National Maternity and Neonatal Investigation

Independent Third-Party Investigation

To: [redacted] (Complainant)

17 December 2025

Re: Request for Clarification on Terms of Reference regarding Coronial Oversight and Escalation Procedure - Workstream 4

Background

A complaint from you sent via email was received by the National Maternity and Neonatal Investigation Team on 22 October 2025. The complaint was in response to an email from [redacted] in the National Maternity and Neonatal Investigation Team (Investigation Team) also sent 22 October advising you that Baroness Amos (Chair of Investigation) would not look to amend the Terms of Reference (TOR) at this stage as these had been finalised with the Secretary of State. [redacted] informed you that Baroness Amos would welcome your feedback on *Workstream 4: Legal framework for Coronial involvement in stillbirths and compensation awards arising from harms sustained from clinical negligence*, along with any other feedback you have on the methodology and how they can gather evidence from families on these important issues.

Your complaint of 22 October follows a series of correspondence between yourself and the Investigation Team which started on 29 September, when you raised concerns about the wording in the TOR around ‘understanding the potential role of coroners in the investigation of late-term stillbirths (37 weeks or later)’. You took issue with the specific wording ’37 weeks or later’ and asked for it to be removed from the TOR. Your complaints have been processed by the Investigation Team in line with the tiered process outlined in the NMNI Complaints Policy and you have already received correspondence from the Investigation Team, including a letter from the Chair, Baroness Amos, on 7 October, responding to your concerns. Following a decision by the senior official overseeing delivery of the investigation that your complaint had not been upheld, which was communicated to you via email on 13 November, you replied on the same date to say that you were not satisfied with the response and wished for the complaint to be escalated to an independent third party which is the final stage of the complaints process.

Independent Third-Party Investigation

I have been approached by the Investigation Team to investigate this complaint in the role of an independent third-party. I am a Deputy Director in the Government Legal Department and do not work for the Department of Health and Social Care or the National Maternity and Neonatal Investigation Team. It is in this capacity that I have agreed to act as the independent third-party in relation to this complaint and to investigate it in line with the Complaints Policy, confidentially and in a fair and thorough manner. I have also been guided by my duties under the Civil Service Code and its values of integrity, honesty, objectivity and impartiality. In investigating this complaint, I have reviewed all relevant correspondence between the investigation team and yourself in relation to this complaint as well as the TOR.

Your Complaint

I have extracted the following from your email of 2 October:

I would appreciate a written response confirming:

- *whether and how errors or contradictions within the TORs can be formally corrected;*
- *what process exists for appeal or escalation where participants believe the investigation's design risks excluding categories of preventable harm; and*
- *how the investigation will ensure that coronial involvement in deaths before 37 weeks gestation are explicitly included in both scope and analysis*.

In my investigation, I have, therefore, focussed on addressing these queries raised in your email which form the substance of your complaint.

Independent Third-Party Investigation – Decision

I will deal with the queries in your complaint in turn.

1. Whether and how errors or contradictions within the TORs can be formally corrected.

The decision communicated to you by [redacted]he Complaints Officer, in the Investigation Team on 13 November confirmed the following as part of the rationale behind the decision not to uphold your complaint:

- Decisions to amend the Terms of Reference ultimately lie with the Chair of the Investigation and the Secretary of State for Health and Social Care.
- The Chair made a clear decision not to amend the Terms of Reference, having considered advice from officials.
- The Chair informed you of her decision in writing, while noting that the investigation would not place any time restrictions on evidence collected (and eventually published) relating to stillbirths.

I have reviewed this rationale as part of my investigation and confirm that it reflects the correct position regarding amendments to the TOR. Amendments to the TOR can be made by the appropriate authority. The authority to do so ultimately lies with the Chair of the investigation and the Secretary of State for Health and Social Care to make such amendments. The TOR has in turn been signed off by the Secretary of State and a decision has been taken by the Chair, acting on advice from officials, not to amend the TOR. Unfortunately, there is no route under the Complaints Policy for escalation of your complaint about this decision.

2. What process exists for appeal or escalation where participants believe the investigation's design risks excluding categories of preventable harm?

You are concerned that the investigation's design risks excluding categories of preventable harm.

The Investigation Team's Complaints Policy is the route through which anyone unhappy with how the investigation's processes have been conducted (including investigation's design) can make a complaint. The policy states and I quote: "*Where we find that things have fallen below our expected standards, we will apologise to you and explain what steps we will take to put things right and ensure the same issue does not happen again*."

As mentioned by [redacted] the Complaints Officer, in his email to you of 13 November, a clear process for appeal and escalation of concerns is set out in the Complaints Policy. This is the process that has been engaged by the Investigation Team in relation to your complaints and which has ultimately resulted in this independent third-party review. However, this level of the Complaints Process does not give an independent reviewer any capacity to consider the quality or substance of the investigation's design.

3. How the investigation will ensure that coronial involvement in deaths before 37 weeks gestation are explicitly included in both scope and analysis.

I note that you received a letter from the Chair of the investigation in which she clarifies that the investigation draft methodology includes a specific workstream ('Workstream 4') which will look at the role of coroners and will not be restricted to 37 weeks when collecting and eventually publishing evidence on stillbirths.

This is assurance provided by the Chair to you and all the correspondence I have considered as part of this investigation reflects the commitment of the Investigation Team to ensuring that Workstream 4 will not be restricted to 37 weeks when collecting and eventually publishing evidence on stillbirths.

I also note that Baroness Amos published her *Reflections and Initial Impressions* on 9 December, in which she stated that:

I recognise that the reference to '37 weeks or later' has been upsetting for some families and want to offer reassurance that the methodology and evidence gathered will not be restricted to 37 weeks.

I appreciate that this response and its conclusions may be disappointing because it does not provide a different outcome from that communicated to you at previous tiers of the Complaints Policy but hope that you will be assured by the Investigation Team's commitments given in relation to Workstream 4.

If you have any further questions please refer them to the Investigation Team at [redacted]

Yours faithfully

[redacted]

Government Legal Department