



College response to consultation on coronial investigations of stillbirths

Background

This is a response from the Royal College of Pathologists to a consultation published on 26 March 2019 by the Ministry of Justice and Department of Health and Social Care. The consultation sought views on proposals for [introducing coronial investigations of stillbirth cases](#) in England and Wales.

The response has been compiled with expert advice from:

- Dr Jo McPartland, Chair of RCPATH Pre/Perinatal/Paediatric Pathology Specialty Advisory Committee
- Dr Mike Osborn, Chair of RCPATH Cellular Pathology Specialty Advisory Committee and Death Investigation Group
- Dr Suzy Lishman, Chair of the Medical Examiners Committee.

Pathology specialties

- Cellular pathology
- Medical examiners
- Paediatric pathology

College responses to main consultation questions (Q1–Q20)

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

We already have a national standardised Perinatal Mortality Review Tool (PMRT) to support reviews across all NHS maternity and neonatal units in England, Scotland and Wales, which will include all stillbirths. In addition, the Healthcare Safety Investigation Branch (HSIB) has proposed investigating all intrapartum term stillbirths. Therefore, careful consideration needs to be given to how these concurrent reviews and a proposed coronial investigation would run alongside and interact with each other, given their often differing timescales. There is a risk of ‘triplcating’ the effort and time of NHS professionals, should a third, coronial process be introduced. Having three separate review systems looking at each case – all publicly funded – appears disjointed, inefficient and not cost-effective.

However, the current situation – where early neonatal deaths soon after birth are subject to coronial investigation, whereas intrapartum stillbirths (occurring possibly only a few minutes earlier) are not – leads to inequity in investigation of perinatal deaths, which often have similar underlying causes.

Coronial investigation of stillbirths may help to identify failings in antepartum or intrapartum care, in the same way that PMRT and HSIB reviews reveal such failings. It is most likely that serious failings of care will be identified in fresh intrapartum stillbirths rather than macerated stillbirths, in which the baby has died some time prior to stillbirth being diagnosed.

If coronial investigation of stillbirths were introduced, to determine which stillbirths should be investigated, it would be useful if the scope of medical examiners (MEs) were expanded to include stillbirths. There could be specifically trained regional MEs who could review stillbirth cases and refer those deemed appropriate for coronial investigation. However, it will be important to ensure that there are enough medical examiners in post with adequate resources to be able to take on this additional role.

The 2015 Report of the Morecambe Bay Investigation by Dr Bill Kirkup recommended that the role of medical examiners should be extended to stillbirths as well as neonatal deaths.

A significant benefit of a coronial investigation from a pathological point of view would be that if autopsy were mandated, the autopsy rate would increase markedly, particularly in areas where there is a low consent rate for hospital autopsies (often on religious grounds). Autopsy in stillbirth often adds useful information to aid the review process. However, it should be remembered that mandated autopsy could be very distressing for some parents.



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?

Coronial investigation, with initial scrutiny by MEs as recommended, could achieve these objectives. However, as discussed, how the coronial investigation will interact with PMRT and HSIB reviews needs to be carefully considered.

Parents may feel that a coronial process is more independent as it is separate from the NHS. Depending upon the coronial district and staffing levels in the coroner's office, appropriate resources for keeping parents engaged and informed may be variable.

For coronial investigations to contribute to system-wide learning, a process for national review of coronial stillbirth findings and dissemination of learning would need to be introduced (see response to Q7 below).

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?

If the case is referred to the coroner, they should have the responsibility of confirming the identification of the mother and the baby's name (if they have one) as they do now: i.e. they confirm the identity of the deceased in current death investigations.

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?

Based on a review of clinical and pathological factors, the coroner could attempt to ascertain the cause of stillbirth. There is often a complex interplay of maternal, fetal and placental factors in addition to obstetric/midwifery care to be considered. In some cases, even after full investigation, the stillbirth may remain unexplained.

The current death certificate format is therefore considered unsuitable for use in stillbirths, and would need to be reviewed.

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?

Exact time of death cannot be determined accurately by autopsy examination in stillbirth. The coroner may be able to estimate time of death in utero if the death occurred during clinical monitoring in labour. However, in many cases this will not be possible, and time of birth may be a more appropriate recordable timepoint.



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

As the exact time and date of stillbirth cannot be determined in many cases, it will not always be possible to state the exact location of the mother at the time fetal death occurred. Therefore, location of birth would be more appropriate to record.

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?

Yes. There are a number of organisations to which this information should be reported, including NHS trusts and boards (maternity services in particular), the independent Health Safety Investigation Branch, the National Medical Examiner and regional medical examiners (when they arrive in post).

We recommend that all information from coronial cases should be coordinated centrally and disseminated to all relevant organisations. It would be for the Department of Health and Social Care to determine the process for this and ensure clear reporting lines. This information would be likely to fall into two categories: how the overall service is being provided and day-to-day service delivery improvements.

As inquests are public enquiries, parents would be able to obtain a copy of the post-mortem report and any depositions taken during the inquest, including a copy of the verdict. These official reports are only available after the inquest has concluded. There is a small fee for these documents. Inquest papers are not available prior to the inquest being held.

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

This is not primarily the role of coroners, although they should flag learning points. Best practice should be promoted by organisations including the Department of Health and Social Care, NICE, the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, who currently 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?

No. Determining lessons learnt is the most relevant outcome, alongside ensuring these are disseminated effectively.



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.

There should be uniformity of approach that aligns with other coronial investigations. The precedent is that there is no consent required for coronial investigations into adult or neonatal deaths. While coronial post-mortem examination of a stillborn baby would have to be handled very sensitively and with the utmost care for families, the risk is that if a parent or parents had to give consent, this could hamper the determination of the cause of stillbirth. In turn, this could affect the opportunity to learn lessons from a stillbirth. However, discussion between the coroner and the paediatric pathologist may be able to limit the extent of autopsy in some cases.

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

The majority of stillbirths will be due to natural causes. However, in some cases, issues with antepartum or intrapartum care may have been contributory to death. An inquest would be able to review the pathological findings and the obstetric and midwifery care and gather information from a range of organisations. Parents would also have an opportunity to give evidence, and they may find this valuable if they have concerns. However, whether a coronial inquest adds greater value than other modes of review (i.e. PMRT or HSIB) is debatable. A mother's personal and potentially sensitive medical details would be revealed during the inquest into a stillbirth.

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

Yes, the system should be similar to investigations into neonatal deaths. We agree with the proposal for links and sequencing between coronial and non-coronial investigations. For example, root cause investigations undertaken by trusts and other bodies should inform the coroner's investigation, but it is important to be mindful of the importance of minimising delays for parents.

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.

Yes, the same criteria should apply to stillbirth investigations. Otherwise this will not be a full coronial investigation.

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

The coroner should have the power to seize the placenta. The coroner will also need access to both maternal and paternal medical records which may pertain to the death of the indications of genetic issues, for example.



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

Yes. The placenta is key to any investigation and provides important information which could help determine the cause of the stillbirth. Placental examination is an integral part of the perinatal autopsy.

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.

Yes, as is the case for current coronial investigations. This will help to ensure independence.

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?

No. Including all stillbirths over 37 weeks' gestation may not be the best way of defining cases to be investigated. It is most likely that serious failings of care will be identified in fresh intrapartum stillbirths rather than macerated stillbirths, in which the baby has died some time prior to stillbirth being diagnosed. It would be more logical to investigate all intrapartum stillbirths in which the baby would have been expected to survive. For example, this could include gestations above 34 weeks but exclude any babies with known congenital abnormalities that would be expected to result in a high risk of death. Medical examiners could make this distinction after reviewing the case history.

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

- All intrapartum deaths in which the baby would have been expected to survive. A gestational cut-off is difficult to define, and medical examiners could select appropriate cases.
- Cases where a placenta is found but is not identified.
- In cases of possible child destruction, police should investigate first, but the coroner should still have jurisdiction.
- If pregnancy is a result of criminal action such as rape or human trafficking, and where there is a stillbirth, consideration should be given as to whether all of these cases should fall under the investigation of the coroner, even if not intrapartum.

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 recommend that investigating stillbirths be added to the remit of medical examiners, who would then make an initial assessment of a stillbirth death in the same way that they do for adult deaths. MEs would refer only those stillbirths they think need further investigation. Coronial investigation of full-term macerated stillbirths is less likely to reveal acute failings in care than investigation of intrapartum stillbirths. However, review of antepartum stillbirths may reveal failings in wider antenatal care.



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

The four flow charts in the proposal all include term gestations only. As indicated in the response to Q18 above, this will exclude some intrapartum deaths at near-term gestations where survival was expected, and there could be failings in intrapartum care.

As suggested in the response to Q19, we would suggest modifying the gestational age to earlier in the pregnancy, and adding in the ME to the flow charts for different scenarios, to triage the cases and refer a proportion of them on to the coroner.

The process whereby a Certificate of the Fact of Stillbirth is provided prior to completion of the inquest and formal registration of the stillbirth seems appropriate.

College response to questions on the Impact Assessment (IA) (Q21–Q28)

Proportion of investigations requiring a post-mortem examination and the cost of a post-mortem examination

Q21.1 (IA): Do you agree with the assumption that the majority of stillbirth investigations would require a post-mortem examination (in the IA we have used an upper bound estimate of 100%)? If not, please explain why, preferably with supporting evidence.

The medical examiner could decide which cases are referred to the coroner, and the coroner then determines which cases proceed to autopsy. For parity with neonatal death investigations, an autopsy would then be requested in most cases. However, the coroner may wish to discuss cases with a paediatric pathologist to determine the extent of the autopsy, as happens now for many paediatric cases, especially where there are strong parental objections to autopsy on religious/cultural grounds.

Q21.2 (IA): We have also assumed that an upper bound estimate of the cost* of a post-mortem examination for a stillbirth is £2,000. We recognise that this varies by region and so would appreciate views on this, and particularly any evidence on the average cost of a stillbirth post-mortem examination in your region.

* Please note that this is the average cost of undertaking a post-mortem rather than the 'price' of a post-mortem – i.e. it's the costs borne by the supplier of post-mortems, not the costs recovered from or paid by commissioners of post-mortems.

This appears to be approximately the cost suggested by many paediatric pathology units, taking into account the time of pathologist, mortuary staff, biomedical scientists and administrative staff, in addition to the use of facilities. Some suggest the true cost may in fact be higher, especially when the time required for pathologists to attend inquests is taken into account, as this may create a full day of back-fill for NHS work in some cases.



Documentary and full inquest

Q22 (IA): Do you agree with the assumption that the inquest in approximately 20% 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% would require witnesses to attend and give oral evidence? If not, please explain why, preferably with supporting evidence.

Yes.

Average time needed by coroners to complete a stillbirth case

Q23 (IA): Do you agree with our assumption that a stillbirth case is complex in nature and would require around 4 hours of coroner's time and around 15 hours of coroner's officer time to review the case (excluding time spent at the inquest)? If not, please explain why, preferably with supporting evidence.

This would appear to be a low estimate as the medical evidence is complex; advice should be sought from the coroners' service.

Q24 (IA): 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?**

This would need to be answered by coroners; we would expect that coroners investigating these cases would need to specialise in them. Respectful and compassionate transport arrangements must be made which are appropriate for stillbirths and placentas, particularly if the stillbirth happens away from home.

Average cost of inquest

Q25 (IA): We would welcome views on the assumption in the IA 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).

This would need to be answered by coroners.



Maximum level of NHS staff involvement

Q26 (IA): 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?

This appears to be unrealistic and is likely to be a significant underestimate. We would suggest modelling cases studies to better understand the number and range of experts who would need to be involved and the time required by each to participate.

Paediatric and perinatal pathology

Q27.1 (IA): Do you agree with our assumption that 1 full-time equivalent (FTE) perinatal pathologist is capable of undertaking between 100 and 200 stillbirth post-mortem examinations a year whereby if coronial investigations of stillbirths result in an additional 450 post-mortem examinations per year, this implies between 2.25 and 4.5 additional FTE perinatal pathologists would be required to meet the anticipated additional workload? If not, please explain why, preferably with supporting evidence.

No, this is an underestimate. A paediatric pathologist undertaking solely perinatal work would usually find that a caseload of up to 150 perinatal autopsies, alongside some placental reporting, attendance at multidisciplinary meetings and supporting professional activities, would be a maximum. Coronial stillbirth cases will be much more complex than an average hospital perinatal autopsy, and would take substantially more time.

A full-time forensic pathologist should carry out a maximum of 95 cases a year. This figure is likely to be more realistic, as the extensive medical evidence to be reviewed and complexity of the autopsy would be more akin to a forensic autopsy.

There are 59 consultant paediatric pathology consultant posts in the UK with an additional 17 posts which are currently vacant. There are also at least seven retirements anticipated in the next five years. The number of current trainees is insufficient to fill these vacancies. Therefore, to cope with any increase in demand, a rapid and significant increase in consultant numbers would be needed. Increased numbers of consultants would be needed in several different units. Currently, we do not see how additional demand for coronial stillbirth post mortem examinations could be met. Recruitment and retention salary premiums may need to be paid. In addition, additional training posts should be funded to ensure succession planning for consultant positions.

Consideration also needs to be given to which other staff groups need to be involved and their existing capacity and workload. This would involve biomedical scientists, radiologists, anatomical pathology technologists and secretarial staff. Additional testing may also be needed by other medical specialties, such as genetics, toxicology or microbiology. Allowance would need to be made for costs to increase in line with inflation.

We would draw attention to the current widespread problems in performing post mortems for adults. Because remuneration is too low and significantly underestimates the time and skill involved, coroners are facing problems in finding histopathologists who will take on these post mortems. We anticipate similar problems with any introduction of coronial stillbirth autopsies unless



remuneration is set at an appropriate level: because remuneration is too low, coroners would face problems in finding histopathologists who would take on these additional post mortems.

Q27.2 (IA): What percentage of the additional stillbirth post-mortem examinations that may be requested in your region would there be a capacity and willingness to complete?

Capacity to undertake additional stillbirth post mortem examinations will vary from centre to centre. Those staffed with single handed paediatric pathologists may not be able to take on any additional work. Some centres currently do not offer a coronial post mortem service, and would not be able to take on coronial stillbirth cases. Coronial work is discretionary (and not part of the NHS contract) and therefore whether pathologists elect to take this work on will depend on remuneration and arrangements with their Trust to carry out the work.

Current pension tax issues, which are well known, mean that consultants are limiting the number of hours they work, reducing overtime and retiring early. This is likely to continue and increase unless the pension tax rules are changed.

Q27.3 (IA): If your answer to question 27.2 is not 100%, what alternative funding arrangements do you think would be required to support the increased demand for post-mortem examinations of term stillbirths?

We recommend that this work become part of pathologists' NHS contracts with additional central direct funding to cover costs. We think consideration should be given to establishing a national service to undertake post-mortem examinations of stillborn babies, with NHSE developing a Perinatal Pathology Group to develop expertise.

Existing investigations of stillbirths

Q28 (IA): 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?

Local trust investigations are likely to carry on in the same way, as long as the coronial process does not interfere with availability of medical notes for local review processes. Information should be shared with the HSIB. Development of HSIB appears to be at an early stage, and therefore it is difficult to comment upon how it will operate.



Equalities

Q29 (IA). 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.

Some groups customarily seek to bury the deceased more quickly for religious or cultural reasons. This was a concern with the introduction of medical examiners but evidence has shown that with sensitivity and clear explanations, delays have been minimised and people have understood when bodies cannot be released rapidly for burial.

There is also a risk that if post-mortem examinations are not carried out, opportunities to identify risks (such as failure to identify inherited diseases) or to learn lessons will be lost.

Where a post-mortem examination has been mandated by the coroner, there have been requests from some religious groups who object to conventional post mortems for imaging post mortems via CT or MRI scanning. However, these would be unlikely to add additional information in many stillbirth cases, as histology of fetal tissues is often very helpful in identifying contributory factors to stillbirth, in addition to placental examination.

Hospital autopsies are not limited in scope, and may include a range of investigations pertinent to aspects relevant for the family, such as genetic conditions. Some coroners may limit the scope of ancillary investigations once they are satisfied that a cause of death is natural. However, this may lead to incomplete results and inferior quality of coronial stillbirth autopsies when compared with hospital autopsies.



Contact details

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About the Royal College of Pathologists

The Royal College of Pathologists is the lead medical royal college for medical examiners.

The Royal College of Pathologists is a professional membership organisation with more than 11,000 fellows, affiliates and trainees, of which 23% are based outside of the UK. We are committed to setting and maintaining professional standards and promoting excellence in the teaching and practice of pathology, for the benefit of patients.

Our members include medically and veterinary qualified pathologists and clinical scientists in 17 different specialties, including cellular pathology, haematology, clinical biochemistry, medical microbiology and veterinary pathology.

The College works with pathologists at every stage of their career. We set curricula, organise training and run exams, publish clinical guidelines and best practice recommendations and provide continuing professional development. We engage with a wide range of stakeholders to improve awareness and understanding of pathology and the vital role it plays in everybody's healthcare. Working with members, we run programmes to inspire the next generation to study science and join the profession.

