IN THE CONSTITUTIONAL COURT OF SOUTH AFRICA

Case no: 120/21

In the matter between:

THE VOICE OF THE UNBORN BABY NPC	First applicant
CATHOLIC ARCHDIOCESE OF DURBAN	Second applicant
and	
MINISTER OF HOME AFFAIRS	First respondent
MINISTER OF HEALTH	Second respondent
and	
CAUSE FOR JUSTICE	First *amicus curiae*
WOMEN'S LEGAL CENTRE TRUST	Second *amicus curiae*
WISH ASSOCIATES	Third *amicus curiae*

FIRST APPLICANT'S HEADS OF ARGUMENT

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APPENDICES

A INTRODUCTION

1 This application deals with pregnancy loss, the emotional consequences of such loss to the expecting parents, and how the state should deal with such bereaved expecting parents in our constitutional dispensation.

2 In particular, this application challenges the constitutionality of extant legislation that relates to how dead fetuses must be dealt with.

3 It should be noted, with respect, that the first applicant does not seek to create any rights or legal subjectivity for the fetus, but builds it case exclusively on the *constitutional rights of expecting parents who suffer miscarriage*.

4 Both the respondents on the one hand, and the first *amicus curiae* on the other – although they take opposing positions – fixate on the innate biological and moral properties of the fetus, such as its biological viability and whether it constitute a 'living human being'. It is settled law that the fetus is not a legal subject and does not have any legal interests of rights.[1] Accordingly, the debate between the respondents and the first *amicus curiae* about the innate properties of the fetus is simply not relevant and only serves to detract from the actual legal issue before the Court.

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[1] *Christian Lawyers Association of South Africa v Minister of Health* 1998 (4) SA 1113 (T).

5 The only relevant legal paradigm in the present case is the constitutional rights of actual legal subjects, namely expecting parents who experience pregnancy loss. It is *uncontested* that expecting parents who experience pregnancy loss may suffer emotional and psychological trauma as a result.[2] It stands *uncontroverted* that many of these expecting parents who suffer pregnancy loss *want* to bury the fetal remains. It also stands *uncontroverted* that such burial of the fetal remains can *assist* bereaved expecting parents to deal with their grief.[3] These are the *facts* that form the foundation of this human rights case.

6 The core question that the respondents failed to recognise or address in their papers is the following: If we are a caring, compassionate society, why do we prohibit expecting parents who suffer pregnancy loss from burying the mortal remains of their unborn child if such burial is their wish, and such burial can bring them psychological healing?

7 The answer is that there is simply is no reason for this prohibition. Accordingly, the prohibition is unconstitutional.

8 For the benefit of the Court, I attach hereto two academic articles on the subject of this lawsuit: One by Dr Lorraine Du Toit-Prinsloo *et al* in the *South African Medical Journal*, and one by Professor Magda Slabbert in the *Journal for Contemporary Roman-Dutch Law*.

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2 Respondents' answering affidavit to the first applicant, para 24, p521 (Court *a quo* index, vol 2).

3 See the judgment *a quo*, para 49, p23 (Constitutional Court index, vol 1).

Structure of these heads of argument

9 In Part B, I provide the Court with a summary of the relevant legislation, and in Part C, with a summary of the facts. Part D is a human rights analysis of the relevant legislation. This analysis concludes that specific parts of our extant legislation is unconstitutional, as found by the court *a quo*. In Part E, I make submissions regarding appropriate remedies. I then provide the Court with a brief comparative legal analysis in Part F. Lastly, in Part G, I address the issue of costs that, in my respectful submission, has been erroneously decided by the court *a quo*.

B SUMMARY OF EXTANT LEGISLATION

10 First, a note regarding terminology: Pregnancy loss can either be due to natural causes (spontaneous pregnancy loss) or due to conscious human decision (induced pregnancy loss / termination of pregnancy / abortion). In the case of natural causes, pregnancy loss can occur either before the fetus is viable (miscarriage) or after viability (stillbirth).

Births and Deaths Registration Act

11 The Births and Deaths Registration Act 51 of 1992 ('BADRA') is the statute that governs burials, and in particular governs which entities qualify to be buried.

12 The relevant definitions of BADRA read as follows:

> **1. Definitions**
>
> In this Act, unless the context otherwise indicates –
>
> […]
>
> **'birth'**, in relation to a child, means the birth of a child born alive;
>
> **'burial'** means burial in earth or the cremation or any other mode of disposal of a corpse;
>
> […]
>
> **'corpse'** means any dead human body, including the body of any still-born child;
>
> […]
>
> **'still-born'**, in relation to a child, means that it has had at least 26 weeks of intra-uterine existence but showed no sign of life after complete birth, and **'still-birth'**, in relation to a child, has a corresponding meaning;

13 Section 18 of BADRA provides for the issuance of still-born certificates or still-born declarations, and consequent to such certificates or declarations, burial orders. The relevant subsections read as follows:

> **18. Still-birth**
>
> (1) A medical practitioner who was present at a still-birth, or who examined the corpse of a child and is satisfied that the child was still-born, shall issue a prescribed certificate to that effect.
>
> (2) If no medical practitioner was present at the still-birth, or if no medical practitioner examined the corpse of a still-born child, any person who was present at the still-birth shall make a prescribed declaration thereanent to any person contemplated in section 4.

(3) The certificate mentioned in subsection (1) or the declaration mentioned in subsection (2) shall be deemed to be the notice of the still-birth, and a person contemplated in section 4 shall, on the basis of such notice and if he or she is satisfied that the child was still-born, issue under the surname of any parent concerned a prescribed burial order authorizing burial.

14 Subsection 20(1) of BADRA makes it clear that no burials may take place in the absence of a burial order. The subsection reads as follows:

20. Burial order

(1) No burial shall take place unless notice of the death or still-birth has been given to a person contemplated in section 4 and he or she has issued a prescribed burial order.

15 Accordingly, subsection 20(1), read with section 1 (the definition of 'still-birth') and subsections 18(1)–18(3) has the effect that no still-birth certificate or declaration can be issued in the event of miscarriage; this in turn has the effect that no burial order can be issued, thus *effectively legally banning the burial of dead fetuses in the event of miscarriage*.

Regulations Relating to the Management of Human Remains

16 The Regulations Relating to the Management of Human Remains made in terms of the National Health Act 61 of 2003 ('the Regulations') govern certain aspects regarding funeral undertakers and burials. The Regulations only make provision for the burial of 'corpses' and 'human remains', not for anything else. The Regulations define 'corpse' and 'human remains' in regulation 1 as follows:

> "corpse" means a dead human body;
>
> "human remains" means a dead human body, or the remains of a dead human body whether decomposed or otherwise;

17 Given that legal personhood only starts with *live birth*, the most apparent interpretation of 'dead human body' is the dead body of a person who actually lived, or, if interpreted aligned with BADRA, also including a still-born fetus (referred to in BADRA as a still-born 'child'). In either interpretation, 'dead human body' is unlikely to mean 'fetal remains following a miscarriage'.

18 Accordingly, the Regulations do not make provision for the burial of dead fetuses in the event of miscarriage.

National Standard: Management of Healthcare Risk Waste

19 The handling of dead fetuses is guided by, inter alia, the South African National Standard 10248, entitled 'Management of Healthcare Risk Waste', issued in terms of section 24 of the Standards Act, Act 8 of 2008, by the South African Bureau of Standards ('the National Standard').

20 The National Standard contains three parts. Each of these parts contains the same definition of 'pathological waste' or 'anatomical waste', which reads as follows:

> <u>waste</u> that contains tissues, organs, body parts, blood and body fluids from patients, <u>foetuses</u> and animal carcasses, but excludes teeth and hair [my emphases]

21 The National Standard groups anatomical or pathological waste as part of 'healthcare risk waste' and requires *incineration* as the main 'treatment' method of healthcare risk waste.

22 However, only dead fetuses that are 'discarded' in the first place are considered 'waste'. 'Waste' is defined as follows:

> undesirable or superfluous by-product, emission, residue or remainder of any process or activity, any matter, gaseous, liquid or solid or any combination thereof, which
>
> a) is discarded by any person;
>
> b) is accumulated and stored by any person with the purpose of eventually discarding it with or without prior treatment connected with the discarding thereof; or
>
> c) is stored by any person with the purpose of recycling, reusing or extracting a usable product from such matter

23 Accordingly – different from BADRA and the Regulations – the National Standard does not necessarily exclude the possibility that fetuses can be buried (rather than being discarded as healthcare risk waste).

C THE EVIDENCE BEFORE THE COURT

24 In the first applicant's founding affidavit, the first applicant shows, with reference to expert opinions, that many expecting parents make significant emotional investment in their prospective child before birth, and that pregnancy loss can cause such parents

intense grief – irrespective of gestational age or whether the pregnancy loss was due to natural causes or due to conscious human decision.

25 This was conceded by the respondents. The respondents state as follows:[4]

> It cannot be gainsaid that pregnancy loss irrespective of when it happens unabatedly results in emotional and psychological trauma to the bereaved parents. It is also correct that different parents would react differently to the pregnancy loss depending on how much they have emotionally invested on [sic] the pregnancy which subsequently terminated.

26 Furthermore, the first applicant shows – relying on expert opinions in the fields of psychology and grief counselling – that expecting parents who suffer miscarriage often have a desire to bury the fetal remains of their prospective child, and that the ceremony or ritual of a burial has a decidedly positive and healing effect on such expecting parents who suffer miscarriage.

27 Importantly, the respondents failed to submit any expert opinions. Accordingly, the expert opinions filed by the first applicant stand uncontroverted.

28 It is insightful to read the expert opinions filed by the first applicant in detail. I respectfully refer the Court to these expert opinions. In the following paragraphs, I

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4 Respondents' answering affidavit to the first applicant, para 24, p521 (Court *a quo* index, vol 2).

highlight just some of the most salient aspects that form the foundation of the first applicant's case.

29 Reverend Braam Klopper, a pastoral therapist who specialises in bereavement counselling, states as follows in his expert opinion:[5]

> It should be clear … that burial or cremation would impact ***positively*** on the process of grief of expecting parents who have experienced miscarriage or termination of pregnancy.

30 This sentiment is echoed by Dr Louise Olivier, a clinical and counselling psychologist, who states as follows:[6]

> From the clinical experience of the undersigned psychologist as well as the literature it is clear that an abortion, miscarriage or still birth of a foetus/baby can be extremely traumatic for not only the mother but also the father of the deceased foetus/baby. The management of the mother and the father after such an event is important for their mental health. One of the important management strategies would be to give the parents the choice if they want to bury the foetus or have the hospital discard it as medical waste.

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5 Klopper expert opinion (attached to the first applicant's founding affidavit as 'Smith4') para 36, p408 (Court *a quo* index, vol 2).

6 Olivier expert opinion (attached to the first applicant's founding affidavit as 'Smith3') para 6, p127 (Court *a quo* index, vol 1).

31 Importantly, Dr Olivier also provides an overview of African culture, and concludes as follows:[7]

> Most of the cultures in Africa recognise the belief of the spirit of each human being (even the unborn) and the importance of rituals to take leave of such a spirit in time of death and if it is not done appropriately that it has consequences for the community and the individual.

32 The positive value of burial must be seen in the following important context given by Reverend Klopper:[8]

> In contrast with incineration, a burial or cremation provides the opportunity for and typically entail ritual and ceremony (whether religious or secular). For such a ceremony to have the maximum effect the following would be of the utmost importance: the physical presence of the body or ashes of the deceased, the physical presence of the bereaved parents, and the physical presence and emotional support of their loved ones. [My emphasis]

33 The physical presence of the body of the dead fetus is also highlighted by Dr Olivier in the context of traditional Black South African culture:[9]

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7 Ibid.

8 Klopper expert opinion (attached to the first applicant's founding affidavit as 'Smith4') para 25, p404 (Court *a quo* index, vol 2).

9 Olivier expert opinion (attached to the first applicant's founding affidavit as 'Smith3') para 3.1, p119 (at the very bottom of the page) (Court *a quo* index, vol 1).

> . . . the ritual whilst the foetus is lying in the coffin allows the family members to help the spirit to resume his or her rightful role in the spirit world.

34 The problematic nature of the current legal position is summed up as follows by Reverend Klopper:[10]

> During my fifteen years of grief counselling, some of the parents who experienced miscarriage expressed their anger and feeling of disempowerment at the fact that their 'baby' was taken from them and in their absence unceremoniously incinerated; for these parents, the fact that their 'baby' was simply perceived and treated as 'waste' is experienced as a deep insult. These negative emotions caused by the current rigid system are acutely counter-productive in a grief counselling therapeutic setting.

35 Accordingly, expecting parents who suffer miscarriage have a clear interest in electing whether to bury the fetal remains of their prospective child.

D HUMAN RIGHTS ANALYSIS

36 In this section of my heads of argument, I submit that BADRA subsection 20(1) and the Regulations' definitions of 'corpse' and 'human remains' ('the impugned provisions') infringe on the constitutionally protected rights of expecting parents who suffer

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[10] Klopper expert opinion (attached to the first applicant's founding affidavit as 'Smith4') para 44, p410 (Court *a quo* index, vol 2).

miscarriage, by not allowing such expecting parents the choice whether to bury the fetal remains.

37 The human rights analysis has two stages: (1) The interpretation stage, in which it is investigated whether the relevant interest falls within the ambit of any constitutional rights, and if so, (2) the limitation stage, in which it is investigated whether the relevant constitutional rights can be limited by a legitimate government purpose.

INTERPRETATION STAGE

38 Given the evidence before the Court, it is clear that expecting parents who suffer miscarriage have a clear *interest* in electing whether to bury the remains of their late prospective child.

39 In the following paragraphs, I argue that this interest falls within the protective ambits of the constitutional rights to dignity, privacy, and equality.

Human dignity

40 Constitutional scholar Woolman identifies five closely related conceptions of human dignity that have crystallised in this Court's jurisprudence:[11] (1) an individual is an end-in-himself or -herself; (2) all individuals are entitled to equal concern; (3) an individual

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11 S Woolman, 'Dignity' in S Woolman and others (eds), *Constitutional Law of South Africa* (2nd edn 2005) 36-6–36-19.

is entitled to a space for self-actualisation; (4) an individual is entitled to self-governance; and (5) individuals are collectively responsible for the material conditions for individual agency. Especially conceptions (1) and (3) are applicable *in casu*.

41 Burial entails a ceremony where the expecting parents who suffered miscarriage and their loved ones can be present. This ceremony serves as an acknowledgement that the prospective child had meaning for the bereaved expecting parents. On a deeper level, it acknowledges the expecting parents who suffered miscarriage as *creators of meaning in their own lives* – as self-actualising individuals who are ends-in-themselves (conceptions (1) and (3) above).

42 Stated in practical terms: For many expecting parents their prospective child is important and meaningful. The law currently disrespects these expecting parents' feelings, and quite literally treats the body of the dead prospective child as waste. This is a slap in the face of these expecting parents who suffered miscarriage – a violation of their dignity.

43 Accordingly, the interest of the expecting parents who suffered miscarriage to be allowed the choice whether to have a burial for the fetal remains is protected within the ambit of the right to dignity.

44 The impugned provisions prohibit and/or fail to provide for such choice, and therefore infringe the right to dignity.

Privacy

45 In *Bernstein v Bester*, this Court held that privacy is acknowledged in the truly personal realm.[12] In *NM v Smith*, this Court held that the right to privacy encompasses the right of a person to – within this truly personal realm – live his or her life as he or she pleases,[13] and not to be interfered with.[14]

46 I submit that pregnancy loss due to miscarriage, and the subsequent decision whether to bury the fetal remains or not, are life events that are within the truly personal realm contemplated in *Bernstein v Bester.*

47 Accordingly, the interest of the expecting parents who suffered miscarriage to be allowed to choose whether to have a burial for the fetus is protected within the ambit of the right to privacy.

48 The impugned provisions prohibit and/or fail to provide for such choice, and therefore infringe the right to privacy.

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12 *Bernstein v Bester* [1996] ZACC 2, 1996 (2) SA 751 (CC) [67].

13 *NM v Smith* [2007] ZACC 6, 2007 (5) SA 250 (CC) [33].

14 Ibid [45].

Equality

49 In *Harksen v Lane* this Court established the steps to be followed to determine whether the right to equality in section 9(1) of the Constitution has been violated:[15] The first step is to ascertain whether the impugned provisions differentiate between people; if so, the second step is to ascertain whether there is a rational connection between the differentiation in question and the legitimate governmental purpose it is designed to further or achieve.

50 The current legislative regime effectively creates two categories of expecting parents who suffer spontaneous pregnancy loss:

50.1 *Category A*: Expecting parents who suffer spontaneous pregnancy loss *after* 26 weeks of gestation – stillbirth.

50.2 *Category B*: Expecting parents who suffer spontaneous pregnancy loss *before* 26 weeks of gestation – miscarriage.

51 While expecting parents in Category A have a duty to bury the remains of their prospective child, expecting parents in Category B are legally banned from burying the foetal remains that would have, had it not been for the miscarriage, belonged to their prospective child.

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15 *Harksen v Lane* [1997] ZACC 12, 1998 (1) SA 300 (CC) [42].

52 As held by the court *a quo*, there is no rational reason for this differentiation.[16]

53 Accordingly, the impugned provisions infringe the right to equality as protected in section 9(1) of the Constitution.

Conclusion on the interpretation stage

54 The impugned provisions infringe on the rights to dignity, privacy, and equality.

LIMITATION STAGE

55 No legitimate government purpose has been suggested by the respondents.

56 There is no conceivable legitimate government purpose for banning expecting parents who suffer miscarriage from choosing to bury the fetal remains.

CONCLUSION ON THE HUMAN RIGHTS ANALYSIS

57 The impugned provisions are unconstitutional to the extent that they ban expecting parents who suffer miscarriage from choosing to bury the fetal remains.

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[16] Judgment *a quo*, para 47, p22 (Constitutional Court index, vol 1).

E REMEDY

58 The remedy, as granted by the court *a quo*, includes three main components: (a) The guiding principle, (b) the permanent solution, and (c) the interim solution. The first applicant respectfully requests the Court to confirm the three components of the remedy.

The guiding principle

59 At the core of the remedy is a declaration of rights in terms of section 38 of the Constitution: In the case of pregnancy loss due to miscarriage, the bereaved parent or parents have the right, based on the constitutional rights to human dignity, privacy, and equality, to elect to bury the dead fetus. I refer to this right as the 'Burial Right'.

The permanent solution

60 The offending section of BADRA is referred back to parliament to review, and the offending parts of the Regulations is referred back to the second respondent to review. The Burial Right will be the guiding principle for these reviews.

The interim solution

61 Given that the reviews will take time, and that the constitutional rights of expecting parents who suffer miscarriage must be vindicated, an interim measure is required. The interim solution entails the use of still-birth certificates in cases of pregnancy loss due to miscarriage where the bereaved parent or parents indicate to their attending physician

that they wish to bury the fetal remains. In order for this interim solution be effective, it needs to be communicated by the respondents within their respective spheres of authority. The court *a quo* can exercise supervisory jurisdiction in this regard.

F COMPARATIVE ANALYSIS

62 In this part, I provide the Court with a non-exhaustive, broad overview of the legal position in comparative jurisdictions concerning the disposal of fetal remains. I limit this overview to jurisdictions that I could find where there exists legislation, rules or guidelines explicitly dealing with the disposal of fetal remains in the case of pregnancy loss because of miscarriage. These jurisdictions are the United Kingdom, and 18 states of the United States of America.

United Kingdom

63 In the United Kingdom, the Human Tissue Authority, a statutory body, issued a guidance document on the disposal of pregnancy remains following pregnancy loss or termination.[17] For the Court's convenience, I attach a copy of this guidance document to these heads of argument. In essence this guidance document provides that a woman who suffers pregnancy loss in the form of miscarriage or termination of pregnancy has

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17 Human Tissue Authority. Guidance on the disposal of pregnancy remains following pregnancy loss or termination. (2015).

the *right to choose* the way in which the pregnancy remains will be disposed of. The guidance document provides that:

> 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.* [Original emphasis.] 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.

64 Furthermore, the guidance document highlights the importance of informing the woman who suffered pregnancy loss of her choices concerning the disposal of pregnancy remains.

18 American states

65 I attach hereto extracts from the relevant statutes and rules of the 18 American states with laws or rules that explicitly deal with the disposal of fetal remains in the case of pregnancy loss because of miscarriage and/or termination of pregnancy.[18] The salient elements of these laws and rules are the following:

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[18] Alabama Code §22-9A-16; Alaska Administrative Code 7.05.450 & 7.05.530; Colorado Revised Statutes § 25-2-110.5 (2016); Florida Statutes § 383.33625 (2016); Georgia Code § 31-10-20; Illinois: Public Act 92-0348 §11.4; Indiana Code § 16-21-11; Kansas Statutes § 65-67a10 (2014); Maine Rules for the Department of Health and Human Services § 10-146, ch 1, s 7; Michigan Compiled Laws § 333.2854 (2014); Minnesota Statutes § 145.1621-1622 (2016); Missouri Revised Statutes § 194 (2012); Nebraska Code § 71-20,121 (2014); Ohio Revised Code § 759.49 (2017); Oregon Revised Statutes § 432.143 & § 432.158 (2013); South Dakota

65.1 The right to choose the way in which the dead fetus is to be disposed of is a common element in these laws and rules.

65.2 In some instances this right belongs to the bereaved expecting parents, in some instances to the bereaved mother.

65.3 In some instances this right only relates to miscarriage, in some instances it also includes termination of pregnancy.

65.4 The options for fetal disposition are not always defined. However, in the instances where these options are defined, they typically include 'cremation or interment' – what would be termed 'burial' in South African law.

65.5 The right to choose the way in which the dead fetus is to be disposed of is often buttressed by a duty on the health care provider to inform the bereaved parents/mother of their/her right.

Conclusion

66 The principle advanced by the first applicant, namely that expecting parents who suffer miscarriage should have the right to bury their fetal remains, is not a new idea. In fact, this right has already been recognised in numerous comparative jurisdictions.

Codified Laws § 34-25-32.3 to 34-25-32.6 (2017); Texas Statutes 241.010; West Virginia Code § 16-5-23.

G COSTS

67 Despite the fact that the applicants were substantially successful, the court *a quo* made no cost order. The court *a quo* held that since the case involved a constitutional issue, the principle established in *Biowatch Trust v Registrar Genetic Resources*[19] applies, and no cost order ought to made.[20]

68 While the court *a quo* was correct that the *Biowatch* principle applies, the court *a quo* erred in the way that it applied the principle.

69 The *Biowatch* principle entails, in brief, that in a constitutional case, the party that relies on a constitutional right is immune against an adverse cost order if unsuccessful, except if the litigation was frivolous or vexatious. However, the *Biowatch* principle does not immunise the state parties against a cost order if they are unsuccessful.

70 Since the applicants were substantially successful, they are entitled to have the respondents – the state parties – pay their legal costs.

71 It was erroneous to hold that no cost order ought to made, since the *Biowatch* principle does not immunise the respondents against a cost order.

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19 *Biowatch Trust v Registrar Genetic Resources* [2009] ZACC 14, 2009 (6) SA 232 (CC).

20 Judgment *a quo*, para 51, p24 (Constitutional Court index, vol 1).

72 Moreover, there are good grounds for a special cost order against the respondents (state parties):

72.1 The respondents have misconducted themselves as litigants by filing notices of opposition, but then failing to file answering affidavits for *six months*.

72.2 The respondents' dilatory attitude caused the first applicant to serve notices in terms of Rule 30A and to launch an application to strike out, which increased the cost of litigation.

72.3 Eventually the respondents only filed their answering affidavit after the Deputy Judge President, the Honourable Mr Justice Ledwaba, directed the respondents to file their answering affidavit.

72.4 In further careless fashion, the respondents failed to request the Court to condone their late filing, and failed to provide the Court with any explanation for being six months late.

73 Given the above, the first applicant requests the Court to set aside the cost order made by the court *a quo* and replace it with an order that awards costs to the first applicant.

74 Lastly, regarding the litigation in this Court: In the event that the first applicant is successful in this Court, the first applicant respectfully requests an order that awards costs to the first applicant.

H CONCLUSION

75 It stands uncontroverted that parents who suffer pregnancy loss and wish to bury their fetal remains can find particular psychological healing through the process of burying the fetal remains.

76 As a country, we should aspire to be a *caring* society. In numerous cases since the inception of our constitutional dispensation, this Court made it clear that we have a constitutional commitment to being a caring society.[21]

77 If we are serious about this constitutional commitment, we cannot without good reason refuse to allow parents who suffer the anguish of pregnancy loss and wish to find psychological healing by burying their fetal remains the right to do so.

78 No good reason exists for such refusal. The narrative about the biological and moral properties of the fetus is not relevant to the issue of the emotional and psychological suffering of expecting parents who suffer miscarriage. Where expecting parents invested emotionally into the pregnancy, they may suffer great emotional pain when

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[21] *S v Williams* [1995] ZACC 6, 1995 (3) SA 632 (CC) [63]: 'our progress towards being a more humane and caring society' (in the context of children's rights); *Port Elizabeth Municipality v Various Occupiers* [2004] ZACC 7, 2005 (1) SA 217 (CC) [37]: 'the constitutional vision of a caring society based on good neighbourliness and shared concern' (in the context of illegal occupation of land), which passage has been quoted and relied upon in several subsequent Constitutional Court judgments; *Khosa v Minister of Social Development* [2004] ZACC 11, 2004 (6) SA 505 (CC) [65]: 'the constitutional commitment to developing a caring society' (in the context of immigrants); *Raduvha v Minister of Safety and Security* [2016] ZACC 24, 2016 (10) BCLR 1326 (CC) [59]: 'our solemn undertaking as a nation to create a new and caring society' (in the context of children's rights).

losing such a pregnancy *irrespective* of whether the fetus was biologically viable, and *irrespective* of the moral status that others may or may not allocate to the fetus.

79 Therefore, given 'our solemn undertaking as a nation to create a new and caring society',[22] we must allow parents who suffer the anguish of pregnancy loss and wish to bury their fetal remains the right to do so.

80 I submit that the Court should, with respect, declare as unconstitutional the impugned provisions that currently prohibit the right of expecting parents who suffer miscarriage to bury the fetal remains, and grant the ancillary relief.

Donrich Thaldar

Counsel for the first applicant

24 July 2021

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22 *Raduvha* (n 21) [59].

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.

S Afr Med J 2016;106(6):578-581. DOI:10.7196/SAMJ.2016.v106i6.10598

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.[32] 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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Pregnancy loss: A burial or medical waste*

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OPSOMMING

Geboorteverlies: 'n Begrafnis of mediese afval

Daar is geweldig baie emosies wanneer 'n verwagtende vrou haar baba verloor. Met die ontwikkeling van tegnologie, soos byvoorbeeld sonars, word die fetus van vroeg af as 'n mens beskou. Indien die fetus natuurlik of gedwonge aborteer voor 26 weke van die swangerskap, word dit ingevolge die Wet op die Registrasie van Geboortes en Sterftes 51 van 1992 as 'n miskraam beskou en die fetus is mediese afval wat deur die hospitaalpersoneel vir verbranding gestuur word. Indien die fetus egter na 26 weke doodgebore word, word 'n doodsertifikaat volgens die Wet uitgereik. So 'n geval is wetlik 'n stilgeboorte en die ouers kan 'n begrafnis hou. Die wetlike bepaling van 26 weke is diskriminerend en daar word betoog dat die Wet nie in lyn is met die grondwetlike waardes onderliggend aan die Handves van Menseregte nie. Die argument word gestel dat ouers die keuse gegee moet word of hulle die fetus van voor 26 weke in die swangerskap wil begrawe of nie.

1 INTRODUCTION

One of the most devastating tragedies to befall any parent is when a baby in the mother's womb fails to survive the full term.[1] This article focuses on the loss of pregnancy by expecting parents, the current legal prescriptions if such a tragedy happens, as well as how the State should deal with such bereaved parents – specifically in South Africa's constitutional dispensation.[2] It is not the focus of the article to analyse the rights or *quasi*-rights of a foetus[3] or when life begins; it is rather grounded on the reality that many expecting parents make a significant emotional investment in their prospective child[4] long before birth and that pregnancy loss[5] consequently has an undeniable negative emotional impact on such bereaved parents. The emotional pain suffered by these parents is based on moral convictions and not the law.

* I am indebted to Adv D Jordaan for his valuable inputs. I remain responsible for any flaws.

1 Anon "Education key to preventing stillbirths" 2011 *Mail and Guardian* http://mg.co.za (accessed on 22 October 2013).

2 The Constitution of the Republic of South Africa, 1996 (hereafter the Constitution).

3 Used in this article to refer to a human *conceptus* until born alive.

4 Prospective child is used to describe the intangible, mental construct of the hoped-for child in the parents' minds. It is used in the same way as the Children's Act 38 of 2005 in the context of surrogate motherhood uses the word "the child that is to be born".

5 Pregnancy loss refers to any manner in which a foetus dies before being born alive. Pregnancy loss can either be spontaneous or induced. The latter type of pregnancy loss is governed by the Choice on Termination of Pregnancy Act 92 of 1996.

Therefore, although cognisance is taken of the pro-life versus the pro-choice debate concerning abortions, this article transcends the debate, as it focuses on the loss of pregnancy and the emotions surrounding the unfortunate event, irrespective of the cause of such loss. Just as expecting parents who experienced the loss of pregnancy due to natural causes may be emotionally impacted by such a loss, so may expecting parents who experienced the loss of pregnancy due to their own conscious decision to end the pregnancy. This could, for example, be due to medical advice that the foetus may be born with a severe defect and will not survive longer than a few hours or days.[6] The emotional impact of pregnancy loss on this type of parent may even be greater than on the former. In the event of induced pregnancy loss, the foetal remains (irrespective of viability) are regarded as medical waste and cannot lawfully be buried.[7] The position of bereaved parents in the context of induced pregnancy loss, accordingly, mirrors the position of bereaved parents in the context of a miscarriage.

Expecting parents make a significant emotional investment in their prospective child before birth, and the gravity of the consequent attachment is not necessarily determined by gestational age.[8] As such, pregnancy loss can cause parents intense grief, irrespective of gestational age or whether the pregnancy loss was due to natural causes or due to conscious human decisions. The bereaved parents often have a desire to bury[9] the foetal remains of their prospective child and the ceremony or ritual of a burial has a decidedly positive and healing effect on the parents. It is argued that in the case of pregnancy loss, other than a stillbirth where a burial is authorised according to section 18 of BADRA, that the bereaved parents should have the right, based on constitutional values,[10] to elect to bury the remains of the pre-viable foetus.

The current legislative gap[11] on burying the foetal remains of a prospective child following pregnancy loss, other than stillbirth, is scrutinised as any legislation that is not in conformity with the values of the Constitution is unconstitutional and invalid to the extent of its unconformity. Before the legal arguments in

6 In this regard, see Moscrop "'Miscarriage or abortion?' Understanding the medical language of pregnancy loss in Britain; a historical perspective" 2013 *Med Humanit* 98–104. The article ends with the following: "[T]he shift of medical language from 'abortion' to 'miscarriage' reminds us that it will take more than words to truly improve patients' experiences."

7 Because such deaths are not viewed as stillbirths, no notice of stillbirth will be issued which is a prerequisite for a prescribed burial order authorising burial. See s 18 read with s 20 of the Births and Deaths Registration Act 51 of 1992 (hereafter BADRA). See also Du Toit-Prinsloo *et al* "Managing the remains of foetuses and abandoned infants: A call to urgently review South African law and medicolegal practice" 2016 *SAMJ* 578 where the position of human foetuses in relation to the Choice on Termination Act 92 of 1996 and the Environmental Conservation Act 73 of 1989 is explained: "pathological waste" includes human foetuses.

8 See Roberts "'Wakey wakey baby': Narrating four-dimensional (4D) bonding scans" 2012 *Sociology of Health & Illness* 299–314. See also Harris "A unique grief" 2015 *Int J of Childbirth Education* 82–83.

9 S 1(ii) of BADRA: "burial means burial in earth or the cremation or any other mode of disposal of a corpse".

10 The Constitution, Ch 2, Bill of Rights.

11 Because BADRA s 18 only allows a stillbirth certificate after 26 weeks of gestation it is assumed that it is legally not possible to bury a foetus of less than 26 weeks gestation lawfully.

favour of a new approach to fill the legislative gap are made, the difference between pregnancy loss and a stillbirth as it is currently legislated is highlighted.

2 PREGNANCY LOSS OR STILLBIRTH?

Spontaneous pregnancy loss is categorised as either early spontaneous pregnancy loss (a miscarriage) or late spontaneous pregnancy loss (a stillbirth),[12] based on whether the foetus is deemed viable, meaning being capable of surviving outside the mother's womb when the pregnancy loss occurred. BADRA posits viability at 26 weeks of gestation.[13] If the pregnancy loss takes place prior to 26 weeks of gestation, it has a dramatic effect on what happens to the foetal remains. If the foetus was *in utero* at least 26 weeks, it is legally posited as a stillbirth and the remains can be buried. If the foetus was *in utero* for less than 26 weeks, the foetal remains cannot legally be buried and are, as default standard practice, treated as medical waste.[14] Taitz and Clow point out that it is extremely difficult to accurately determine gestational age or viability and that a foetus of 24 weeks may survive minutes, hours or days after complete birth and is therefore viable. It is thus anomalous that while the ability to survive may depend on modern medical skill and technology, the foetus, in terms of the Act, is regarded as not viable.[15]

Section 18 of BADRA provides for the issuance of stillborn certificates or stillborn declarations and, consequent to such certificate or declaration, burial orders. Section 20(1) of BADRA makes it clear that no burials may take place in the absence of a burial order. Accordingly, section 20(1), read with section 1 (the definition of stillbirth) and section 18(1)–18(3) has the effect that no stillbirth certificate or declaration can be issued in the event of either a miscarriage or induced pregnancy loss. This, in turn, has the effect that no burial order can be issued, thus effectively legally prohibiting the burial of dead foetuses in the event of pregnancy loss other than a stillbirth. To obtain a burial order, the only alternative to a notice of stillbirth is a notice of death. However, what all types of pregnancy losses have in common is that there is never a live birth, and as such there is no person capable of death. A notice of death is thus not applicable in the event of either a miscarriage or induced pregnancy loss.[16]

Neither the Choice on Termination of Pregnancy Act[17] nor the National Health Act[18] deals with burials in general or with burials of dead foetuses. The regulations in terms of the National Health Act, Regulations to the Management of

12 As used in BADRA s 1(xviii), "still-born in relation to a child, means that it has had at least 26 weeks intra-uterine existence but showed no sign of life after complete birth, and still-birth, in relation to a child, has a corresponding meaning".

13 BADRA s 1(xviii).

14 Du Toit-Prinsloo *et al* 2016 *SAMJ* 579 "Should a pregnancy of less than 26 weeks' gestation come to an end, the fetal remains will be assigned the status of pathological waste."

15 Taitz and Clow "Effect of the legislative definition of the terms 'stillborn' and 'viable'" 1987 *SAMJ* 241.

16 See the South African Medical Council April 2009 Cause of Death Certification: A guide for completing the death notification form (DNF) – BI-1663. The DNF is a permanent record of the fact of death that allows the Department of Home Affairs to issue a death certificate. Once the notification of death has been accepted by the Department of Home Affairs, a burial order will be issued. No corpse can be buried without this order. A DNF must be filled in after a stillbirth.

17 Act 92 of 1996.

18 Act 61 of 2003.

Human Remains[19] govern certain aspects regarding funeral undertakers and burials but it fails to make any reference to BADRA or foetuses. The regulations define a "corpse" and "human remains" in section 1, as "a dead human body". No mention is made of foetuses. In fact, no mention is made of stillbirths unless it is accepted that the word "child" as used in the definition of a stillbirth in BADRA, is seen as a "dead human body". No other form of pregnancy loss is addressed in the regulations. If the general rule of law that a foetus is not a person is applied to the interpretation of the regulations, "human body" in the regulations would pertain only to the physical body of a person[20] and not the physical body of a foetus. Accordingly, the regulations would fail to provide for the burial of dead foetuses following any type of pregnancy loss, including stillbirth.

The primary legal instrument in our law that governs burials is BADRA. The legal regime created by BADRA requires the issuance of a burial order[21] as general precondition for a burial; in turn the issuance of a burial order requires a notice of death or a notice of a stillbirth.[22] BADRA is rigid in the prescription that persons who died and stillbirth foetuses can be buried, but dead foetuses following either a miscarriage or induced pregnancy loss, should not be buried.[23] As stated above, the regulations in terms of the National Health Act simply fails to make provision for the burial of foetuses.

If foetuses cannot be buried according to BADRA, a general rule is that they are incinerated as medical waste regulated by the South African National Standard 10248, entitled Management of Healthcare Risk Waste, issued in terms of section 24 of the Standard Act,[24] by the South African Bureau of Standards.[25] According to these standards, "pathological waste" or "anatomical waste" is defined as "waste that contains tissue, organs, body parts, blood and bodily fluids from patients, foetuses and animal carcasses, but excludes teeth and hair". The definition does not state all foetuses (or all organs etc) are pathological or anatomical waste – it must first qualify as waste. Waste is defined as

> "undesirable or superfluous by-product, emission, residue or remainder of any process or activity, any matter, gaseous, liquid or solid or any combination thereof, which is discarded by any person; is accumulated and stored by any person with the purpose of eventually discarding it with or without prior treatment connected with the discarding thereof; or is stored by any person with the purpose of recycling, reusing or extracting a usable product from such matter".[26]

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19 GN R363 in *GG* 36473 dated 22 May 2013.

20 In South Africa, the legal concept of person does not include the unborn. See *S v Mshumpa* 2008 1 SACR 126 (E).

21 BADRA s 14(2).

22 BADRA s 18.

23 BADRA s 20 read with s 18 and s 1 (definitions). Du Toit-Prinsloo *et al* 2016 *SAMJ* 579 give the following example: If a woman is 32 weeks pregnant and a stillborn foetus is born, the parents will be issued with a death notification form in terms of BADRA and can bury or cremate the foetus. 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, the foetus will be pathological waste.

24 Act 8 of 2008.

25 See also the Health Professions Council of South Africa *Booklet 16* "Guidelines for the management of health care waste" (2008), available at http://www.hpcsa.co.za (accessed on 9 February 2016).

26 The South African National Standard 10248, definitions.

The definitional framework of the National Standard is therefore sufficiently supple to accommodate the right of the bereaved parents to elect to bury the dead foetus. If the parents elect to bury the foetus, the foetus will fall outside the definitional ambit of waste. If the parents elect not to bury the foetus, the foetus will effectively be "discarded" and will, as such, fall within the definitional ambit of waste – more specifically, anatomical or pathological waste. The National Standard categorises anatomical or pathological waste as part of "health care waste" which requires incineration as the main "treatment" method. The National Standard thus provides a mechanism for dealing with those foetuses that will not be buried, without obstructing the right of the bereaved parents who would elect to bury the dead foetus. In other words, should the Department of Health issue a policy document allowing for a choice to bury a foetus of any stage of gestation, such a choice would not affect the handling of waste or even BADRA.

What happens in practice in South African hospitals is that the aggrieved parents can ask for the foetus to be disposed of in a legal manner, but which does not include a burial, as there will not be a legally valid burial order. Should parents thus ask for the foetus, it is usually described as the "placenta" and the parents have to fill in a form entitled "Safe disposal of human tissue by patient or family" accompanied by an affidavit stating the religious or other reasons why they would like to have the "placenta".[27] Another problem with filling in the form is that it must be done before the removal of a body part. In the case of a pregnancy loss, it is impossible to fill in such a form before the event, as miscarriages usually happen very fast and without previous planning. This raises concerns for the parents and results in the fact that it is not the 'placenta' being removed from the hospital but, actually, a foetus. It seems, in the interest of legal clarity, that it would be more beneficial to develop an official policy to allow a legal burial for a pregnancy loss before 26 weeks of gestation or to give the parents the choice between sending the dead foetus for incineration or to have a burial.

South Africa has little to be proud of concerning stillbirths as the country ranks 176 out of 193 countries for stillbirths, which amount to an average of more than 61 per day.[28] These are stillbirths recorded according to BADRA. No statistics are available of how many pregnancy losses, either spontaneous or induced occur, but if the recorded stillbirth rate is any indication, the situation of losing a prospective child in South Africa looks dismal and consequently, many people (parents) are affected.

Viability and therefore also pregnancy losses and stillbirths are essentially social constructs as there is no uniform consensus on these matters. This socially constructed nature of viability is also demonstrated by the divergent judgements recently handed down in this regard by the South African High Courts. In the context of the crime of concealment of birth, the court, referring to case law on the subject, held in *S v Molefe*[29] that viability is 28 weeks of gestation. In contrast, when requested to develop the common law to include the killing of a foetus *in utero qua* murder, the Eastern Cape High Court, based on medical expert opinion, accepted *obiter* in *S v Mshumpa*[30] that viability is 25 weeks.

27 See the forms of the Netcare and Life Hospital groups.
28 Anon "Education key to preventing stillbirths" 2011 *Mail and Guardian* http://mg.co.za (accessed on 22 October 2013).
29 2012 2 SACR 574 (GNP) 578.
30 2008 1 SACR 126 (E) para 48.

In 2015, a questionnaire-based study was conducted amongst the delegates attending the Obstetrics and Gynaecology Conference to evaluate the current knowledge of the specialists on legislation concerning the management of foetal remains in South Africa.[31] The overwhelming majority of the respondents (95.7%) indicated that the gestational age is defined with reference to the first day of the last normal menstrual period despite the fact that no Act in South Africa provides such a definition.[32] A significant number of clinicians have also admitted that they had given the foetal remains of a pregnancy loss to the parents for a burial despite the provisions of BADRA. These foetuses were therefore, strictly speaking, buried illegally. Yet, it was in the interest of the bereaved parents. Taking the variances in establishing viability internationally into account, it could be accepted that physicians seem to be uncertain as to when exactly viability is established.

3 VIABILITY AND PRACTICES INTERNATIONALLY

The World Health Organisation recommends 28 weeks of gestation, given the fact that a foetus has little chance of survival outside a mother's womb in low-income countries prior to 28 weeks of gestation.[33] Other countries that follow the 28 week cut-off time are Belgium, Denmark, Finland, France, Greece, the Netherlands, Norway, Portugal and Sweden.[34] Although body weight is also sometimes proposed as a more reliable indicator of viability than gestational age, there is no international consensus on what the minimum weight to constitute viability should be. Germany, for example, does not determine viability through the counting of weeks, but only takes body weight of 500g into consideration.[35]

The United Kingdom (UK) (England, Wales, Scotland and Northern Ireland) determines viability at 24 weeks' gestational age.[36] There are more than 3 600 stillbirths every year in the UK.[37] The definition of a "stillborn child" in England and Wales is contained in the Births and Death Registration Act,[38] section 41 as amended by the Stillbirth (Definition) Act.[39] Section 1(1) states that a stillbirth is "a child which has issued forth from its mother after the 24th week of pregnancy and which did not at any stage breathe or show any other signs of life". Similar definitions apply in Scotland[40] and Northern Ireland.[41] There is no provision in

31 Du Toit-Prinsloo *et al* "Evaluating current knowledge of legislation and practice of obstetricians and gynaecologists in the management of fetal remains in South Africa" 2016 *SAMJ* 403–406.

32 *Idem* 404.

33 See http://www.who.int/mediacentre/factsheets/fs363/en/ (accessed on 16 March 2016).

34 Graafmans *et al* "Comparability of published perinatal mortality rates in Western Europe: The quantitative impact of differences in gestational age and birthweight criteria" 2001 *British J of Obstetrics and Gynaecology* 1240.

35 *Ibid*.

36 *Ibid*.

37 Anon "A stillbirth is a baby born dead after 24 completed weeks of pregnancy" http://bit.ly/2auvpaW (accessed on 27 August 2015).

38 Of 1953.

39 Of 1992.

40 S 56(1) of the Registration of Births, Deaths and Marriages (Scotland) Act 1965, as amended by the Stillbirth (Definition) Act 1992.

41 Births and Deaths Registration (Northern Ireland) Order 1976, as amended by the Stillbirth Definition Northern Ireland Order 1992.

UK legislation to allow for the registration of stillbirths before the 24th week of pregnancy. In 2014, a private Members' Bill in this regard to ask for the registration of a stillborn child before the threshold of 24 weeks was introduced – but it did not progress any further.[42] In March 2014, the junior Health Minister said the following in a House of Commons debate:

> "Although some parents are very distressed that they cannot legally register the birth of a baby born before 24 weeks who did not breathe or show any signs of life, others would be distressed at the possibility of having to do so. Getting the right balance between those conflicting wishes is challenging, but the existing system, whereby hospitals can issue local commemorative certificates . . . for those parents who want them goes some way to addressing the issue."[43]

In 2015, the Human Tissue Authority published a document called "Guidance on the disposal of pregnancy remains following pregnancy loss or termination".[44] These guidelines, in accordance with the Human Tissue Act,[45] provide that the particular sensitive nature of [foetal] tissue means that the wishes of the woman and her understanding of the disposal options open to her, are of paramount importance and should be respected and acted upon.[46]

In other words, for babies born prior to 24 weeks' gestation, there is no legal requirement to be buried or cremated, although it can be done. No death certificate is issued, but a Non-Viable Certificate will be issued if a funeral is arranged. This is not a legal requirement and actually only an acknowledgement of the baby's existence.[47] Having done extensive research on the issue of stillbirths or miscarriages, Lovell concludes that there is no single right answer to the question of what to do with foetal remains but she is clear that it is not the weeks of gestation that determines the bereavement of prospective parents and their need to grieve. Individual needs and emotions do not necessarily fit in with legal definitions.[48]

In the United States of America (US) the gestational age of viability is 20 weeks.[49] Peppers and Knapp state the following:

> "[W]hat people do not realize is that for the mother, the infant has been a part of her since conception. She has come to know it in a way that no one else has . . . Maternal love, whatever its source, reaches deeply into the earliest stages of pregnancy and attaches itself firmly to the growing infant."[50]

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42 Fairbairn House of Commons Library SN/HA/5595 30 April 2014.

43 HC Deb 26 March 2014 c113WH.

44 Human Tissue Authority. Guidance on the disposal of pregnancy remains following pregnancy or termination at https://www.hta.gov.uk/polocies/hta-guidance-sensitive-handling-pregnancy-remains (accessed on 27 August 2015).

45 United Kingdom legislation, Human Tissue Act, 2004 http://bit.ly/2aJU0Zv (accessed on 27 August 2015).

46 See fn 44 above.

47 Lovell "The changing identities of miscarriage and stillbirth" 2009 (20)3 *Bereavement Care* 38.

48 *Idem* 37–40.

49 Varney "Perinatal loss and its vicissitudes" 2014 *J of Infant, Child and Adolescent Psychotherapy* 51.

50 Peppers and Knapp *Motherhood and mourning: Perinatal death* (1980) 29. See also Limbo *et al* "Respectful disposition in early pregnancy loss" 2010 *MCN Am J Matern Nurs* 272: "For some having a miscarriage is a simple life event, a logical outcome of pregnancy that somehow wasn't meant to be. For others, a miscarriage is the loss of a wished-for child, imbued with dreams, and hopes for parenthood."

It seems clear that attachment to a "baby" does not begin at birth, but long before.[51] Since 1998 the states of South Dakota, Ohio, Nebraska, Missouri, Minnesota, Kansas, Illinois, Florida and Colorado have enacted legislation concerning foetal remains.[52] The different Acts in the mentioned states, allow in some way or another for a request by the mother for the foetal remains in order to decide whether she wants a burial or not.[53] Each legislative effort was driven by parents who suffered a miscarriage.[54]

An interesting US case concerning the disposal of foetal remains is the case of *Emeagwali v Brooklyn Hospital.*[55] The case involved a dispute arising from an alleged improper disposal by the defendant of the remains of a stillborn foetus, depriving the parents of a chance to conduct a religious burial ceremony for the prospective child and causing emotional distress. Even though the case concerned a stillborn foetus, the judge did indicate that the same rights apply to other foetuses as well.

At 21 and a half weeks of pregnancy, the plaintiff delivered a stillborn female weighing 400 grams. The hospital disposed of the foetus whereafter the plaintiffs (the parents) instituted action against the hospital in that the plaintiffs' right to bury their stillborn foetus had been violated. In common law, this right is known as sepulcher. The judge said that although common law did not regard dead bodies as property, USA courts, through the centuries have treated them in a *quasi*-property context. That means that the next of kin has a legal right to possession of the body for the purposes of burial. He continued that the deprivation of this right of possession and the common law right of sepulcher is an actionable cause and the plaintiffs had a right of sepulcher whether or not the foetus was ever alive after delivery or not. He went on to say that the mother retains a *quasi*-property right in the body because foetuses, *stillborn or not* (own emphasis), have symbolic importance vastly different from that of ordinary tissue due to the physical presence mothers feel in their bodies and the hopes and dreams she had for its future. This view is mirrored in an article written by Sanger where she argues for the therapeutic use of law – that "law should value psychological health . . . and when consistent with other values . . . should attempt to bring about healing and wellness".[56]

4 CONSTITUTIONALITY OF PRESCRIPTIONS CONCERNING PREGNANCY LOSS

Despite the differences in gestational age that warrant a burial or cremation, as indicated above, the current legislation in South Africa is clear that 26 weeks' gestation is the cut-off point where a burial order will be granted or not. As such, bereaved parents currently have no right to ask for a burial following a pregnancy loss before 26 weeks' gestation. This situation seems to be in contrast with the

51 Robinson *et al* "The relationship of attachment theory and perinatal loss" 1999 *Death Studies* (23)257.
52 Limbo *et al* 2010 *MCN Am J Matern Nurs* 275 Table 1.
53 *Ibid.*
54 *Ibid.*
55 CTR 2006 NY Slip Op 50221 (U) [11 Mic 3d 1055(A)] decided on 22 February 2006, Supreme Court Kings County.
56 Sanger "The birth of death: Stillborn birth certificates and the problem for law" 2012 *Calif LR* 295.

underlying values of the Constitution in general and the Bill of Rights in particular. To be more in line with human rights values, bereaved parents should be given a choice between burying the remains of their late prospective child following pregnancy loss or letting it be destroyed as medical waste. Such a decision is an important decision to be made by the parents and as such falls within the right to human dignity, which entails the protection of a person's autonomy, as guaranteed by section 10 of the Constitution.[57] McQuoid-Mason refers to personal-autonomy privacy rights as substantive privacy rights which permit individuals to make decisions about their lives without state interference, ultimately empowering them to exercise control over procreation, contraception and child rearing.[58] The choice to bury a foetus of any gestational age could well fit in his argument.

The decision to elect to bury the remains of the prospective child is also a decision within the core personal sphere of a person and, therefore, it could be argued that it falls within the protective ambit of the right to privacy as guaranteed by section 14 of the Constitution.[59] In *Bernstein v Bester*[60] the right to privacy was found to shield a person's inner sanctum (family life, sexual preference and home environment) from erosion by the exercise of the conflicting rights of the community. Privacy is based on the notion of what is necessary to have one's own autonomous identity.[61] At the very least, the right to privacy includes the right to be free from intrusions and interference by the state and others in one's personal life.[62] Thus, to elect to bury a non-viable foetus should be the private decision between the parents of the prospective child.

Section 9 of the Constitution protects the right to equality.[63] The current legislative regime concerning stillbirths, as discussed above, effectively creates two categories of bereaved parents. Category A includes bereaved parents who

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57 S 10: "Everyone has inherent dignity and the right to have their dignity respected and protected." See also *National Coalition for Gay and Lesbian Equality v Minister of Justice* 1999 1 SA 6 (CC) 28D–E: honouring someone's dignity requires us to acknowledge the value and worth of all individuals as members of society. See also Woolman "Dignity" in Woolman *et al* (eds) *Constitutional law of South Africa* (2011) 36-10 and 11: the right to dignity secures the space for self-actualisation. See also *Barkhuizen v Napier* (CCT72/05 [2007] ZACC 5 para 57 where the majority per Ngcobo J specifically deals with autonomy and states unequivocally that autonomy "is the very essence of freedom and a vital part of dignity". In *MEC for Education: KwaZulu-Natal v Pillay* (CCT 51/06) [2007] ZACC 21 para 64 it was stated: "A necessary element of freedom and of dignity of any individual is an entitlement to respect for the unique set of ends that the individual pursues" – applying the position that autonomy is a *conditio sine qua non* for the individual's pursuit of his or her unique set of ends, autonomy is confirmed as a necessary element of human dignity.

58 McQuoid-Mason "Privacy" in Woolman *et al* (eds) 38-23. See also Pickles "Termination-of-pregnancy rights and foetal interest in continued existence in South Africa: The Choice on Termination of Pregnancy Act 92 of 1996" 2012 *PELJ* 408.

59 S 14: "Everyone has the right to privacy." See also art 8 of the European Convention for the Protection of Human Rights and Fundamental Freedoms which provides that "everyone has the right to respect for his private family life".

60 1996 2 SA 751 (CC) 788D.

61 *Bernstein v Bester* 1996 2 SA 751 (CC) 788B.

62 See *Case v Minister of Safety and Security* 1996 3 SA 617 (CC).

63 S 9(1): Everyone is equal before the law and has the right to equal protection and benefit of the law. *In Harksen v Lane* 1997 BCLR 1489 (CC), 1998 1 SA 300 (CC) para 35 the Constitutional Court proposed the steps to be followed to determine whether the right to equality has been violated. See also *Prinsloo v Van der Linde* 1997 3 SA 1012 (CC) paras 24–25.

suffered a stillbirth and category B includes bereaved parents who suffered pregnancy loss other than a stillbirth. While parents in category A have a right to bury the remains of their prospective child, the bereaved parents in category B do not have such a right to bury the remains of their prospective child. It is accepted that not all bereaved parents in category B experience pregnancy loss in the same way. Some may be relatively unaffected, while others may be overcome with grief. It would thus not be justifiable to place a general duty on all bereaved parents in category B to bury the remains of their prospective child. But, there is such a choice for all parents in category A, as the foetus has passed the point of viability, despite the fact that viability seems to be an arbitrary social construct. It seems as if in the present context, the right to bury one's dead prospective child is completely severable. Equality demands that the right given to parents in category A by BADRA, namely the right to bury the remains of their dead prospective child, should be afforded to parents in category B as well. Some bereaved parents in category B experience the emotional loss associated with a pregnancy loss in the same way as (or even more intense than) the bereaved parents in category A. It seems only fair under the protection of the right to equality to give both categories of parents the same right.

There is a need to make the law governing the burial of foetuses less rigid and more attuned to the human side of bereavement in the event of pregnancy loss. It could therefore be argued that the current legal position infringes the constitutional rights of dignity, privacy and equality of such parents. The sections of BADRA dealing with foetal death therefore seem unacceptable, insofar as they do not make provision for the right of a choice to a burial pre-26 weeks' gestation.

5 CONCLUSION

Social birth, meaning the identification and incorporation of a child into its family during pregnancy, frequently precedes biological birth.[64] If things then go wrong and the woman does not carry the baby to full term, it is as if a child has died. If the tragic event materialises before 26 weeks' gestation, the current statutory legal regime of BADRA makes it very difficult – if not impossible – for grieving parents to bury or cremate the non-viable foetus after pregnancy loss. A change in the strictness of the law or a policy document giving parents a choice between a burial or the incineration of the foetus will go a long way.

Having the opportunity to give their lost "child" a dignified burial or cremation is essential to facilitate such parents' emotional process of dealing with their grief. The healing value of going through a burial ritual transcends cultures and religions – it is universal. Some parents cannot find peace knowing their "child" was unceremoniously incinerated with other medical waste. All expecting parents who suffer pregnancy loss should be entitled as of right to elect to have the foetal remains buried. Limbo *et al* state that with or without legislative mandates, a culture of respectful disposition of foetuses is necessary.[65]

As Thompson summarises:

> "With the advent of technologies that allow earlier foetal bonding, the pregnancy narrative has changed. Women are inadvertently (or otherwise) encouraged in the

64 Sanger 2012 *California LR* 273.
65 Limbo *et al* 2010 *MCN Am J Matern Nurs* 274.

> creation of foetal personhood, however, when these pregnancies do not produce a live birth they are faced with an old narrative which does not allow for support of the prospective parents or the grieving of this socially created identity."[66]

Consequently, it is recommended that the prescription of 26 weeks' gestation for the certification of a stillbirth in BADRA could stay BUT a policy document in terms of the Act should state that parents who lose a prospective child should be given a choice. Parents of a non-viable foetus should be given the choice to have a burial or not. Should they elect to bury the prospective child, a non-viable certificate should be issued, as is the case in the UK. Should they not want the foetus for burial, the foetus should be incinerated as medical waste.

66 Thompson "Improving miscarriage support in New Zealand 2009, available at http://bit.ly/2aJUKhw (accessed 5 November 2015).

HTA
Human Tissue Authority

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

Issued: March 2015

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

EXTRACTS FROM RELEVANT UNITED STATES LEGISLATION

Alabama Code §22-9A-16 (2009)

(c) Prior to final disposition of a dead fetus, the funeral director, the person in charge of the institution, or other person assuming responsibility for final disposition of the fetus shall obtain from the parents authorization for final disposition. In the event the parents are incompetent, unable, or unwilling to sign the documents authorizing final disposition, the institution where the fetal death occurred, or if the fetal death occurred outside an institution, any licensed hospital in reasonable proximity, shall establish a mechanism to determine the final disposition.

Alaska Administrative Code 7.05.450 & 7.05.530

7 AAC 05.450. Fetal deaths. Any product of gestation of less than 20 weeks duration of pregnancy, showing no evidence of life, may have a fetal death certificate prepared, filed, recorded, and registered as required above, at the option of the parents or others concerned; such certificate is not mandatory for fetal deaths with a duration of pregnancy of less than 20 weeks. However, this regulation does not release anyone from the duty of reporting any suspicion of foul play or illegal act; nor does it except such cases from any existing burial requirements or restrictions, or other health requirements, either state or local.

7 AAC 05.530. Gestation period. A burial-transit permit may be issued by a local registrar for the disposition of a fetus with a gestation period of less than 20 weeks, with or without the filing of a fetal death certificate; provided all other requirements have been met. For movement out of the state; for any shipment by common carrier; or for burial or other disposition in any public or other organized burial ground, vault, or crematory, a burial-transit permit shall be a

prerequisite in cases of a fetus, irrespective of the length of gestation. All additional requirements pertaining to any dead body must also be fulfilled in such cases.

Colorado Revised Statutes § 25-2-110.5 (2016)

Fetal deaths - treatment of remains. (1) In every instance of fetal death, the pregnant woman shall have the option of treating the remains of a fetal death pursuant to article 54 of title 12, C.R.S. (2) In every instance of fetal death, the health care provider, upon request of the pregnant woman, shall release to the woman or the woman's designee the remains of a fetal death for final disposition in accordance with applicable law. Such request shall be made by the pregnant woman or her authorized representative prior to or immediately following the expulsion or extraction of the fetal remains. Unless a timely request was made, nothing in this section shall require the health care provider to maintain or preserve the fetal remains. (3)(a) Nothing in this section shall prohibit a health care provider from conducting or acquiring medical tests on the remains of a fetal death prior to release. (b) Upon a request pursuant to subsection (2), whenever a medical test is conducted pursuant to paragraph (a) of this subsection (3), the health care provider conducting the test shall, where medically permissible and otherwise permitted by law, release to the pregnant woman or the woman's designee the remains of a fetal death for final disposition. (4) Nothing in this section shall prohibit the health care provider from requiring a release of liability for the release of the remains of a fetal death prior to such release. (5) A health care provider shall be immune from all civil or criminal liability, suit, or sanction with regard to any action taken in good faith compliance with the provisions of this section.

Florida Statutes § 383.33625 (2016)

Stephanie Saboor Grieving Parents Act; disposition of fetus; notification; forms developed.—

(1) This section shall be known by the popular name the "Stephanie Saboor Grieving Parents Act."

(2) A health care practitioner licensed pursuant to chapter 458, chapter 459, chapter 464, or chapter 467 having custody of fetal remains following a spontaneous fetal demise occurring after a gestation period of less than 20 completed weeks must notify the mother of her option to arrange for the burial or cremation of the fetal remains, as well as the procedures provided by general law. Notification may also include other options such as, but not limited to, a ceremony, a certificate, or common burial of the fetal remains.

(3) The Department of Health shall adopt rules to develop forms to be used for notifications and elections by the health care practitioner, and the health care practitioner shall provide the forms to the mother.

(4) A facility licensed pursuant to chapter 383 or chapter 395 having custody of fetal remains following a spontaneous fetal demise occurring after a gestation period of less than 20 completed weeks must notify the mother of her option to arrange for the burial or cremation of the fetal remains, as well as the procedures provided by general law. Notification may also include other options such as, but not limited to, a ceremony, a certificate, or common burial of the fetal remains.

(5) If the mother chooses the option of using the procedures provided by general law, the facility or health care practitioner in custody of fetal remains shall follow the procedures set forth in general law.

(6) The Agency for Health Care Administration shall adopt rules to develop forms to be used for notifications and elections by the facility, and the hospital shall provide the forms to the mother.

Georgia Code § 31-10-20

Permits for disposition, disinterment, and reinterment

(d) Prior to final disposition of a dead fetus, irrespective of the duration of pregnancy, the funeral director or person acting as such, the person in charge of the institution, or other person assuming responsibility for final disposition of the fetus shall obtain from the parent(s) authorization for final disposition.

Illinois Public Act 92-0348

§11.4. Disposition of fetus. A hospital having custody of a fetus following a spontaneous fetal demise occurring after a gestation period of less than 20 completed weeks must notify the mother of her right to arrange for the burial or cremation of the fetus. Notification may also include other options such as, but not limited to, a ceremony, a certificate, or common burial or cremation of fetal tissue. If, within 24 hours after being notified under this Section, the mother elects in writing to arrange for the burial or cremation of the fetus, the disposition of the fetus shall be subject to the same laws and rules that apply in the case of a fetal death that occurs in this State after a gestation period of 20 completed weeks or more. The Department of Public Health shall develop forms to be used for notifications and elections under this Section and hospitals shall provide the forms to the mother.

Indiana Code 16-21-11

Chapter 11. Treatment of Miscarried Remains

Sec. 1. As used in this chapter, "health care facility" means any of the following: (1) A hospital. (2) A birthing center. (3) Any other medical facility.

Sec. 2. As used in this chapter, "miscarried fetus" means an unborn child, irrespective of gestational age, who has died from a spontaneous or accidental death before expulsion or extraction from the unborn child's mother, irrespective of the duration of the pregnancy.

Sec. 3. As used in this chapter, "person in charge of interment" means a person who places or causes to be placed the body of a miscarried fetus who has a gestational age of less than twenty (20) weeks of age or the ashes, after cremation, in a grave, vault, urn, or other receptacle, or who otherwise disposes of the body or ashes.

Sec. 4. Subject to sections 5 and 6 of this chapter, the parent or parents of a miscarried fetus may determine the final disposition of the remains of the miscarried fetus.

Sec. 5. (a) Not more than twenty-four (24) hours after a woman has her miscarried fetus expelled or extracted in a health care facility, the health care facility shall: (1) disclose to the

parent or parents of the miscarried fetus, both orally and in writing, the parent's right to determine the final disposition of the remains of the miscarried fetus; (2) provide the parent or parents of the miscarried fetus with written information concerning the available options for disposition of the miscarried fetus; and (3) inform the parent or parents of the miscarried fetus of counseling that may be available concerning the death of the miscarried fetus.

(b) The parent or parents of a miscarried fetus shall inform the health care facility of the parent's decision for final disposition of the miscarried fetus after receiving the information required in subsection (a) but before the parent of the miscarried fetus is discharged from the health care facility. The health care facility shall document the parent's decision in the medical record.

Sec. 6. (a) If the parent or parents choose a means of final disposition other than the means of final disposition that is usual and customary for the health care facility, the parent or parents are responsible for the costs related to the final disposition of the fetus.

(b) If the parent or parents choose a means of final disposition that provides for the interment of a miscarried fetus who has a gestational age of at least twenty (20) weeks of age, the requirements under IC 16-37-3 apply.

(c) Notwithstanding any other law, the parent or parents whose miscarried fetus has a gestational age of less than twenty (20) weeks of age may choose a means of final disposition that provides for the cremation or the interment of the miscarried fetus. If the parent or parents choose the cremation or interment of the miscarried fetus, the local health officer shall provide the person in charge of interment with a permit for the disposition of the body. A certificate of stillbirth is not required to be issued for a final disposition under this subsection.

Kansas Statutes § 65-67a10 (2014)

Disposition of fetal remains. Every maternity center and medical care facility licensed by the department of health and environment to operate in the state shall adopt written policies and

inform parents regarding their options for disposition or taking of fetal remains in an event of a fetal death.

Maine Rules for the Department of Health and Human Services, 10-146, Chapter 1

7. Disposition of Fetuses. Transportation and final disposition of fetal remains, regardless of the length of gestation, are subject to the same regulations as dead bodies except as specified in this section.

A. A facility may dispose of fetal remains directly without obtaining a burial-transit permit.

B. A burial-transit permit is required if the fetal remains are to be buried in a cemetery, disposed of in a crematorium, buried at sea, used by medical science, or removed from the state.

C. Notwithstanding section 2(S)(3)(h) of this chapter, a burial-transit permit for disposition of the remains of a fetus of less than 20 weeks gestation, or the product of an induced abortion of any gestation, shall be issued upon presentation of a statement from the facility that the parents have chosen to dispose of the remains outside the facility and that the required miscarriage or induced abortion report has been filed. The letter shall name the person who will be responsible for the disposition and shall contain that person's signature.

Michigan Compiled Laws § 333.2854 (2014)

Authorization for final disposition of dead body or fetus; time; form; retention of permit; religious service or ceremony not required; cremation; moving body; permit issued by other state. (2) Except as otherwise provided in section 2836, or unless the mother has provided written consent for research on the dead fetus under section 2688, before final disposition of a dead fetus, irrespective of the duration of pregnancy, the funeral director or person assuming responsibility for the final disposition of the fetus or fetal remains shall obtain from the parents, or parent if the mother is unmarried, an authorization for final disposition on a form prescribed

and furnished or approved by the state registrar. The authorization may allow final disposition to be by a funeral director, the individual in charge of the institution where the fetus was delivered or miscarried, or an institution or agency authorized to accept donated bodies, fetuses, or fetal remains under this act. The parents, or parent if the mother is unmarried, may direct the final disposition to be interment or cremation as those terms are defined in section 2 of the cemetery regulation act, 1968 PA 251, MCL 456.522, or incineration. After final disposition, the funeral director, the individual in charge of the institution, or other person making the final disposition shall retain the permit for not less than 7 years. This section as amended by the amendatory act that added this sentence does not require a religious service or ceremony as part of the final disposition of fetal remains.

Minnesota Statutes § 145.1621 & 145.1622 (2016)

145.1621 DISPOSITION OF ABORTED OR MISCARRIED FETUSES.

Subdivision 1. Purpose. The purpose of this section is to protect the public health and welfare by providing for the dignified and sanitary disposition of the remains of aborted or miscarried human fetuses in a uniform manner and to declare violations of this section to be a public nuisance.

Subd. 2. Definition; remains of a human fetus. For the purposes of this section, the term "remains of a human fetus" means the remains of the dead offspring of a human being that has reached a stage of development so that there are cartilaginous structures, fetal or skeletal parts after an abortion or miscarriage, whether or not the remains have been obtained by induced, spontaneous, or accidental means.

Subd. 3. Regulation of disposal. Remains of a human fetus resulting from an abortion or miscarriage, induced or occurring accidentally or spontaneously at a hospital, clinic, or medical

facility must be deposited or disposed of in this state only at the place and in the manner provided by this section or, if not possible, as directed by the commissioner of health.

Subd. 4. Disposition; tests. Hospitals, clinics, and medical facilities in which abortions are induced or occur spontaneously or accidentally and laboratories to which the remains of human fetuses are delivered must provide for the disposal of the remains by cremation, interment by burial, or in a manner directed by the commissioner of health. The hospital, clinic, medical facility, or laboratory may complete laboratory tests necessary for the health of the woman or her future offspring or for purposes of a criminal investigation or determination of parentage prior to disposing of the remains.

Subd. 5. Violation; penalty. Failure to comply with this section constitutes a public nuisance. A person, firm, or corporation failing to comply with this section is guilty of a misdemeanor.

Subd. 6. Exclusions. To comply with this section, a religious service or ceremony is not required as part of the disposition of the remains of a human fetus, and no discussion of the method of disposition is required with the woman obtaining an induced abortion.

145.1622 POLICY FOR NOTIFICATION OF DISPOSITION OPTIONS. Hospitals, clinics, and medical facilities must have in place by January 15, 2009, a policy for informing a woman of available options for fetal disposition when the woman experiences a miscarriage or is expected to experience a miscarriage.

Missouri Revised Statutes § 194 (2012)

194.378. Final disposition of fetal remains, mother has right to determine. — In every instance of fetal death, the mother has the right to determine the final disposition of the remains of the fetus, regardless of the duration of the pregnancy. The mother may choose any means of final disposition authorized by law or by the director of the department of health and senior services.

194.381. Means of disposition. — 1. The final disposition of the remains of a human fetus may be by cremation, interment by burial, incineration in an approved medical waste incinerator, or other means authorized by the director of the department of health and senior services. The disposition shall be in accordance with state law or administrative rules providing for the disposition. If the remains are disposed of by incineration, the remains shall be incinerated separately from other medical waste. 2. No religious service or ceremony is required as part of the final disposition of the remains of a human fetus.

194.384. Written standards required for protection of mother's right to determine final disposition. — Every hospital, outpatient birthing clinic, and any other health care facility licensed to operate in this state shall adopt written standards for the final disposition of the remains of a human fetus as provided in sections 194.375 to 194.390 for protection of a mother's right pursuant to section 194.378 and for notice as required in section 194.387.

194.387. Miscarriage — mother's right to determine final disposition of remains — counseling made available, when. — 1. Within twenty-four hours after a miscarriage occurs spontaneously or accidentally at a hospital, outpatient birthing clinic, or any other health care facility, the facility shall disclose to the mother of the miscarried fetus, both orally and in writing, the mother's right to determine the final disposition of the remains of the fetus. The facility's disclosure shall include giving the mother a copy of the facility's written standards adopted pursuant to section 194.384. 2. The facility shall make counseling concerning the death of the fetus available to the mother. The facility may provide the counseling or refer the mother to another provider of appropriate counseling services.

194.390. Right to legal abortion not affected. — Nothing in sections 194.375 to 194.390 shall be construed to prohibit a woman's ability to obtain a legal abortion.

Nebraska Code § 71-20,121 (2014)

Disposition of remains of child born dead; hospital; duties.

(1) Every hospital licensed under the Health Care Facility Licensure Act shall maintain a written policy for the disposition of the remains of a child born dead at such hospital. A parent of such child shall have the right to direct the disposition of such remains, except that disposition may

be made by the hospital if no such direction is given by a parent within fourteen days following the delivery of such remains. Such policy and such disposition shall comply with all applicable provisions of state and federal law. Upon the delivery of a child born dead, the hospital shall notify at least one parent of such parents' right to direct the disposition of the remains of such child and shall provide at least one parent with a copy of its policy with respect to such disposition.

(2) For purposes of this section, child born dead means a child at any stage of gestation (a) who has died in utero, (b) whose remains have been removed from the uterus of the mother, for whom pregnancy has been confirmed prior to such removal, and (c) whose remains are identified with the naked eye at the time of such removal by the attending physician or upon subsequent pathological examination if requested by a parent. This section shall not apply to the performance of an elective abortion.

(3) Except as otherwise provided by law, nothing in this section shall be interpreted to prohibit any hospital from providing additional notification and assistance to the parent of a child born dead at such hospital relating to the disposition of the remains of such child, even if such remains cannot be identified with the naked eye at the time of delivery or upon subsequent pathological examination.

Ohio Revised Code § 759.49 (2017)

Rules governing product of fetal death.

(A) As used in this section and section 759.491 of the Revised Code, "fetal death" has the same meaning as in section 3705.01 of the Revised Code.

(B) The legislative authority of a municipal corporation owning a public burial ground or cemetery, whether within or without the municipal corporation, may pass and provide for the enforcement of ordinances for the burial, re-interment, or disinterment of the product of a fetal death in that public burial ground or cemetery.

(C) With regard to the product of a fetal death, on the request of the mother and in compliance with the public burial ground or cemetery's ordinances, a public burial ground or cemetery shall inter the product of the fetal death in accordance with one of the following:

(1) In a single grave within the public burial ground or cemetery that contains, or will contain, the remains of a parent, sibling, or grandparent;

(2) In another location of the public burial ground or cemetery, including a separate burial ground for infants, on a temporary or permanent basis.

Oregon Revised Statutes § 432.143 & § 432.158 (2013)

432.143 (1) (a) A report of each fetal death of 350 grams or more or, if the weight is unknown, of 20 completed weeks gestation or more, calculated from the date the last normal menstrual period began to the date of the delivery, that occurs in this state shall be submitted within five calendar days after the delivery to the Center for Health Statistics or as otherwise directed by the State Registrar of the Center for Health Statistics. The state registrar shall register the report of fetal death if it has been completed and submitted in accordance with this section and any rules adopted by the state registrar under this section.

(b) All induced terminations of pregnancy shall be reported in the manner prescribed in ORS 435.496 (Report to Center for Health Statistics) and shall not be reported as fetal deaths.

432.158 (4) Upon request of a parent or the parent's authorized representative, a disposition permit may be issued for a fetus that is not reportable as a fetal death.

South Dakota Codified Laws § 34-25-32.3 to 34-25-32.6 (2017)

34-25-32.3. Disposition of remains of embryo or fetus. Remains of a human embryo or fetus resulting from an abortion or miscarriage, induced or occurring accidentally or spontaneously

at a hospital, clinic, or medical facility shall be disposed of in the manner provided by §§ 34-25-32.3 to 34-25-32.7, inclusive.

34-25-32.4. Medical facility to provide for disposal of aborted fetuses. Any hospital, clinic, or medical facility in which abortions are induced or occur spontaneously or accidentally or any laboratory to which the remains of human embryos or fetuses are delivered shall arrange for the disposal of the remains by cremation, interment by burial, or by incineration in a medical waste incinerator approved by the Department of Environment and Natural Resources. If incineration is used, the remains of the human embryo or fetus shall be incinerated separately from other medical waste. The hospital, clinic, medical facility, or laboratory may perform any laboratory tests necessary for the health of the woman or her future offspring, or for the purposes of a criminal investigation, or for determination of parentage prior to disposing of the remains.

34-25-32.5. Failure to comply as public nuisance. Any failure to comply with the provisions of §§ 34-25-32.3 to 34-25-32.7, inclusive, constitutes a public nuisance. Any person, firm, or corporation failing to comply with the provisions of §§ 34-25-32.3 to 34-25-32.7, inclusive, is guilty of a Class 1 misdemeanor.

34-25-32.6. Disposition of fetal remains--Method. No religious service or ceremony is required as part of the disposition of the remains of a human embryo or fetus. The hospital, clinic, or medical facility shall discuss or disclose the method of disposition with the woman who had the miscarriage.

Texas Statutes 241.010

DISPOSITION OF FETAL REMAINS. (a) A hospital shall release the remains of an unintended, intrauterine fetal death on the request of a parent of the unborn child, in a manner appropriate under law and the hospital's policy for disposition of a human body. (b) Notwithstanding Subsection (a), if the remains of an unintended, intrauterine fetal

death weigh less than 350 grams, a hospital shall release the remains on the request of a parent of the unborn child, in a manner that is appropriate under law and consistent with hospital policy.

West Virginia Code §16-5-23

(b) Prior to final disposition of a fetus, irrespective of the duration of pregnancy, the funeral director, the person in charge of the institution, or other person assuming responsibility for final disposition of the fetus shall obtain from a parent authorization for final disposition on a form or in a format prescribed by the state Registrar.