Law Reform Essay Competition 2023: Highly Commended

'Extending the Coroner's Jurisdiction to Stillbirths: Transparency, Accountability, and Independent Answers' by **Bryn Auger**

Introduction

Stillbirths are a heartbreaking medical tragedy still affecting modern society. Families have a simple question: what could have been done differently. Current investigation practices often fail to answer. This is because these practices lack independent scrutiny, in reality and perception, fail to be accountable, and are limited in scope. This requires intervention.

One way to achieve this is to expand the coroner's jurisdiction to allow coroners to investigate all stillbirths, including holding an inquest. The coroner has no such jurisdiction in cases of stillbirth.[1] Following concerns around consistency of investigations, feelings of mistrust, and a need for greater insight into why stillbirths happen, a 2019 government consultation proposed to expand the coroner's jurisdiction to investigate stillbirths from 37 weeks onwards, running concurrently with current investigation practices.[2] However the consultation has stalled.[3]

This essay seeks to revive those proposals by arguing for an expansion of the coroner's jurisdiction to investigate stillbirths. It shall do so by evaluating the current law, proposing several arguments in favour of reform, dismissing arguments against reform followed by proposing the style of reform.

1: Insufficiency of the law

A stillbirth is defined as a child which has issued forth from its mother after the 24th week of pregnancy which did not at any time after being completely expelled breathe or show any signs of life.[4] The question of what legal rights attach to an unborn child is an intense debate.

[1] Paul Matthews (ed), *Jervis on Coroners*, (14th Edn Sweet & Maxwell 2019), 5-04.
[2] Ministry of Justice, 'New powers to investigate stillbirths' (*Gov.uk* 26 March 2019) <https://www.gov.uk/government/news/new-powers-to-investigate-stillbirths> accessed 13 September 2023.
[3] HC Deb 11 July 2023, vol 736, col 168.
[4] Births and Deaths Registration Act 1953, s 41.

In *Attorney General's Reference (No 3 of 1994)*[5], concerning whether a person may be guilty of murdering an unborn child, the court stated the unborn have no distinct personality independent of its mother whose extinguishment gives rise to penalties at common law.[6] This position is reinforced in *Re MB*, concerning declarations of a pregnant woman refusing to have a C-section and whether the court should consider the interests of the unborn in a balancing exercise.[7] The court could not take the unborn child's interests into account because it does not have separable interests from their mother so does not possess independent legal status.[8]

The common law position establishes the coroner's position. Under section 1 of the Coroner's and Justice Act 2009, a coroner made aware of the body of a deceased person must investigate that death.[9] The duty activates if the coroner suspects that it was a violent, unknown or a death in state detention.[10]The operative word is death. As a stillborn child was never alive, it has no independent legal status. There is no legal death meaning the duty to investigate has no mechanism to attach.[11] This construction is impracticable in practice.

Smokescreen to scrutiny

The coroner's function is in establishing facts. It is non-adversarial with no cases to promote.[12] Yet, the construction creates an exculpatory loophole. If the death is classed as a stillbirth, the investigation ceases.[13] What results is a painstaking analysis to establish clear or lacking signs of life including minutiae of alveoli aeration or a pulsing umbilical cord. The construction produces adversarial interests to promote a stillbirth finding which run contrary to the spirit of coronial inquiry. It can give a subtle incentive for medical staff to record deaths as stillbirths where there are doubts of independent life.[14] This loophole was even employed by Morcombe Bay NHS Trust in one stillbirth case.[15] The construction therefore allows propagation of mistrust of hospitals purposefully covering up deaths by recording those as stillbirths.[16]

[5] *Attorney-General's Reference (No. 3 of 1994)*, [1998] AC 245.
[6] ibid 261.
[7] *Re MB (an adult: medical treatment)* [1997] 2 FLR 426, 439.
[8] ibid, 441.
[9] Coroners and Justice Act 2009, s 1(1).
[10] ibid s 1(2).
[11] HHJ Tomas Teague KC, 'Chief Coroner Guidance No 45, Stillbirth, and Live Birth Following Termination of Pregnancy' (Courts and Tribunals Judiciary 03 February 2023) https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-45-stillbirth-and-live-birth-following-termination-of-pregnancy accessed 04 September 2023, [3] – [6].
[12] Paul Matthews (ed), *Jervis on Coroners*, (14th Edn Sweet & Maxwell 2019), 1-20.
[13] HHJ Tomas Teague KC, 'Chief Coroner Guidance No 45, Stillbirth, and Live Birth Following Termination of Pregnancy' (Courts and Tribunals Judiciary 03 February 2023) https://www.judiciary.uk/guidance-and-resources/chief-coroners-guidance-no-45-stillbirth-and-live-birth-following-termination-of-pregnancy accessed 04 September 2023, [5].
[14] Dr Bill Kirkup CBE, 'The Report of the Morecambe Bay Investigation' (TSO 2015) https://assets.publishing.service.gov.uk/media/5a7f3d7240f0b62305b85efb/47487_MBI_Accessible_v0.1.pdf accessed 18 September 2023, 6.4.
[15] ibid.
[16] Investigations Team, 'NHS logging baby deaths as stillbirths 'to avoid scrutiny' *The Telegraph* (16 October 2022) https://www.telegraph.co.uk/news/2022/10/16/nhs-logging-baby-deaths-stillbirths-avoid-scrutiny/ accessed 13 September 2023.

Artificial results

It cannot be said the current construction serves the purpose of recording facts concerning the death as public interest requires.[17] The focus on establishing life on a microscopic level has no real purpose other than to satisfy the legal construction. The process is distressing for the family as their tragedy is reduced to moot medical gymnastics with no resolution or lessons learned. The artificial nature is clear in cases where survival is impossible. A baby born alive yet with a fatal congenital defect falls within the coroner's jurisdiction.[18] A stillbirth, even one where the baby could have been born alive but for different medical intervention invites no jurisdiction. This is particularly illogical in light of existing understanding that stillbirths occurring at 37 weeks would in many instances likely survive.[19] A death 2 minutes prior to delivery invites no duty whereas 2 minutes after engages the duty. Where lessons can be learned, the construction excludes inquiry.

Reflection of modern medicine

The construction is artificial because it purports that life is instant following full expulsion which is not necessarily a universal conclusion. A child has individual life force when it is no longer dependant on oxygen, blood, and intravenous feed. As highlighted in the Kirkup report, transition from life in the womb to life outside is a drastic alteration of mainly blood circulation and lungs, yet is not instantaneous on delivery.[20] Life does not start at the point of the breath of life, rather it marks the 'climax of physiological upheaval'.[21] The first breath can occur up to 60 seconds after birth.[22] Some say that life begins following the extremely rapid activation of the central nervous system following sensorial stimulation by the new environment triggering neuro-muscular activity resulting in the first breath.[23] What is clear from these conflicting views is that many events happen before the full expulsion. The strict binary approach of legal life does not reflect a more nuanced understanding.

Modern developments make little progress

In *R. (T) v West Yorkshire Senior Coroner*[24], the court held that a coroner can investigate the death of a baby who may have been born alive or stillborn without first being satisfied on the balance on probabilities that it was born alive provided that one of section 1(2) criteria is engaged.[25] This means that a coroner is not limited to determining life or death as a preliminary issue. They can hold an inquest into a

[17] Paul Matthews (ed), *Jervis on Coroners*, (14th Edn Sweet & Maxwell 2019), 1-22; *R. v South London Coroner, Ex p. Thompson* (1982) 126 SJ 625, DC.
[18] Paul Matthews (ed), *Jervis on Coroners*, (14th Edn Sweet & Maxwell 2019), 5-06.
[19] Ministry of Justice *Consultation on Coronial Investigations of Stillbirths* CP16 (2019) para [84] – [86].
[20] Dr Bill Kirkup CBE, 'The Report of the Morecambe Bay Investigation' (TSO 2015) https://assets.publishing.service.gov.uk/media/5a7f3d7240f0b62305b85efb/47487_MBI_Accessible_v0.1.pdf accessed 18 September 2023, 6.5.
[21] Daniela Polese, Marcella Fagioli, Fabio Virgilli and Paolo Fiori Nastro, 'Something must happen before first breath' (2021) BMC Medical Ethics < https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8114486/#> accessed 03 October 2023, 2.
[22] ibid, 2.
[23] ibid, 2.
[24] *R. (T) v West Yorkshire Senior Coroner* [2017] EWCA Civ 318, [2018] 2 WLR 211.
[25] ibid, [54].

possible stillbirth arguably setting a low threshold. However, this development does not go far enough to exclude reform.

First, the decision is limited to controversial cases where there is a dispute whether the child was born alive. In cases where there is no doubt that the baby was stillborn, there is no jurisdiction. Second, the court is limited determining whether the child was stillborn. In the case of baby F, a stillbirth following failed forceps delivery, the inquest was halted following conclusions that there had been a stillbirth.[26] The coroner then called for the 2019 proposals to progress as exploring the treatment would have been 'useful'.[27] Third, the impact of this development does not reflect in data. In 2021 there were 3 stillbirth inquest conclusions.[28] MBRACE's 2021 Perinatal Mortality Surveillance report recorded 2473 stillbirths.[29] Therefore 0.1% of cases post decision had an inquest. [30]

2: Arguments for Reform

Parties against reform may point to sufficient avenues of investigation to enable effective accountability into stillbirths. Two such avenues are the local level within the NHS Trust and the statutory investigation body, the Heathy Safety Investigation Bureau (HSIB). Neither option provides suitable investigation compared to coroner's jurisdiction.

Failings at Local Level

Well evidenced failures in the standard of local level investigations show why this avenue is no longer suitable. In the Morcombe Bay NHS Trust report, concerning patterns were overlooked due to failings in serious untoward incident reporting.[31] In one stillbirth, a lack of investigation lead to a failure to recognise root causes and lessons.[32] The Trust treated intrapartum stillbirths (healthy at term stillbirths considered very serious) with less concern than expected, resulting in failings to identify substandard practice.[33] As there was no alternative scrutiny, such as at an inquest, there were concerns of accountability in cases with 'less than frank' admissions.[34]

[26] 'Baby died after failed forceps delivery at Essex Hospital' BBC *News*, (17 November 2020) <https://www.bbc.co.uk/news/uk-england-essex-54965288> accessed 01 October 2023.
[27] Caroline Beasley-Murray, 'Regulation 28 Report To Prevent Future Deaths (2)' (Courts and Tribunals Judiciary) https://www.judiciary.uk/prevention-of-future-death-reports/frederick-terry/ accessed 01 October 2023.
[28] Ministry of Justice, 'Coroner's Statistics Annual 2022' (May 2023) <https://www.gov.uk/government/statistics/coroners-statistics-2022> accessed 25 September 2023.
[29] MBRACE-UK, 'MBRRACE-UK Perinatal Mortality Surveillance
UK perinatal deaths for births from 1 January 2021 to 31 December 2021 (September 2023) https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/surveillance/ accessed 25 September 2023, 2.3.
[30] 3 ÷ 2473 x 100 = 0.12131 (0.1).
[31] Dr Bill Kirkup CBE, 'The Report of the Morecambe Bay Investigation' (TSO 2015) https://assets.publishing.service.gov.uk/media/5a7f3d7240f0b62305b85efb/47487_MBI_Accessible_v0.1.pdf accessed 18 September 2023, 1.10 - 1.11.
[32] ibid, 4.22.
[33] ibid, 6.10.
[34] ibid, 6.3.

In the Shrewsbury and Telford Hospital NHS Trust report, adverse outcomes were not declared properly or were inappropriately downgraded due to the local investigation methodology.[35] This resulted in a lack of external scrutiny with the scale of failings being unknown.[36] Evidence was heard of staff criticised for having too many serious investigation reports.[37] When serious incident investigations were carried out, many were poor quality.[38] In one example, a family suffering an intrapartum stillbirth, were not involved in the investigation, nor found out the outcome for 12 months or received an apology.[39] Of 498 reviewed stillbirths, one in four had significant or major concerns which may have had a different outcome with better care.[40] From 2011-2019, 40% of those stillbirths did not have an investigation. Where an investigation occurred, only 36 % were appropriate.[41] A theme of local level investigations is that they were attempted to escape scrutiny. Many stillbirths that should have been investigated were not. There was a failure to spot patterns, learn lessons, and create a culture which may not have persisted with external scrutiny by a coroner.

Limited Statutory Solution

HSIB do provide independent investigation into stillbirths. However, they are too limited to provide substantive oversight. HSIB's terms of reference for stillbirth investigations are limited to babies at 37 weeks.[42] This covers a limited period omitting 13 weeks of cases because stillbirth is defined from 24 weeks. In 2021, there was a reduction of 3% of stillbirths from 37 weeks whereas there was an 18% increase of stillbirths between 24 - 27 weeks.[43] The gestational periods where stillbirths are increasing, needing scrutiny, are missed. Moreover, HSIB are dependent on local level referrals which itself is flawed due to evidenced local level investigation failures.[44]

Improving Accountability

Often cited by advocates for reform is the decision in *Attorney General for Northern Ireland v Senior Coroner for Northern Ireland*.[45] The decision has little assistance in providing precedent as the decision was based on the wording of section 18 of the Northern Ireland 1959 Coroners Act. On a literal interpretation, the court concluded that a coroner can carry out inquests into stillbirths as child destruction is provided as an, *inter alia,* instance activating the duty to investigate.[46] However, reported inquests

[35] Department of Health and Social Care, *Findings, Conclusions and Essential Actions from the Independent Review of Maternity services at The Shrewsbury and Telford Hospital NHS Trust* (HC 2022 1519) para 4.8.
[36] ibid, para 4.11.
[37] ibid, para 4.10.
[38] ibid, para 4.18.
[39] ibid, para 4.22.
[40] ibid, para 6.9.
[41] ibid, 6.16.
[42] Healthcare Safety Investigation Branch, 'Investigation overview for families < https://www.mnsi.org.uk/for-families/investigation-overview-for-families/> accessed 05 September 2023.
[43] MBRACE-UK, 'MBRRACE-UK Perinatal Mortality Surveillance
UK perinatal deaths for births from 1 January 2021 to 31 December 2021 (September 2023) https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/surveillance/ accessed 20 September 2023, 4.4.
[44] Healthcare Safety Investigation Branch, 'Investigation Process' https://www.mnsi.org.uk/our-investigations/investigation-process/ accessed 05 September 2023.
[45] *The Attorney General for Northern Ireland, Siobhan Desmond v The Senior Coroner for Northern Ireland* [2013] NICA 68, [2015] NI 14.
[46] ibid, [34].

following this decision act as a lens demonstrating how stillbirth inquests improve accountability.

In one such 2019 example, many lessons were learned following the inquest.[47] The mother's midwifery care was appropriate bar one non-causative failing to attend on the mother to commence monitoring promptly on admission.[48] There were failings by Doctors on call to correctly interpret a CTG resulting in an inappropriate pathway favouring natural delivery.[49] This was due to misclassification instead of poor hospital-wide training.[50] There were systemic concerns with the use of different policies and practices within different hospitals of the same Trust.[51] The coroner concluded that the baby died four hours after attendance from contracting strep B therefore the misclassifications would not have affected the outcome.[52] Had there not been an inquest, omissions in individual training may not have been highlighted and a systemic well established policy failing may have remained undiscovered. Independent scrutiny created both learning points and closure for the family. No such scrutiny would be available if the stillbirth occurred in England and Wales.

Tenants of the Coroner's Court

The coroner improves accountability due to the inquisitorial nature of the inquest process. Their function is to seek out and record a conclusion via non-adversarial fact finding. The factual analysis provides a degree of independent oversight not otherwise available. This is possible through the coroner's questions, particularly how the deceased came by their death.[53] Coroners create perceived independence. The coroner alone takes decisions, decides witnesses, and calls to what matters their evidence will be directed.[54] This is beneficial because families experiencing stillbirth, particularly following a poor experience, have lost faith in the Trust. With no formal links, the distance increases family confidence in investigations. A coroner can prepare a Report to Prevent Future Deaths which highlights concerns to reduce the risk of death in similar future circumstances.[55] It is sent to a person who can take action, the Chief Coroner, and interested persons.[56] This mechanism has far wider impact than the local level.

[47] *An Inquest Into the Death of Clara Rose Hyndman-Stewart* [2019] NICoroner 2.
[48] ibid, [8], [11], [14], [17], [22].
[49] ibid, [24] – [25].
[50] ibid [25].
[51] ibid [73].
[52] ibid [60].
[53] Paul Matthews (ed), *Jervis on Coroners*, (14th Edn Sweet & Maxwell 2019), 1-23; *R. (Maughan) v. Oxfordshire Coroner* [2019] EWCA Civ. 809, [2019] 3 WLR 365, [25].
[54] Paul Matthews (ed), *Jervis on Coroners*, (14th Edn Sweet & Maxwell 2019), 1-21.
[55] ibid, 13.124.
[56] ibid, 13-126.

3: Arguments Against Reform

Rights for the Unborn

The interplay between rights of the unborn and reform creates complexities. One may argue that reform creates an avenue to challenge existing laws on reproductive rights, such as abortion, because statute recognises an unborn child possessing independent life and legal rights by treating a stillbirth as if were a death engaging the coroner's duty. This risk jeopardises the positive intention of reform by causing unintentional damage to established reproductive rights. Statutory safeguards may prevent this.

First, the risk is mitigated through careful statutory wording. As considered in the *Northern Ireland* decision, if such an expansion was to apply to other areas then the legislature would have expressly provided for such a power.[57] Reform must emphasise the exclusivity of the stillbirth jurisdiction to stymie attempts to recognise unborn rights in other contexts. Second, the law could state that reform acts as an exception to the rule attaching the duty to formal death. Third, an explanatory note makes clear that parliament's intention is in exclusive expansion allowing investigation of stillbirths only and that no comment is intended on reproductive rights. This will mirror the Northern Ireland court who stated that expansion does not indicate a view on rights of the unborn child.[58] The proposed safeguards prevent challenges on a literal interpretation through unambiguous wording, on the mischief rule by expressing this is an exception, and on a purposive approach by providing clear explanatory notes on its purpose.

Parental Psychology

The stillbirth jurisdiction must be absolute to be effective, even if a family does not want to take part. Consequently, this removes informed choice causing further distress to those unwilling to participate.[59] Reform has ambitious objectives of rebuilding accountability across all stillbirth cases. This is necessary to ensure greater scrutiny benefitting the greatest number of families, improving the global standard of care. Perpetual societal benefits must outweigh the individual. Reform does degrade standard coronial investigative practices. In all cases, the duty engages when the criterion under section 1(2) is met. The duty is blind to the interests of others because its focus is on the deceased, but the coroner cannot intrude upon the family privacy without undue cause.[60] Intrusion is therefore limited to only where necessary. Not all stillbirths will result in a formal inquest as the cause may be resolved following

[57] *The Attorney General for Northern Ireland, Siobhan Desmond v The Senior Coroner for Northern Ireland* [2013] NICA 68, [2015] NI 14, [4].
[58] ibid, [28].
[59] Birthrights, 'Coronial investigation of stillbirths consultation: Birthrights response' (June 2019) https://www.birthrights.org.uk/wp-content/uploads/2019/06/Coronial-response-in-template-120619-FINAL.pdf accessed 17 September 2023.
[60] Paul Matthews (ed), *Jervis on Coroners*, (14th Edn Sweet & Maxwell 2019), 5-75.

preliminary investigations, as was the case in 2022.[61] The potential for undue distress is a possible but proportionate.

Creating Costs

It has been suggested that a stillbirth inquest requires at least a consultant paediatric pathologist, a post mortem and consultant obstetricians.[62] This raises a concern that reform may create a disproportionate increase to caseloads and costs however this can be dismissed. In 2021 there were 195,180 deaths reported to the coroner and 32,762 inquests.[63] In 2021, MBRACE reported 2,473 stillbirths.[64] If all 2021 stillbirths reached an inquest, there would only be a 7.5% increase.[65] The coroner's inquiry may yet be satisfied following initial investigations.

4: Reform

Location

The reform must be a new section instead of an amendment to create an exclusive investigative jurisdiction. This minimises scope for misappropriated interpretation. It must be clear that parliament's intention is to create a new investigative duty as an exception to the standard duty attaching to a death. It should fall under the 'miscellaneous' provisions of the Coroners and Justice Act 2009 to emphasise its precise use. Section 17 creates specific provisions relating to a special class, service personnel, therefore the reform should comprise a new section 17A introducing a new class: stillbirths.

Jurisdiction

The wording must be clear in expanding the jurisdiction but does not require all stillbirths to conclude by an inquest. If preliminary examination reveals the cause of death before an inquest, and the coroner thinks it is not necessary to proceed further then the coroner must discontinue.[66] The reform must make clear that the expansion confers the right to investigate and hold an inquest, if necessary, but it is not mandatory.

Week of Pregnancy

The government consultation proposed commencing the jurisdiction from 37 weeks instead of 24 weeks.[67] They consider the jurisdiction should be reserved cases where all or most negative outcomes could be avoided through better healthcare. They

[61] Ministry of Justice, 'Coroner's Statistics Annual 2022' (May 2023) <https://www.gov.uk/government/statistics/coroners-statistics-2022> accessed 25 September 2023.
[62] Andrew Haigh and Katheryn Haigh, 'Coroners' investigations of stillbirths' (2019) 394 The Lancet , 564 <https://www.thelancet.com/action/showPdf?pii=S0140-6736%2819%2931358-3?- accessed 05 September 2023.
[63] Ministry of Justice, 'Coroner's Statistics Annual 2022' (May 2023) <https://www.gov.uk/government/statistics/coroners-statistics-2022> accessed 25 September 2023.
[64] MBRACE-UK, 'MBRRACE-UK Perinatal Mortality Surveillance
UK perinatal deaths for births from 1 January 2021 to 31 December 2021 (September 2023) https://timms.le.ac.uk/mbrrace-uk-perinatal-mortality/surveillance/ accessed 21 September 2023, 4.4.
[65] 35,235 – 32,762 ÷ 32,762 x100 = 7.54837 (7.5).
[66] Paul Matthews (ed), *Jervis on Coroners*, (14th Edn Sweet & Maxwell 2019), 8-37.
[67] Ministry of Justice, 'New powers to investigate stillbirths' (*Gov.uk* 26 March 2019) https://www.gov.uk/government/news/new-powers-to-investigate-stillbirths accessed 13 September 2023.

consider that stillbirths before the 37 week mark are unlikely to be preventable and not warrant the coroner's involvement.[68] However, the jurisdiction should commence from 24 weeks. Stillbirth rates are increasing prior to 37 weeks. A 37 week remit conflicts with the legal definition of stillbirth. Reform must be insulated against future healthcare developments. It may transpire, many years post reform, that the period considered amenable to care improves. Viability from 24 weeks only is already subject to challenge.[69] To reduce stillbirths at present and in future, the jurisdiction must be from 24 weeks.

Exclusivity of Jurisdiction

The use of 'exclusive' provides a presumption that an express reference to stillbirths excludes other contexts. To ensure complete unambiguity, an explanatory note will ensure that the section holds no bearing on other questions of additional rights to an unborn foetus.

Schedule 1 & Statute Substitutions

Express deference to schedule 1, including the provision suspending investigations where there is a suspicion of a criminal offence, is required to ensure contemplated criminal proceedings are unaffected. The reform should also substitute the word 'death' for 'stillbirth' to create equal investigation standards.

The New Law

The new section should be:

Section 17A

(1) The coroner holds an exclusive jurisdiction, subject to the provisions within schedule 1 of this Act, to investigate a stillbirth.

(2) If the deceased person is one to which section 17A of this Act applies, section (1) and section (5) above shall have effect as if for the words "death" or "deceased person" there were substituted the word "stillbirth"

(3) For the purposes of this section, "investigate" means the coroner may hold an inquest.

(4) ***For the purposes of this section, "stillbirth" holds the same definition as section (41) of the Births and Death Registration Act 1953.***

[68] Ministry of Justice *Consultation on Coronial Investigations of Stillbirths* CP16 (2019) para 84.
[69] Lydia Mietta Di Stefano, Katherine Wood, Helen Mactier, Sarah Elizabeth Bathes and Dominic Wilkinson, 'Viability and threshold for treatment of extremely preterm infants: survey of UK neonatal professionals'(2021) Arch Dis Child Fetal Neonatal Ed <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8543207/> accessed 02 October 2023.

This reform will achieve transparency, accountability, and a future modern society where stillbirths are given better scrutiny through independent answers. It may even achieve the government goal of halving the rate of stillbirths by 2025.[70]

[70] Department for Health and Social Care, 'New maternity strategy to reduce the number of stillbirths' (Gov.uk 28 November 2017) <https://www.gov.uk/government/news/new-maternity-strategy-to-reduce-the-number-of-stillbirths> accessed 21 September 2023.