

Ref: Progress regarding Section 4 of the Civil Partnerships,
Marriages and Deaths (Registration etc) Act 2019

The Rt Hon David Lammy MP
Secretary of State for Justice



30th September 2025

Dear Secretary of State,

We write to you as parents of babies who were born without taking a breath or showing signs of independent life. It is important to note that, for some of us, there remains dispute over whether our children did in fact show signs of life at birth, disputes that have never been independently resolved. We introduce ourselves in this way because many bereaved parents find the legally defined term stillbirth to be an inaccurate and dehumanising description, one that contributes to a culture in which our children are not recognised as people in their own right.

Among us are also families whose babies took a first breath but died shortly afterwards. They recognise that it is only by chance their children survived birth long enough to be classified as neonatal deaths rather than stillbirths, and that, in truth, our experiences and the failures that led to them are shared. Perversely, the current system creates a cruel inconsistency whereby a baby who lives briefly after birth is afforded coronial oversight, but a baby who dies moments earlier, before taking a first breath, is not. This leads to the untenable situation in which poorer care, resulting in an earlier death, attracts *less* scrutiny. No parent should have to accept that the timing of their baby's final heartbeat determines whether justice is possible.

For too long, our babies have been denied the human right to a truly independent investigation into the circumstances of their deaths. We, as parents, have been told that our children do not count as people and that their deaths do not warrant coronial oversight.

Have no doubt: had any of us attempted to end our pregnancies at the same gestations at which our babies died, we would have faced criminal investigation and likely prosecution. Why, then, is it acceptable that when those deaths occur following alleged failures in clinical care or systemic maternity safety, we are forced to rely on inadequate internal investigations by NHS Trusts and regulators, with only the Parliamentary and Health Service Ombudsman or civil litigation as escalation routes when official findings deny what the evidence shows?

We are aware, via a recent Freedom of Information response from the MoJ and DHSC, that the Government referred to the ongoing Rapid Review of Maternity Services led by Baroness Amos, stating that "the independent investigation may wish to consider the overall investigation more broadly."

It is unacceptable that a Government which has held a statutory duty under Section 4 of the Civil Partnerships, Marriages and Deaths (Registration etc) Act 2019, to make arrangements for the preparation and publication of a report on whether, and if so how, coroners should investigate stillbirths, should now defer to a non-statutory review commissioned by the DHSC, more than six years after Royal Assent. The question before you is not one of clinical outcomes but of justice, Section 4 of the 2019 Act places this responsibility firmly within your Department's remit.

As bereaved parents, we are accustomed to our voices being minimised, dismissed as too emotional to be heard. Reviews of maternity care have come and gone, with recommendations left unimplemented. We have endured self-investigation by individual Trusts and the wider NHS. We will not stand by while this statutory requirement is allowed to stall any longer. You do not need the Amos Review to confirm that NHS investigative processes are flawed, this has been documented repeatedly, including by parliamentary committees, regulators, and inquiry chairs.

Timeline

We note that there has been no progress on this matter since this Government came to power, and therefore set out below the recent timeline for clarity:

- 26 March 2019 – Royal Assent to the Civil Partnerships, Marriages and Deaths (Registration etc) Act 2019. Section 4 places a duty on the Secretary of State to “make arrangements for the preparation and publication of a report on whether, and if so how, coroners should investigate stillbirths.”
- 26 March 2019 – Launch of consultation on coronial investigations of stillbirths by the MoJ and DHSC.
- 26 May 2019 – Commencement of the Act (two months after Royal Assent).
- 18 June 2019 – Consultation closing date.
- 10 September 2019 – Expected publication date for Government response (as stated in consultation document).
- 7 February 2024 – Publication of “Factual Summary of Consultation Responses” (summary only, no policy position).
- 8 February 2024 – Parliamentary Question on publication status (Tim Loughton MP).
- 20 February 2024 – MoJ response stating that publication was paused during the pandemic.
- 19 March 2024 – Westminster Hall debate: “Baby Loss: Coroners.” MPs expressed disappointment at continued inaction. No timetable was published, no legislative proposal was tabled, and no firm commitment was made to extending coronial jurisdiction. The statutory duty under the 2019 Act was not described as discharged.
- 5th July 2024 – Labour Government formed. No known progress has been made regarding this issue.

Our Position

It is inexcusable that:

- the statutory requirement to publish a position was paused, citing COVID-19, and that it took 56 months from consultation close to release even a factual summary;
- the previous Government made no substantive progress on discharging the duty; and
- this current Government, up to the announcement of the Rapid Review on 23 June 2025, has made no commitment to completing the report required by law.

Now, the MoJ appears again to defer action pending the outcome of the Rapid Review. This is misplaced. The 2019 consultation has already been undertaken; and the Terms of Reference for the Amos Review do not encompass the full question posed by Section 4.

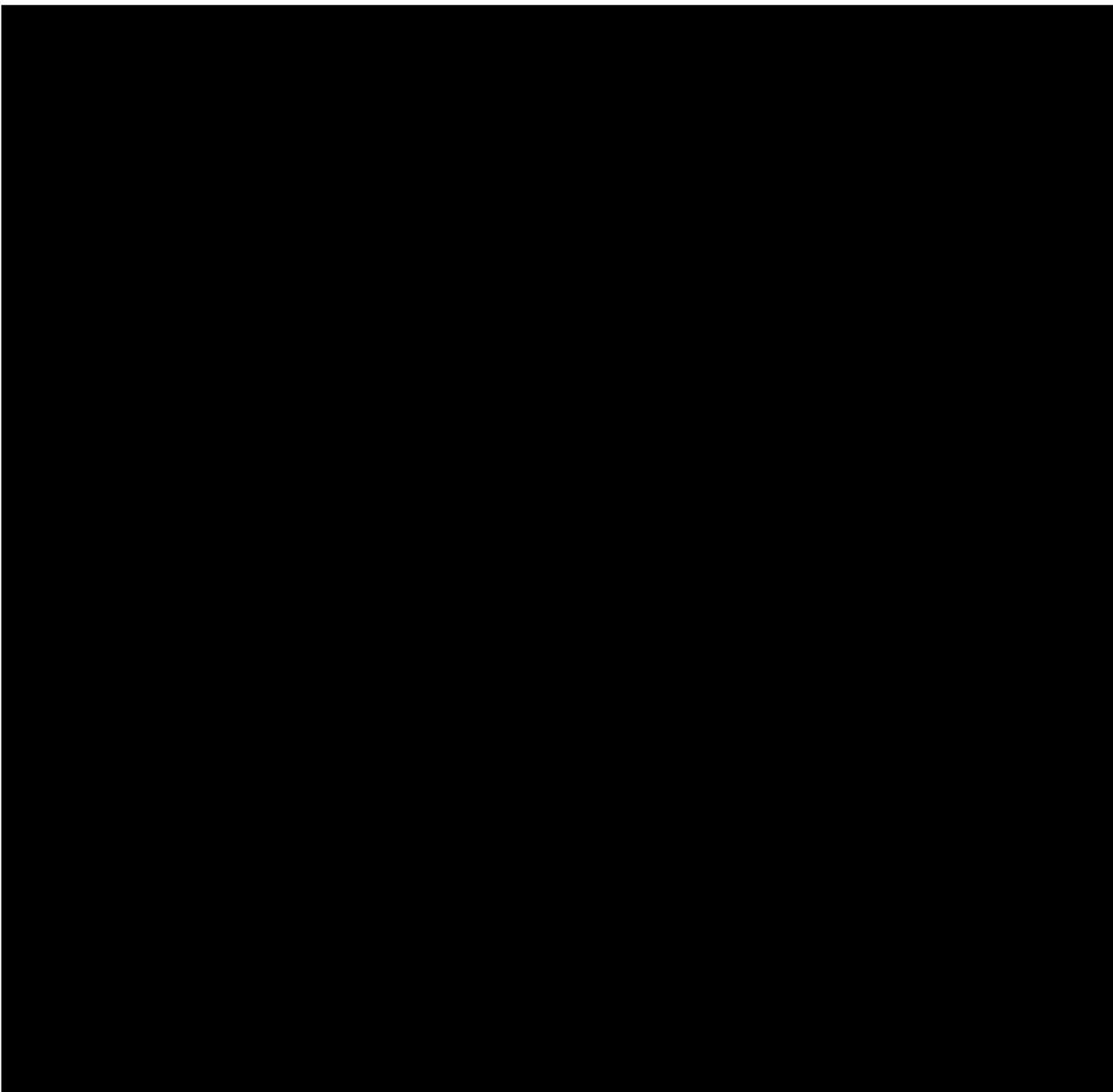
While those ToRs include reference to exploring “the potential role of coroners in the investigation of late-term stillbirths (37 weeks or later),” such limitation is absent from the 2019 Act which takes its definition for stillbirth (being after the 24th week of pregnancy) from Section 41 of the Births and Deaths Registration Act 1953 as amended by the Stillbirth Definition Act 1992. The Government’s 2019 consultation did propose that coronial involvement be limited to gestations over 37 weeks, without clinical or legal justification, however the 2024 factual summary of responses noted multiple objections to gestational

limit and did not highlight any supporting opinions. Families whose babies died before 37 weeks are no less entitled to justice than those whose losses occurred after.

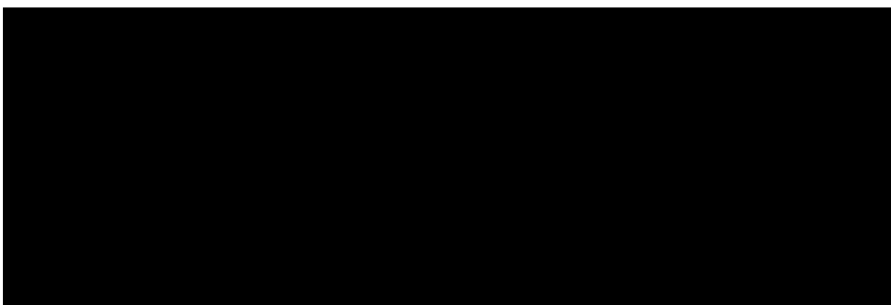
Our Request

Given that the Civil Partnerships, Marriages and Deaths (Registration etc) Act 2019 imposes a clear statutory duty to publish a report on coronial jurisdiction for stillbirths, and that the consultation closed over six years ago, we respectfully request that the Ministry of Justice now publish its full response and position no later than three months from the date of this letter, i.e. by 31 December 2025.

Yours sincerely,



Supported by:



- c.c. - The Rt Hon Wes Streeting MP Secretary of State for Health and Social Care
- The Rt Hon the Baroness Amos Chair of the Independent Maternity and Neonatal Investigation