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Ref: NBR/2026/004 – Coronial oversight of stillbirths and Section 4 of the Civil Partnerships, Marriages and Deaths (Registration etc.) Act 2019

Her Honour Judge Alexia Durran
Chief Coroner of England and Wales
Office of the Chief Coroner
Royal Courts of Justice
London
WC2A 2LL

27th August 2026

Dear Chief Coroner,

I am writing regarding the long-outstanding work on extending coronial jurisdiction to stillbirths.

Section 4 of the Civil Partnerships, Marriages and Deaths (Registration etc.) Act 2019 requires the Secretary of State to report on whether coroners should investigate stillbirths, and if so, how.

A public consultation was undertaken in 2019, the factual summary of responses to which was not published until 2024. The substantive report required by the Act remains outstanding more than seven years after Royal Assent.

The recent Maternity and Neonatal Investigation led by Baroness Amos provided some comment on the issue and recommended that the Ministry of Justice publish its response without further delay. The Investigation also considered the potential impact on coronial capacity. It noted that extending jurisdiction would not require all stillbirths to be investigated and recorded evidence from a former National Medical Examiner that, if cases followed a similar pattern to neonatal deaths and medical examiners were involved, there was unlikely to be a significant increase in cases,

I am therefore trying to understand whether there remain any substantive concerns within the coronial system which are contributing to the continued delay.

I would be grateful if you could clarify the following:

1. Whether the Chief Coroner, The Office of the Chief Coroner, or previous Chief Coroners were consulted by the Ministry of Justice in connection with the 2019 consultation or subsequently in relation to extending coronial jurisdiction to stillbirths.
2. Whether any advice, representations or concerns have been provided to the Ministry of Justice on this issue and, if so, whether you are able to summarise the main issues raised.
3. Whether the Chief Coroner presently considers there to be any material legal, operational or resource obstacle to Parliament extending coronial jurisdiction to stillbirths.
4. Whether the Office of the Chief Coroner is currently engaged with the Ministry of Justice regarding completion of the work required under Section 4 of the 2019 Act.

5. To the extent that concerns do exist, would a referral-based model rather than automatic investigation of every stillbirth address some or all of them?

I would also be grateful for clarification on one particular point concerning the distinction between stillbirth and neonatal death.

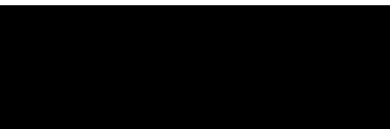
Coroners already have jurisdiction where a baby is born alive and subsequently dies. Where there is uncertainty about whether signs of life were present following birth, that distinction may already require consideration within the existing legal framework. Are you able to confirm therefore that extending coronial jurisdiction to stillbirths would not create a new classification issue between stillbirth and neonatal death, but that allowing appropriate stillbirth cases access to coronial investigation may reduce the significance of that boundary when determining whether independent investigation is available.

For clarity, we are not suggesting that every stillbirth should automatically result in an inquest. The Amos Review expressly recognised that extending coronial jurisdiction would not necessarily require all stillbirths to be investigated, and considered how a proportionate system might operate alongside existing investigation processes.

After more than seven years, I am keen to understand what barriers remain to implementation and whether those barriers arise within the coronial system or elsewhere.

I would be very grateful for any assistance you are able to provide.

Yours sincerely,

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Copied to:

Sir Gavin Williamson MP