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TRANSCRIPT OF "FILE ON 4" – "STILLBIRTHS"

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ALEXANDER: Every day in the UK, seventeen babies die either at birth or in the first four weeks of life.

SPENCER: I was wheeled back to the delivery room, and it's still in my mind now, a very vivid picture of seeing my husband there, tears streaming down his face, holding my dead baby girl.

ALEXANDER: So why, at such a vulnerable time, do so many parents have such a battle to learn why their baby's died?

SPENCER: It's been really hard. The last thing you really want to be doing is going over and over again what's happened to you, but something keeps you going because you're doing it for your child. I can fully appreciate why people wouldn't have the strength to do that, considering what they've gone through emotionally.

ALEXANDER: Tonight, File on 4 reveals serious shortcomings in the way babies' deaths are investigated. Are hospitals being open enough with families, and should the inquest system be used more widely to get to the truth?

MAN: I think it's one of the most important areas that Coroners ought to be looking at. We should investigate all deaths properly, and the highest priority in an investigation should be those of children and babies.

SIGNATURE TUNE

MCCALL: The morning that she went in, she'd woken up in a lot of pain. Her mum contacted the hospital for advice and spoke to the labour ward and the advice was to bring Amanda in and they would admit her.

ALEXANDER: Terry McCall was with his daughter, Amanda, when she was admitted to Milton Keynes Hospital on the 8th of May last year. Both he and his wife Breda went with 17 year old Amanda to the hospital. The pregnancy had been straightforward and the whole family was looking forward to the baby's arrival. Amanda only had one kidney. Tests showed that it was swollen and that was the cause of her pain. So she stayed in hospital and later that night went into labour.

MCCALL: The department itself isn't large. I mean, they have about nine delivery rooms. The midwife that was looking after Amanda was supposed to be the midwife in charge and it was her role to run the department. Not only did she have to run the department, she also had to help Amanda and she was also dealing with another woman who was in active labour and was, in fact, further advanced than Amanda, so she wasn't in with Amanda a lot of the time. Most of the time she was out of the room.

ALEXANDER: Even though the ward was busy, Terry felt that everything was going well, so he left Breda with Amanda and went home to get some sleep.

MCCALL: I got a phone call at 3 o clock from Amanda's mum, saying that there was big problems and that she'd been rushed for a caesarean, an emergency caesarean.

ALEXANDER: And was that very unexpected?

MCCALL: Yes. When I left the hospital, Amanda was pain free, she was being cared for and being monitored and was expecting an ordinary delivery.

ALEXANDER: So what was the situation when you arrived back at the hospital?

MCCALL: When I arrived at the hospital, Amanda had been taken through to the theatre, we were having problems finding out anything as to what was going on in the theatre. And in fact, Breda had gone out to the nursing station to ask if there was any news and she'd been asked to wait in Amanda's room, that we would be told as and when there was any news.

ALEXANDER: Breda was the first to find out that Amanda's baby, Ebony, had died.

MCCALL: Breda was talking to a paediatrician that had been trying to resuscitate Ebony. I could tell from Breda's face that it wasn't good. And in fact, when she saw me coming through, she looked over and just shook her head. Ebony was cleaned up and taken into Amanda's room. Breda went with Ebony into Amanda's room and I stood outside theatre … sorry. When Amanda was brought out of theatre back into the delivery ward, Amanda was still heavily under anaesthetic. She kept waking up and falling back asleep, and one of the times that she woke up, she asked me what had happened.

ALEXANDER: And then you had to tell her?

MCCALL: Yeah, as best I could, because of course we didn't know what had happened. All we knew was that Ebony had died.

ALEXANDER: Amanda was taken from the operating theatre back to the maternity ward. It was very busy and there had been a number of unexpected admissions during the night.

MCCALL: Before Ebony was taken down to the morgue, she was just put into a cupboard. That was the only place on the delivery unit that there was. They didn't want the expectant mums and mums that have just delivered to see a dead baby in the unit, and there wasn't anywhere else to put her, so she was put in a store cupboard.

ALEXANDER: Literally a store cupboard?

MCCALL: Yeah, literally. When we went to see her later the morning that she died, we went into the store cupboard and she was completely surrounded by blankets, clothing, nappies, rubber gloves. It's just a store cupboard. It was like a way of rubbing salt in the wounds. They couldn't even give her any dignity in death.

ALEXANDER: Ebony McCall died just half an hour after she was born. At an inquest into Ebony's death, the Coroner described midwife shortages at the hospital as "nothing short of scandalous". He said that "systems failures" and overstretched staff had contributed to her death and he wrote to the Health Secretary to demand that improvements be made.

ACTUALITY IN OFFICE, WITH FILING CABINET

SEABROOK: As you can see, this is the midwifery report commissioned by the Coroner, highlighting particularly the staff shortages. The staffing was at such a low level that there was, in my opinion, a disaster waiting to happen.

ALEXANDER: Vicky Seabrook is the solicitor who represented the McCall family

SEABROOK: The problem in this case is the midwife wasn't able to devote her whole attention to Amanda and the baby wasn't sufficiently monitored, so the developing problems with the labour weren't adequately appreciated. Eventually, when it was clear that the baby was in distress, an emergency caesarean section was ordered and the baby was delivered, but in poor condition and survived only for about half an hour. Part of the finding of the inquest, that with appropriate levels of monitoring this baby should have been delivered alive and in good condition. There were just too many women in labour for the number of staff available.

ALEXANDER: What the McCalls didn't know was that another newborn baby, Romy Feast, had died less than a year earlier at the same hospital. Romy had suffered a lack of oxygen after a three hour delay in carrying out an emergency caesarean section. At the inquest into Romy Feast's death, the Coroner had also described the situation as "scandalous" and he had criticised a "series of system and communication failures". Vicky Seabrook had also represented the Feast family.

SEABROOK: The Coroner expressed extreme concerns about the level of care offered to Mrs Feast, and he reported his findings to the Care Quality Commission, and there followed a report with a significant number of recommendations about the care offered to mothers in labour at Milton Keynes Hospital, and I think the fact that he did so reflects the level of his concern about the standard of care. The Care Quality Commission report made twelve recommendations, perhaps the most significant of which was that they should increase the number of supervisors of midwives and that they should strive to fill the vacant posts so that they had a full complement of midwives on duty at all times.

ALEXANDER: These recommendations about the urgent need to improve staffing levels were published five months before Amanda was admitted to hospital and yet it was only after Ebony's death that Terry McCall found out they hadn't been implemented.

MCCALL: I was only aware because, after Ebony had died, I did a search on the internet and it made me feel extremely angry that the fact that there was huge staff shortages putting people at risk. I made a formal complaint. I had a response from the hospital confirming that they'd received my complaint and that I should expect to hear something within 25 working days, but then later down the line I had another letter from the hospital, saying all this is a serious complaint and as such it needs something like sixty working days to look at. Now even then the hospital weren't able to respond to my complaint within the timeframe that they stated. They took longer, and at the end of which there just wasn't an adequate response.

ALEXANDER: Going through it, do you feel that if you were not as determined as you obviously are, that you would have been put off and perhaps given up by now?

MCCALL: Yeah, I think that the ordinary member of the public, who isn't used to dealing with an official organisation such as the NHS, will be put off. It could just be the cynic in me that sees it, but it seems as though the system is designed to hope that if you're not addressed correctly that you'll go away and the problem will disappear, rather than to deal with the problem and cure the problem.

ALEXANDER: Milton Keynes Hospital wouldn't be interviewed for the programme, but in a statement they admitted they'd made an administration error and had apologised to the family. And they said:

READER IN STUDIO: As a Trust, we always work hard to ensure our complaint responses are as honest and open as possible. The Trust has made a formal apology to the McCall family, we have accepted liability and the family have accepted a settlement. An external clinical expert team is now working with us to accelerate progress in delivering even safer care and raising the quality of the birthing experience for the women of Milton Keynes.

ALEXANDER: The McCalls are one of many thousands of families across the UK affected each year by a death rate that's now causing growing concern.

SCOTT: Every day in the UK, ten babies are stillborn and another seven die within the first four weeks of their life, so overall in the UK that's 6,500 babies a year and there are ten times more stillbirths than cot deaths.

ALEXANDER: Janet Scott is from SANDS, the charity which supports parents affected by stillbirth and neonatal deaths.

SCOTT: Northern Ireland has better stillbirth rates, so fewer deaths than in England. Scotland has amongst the highest stillbirth rates in Europe, but overall, the UK doesn't do well in comparison to other European countries.

ALEXANDER: Has the level of the incidence of stillbirth changed at all?

SCOTT: That's one of the really shocking things is that the rates are almost the same as they were ten years ago. There was a significant drop twenty, thirty years ago, but since that drop, when maternity care was significantly improved, there has been no change at all, despite falling infant mortality rates, falling mortality rates in almost any other area but not in stillbirths.

ALEXANDER: Failures in care are just one of the reasons why babies are stillborn or die in the first few weeks of life. But very little is known about how many deaths could be avoided. A baby is classed as stillborn if it dies after 24 weeks of pregnancy. But stillbirth isn't well researched. While poverty and diet are factors in such deaths, a significant proportion are still unexplained and happen without warning. Janet Scott of SANDS is concerned that not enough light is being shed on why these babies are dying.

SCOTT: There's a perception that somehow stillbirth's just one of those things that you can't do anything about. We hear from parents about different standards of review. Some parents feel that their baby's death has been really thoroughly investigated, but other parents feel that their baby's death has been swept aside as if it were somehow insignificant.

ALEXANDER: So in other words, there's a real variant around the country as to how these babies' deaths are investigated?

SCOTT: Yes, I think so, and in that some parents have been very badly let down. But also lessons are not being learnt, because if a baby's death is not fully investigated, then mistakes or failures of care or areas where understanding isn't good enough are going to be missed.

ACTUALITY WITH PHOTOS

SPENCER: That photograph was taken in 2005. My oldest boy, he's nearly nine, my middle boy is seven and my youngest boy is five.

ALEXANDER: The boys look completely angelic. Are they always like that?

SPENCER: They're good most of the time.

ALEXANDER: Rachel and Chris Spencer have three little boys, and in October last year were looking forward to the imminent birth of their fourth child. They knew the baby was a girl, the pregnancy had gone well and the whole family was excited about the new arrival. One evening, just before her due date, Rachel thought she might be in labour, and she and Chris went to Stoke Mandeville Hospital. Rachel was examined but nothing much was happening, and after a while she and Chris were told to go home. Rachel went to bed.

SPENCER: I woke up. I was in a lot of pain, I nearly passed out, I knew something was badly wrong, so we phoned the hospital and we told them what had happened. We went back into the hospital where the midwife, she was concerned because I was having a lot of contractions, The registrar came and checked me and he came to the conclusion that I was in early labour.

ALEXANDER: Several hours passed and eventually she was taken to a delivery room.

SPENCER: I felt my waters break and so I got my husband to ring the bell to get the midwife to come in. And when she came in, basically, they pulled the sheets back and there was blood everywhere and I was a Code Red at that point.

ALEXANDER: What sort of state were you in at that point?

SPENCER: Very very frightened. The staff just descended in on the room and I had one arm pulled out one side, one arm pulled out the other side, they were trying to get lines into me, but I'd gone into hypothalemic shock at that stage and they were

SPENCER cont: trying to resuscitate me because they couldn't get lines in, my blood vessels were collapsing. I'll never forget the look on the people's faces who were in the delivery room with me, the look of horror on their faces. I just remember laying there and saying, "Is my baby all right? I'm really scared. Is my baby all right? I'm really scared."

ALEXANDER: Rachel was taken to the operating theatre, where she was given a general anaesthetic so the baby could be delivered by caesarean section.

SPENCER: I remember being woken up in the recovery room and I remember the midwife saying to me, "You had a daughter," and she didn't need to say any more. And then I was wheeled back to the delivery room, and it's still in my mind now, a very vivid picture of seeing my husband there, tears streaming down his face, holding my dead baby girl, and you know, you don't forget that.

ALEXANDER: Whilst she was still in hospital, Rachel was told there was a problem with the placenta and that was why the baby hadn't survived. Rachel wanted to know exactly what had happened and if her baby's death could have been avoided, but she really had to stand her ground when it came to discussing the possibility of a post mortem.

SPENCER: We were told by the two registrars who came in that the post mortem, a lot of parents didn't bother with this, but we at that stage were becoming aware that something had gone badly wrong. At no point were we actually told, you might want to do this to check if there was anything wrong with your baby which could have caused the death of your baby. We were never told that.

ALEXANDER: And it was suggested to you that a lot of parents don't bother?

SPENCER: Yes, that's what they said to us, which I found a bit strange. But we had to have that done, there was no two ways about it.

ALEXANDER: As well as the post mortem examination, the hospital carried out an internal review, which is a standard investigation following a stillbirth. Rachel is a biochemist and she spent several weeks doing research in preparation for the meeting where the hospital's doctors would present their report into what had happened. She had to ask for a copy of her medical notes as well as a copy of the hospital's report. When she got that, she was puzzled to read the conclusion that her baby had died when she was at home, before she came back to the hospital.

SPENCER: What they expected was for us to sit there and to listen to the report, listen to the findings that they had from that report, to be able to tell us what was done well that night at the hospital, what mistakes were made at the hospital that came out of the report, and then to tell us that they thought that our baby had died at home.

ALEXANDER: So in other words, the conclusion in their own internal review document was that the baby had died at home?

SPENCER: That's what they suggested, yes.

ALEXANDER: But when you raised other issues with them, having been through your medical notes, the situation they realised was different?

SPENCER: When I looked at my medical notes, it became clear that the baby was still alive when we got back to the hospital, because the pulse rate that they picked up from me was significantly different to the two readings that they took for the baby when they first checked me.

ALEXANDER: So the baby couldn't have died at home?

SPENCER: No. I think we were very fortunate to have the background that we have - both my husband and I are scientists by training - to be able to look over all of the information that we had and to be able to go into the meetings very well prepared.

ALEXANDER: It wasn't until March, five months after their baby, Rose Elizabeth, died that they received a letter from the Chief Executive at Stoke Mandeville, offering an unreserved apology for her care. The letter also admitted that care was below standard and outlined the plans put in place to make sure the same mistakes wouldn't be repeated. We wanted to talk to the Trust about Rachel's experience in trying to get answers, but they declined to be interviewed. However they told us in a statement:

READER IN STUDIO: We have a thorough and well established method of case review, which does involve recommendations, action plans for practice and evaluation.

ALEXANDER: They also told us they have been very open and honest with the Spencers and their investigations concluded the Trust couldn't have done anything to change the outcome. Despite concerns about the lack of consistency in looking into these baby deaths, the Department of Health in England maintains there should be a thorough investigation in every case. Dr Sheila Shribman is the National Clinical Director for Children, Young People and Maternity Services.

SHRIBMAN: We would expect a thorough review. It has to be thorough and people have to be informed that it's a process that requires thoroughness and discussion and may take a little time to make sure that it's all been examined properly.

ALEXANDER: So why is it that parents that we've spoken to have really had to fight for answers? One family in particular had to insist on having a copy of their medical notes, having a copy of other documents, had to really prepare to go into the meeting in order to put their point across and to get to the bottom of what actually happened in their case. And that has not been an isolated situation.

SHRIBMAN: Well, that's of course disappointing. It's not good enough that parents end up feeling that way. This is a process that should be thorough, it should be open, parents should understand what's happening, so they shouldn't have to fight for that sort of thing.

ALEXANDER: And in terms of post mortem, why is it not happening universally across the country? I mean, during the course of our research for the programme, we have spoken to clinicians who have explained to us that they aren't routinely offered across the country. We have had one parent who has told us, when it was explained to her about post mortem, it was suggested to her that most parents don't bother.

SHRIBMAN: Well, that's not the appropriate way to offer the explanation, so there are issues about people doing this to the highest standards and offering full information, so the numbers where it's not offered is going down, but on the other hand you are right that there is still patchiness and we want to see that improved.

ALEXANDER: Do you see, in the Department of Health, that the investigative system in general is sufficiently transparent?

SHRIBMAN: I think it's become increasingly transparent. Do I think that there's more that could be done? Yes I do, and it's always sad to hear that parents haven't had an optimum experience when they've wanted to look at what's happened in relation to their baby. But again, it's improved considerably compared to how it was, but I wouldn't wish you to interpret that as in any way a complacent approach. I think we want to see continuous quality improvement in this area as well as a number of others.

ALEXANDER: But there is a practical reason why there isn't enough transparency.

ACTUALITY IN MORTUARY

COX: We are now coming into the mortuary. We've come into the reception area where babies will come with an undertaker.

ALEXANDER: Post mortems are only carried out in four out of ten cases. It's one of the most important ways of investigating a stillbirth or neonatal death. But these examinations should be carried out by pathologists specially trained to deal with babies and there aren't enough of them.

COX: That's where the paperwork is being checked. The mortuary technicians will put the details onto the laboratory computer ….

ALEXANDER: Philip Cox is a consultant perinatal pathologist at the Birmingham Women's Hospital. His unit is the largest centre of its kind in the country and last year carried out 780 post mortems.

COX: We go through here and this is our post mortem room. We have two tables, they're the areas where we perform the post mortems, and we have an area to take photographs …

ALEXANDER: That's this piece of equipment here?

COX: Yes, a digital camera with lighting. This morning I had three post mortems, that's three stillborn babies in fact.

ALEXANDER: Where were they from, those babies?

COX: They had come from different hospitals around the West Midlands, and that took me really the whole morning to do those examinations.

ALEXANDER: Some parents are reluctant to have their baby go through the procedure because it may not provide any answers, but Philip Cox says that nevertheless it's vital.

COX: Somewhere around 30% of post mortems will give you an absolute diagnosis in the situation of a stillbirth, and in many more of those, useful info will come out of the post mortem. And the other misconception that is commonly held is that a post mortem that does not find a specific cause of death is therefore of no value, whereas in fact, particularly in the situation of a stillbirth, knowing that this is what is often described as an unexplained stillbirth where we find that the baby has been growing normally, that it's got no congenital abnormalities is very important. It's firstly important because it's a reassurance to the family. It also helps the clinicians to know what to do next time. So whilst it is a negative post mortem, as you might say, in fact that negative information is very important in the management of that family in the future.

ALEXANDER: Not all hospitals have access to these specialist services. In England, there are no national funding arrangements for perinatal pathology, so while Philip Cox's facilities are paid for at a regional level and are available to all Trusts in the West Midlands, elsewhere each Trust has to make its own local arrangements. This can inevitably mean there will be difficulties.

COX: It is very patchy. Some areas are much better served with perinatal pathologists and in other areas they are very thin on the ground. It depends on local pressures and commissioners and hospitals as to how important they see it as a priority. I have certainly been at least at one hospital in the south-west where that was what they said – we don't send babies for post mortems because there is nobody to do them.

ALEXANDER: How can that be fair to the families who might want one?

COX: Well, it isn't fair to the families. It is every family's right to have the opportunity to have a post mortem. It does not mean that everybody has to have a post mortem on a baby who has died, but they should at least have the opportunity and should be asked and be given the chance to consent to post mortem, and to understand what they might gain from it. And that really isn't the case in those places and those families are losing out.

ALEXANDER: Do you think there should be some national target?

COX: Certainly in other specialties there are recommendations of the number of a particular type of specialty compared to the population that they are serving. I mean, if you compare most parts of the country to the West Midlands, where we are reasonably well-funded, the number of perinatal pathologists that are available to do this sort of work could easily double.

ALEXANDER: So there is a severe shortage of perinatal pathologists - and this isn't a new problem. But does the Department of Health have a strategy for addressing this? Dr Sheila Shribman.

SHRIBMAN: It's increasingly been the case that the services are more centralised and provided in specialist units where the expertise is available, because that of course offers the family the best information possible if a post mortem is needed, so we wouldn't expect to have a paediatric pathologist in every hospital, for example. That would be not the right thing to do.

ALEXANDER: But it's been suggested to us that there needs to be double the number of perinatal pathologists that there are currently in order to meet the current demand.

SHRIBMAN: I'm not sure if double is the correct figure, but there certainly does need to be an increase, and that's why we have worked between the Department and the Royal College of Pathologists to stimulate that interest and to get young doctors into training in pathology and to go into this very highly specialist and important area.

ALEXANDER: Philip Cox, who is a clinicians at the largest centre in the country, maintains that there does need to be twice as many as there are now in order to meet the needs of the parents whose babies are dying.

SHRIBMAN: Well, I can only say the Department has worked very closely with the Royal College of Pathologists on this issue, so the trainee numbers have increased.

ALEXANDER: Is there any reason why there are no targets? Would it not be a good idea if there were targets – you know, to have so many perinatal pathologists available for so many births, for example?

SHRIBMAN: Well, it simply doesn't work that way, as I'm sure you know. It's for local areas, whether they're strategic health authority areas or groupings, to ensure that they are able to meet the local needs. Some parts of the country have higher perinatal death rates than others, so again it's not going to be an even distribution in that sense. It's about meeting the needs of that population in that area.

ALEXANDER: But the Health Service doesn't have sole responsibility for investigating these deaths. While Trusts are responsible for carrying out their own internal inquiries into all babies who have died, there is a further opportunity for an independent investigation in the inquest system, or in Scotland through a fatal accident inquiry. However, this only happens when the baby dies after birth and if the hospital itself decides to refer it to the Coroner or to the Procurator Fiscal.

ACTUALITY WITH DEATH CERTIFICATE

SARAH: This is the death certificate that we obtained on the day after our baby's death. So it just really gives our names and professions.

ALEXANDER: And this document shows us the cause of death.

SARAH: The cause of death that's recorded on here is sagittal sinus thrombosis and straight sinus thrombosis, which I understand to be a blockage, which is what we'd been told in the hospital, that had caused the death.

ALEXANDER: Sarah - that's not her real name - gave birth to her first baby eighteen months ago at Queen Charlotte's Hospital in London. Everything should have been fine, but there were difficulties and the baby died when she was just three days old. The thrombosis Sarah was told about can be a natural cause of death, but she and her husband decided to have a post mortem examination, because they wanted to know more about what happened. They returned to the hospital to meet the doctors, where a different story began to emerge.

SARAH: It was at that meeting that they confirmed that the cause of death was a rupture to the vein of Galen at the base of the brain, and this was the first time that we fully appreciated that the actual cause of death that had occurred during the delivery was very different from what we had originally been led to believe.

ALEXANDER: Did he explain to you how that had actually happened?

SARAH: No, he didn't give an answer as to how exactly this injury could have occurred and I think that's what we felt quite dissatisfied with. I think we still felt that we didn't actually know what had caused this injury, why had this injury occurred and could it have been prevented?

ALEXANDER: Sarah now feels, with hindsight, that she would have liked an independent investigation into what had happened.

SARAH: It wasn't until I saw a story on the news, where a baby had died during the birth and the delivery, it mentioned that this Coroner was involved and that was the first time I thought, 'Oh, should we have had an inquest, should we have had this looked into more thoroughly by a Coroner?' I think at that time actually, had that been offered to us and we knew there was going to be a more thorough independent investigation, I think we would have definitely agreed to it and would have felt a lot happier that this was, yeah that there was being some sort of external, more independent body looking at everything. But it didn't even occur to us.

ALEXANDER: And nobody suggested it to you at all?

SARAH: Not at all, nobody, not at all.

ALEXANDER: Queen Charlotte's were entitled to make that decision. They wouldn't be interviewed for the programme, but told us they had a robust procedure for investigating babies that are born unwell, but admitted that some aspects of communication with Sarah could have been improved. We asked them why they didn't refer this case to a Coroner, and in a statement they said:

READER IN STUDIO: Circumstances which mean a death should be referred to a Coroner's office include a sudden, unnatural or violent death. We therefore did not refer this case to the Coroner's office.

ALEXANDER: Just because a death is referred to the Coroner doesn't automatically mean that there will be an inquest. That decision is taken by the Coroner. And even where a family might be keen for an investigation, that won't necessarily happen. File on 4 has heard concerns that some Coroners are reluctant to investigate the deaths of very young babies.

ACTUALITY IN SOLICITOR'S OFFICE

COHEN: How did the meeting go?

WOMAN: Oh it was fine. The client interview went really well.

COHEN: Fine. And he understood everything that was said to him?

WOMAN: Yes, yes, his instructions were very clear and he seemed pleased with everything.

COHEN: Fine, okay, and we know where we're going to go …

WOMAN: Yes, yes, action plan sorted.

COHEN: Good, good.

ALEXANDER: Ian Cohen is a solicitor on Merseyside, who has many years experience dealing with bereaved families, and he's recently been involved in a confrontation with a Coroner who didn't want to investigate a death.

COHEN: The family spoke to the Coroner, requested that it be investigated and that there be an inquest, and the Coroner refused. They tried to speak with the Coroner again, for the Coroner to at least give some justification for the decision that was reached, that wasn't forthcoming.

ALEXANDER: What did you feel about the coroner's decision?

COHEN: In this particular instance I was shocked because it was so clearly one that had to be investigated. There were so many factors around it that could have implications across the board around the country that it had to be investigated. We felt very strongly about that particular case. We wrote to the Coroner on their behalf, setting out what we understood the law to be. The matter was then referred to the solicitors representing the Coroner, and literally just before we were about to start the court process to challenge the decision, the Coroner made the decision through his lawyers to agree to hold an inquest. And so had it not been for the family and, to a degree, our perseverance, this inquest would not have been held.

ALEXANDER: From the experience that you have in dealing with other early neonatal death cases, to what extent do you think in other parts of the country, that Coroners are not holding inquests when they ought to be?

COHEN: If I base it upon my personal experience, I would have to reach the conclusion that there are sudden and unexpected neonatal deaths around the country that are not being investigated.

ALEXANDER: All Coroners in England and Wales are members of the Coroners Society and we wanted to discuss this apparent inconsistency, but the Society declined to take part in the programme. They did tell us that it's up to each individual Coroner to decide how to interpret the law on a case by case basis. They said it wasn't within their authority to direct Coroners to follow a particular practice.

POLLARD: In my Coroner's area, I have asked that the deaths of all babies should be reported to me. I cannot say categorically that they are being, because of course that's a matter for the doctors, but I have asked that that should be done.

ALEXANDER: In Stockport, Greater Manchester, the Coroner John Pollard has his own views on the importance of investigating baby deaths and issued an edict to try and make sure that they're all referred to him

POLLARD: My own view is that it would be helpful if the death of all children, and particularly very young children and babies, could be reported to the Coroner so that we had a consistent overview of what was happening.

ALEXANDER: Are the steps that you're taking within your district happening everywhere else in England and Wales?

POLLARD: They're not happening in all Coroners' jurisdictions. In fact they are happening, I would suggest, in a small minority of jurisdictions, mainly because there is no legal basis upon which I can make the doctors report those deaths to me. I work with their good will and consideration.

ALEXANDER: So what are the implications for healthcare in other areas where those deaths are not being reported to the Coroner?

POLLARD: The potential implications that unnatural deaths are being missed, and if we can learn from what has happened, then I think we can prevent further deaths, so obviously the corollary of that in other jurisdictions where they're not looking at these deaths is that sadly there may be a repetition of the type of deaths that we're talking about.

ALEXANDER: Do you think that it ought to be the rule throughout England and Wales that all child deaths are reported to the Coroner?

POLLARD: I would like to see a situation where all deaths of adults and children throughout England and Wales are reported to the Coroner. That would be my preference as to the way the system should work. I would like to see a situation where as many Coroners as possibly can adopt the system of asking the doctors to report child deaths to them so that they can at least be investigated and looked at.

ALEXANDER: The rate of stillbirth and neonatal death remains stubbornly high and there's been little change over the last ten years. There are shortages of staff, from midwives to pathologists, and patchy investigation procedures. And parents still find it difficult to get answers. Campaigners like Janet Scott of SANDS argue that lessons need to be learned if more babies' lives are to be saved.

SCOTT: The attention paid to the deaths of babies is insignificant compared to the amount of attention paid to trying to save lives on the roads. But because stillbirths are somehow not considered to be as significant deaths as other deaths, there's a perception that there's nothing that can be done. We wouldn't have that view of any other mortality rate. Having some sort of answer is really important and it's also important that parents are sure that every avenue that could be explored has been explored, so that they really have a full picture of what led up to the death of their baby. There are deaths happening now that could be avoided.

SIGNATURE TUNE