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By Catherine Fairbairn,
Tom Powell,
Rachael Harker

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Investigation of stillbirth

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Summary

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

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 Social Care and the Welsh and Scottish Governments have also jointly commissioned a standard Perinatal Mortality Review Tool, to assist maternity and neonatal units in investigating stillbirths and perinatal deaths. Following a phased national roll out in England, all term stillbirths where the baby dies during labour or birth are investigated by the Health Safety Investigation Branch (HSIB).

The HSIB's national review of intrapartum stillbirths during the Covid-19 pandemic was published on 15 September 2021. The review was prompted by an increase in referrals of intrapartum stillbirths to HSIB which fitted specific criteria between April and June 2020 (45 compared to 24 in the same period in 2019). The report describes how the pressures and changes as a result of the pandemic may have impacted on the care received.

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. There have been calls for the law to be changed.

In Northern Ireland, which has its own legislation, the position is 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 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 following this 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 described as a joint undertaking between the Ministry of Justice and the Department of Health and Social Care.

The Government proposes that stillbirths occurring at or after the 37th week of pregnancy should be in scope of an inquest. The stated aims of the consultation proposals were 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 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.

The consultation closed on 18 June 2019. 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 response, published in September 2021, said the delay 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 to the 2019 consultation as soon as possible.

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.

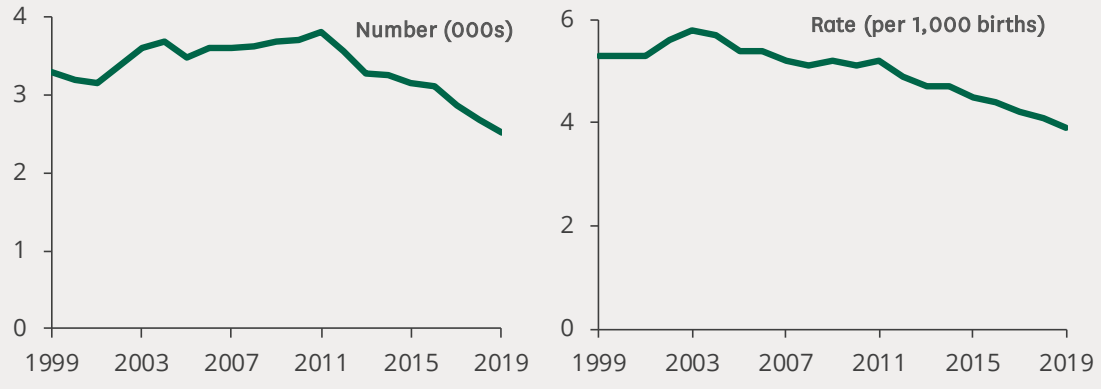
A term sometimes used in relation to stillbirths is 'perinatal mortality', which refers to a child who has died between the 24th week of pregnancy and the first week of life.

1.2 Number of stillbirths

The charts below show the number and rate of stillbirths in England and Wales in each year from 1999 to 2019.

Number and rate of stillbirths

England and Wales, 1999-2019



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

Source: ONS Childhood and infant mortality in England & Wales, 2019

In 2019, there were 2,522 stillbirths recorded in England and Wales, a 24% reduction on the 1999 figure of 3,305. Stillbirth numbers tended to increase in the 2000s but then declined year on year from 2011 onwards. When stillbirths are expressed as a rate per 1,000 births, a declining trend is observed from 2003 onwards; falling from 5.8 per 1,000 births in 2003 down to 3.9 in 2019 (a 33% reduction).

The table below compares the number and rate of stillbirths in the countries and regions of the UK in 2019. 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 (4.6) and lowest in Northern Ireland (3.0).

London had the highest rate of stillbirths (4.4) out of the regions of England, followed by Yorkshire and the Humber (4.1) and the West Midlands (4.1). The East of England and the East Midlands had the lowest rate of stillbirths in 2019 (3.1 per 1,000 births).

Number and rate of stillbirths by country and region

United Kingdom, 2019

	Number	Rate per 1,000 births
United Kingdom	**2,763**	**3.9**
England	2,346	3.8
Wales	138	4.6
Scotland	174	3.5
Northern Ireland	67	3.0
London	541	4.4
Yorkshire and the Humber	241	4.1
West Midlands	271	4.1
North East	103	4.0
North West	315	3.9
South East	333	3.5
South West	185	3.5
East of England	220	3.3
East Midlands	162	3.3

Source: ONS Childhood and infant mortality in England & Wales, 2019

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:

> 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 Government's response to the Kirkup report, Learning not blaming (July 2015), accepted this recommendation and highlighted NHS England's 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).[2]

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

[1] The Report of the Morecambe Bay Investigation, March 2015, p188

[2] NHS England, Serious Incident Framework: Supporting learning to prevent recurrence, March 2015, p41

commitment, and called on the Government to consider how such a tool could be expanded to cover neonatal mortality,[3] 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 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.[4] The PMRT was launched in 2018 to support NHS trusts to undertake systematic reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death.

In May 2019, MBRRACE-UK introduced a new real-time data monitoring tool, incorporated into the MBRRACE-UK web-based system. The tool allows registered users of the MBRRACE-UK surveillance system to monitor, filter and summarise the perinatal deaths reported for their organisation, using live surveillance data from the MBRRACE-UK system.[5]

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 medication errors. There may be some capacity to examine cross cutting themes from these investigations.[6]

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 Health Services Safety Investigations Bill 2019 was subsequently introduced in the

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[3] This refers to a child which has died before 28 days following birth

[4] National Perinatal Epidemiology Unit, Perinatal Mortality Review Tool (last accessed 30 January 2018)

[5] PQ547, Perinatal Mortality, 24 February 2020

[6] 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

House of Lords on 15 October 2019. As a result of the dissolution of Parliament for the December 2019 general election, the Bill progressed no further than second reading stage in the Lords. Legislative provisions to establish HSIB were reintroduced under Part 4 of the Health and Care Bill on 6 July 2021.[7]

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, the then-Health Secretary, Jeremy Hunt, made a statement to the House on the Government's new strategy to improve safety in NHS maternity services. This included an announcement that from April 2018, HSIB would start investigating 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 Secretary of State noted that this new approach meant the Government had met recommendation 23 of the Kirkup report.[9]

HSIB investigations began in the South region of England in April 2018 and were rolled-out across the rest of the country by March 2019. It is for individual NHS trusts to decide on actions to take following HSIB reports, but the Government has confirmed that the Care Quality Commission can take into account trusts' responses to recommendations when carrying out inspections and monitoring.[10]

The Royal College of Pathologists responded to the November 2017 announcement by calling for all cases of stillbirth to instead be initially reported to a medical examiner, who would then decide which cases to refer to the coroner for further investigation. It argued that medical examiners were ideally placed to identify trends relating to deaths and to highlight areas for further investigation.[11] In June 2018, the Government announced the

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7 Further background can be found in section 5 of the Library briefing on the Health and Care Bill (CBP9232, 12 July 2021)

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 PQ 144996, 16 May 2018

11 Royal College of Pathologists, College response to Secretary of State's announcement, 29 November 2017

roll-out of a national network of medical examiners by April 2019, but did not set out any specific role for them in relation to investigating stillbirths.[12]

The HSIB's national review of intrapartum stillbirths during the Covid-19 pandemic was published on 15 September 2021. The review was prompted by an increase in referrals of intrapartum stillbirths to HSIB which fitted specific criteria between April and June 2020 (45 compared to 24 in the same period in 2019). The report describes how the pressures and changes arising from the pandemic may have impacted on the care received. Findings in the report suggest that many safety risks identified in the review were already known to maternity services and that these were further exacerbated by the pandemic. For example, the sustainability of staffing levels in maternity units. It also highlighted that Covid-19 created specific safety risks, including the impact of limiting face-to-face interactions and increasing remote consultations.[13]

Further background on policy in this area can be found in the Library debate packs on progress towards the national ambition to reduce baby loss (CDP 2021-128, 19 July 2021) and Black Maternal Health Week (CDP 2021-141, 10 September 2021).

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 one calling 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 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.[14]

The Welsh Government's response accepted the recommendation and said 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

[12] Department of Health and Social Care, Death certification reforms, June 2018

[13] HSIB, Report concludes review into intrapartum stillbirths during first wave of Covid-19, 15 September 2021

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

and the charity Sands, to develop 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 deaths[15]

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.

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

3 Coroners and stillbirth: current position

3.1 England and Wales

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 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.[16]

Another Library briefing paper provides further information, Coroners' investigations and inquests.[17]

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 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

[16] Coroners and Justice Act 2009 section 1(7)

[17] Number 03981, 19 February 2021

> 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.[18]

Cases where there is doubt as to whether child was stillborn

Pre-investigation inquiry

Where there is doubt about whether the child was stillborn, the coroner may conduct a pre-investigation inquiry, treating the question of stillbirth as a preliminary issue.[19]

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 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 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.[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 five inquest conclusions recorded as stillbirths in 2020 and an average of nine per year over the past 20 years.[21]

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

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

[19] Ibid paragraph 5.05

[20] Explanatory Notes to the Coroners and Justice Act 2009, para 135

[21] Source: Coroners' statistics 2020, Table 7

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.[22]

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 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 coronial investigation of stillbirth had not changed since 1887:

> ...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.[23]

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.[24]

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.[25]

[22] *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)

[23] Ibid, paragraph 43

[24] Ibid, paragraph 54

[25] Accessed 20 September 2021

3.2 Northern Ireland

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

In 2013, in a landmark decision 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.

A previous case[26] 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.[27]

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.[28]

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

[27] Attorney General for Northern Ireland and Siobhan Desmond v The Senior Coroner for Northern Ireland [2013] NICA 68 paragraph 34

[28] Accessed 20 September 2021

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, Sands, the stillbirth and neonatal death charity, issued a position statement supporting calls "to broaden the jurisdiction of the coroner so that they are able, at the request of parents, to investigate a stillbirth".[29]

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".[30]

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.[31] 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, 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' gestation. 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

[29] Sands' position statement, Coroners' inquests into stillbirths, May 2017 [accessed 20 September 2021]
[30] Ibid
[31] HC Deb 10 October 2017 cc267-300

> 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.[32]

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".[33]

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.[34]

[32] HC Deb 10 October 2017 cc282-3
[33] HC Deb 10 October 2017 c296
[34] 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 ["the 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 may not:

- create any criminal offence, or
- confer any power to make provision of a legislative character,

other than by applying (with necessary modifications), or making equivalent or similar provision to, provision already contained in Part 1 of the 2009 Act.

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, including:

- the Lord Chancellor may by regulations make provision in consequence of regulations made under Section 4;
- a statutory instrument that contains (with or without other provision) regulations that amend, repeal or revoke any provision of primary

legislation is subject to the affirmative resolution procedure, requiring the approval of both Houses of Parliament to become law.

5.2 Debate on the preceding Bill

The Act started as a Private Member's Bill introduced by Tim Loughton (Conservative) who came fifth in the Private Members' Bill ballot which took place in June 2017. In July 2017, he introduced the Civil Partnerships, Marriages and Deaths (Registration Etc.) Bill 2017-19 (the Bill).[35] Information is provided on the Bill page on the Parliament website.

Another Library briefing paper provides further information: Commons Library analysis: Civil Partnerships, Marriages and Deaths (Registration Etc.) Bill (CPB 08217).

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):

> 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

[35] HC Deb 19 July 2017 c875

> of other improvements that the Government are currently introducing, on which they are to be congratulated.[36]

Victoria Atkins, who was then a junior Home Office Minister, agreed with the need to look at the role that 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.[37]

House of Lords debate

At Committee stage in the House of Lords, Baroness Barker (Liberal Democrat) questioned the inclusion of "quite wide-ranging powers" to make regulations in Clause 4.[38] She said she shared the concerns set out in the report of the Delegated Powers and Regulatory Reform Committee.[39]

Home Office Minister, Baroness Williams of Trafford, said the power to make regulations was intended to allow for the existing framework for coronial investigations to be extended to include the investigation of stillbirths.[40]

Baroness Barker returned to this issue at Report stage when she moved a probing amendment intended to leave out Clause 4. She set out her aim in asking questions about this provision:

> 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.

36 HC Deb 2 February 2018 cc1109-10
37 HC Deb 2 February 2018 cc1124-5
38 HL Deb 1 February 2019 cc1315-16
39 House of Lords Delegated Powers and Regulatory Reform Committee, 45th Report of Session 2017–19, 29 January 2019, HL Paper 274
40 HL Deb 1 February 2019 c1316

> 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.[41]

Baroness Williams said the Government would consult:

> 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.

She 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.[42]

Baroness Barker withdrew her amendment.

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41 HL Deb 1 March 2019 cc414-5

42 HL Deb 1 March 2019 cc416

6 Government consultation

6.1 November 2017: Government statement

On 28 November 2017, in his statement to the House on the Government's new strategy to improve safety in NHS maternity services, the then-Health Secretary, Jeremy Hunt, also spoke of extending the jurisdiction of coroners. He said, 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".[43]

Shadow Health Secretary, Jonathan Ashworth, welcomed this move and said 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".[44]

6.2 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 on introducing coronial investigation of stillbirths in England and Wales.[45] He provided further information about the consultation which, he said, was a joint undertaking between the Ministry of Justice and the Department of Health and Social Care:

> 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

[43] HC Deb 28 November 2017 c179
[44] HC Deb 28 November 2017 c181
[45] HCWS1448, Consultation on coronial investigations of stillbirths, 26 March 2019

> 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.[46]

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.

The consultation paper, Consultation on coronial investigations of stillbirths and an Impact Assessment are available online.

The Government said it is 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.[47]

The consultation closed on 18 June 2019. The Government is still analysing feedback.[48]

6.3 Justice Committee recommendation

On 27 May 2021, the House of Commons Justice Committee published its report, The Coroner Service.[49] The Committee expressed disappointment that the "welcome" consultation on coronial investigation of stillbirths appeared to have stalled. It recommended that the Ministry of Justice should revive the consultation and publish proposals for reform.[50]

[46] Ibid
[47] HM Government, Consultation on coronial investigations of stillbirths, CP 16, March 2019, p5
[48] Gov.UK, Coronial investigations of stillbirths [accessed 20 September 2021]
[49] House of Commons Justice Committee, The Coroner Service, HC 68, 27 May 2021
[50] Ibid, paragraph 118

The Government's response to the Justice Committee report was published on 10 September 2021.[51] It said there had been over 300 responses to the consultation from a wide range of stakeholders, adding:

> Officials have spent time carefully considering the consultation responses, but the Government response has been delayed due to the impact of Covid-19 on work programmes.[52]

The Government accepted the Committee's recommendation and said it would publish a response as soon as possible:

> The Department of Health and Social Care have been leading on a range of initiatives to improve maternity reviews and investigations of stillbirths, neonatal and maternal deaths and brain injuries that occur during labour and birth. The Department of Health and Social Care and the Ministry of Justice plan to publish a joint response to the consultation as soon as possible.[53]

[51] House of Commons Justice Committee, The Coroner Service: Government Response to the Committee's First Report, HC 675, 10 September 2021

[52] Ibid, p10

[53] Ibid

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