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 surrounding 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 stillbirth cases. There are coroners in England who have also investigated cases of perinatal death which would conventionally not be seen as being within their jurisdiction.

Importantly, 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 does 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 is not appropriate in all cases.

A robust system of investigation at unit level, identifying what might have gone wrong and what could have been done differently, is urgently needed. Sands echoes NHS England's Maternity Review *Better Births* report, the Morecambe Bay Investigation report, the MBRRACE-UK Perinatal Mortality Surveillance 2014 Report and the Royal College of Obstetrics and Gynaecology's Each Baby Counts 2016 report, calling for a standardised perinatal mortality review process to be undertaken in the event of a baby's death across all units in the UK. This would apply to all baby deaths from 22 weeks gestation to 28 days of life.

Sands is part of a collaborative, commissioned by the Health Quality Improvement Programme, led by MBRRACE-UK and including the Royal College of Obstetrics and Gynaecology and the Royal College of Midwives, developing a web-based tool to support and guide local reviews. An initial version of the tool will be completed by the end of 2017. The tool will be free to maternity units and will facilitate including the parents' perspective of their care in the review process.

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. We urge units around the country to conduct a robust local review of care when any baby dies, fostering an open and honest culture, and ensuring it does what it is supposed to – identify preventable deaths and lessons to ensure mistakes are not repeated.**
We look forward to the standardised perinatal mortality review tool being rolled out in hospitals across the country at the end of the year.”

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