Bar Council response to the Ministry of Justice's consultation paper on Coronial Investigations of Stillbirths

1. This is the response of the General Council of the Bar of England and Wales (the Bar Council) to the Ministry of Justice's consultation paper on Coronial Investigations of Stillbirths.[1]

2. The Bar Council represents over 16,000 barristers in England and Wales. It promotes the Bar's high-quality specialist advocacy and advisory services; fair access to justice for all; the highest standards of ethics, equality and diversity across the profession; and the development of business opportunities for barristers at home and abroad.

3. A strong and independent Bar exists to serve the public and is crucial to the administration of justice. As specialist, independent advocates, barristers enable people to uphold their legal rights and duties, often acting on behalf of the most vulnerable members of society. The Bar makes a vital contribution to the efficient operation of criminal and civil courts. It provides a pool of talented men and women from increasingly diverse backgrounds from which a significant proportion of the judiciary is drawn, on whose independence the Rule of Law and our democratic way of life depend. The Bar Council is the Approved Regulator for the Bar of England and Wales. It discharges its regulatory functions through the independent Bar Standards Board (BSB).

4. We have used the expressions "stillbirths at term" and "term stillbirths" to refer to all term, full-term and post-term stillbirths (as set out in paragraph 87 of the consultation).

Q1. Do you think coroners should have a role in investigating stillbirths? Please provide reasons.

5. Yes.

An independent, fair and transparent investigation into how their baby came to be stillborn at term is something that most parents will welcome and find beneficial.

[1] Ministry of Justice's consultation on coronial investigations of stillbirths

6. Coronial investigations into stillbirths at term (third trimester stillbirths) have a strong potential to:

a) Reduce the number of live births of babies born with catastrophic brain injuries;
b) Reduce the number of stillbirths;
c) Reduce the psychiatric injury that parents witnessing the diagnosis of intrauterine death and/or witnessing the stillbirth of their child with no or no proper preparation often suffer;
d) Improve the care provided to pregnant women antenatally and during labour (there may be the opportunity to reduce instrumental birth injuries or third and fourth degree tears if induction of labour or caesarean section delivery result from improved care);
e) And as a result of a) to d), reduce the cost to the state of providing financial support to bereaved parents and reduce the number of clinical negligence claims and payments;
f) At an early stage, identify individuals or specific units or wards associated with a disproportionately high number of term stillbirths thereby avoiding future tragedies, loss of trust in maternity services by pregnant women and their partners and costly investigations such as the current Ockenden review into Shrewsbury and Telford Hospital NHS Trust.

7. Where widespread deficiencies in clinical care are identified by inquests, for example inadequate understanding of how to interpret CTGs, poor understanding of how induction can impact on the wellbeing of the fetus, failure by midwives to challenge doctors and so on, that evidence can inform national improvement programs.

8. In some cases, decisions made in labour (and/or speed of delivery) have the potential to alter the outcome of the pregnancy to anywhere between a term still birth, the live birth of an infant who dies within hours or a few days, lifelong catastrophic brain damage and a live, healthy baby. Of these, only the second have an inquest. Bringing term still births within the coronial process so that lessons can be reliably identified, collated centrally and implemented nationally is highly likely to reduce the number of babies born with catastrophic birth injuries and thus reduce the number of multi-million pound claims.

9. There are instances of NHS Trusts undertaking a series of untoward incident investigations into poor care at birth resulting in injury or still birth but **failing to learn the lessons**: see Shrewsbury, where there is a current independent investigation, and where there are still problems: https://www.cqc.org.uk/news/releases/cqc-publishes-inspection-report-shrewsbury-telford-hospital-nhs-trust. And the Review of maternity services at the former Cwm Taf University Health Board report,

published on 30 April 2019, evidences under reporting of serious incidents in maternity services: https://gov.wales/review-maternity-services-former-cwm-taf-university-health-board. Central collation and analysis by the relevant bodies, of the conclusions of inquests into all stillbirths at term and all resulting PFD reports will ensure that life-saving lessons are not only identified but implemented.

10. One reason why lessons are not learned is possible **conflict of interest**. The duty to undertake or arrange a Serious Untoward Investigation falls to the potential tortfeasor. The duty of candour is still not universally embraced. A coroner's inquest into every still birth at term would safeguard against under-reporting of serious incidents in connection with stillbirths and ensure a full and fearless investigation.

11. **Serious Untoward Investigations** in hospitals continue to be of a variable standard. For example written witness statements are frequently not obtained, parents are involved insufficiently or not at all (there are still instances where parents are not informed that an SUI is taking place and/or are not asked to give evidence or allowed to see and comment on the report in draft). Independent scrutiny of or quality control in relation to NHS SUIs is either lacking or inadequate.

12. Coroners' inquests into how stillbirths at term occur will provide the trained judicial, independent and public investigation that is currently lacking. If lack of resources – whether insufficient staff or operating theatres – has caused or contributed to a stillbirth, an independent coroner will be better placed to identify and record that inadequacy than the Trust responsible. (Understaffing played a part in what went wrong with maternity services at Cwm Taf Health Board).

13. Inquests into term stillbirths have the potential to benefit parents who wish to understand what happened, and why. Further, since the Trust will probably instruct lawyers to advise and represent them at inquest, the inquest process may prompt an early **apology**. It would also give the Trust the opportunity to offer and provide early **counselling**, which could reduce the parents' distress and enable a better or quicker recovery from psychiatric illness resulting from stillbirth at term which many parents experience as a catastrophic loss.

Q2. Do you consider that coronial investigations of stillbirths would achieve the policy objectives set out in paragraph 41? Are there any other policy objectives that we should consider in improving the systems for determining the causes of stillbirths and delivering better services?

14. Yes, provided the existing coronial legislative framework is appropriately adapted.

15. In relation to the wording of the objectives we suggest:

a. In the second objective, we suggest: "*to provide for transparent investigations and public* hearings"

b. In the third objective, we would invite consideration as to making the objective expressly to reduce the number of babies suffering catastrophic brain injuries at birth.

16. Other policy objectives which should be considered are to improve systems and deliver better services:

17. Coroners should be tasked specifically with stating whether the Trust or Health Board's SUI has been adequate.

Q3. Do you agree with the proposal about ascertaining who the mother of the stillborn baby is and the baby's name if they have been given one? Do you think there is anything else that should be considered?

18. Yes.

19. It should not be only the mother's name which is to be ascertained in addition to the child's. The name of the father or second legal parent, if applicable, should also be ascertained. If the mother objected to the other parent's name being recorded for good reason, coroners should have flexibility to record the mother's name only.

20. This would be consistent with the current statutory regime relating to birth certificates.

21. Transgender issues may arise and coroners should have flexibility about the language they use in such cases.

Q4. Do you agree with the proposal about ascertaining how it was that the baby was not born alive? Do you think there is anything else that should be considered?

22. The objective of improving maternity outcomes would best be met by giving coroners direction. They should be specifically asked to consider a list of commonly arising factors that have the potential to cause or contribute to a stillbirth at term (this to be identified in consultation with the relevant Royal Colleges) for example: lack of resources, lack of training, delay in acting, inadequate clinical understanding etc. That

would not preclude a conclusion for other reasons but it would assist with analysing data.

23. The focus should be on stillbirth amenable to care and improvement of maternity services. Therefore, in a case where it appears that maternal factors may have contributed to stillbirth eg obesity/anorexia, alcohol or drug abuse or smoking, great sensitivity will be required. Thought should be given as to whether the contribution made by a person's specific features is sufficiently relevant that it needs to be recorded.

24. The inquest should never cause grieving parents to feel shamed or blamed, particularly the mother who is in a unique relationship with an unborn child.

25. Coroners should be given guidance on when and how such person specific factors should be recorded. The current coronial regime is well able to leave out of account matters which have had no more than a minimal contribution to the death under investigation. Coroners should, generally speaking therefore, with guidance be well placed to manage this issue sensitively.

Q5. Do you agree with the proposal about ascertaining when fetal death occurred or was likely to have occurred and when the baby was delivered stillborn? Do you think there is anything else that should be considered?

26. Yes. Nothing to add.

Q6. Do you agree with the proposal about ascertaining where fetal death occurred or was likely to have occurred and where the stillborn baby was delivered? Do you think there is anything else that should be considered?

27. Yes. Nothing to add.

Q7. Do you agree that, as part of their findings, coroners should identify learning points and issue recommendations to the persons and bodies they consider relevant? If not, how do you think coroners should disseminate learning points?

28. Yes. In order to best achieve the policy objectives set out above, all learning points and recommendations identified and made by coroners investigating stillbirths should be sent to the Royal College of Obstetricians and Gynaecologists, NHS Resolution, NHS England, the CQC, HSIB and its successor and other relevant bodies.

Q8. Beyond identifying learning points in individual cases, do you think coroners should have a role in promoting best practice in antenatal care?

29. Probably not. The Bar Council recognises the policy objective behind the question but considers that there are others better placed than coroners who can use the outcome of the coronial investigation to promote best practice in antenatal care: see Q7. Coroners lack the resources and medical knowledge to promote best practice in any aspect of healthcare. Dissemination of their learning points to the bodies set out above would be more useful in achieving this aim.

Q9. Is there anything else you would like to see come out of a coroner's investigation into a stillbirth? What other determinations should be made?

30. There should be a determination about the Trust/Health Board's SUI. A properly undertaken, robust, thorough internal investigation where the parents have been appropriately involved should be the norm.

31. An SUI of that description will be a reliable starting point for the Coroner and will enable a shorter more focused inquest.

32. The SUI process will conclude more swiftly than the inquest. If hospital investigations continue to be inadequate then there will be a delay before lessons are learned and implemented during which further term stillbirths may occur.

33. If an NHS Trust (or other body whether NHS or otherwise) has undertaken a Serious Untoward Incident investigation that the Coroner considers has not been robust enough to enable the Trust to identify mistakes, systemic failings, failings by individuals and thereby learn lessons, or the Trust has failed to undertake an SUI in circumstances when it should have done, then the Coroner should make a separate determination to that effect and issue a PFD.

34. If SUIs by the same Trust repeatedly fail to be sufficiently robust then a separate report should be made to the Chief Coroner at the end of the year. Without separate and additional scrutiny of SUIs into term stillbirth, there will be a delay in identifying and implementing life-saving lessons and the policy objectives will not be achieved as fully as they might be otherwise.

Q10. Do you agree that no consent or permission from the bereaved parents, or anyone else, should be required for a coronial investigation into a stillbirth to be opened? Please give your reasons.

35. Yes. If coroners are to investigate stillbirths, the process should have parity with existing coronial investigations, which do not require any person's consent before they are opened. To place the burden of deciding whether or not to have the death investigated onto the bereaved parent(s) is unfair. It may also cause pragmatic

difficulties and add to the sensitives involved if, for example, there was disagreement between the parents or the mother and the wider family, as to the need for an investigation.

Q11. Do you agree that the coroner's duty to hold an inquest should apply to investigations of stillbirths? Please give your reasons.

36. Yes. See Q10. The inquest process, which usually involves the direct questioning of witnesses, is uniquely placed to support the policy objectives identified hereinabove.

Q12. Do you agree with the proposals for the links and sequencing between coronial and non-coronial investigations? Please give your reasons.

37. Yes. It is difficult to envisage a logical, workable set of links and sequences.

Q13. Do you think coroners should have the same powers in relation to evidence, documentation and witnesses in stillbirth investigations, as well as in ordering medical examinations, as they do for death investigations now? Please give your reasons.

38. Yes. The legal status of the stillborn should be considered.

39. The law of England and Wales provides that a fetus has no rights and is not a legal person. Inquests into term stillbirths that are almost identical to inquests into the deaths of those born alive have the potential to give rise to confusion and/or perceived inconsistency with the legal standing of a fetus in other jurisdictions.

40. It may be advisable to state expressly in the statutory instrument that permits inquests into babies not born alive that nothing in that instrument grants the fetus rights or alters or amends the law relating to fetuses outside the coronial system.

Q14. What, if any, other powers should coroners exercise to aid in their investigations into stillbirths?

41. No recommendations.

Q15. Do you think it is appropriate for coroners to assume legal custody of the placenta? If not, why?

42. Yes. The Bar Council agrees that treatment of the placenta is sensitive and difficult. A provision that for the purposes of the coroner's investigation only, the placenta is to be treated as part of the fetus and not the mother (even after delivery of the placenta) may be the least worst option. In that way, parents are relieved of the

burden of deciding whether to give or withhold consent and also the pain of the coroner proceeding with an examination to which they have not consented. It also means that all parents are treated the same and they know what to expect from the outset.

Q16. Do you agree that coroners should not have to obtain consent or permission from any third party in exercising their powers, except where existing rules already provide for such a requirement? Please give your reasons.

43. Yes. See Q10.

Q17. Do you agree with the proposal to investigate only full-term stillbirths, or do you think the obligation to investigate should encompass all stillbirths?

44. The Bar Council recognises that coronial investigation of stillbirths at term will be a significant extension of their obligations and that there is merit in proceeding incrementally. The Bar Council's view is that in time, the policy objectives will best be met by investigating all third trimester stillbirths.

Q18. If you answered 'no' to both parts of the question above, which group of stillbirths do you think should be investigated?

45. See Q17.

Q19. Do you agree that coroners should investigate all full-term stillbirths (i.e. all stillbirths in scope)? Or do you think a further distinction should be made within this category?

46. Yes to the first question.

Q20. Do you agree with the above proposal as to how a stillbirth should be registered when a coronial investigation has taken place?

47. Yes.

48. **Impact Assessment Questions**

49. The Bar Council has no view on many of the questions asked.

50. Achievement of the National Maternity Safety Ambition by 2025 will be facilitated by implementing the Chief Coroner's recommendation that there be a national coroner service.

Q24. Do you agree with our assumptions that: (i) the investigation of stillbirth cases is likely to be undertaken by a senior or area coroner and would be resourced by increasing the number of assistant coroners to deal with the less complex cases currently undertaken by senior or area coroners; and (ii) assistant coroners would take the same number of hours on these cases that have been redistributed as Senior/Area coroners?

51. The Bar Council does not agree that a term stillbirth inquest will be so complex, or different from any other medical/hospital death inquest, that it will inevitably require to be conducted by Senior or Area Coroner.

52. Assistant Coroners often deal with healthcare inquests involving NHS Trusts/Health Boards and expert witnesses and there is no reason to think that a stillbirth inquest will be more complicated. Some assistant coroners are practising barristers who specialise in healthcare law and are ideally suited to conduct inquests into stillbirths.

53. The Bar Council notes the proposal for specialist training. That will further promote the policy objectives since it will mean that only "ticketed" coroners can investigate stillbirths so that there will be consistency of approach to both the investigation and its conclusion and PFD reports.

Qs 26 and 28. Do you agree with our assumption that a coronial investigation of a stillbirth could require up to 6 members of NHS staff (medical consultant, junior doctor, 3 midwives/nurses and an NHS manager) to each provide up to a maximum of 7 hours of their time?

What impact do you think coronial investigations of stillbirths will have on investigations of stillbirths undertaken: a) locally; and b) by the Healthcare Safety Investigation Branch (HSIB)? Will the current investigation of stillbirths continue independently of coronial investigations or will some current activity be displaced or otherwise impacted by coronial investigation of stillbirths?

54. NHS SUIs which involve parents appropriately and in which the relevant staff are interviewed and have those interviews documented and which are robust and thorough will minimise the amount of time that staff have to spend in relation to the coronial investigation.

55. After perhaps 3 years, it will be possible to consider the interaction of NHS SUI, HSIB and coronial investigations and whether any of them can be dispensed with or reduced, safely and consistently with the policy objectives of this consultation.

Bar Council[2]
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