publish the report.

Following publication of the report, the Lord Chancellor may make regulations to amend Part 1 of the Coroners and Justice Act 2009 (the 2009 Act) to:

- enable or require coroners to conduct investigations into stillbirths (whether by treating stillbirths as deaths or otherwise);
- specify the circumstances in which investigations are to take place (including by limiting the duty or power to investigate to certain descriptions of stillbirth);
- provide for the purposes of those investigations;
- make provision equivalent or similar to provision in Part 1 of the 2009 Act relating to investigations into deaths.

The regulations must be made within five years of the date on which the report is published.

Section 5 of the Act sets out supplementary provision about regulations.

5.2 Debate on the preceding bill

The Act started as a Private Member's Bill introduced by Tim Loughton (Conservative) in July 2017, the Civil Partnerships, Marriages and Deaths (Registration Etc.) Bill 2017-19 (the Bill). Information about the Bill is provided on the Parliament website.

Another Library briefing provides further information: Commons Library analysis: Civil Partnerships, Marriages and Deaths (Registration Etc.) Bill.[31]

Commons Second Reading

At second reading of the Bill in the Commons, Tim Loughton set out the intent of what was then Clause 4 (now, as amended, Section 4) and the benefits it would bring about:

> My Bill proposes an enabling clause to give the Secretary of State powers to amend the Coroners and Justice Act 2009 to give coroners the power to investigate stillbirths. The preference would be for the change to apply to late-term stillbirths and for discretion to remain with coroners to determine which deaths they wished to investigate rather than be swamped by having to investigate large numbers of otherwise straightforward stillbirths. However, I appreciate the complexities of making such a change, given that the responsibility lies between the Department of Justice and the Department of Health and Social Care. I do not seek to be prescriptive about the enabling power at this stage, but I am sure that both Secretaries of State would wish to get on with this sooner rather than later, given the imperative that the Health Secretary has already placed on this issue, on record.
>
> Importantly, coroners tell me that they have the capacity to take on these additional investigations, and indeed it is likely that the measure will cut down on subsequent litigation, as it will afford greater certainty about exactly what has happened. It will also lead to reduced care costs on the back of fewer damaged babies and give much greater comfort to parents who are struggling to come to terms with such a traumatic loss. As such, it should certainly be seen not as a stand-alone measure but as complementary to the panoply of other improvements that the Government are currently introducing, on which they are to be congratulated.[32]

Victoria Atkins, who was then a junior Home Office Minister, agreed with the need to look at the role coroners could play in investigating stillbirths, while emphasising the importance of a review:

> The Government think that it is important to carry out a review and produce a report in this area before making any changes. There are important and sensitive issues to explore, such as the question of how far into a pregnancy coronial involvement should be triggered, and the potential role of other factors, such as violence to the mother or medical negligence. We need to hear a wide range of views, including those of coroners, including the chief coroner, medical professionals, researchers in the field and, of course, bereaved parents and the organisations that support them.[33]

House of Lords debate

At report stage in the House of Lords, Baroness Barker (Liberal Democrat) moved a probing amendment intended to leave out Clause 4. She said her

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31 Commons Library research briefing CPB-08217, Commons Library analysis: Civil Partnerships, Marriages and Deaths (Registration Etc.) Bill

32 HC Deb 2 February 2018 cc1109-10

33 HC Deb 2 February 2018 cc1124-5

aim in asking questions about this provision was to try to ensure it did not cause delays:

> The aim of all of them is to ensure that, whatever happens as a result of this legislation, the involvement of coroners—the legal process—does not, in ways that may be unintended, get in the way of women and families having fairly swift access to discussions with medical professionals about what has gone wrong in their cases. I firmly believe that, like most victims of medical negligence or poor practice, people do not want money or compensation but to know what happened and to try to stop it happening to somebody else. My efforts in this regard are to try to make sure we do not delay that process.
>
> I make the points that I make in the knowledge that the Royal College of Obstetricians and Gynaecologists has moved a long way, with its Each Baby Counts programme and its involvement in a number of multidisciplinary programmes to try to monitor and improve performance in perinatal deaths.[34]

Baroness Williams of Trafford, who was then Home Office Minister, said the Government would consult, so all views could be heard:

> The consultation will be wide-ranging and will seek views from a number of interested parties, including, as the noble Baroness asked, the Royal College of Obstetricians and Gynaecologists, whose members provide crucial services to all expectant mothers. We recognise that, while there are those who are keen to see this change, there are others who have well-considered reservations, and it is important for us to hear from them.[35]

Baroness Williams set out how the Government would proceed:

> I reassure the noble Baroness that, if the Government decide to proceed with giving coroners powers to investigate stillbirths and draw on the power provided at Clause 4(4), we will publish our regulations before they are laid in Parliament. This additional scrutiny will ensure that robust and well-understood provisions for changing Part 1 of the Coroners and Justice Act 2009 are brought before Parliament. Should we make such change, the Government will also undertake a post-implementation review within two years of its implementation.
>
> The Bill as it stands provides for the enabling power to expire after five years beginning from the day on which the report is published. This would allow further amendments to the provisions for investigating stillbirths if they are deemed necessary once any new legislation has bedded in.
>
> Finally, the powers provided for in Clause 4(4) are intended to allow the existing framework for coronial investigations to be extended to include the investigation of stillbirths. The existing provisions were thoroughly scrutinised when the Coroners and Justice Bill was debated in this House and another place. In exercising this power, the Lord Chancellor will be required to lay any regulations before your Lordships' House for noble Lords' consent whenever they amend the Coroners and Justice Act 2009.[36]

34 HL Deb 1 March 2019 cc414-5

35 HL Deb 1 March 2019 cc416

36 As above

Baroness Barker withdrew her amendment.

6 Government consultation

6.1 March 2019: Government consultation paper

In a written ministerial statement on 26 March 2019, Edward Argar, who was then junior Justice Minister, announced publication of a consultation (a joint undertaking between the Ministry of Justice and the Department of Health and Social Care) on introducing coronial investigation of stillbirths in England and Wales.[37] He set out the matters on which the Government was seeking views, including a proposal that stillbirths occurring at or after the 37th week of pregnancy should be in scope of an inquest:

> The consultation seeks views on the merits of coroners inquiring into the causes of stillbirths and contains proposals as to when and how those investigations should take place, reflecting existing processes and arrangements for coronial investigations into child and adult deaths.
>
> We propose that all stillbirths that occur at or after the 37 week of gestation should be in scope of an inquest and our proposals cover such matters as access to documents and medical examination of the stillborn baby.
>
> A coronial investigation would provide greater transparency in stillbirth cases. Under our proposals evidence would be available to all interested persons, including the bereaved parents, who may not otherwise have the opportunity to hear or read everything that is presented when a stillbirth is reviewed. The coroner would bring judicial independence which would help build confidence in the conclusions of the investigation.
>
> We propose that coroners should identify where lessons can be learnt from individual stillbirths in ways that will deliver system-wide improvements to the delivery of maternity services and the general care and safety of expectant mothers.[38]

Edward Argar said the consultation document took account of the views expressed by Members of both Houses during the debates on the bill which is now the Civil Partnerships, Marriages and Deaths (Registration Etc.) Act 2019.

In the consultation paper, the Government said it was not seeking to replace the role of the NHS in investigating stillbirths. Instead, coronial investigations would supplement and support those investigations and ensure that coroners could contribute to learning and play a role in reducing the stillbirth rate.[39]

37 HCWS1448, Stillbirths: Coronial Investigations, 26 March 2019

38 As above

39 HM Government, Consultation on coronial investigations of stillbirths, CP 16, March 2019, p5

The consultation closed on 18 June 2019. As of 12 October 2023, the Government is still analysing feedback.[40]

6.2 Justice Committee recommendation

On 27 May 2021, the House of Commons Justice Committee published its report, The Coroner Service.[41] The Committee expressed disappointment that the "welcome" consultation on coronial investigation of stillbirths appeared to have stalled. It recommended the Ministry of Justice should revive the consultation and publish proposals for reform.[42]

The Government published its response to the Justice Committee report on 10 September 2021.[43] It said there had been over 300 responses to the consultation from a wide range of stakeholders, and that the impact of Covid-19 on work programmes had delayed the response.[44]

The Government accepted the Committee's recommendation and said the Department of Health and Social Care and the Ministry of Justice planned to publish a joint response to the consultation as soon as possible.[45]

On 12 September 2023, in answer to a parliamentary question from Tim Loughton asking when there would be progress, Mike Freer, Parliamentary Under-Secretary of State for Justice, said "Both the Health Minister and I are pushing this as fast as we possibly can".[46]

40 Gov.UK, Coronial investigations of stillbirths (accessed 12 October 2023)
41 House of Commons Justice Committee, The Coroner Service, HC 68, 27 May 2021
42 As above, para 118
43 House of Commons Justice Committee, The Coroner Service: Government Response to the Committee's First Report, HC 675, 10 September 2021
44 As above, section 14
45 As above
46 HC Deb 12 September 2023 c766

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