Royal College of Obstetricians & Gynaecologists

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Antenatal Results & Choices

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Position statement following Chief Coroner's Guidance no. 45, "Stillbirth and Live Birth Following Termination of Pregnancy"

Advice for clinicians following abortion care at later gestation

December 2023

Executive Summary

In February 2023 the Chief Coroner for England and Wales published Guidance No. 45 entitled "*Stillbirth and Live Birth Following Termination of Pregnancy"* with a view to achieving consistency in coronial practice.[1] The guidance has prompted a need for clarity for healthcare professionals caring for women needing an abortion. This statement is intended to act as a resource for healthcare professionals to inform standards of clinical practice, mitigate potential variations in care, and to ensure that no unnecessary barriers are introduced for those accessing abortion care.

- Livebirth following medical abortion is uncommon but can occur, particularly at later gestations. Determining whether a livebirth has occurred at earlier gestations can be challenging, thus healthcare professionals need to be aware of guidance for determining signs of life, and what to do when there is uncertainty.
- Healthcare professionals should draw on the principles of the MBRRACE-UK guidance for determining signs of life after birth and should include one or more of the following: easily visible heartbeat seen through the chest wall; visible pulsation of the cord after it has been clamped; breathing, crying or sustained gasps; definite movement of the arms and legs. They should be aware that fleeting reflex activity including transient gasps, brief visible pulsation of the chest wall or brief twitches or involuntary muscle movement can be observed in neonates that have died shortly before birth and therefore should not be considered as representing signs of life when observed in the first minute after birth.
- Healthcare professionals should support women to make informed choices through an individualised, informed discussion, related to the chance of signs of life after medical abortion, and where appropriate, a discussion of feticide and plan of care for the neonate if it is born with signs of life. These discussions should be clearly documented.
- Feticide, as a procedure to prevent the fetus from being born alive, should be discussed with patients when there is a significant chance of a livebirth occurring following abortion and is recommended by the RCOG where medical abortion is performed after 21 weeks and 6 days.
- Health care professionals need to be aware of the relevant legislation related to abortion and the responsibilities of medical practitioners related to establishing whether there has been a livebirth and whether referral to the coroner/Procurator Fiscal is required. There is variation in these responsibilities among the four nations in the UK. When there is a livebirth following an abortion, or where there is uncertainty about whether there were signs of life, the coroner/Procurator Fiscal should be notified.
- Services that provide abortion care should establish close working relationships with local coroners/Procurator Fiscals to establish local pathways and to facilitate prospective discussions in situations where a livebirth after an abortion is anticipated.

1. Purpose

This paper has been produced in response to the publication of the Chief Coroner's Guidance No. 45 *Stillbirth and Live Birth Following Termination of Pregnancy* (released 3rd February 2023) [hereafter Guidance No. 45].[1] Guidance no. 45 applies to England and Wales and is written with a view to achieving consistency in Coronial practice. It is intended to "*help coroners understand and apply the current law relating to stillbirth, and live birth following termination of pregnancy, to promote consistency in the scrutiny of unnatural neonatal deaths*".[1] Thus, Guidance No.45 does not set clinical standards. The purpose of this position statement is to act as a resource for all healthcare practitioners (HCPs) involved in abortion care, to inform standards of clinical practice, mitigate potential variations in care, and to ensure that no unnecessary barriers are introduced for those accessing abortion care. To support practitioners in Scotland and Northern Ireland we have highlighted where there are any variations.

Whilst there has been no change in law, Guidance No.45 has caused concerns amongst healthcare professionals around: (i) how to discuss with and counsel women about the possibility of signs of life following an abortion and the possibility of coronial involvement; ii) when feticide should be offered; (iii) whether staff are familiar with signs of life guidance; (iv) which cases should be reported to the coroner; and (v) completing the medical certificate of cause of death (MCCD). This position statement aims to provide clarity for HCPs throughout the UK on their legal and caring responsibilities to women, following release of Guidance No. 45.

This resource applies to all women undergoing abortion for any indication from late second trimester onwards. The information within this document is supplementary to the existing 2010 RCOG report of a working party for women undergoing abortion for fetal anomaly entitled "Termination of Pregnancy for Fetal Abnormality in England, Scotland, and Wales".[2]

2. Legal responsibilities and guidance from the Chief Coroner

This section discusses the relevant legislation related to abortion and the responsibilities of medical practitioners related to establishing whether there has been a livebirth and whether referral to the coroner/Procurator Fiscal is required. There is variation in these responsibilities according to nation and thus these responsibilities, and the relevance of Guidance No. 45, are discussed further.

2.1 The Abortion Act

An abortion is a medical or surgical procedure to end a pregnancy. The 1967 Abortion Act,[3] as amended, sets out the grounds and time limits for abortion, as well as stating who can perform an abortion and where it can be performed in Great Britain. In situations where there is a livebirth and subsequent neonatal death following abortion, concern has been raised about whether a clinician could be accused of wrongdoing, specifically the possibility that they may be charged with murder or manslaughter. As per the 2010 RCOG Guidance, a doctor acting "*within the terms of the Abortion Act … cannot be acting 'unlawfully', which is one of the necessary ingredients of the law of homicide"*.[2,4] Guidance No.45 does not change this.

2.2 Establishing whether there has been a livebirth

There are some circumstances following abortion, particularly at or after the late second trimester, when a fetus can be born showing signs of life, and as such is then considered to have an independent life (regardless of gestation).

Paragraph 12 of Guidance No. 45 states that,

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

The Guidance further states in paragraph 14 that,

"*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*."[1]

Thus, HCPs caring for women undergoing abortion need to be informed as to how to appropriately determine if there have been signs of life. They also need to be aware of the process when there is unresolved uncertainty as to whether there have been signs of life. This is discussed in section 3.

2.3 Livebirth following an abortion

When a livebirth has occurred, the birth and subsequent death must be registered. To allow the registrar to register the death, doctors have a legal responsibility to complete a medical certificate of cause of death (MCCD).[5] Strictly speaking, in England and Wales the law requires where a doctor can issue an MCCD they should do so, even when a death has been referred to the coroner.[6,7] In practice, if the coroner has decided to investigate the death, he/she may tell the doctor not to complete the MCCD. However, the coroner can only legally certify the cause of death if he/she has investigated it through autopsy, inquest, or both. This means that, if the coroner decides not to investigate, the registrar will need to obtain an MCCD from a doctor who attended the neonate before the death can be registered. This may cause inconvenience to the patient if an MCCD has not already been provided.

In England and Wales, although requirements to notify the coroner are set out in The Notification of Death Regulations 2019 these regulations do not specifically reference neonatal deaths.[5] However, Guidance No 45 states,

"*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*" [paragraph 9, Guidance no. 45].[1]

Thus, for England and Wales Guidance No 45 makes clear that the decision whether to open an investigation lies with the coroner in accordance with their statutory obligations [Paragraph 21, Guidance no. 45] regardless of the views of bereaved parents or clinicians ("Interested Persons").*

In Northern Ireland neonatal deaths must be notified if Section 7 of the Coroners Act (Northern Ireland) 1959 is engaged.[8] An MCCD should not be completed if the death is being referred to the coroner.[9] In Scotland there is no requirement to refer to the Procurator Fiscal unless the death falls within one of the notifiable categories outlined in "Reporting deaths to the Procurator Fiscal: Information and Guidance for Medical Practitioners", 2019a.[10] In Scotland, when a death is being reported to the Procurator Fiscal the MCCD should not be completed until directed to do so.[10]

The process of confirming if there have been signs of life, and whether a doctor may complete the MCCD, varies by nation and is discussed in section 3.2.

3. Assessing and confirming signs of life

The key issue for HCPs in determining whether a neonatal death has occurred is whether there was a livebirth following an abortion, determined by the presence of signs of life. Guidance No.45 provides limited information about signs of life but does highlight to coroners that there is no legal definition of that term, and that there are various signs, in addition to breathing, that might indicate a neonate has been born alive [Guidance no 45, paragraph 12].[1] Where there is uncertainty over whether a neonate was born alive, or there is a dispute between those who attended a birth in relation to signs of life, it is the responsibility of HCPs to refer to the coroner and for the coroner to consider relevant medical evidence and decide whether or not a livebirth occurred.[1]

3.1 Assessing signs of life

While there is no formal definition as to what constitutes a sign of life, the World Health Organization (WHO) definition (ICD-11)[11] is in general use in the UK and states that:

"*Signs of life at birth include breathing, beating of the heart, pulsation of the umbilical cord and definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached. Fleeting reflex activity observed only in the first minute after birth does not warrant classification as a sign of life*."

The MBRRACE-UK Signs of Life Guidance was developed by a multidisciplinary group that included representation from the RCOG, RCM, BAPM, ARC and SANDS and included input from a national consultation. It provides support to HCPs with the assessment of signs of life for spontaneous births before 24 weeks of pregnancy where active survival-focused care is not appropriate.[12] While the

* = *The Notification of Deaths Regulations 2019 set out the circumstances where doctors must notify deaths to the coroner. Guidance No 45 is unclear about which aspect of the regulations give rise to the requirement to notify the coroner. For example, footnote 4 of Guidance No 45 references Regulation 3(1)(iiiv), however, there is no such regulation. It is an open question whether the Guidance is directing readers towards Regulation 3(1)(iii) or whether it has inverted the number and is referring to Regulation 3(1)(viii). At other times, e.g. paragraph 20, there is a reliance instead on the death being considered 'unnatural'. Notwithstanding the ambiguity of reasoning the broader message about the requirement from the coroner to notify is clear.*

guidance excludes abortions, the principles of the guidance around how to determine signs of life are helpful in this situation.

The MBRRACE-UK Guidance recommends that assessment of signs of life following birth is discreet and respectful, and the individual needs of the neonate, the woman and her partner are prioritised at this difficult time.

"*Assessment should be based on persistent, readily evident, visible signs. Listening for a heartbeat with a stethoscope or palpation of the umbilical cord is not necessary. Evident signs of life after birth would include one or more of the following:*

- *easily visible heartbeat seen through the chest wall*
- *visible pulsation of the cord after it has been clamped*
- *breathing, crying or sustained gasps*
- *definite movement of the arms and legs*

Since fleeting reflex activity including transient gasps, brief visible pulsation of the chest wall or brief twitches or involuntary muscle movement can be observed in babies that have died shortly before birth we recommend that such fleeting reflex activity observed only in the first minute after birth does not warrant classification as signs of life."

Further detail is given in the MBRRACE-UK Signs of Life Guidance document.[12]

3.2 Confirming signs of life

In England, Wales and Northern Ireland a doctor can determine signs of life if these are witnessed by them. If a doctor does not witness signs of life, they must discuss with the attending HCP, sensitively, and decide together whether signs of life were present (using the guidance in section 3.1). This discussion can include the woman's observations and views if she wishes to share them and have them conveyed to the coroner. In this situation, the doctor must inform the coroner (as they did not witness the signs of life) to allow a neonatal death certificate to be issued.

It is preferable, in the context of abortion, for the neonate to be seen by a member of the obstetric team rather than the neonatal team. Calling a neonatologist may result in confusion for the family, and a perception that the decision to provide comfort care, rather than survival focused care, is inappropriate. Agreed pathways of care and individualised counselling are thus required (see section 4.2). Legally, there is no requirement to take all possible measures "*to prolong the life of a baby born alive if it is not in his or her best interests*." [13] This is the case regardless of whether the child is born following abortion or otherwise.[1]

In Scotland it is not necessary to call a doctor to confirm signs of life, as observations provided by the attending midwife or other HCP can later be used in completion of a MCCD without the doctor having been present prior to the death.

3.3 Potential for coronial investigation and establishing local relationships with the coroner/Procurator Fiscal

The potential for coronial/Procurator Fiscal investigation and what this might involve should be discussed with parents and documented. Guidance no.45 states the following:[1]

- "*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.*" [paragraph 22]
- "*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*." [paragraph 23]
- "*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'.*" [Paragraph 24]

It is important for NHS Trusts / Health Boards / clinicians to have good working relationships and open communications with the regional coroner / Procurator Fiscal and agree on pathways for different scenarios.

Where there is a significant risk of a livebirth, the situation should be discussed prospectively with the coroner / Procurator Fiscal and include discussions about completion of the MCCD in the event of a livebirth.

3.4 Safeguarding Requirements

Paragraph 27 of Guidance No.45 states that child deaths in England must be reported to the local Child Death Overview Panel (CDOP). However, it should be noted that the statutory guidance for CDOPs specifically exclude "planned terminations of pregnancy carried out within the law"[15] with no requirement for the CDOP to collect information on the case or report it to NCMD (National Child Mortality Database). This is the case, regardless of the gestation of the fetus and whether or not it has been established as being live born.[16]

4. Pathways of care

As highlighted in the introduction, coronial / fiscal law differs throughout the UK and Guidance No. 45 is applicable to England and Wales only. Clinicians must be aware of their legal obligations, dependent on their region of practice. Counselling and informed consent for the abortion process should include individualised discussion of the chance of livebirth, feticide, management plan for the neonate if there are signs of life after delivery, and the potential for coronial investigation. These discussions should be clearly documented.

4.1 Likelihood of signs of life in the second trimester

Signs of life can occur from the second trimester onwards and become more likely as gestation advances, both following medical abortion without feticide and if birth were to occur prior to completion of surgical abortion (e.g. after cervical preparation). A UK based registry study reported

on livebirths following medical abortion for fetal abnormality between 1995 and 2004. Of n=3189 abortions there were n=102 (3.2%) livebirths. Of those delivered at 16-20 weeks, 3.5% were born with signs of life, compared to 5.4%, 6.4%, 9.7% by 21 weeks, 22 weeks, and 23 weeks, respectively.[17] Since this data has been published, reporting of signs of life has increased.[18] To ensure that signs of life do not occur, women can be offered feticide.

4.2 Feticide

Feticide is a procedure that induces irreversible asystole of the fetal heart prior to delivery. It should be considered in line with the general principles of good clinical practice and informed consent. The decision to undergo feticide is the woman's choice, but it is recognised that for many fetal medicine practitioners after 21^{+6} weeks gestation, feticide is seen as part of the procedure of abortion care (as recommended by the RCOG).[2] Rare maternal risks include septicaemia, inadvertent visceral or vascular injury or inadvertent injection of the drug into the maternal circulation.[19,20] Two maternal deaths from sepsis were reported in the most recent MBRRACE-UK confidential enquiry into maternal deaths 2019-2021 after an invasive feticide procedure conducted as part of late abortion.[21] There is no scientific basis for concern over fetal perception of distress from pain under 28 weeks.[22]

In line with existing RCOG guidance, in instances of medical abortion for fetal anomaly, feticide is advised where birth will occur beyond 21 weeks and 6 days weeks' gestation when there is a higher risk of signs of life following birth.[2]

As signs of life are possible prior to 21^{+6} weeks gestation, when birth is likely to occur between 20^{+0} to 21^{+6} weeks and women are concerned about the chance of livebirth after individualised counselling, it is reasonable to discuss the option of feticide prior to medical abortion. However, feticide should not be recommended in this gestational age range due to lower overall chances of livebirth. While it is likely that most women will decline feticide between 20^{+0} and 21^{+6} weeks, it is important to consider the potential added case load of offering feticide at this gestation and devise appropriate regional pathways to ensure access to abortion care is not restricted.

When birth is likely to occur at gestations $<20^{+0}$ weeks feticide should not be routinely offered as the procedure is technically more difficult, and there are concerns that potentially serious procedure-related maternal risks would outweigh any possible benefit of the procedure where there is no chance of survival for the fetus.

Where there is an increased risk of a livebirth, for example with medical abortion after 21^{+6} weeks' gestation where the woman declines feticide, the situation should be discussed prospectively with the coroner. Additionally, where gestational age is ascertained and a livebirth possible, it is valuable to have local pathways in place to plan for palliation in the event of a livebirth, including not calling for neonatal resuscitation. In each case, discussions and the plan of management following a livebirth should be documented, including discussions with the coroner.

Guidance No 45 does not change the clinical standards on feticide, but it does make clear that where there is a neonatal death following abortion the coroner must be notified and they may open an investigation. It is important to make sure women are aware of this.

4.3 Management plan for the neonate if born alive

Paragraph 25 of Guidance no.45 states that,

"*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."*[1]

It is thus imperative that when there is a significant chance of a neonate being born alive following an abortion (e.g. medical abortion with birth likely to occur ≥21^{+6} weeks with no prior feticide) a plan of care has been discussed and agreed in advance. This is to prevent inappropriate resuscitation of a neonate at extremely high risk of poor outcome.

The British Association of Perinatal Medicine (BAPM) has published a Framework for Practice to assist decision-making prior to and/or at the time of birth, relating to perinatal care and preterm delivery at 26 weeks and 6 days of gestation or less in the UK.[13] It considers the most recent available outcome data both from the UK and internationally, and was produced following wide consultation. Whilst this framework does not relate to decision-making around abortion, its principles are useful in scenarios where there are signs of life after an abortion, specifically the importance of acting in the 'best interests' of the child and how this standard might be interpreted in practice. The executive summary is that for fetuses/neonates at extremely high risk of poor outcome, palliative (comfort focused) care would be the usual management.[13] For fetuses/neonates at high risk of poor outcome, the decision to provide either active (survival focused) management or palliative care should be based primarily on the wishes of the parents.

5. Summary

- Healthcare professionals need to be aware of their legal responsibilities with relation to completion of the medical certificate of cause of death and referral to the coroner / Procurator Fiscal, and the variation in the different home nations. Healthcare professionals in England and Wales need to be aware of Guidance No. 45 and the guidance of the Chief Coroner with respect to livebirths following abortion.

- Healthcare professionals have a responsibility to provide access to abortion care and to ensure that there is no variation in care for women.

- Healthcare professionals should understand what constitutes signs of life. They should be aware of, but not actively seek out signs of life, nor confuse fleeting reflex activity with signs of life.

- When there is a livebirth following an abortion, or where there is uncertainty about whether what was observed represented signs of life, the coroner / Procurator Fiscal should be notified.

- Women should have an individualised, informed discussion related to the chance of signs of life after abortion at later gestation and, where appropriate, a discussion regarding feticide and the plan of care for the neonate if there are signs of life. These discussions should be clearly documented.

- For medical abortion where birth is likely to occur after 21^{+6} weeks' gestation, feticide is recommended. If this is declined by the woman, she needs to be aware that if there are signs of life the coroner / Procurator Fiscal must be notified with the possibility of further investigation and potentially an inquest.
- All women should have an individualised discussion around signs of life when deciding on medical abortion between 20^{+0} and 21^{+6} weeks. Feticide should be discussed if a woman is concerned about the chance of livebirth and/or referral to the coroner.
- When medical abortion is to occur under 20-weeks' gestation signs of life are possible but rare, and feticide is not recommended as it is more technically challenging, with risks that outweigh the intended benefits of feticide in preventing livebirth.
- For surgical abortion there is a small risk of delivery between cervical preparation and the surgical procedure, although signs of life are very rarely reported. Providers can offer feticide after 21^{+6} weeks following discussion with the woman, but the benefits do not outweigh the risks at earlier gestations, especially as the action of performing feticide may in itself make spontaneous delivery more likely.

- NHS Trusts / Health Boards / clinicians should develop close working relationships with local coroners / Procurator Fiscals and consider prospective communication in instances where signs of life are anticipated following abortion. These discussions should be clearly documented.

6. Provenance

This paper was commissioned by the RCOG abortion taskforce and developed using the methodology and governance of the RCOG. The abortion taskforce includes members of all key stakeholders, including officers of RCOG, FSRH and BSACP, and invited observers from RCM, RCN, DHSC, NIO, BMA, GMC, NMC, NHSE, CQC, providers and commissioners.

The working party is grateful for the help and support provided by the RCOG clinical quality and guidelines secretariat, to the BAPM for their contribution and to the following for their help with the development and review of the guideline:

Carmel Bagness (RCN), Jane Fisher (ARC), Edward Dorman, Tracey Johnston (BMFMS), Patricia Lohr, Jonathan Lord (BSACP, chair guideline working group), Sheelagh McGuiness, Tracey Masters (BSACP, FSRH), Fionnuala Mone (BMFMS), Katie Morris (BMFMS), Kate Navaratnam (BMFMS), Lesley Regan (RCOG), Lucy Smith (MBRRACE-UK), Steve Wardle (BAPM)

Although most abortion care is provided to women, other people whose gender identity does not align with the sex they were assigned at birth can also experience pregnancy and abortion. For simplicity of language this document uses the term women, but this should be taken to also include people who do not identify as women but who are pregnant.

In line with international and RCOG convention, the term “abortion” is used in this document. When developing local guidelines and patient information, “termination of pregnancy” may be preferred for local use particularly in the context of fetal indications.

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18 December 2023

7. Abbreviations and Glossary

ARC	Antenatal Results and Choices (national charity)
BAPM	British Association of Perinatal Medicine
BMA	British Medical Association
BMFMS	British Maternal & Fetal Medicine Society
BSACP	British Society of Abortion Care Providers
CQC	Care Quality Commission
DHSC	Department of Health and Social Care
FSRH	Faculty of Sexual and Reproductive Healthcare
GMC	General Medical Council
ICD-11	International Classification of Diseases 11th Revision
ISP	Independent Service Provider
MBRRACE-UK	Mothers and Babies: Reducing Risk through Audit and Confidential Enquiries across the UK (the MBRRACE-UK collaboration)
NIO	Northern Ireland Office
NHS	National Health Service
NHSE	NHS England
NMC	Nursing and Midwifery Council
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists
SANDS	Stillbirth and Neonatal Death charity and support group
WHO	World Health Organization

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