



# Chief Coroner

## GUIDANCE NO.45

### STILLBIRTH, AND LIVE BIRTH FOLLOWING TERMINATION OF PREGNANCY

#### INTRODUCTION

1. The purpose of this guidance is to help coroners understand and apply the current law relating to stillbirth, and live birth following termination of pregnancy<sup>1</sup>, to promote consistency in the scrutiny of unnatural neonatal deaths.
2. Because the guidance is primarily intended for a professional readership, it is necessarily expressed in legal and medical terminology which the Chief Coroner acknowledges, with sincere regret, may strike some readers as insensitive.

#### THE CORONER'S JURISDICTION

3. For the purposes of death registration, a stillborn child is one which has issued forth from its mother after the 24<sup>th</sup> week of pregnancy and which did not at any time after being completely expelled from its mother breathe or show any other signs of life<sup>2</sup>.
4. Coroners do not have jurisdiction to conduct an investigation concerning a foetus or a stillborn child, as where there has not been an independent life, there has not legally been a death<sup>3</sup>.
5. However, a child who is born showing signs of life, whether that is prior to the 24<sup>th</sup> week of pregnancy or after it, has had an independent life and that child's death must be investigated if section 1 Coroners and Justice Act 2009 is engaged. This is so even where the mother's pregnancy was intentionally terminated.
6. Where there is doubt over whether a child was born alive, that is a matter for the coroner to determine (see 'Establishing whether there has been a live birth' below).

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<sup>1</sup> In this guidance 'termination of pregnancy' refers to termination of pregnancy in accordance with the provisions of the Abortion Act 1967

<sup>2</sup> Section 41 Births and Deaths Registration Act 1953

<sup>3</sup> Attorney General's Reference (No.3 of 1994) [1998] A.C. 245

## NOTIFICATION OF DEATH

7. Medical Practitioners and registrars of births and deaths have a legal obligation to report certain types of death to the coroner.

### Reporting by Medical Practitioners

8. The Notification of Death Regulations 2019 set out the circumstances in which registered medical practitioners must notify the coroner. The Regulations do not specifically reference neonatal deaths. However, some of the prescribed circumstances might apply to them, including where a medical practitioner suspects:
  - i) the death was caused by the person undergoing a treatment or procedure of a medical or similar nature<sup>4</sup>;
  - ii) the death was unnatural, but does not fall within any of the circumstances specifically listed in the Regulations; or
  - iii) the cause of death is unknown.
9. Accordingly, if a child was born alive (or may have been) and there are questions about the medical care that was provided, the reason for the child's death is unknown, or the mother's pregnancy was terminated (and the child's death was therefore caused or contributed to by a medical procedure), the coroner should be notified.

### Reporting by registrars

10. Regulation 41 of The Registration of Births and Deaths Regulations 1987 sets out the circumstances in which registrars must notify the coroner. The Regulations may lead to the referral of neonatal deaths, as the circumstances include where the cause of death appears to be unknown<sup>5</sup>, and where the registrar has reason to believe the death was suspicious, unnatural, caused by violence, caused by neglect, or caused by abortion<sup>6</sup>.
11. Regulation 33 of the 1987 Regulations also requires the registrar to report any alleged stillbirth where there is reason to believe that the child was born alive.

## ESTABLISHING WHETHER THERE HAS BEEN A LIVE BIRTH

12. To be considered to have been born alive, a child must:
  - i) **have issued completely from its mother's body.** It does not matter whether the birth was natural or by caesarean section, and it is not necessary for the placenta to have been delivered, or for the umbilical cord to have been cut.
  - ii) **have shown signs of life.** There is no formal definition as to what constitutes a sign of life and coroners may need to obtain a medical opinion. Signs that are generally accepted as being signs of life include (but are not

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<sup>4</sup> Regulation 3(1)(iiiiv). NB/ Guidance by the Ministry of Justice states that this applies if the death may be related to surgical, diagnostic or therapeutic procedures and investigations, anaesthetics, nursing or any other kind of medical care (link: [MoJ Guidance](#))

<sup>5</sup> Section 41(1)(c)

<sup>6</sup> Section 41(1)(d)

limited to): breathing, crying, or sustained gasps; a heartbeat; a pulsing umbilical cord; or making definite movement of voluntary muscles.

13. If a child has been born alive (no matter how brief that child's life is, and whatever the extent of any physical defects the child might have), the coroner will have a duty to investigate the child's death if section 1 Coroners and Justice Act 2009 applies. However, it can be difficult to establish whether a child showed signs of life after birth, as medical opinion suggests there may be fleeting reflex activity in babies that have died shortly before birth. Parents and medical professionals might also have opposing views as to whether signs of life were observed.
14. Where there is doubt about whether a child was born alive or was stillborn, a coroner can either make preliminary inquiries to try to establish the position, or can begin an investigation. A coroner does not have to be satisfied on the balance of probabilities that the child was born alive before an investigation can be commenced<sup>7</sup>.
15. A post-mortem examination can be requested under s14 Coroners and Justice Act 2009, either as part of a coroner's preliminary inquiries, or as part of an investigation<sup>8</sup>. Other evidence can also be obtained where appropriate.
16. Where there is any dispute over whether a child was born alive, and s1 Coroners and Justice Act 2009 would be engaged if there had been a live birth, it is the Chief Coroner's view that there should always be an investigation, and this issue should be determined at inquest.
17. If it transpires before an inquest that a child was stillborn, the coroner should notify the registrar using Form 9<sup>9</sup>, and should set out the facts as far as they are known.
18. Where it has been found at an inquest that a child was stillborn, the short-form conclusion of 'Stillbirth', which is listed in Note (i) in the Schedule to The Coroners (Inquests) Rules 2013, should usually be used.

#### **LIVE BIRTH AFTER TERMINATION**

19. The subject of termination of pregnancy is a sensitive one. However, the law as it applies to coronial investigations is clear and must be applied consistently.
20. A lawful termination of pregnancy under the Abortion Act 1967 can trigger the coroner's duty to investigate. This is because a child who is born alive and whose death is caused by prematurity following a termination of pregnancy, will have died an unnatural death.
21. Investigations of a child's death following termination of pregnancy are likely to be highly emotive, but however the coroner or Interested Persons may feel, there is a statutory requirement that an investigation takes place.

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<sup>7</sup> R. (T) v West Yorkshire (Western Area) Senior Coroner [2018] 2 W.L.R. 211

<sup>8</sup> R. (T) v West Yorkshire (Western Area) Senior Coroner [2018] 2 W.L.R. 211

<sup>9</sup> Regulation 35 The Registration of Births and Deaths Regulations 1987

22. Any investigation must be sensitive, empathetic and sufficient to make the findings and determinations required by sections 5 and 10 Coroners and Justice Act 2009.
23. Coroners should consider whether it would be appropriate to conduct any inquest in writing, or admit written evidence under rule 23, to avoid the family going through the stress of an in-person hearing.
24. An example of a sensitive narrative conclusion where there has been a live birth following termination is: 'X died from extreme prematurity after being born alive following a termination of pregnancy under section 1 of the Abortion Act 1967'.
25. Coroners should bear in mind that a child who is born alive following a termination of pregnancy has the same rights as any other person in this jurisdiction, including the Article 2 Right to Life. This means the child should receive the same life-saving treatment, or palliative care, as would be appropriate for a child in the same condition whose birth occurred naturally.

## **NOTIFICATION REQUIREMENTS**

### Live births

26. For live births ending in neonatal death, both the child's birth and death must be registered. The coroner should supply to the registrar the same forms as with all death investigations.
27. In England, child deaths must be reported to the local Child Death Overview Panel<sup>10</sup>. In Wales, all child deaths must be reported to the relevant Regional Safeguarding Children Board<sup>11</sup>.

### Stillbirths

28. Where a potential neonatal death is reported to the coroner, but the coroner decides without an inquest that the child was stillborn, the coroner should notify the registrar using either Form 100A or Form 100B, as appropriate. The coroner should complete as much of the information on the form as possible (e.g. recording the date of the stillbirth, as opposed to the date of death), and should clearly state on the form that the child was stillborn.
29. Similarly, the child's body should be released by the coroner as soon as is reasonably practicable using the usual Order for Burial Form 101 or Form Cremation 6, but the coroner should clearly state on the form that the child was stillborn.

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<sup>10</sup> Regulation 24 of the Coroners (Investigations) Regulations 2013 requires the Coroner to inform the Local Safeguarding Children Board of investigations and/or post-mortems into child deaths. As LSCBs no longer exist, the statutory guidance on Working Together to Safeguard Children ([guidance link](#)) confirms that coroners should instead provide the information to the local Child Death Overview Panel. Here is a link to the relevant contact details: [link](#)

<sup>11</sup>Safeguarding Boards in Wales have the power to request that child deaths are reported to them by virtue of s137 Social Services and Well-being (Wales) Act 2014. A link to the websites for the Safeguarding Children Regional Boards is here: [link](#)

30. Following an inquest into a potential neonatal death where the conclusion is that the child was stillborn, coroners should notify the registrar using Form Rev 99A (see below).

**HHJ THOMAS TEAGUE KC  
CHIEF CORONER**

**2 February 2023**

**CORONER'S CERTIFICATE AFTER INQUEST (Still-Born Child)**

To be completed by Registrar	
Register No.	
Entry No.	

To the  Registrar of Births and Deaths

Inquest held on XXXXXXXX on the body of child  
 \*I/the jury found that  
 \* the body was that of a still-born child  
 \* there was not sufficient evidence to show that the child was born alive

Was a post-mortem held?

**PARTICULARS OF STILL BIRTH**

**CHILD**

1a Date and place of birth:

1b Name and Surname:

2 Cause of death and nature of evidence that child was still-born

- a Main diseases or conditions in foetus
- b Other diseases or conditions in foetus
- c Main maternal diseases or conditions affecting foetus
- d Other maternal diseases or conditions affecting foetus
- e Other relevant causes

3 Sex:

**FATHER**

4 Name and Surname:

5 Place of birth:	6 Occupation:
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**MOTHER**

7 Name and Surname:

8a Place of birth:	8b Occupation:
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9a Maiden surname:	9b Surname at marriage if different from maiden surname:
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10 Usual address (if different from place of child's birth):

**BURIAL/CREMATION**  
 Enter Order for Burial/Certificate E for Cremation  
 I have issued  
 on

I certify that the findings of the inquest were as above.

Signed: «AuthorisingUserSignature»	Date: «AuthorisedDateDayFirstLong»
Name: «AuthorisingUserFullName»	
Appointment: «AuthorisingUserAppointment»	Jurisdiction: «AuthorisingUserJurisdiction»