Sands’ position statement

Coroners’ inquests into stillbirths

If a baby dies after 24 weeks of pregnancy, before or during labour, the death is classified as a stillbirth. Stillbirths are currently not covered by coronial law. Parents who have petitioned for the circumstances surrounded the death of their baby to be referred to the coroner (or procurator fiscal in Scotland) have often done so in instances where local hospital reviews were inadequate or not undertaken, and the parents’ views of events leading up to their baby’s death were not addressed. Inquests eventually ordered by individual coroners into baby deaths have revealed vital gaps in quality of care. In Northern Ireland, a landmark case led to the ruling that coroners take on stillbirths. There are coroners in England who have also investigated cases of perinatal death which would conventionally not be seen as being within their jurisdiction.

The current system of investigation when a baby dies is wholly inadequate. Parents want and deserve honest answers about why their baby died, from the hospital who cared for them. If poor care played any part, they need and should receive acknowledgement, an apology, and assurances that lessons will be learned to inform future care of mothers and babies.

This is why Sands supports calls on the Ministry of Justice to broaden the jurisdiction of the coroner so that coroners are able to investigate a stillbirth, should parents believe that the hospital’s internal review process will not adequately answer questions around their baby’s death.

However, Sands does not believe that reporting all stillbirths to a coroner/procurator fiscal would be beneficial for all parents. The process can be drawn out and complex and may not be appropriate in all cases.

A robust system of investigation (as outlined by Sands/DH Standardised Perinatal Mortality Review Task and Finish Group) identifies what might have gone wrong and what could have been done differently, is urgently needed. Sands echoes both the Morecambe Bay Investigation report and the MBRRACE-UK Perinatal Mortality Surveillance 2013 Report, calling for standardised perinatal mortality review across all units in the UK. This would apply to all baby deaths from 22 weeks gestation to 28 days of life.

QUOTE: “Sands supports calls to broaden the jurisdiction of the coroner so that they are able, at the request of parents, to investigate a stillbirth. In addition, we urge the government to fast-track vital work already underway, to roll out standardised perinatal mortality review in hospitals across the country and to ensure that this process is robust, externally peer reviewed and does what it is supposed to –identify preventable deaths and lessons to ensure mistakes are not repeated.”

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