Chapter 4

Pregnancy Remains, a Baby or the Corpse of a Child?

Governance Classifications of the Dead Foetal Body

In the previous chapter, I showed how classifications of the foetal body established by civil registration law affect the governance of legally recognised personhood and parent-offspring relations through the biomedical assessment of gestational time and the living or dead status of the born foetal body. In this chapter,[1] I address the governance of the material body of the dead, born foetus or baby through classificatory action on the body. Once a second trimester foetal being has emerged from the pregnant body, its substantial material body needs to be dealt with through some form of disposal. Morgan (2002, 1999) has described how the classification of a dead foetal being affects attitudes to, and regulation of, the ways in which its material presence is dealt with in specific geographic and historical contexts, for example as anatomical specimen, medical waste, or as a human corpse. Classificatory judgements about the ontological status of different types of foetal body in the UK are also made in relation to medical utility value, such as the permitted use of aborted foetal bodies in medical research (Pfeffer and Kent 2007). Confusion of classificatory categories in relation to management of the dead and of human body parts has historically been very controversial in England because of the way parts of human bodies are understood as adjacent to conceptualisations of personhood and kinship. The medical retention of human body parts and foetal bodies at Bristol Royal Infirmary and Alder Hey

Children's Hospital in Liverpool caused public outrage in the late 1990s (Mason and Laurie 2001, Sque et al. 2008). Earlier in the same decade, disquiet about the sluice disposal of aborted foetal tissue had led to new guidance requiring special separate disposal of pregnancy tissues (Myers, Lohr and Pfeffer 2015). These events formed part of the move towards the regulation of storage and disposal of human tissue by the 2004 Human Tissue Act, which itself forms the basis of many practices described in this chapter.

Conversely, the social production of a foetal body as a person, in need of disposal as a human corpse, can lead to the ritual burial or cremation of foetal bodies alongside other human bodies. In France, Memmi (2011) shows how the possibility of funerals for foetuses from 15 weeks produces them as a form of person, and Charrier and Clavandier (2019a) describe a shift in French disposal regulation away from classifying the post-15-week foetal body as waste and towards its inclusion in cemeteries. In the USA, laws about the disposal of the foetal body as a corpse after abortion have been critiqued as producing legal foetal personhood which could further threaten abortion rights (Leach 2020). Persons can thus be produced by disposal of remains, and so can kin relations of those persons. Recent work on ceremonies of disposal for foetal tissue in England points out that guidance on pre-24-week foetal disposal in England places these tissues alongside those of persons who have lived and died, with the ceremonies producing an 'invisible mourner who is a parent' (Kuberska 2020: 212).

In this chapter, I examine how law, regulation, recommendations and practices around the dead foetal body in England and Wales produce the material bodies of foetal beings as multiple, different, classificatory entities. I show that this reproductive governance can produce forms of foetal personhood and parental kinship with the foetal being, which are interventions at the level of ontology. At the same time, the accumulation of governance relevant to the foetal body over time has produced classificatory practices which clash with one another: apparently clear-cut boundaries of personhood, kinship and the status of human tissue are breached in circumstances where different forms of governance interact. The liminality of the second trimester foetal body makes visible some of these incoherences, which apply to all pregnancy. Furthermore, these legal, regulatory and practice-based classifications, produced by multiple actors in processes of reproductive governance, structure women's and families' choices about what happens to the body of the foetal being, including in post-mortem and disposal.

Bereavement Practices in the Medical Setting: Producing a Baby

In Chapter 2, I described how the presence of medical staff at live births in the second trimester facilitated an ontological shift from 'foetus' to 'baby', which is the shift which happens in a normative full-term birth. In my research, despite being before legal viability, live births immediately fulfilled the classificatory requirements for being 'real' babies and 'real' births creating kinship relations, despite the fact that medical intervention was rare and all the babies died. These babies were treated otherwise in ways which echoed other living babies – they were wrapped up, staff facilitated their parents holding them, sometimes skin-to-skin, and they were kept in the room until they died. Georgia's first son was born alive after premature labour and she found that the moments after birth conformed to her expectations of the birth of a baby:

> They didn't make too much of a drama of that situation, do you know? It was kind of just like a delivery. Now I've watched *One Born Every Minute* [a UK reality TV show about birth in the NHS]. I've watched *One Born Every Minute* loads, and I don't know why. [this made Georgia cry] . . .
>
> *So did they sort of wrap him up and give him to you?*
>
> Yeah. Just like a normal baby, in a towel. But there was no, like, there was no effort to, there was no way they could do anything. So yeah. It was just like a normal baby.

Where babies had already died before birth, there was also usually the option of encountering the body after birth, which is widely believed in Euroamerican psychological and biomedical discourse to be useful to the parental couple in coming to terms with what has happened (Heinsen 2022, National Bereavement Care Pathway 2022, Mitchell 2016). In my research, when the foetal being had died before birth there was less emphasis on parents immediately accessing the body after birth as they would in a normative birth, especially if the body was morphologically different, perhaps in a termination for foetal anomaly or if it had been dead for some time. Sometimes such bodies were represented as deviant by medical staff, as described in Chapter 2. In other cases, the foetal body was partly presented as a baby, but less comprehensively than with a live birth. Tamsin's twins who had died before birth were born in a somewhat chaotic experience during which she fainted:

> The midwife took them away, while I was kind of coming round. And it always sticks with me because she said to me, 'I'm going to take the babies to the nursery, I'll look after them.' And the fact that she called them babies, and that she was going to look after them was just really poignant.

Tamsin had glimpsed her babies during their births, but wanted to see them properly. When she was ready, they were brought in, with some attention paid to their presentation as babies. However, this normative presentation was only partial:

> They were in a nice little basket. But they were naked. Which I didn't like. And they there was a lot of blood around them, which again I didn't really like. Because the photos that I've got of them, you know, it's very clear that it's a trauma. There's blood around their heads and one of the babies has got like a big blood clot on its head. So that bothered me, that the photo I've got of them is quite a traumatic photo. They don't look peaceful.

Tamsin showed me the photograph, and her babies were presented in a bare and clinical manner, somewhat like medical specimens. This contrasted with images some other women showed me of their clothed and wrapped babies. In some cases, therefore, the dead foetal body was represented as a (sleeping) baby, but other times this presentation was more ambiguous. It was not necessarily taking its cue from the pregnant woman: Tamsin was very clear that she considered her twins to be babies and full persons, but the management of their bodies within the pregnancy bereavement unit where they were born was not quite congruent with this. The ambiguity of foetal bodies is often maintained by practice, even as they are produced as partial babies by that same practice.

Yet even as ambiguity is maintained in practice, there is a strong governance push towards producing pregnancy loss as a bereavement – with implications of a person being lost – representing the foetal being at any stage of pregnancy as a baby who has died. Paula experienced a pregnancy loss through termination for foetal anomaly, but of a foetus not a baby. Her definition of her experience was repeatedly challenged in favour of a bereavement discourse:

> We said we didn't want a funeral. 'Oh can you go and consult with the grandparents?' . . . Had to go and talk to my mum! Had to say to my mum, 'do you want a funeral?' my mum was like, 'what?' I said, that's ok. So then I think it [foetal body] goes off and is cremated somewhere isn't it? But then we had a letter, like 2 months later, 'do

> you want an entry in the baby [memorial] book?' My husband was going mad. Going mad!

Like Tamsin, Paula's own definition of her pregnancy loss and what it ontologically meant to her was not prioritised in the options she was given in relation to the body of her foetus.

I have already mentioned how NHS family-facing pregnancy literature uses the term 'baby' throughout the gestational period. Other actors in the governance of pregnancy loss include the third sector and professional medical organisations, who since 2017 have developed guidelines for dealing with all types of pregnancy loss and baby death, approaching all these experiences as bereavements as a default ontological position. They have produced a set of practice guidelines to which they invite NHS England Trusts to commit, known as The National Bereavement Care Pathway (National Bereavement Care Pathway 2022). This is in line with the approach of the All Party Parliamentary Group on Baby Loss, founded in 2016, where many of these actors meet in a parliamentary context and where the successes of the Pathway are celebrated. The Pathway recommends that all families are offered a parent-led 'bereavement care plan' in cases of pregnancy loss, including offers of 'memory making' such as the provision of hand and footprints, photographs, weight and measurement of the foetal body, clothing and wrapping with blankets, some of which were experienced by women in my research in live and non-live births.

Such practices have been described as 'mainstream bereavement discourse' in relation to pregnancy loss in England (Fuller and Kuberska 2020), and research on similar practices in Canada has shown how they are used to produce forms of foetal personhood, babyhood and the motherhood of the pregnant woman (Mitchell 2016). The practices situate the dead foetal body as the body of a baby when they reflect practices around the normative birth of a living baby. Interestingly, the emphasis is on aligning the dead baby with a living baby rather than with other human corpses, for example, through practices of photographing or weighing which are associated with newborns and not with the bodies of the dead. The National Bereavement Care Pathway is a form of reproductive governance applied to all pregnancy loss which takes an ontological position on the babyhood and implicit personhood of foetal beings. Despite being located in a biomedical context, this approach counters the biomedical-legal discourse which states that a pre-viable non-living foetus is not a person. It represents the confusion in

ontologies and governance of pregnancy loss and the dead foetal body which the rest of this chapter describes.

Managing the Disposal of the Foetal Body: Human Tissue or Human Corpse?

In the UK, being dead or alive at birth, combined with the biomedically determined gestational timeframe, determines the legal classifications of the dead body of a foetus/baby. If a baby is born alive (and registered as a birth and death), or registered as a post-viability stillbirth, including after termination, then the body is classified as a human corpse. A human corpse in the UK does not belong to anyone, not even surviving kin, but there are common law obligations to dispose of it appropriately as established in the case of R. v. Stewart (1840) (Sperling 2008). These obligations fall to various people including executors, close family and sometimes local authorities which will be discussed below. A human corpse must be buried, or in England and Wales cremated (under the Cremation Act 1902), or it can sometimes be preserved (Conway 2016). Esther's son was born alive and midwives explained her options about his body once he had died:

> They said that I actually *had* to arrange something for him because he, you know, he'd sort of lived. They explained to me that it was a neonatal death even though it was also technically a miscarriage because it was before 24 weeks . . .
>
> The hospital could do it, but I wanted to organise it myself. I didn't really fancy the idea of him – I wouldn't have minded the idea of, the concept of, being in with a load of other babies – but then the fact that it's not your baby's own grave, it's sort of shared, kind of thing.

Esther and her husband bore the legal responsibility of making sure their son's body was buried or cremated, as do all parents whose registered child dies (Conway 2016, HTA 2015). The outcome, of a separate grave site in a general cemetery, aligned their son's death with other deaths through the disposal of his corpse. Their involvement as parents in the burial aligned their bereavement with that of other parents who lose a child. The same requirement is in place for stillbirths after viability and there may be further changes to the law in future which also align stillborn corpses with those of fully registered infants and older persons through coronial law. The government is required by the Civil Partnerships, Marriages and

Deaths (Registration etc) Act 2019 to consult on extending coronial powers to investigate the circumstances of a death to babies who are stillborn, a change which would establish them still further as persons to whom the state has a responsibility.

Pregnancy Remains: Classifying the Pre-viable Foetal Body as Human Tissue

In other circumstances, such as non-live birth in the second trimester, the dead foetal body is legally classified as 'pregnancy remains'. This is a form of human tissue belonging to the pregnant woman (and not the genetic father), under the Human Tissue Act 2004, regulated by the Human Tissue Authority in England, Wales and Northern Ireland. The consequences of such classifications are that the pre-viable foetal body is not understood to be the body of a dead person. For those women who did not share this ontology, the resulting medical terminology could be distressing. Eva's son, who died *in utero* and was born after a long and difficult induction, was sent to the neighbouring county for post-mortem, in the hope of discovering a reason for the death. Visiting her consultant to be told the inconclusive results of that investigation, Eva described how she stole a look at her notes:

> He went out of the room for some reason, and he left my files, like, open on the desk. And I looked. And I remember it said something really horrific about [son's] body, like, it refers to the body, as I don't know, medical waste? Something about 'the foetus has arrived and the leftover bits have been, like, sent back.'

For Eva, the thought that his body was classified as a form of waste still disturbed her when she spoke to me seven years after his death. She had been told that her son, who died before viability, would not be registered as a birth and death or as a stillbirth and was legally 'pregnancy remains'. He was not recognised as a person to whom she was a mother. Yet she and his father had been required as parents to officially consent to post-mortem and cremation, which will be further discussed below.

Similarly, Tess saw a reference to 'foetal remains' on her medical notes which she found dismissive and inattentive to her feelings about her daughter, who died after a termination for foetal anomaly:

> That language wasn't helpful. I think that's, that's a shame, because that wouldn't have been used had she been 3 weeks older. And that's

> like 'hmm'. The definition of a life. She's not really a life. She's not really considered worthy of a title of proper human. And that's a bit hurtful . . .
>
> And it seems very disjointed, it seems very discordant with my experience than what they're describing it as [*sic*].

Besides potentially clashing with women's ontological position on what has happened to them, classification of the dead foetal body has legal consequences for disposal. Under the Human Tissue Act 2004, the pregnant woman's consent regarding how 'pregnancy remains' are disposed of is not legally required. This is similar to any other material from the human body, such as amputated body parts where consent for disposal is considered part of amputation consent (Hanna and Robert 2019). However, the HTA says that the woman's wishes regarding 'pregnancy remains' should be given special attention because of 'the particularly sensitive nature of this tissue' (HTA 2015) and guidance is built around choice for women (McGuinness and Kuberska 2017). The fact that 'pregnancy remains' are considered different to other human body parts relates to the potential presence of the foetal body. Pregnancy remains can include the placenta, umbilical cord etc, but it is the foetal body rather than these which produces a special status. The HTA recommends three options for the disposal of 'pregnancy remains':

> 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. (HTA 2015, emphasis in original)

In addition, because 'pregnancy remains' before 24 weeks are legally part of the woman's body, she can choose to take them away from hospital, as Tess did. The prevalence of each choice in practice is not known (Kent 2008). The multiplicity of disposal options including incineration is an attempt to cover multiple ontological outcomes in pregnancy outcomes. For example, it attempts to manage circumstances where women do not want to choose the disposal outcome, or wish for disposal that aligns the foetal tissue with other human tissue, in which case they can delegate the decision about disposal to the hospital. This might be particularly relevant in some abortion circumstances – for example, Paula delegated the disposal of her foetus to the hospital. The HTA regulations also try to govern

situations where there is no identifiable foetal body but there may be one present amongst other tissue. The separation from other clinical waste is designed to allow for that possibility because, as the HTA explains, crematoria will not usually accept remains that do not include foetal tissue. The flexibility of the HTA guidelines reflects the liminality of the status of the foetal body, but it also emphasises the 'sensitive' nature of the experience of termination or pregnancy loss (HTA 2015, n.d.), producing it as an ambiguous and liminal experience for women through the treatment of the foetal body.

Research into the acceptability of these forms of disposal was undertaken for the Human Tissue Authority and found that choice in the disposal of pregnancy remains is still not widely available: most hospitals offer only shared cremation (McGuinness and Kuberska 2017). Women in England are not routinely given information about all the legal disposal options for 'pregnancy remains' incineration (McGuinness and Kuberska 2017, Austin and McGuinness 2019). In my research, the clarity for women regarding what is actually happening in second trimester disposal is limited in practice, despite the HTA's insistence on women having choices about disposal. The HTA spells out in its guidance that 'pregnancy remains' from multiple pregnancies will be disposed of in one package (which should be made up of separately packaged units) unless women specifically object: 'The current practice of collecting several pregnancy remains in one receptacle separate from clinical waste can be the default position, providing there are safeguards in place that ensure women know they have choices, that they are given the opportunity to make their choice and that their wishes are carried out' (HTA n.d.).

I found that these distinctions are not widely spelt out to women, who were often told that if they chose group disposal their baby would be cremated 'with other babies' without any detail about how this form of disposal actually occurs. This echoes concerns that some hospitals are conflating cremation and 'sensitive incineration' practices and calling hospital-based incineration 'cremation' (McGuinness and Kuberska 2017). In 'shared' cremations, multiple pregnancy remains are placed in separate boxes but put together in one coffin or larger box (Kuberska 2020). Joelle initially picked a group cremation, and then changed her mind and decided on an individual funeral for her daughter who died during termination for foetal anomaly. However, later she inadvertently discovered that the standard 'group cremation' would have included other pregnancy remains such as placental material:

> When you fill out the paperwork you have the option of having the group cremation, but they can't tell you when it is, or, you can't go to it. And that's it, you just leave the baby and they deal with it. And I found that when I had the surgery to have the placenta removed, I filled out the same paperwork. Because it's classed as, what is it, like, 'foetal remains'? Even though it was just the placenta? And when I did that I was just so glad I'd chosen to have my own funeral [for her daughter]? Because it just made me think, like, what are they doing? Everything just goes into one, one thing?
>
> *And that wasn't what you wanted for her, or for you, or for?*
>
> No, I think. At the time, when I picked the group cremation [an initial decision she later changed], they didn't tell me that it's literally like, everything. [Pause] So I'm glad we did it ourselves and we got the ashes and things.
>
> *And would that have seemed disrespectful, then, putting her in with things like?*
>
> Yeah, I think it does, because it's not saying that there's any difference between a bit of someone's placenta, and the baby? [Pause] And I guess it's the same, like, if people have abortions and things, it's not treated very respectfully, is it?

For Joelle, this classificatory alignment of her daughter's body with placental material through disposal decisions would have been inappropriate, and it conflicted with her belief that that foetal remains should always be treated with the respect due to a dead body rather than as clinical waste, whether they had been the object of an abortion or not. The HTA guidelines' lack of clarity is not without its casualties when it tries to produce categorical boundaries which meet everyone's needs in its governance of pre-viability dead foetal bodies.

'Infant Remains': Reclassifying all Foetal Bodies through Cremation Regulation

As with so many of the classificatory issues in second trimester loss, there exists a certain amount of incoherence in cremation regulations about the status of the foetal body. This was touched on above, where the HTA suggests that the presence of a foetal body is required by crematoria, but also that whether there is a discernable foetal body or not, cremation should be an option. Cremation has been heavily regulated in the UK since it was made legal by the Cremation Act 1902, and a set of regulations were established and came into force in 1903, which have since been repeatedly

amended. The original regulations paid attention to pregnancy loss in that they included the first regulation of 'stillborn' corpses, even prior to their first state registration under the Births and Deaths Registration Act 1926.[2] In the 1903 cremation regulations, a 'stillborn child' could be cremated if a medical practitioner confirmed it was born dead, but there was no gestational timeframe related to the definition of 'stillborn' as a classificatory category. This was to be legally developed over the following century in relation to the increasing linkage of the concept of foetal 'viability' with that of 'stillbirth', through successive legal moves including the Infant Life (Preservation) Act 1929, the Abortion Act 1967 and the Human Fertilisation and Embryology Act 1990.

Recently, however, there have been moves to partly decouple disposal from notions of viability, and to situate all cremated foetal beings alongside other human corpses in cremation regulation. Regulation in this area has recently begun to expand beyond the category of 'infant remains' to include second trimester and other foetal bodies. One pressure to move regulation in this way involves an acknowledgement of mourners' desire to receive identifiable ashes from the cremation process. Two reports into the non-collection of individual ashes from infant cremations, the *Report of the Infant Cremation Commission* in Scotland in 2014 and the *Report into Infant Cremations at the Emstrey Crematorium Shrewsbury* in England in 2015, criticised practices in which parents were not given the ashes of registered children (House of Commons 2018). The reports prompted both the Scottish government and the UK government to review practices at crematoria, with the intent of recovering more individual ashes to give to mourners. In the process they have extended the definition of 'infant remains' in crematorium regulation to unregistered foetal bodies. Justice minister Caroline Dinenage explained the plans in the House of Commons in 2016:

> Where parents choose a cremation following a pregnancy loss of a foetus of less than 24 weeks' gestation, we will bring such cremations into the scope of our regulations, like all other cremations. I must stress that we have no plans to alter parents' current choices following a pre-24-week pregnancy loss, so parents will continue to be able to choose between cremation, burial and sensitive incineration or they can ask the hospital to make all arrangements on their behalf. (Dinenage 2016)

This change produces the foetal body as a human corpse, particularly in the second trimester where the body is substantial enough

to be identified and to produce some ash residue after cremation. Furthermore, the Cremation (England and Wales) Regulations 2008 require that records of cremation of stillborn babies must be kept by crematoria, and stipulate that these records can be accessed on request. Substantial documentation is also already kept on the disposal of pre-24-week foetal remains at the recommendation of the professional body the Institute of Cemetery and Crematorium Management (ICCM 2015). Research with funeral professionals has found that the record-keeping aspects of pre-24-week loss are already being attended to by funeral directors because of emissions requirements, retaining a traceable link to the hospital records of the woman who had been pregnant (Kuberska 2020). The government's plans to dispose of pre-24-week foetal bodies on the same terms as post-24-week bodies, which are recorded under the Cremation (England and Wales) Regulations 2008, mean that the record-keeping of crematoria will be further extended to become another site of bureaucratic governance through which there is a form of personhood recognition for second-trimester deaths based around the status of the foetal body.

Defining Parents through Their Obligations Towards the 'Corpse of a Child'

The final factor in the governance of the disposal of foetal bodies is the role of parents. I have described above how the classification of the foetal body as human corpse, pregnancy remains, or infant remains in the cremation context affects the choices available to relations about the disposal of the body. It also affects who has responsibility to pay for and arrange the disposal, conceptualised through normative UK cultural assumptions about family relations and obligations reflected in state financial support for funerals (Woodthorpe and Rumble 2016). In relation to disposal responsibility, there is some flexibility in English law about who this falls upon, as I noted above, except in the case of parents. In common law, parents are responsible for the disposal of the body of a dead child (Conway 2016), unless they do not have the means to carry out disposal, in which case the local authority may be responsible under the Public Health (Control of Disease) Act 1984. This applies to all registered children, including stillborn and post-viability foetal deaths caused by termination. This means that parental kinship relations are recognised through legal responsibilities in certain types

of pregnancy deaths, including the live born and post-viability stillborn. In terms of legal rights acquired through these relationships, parents may be entitled to Funeral Expenses Payments if they have a low income (UK Government n.d.-c). Some dead foetal bodies are classified as children, and some of their parents are given a parental responsibility for them. For some women in my research, this was a welcome confirmation of their ontological position on what had happened. In the last chapter, I described how Georgia's cousin had questioned her son being entitled to a birth certificate. For Georgia, the requirement to treat her son's body like a human corpse also validated her grief: 'And [her dismissive cousin] had said something about "babies that age don't have a funeral", and stuff like that. And because he was born alive we legally *have* to have a funeral.'

At the same time, the classification produces exclusions, in the form of those second trimester deaths where there is no parental responsibility to provide for the disposal of the foetal body, although because of the pregnant woman's disposal decision making required by the Human Tissue Act 2004, this distinction is usually concealed from parents. One case, however, where the distinction was brought into sharp relief was for Alice, who had terminations for foetal anomaly within a year of one another but either side of the viability threshold and who had already faced the need to register one baby and not the other:

> Afterwards they said 'you can see the bereavement counsellor if you like, you don't have to have a funeral because it's not 24 weeks, but you obviously can if you want to, and we will pay for it and arrange it for you if you want.'
>
> And we said 'yes, please. We want to do exactly the same as we did before, because that would be the right thing to do.'
>
> *Is that because you were treating them both the same?*
>
> Yeah, yes. Yes. We felt that they were both equally valid as individuals and relevant to us in our lives. And it just would have been awful saying yes, for our little girl we had a lovely funeral and flowers and all this stuff, and no, for the little boy, 'no, you can do what you like with *him*.' It doesn't make any sense. You know? Just because he was littler? But I just don't know where that cut off point is as to.
>
> *And I think it's part of your parenting again, isn't it, that you are parenting a being that is your son?*
>
> Yes. It's acknowledgement. Exactly. It's acknowledging that he was there.

Alice was one of the few women in my research who was in a position to see that there was a difference between the requirement to

have her post-viability daughter's body disposed of officially, and the hospital's concession that her pre-viability son's body could be treated similarly. Her case highlighted the classificatory decisions behind the governance of pregnancy loss.

Producing Liminal Parental and Foetal Personhood Status through Funeral Funding and Organisation

The actual enactment of parenthood in relation to born foetal beings is also partly defined by the way in which regulations around second trimester and other pregnancy loss disposal by hospital settings are applied in practice in different settings. In many cases, such as that of Alice above, payment of funeral costs and arrangement of the event was undertaken by the hospital. This could be a practical relief to parents, as well as an acknowledgement of the alignment of their loss with other child deaths, as in the case of Hayley:

> I turned round and said, 'how much is all this going to cost?' When they mentioned a funeral. I was like, 'this sounds daft, it doesn't matter, but what are we facing?' They said, 'there's no charge for any child under 2.' They pay for it. Which that, I have to say, was the biggest relief.

On the one hand, the expectation that Hayley would not bear the costs of her baby's funeral meant that she was classified as having a diminished parental responsibility compared to a parent whose older child had died, who would have legal responsibility and financial responsibility for disposal. On the other hand, the fact that the hospital paid for all costs for other under 2-year-old deaths meant Hayley was classified as having experienced a similar parental loss to other infant deaths, aligning her experience with that of the parents of registered infants. Payment and arranging of funerals, on the terms which hospitals were prepared to offer under the HTA regulations, produced both a liminal type of dead foetal body and a liminal type of parent. Women in my research were usually excluded from the group disposal arrangements by hospitals, who either specifically told them they could not attend a group funeral, or never mentioned the possibility of attending, in line with findings from research with funeral directors (Kuberska 2020). Stacey, whose daughter died during termination for foetal anomaly, explained how she had special dispensation to attend the cremation:

> We were told, 'you're not allowed to attend. You're not allowed to attend the mass cremation.' But the [hospital] chaplain agreed that we could go. Apparently it's because I was so upset. He made a special decision to allow us to go . . . We were treated special, and apparently they did special compensation for us. They treated us differently, they went the extra mile.

Stacey felt her extreme grief as a bereaved parent had made the hospital recognise her parental status and change its ordinary rules to accommodate her suffering. The bending of the rules classified her as a less liminal parent than those of other second trimester babies, but she felt upset that other parents had not had this opportunity:

> I felt like I was there for *all* these babies. [Pause] And that still gets me now, it still gets me now, that we were the only ones there. Why should you not be allowed to go?

Stacey was satisfied with the acknowledgement of her parenthood which took place during the ceremony, for example, when the funeral director told her he was sorry for her loss. However, whilst in this case she was acknowledged as a bereaved parent, her daughter was still a liminal being, in a casket with several others. Whilst the fact that there was a funeral was an acknowledgement of some form of personhood, the way the funeral was conducted produced the foetal beings as generic and non-individualised:

> The one thing that bothered me during the whole funeral was that he didn't read out names of the babies. It was just, 'we bless all these babies, dahdahdah'.

The hospital arranged funeral was in itself a sort of second-best arrangement, not quite a normal funeral, access to which Stacey thought was restricted because parents did not have to pay:

> I think it's because [the crematorium] do it, I think it's for free. They do it before the day starts and because they're doing it out of the goodness of their hearts, they don't. I think it's the crematorium that don't allow it, rather than the hospital, but you're told when you're given the option, if you choose a hospital cremation you're not allowed to go. You know the date it's happening, you don't know anything else.

At other times, it was funeral services which offered funerals for free to the parents experiencing second trimester death. However, these funerals also often occupied a liminal space between a 'normal'

funeral and the pregnancy loss version, producing different types of loss. Joelle arranged her own funeral through a funeral director near her home, but there was a particular set of arrangements in place for the free cremation of babies who died in pregnancy. Normally these took place early on a Wednesday morning, before other people were likely to want to use the crematorium. This was the same for the group cremation for her local hospital, which also took place early in the day at the same venue. However, there was heavy snow on the day scheduled for Joelle's daughter's cremation and the roads were impassible:

> So we got as far as [next village], and we couldn't get anywhere and we just phoned them and we said, 'we can't get there, we can't get to the funeral!' And so we had to cancel it.
>
> And then luckily they managed to reschedule it that afternoon, but they said 'just to let you know, there is a big funeral on at the same time.' So we went there . . . and there was [*sic*] like 10 cars, and a massive coffin with lots of flowers, and all these people turning up to this other one, and then there was just us. [Pause]
>
> [Fiancé] carried the coffin in, we had some songs and did some readings, and that was it.

Accepting the free funerals where the normal parental responsibility to pay for the disposal of a child's corpse was delegated to hospitals or funeral directors produced pregnancy losses as different to the loss of an older person, or older child, and removed some control over the event for parents. This liminality reflects findings in research into funeral directors' attitudes to pre-24-week loss, in which different language, such as 'products of conception', was used behind the scenes by professional funeral staff, compared to language such as 'son' or 'daughter' used when speaking to parents (Kuberska 2020). It also reflects research into the use of separate areas known as 'baby gardens' in cemeteries in which infant and foetal remains may be buried or ashes scattered, and in which the use of separate space differentiates these deaths from other deaths (Woodthorpe 2012).

In my research, parents were aware that professionals viewed the foetal body as not quite the body of a person, and the parents as not quite the same as other parents or mourners as a consequence. Amanda felt this keenly after her son died from feticide during a termination for foetal anomaly:

> And so [funeral directors] were like 'well, what do you want?'
>
> I said, 'I want a willow casket.'

> 'Well, no, they don't do them small enough.' And that was the message of everything that I asked for, 'no, he's too small.' They didn't do a hearse, because he was too small for a hearse: 'It's not worth getting the hearse out. He can go in the boot of the people carrier.'

Amanda found that a combination of the size of her son, his gestation and his lack of registered personhood set parameters on the disposal of his body which was not considered to be so formal an event as the disposal of an older being, even when she was accepting the financial liability of his disposal and thereby acting as his parent. Her actions and choices as a parent regarding disposal were partly limited by the material condition and status of her son's body, as her actions and choices in her own medical treatment had been during the termination of her pregnancy.

Defining Parents as Kin through Post-Mortem Consent

Apart from burial, cremation, or sensitive incineration, the material foetal body which has died in the second trimester may be subject to post-mortem.[3] Of the 31 women in my study, 14 consented to post-mortem at least once. Post-mortem consent and procedure is a sensitive subject in England because of the historic scandals at Bristol Royal Infirmary and Alder Hey. Consent levels have been declining (Breeze et al. 2012) and are considered particularly problematic in perinatal post-mortem (Reed, Ferazzoli and Whitby 2021). Many of the bodies from which parts were retained without consent in the past were those of infants and foetuses (Sheach Leith 2007). Several women in my research mentioned these scandals during the interviews. Perhaps as a result of anxieties around retention of body parts, the regulation of consent to processes concerning the dead foetal body other than disposal, such as post-mortem or organ donation for research, is derived from multiple agencies working together in a classic example of governance (Bevir 2011). Responsibility is thus both spread out across actors and also devolved to parents. In this respect, governance of post-mortem consent for perinatal beings is similar to governance of termination for foetal anomaly, in which a combination of legal and medical frameworks and institutions interact with the wishes and intentions of parents, an example of a tactical polyvalence of

discourses, in which people and institutions may align their interests for a particular purpose (Foucault 1998).

Post-mortem consent for adults and older children is regulated by the Human Tissue Authority (HTA), but the HTA has delegated the production of advice on perinatal and pregnancy loss post-mortem to the pregnancy loss charity Sands, funded for this work by the Department of Health. Sands have produced a package of advice and consent forms in consultation with a number of other actors including medical professionals, mortuary managers and parents, and this is now the standard practice for England recommended by the HTA (Sands n.d.). This best practice on the consent and authorisation of a post-mortem applies to all foetal beings born alive or dead and at any gestation, which are referred to by the guidance as 'babies', and who, on the sample consent form, have separate spaces for name, surname and date of birth (Sands 2013b), producing them as a form of person recognised by state and NHS bureaucracy, individually accounted for as a 'case' through which power produces a form of reality (Foucault 1991). It appears that Sands have used the post-24-week stillbirth scenario, historically the charity's main interest and site of action, as the standard for all pregnancy loss.

The Sands/HTA guidance states that consent and authorisation for a post-mortem must be received, and this 'should always' be given by the pregnant woman (referred to as 'the mother' in the text) unless there are exceptional circumstances such as her being too ill to consent, and 'wherever possible' should be sought from 'the father' (Sands 2013a: 13).[4] Having noted the heteronormative nature of the guidelines, they are also potentially problematic in their undermining of the definition of 'pregnancy remains', which as discussed above are legally considered part of the pregnant woman's body. The Sands guidelines applied in a second trimester pregnancy loss therefore effectively allow the other parent of the foetus (assumed by them to be male) to give permission for the medical examination of tissue which legally belongs to the pregnant woman. It is not clear what would happen if one party consented and the other did not.

The appearance of a 'partner with parental responsibility' on the consent form suggests that permission is not given on the basis of biological link with the foetus, as the male genetic parent, nor as next of kin of the pregnant woman, as her partner, but on the basis of a social parenting role in relation to the foetal being. The effect, therefore, of this confused position, is to produce a second parent

or a father to the dead baby through the consent to post-mortem. This aligns post-mortem consent for all pre-viability foetuses, including those who were born dead and who do not have legal personhood status, with the HTA post-mortem consent processes which apply when a dead legal person has not themselves given permission for a post-mortem, and a series of qualifying kinship relations can give consent in their place (HTA 2017b, 2017a). These qualifying persons are defined in the 2004 Human Tissue Act and include parent-child relationships second only to spouses and partners. The governance of post-mortem consent therefore produces parents as kin to foetal beings which are not otherwise considered persons and whose kinship with parents is in doubt in other areas of the governance of pregnancy, such as civil registration or maternity entitlements, discussed in the last chapter.

The post-mortem therefore constructs a foetal personhood through the individualisation of the foetal being, and a parent-child relationship through consent procedures. It is also implicated in the production of a foetal person because of its judgement on the sex of the foetal being which has died. In the second trimester, the formation of foetal sex organs may not yet clearly indicate biological sex, or the foetal body which has died in utero may have deteriorated so that sex is hard to determine visually at birth. A perinatal post-mortem involves chromosome analysis which fixes the sex of the foetal being. For many women in my research, the pronouncement of sex after post-mortem chromosomal diagnosis was an important moment which sometimes conflicted with their own idea of the sex of the baby, or at other times confirmed it. For some women, such as Natalie, the unexpected disclosure of sex in the post-mortem results was distressing. Natalie's previously unnamed and unsexed baby born dead before viability was not legally classified as a person, but the post-mortem gave him a sex, and for her this made him a more tangible form of person:

> [The consultant] wrote to me, and I just opened the letter, and, and it said, you know, 'I can confirm that your baby was a boy.' And I was here on my own, and I hadn't actually asked to know the sex. They hadn't given me the option, 'Would you like to know the sex?' If I had, I would have preferred to have been told verbally, rather than in a black and white letter. I was here on my own, and I opened it, and suddenly it changed things, you know.
>
> *What did it change?*
>
> It just changed to having another son. You know. From just losing a baby, to losing a son.

The governance of perinatal post-mortem through the HTA guidance and medical practice produces a foetal being in the second trimester which has a definite sex, which is individualised in bureaucratic records linked to the state using a personal and family name, and which is situated in relation to parental kinship. This being, although dead, has many of the prerequisites of personhood which apply to other beings, such as the post-viability stillborn person.

Conclusion: Incoherence in the Reproductive Governance of the Dead Foetal Body

In this chapter, I have shown that the death of the foetal being in the second trimester of pregnancy brings together different governance arrangements in relation to the material dead foetal body which are confused and contradictory, and which can limit the agency of the pregnant woman. Bereavement body management practices, disposal laws and regulations and post-mortem consent situate the second trimester pre-birth death (which was the case for most of the babies in this research) as a liminal being. On the one hand, the death is categorised as similar to the neonatal death of a recognised person, in the sense that special attention is paid to the material foetal body, it can be subject to post-mortem and buried or cremated, and it is likely to be understood as the focus of bereavement in biomedical settings. New cremation regulations individualise the pre-viability foetal body, and produce it as a corpse with identifiable ashes belonging to next of kin, which includes both parents. This aligns it with the stillborn corpse, which has a recent history of being treated legally like the corpse of a recognised human, and produces the foetal being as a form of person. On the other hand, under the Human Tissue Act, the body is not legally classified as a 'real' human corpse but as part of the pregnant woman's body. In this guise, it may be incinerated as a form of clinical waste, if the pregnant woman chooses this. Kinship with the father or other parent is not recognised in these cases, and such foetal beings exist only in relation to the pregnant woman who can decide their disposal. Sometimes this relationship is understood as a form of mother, if burial and cremation are selected, and other times this is a form of clone relationship, with the foetal being simply understood as a separated part of the gestational mother. Whilst the pregnant woman can make some choices in this situation, these

are limited – the foetal body cannot be treated as medical waste, nor can it be registered as a person.

At the same time, there is a clear distinction between the legal status of the second trimester foetal being born dead and the live born gestationally similar baby. A live born baby in the second trimester is always a person, and must be buried or cremated, and this responsibility must be executed through parental agency, although the hospital can assist. In these cases, personhood status of the foetal being, and related parental status, has been fully established through the civil registration of live born babies, and this cannot be disavowed by parents, whatever their own desires might be. In all cases, therefore, the pregnant woman's choices and options about what happens to the foetal body are constrained by governance, despite an apparent focus on choice in the HTA regulations.

This governance is reproductive governance, through which dead foetal bodies and their parents are at times recognised as persons who are kin to one another, with responsibilities and rights, and at other times these statuses are withheld from them. Sometimes pregnancy governance produces dead babies and grieving mothers and other parents who can make choices for one another's bodies. At other times there is just foetal tissue belonging to one individual rather than forming two. In relation to the bereavement practices embedded in biomedical settings which follow the National Bereavement Care Pathway, underlying assumptions about all pregnancy loss as bereavement actually contradict the dominant biomedical-legal discourse which says personhood is dependent on live birth and post-viability birth. In all of these cases, the determining factors are not the choice of the pregnant woman, but the governance parameters set by actors in this field, often based on the biomedically assessed status of the dead foetal being in relation to gestational time and live birth personhood.

Notes

1. A version of this chapter has been published in the journal *Mortality* (Middlemiss 2021).
2. The Births and Deaths Registration Act 1926 was the first to require the medical diagnosis of stillbirth before disposal through burial could take place, but this was not linked to a legally defined gestational timeframe until the Births and Deaths Registration Act 1953 drew on the Infant Life (Preservation) Act 1929 to establish stillbirth as after the 28th week of pregnancy, later amended to 24 weeks.

3. Post-mortem consent also affects disposal options for any tissue which is removed from the body of the baby. If tissue has been removed and preserved, for example in slides for microscopes, these cannot be cremated and another form of disposal must be decided on for these body parts (Sque et al. 2008, Sands n.d.). If burial has already taken place, it is unlikely that a grave could be reopened to bury any additional tissue later on. No-one in my research mentioned this having been explained to them in our conversations about post-mortem consent, although neither did I ask directly because I was unaware of this information at that point in my research.
4. The HTA sample consent form itself sets 'father' alongside an option of 'partner with parental responsibility' (Sands 2013b).