5. Have you seen and questioned any other medical practitioner who attended the deceased?----------
---

---

6. Have you seen and questioned any person who nursed the deceased during his last illness, or who was present at the death? ----------
---
---

7. Have you seen and questioned any of the relatives of the deceased? ----------
---

---

8. Have you seen and questioned any other person? ----------

(On the answers to questions 5, 6, 7 and 8, give names and addresses of persons seen and say whether you saw them alone).

I am satisfied that the cause of death was ---------- and I certify that I know of no circumstances which can give rise to any suspicion that death was due wholly or in part to any other cause than disease/accident ---------- and that there is no circumstance of any sort known to me which makes it undesirable that the body should be buried at sea.

(signature) ----------

(Address) ----------

(Registered qualifications) ----------

(Date) ----------

(Place) ----------

ANNEXURE F

CHECKLIST FOR CONVEYANCE OF HUMAN REMAINS, IN TERMS OF CHAPTER 4 OF THE REGULATIONS.

(1) Documents needed for importation (non-infectious):

(a) The following documents must be provided for the importation of human remains: death certificate, Identity Document/ Passport, Embalming Certificate, Letter from the family member requesting importation, If the documents are not in English, a certified translation must be attached, A covering letter from either the Embassy or the undertaker that includes:

(i) Name of deceased

(ii) Date of death

(iii) Cause of death

(iv) Country of death

(v) Place of burial

(vi) Full contact numbers including codes.

(2) Documents needed for importation (infectious):

(a) The following documents must be provided for the importation of human remains: death certificate, Identity Document/ Passport, Embalming Certificate, Autopsy Report, Letter from the family member requesting importation. If the documents are not in English, a certified translation must be attached, A covering letter from either the Embassy or the undertaker that includes:

(i) Name of deceased

(ii) Date of death

(iii) Cause of death

(iv) Country of death

(v) Place of burial

(vi) Full contact numbers including codes.

Exportation of human remains

(1) Documents needed for exportation (non-infectious):

(a) The following documents must be provided for the exportation of human remains: death certificate, Identity Document, Passport, Embalming Certificate. Letter from the family member requesting exportation, If the documents are not in English, a certified translation must be attached, A covering letter from either the Embassy or the undertaker that includes:

(i) Name of deceased,

(ii) Date of death,

(iii) Cause of death,

(iv) Country of death,

(v) Place of burial,

(vi) Full contact numbers including codes.

(2) Documents needed for exportation (infectious):

(a) The following documents must be provided for the exportation of human remains: death certificate, Identity Document, Passport, Embalming Certificate, Letter from the family member requesting exportation. If the documents are not in English, a certified translation must be attached, A covering letter from either the Embassy or the undertaker that includes:

(i) Name of deceased

(ii) Date of death

(iii) Cause of death

(iv) Country of death

(v) Place of burial

(vi) Full contact numbers including codes.

Transit through South Africa - human remains

(1) Documents needed transit through South Africa:

(a) The following documents must be provided for the exportation of human remains: death certificate, Identity Document, Passport, Embalming Certificate, Letter from the family member

requesting importation, If the documents are not in English, a certified translation must be attached, A covering letter from either the Embassy or the undertaker that includes:

(i) Name of deceased

(ii) Date of death

(iii) Cause of death

(iv) Country of death

(v) Place of burial

(vi) Full contact numbers including codes.

Exhumation and importation/ exportation of human remains

(1) Documents needed for exhumation and exportation.

(a) The following documents must be provided for exhumation and exportation: death certificate, Identity Document, Passport, Embalming Certificate, Letter from the family member requesting importation, If the documents are not in English, a certified translation must be attached, A covering letter from either the Embassy or the undertaker that includes:

(i) Name of deceased

(ii) Date of death

(iii) Cause of death

(iv) Country of death

(v) Place of burial

(vi) Full contact numbers including codes.

(2) Documents needed for exhumation and importation:

(a) Covering letter from either the Embassy/ Undertaker, this must include:

(i) Name of Deceased

(ii) Date of Death

(iii) Place of Burial

(iv) Place of Reburial (including grave numbers)

(v) Full contact numbers including correct codes for phone and fax.

(b) Death Certificate (If body is over 20 years in grave, no death certificate is required)

(c) Letter from a family member requesting exhumation

(d) If graves are on private owned ground, a letter of permission from the owner to allow the burial or exhumation of the body is needed. Or permission must be granted from the relevant government.

Unknown Grave/Graves

(a) Request from Company / undertakers must include:

(i) Place of grave,

(ii) Copies of the newspaper advertisement advertising the discovery of the grave (the advertisement must run for two weeks),

(iii) Place of reburial,

(iv) If graves are on private owned ground, a letter of permission from the ground owner to allow the burial or exhumation of the body /bodies is needed,

(v) Full contact number including correct codes.

Documents needed for exhumation and cremation:

(1) Identity Document/Passport,

(2) Death Certificate,

(3) Letter from the family member requesting exhumation and cremation,

(4) If the grave is on owned ground, a letter of permission from the ground owner to allow exhumation of the body. Or permission must be granted from the relevant government.

(5) In the documents are not in English, a certified translation must be attached,

(6) A covering letter from the undertaker must include:

(a) Name of deceased

(b) Date of death

(c) Cause of death

(d) Place of burial (including grave number)

(e) Full contact numbers including codes.

ANNEXURE G

CERTIFICATE NO: .....

CERTIFICATE OF COMPETENCE FOR FUNERAL UNDERTAKERS PREMISES OR MORTUARIES IN TERMS OF REGULATION 3.

FUNERAL UNDERTAKERS PREMISES/MORTUARY

Name _____

Address

_____

_____

OWNER/PERSON IN CHARGE

Name _____

Identity number:

CERTIFICATION AND RESTRICTION

It is hereby certified that the above mentioned premises complies with the provisions of these regulations.

RESTRICTIONS, CONDITIONS OR STIPULATION

_____

_____

_____

_____

ENVIRONMENTAL HEALTH PRACTITIONER

NAME:

PLACE:

DATE:

** THIS CERTIFICATE IS NOT TRANSFERABLE"*

ANNEXURE H

CHECKLIST FOR ISSUING CERTIFICATE OF COMPETENCE IN TERMS OF REGULATIONS 5, 6 AND 7.

The following areas should be checked for compliance. All facilities should also be checked to ascertain that they are in a working order.

AREAS OF FOCUS	COMPLY	NOT COMPLY	COMMENTS
A preparation room for the preparation of human remains.			
Change-rooms, separate for each gender, for the use of the employees employed at such premises			
Refrigeration facilities for the refrigeration of human remains.			
Facilities for the washing and cleansing of utensils and equipment inside the			

building.			
Facilities for the cleansing of vehicles on such premises.			
Facilities for the loading and unloading of human remains as contemplated in regulation 10 (2).			
Comply with all the requirements mentioned in regulations 10 and 11.			

ANNEXURE I

AUTHORIZATION FORM TO IMPORT/EXPORT HUMAN REMAINS IN TERMS OF REGULATION 14.

Authorization number: .....

WHEREAS application has been made for the importation/exportation of the remains of:

Name of the deceased .....

Address .....

Place of death .....

Cause of death .....

Country and place of burial .....

Declaration of whether the human remains are infectious or non-infectious .....

AND WHEREAS I have satisfied myself that all the requirements of these regulations and any other relevant legislation have been complied with, and that there exists no reason for any further enquiry or examination.

I hereby give permission for the importation/exportation of the said human remains from ..... (Country), to the REPUBLIC OF SOUTH AFRICA/COUNTRY OF DESTINATION on condition that the human remains will be embalmed and sealed in an airtight container and placed in a sturdy non-transparent coffin.

Any other conditions .....

(Signature) .....
(Designation) .....
(Date) .....

ANNEXURE J.

AN ORDER FOR A FUNERAL UNDERTAKER'S PREMISES OR MORTUARY TO STOP ACTIVITIES OR REMEDY A SITUATION PENDING OCCURANCE OF A NUISANCE WHICH SHOULD BE REMEDIED.

FUNERAL UNDERTAKERS PREMISES

Name: _____

Postal Address: _____

Physical Address: _____

E-mail Address: _____

OWNER/PERSON IN CHARGE

Name: _____

Identity number: _____

Tel: _____ Mobile: _____ Fax: _____

You are hereby informed of the occurrence of a nuisance and/or non-compliance with the provisions of these regulations as listed below.

_____

_____

_____

_____

_____

You are therefore requested to implement the following recommendations by (date):

_____

_____

_____

_____

_____ Or

Stop all activities for a Funeral Undertaker's premises or the activities listed hereunder as from (date)

_____

_____

_____

_____

_____

_____

ENVIRONMENTAL HEALTH PRACTITIONER (SIGNATURE)

NAME:

PLACE:

DATE:

MEDICINE AND THE LAW

Managing the remains of fetuses and abandoned infants: A call to urgently review South African law and medicolegal practice

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This article reviews South African (SA) law and its impact on the medicolegal management of fetal remains emanating from elective and therapeutic termination of pregnancies, stillbirths and miscarriages and the remains of abandoned or exposed infants. It was found that remains are treated differently, some constituting medical waste while others have sufficient status in law to allow for burial. This approach results in some women or couples being denied a choice with regard to disposal via culturally relevant practices, and is insensitive to the fact that all remains ultimately constitute human remains. The article argues that SA law is in urgent need of reform, and turns to foreign law and forensic practice to shed light on possible alternative approaches that could assist with developing the SA position and thereby improve the practical management of fetal and infant remains in SA.

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Current South African (SA) legislation and common law principles leave many questions pertaining to the management of fetuses and infants in clinical and forensic pathology practice. The application of different legislation to different areas of medical practice results in different status being assigned to fetal and/or infant remains. Some women or couples are denied a choice with regard to disposal of fetal remains via culturally relevant practices such as burial or cremation. Current legislation also compromises effective investigation into problematic areas such as the illegal disposal of fetal remains or infants by members of the public.

This article considers the SA law relevant to fetal and infant remains and reveals a number of inconsistencies and concerns. It then turns to foreign law and forensic practice to inform possible changes to the SA position with the aim of improving the practical management of fetal and infant remains in SA.

Legislation pertaining to the management of fetal remains in SA

In SA, the fetus is not vested with any constitutional rights and is primarily viewed as being part of the body of a pregnant woman.[1] This position is accepted by the authors. However, the authors assert that legislative provisions relating to the management of fetal and infant remains should be clear and consistent, providing appropriate guidance for all reasonably foreseeable outcomes. Legislative provisions should specifically also cater for the subjective need for respectful and sensitive management of all forms of human remains, including those of fetuses and abandoned infants. It is not possible to accommodate this stance in practice because of the approach currently adopted by the law.

Choice on Termination of Pregnancy Act 92 of 1996[2]

The Choice on Termination of Pregnancy Act[2] (Choice Act) is primarily concerned with ensuring access to safe termination of pregnancy (TOP) services and the regulation of the provision of these services.

Section 1 of the Act defines a TOP as 'the separation and expulsion, by medical or surgical means, of the contents of the uterus of a pregnant woman'. The term 'contents' is not defined, and it can be taken to broadly include fetal matter, placenta, and any other tissue and blood material removed from a woman's uterus. Once removed, section 3(1)(i) of the Choice Act requires that the products of conception must be managed, but aside from requiring facilities to have 'access to safe waste disposal infrastructure' the Act and regulations do not deal with this issue. The Act does not define 'waste' or 'disposal'.

According to regulation 2(xxxv) of the Gauteng Health Care Waste Management Regulations,[3] in terms of the Environment Conservation Act 73 of 1989,[4] the definition of 'pathological waste' includes 'human fetuses'. Consequently, all fetal remains derived from TOP are afforded the status of medical waste and are disposed of in such a manner as to not pose a risk to public health.

This position presumes that all fetal remains stemming from TOP procedures are equally of no value, and all are accorded the status of pathological waste without any meaningful consideration of parties involved (including the mother/father). The presumption stands regardless of whether the TOP is an elective or therapeutic procedure, or whether the pregnancy is viable or non-viable. This hampers the development of alternative methods of disposal and denies choice with regard to disposal methods. The fact is that even pregnancies that are deliberately terminated can be considered a loss by women or couples.[5] The current approach is devoid of respect and sensitivity.

Births and Deaths Registration Act 51 of 1992[6]

Miscarriages and stillbirths are both serious complications of pregnancy that result in loss of the pregnancy and produce fetal remains. The dividing line between miscarriage and stillbirth pivots on the viability or ability to survive of a fetus. *Dorland's Medical Dictionary* defines a miscarriage as 'a popular term for spontaneous

abortion', spontaneous abortion as 'abortion occurring naturally; popularly known as miscarriage', and stillbirth as 'the delivery of a dead child'.[7-9] Many countries have legislation pertaining to the registration of stillbirths, with a specified gestational age attached to the definition. However, the conceptualisation of fetal viability in law is problematic, since the term generally fails to capture the essence of what viability means in a clinical setting. This failure relates to the fact that the law primarily relies on gestational age as an indicator of the ability to survive, while research indicates that viability is context sensitive, making the consideration of gestational age inconclusive when considered in isolation.[10]

In SA, the Births and Deaths Registration Act[6] regulates the registration of births and deaths. Section 1 of the Act also defines 'burial' as 'burial in the earth or the cremation or any other mode of disposal of a corpse'. This legislation is also applicable to the management of fetal remains emanating from a stillbirth or miscarriage, as it specifies what remains qualify for registration of 'deaths' and later burial, but uses gestational age alone as an indicator of whether one is dealing with a stillbirth or miscarriage.

The provisions relevant to the registration of deaths relate to 'persons' and those who are 'stillborn', indicating that the option of burial is limited to a particular 'person' or 'stillborn child'. 'Person' is not defined in the Act, but in SA, the legal concept of person does not include the unborn.[11] Furthermore, section 1 of the Act narrowly defines 'stillbirth' or 'stillborn' as involving a 'child' that 'has had at least 26 weeks of intra-uterine existence but showed no sign of life after birth'. Consequently, not all fetal remains originating from pregnancy complications can be buried. Should a pregnancy of less than 26 weeks' gestation come to an end, the fetal remains will be assigned the status of pathological waste.

This Act[6] treats fetal remains emanating from pregnancy complications differently to remains emanating from TOP, especially TOP at a later gestational age (see the example below). The differentiation in status and resulting implications with regard to disposal methods cannot be justified and are insensitive to the position of individuals who experience these situations.

The differences in legal status assigned to a stillborn fetus in terms of the Choice Act[2] and the Births and Deaths Registration Act[6] can be illustrated by the following example. If a woman is 32 weeks pregnant and a stillborn fetus is born, the parents will be issued with a death notification form in terms of the Births and Deaths Registration Act[6] and can bury or cremate the fetus. If the same woman is informed that continuation of her 32-week pregnancy will result in a severely abnormal infant, and she decides to terminate the pregnancy in terms of the Choice Act,[2] the stillborn fetus has to be treated as pathological waste.

'Viability' is not defined by SA legislation, but in case law. S v. Mshumpa[11] accepted that a fetus is capable of independent survival at 25 weeks' gestation. However, in S v Molefe[12] the court ruled that fetal viability occurred at 28 weeks' gestation for purposes of the crime of concealment of birth. The court came to this conclusion without taking into consideration any expert medical evidence, relying on outdated case law from Zimbabwe and Venda. The distinction imposed by the Births and Deaths Registration Act[6] is not only founded on an ill-established legal premise of viability, but it is used as the basis to determine the status of fetal remains and whether the family has the right to bury those remains.

Medicolegal management of remains emanating from abandoned fetuses or infants

This part of the article considers the general social disregard of fetal or infant remains more broadly and takes its cue from the poor management of fetal remains in the realms of the criminal justice system. Here, the management of fetal or infant remains involves cases in which they are 'inappropriately' disposed of in places not approved of by current legislation and regulations, such as in public toilets, dumps, dustbins or fields or alongside pathways.[13,14] These remains generally originate from unlawful TOP, concealed births or abandoned infants who have died from exposure.

Section 113 of the General Law Amendment Act 46 of 1935[15] criminalises concealment of birth. It provides that a person commits this offence if he or she disposes of a body of a newly born child without a lawful burial order, and does so with the intention of concealing its birth. The offence stands regardless of whether the child was born alive or died before, during or after birth. The Act does not define 'child'. However, S v. Molefe[12] provides that 'child' refers to a fetus that has reached at least 28 weeks' gestation. One will therefore not commit this crime if one's conduct involves a fetus of less than 28 weeks' gestation.

The common-law crime of 'exposing' an infant is the unlawful and intentional exposure and abandonment of a liveborn infant in circumstances that are likely to lead to its death.[16] Prosecutions are rare, and if prosecution is pursued, individuals are usually charged with murder.[16] However, the crime of murder can only be committed against a 'person', i.e. one who is born alive.[11] According to section 239(1) of the Criminal Procedure Act 51 of 1977,[17] breathing is sufficient evidence of live birth for purposes of criminal prosecution.

The discovery of discarded fetal or infant remains clearly requires investigation into a number of issues before a criminal charge can be anticipated. When such fetal material or deceased infants are found, the South African Police Service and the Forensic Pathology Service are contacted and the case is usually investigated under the Inquests Act 58 of 1959.[18] An inquest docket is opened and a medicolegal postmortem examination is conducted to establish gestational age, whether the fetus had lived outside the mother, and the cause of death or stillbirth.[19]

Since the crimes of murder or exposure are only applicable to those who are born alive, only viable or sufficiently developed fetuses, who were able to breathe, would constitute the subject of a criminal investigation. However, in respect of all possible criminal offences (concealment of birth, exposure or murder), postmortem examination of remains can be very challenging and even rendered fruitless as a result of decomposition, postmortem trauma or predation.[19,20] A criminal charge may not follow simply because essential forensic evidence could not be objectively established.

This discussion demonstrates that not all abandoned remains receive adequate attention in law, despite the fact that all constitute human remains. The dividing line rests on the notion of viability or ability to survive and sufficient evidence thereof. While criminal law provisions and regulatory frameworks appear to provide reasonably clear directions, their application can therefore be difficult in a practical setting. When the required essential characteristics of the remains cannot be established, no legal consequences ensue and perpetrators are not held accountable. It is not unusual practice for fetal remains (or products of conception) that have undergone medicolegal examination to be disposed of as human waste or incinerated. This implies that the remains are worthless. This conclusion is supported by the fact that not all discovered remains are recorded, and statistics relating to the inappropriate disposal of fetal and infant remains are not readily available. According to Jacobs *et al.*,[21] 'no research was found that specifically investigates the phenomenon of dumping babies and fetuses'.

Discussions on improving criminal/statutory provisions and social support systems cannot be meaningfully engaged in as long as fetal

and infant remains are deemed pathological waste. The current legal situation results in acts of abandonment remaining invisible and unaddressed. The extent of abandonment, factors facilitating that behaviour and the underlying social reasons are likely to remain unknown. Accordingly, effective regulatory or criminal law provisions will not be developed and meaningful social reform will not take place.

Overall, fetal remains hold an unfortunate position in SA, and the reason for this is not clear. There is no legislation or directives indicating what should be done with fetal remains in practice. The management and method of disposal of the remains should not cause offence, and should advance dignity without compromising the health of the public.

Alternative positions on the management of fetal remains emanating from obstetric practice

There are approaches that can be adopted to develop a sensitive position regarding the management of fetal remains emanating from obstetric practice. These approaches may be policy based or statute based. Each provides various options for methods of disposal, but also provides decisional space that allows for individualised choices.

The UK adopts a policy-based approach. Methods of disposal of fetal remains were contemplated in the Polkinghorne report.[22] This report proposed that 'on the basis of its potential to develop into a human being, a fetus is entitled to respect, according it a status broadly comparable to that of a living person'.[22] The report questioned the ethical validity of treating pre-viable and viable fetuses differently. Debates concerning the disposal of fetal remains followed, with subsequent formulation of policies and guidelines. One of the issues arising from these debates was the fact that only stillborn infants could be buried, 'stillborn infant' being defined as a fetus of at least 24 weeks' gestation, born without showing any signs of life.[23] Any loss of pregnancy before 24 weeks could not be registered as a death, and no burial of the remains was possible.[24] The Human Tissue Authority's[25] best practice guidelines on the storage and disposal of human organs and tissues now encourages respectful disposal of remains emanating from a pregnancy loss before 24 weeks' gestation: 'pregnancy loss should always be handled sensitively. The needs of the woman or couple should be paramount and disposal policies should reflect this.'[25] Issues surrounding viability, pre-viability, or distinguishing between TOP or various pregnancy complications are therefore no longer relevant for the purposes of sensitive disposal of fetal remains.

Even though the Human Tissue Authority's[25] code of practice is not law, it has been well received. The Cardiff and Vale University Health Board's Policy for the Management of Fetal Remains, Stillbirth and Neonatal Death[26] states that 'women/couples should have choices, regardless of pregnancy gestation and it acknowledges that the death of a baby for some individuals, irrelevant of gestation can be as significant as any bereavement ... staff will ensure that care meets personal, cultural, spiritual, religious and holistic individual requirements'. The Royal College of Nursing acknowledges that 'sometimes parents don't recognise their loss at the time, but may return months or even years later to enquire about the disposal arrangements. Therefore it is important to respect the wishes of parents who may not want to be involved, but to ensure that sensitive and dignified disposal is carried out.'[27]

Common to all guidelines is the need to dispose of fetal remains sensitively and that disposal should be governed primarily by the wishes of those affected. The guidelines assert that remains should not be categorised as 'medical waste', regardless of how the remains came to be. All directives merely constitute guides, and different institutions or organisations in the healthcare sector each still draft their own guidelines, resulting in inconsistencies between different guidelines and implementation more generally.[28] Furthermore, since guidelines serve as guides only, their authority and weight beyond the clinical setting are limited and they therefore cannot be imposed on those institutions or medical personnel functioning under other legal instruments such as burial and cremation laws. When burial or cremation laws are not aligned with the various health sectors' guidelines, the intention to dispose of fetal remains sensitively may therefore be frustrated. In fact, the authority and weight of guidelines is even questionable in clinical settings, since reports have recently emerged that fetal remains emanating from TOP procedures were being used to 'heat UK hospitals' and that patients were not consulted about what would happen to the remains of their fetuses.[29]

The Canadian province of Alberta takes a different approach, adopting a statute-based system that secures respectful and sensitive management of fetal remains. According to the Vital Statistics Act 2007,[30] every birth must be registered. The term 'birth' is not limited to specific gestational age; instead, any sign of life after complete expulsion or extraction will suffice. A stillbirth is defined as the complete expulsion or extraction, after at least 20 weeks' gestation or the attainment of at least 500 g, of a fetus that shows no signs of life when delivered. All stillbirths must be registered, but registration takes place as if there has been a birth followed by a death. The death of a person must be registered, and upon receipt of the death registration document, a burial permit must be issued. No person may dispose of a body without such a permit.[30]

While there seems to be a gap in respect of burial options for dead pre-viable fetuses, the Alberta Cemeteries Act RSA 2000 CC-3[31] offers support in this regard. The Act authorises the development of regulations that allow for 'the disposal of fetuses and the bodies of newborn infants who have died, subject in each case to the parents' or guardians' request, and defining a newborn infant for the purposes of the regulations'.[31] Regulation 8 of the General Regulation 249/1998[32] provides that in the case of death of a fetus, the remains need not be disposed of in accordance with the burial requirements specified for a deceased human body, but it specifies that the manner of disposal is subject to the 'parents' or guardian's' request. It further specifies that disposal must not cause public offence. In the case of death of a fetus or newborn infant in a hospital, the hospital may dispose of the remains, but the manner of disposal is subject to the parents' or guardian's request and such disposal may not cause public offence.[33] No distinction is made between remains emanating from elective or therapeutic TOP, or those resulting from pregnancy complications.[32,33]

Alternative positions regarding forensic (medicolegal) management of the remains of abandoned fetuses and infants

A review of practices in the medicolegal management of the remains of abandoned fetuses and infants proved difficult, to the extent that no clear alternatives for managing these cases have been defined.

There are troublesome gaps in the available data. The World Health Organization has indicated that globally an estimated 20 million pregnancies are unsafely terminated each year.[34] While it is accepted that the products of illegally performed early TOPs may not be recognisable and are therefore easily disposed of, there must be later-term TOPs that do not result in viable births but produce remains that are more difficult to dispose of because of their recognisability and size. From a medicolegal perspective, there are few or no data

concerning the finding and management of remains emanating from these practices.

Finally, in many countries there is a seemingly endless record of cases of neonaticide and infanticide. Schulte *et al.*[35] reported that in Germany there were 150 cases of suspected neonaticide from 1993 to 2007, with 45% remaining unsolved. Herman-Giddens *et al.*,[36] writing on experiences from North Carolina, USA, stated that 'at least 201 per 100 000 newborns are known to be killed or left to die per year', and although they did not review the outcomes of all the cases prosecuted, the sentences varied from none to 25 years' imprisonment. No research is available on the outcomes of such cases in SA.

Conclusions

SA urgently needs to review the current legislation pertaining to the management of the remains of abandoned fetuses and infants, TOPs and miscarriages. Law reform will allow for improved, sensitive clinical practice.

In the context of clinical management, these changes should strive to allocate the same status to all remains, regardless of how the pregnancies ended. Development in this area should provide people with the opportunity to bury remains appropriately regardless of the gestational age, since it is well known that this assists the grieving process. It should be emphasised that this option should be permissive in nature, rather than an obligation to dispose of a fetus in a culturally relevant way. Where no choice is exercised, disposal should nevertheless be sensitive and respectful.

There appear to be wide variations in reported incidences of abandoned fetuses and infants. Sadly, this is a glaring global concern. Clear frameworks and informative legal guidelines are needed, specifically with regard to medicolegal investigation protocols when handling the remains of abandoned fetuses and infants. Protocols should demonstrate and inculcate respect for fetuses or infants, since these remains are human in nature, and this should stand regardless of whether prosecution is possible or not. This approach will also assist in developing much-needed statistics on the prevalence of illegal TOP and abandonment of infants.

Although all fetal remains are similar, especially in the medicolegal environment, why are they treated so differently?

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Guidance on the disposal of pregnancy remains following pregnancy loss or termination

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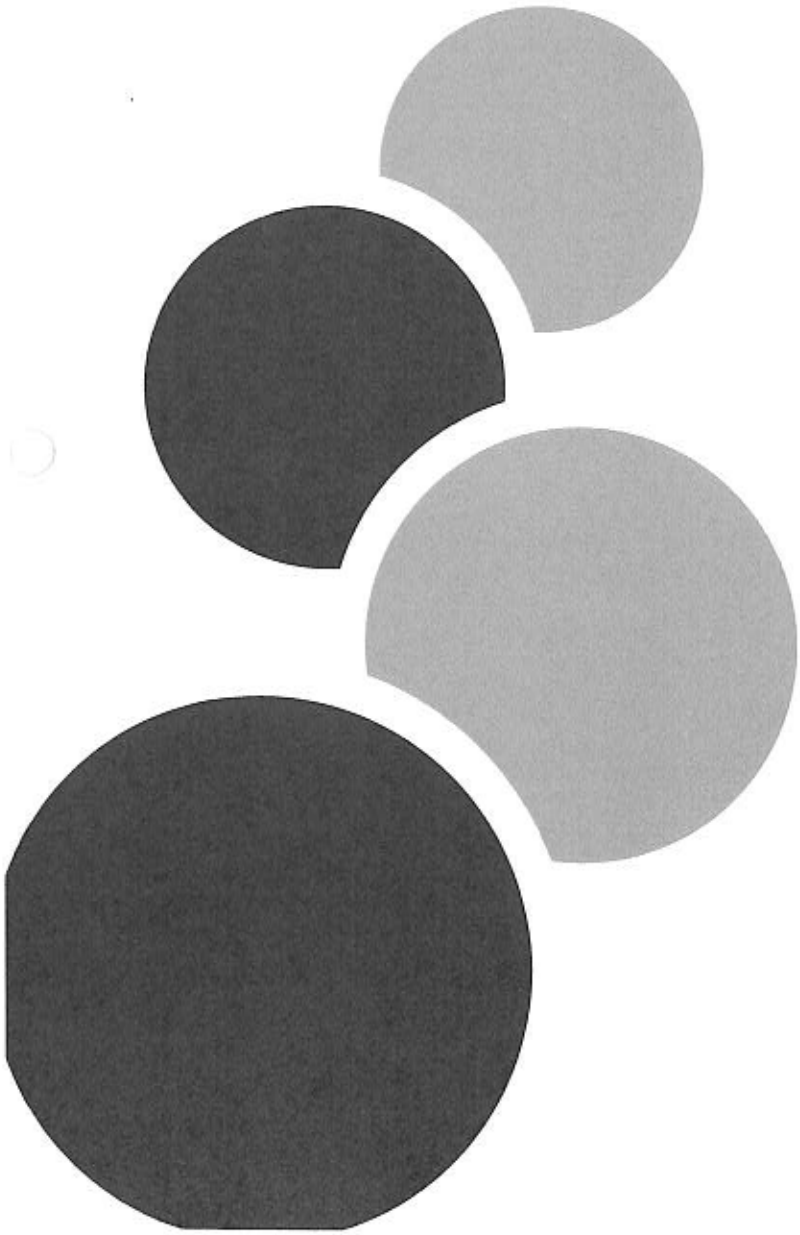

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GUIDANCE ON THE DISPOSAL OF PREGNANCY REMAINS FOLLOWING PREGNANCY LOSS OR TERMINATION

Introduction

1. This guidance should inform policies and procedures governing the disposal of pregnancy remains resulting from pregnancy loss or termination of pregnancy in a clinical setting, including NHS and independent hospitals and abortion clinics. It is the result of consultation with key stakeholder groups (see Appendix 1). The geographical extent of the guidance is England, Wales and Northern Ireland.

2. The term 'pregnancy remains' is used throughout in relation to all pregnancy losses, for example as a result of ectopic pregnancy, miscarriage or early intrauterine fetal death; it also applies to terminations of pregnancy that have not exceeded the 24th week of pregnancy[1].

3. The guidance does not apply to stillbirths (babies born dead after the 24th week of pregnancy) and neonatal deaths (see paragraphs 34-37). Nor does it apply to the disposal of embryos created in vitro (for fertility treatment or embryo research); these are regulated by the Human Fertilisation and Embryology Authority (HFEA).

4. The Human Tissue Act 2004 (HT Act) makes no distinction between the disposal of pregnancy remains and the disposal of other tissue from a living person; pregnancy remains are regarded as the tissue of the woman. Although under the HT Act, consent is not required for the disposal of pregnancy remains, the particularly sensitive nature of this tissue means that the wishes of the woman[2], and her understanding of the disposal options open to her, are of paramount importance and should be respected and acted upon.

5. The guidance sets out the minimum standard expected for the disposal of tissue following pregnancy loss or termination of pregnancy, which is: cremation, burial or incineration in certain circumstances. Incineration should only occur where the woman makes this choice, or does not want to be involved in the decision, or does not express an opinion within the stated timescale (see para 19), and the hospital

[1] As specified in section 1(1)(a) of the Abortion Act 1967. Late terminations that exceed 24 weeks gestation are subject to the requirements of the Birth and Deaths Registration Act 1953, and must be registered as still-births.

[2] Throughout the guidance, we refer to 'the woman'; however, it should be taken into account that a women may choose to delegate the decision to her partner, a family member or friend.

considers this to be the most appropriate method of disposal. Hospitals that currently do not offer incineration as an option and cremate or bury all pregnancy remains as a matter of routine, should consider whether their policy limits the options given to women and how they would respond should a woman's preference be for her pregnancy remains to be incinerated.

6. The guidance applies equally to NHS hospitals and independent sector providers.

7. Guidance on the disposal of pregnancy remains is also available from the Royal College of Nursing: http://www.rcn.org.uk/__data/assets/pdf_file/0020/78500/001248.pdf

The importance of communication and information

8. In all cases, the woman should be made aware that there are options for disposal. She should be given verbal or written information about the options, given the opportunity to discuss them, and supported in an individual and sensitive manner to ensure that she can make a decision that is right for her.

9. The information provided should include an explanation of how the pregnancy remains will be disposed of if the woman does not wish to make a decision and would prefer the hospital to handle the matter. It should also explain who to contact to request a particular disposal option and the timescale for this. Personal, religious or cultural needs relating to the disposal of the pregnancy remains should be met wherever possible. For example, in Islamic teaching, all pregnancy remains must be buried.

10. Some women may not wish to know about the disposal of the pregnancy remains or be involved in decisions about disposal, and may decline the offer of information about the possible options. Providing they have been told that the information is available, establishments should recognise and respect the wishes of those women who choose not to engage in the matter of disposal.

11. Whatever she decides, including whether she declined the offer of information and chose not to be involved in the decision, should be recorded in the woman's medical notes.

12. The loss or termination of a pregnancy, whatever the circumstances, is clearly an exceptionally sensitive and emotional time for a woman. Policies and procedures need to acknowledge and make provision for the fact that, whilst a woman may not wish to engage in discussions about disposal of pregnancy remains (or make a

decision), she may change her mind at a later date or ask about what arrangements were made. It is therefore important to ensure that as well as respecting the wishes of those who choose not to be involved at the time, the disposal of pregnancy remains is carried out as outlined within this guidance.

13. Detailed guidance on communication with women regarding pregnancy loss may be found in guidance from the Stillbirth and neonatal death charity (Sands) [https://uk-sands.org/resources].

Developing a disposal policy

14. Hospitals' disposal policies should ensure that pregnancy remains are treated with respect regardless of the circumstances of the loss or termination, and that women are aware that there are disposal options available to them.

15. It is essential that guidance and practice on disposal reflect the sensitivity required when dealing with pregnancy remains. The needs of the woman are of paramount importance in the development of a disposal policy, which should be written in such a way as to make it suitable for women who choose to access it.

16. All staff who may be asked, or expected, to provide information about disposal should be aware of the policy and prepared to discuss it. They should be sensitive to the values and beliefs of a wide range of cultures and religions, particularly those of their local community, whilst at all times remembering that each decision is particular to the individual woman. The staff involved with these discussions should have detailed knowledge of, and understand the practical aspects of, each form of disposal to be able to properly communicate this information to the woman. This might include the likelihood of recovering remains following a cremation, or perhaps the opportunity for some form of memorialisation if burial is chosen.

17. There should be training for staff to equip them to best support the woman in a sensitive and caring manner. Because of the very sensitive nature of the disposal of pregnancy remains, all staff should have access to education about the process and be reminded about access to counselling services should they feel the need for support themselves.

18. The policy and supporting procedures should ensure that disposal of pregnancy remains in line with the woman's wishes take place as soon as practicable after she has communicated her decision.

19. Where the woman has not made a decision about disposal within a locally specified period of time since the pregnancy loss or termination (which should not exceed 12 weeks), the hospital responsible for the woman's care should make arrangements for disposal in line with this guidance. The woman should be made aware of the time period when first given information about disposal options.

20. Records of how and when the remains were disposed of, including, where relevant, the name of the cemetery or crematorium, should be maintained by the hospital in order that full information may be provided at a later date if requested.

Disposal options

21. Cremation and burial should always be available options for the disposal of pregnancy remains, *regardless of whether or not there is discernible fetal tissue.* Sensitive incineration, separate from clinical waste, may be used where the woman makes this choice or does not want to be involved in the decision and the establishment considers this the most appropriate method of disposal.

Cremation

22. Although not covered by The Cremation (England and Wales) Regulations 2008, pregnancy remains may be cremated and most crematoria are willing to provide this service. Establishments will need to negotiate with the local crematoria to agree the level of service to be provided. If this service is not available locally, they should consider negotiating with other service providers further afield. The ICCM's policy and guidance 'The Sensitive Disposal of Fetal Remains' contains a draft agreement which may be helpful to establishments [http://www.iccm-uk.com/iccm/index.php].

23. If the establishment is not able to access the services of a crematorium, they should explain to the woman that they will not be able to arrange for the pregnancy remains to be cremated and give her the opportunity to make her own arrangements or identify a crematorium to which the remains may be sent on her behalf.

24. Where the pregnancy remains will be cremated alongside others, the woman should be informed and, if necessary, made aware of what alternative options exist. As a minimum, the remains should be in individual sealed containers, collected together into a larger sealed container. In order to maintain an audit trail, in any communications with the crematorium about shared cremation, hospitals should identify each set of pregnancy remains with either the woman's name or a

unique reference/case number if confidentiality needs to be maintained. Patient details should not be shared without the express permission of the woman.

25. When discussing the option of cremation of pregnancy remains, women should be told that ashes may not always be recovered in the case of an individual cremation. Sands has produced guidance on this topic, which can be accessed via their website.

Burial

26. Pregnancy remains may also be buried. Establishments should consult the local burial authorities to establish what level of service is available and if the service is not available locally, they should consider contacting other service providers further afield.

27. Where the pregnancy remains will be buried in the same plot as other sets of remains, the woman should be informed and, if necessary, made aware of what alternative options exist. As a minimum, the remains should be in individual sealed coffins or containers, collected together into a larger sealed container. In order to maintain an audit trail, in any communications with burial authorities about shared burial, hospitals should identify each set of pregnancy remains with either the woman's name or a unique reference/case number if confidentiality needs to be maintained. Patient details should not be shared without the express permission of the woman.

28. When discussing the option of shared burial, the woman should be told that there will be no individual memorialisation available to mark the location of the burial.

Sensitive Incineration

29. Incineration may be used where the woman makes this choice or does not want to be involved in the decision, preferring to leave it to the hospital to make arrangements, or does not make a decision within the stated timescale and the hospital has made a considered decision that this is the most appropriate method of disposal.

30. Although incineration and cremation both involve the pregnancy remains being burnt, they are not the same. It is important that the woman understands what is meant by incineration and the distinction between this and cremation, in order that she can make an informed choice. The staff involved with communicating the

information to the woman should have detailed knowledge of the processes to ensure that they are able to properly explain this information.

31. Pregnancy remains should be subject to a different process from clinical waste. They should be packaged and stored separately in suitable containers prior to their disposal, and incinerated separately from clinical waste. Establishments may wish to consider optional additional arrangements they could make to dispose of the tissue sensitively, for example by involving their hospital chaplain or local spiritual leaders. However, the woman's wishes are paramount and where a woman has opted for incineration precisely because she does not wish her pregnancy remains to be given any special status, this should be respected.

32. Where incineration is the disposal method used, it must be done as sensitively as possible. The date of the collection and the location of the incineration should be recorded.

Returning the pregnancy remains to the woman

33. Some women may wish to make their own arrangements for the disposal of their pregnancy remains. It is appropriate in these cases for the hospital to offer advice and assistance, although any costs incurred will normally be the responsibility of the woman. If the woman requests that the remains be returned to her, they should be stored in an appropriate container in a safe place and made available for collection by the woman or her representative. The decision, and the date of collection, should be recorded in the woman's medical notes and she should be given written confirmation that she is entitled to take the remains to make her own arrangements.

Stillbirths and neonatal deaths

34. Babies born dead after the 24th week of pregnancy are defined in law as stillbirths and must be registered as such. This includes late terminations that take place at gestations exceeding 24 weeks. Common law requires that stillborn babies must be buried or cremated.

35. A baby or fetus of any gestational age which is born showing signs of life and dies before the age of 28 days is a live birth and neonatal death. The law requires that where a baby or fetus is born showing signs of life and then dies, their birth must be registered and they must be buried or cremated.

36. While the legal duty to make funeral arrangements following a stillbirth or neonatal death rests with the parents, with their consent, it may be done by establishments on their behalf. In respect of stillbirths, it has long been recognised as good practice for hospitals to offer to arrange and pay towards burial or cremation. If parents would like this, they should be given the opportunity to attend the ceremony.

37. Further guidance on the requirements for the registration and disposal of stillbirths and neonatal deaths is available within the Sands guidelines [http://www.uk-sands.org/].

Appendix 1

The following organisations were consulted in the development of this guidance:

Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Midwives
British Pregnancy Advisory Service
Stillbirth and Neonatal Death Charity (Sands)
Miscarriage Association
Institute of Cemetery and Crematorium Management (ICCM)
The Federation of Burial and Cremation Authorities (FBCA)
Care Quality Commission
Department of Health
Ministry of Justice

Frequently asked questions

A set of FAQs which provide more practical information on implementing this guidance are available on the HTA website:
https://www.hta.gov.uk/faqs/disposal-of-pregnancy-remains-faqs