Response of 5 Essex Court to the consultation on coronial investigations of stillbirths

Introduction

1. This is a response on behalf of the Members of 5 Essex Court to the joint Ministry of Justice and Department of Health and Social Care consultation entitled: "Consultation on coronial investigation of stillbirths."

2. 5 Essex Court has considerable experience in inquests and coronial investigations. Chambers' Inquest Team comprises specialist practitioners with expertise encompassing all aspects and stages of inquests. We have been involved in many of the most high-profile inquests of recent years, both as counsel to Interested Persons and as counsel to the inquest. The 5 Essex Court Inquest Team is ranked in Band 1 in *Chambers and Partners* and has nine ranked individuals. As such, we believe we are in a good position to comment on some of the important and sensitive matters that are raised in this consultation paper.

Coroners' role in investigating stillbirths

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

3. The current legislative framework, set out in the Coroners and Justice Act 2009 (the '2009 Act'), is not amenable to coronial investigations in relation to stillbirths. The legal duty giving rise to a coronial investigation under s.1 of the 2009 Act is triggered upon a coroner being made aware of "the body of a deceased person" where (a) that person died a violent or unnatural death; (b) the cause of death is unknown; or (c) the deceased died while in custody or otherwise in state detention.

4. The consultation document presented to Parliament in March 2019 (the 'consultation document') recognises the tragic and profound impact a stillbirth is likely to have upon bereaved families. The rate of stillbirths in England and Wales decreased to 4.2 per 1,000 births in 2017. This is the lowest rate since records began in 1927, with a 7.7% decrease since 2016, and a 19.2% decrease in the last decade.[1] However, it is also recognised that while the stillbirth rate is at historically low levels in England and Wales, this jurisdiction continues to lag behind other countries, where stillbirth rates have fallen even further.

5. In 2015, the then Health Secretary Jeremy Hunt announced the Government's commitment to reducing stillbirths, neonatal and maternal deaths in England by 50% by 2030.[2] In our view, extending the scope of coronial investigations to encompass stillbirths would likely materially contribute to the achievement of this ambition.

6. There are a number of existing mechanisms by which the circumstances, including the quality of care, leading up to and surrounding stillbirths and neonatal deaths are investigated. For instance, the Healthcare Safety Investigation Branch (HSIB) is currently rolling out maternity investigations in England (but not in Wales) in relation to intrapartum stillbirths. NHS Trusts now have recourse to multidisciplinary reviews by reference to the Perinatal Mortality Review Tool which was launched in February 2018. However, such mechanisms are not completely independent and may not provide a satisfactory process

[1] Office for National Statistics, Births in England and Wales: 2017 (18 July 2018).
[2] See: https://www.gov.uk/government/news/new-ambition-to-halve-rate-of-stillbirths-and-infant-deaths

from the perspective of the bereaved family. In our view, coroners are likely to be better placed to carry out investigations in relation to stillbirths, with an ability to adduce sufficient evidence to establish the facts of what happened and to draw on a wide range of independent expertise and experience, in a process in which the bereaved family is an active participant.

7. We note that the position in Northern Ireland differs from that in England and Wales. In *Attorney General's Application* [2013] NICA 68, the Court of Appeal in Northern Ireland was called upon to consider the effect of s.18(1) of the Coroners Act (Northern Ireland) 1959 (the 'Northern Ireland Act)', which provides that:

> 18(1) If it appears to the coroner, either before he proceeds to hold an inquest or in the course of an inquest began with a jury, that there is reason to suspect that–
>
> (a) the deceased person came by his death by murder, manslaughter, child destruction, or infanticide…
>
> he shall instruct [the relevant police officer] to summon a sufficient number of persons of full age and capacity to attend and be sworn as jurors upon such inquest at the time and place specified by the coroner.

8. The Court noted the presence of the words "child destruction" in s.18(1)(a) of the Northern Ireland Act, which do not appear in the 2009 Act applicable in England and Wales. As a result, it was held that the term "deceased person" includes "a foetus in utero then capable of being born alive." The Court concluded that:

> "In *Rance v Mid-Downs Health Authority* [1991] 1 QB 587 it was held that the words 'a child then capable of being born alive' in the 1945 Act 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. We are satisfied that the effect of section 18 of the 1959 Act as enacted is that the Coroner can carry out an inquest into a foetus in utero falling within that definition." (at §35)

<u>Achieving the desired policy objectives</u>

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?

9. The Government's policy objectives with regard to coronial investigations of stillbirths are as follows:

- *to provide an independent assessment of the facts and causes of the stillbirth being investigated;*
- *to provide for transparent investigations which give parents an opportunity to express their views on the circumstances leading to the stillbirth of their baby and keep them engaged and informed throughout the process; and*
- *to contribute to system-wide learning about the causes of stillbirths and the circumstances leading to them, with a view to contributing to the wider health-system efforts being made to improve maternity outcomes.*

10. Provided the existing legislative framework is appropriately adapted, we consider that the Government's policy objectives are highly likely to be achieved by expanding coronial investigations to encompass stillbirths.

11. As to the first objective, coroners are independent judicial office-holders, with a specialist mandate to carry out an inquisitorial investigation of the facts and underlying causes of a death. Coronial proceedings are generally open to the public and allow for Interested Persons to ask questions of witnesses and make oral and/or written submissions on the law.

12. In relation to the second objective, the bereaved parents would automatically be granted Interested Person status by virtue of s.47 of the 2009 Act. The Government may want to consider the extent to which legal aid is made available in cases where it is most needed. The mother, and in some cases both parents, are likely to be important witnesses and the issues arising are likely to be exceptionally sensitive and distressing, and may be complex. This matter could form part of the continuing work looking into further options for the funding of legal support at inquests where the state has state-funded representation.[3]

13. As to the third objective, we see merit in establishing system-wide learning about the causes of stillbirths and efforts to contribute to wider health-efforts. However, we also recognise that systemic concerns will not arise in all stillbirths and each case will need to be assessed individually.

<u>The scope and purpose of coronial investigations</u>

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?

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?

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?

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?

14. Section 5 of the 2009 Act sets out the matters to be ascertained for the purposes of a coronial investigation:

    (1) The purpose of an investigation under this Part into a person's death is to ascertain—

    (a) <u>who</u> the deceased was;

    (b) <u>how</u>, <u>when</u> and <u>where</u> the deceased came by his or her death;

    (c) the particulars (if any) required by the 1953 Act to be registered concerning the death.

    (2) Where necessary in order to avoid a breach of any Convention rights (within the meaning of the Human Rights Act 1998 (c. 42)), the purpose mentioned in

[3] Ministry of Justice, Final Report: Review of legal aid for inquests (February 2019).

subsection (1)(b) is to be read as including the purpose of ascertaining in what circumstances the deceased came by his or her death.

15. We agree that if a new duty is placed on coroners to investigate stillbirths, responsibilities equivalent to s.5 of the 2009 Act should be established, but suitably adapted to reflect the particular circumstances of a stillbirth. Ascertaining the identity of the mother is essential to ensure that a stillborn baby can always be identified (whether directly or indirectly). We also see no reason why the identity of the father should not also be brought within scope of the "who" question, not least as the father may also wish to have Interested Person status in his own right.

16. As is recognised in the consultation document, the "when" and "where" questions may be difficult to answer if interpreted as relating to the moment when fetal death occurred, but the point at which death occurred should be ascertained as accurately as the evidence permits. A coroner must also ascertain when and where the baby was delivered stillborn.

17. Finally, the "how" question – in common with existing coronial investigations – is likely to be the most challenging. The scope of an inquest should include ascertaining why it was that the baby died before birth and whether any lessons can be learned to prevent further stillbirths, including learning points for maternity care providers and future mothers. We consider that there is no reason for amending s.7 of the 2009 Act to displace the presumption that an inquest will be held without a jury. We are mindful that medical expert evidence is likely to play an important role in coronial investigations into stillbirths. In our view, medical expert evidence of a complex and technical nature would be more amenable to analysis by a coroner sitting alone.

<u>Prevention of further deaths</u>

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?

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

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?

18. Paragraph 7 of Schedule 5 to the 2009 Act sets out the circumstances that trigger a coroner's obligation to make a Report to Prevent Future Deaths ('PFD') and the consequences of him/her doing so:

    (1) Where—

    (a) a senior coroner has been conducting an investigation under this Part into a person's death,

    (b) anything revealed by the investigation gives rise to a concern that circumstances creating a risk of other deaths will occur, or will continue to exist, in the future, and

(c) in the coroner's opinion, action should be taken to prevent the occurrence or continuation of such circumstances, or to eliminate or reduce the risk of death created by such circumstances,

the coroner must report the matter to a person who the coroner believes may have power to take such action.

(2) A person to whom a senior coroner makes a report under this paragraph must give the senior coroner a written response to it.

(3) A copy of a report under this paragraph, and of the response to it, must be sent to the Chief Coroner.[4]

19. In our view, the existing PFD regime would be an appropriate starting point to identify learning points in relation to stillbirths by reporting relevant facts to relevant persons or organisations. This regime is well known to coroners and practitioners, and has proved effective in other contexts.

20. However, coroners do not currently make "recommendations" for change. Section 5(3) of the 2009 Act provides that coroners and juries may not express a view on any matter other than those set out in s.5(1) (*i.e.* who the deceased was; how, when and where the deceased came by his or her death; and any particulars required to register the death). Bearing in mind that (i) coroners are judicial office-holders and (ii) inquests are inquisitorial in nature focusing on ascertaining the circumstances of individual deaths, it is difficult to see how the current regime would enable coroners to make recommendations. It seems to us that the most effective way in which coroners could assist in promoting best practice in antenatal care would be for any PFD Report to be provided to an appropriate national co-ordinator (person or organisation) with sufficient expertise to collate the information, learn lessons and recommend change as necessary, and disseminate the same nationally.

<u>Coroners' duty to hold an inquest</u>

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.

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

21. We agree that it would be inappropriate for coroners to be required to seek the consent or permission from bereaved parents (or anyone else) before opening a coronial investigation into a stillbirth; requiring such consent or permission is likely to be incompatible with the Government's policy objectives.

22. By the same token, if the scope of coronial investigation is expanded to encompass stillbirths, the duty on senior coroners to conduct such investigations should also be expanded accordingly. This would ensure consistency and further the Government's objectives with regard to an independent and transparent investigatory process; it would be premised on a legal duty rather than on a need to be given anyone's prior permission or consent.

[4] See also Regulation 28 of the Coroners (Investigations) Regulations 2013 and the Chief Coroner's Guidance No. 5 (https://www.judiciary.uk/wp-content/uploads/2013/09/guidance-no-5-reports-to-prevent-future-deaths.pdf)

23. We do not think it would be appropriate to leave it to coroners (or to any other individual or body) to decide for themselves which stillbirths trigger the investigative duty. There should be – as there is in relation to violent or unnatural deaths, or where the cause is unknown, or for deaths in custody – a set of clear and objective criteria, which if met trigger a duty on a senior coroner to conduct an investigation (relatedly, see the answer to questions 17-20 below). This could readily be achieved by the publication of further guidance from the Chief Coroner once the applicable amendments have been made to the legislation, if necessary.

Links and sequencing between coronial and non-coronial investigations

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

24. We agree that coroners should have the power to suspend inquests into stillbirths pending other investigations and/or the determination of criminal charges, in particular where a person is charged with an offence of child destruction. We note that such an obligation already exists by way of s.11 and Schedule 1 to the 2009 Act.

25. Internal and/or independent reviews by healthcare professionals are likely to result in reports that could materially assist an independent coronial investigation, particularly because they may identify the issues arising and gather important evidence (for example by obtaining statements from the clinicians involved). However, if an inquest is to be held it will be important that the coroner reaches findings of fact and a conclusion independently, and does not simply adopt and "rubber-stamp" the report's outcomes. It is recognised that part of the impetus for this consultation is that such non-coronial reviews are occasionally seen by bereaved parents as being of limited value or accuracy.

Coroners' powers

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.

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

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

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.

26. In our view, the existing powers of coroners set out in the 2009 Act (including Schedule 5) and the 2013 Rules and Regulations are entirely appropriate and sufficient for stillbirth investigations. We do not see the need for any additional powers, or for the need to obtain consent or permission from any third party.

27. The only exception is in relation to the placenta. We recognise that there is very likely to be a need for medical examination and testing of stillborn babies and/or the placenta for the purposes of reaching the required statutory determinations. It is not clear whether coroners are currently entitled to arrange examination of the placenta without the mother's permission (it being part of her body); if necessary, that matter would need to be addressed

as examination of the placenta may be needed to establish the cause of the death and how it came about.

28. **Extent of investigative duty**

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?

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

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?

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

29. In relation to question 17, we would answer 'no' to both parts of the question. We recognise the general desirability of coroners focusing their attention on stillbirths that are most likely to have been amenable to care (*i.e.* where the cause of death could have been avoided by the provision of higher quality healthcare). However, we are concerned about imposing a bright line requirement for 37 weeks gestation, particularly in circumstances where the calculation of a gestation period may be uncertain. Equally, we accept that extending coronial investigations to encompass all stillbirths may be too onerous on the coronial system and result in some investigations that do not warrant the involvement of a coroner.

30. We would advocate an approach whereby there is possibility for certain pre-term stillbirths to be investigated where circumstances are such that a coronial investigation is desirable. One possible approach would be to adopt a regime similar to that which exists in s.1(4) of the 2009 Act in relation to missing persons or where there has been destruction or absence of the body. Applying this approach to pre-term stillbirths, a senior coroner would have a discretionary power to prepare a report for the Chief Coroner if the circumstances of the stillbirth were such that there should be an investigation. The Chief Coroner would be empowered to direct there to be an investigation into pre-term stillbirths only upon receipt of such a report. In our view an approach along these lines would strike the right balance between (i) the need for clear and objective criteria and (ii) allowing for a coronial investigation in all appropriate cases.

31. We agree with the proposals as to registration.

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