HM Government

Consultation on coronial investigations of stillbirths

A response by the Association of Personal Injury Lawyers

June 2019

The Association of Personal Injury Lawyers (APIL) is a not-for-profit organisation with a history of over 25 years of working to help injured people gain access to justice they need and deserve. We have over 3,500 members committed to supporting the association's aims and all of which sign up to APIL's code of conduct and consumer charter. Membership comprises mostly solicitors, along with barristers, legal executives and academics.

APIL has a long history of liaison with other stakeholders, consumer representatives, governments and devolved assemblies across the UK with a view to achieving the association's aims, which are:

- To promote full and just compensation for all types of personal injury;
- To promote and develop expertise in the practice of personal injury law;
- To promote wider redress for personal injury in the legal system;
- To campaign for improvements in personal injury law;
- To promote safety and alert the public to hazards wherever they arise;
- To provide a communication network for members.

Any enquiries in respect of this response should be addressed, in the first instance, to:

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Introduction

APIL welcomes the opportunity to respond to the Ministry of Justice's consultation on coronial investigation of stillbirths. We do not agree with the assertion at paragraph three of the foreword to the consultation that the current systems for establishing the possible causes of stillbirth are "robust". We welcome any progress in the improvement of the investigation of stillbirths, and greater transparency in investigations.

Executive Summary

- APIL welcomes the proposal to introduce coronial investigation of stillbirths. The distinction between stillbirths and neo-natal deaths is artificial, and it is often a matter of only minutes between a death being recorded as a still birth or a neo-natal death.
- Families must be fully informed and be able to engage with the coroner's investigation. We reiterate our earlier response to the Ministry of Justice consultation on the need for non means tested legal aid for bereaved families at inquests. Consent from the parents should not be the basis on which it is determined whether an inquest takes place.
- In order to ensure that lessons are learned, there should be oversight of the coroner's duty to produce Prevention of Future Deaths reports. This oversight would ensure that coroners produce PFDs when necessary, and there should be central collation of these PFD reports, so that harmful trends can be identified and addressed at the earliest opportunity.
- Coronial investigations must be completely independent of the hospital's own investigations. The coroner should not be required to wait until the hospital investigation has concluded, and the coroner should not "draw heavily" from the hospital's report, as suggested at paragraph 64 of the consultation. Simply rubber stamping the hospital's report may render the inquest meaningless.
- We acknowledge that there are limited resources, therefore the proposal to introduce coronial inquests currently only extends to full-term still births. However, if the ultimate goal is to reduce stillbirths, coronial investigations must take place whenever there is a death within the definition of a stillbirth, not only when there is a full-term stillbirth. We accept inquests into full-term still births as a starting point, but call for a commitment from the government to extend the proposals to all still-births when resources allow.

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

As the consultation sets out, the stillbirth rate in England and Wales is still too high when looking at the rates of other comparable countries. Despite a decrease in stillbirths between 2016 and 2017, there were still almost 3,000 stillbirths in England and Wales in 2017. There needs to be improvement in the way that stillbirths are investigated, in order to understand why they are happening and so that lessons can be learnt for the future. The coronial system is the logical choice to carry out these investigations, given that it is already an established system to investigate deaths. Coroners should also carry out inquests into stillbirths, as the current distinction between stillbirths and neo-natal deaths is completely artificial. Regardless of whether the baby was stillborn, or was born alive but only lived for a short time, the parents deserve to know what happened, and why their baby did not survive. Yet, whether the baby was born alive is currently the deciding factor about whether the parents can access this important investigation.

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?

The language throughout the consultation document, and particularly at paragraph 41 leans towards treating the family as bystanders, rather than them being actively involved and engaged with the inquest. The second policy objective is 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." This is very passive language, giving the impression that the family will be engaged in name, but kept at arms-length. There should be a stated aim to ensure that the family are actively engaged with the investigation process, should they wish to do so. It is important that the family is listened to, and their views are taken into account.

It is vital that the bereaved parents have access to legal aid to fund representation at inquests, to ensure that they can be fully engaged. The experience of our members' clients has been that where the family does not have legal representation, the family may be present at the inquest, but they are not able to properly engage, as they simply do not know how to, and the inquest is ultimately a whitewash. It must also be remembered that the bereaved parents will be important witnesses to what happened, they have important information and evidence that should be taken into account, so should not be treated as a separate category of people who are simply given an opportunity to "express views".

We believe that the policy objective of providing an independent assessment of the facts and causes of the stillbirth being investigated is extremely important, and would be delivered throughout coronial investigations, provided that the family is fully involved. Currently, Serious Untoward Incident reports (SUI reports) into stillbirths are not an independent assessment. Families are often not even told that these investigations are taking place, and have no opportunity to feed in to the findings. Often, the first time that the family is aware that an investigation has taken place is when they are presented with a copy of the completed report.

The inquiries into the failings in care at Morecombe Bay (the Kirkup Report), Shrewsbury and Telford NHS Trust and Cwm Taf all identified that despite numerous serious untoward investigations failings were not identified at the earliest opportunities and as a result additional avoidable deaths occurred. These inquiries confirm that internal investigations are <u>not</u> the route to identifying repeated failures and placing strategies in place to avoid them in the future.

If the involvement of coroners does begin to make a difference in the occurrence of stillbirths, we recommend that coroners' findings should also be included within the MBRRace-UK information, to give the findings more depth.

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?

We agree that who the mother is should be ascertained, as should the identity of the father.

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?

“Future parents” should be referred to, instead of “future mothers”. Additionally, there should be learning points not just for maternity care providers at the particular trust in question, but for those whose responsibility it is to create overarching guidelines and policies, and decide funding in this area.

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?

We agree.

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?

We agree.

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?

We strongly agree that coroners should identify learning points and issue recommendations to the relevant persons/bodies. This is vital to ensure that lessons can be learnt from stillbirths, so that ultimately, the number of stillbirths can be reduced. We believe that in order to ensure there is effective dissemination and consistency, there should be broad oversight of this function by another body, rather than leaving the decision of whether to disseminate learning points solely to the coroner. In order for there to be truly effective dissemination of learning points, this other body – as yet to be identified – should be able to hold the coroner to account and ensure that information is distributed as and when necessary. It is a duty, rather than a choice, for the coroner to report to any person who is able to take action to prevent future deaths whenever their investigation raises concerns that circumstances exist that put other lives at risk, and coroners must be held to account that they are complying with this duty.

There is a wider issue in the current coronial system that Prevention of Future Death (PFD) reports are not used in any joined-up fashion at present. There must be consideration as to how the PFD system can be harnessed in a more consistent and nationwide approach. In particular for stillbirths, we recommend that PFDs should be collated annually and a trend report produced, to identify the key problem areas that need to be focused on the following year. We suggest that PFDs could be reported to MBRRace-UK for this report to be produced.

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

Yes. Please see response to Q7.

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?

It is important that the coroner’s investigation is a platform for lessons to be learnt and future stillbirths prevented.

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.

We agree that the decision to open a coronial investigation into a stillbirth should not be based on the consent of the bereaved parents or others. Given the choice at such an emotional time, the parents may want to distance themselves from their traumatic experience, and may refuse permission for an inquest to go ahead. Several months later, they may regret this decision, and wish that there had been a full investigation into what had happened. All efforts should be made to involve the parents in the process, and they should be fully informed in relation to what is going to happen. Parents should be talked through the process and provided with fact sheets perhaps, and signposted to people who can help them understand what is going to happen – but they should not be expected to make a decision as to whether an inquest should go ahead. There must be particular consideration and discussion with the bereaved parents, for example, to explain how an inquest may clash with religious requirements of a prompt burial. The parents can have the choice as to whether to attend the inquest, and can choose to distance themselves if they feel this is the right thing to do.

If the decision were left to the bereaved parents, there may also be a risk that the treating hospital or others would look to prevent or advise the bereaved parents not to proceed with the inquest.

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

Yes. Currently for neonatal deaths the Coroner has a duty to investigate an unnatural death. The same duty should apply for stillbirths. There should be no discretion as to whether a stillbirth is reportable to the coroner.

In order for inquests into stillbirths to be effective, the coroner must have the same duties in relation to stillbirth inquests as they do for other inquests.

Q12) Do you agree with the proposals for the links and sequencing between coronial and non-coronial investigations

We agree that criminal investigations should go ahead before coronial investigations. However, we disagree with the assertion at paragraph 64 that coroners' investigations could "draw heavily on the reports and findings of those done by the NHS and HSIB". The coroner should conduct their own investigation. There is a risk that they may simply rubber stamp the serious untoward incident report, if they are encouraged to draw heavily on the findings of the NHS and HSIB, rendering the inquest a whitewash. This would allow a repeat of the failures at Morecombe Bay, Shrewsbury and Cwm Taf. Further, the investigations of the NHS and HSIB tend to highlight what happened, rather than why it happened. Coroners must carry out their own investigations to determine why the death happened. This should involve a full and fearless investigation of the facts upon which to draw a conclusion. The Coroner has wider powers of disclosure and ability to call witness evidence.

We suggest that the coronial investigation could take place before, or in tandem with, the NHS and HSIB investigations. There is no need for the inquest to wait for the NHS to complete its investigations, and if coroner investigations are completed before the NHS's own investigation, the findings of the coroner could be fed back into the NHS's report as learning points for the future.

The coroners cover geographical locations will be able to identify patterns and, if necessary, issue PFD reports and potentially share these with other bodies in the NHS such as Clinical Commissioning Groups or Royal Colleges. It would be valuable for coroners to be able to issue PFD reports as a matter of urgency, should they deem it appropriate – for example if the coroner has concerns that there is a systemic issue, and urgent steps are required to prevent further loss of life at the hospital in question.

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

We believe coroners should have the same powers that they do in relation to death investigations now.

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

Generally, in our members' experience the coroner's powers under the Coroners and Justice Act 2009, that the coroner is unable to summon a witness from outside of the jurisdiction has proven to be problematic. We suggest that there should be a general review of the scope of the coroner's powers under the 2009 Act.

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

We agree that the placenta holds valuable information that would be useful in determining the cause of the stillbirth. However, this is a difficult legal area as the placenta is a body part of the mother. The coroner will need the permission of the mother before taking custody of the placenta.

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.

We agree.

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?

The coroner should investigate all stillbirths, not only those that are full-term. The logical approach, if the aim is to reduce the number of stillbirths that occur, should be to allow for coronial inquests into all deaths which fit the existing definition of stillbirth. If only full-term stillbirths are investigated, mistakes made earlier on in pregnancy may not be brought to light. Deaths occurring because, for example, twin to twin transfusion syndrome has been missed on a scan are equally worthy of investigation by the coroner.

We acknowledge the limited resources available, however, and understand the decision not to extend the duty to all stillbirths. We note that the number of full and post term still births is around 800, whereas if all stillbirths were investigated, this figure would be closer to 3,000. We suggest that perhaps the starting point should be for coroners to investigate only full-term stillbirths, but call for the government to make a commitment to extend the proposals to all stillbirths when resources allow. The starting point should be at the time a fetus is viable.

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?

We believe that all stillbirths should be investigated by a coroner.

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

We agree. If the decision is made to extend the proposals to stillbirths from 24 weeks, the proposals here need to be amended in light of this.

Q22) Do you agree with the assumption that the inquest in approximately 20 per cent of stillbirth investigations could be conducted solely on the basis of written evidence (this is sometimes referred to as a documentary inquest) and approximately 80 per cent would require witnesses to attend and give oral evidence? If not, please explain why, preferably with supporting evidence.

We question how this assumption was arrived at. The coroner has the power to instruct independent expert evidence which could narrow the issues and time taken to hear evidence.

Q25) We would welcome views on the assumption in the impact assessment that the average cost of a documentary inquest is £400, and the average cost of a full inquest is £3,000 (including coroner costs, investigating officer costs, witness costs and court building costs).

The financial costs for the family should be taken into account. Representation at inquests is vitally important, to ensure that families can fully engage with the process. APIL continues to call for non-means tested legal aid to be available to all bereaved families at inquests. Hospitals are invariably fully represented, at the cost of the taxpayer, and it is highly unjust to expect the bereaved family to represent themselves in the inquest of their loved one.

Q28) 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?

We hope that local investigations would be improved, and would be more open and transparent, given that the hospitals will know that a coroner will also be looking at what has happened. We suggest that current investigations of stillbirths could be carried out in tandem with the coroner's inquest. The two investigations could complement each other to ensure that the bereaved family is kept fully informed, and can actively engage with the investigation if they wish to do so, and that ultimately, lessons are learnt and the number of stillbirths are reduced. We consider it is too early to consider what impact HSIB will have on maternity investigations. There is no commitment to the length of time that HSIB will have responsibility for the investigation of stillbirths – this is concerning.[1]

Q29) Do you think the proposals in chapters 1 to 6 may have any further impact on a group with a protected characteristic? If so, please explain what these impacts would be and which groups could be affected.

[1] Maternity Services: Safety: Written Question 253439, 13 May 2019

By not basing the decision as to whether an inquest goes ahead on whether the family raises a complaint, this could be beneficial to those from certain cultures who are less likely to raise complaints if something has gone wrong. They may not wish to complain or attempt to bring a claim against the hospital for what has happened, but an inquest will ensure that they are provided with answers as to what happened to their baby.

Women who are more disadvantaged in society are at greater risk of stillbirth, according to a 2018 study[2]. At the same time, these women may be less likely to engage with a hospital's internal investigation, for a variety of reasons. Inquests, if carried out properly and ensuring that the family is fully informed and can actively engage with the investigation, will be of benefit to these groups of people.

[2] Women residents in areas of greatest social deprivation in the United Kingdom are more than 50% more likely to have a stillbirth compared with women residents in areas of greatest affluence with rates of 5.05 and 3.00 per 1000 births, respectively
https://onlinelibrary.wiley.com/doi/full/10.1111/birt.12335