CONSULTATION ON CORONIAL INVESTIGATION OF STILLBIRTHS

I am writing in confidence to let you know that, on 26 March, the Ministry of Justice and the Department of Health and Social Care will launch a consultation on introducing coronial investigations of stillbirths in England and Wales. The consultation will run for a period of 12 weeks and seek views on proposals as to whether, and if so how, stillbirths should be investigated by coroners.

The consultation flows from the commitment made by the then Secretary of State for Health on 28 November 2017, that he would work with the Ministry of Justice to consider enabling coroners to investigate stillbirths. This came as part of his announcement of the Government’s refreshed Maternity Safety Strategy, which set a national ambition to halve the rate of stillbirths by 2025.

The Government has also provided its support to a Private Members’ Bill, introduced by Tim Loughton MP, the Civil Partnerships, Marriages and Deaths (Registration Etc.) Bill. The Bill, which has now been passed, places a duty on the Secretary of State to prepare and publish a report on whether, and if so how, the law should be changed to enable or require coroners to investigate stillbirths. It also gives the Lord Chancellor the power to amend Part 1 of the Coroners and Justice Act 2009 by way of regulations to introduce coronial investigations of stillbirths.

At present, stillbirths are investigated through mainly internal processes by the NHS in England and Wales. A standardised Perinatal Mortality Review Tool was introduced in 2018 and is now used by all NHS Trusts in England and all Health Boards in Wales to review the stillbirths that occur in their maternity services. Eligible cases are also beginning to be investigated by the independent Healthcare Safety Investigation Branch. Under existing legislation, coroners can only investigate the deaths of babies who were born alive. If there is a doubt as to whether a baby was born alive or stillborn, the coroner can investigate but that investigation will cease if they determine that the baby was stillborn.

In 2016, there were 3,112 stillbirths in England and Wales, a rate of 4.4 per 1,000 total births. Whilst the annual rate of stillbirths is at a historically low level, England and Wales lag behind some other comparable countries whose stillbirth rates are lower and have been declining faster.

Parents and charities we have spoken to have called for a new system which ensures that lessons from past experiences are learnt and disseminated, so as to further improve maternity outcomes. They have
also emphasised the need for a greater guarantee of independence and a transparent investigatory process that gives parents an opportunity to hear the evidence as to what led to the stillbirth of their baby. While a variety of views exist on the best approach, the investigations of stillbirths by coroners has been identified by some as a means through which to achieve these objectives.

Our consultation aims to explore the merits of coroners investigating stillbirths and sets out proposals that we believe would help deliver the three objectives of increased learning, independence and transparency.

In developing these proposals, officials in the Ministry of Justice and the Department of Health and Social Care have met with a wide range of stakeholders including: bereaved parents; charities; the Chief Coroner and senior coroners; NHS and Healthcare Safety Investigation Branch representatives; representatives of the Royal Colleges of Obstetricians and Gynaecologists, Midwives and Pathologists; perinatal pathologists; academics; and officials in the Welsh Government.

Under the proposals outlined in this consultation, coroners would investigate all cases of a term or post-term stillbirth, that is, all stillbirths that happen from 37 weeks of gestation. These cases offer the best potential to identify the cause of the stillbirth and whether different medical care could have resulted in a different outcome.

In investigating a stillbirth, the coroner would seek to ascertain how it was that the baby was stillborn; when foetal death occurred and when the baby was delivered; where the mother was at the time foetal death occurred and where the mother was when the stillborn baby was delivered.

In addition, it would be the coroner’s duty to consider what lessons can be learned from the case being investigated that could improve the safety of, or the care provided to, pregnant women. Where lessons are identified, the coroner would make recommendations to any person or organisation who would benefit from them, or who has the authority to implement them. This presents an opportunity to identify trends which can assist in preventing avoidable stillbirths.

It is proposed that the conduct of these investigations reflects the current process for coronial investigations into deaths, including the coroner’s duty to hold an inquest, as well as the coroner’s powers to order or access evidence and to call witnesses to testify. Evidence would be available to all interested persons, including the parents of the stillborn baby.

Finally, the consultation considers the registration of stillbirths to be subject to a coronial investigation. In particular, it is proposed that registration can only take place after the coroner has concluded their investigation.

The consultation closes on 18 June and the Government will publish its response later this year. We are publicising it widely and we are keen to hear from anyone with a view on this important subject. We would welcome the views of the Justice Select Committee.

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