Review

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The role of Coroners in perinatal death investigation in high-income countries: a scoping review

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Abstract

Introduction: The primary role of a Coroner is to investigate unexpected deaths. However, the global literature on Coroner's role in perinatal death cases is limited.
Content: This study used the Joanna Briggs Institute framework and comparative law methodology to evaluate existing literature from high-income countries and jurisdictions (including where relevant states or provinces). A dual-source approach reviewed peer-reviewed and grey literature across 12 electronic databases, alongside national legislation from jurisdictions with a Coronial or equivalent system.
Summary: After analysing 24 countries with Coronial or equivalent systems and legislation available in English, the study found that only 12 of these countries had Coroners investigating perinatal deaths, and only one country mandated reporting of all perinatal death cases. A significant gap was found in Coroner's role in perinatal death cases through legislative sources and peer-reviewed literature.
Outlook: While global uniformity in Coronial law is not feasible, countries should adopt standardised reporting guidelines, training, and expertise to ensure consistent and high-quality death investigations. Further research is needed on holistic approaches, examining the emotional, social, and systemic factors involved in perinatal death inquiries, understanding their impacts on families, healthcare professionals, and other stakeholders, and encouraging multidisciplinary collaboration to ensure thorough and comprehensive investigations.

Keywords: coroner; perinatal death investigation; medical examiner; perinatal mortality; stillbirth

Introduction

Perinatal death includes stillbirths (either antepartum or intrapartum) and early neonatal deaths (death within first 7 days after birth) [1]. Despite a global reduction in perinatal mortality rates since 2000, approximately 47 % of all child deaths under the age of five years occur within the first 28 days of life [2]. An estimated 1.9 million stillbirths occur annually worldwide, with over 40 % of these events taking place during labour, underscoring the burden of perinatal mortality in global health statistics [3]. In most European countries, stillbirth rates have either continued to reduce to levels of less than three per 1,000 births or tended to plateau since 2010 [4].

When possible, establishing the cause of perinatal death can be crucial for understanding the factors surrounding a baby's death and providing support to bereaved parents in making informed decisions about future pregnancies [5]. In high-income countries like the United States (US), perinatal deaths reported to the Government are used for vital statistics and public health monitoring by the National Center for Health Statistics [6, 7]. In some European Union (EU) countries and the United Kingdom (UK), perinatal deaths are considered reportable events by the Government [8–11]. For example, in Ireland, perinatal deaths are reportable events by the healthcare professional and the Health Service Executive (HSE), requiring mandatory reporting and review processes to identify contributing factors and guide evidence-based improvements in maternal and neonatal healthcare services [11].

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Internationally, medico-legal deaths, including perinatal deaths are investigated by officers such as Coroners, Medical Examiners, Procurator Fiscal, or Sheriffs [10, 12]. A Coroner, as a judicial officer is responsible for investigating reportable deaths that fall under their jurisdiction [12]. The title, designation, and scope of a Coroner's role in perinatal death investigation differs significantly across jurisdictions in high-income countries [10, 12, 13]. Specifically, not all jurisdictions mandate Coroner-led investigations for all perinatal deaths, allowing a nuanced understanding of regional-specific regulations governing Coroner authority [13–17]. Contrarily, in countries like Ireland, all perinatal deaths must be reported to the Coroner by law [18]. The rules governing Coronial jurisdiction in perinatal death investigations are complex due to the varied requirements and circumstances that determine their authority to investigate such incidents [19, 20]. In many cases, deaths are not suspicious and only require Coroners to decide whether to hold an inquest [20]. However, this process can be hindered by unclear guidelines and inconsistent legislative approaches, leading to ambiguity about Coroner's scope in such cases [19].

We conducted a scoping review to identify existing literature on Coroner's role in perinatal death investigations within high-income countries. Medical Examiners perform a similar, if not identical, role as Coroners in some jurisdictions. Medical Examiners will be referred throughout this article as equivalent to Coroners. The study is specifically centred on Coroner's investigation of perinatal deaths in Coronial or Medical Examiner systems. Other perinatal death review processes, such as Netherlands' PERINED or Perinatal Mortality Review Tool (PMRT), are not covered in this study.

Methods

Study design

The scoping review was conducted following Joanna Briggs Institute (JBI) [21] methodology for scoping reviews and reported using the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews Checklist [22, 23].

A Comparative Law methodology [24], analysing and evaluating various legal data through a process of comparison was also employed. Data for the review was collected by two types of sources: primary sources and secondary sources. Primary sources comprised national legislation governing perinatal death investigations conducted by Coroners. These were identified through an exhaustive search of government websites of all high-income countries as defined by the World Bank that also had laws in the English language. Secondary sources consisted of articles retrieved from legal and academic databases. The secondary sources were used to complement and confirm information from primary sources.

The research questions (RQs) for our scoping review are provided below and outlined in the protocol, registered prospectively with the open science framework (OSF) in September 2024 [25].

(RQ1) When was the Coroner's role first defined for medico-legal purposes, and when was it established in perinatal death investigation?

(RQ2) Who are Coroners and what expertise is required for this role in high-income countries with national legislation in English?

(RQ3) What titles or designations are applied to Coroners in different high-income countries?

(RQ4) What is the role of a Coroner (or equivalent authorities) in perinatal death investigation in high-income countries?

Protocol

A scoping review protocol in line with the JBI Methods Manual [21] for scoping reviews was registered with the OSF [25]. The objectives, inclusion criteria, and methods for this scoping review were detailed in advance and documented in our protocol, they are outlined briefly in Table 1.

Eligibility criteria

Our eligibility criteria were conceptualised using the JBIs Population, Concept, and Context (PCC) framework [21].

Information sources and search strategy

Primary sources

A comprehensive review was carried out in January 2024, including official government websites of all 83 high-income countries, to identify those with a Coronial or its equivalent system in place. Various terms related to Coroners, such as Medical Examiner, Procurator Fiscal, and Juge d'Instruction, among others (refer Figure 1) were used to ensure a thorough and exhaustive search was conducted. This search was not limited by language barriers, using Google's webpage translation feature to provide access to non-English websites.

Subsequently, between February and May 2024, an extensive search was conducted on legislation from high-income countries found to have established Coronial or its

Table 1: Eligibility criteria.

	Inclusion criteria	Exclusion criteria
Population	Individuals employed in perinatal death investigations as Coroners or Medical Examiners, or equivalent officers were included in the review.	Medico-legal death investigators who are not directly involved in perinatal death investigations and not performing duties equivalent to those of Coroners, Medical Examiners or equivalent officers were excluded.
Concept	Perinatal death investigations that occurred only within hospital settings. Deaths that were categorised as either stillbirths or early neonatal deaths, depending on the specific classification used in the country where the event occurred were included. Coroners' investigation of perinatal deaths in Coronial or Medical Examiner systems. Coroners' investigation of perinatal deaths in Coronial or Medical Examiner systems. Other perinatal death review processes, such as Netherlands' PERINED or Perinatal Mortality Review Tool (PMRT), are not covered in this study.	Neonatal deaths after seven days of birth in hospital. Infant deaths that do not fit within the scope of this study. Perinatal deaths without medical assistance or outside hospital settings. Other types of perinatal death review processes that are not involving Coroners or equivalent officers are not included in this study.
Context	Countries classified by the World Bank as high-income as of January 2024 and that had a Coronial or equivalent system with national legislation available in English were included in the review.	Countries where national legislation outlining Coroner's role was not available in English on Government websites, and countries that did not employ the Coronial or Medical Examiner systems or had significantly distinct systems.
Language and time periods	To increase feasibility and timeliness of review completion, only literature written in English between 2000 and 2024 were included.	Literatures available in languages other than English and published before 2000.
Type of literature included	Any type of article, qualitative and quantitative studies, case report, case law, expert opinions, book chapters, or complete books that described the role of Coroners in perinatal death investigation in high-income countries.	News reports and social media reports.

Title(s)*
Chief Coroner, Chief Deputy Coroner, Coroner, Coroner Investigator, County Medical Examiner Death Investigator, Death Investigator, Forensic Investigator, Forense/Medical Examiner, Justice of Peace, Koroner, Ligsynsm and, Legal aid, Médico Legista, Medico legale, Medical Examiner Investigator, Medical Investigator, Ombudsman, Peace Officer, Rättsläkar/ Obducent, Rettslege, Sheriff-Coroner Investigator, Sheriff-Coroner.

Figure 1: Various terms used related to a Coroner or equivalent officer. *Some jurisdictions employ multiple titles to refer to officials who investigate deaths reflecting local variations in terminology. The provided list is not exhaustive and may not include all titles used across different countries or regions.

equivalent systems. The focus was on legislation that outlined the roles and responsibilities of Coroners or similar officials, specifically that was readily available in English. Additionally, other legislation performing a comparable function in each country was also searched on government websites to determine the specific role of Coroners or equivalent officers concerning perinatal death investigation (if applicable). The search identified high-income countries where perinatal deaths are legally mandated to be reported to Coroners (refer Figure 2).

Secondary sources

Electronic database search

The 12 electronic databases searched were MEDLINE Complete (EBSCO), CINAHL plus with full text (EBSCO), Academic Search Complete (EBSCOhost), Web of Science, EMBASE (Elsevier), Sage Journals, Criminal Justice Database (ProQuest), Hein online, Oxford Academic Journals, Scopus, Westlaw IE, and Lexis+. Keywords were combined using Boolean operators "AND" and "OR". References from included articles were hand-searched for additional relevant studies.

Separate search strategies were tailored for use with legal databases (refer Table S1 for an example). The legal search engine enabled the capture of articles and literature in non-indexed journals that were not accessible through traditional search tools (e.g., PubMed, EBSCO). The same set of keywords were employed in conjunction with Boolean operators for searching academic and legal databases in August 2024. The complete bibliographic search strategy, including all the filters used, for one of the databases is presented in supplementary files as document File 1.

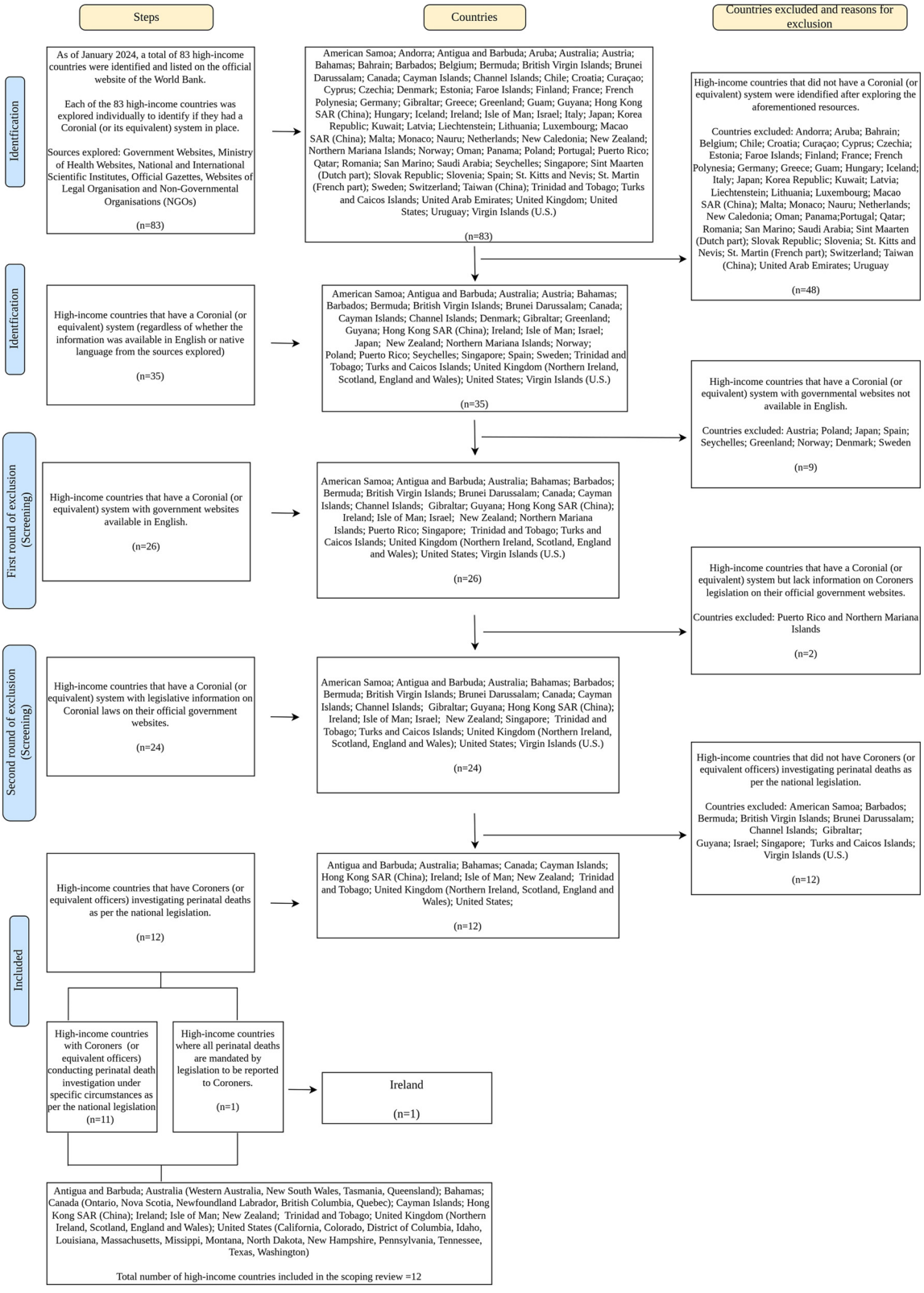

Figure 2: Selection of high-income countries that have perinatal deaths investigated by Coroners as per national legislation.

Study selection process

Following the search, retrieved records were systematically managed through two stages of data cleaning. First, they were imported to Zotero to exclude duplicate entries and then exported to Rayyan online software for further deduplication. Titles and abstracts were screened and irrelevant records such as those with no abstracts were excluded. Inclusion and exclusion criteria outlined in the eligibility criteria, were applied to the literature sourced. Full texts of the selected records were retrieved and assessed further against the eligibility criteria. This process was conducted by two independent reviewers. Any disagreements were resolved by a third reviewer. Figure 3 shows the study selection process for secondary sources.

Data items and data abstraction process

Data were extracted by one reviewer and cross-checked for accuracy by the second reviewer. A 20 % quality check was completed by a medical expert and a legal expert. Data were collected using a spreadsheet consisting of study characteristics (e.g. publication year, country, study design), type of perinatal death mentioned, and practices relating to Coroners or equivalent officers in perinatal death investigation. Data extraction tables were created, and a narrative synthesis was carried out to report findings. A risk of bias assessment was not conducted, in line with the JBI Scoping Review Methods Manual [21].

Synthesis of results

To effectively communicate the findings, this study employed a narrative synthesis approach, presenting key information on the Coroner's role in perinatal death investigations across high-income countries in clear and concise tables and figures (detailed in Tables 2–4). Additionally, Tables S2, S3 and S4 in the supplementary file details the general role of Coroners across 12 included high-income countries.

Results

Primary source: national legislation searches of different high-income countries

Of the 83 high-income countries searched, 24 had an established Coronial or equivalent system in place with legislation available in English (Table 2 and Figure 2). Among these, 12 countries had national legislation specifying perinatal deaths (either stillbirths and neonatal deaths or both) under reportable deaths to Coroners. Within this subset of 12 countries only Ireland mandated reporting of all perinatal deaths to Coroners (Figure 2). A comprehensive list of high-income countries considered for analysis is shown in Figure 2.

Secondary source: electronic database search

Twelve electronic database searches yielded a total of 1,454 records, which were deduplicated using Zotero and Rayyan, resulting in 1,062 records for title and abstract screening. 73 full-text documents were evaluated, and 20 were eligible for final analysis. The Eligibility criteria were applied to literature sourced, and an additional four documents were retrieved from reference lists, expanding the final corpus to 24 records. Figure 3 depicts the PRISMA flow chart for the 24 included records.

The comprised 24 documents were published between 2000 and 2024. Geographically, the documents were distributed across six regions: Australia (n=3), Ireland (n=3), New Zealand (n=2), UK (n=15), and US (n=1).

Research questions

(RQ1) When was the Coroner's role first defined for medico-legal purposes, and when was it established as having a role in perinatal death investigation?

Brief history and function

The word Coroner comes from the Anglo-Norman word *Corouner* and its exact origins are unknown [166]. England and Wales have the world's oldest Coronial government, which is thought to have existed as early as the 9th century, although its modern form was formally established in 1194 [166].

Over time, Coroners roles and responsibilities have evolved significantly in the UK, with notable changes specified in the Magna Carta (1215), the Statute of Coroners (1276), the Local Government Act (1888) [167] and, eventually the Coroners and Justice Act 2009 (UK) that was also modified and updated in July 2013 [68, 167]. The role of Procurator Fiscal in Scotland was established in the 16th century, with the primary focus on collecting fines imposed by police

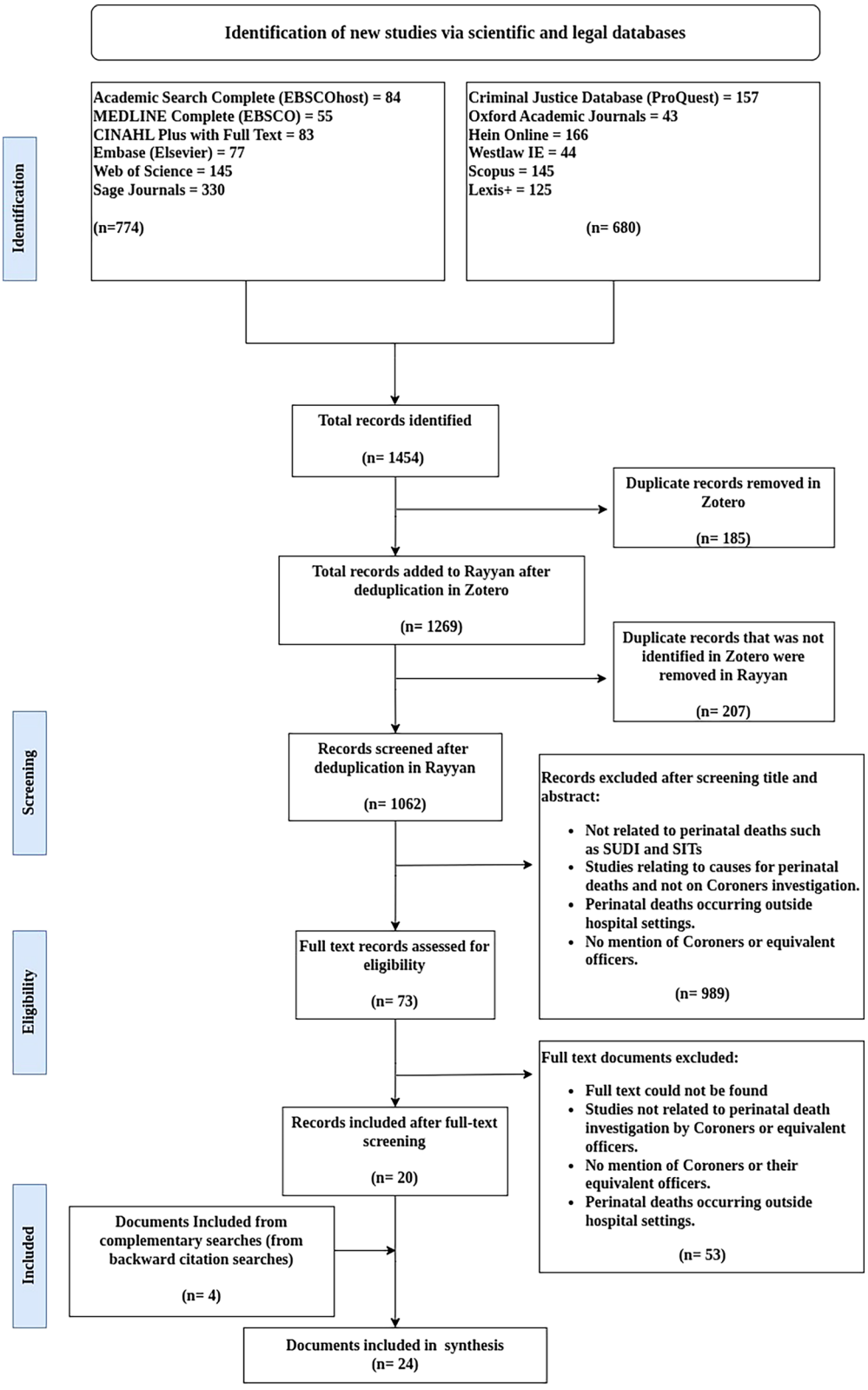

Figure 3: PRISMA flow chart. Literature selection process (n=24).

Table 2: High-income jurisdictions that have a Coronial system with legislation available in English, whether or not Coroners investigate perinatal deaths (n=24).

S/No.[a]	Country and regional jurisdiction	Type of system in the country	Source	National legislation as per the jurisdiction	Legislation last update, year	Coroner or equivalent officers has jurisdiction to investigate perinatal deaths (in hospitals) (Y/N)
1	American Samoa	Coronial system	Ministry of Justice and Courts Administration	The Coroners Act 2017 [26] The Births, Deaths, and Marriages Registration Act 2002 [27]	2018	No
2	Antigua and Barbuda	Coronial system	Laws of Antigua & Barbuda	The Coroners Act [28] The Births and Deaths (Registration) Act [29]	2018	Yes
3	Australia	Coronial system	The National Coronial Information System (NCIS) [16]			
3.1	Australian Capital Territory	Coronial system	The National Coronial Information System (NCIS)	The Coroners Act 1997 [30]	2022	No
3.2	Western Australia	Coronial system	Coroners Court of Western Australia	Coroners Act 1996 [31] Births Deaths and Marriages Registration Act 1998 [32]	2024	Yes
3.3	New South Wales	Coronial system	Coroners Court New South Wales, NSW Legislation.	Coroners Act 2009 [33] Births, Deaths, and Marriages Registration Act 1995 No 62 [34]	2024	Yes
3.4	Victoria	Coronial system	Coroners Court of Victoria	Coroners Act 2008 [35]	2024	No
3.5	Queensland	Coronial system	Queensland Legislation, Coroners Court of Queensland	Coroners Act 2003 [36]	2024	Yes
3.6	South Australia	Coronial system	Courts Administration Authority of South Australia	Coroners Act 2003 [37] Birth, Deaths, And Marriages Registration Act 1996 [38]	2023	No
3.7	Tasmania	Coronial system	Government of Tasmania. Magistrate court of Tasmania Coroners Court.	Coroners Act 1995 [39] Births, Deaths, and Marriages Registration Act 1999 [40]	2022	Yes
4	Bahamas	Coronial system	Government of Bahamas	The Coroners Act 2011 [41] Birth And Death Registration Act [42]	2011	Yes
5	Barbados	Coronial system	Statutes of Barbados	The Coroners Act [43]	2007	No
6	Bermuda	Coronial system	Laws of Bermuda	Coroners Act 1938 [44]	2000	No
7	British Virgin Islands	Coronial system	Law of Virgin Islands Virgin Islands Statutes	Coroners Act [45]	2013	No
8	Brunei Darussalam	Coronial system	State Judiciary Department	Subordinate Courts Act [46]	2001	No
9	Canada	Coronial system and Medical Examiner system	Government of Canada [47]			
9.1	Ontario	Coronial system	Government of Canada; The Coroner and Medical Examiner Systems	Coroners Act 1990 [15]	2024	Yes
9.2	Alberta	Medical Examiner system	Ministry of Justice, Alberta. Office of the Chief Medical Examiner (OCME).	Fatality Inquiries Act [48]	2023	No

Table 2: (continued)

S/No.[a]	Country and regional jurisdiction	Type of system in the country	Source	National legislation as per the jurisdiction	Legislation last update, year	Coroner or equivalent officers has jurisdiction to investigate perinatal deaths (in hospitals) (Y/N)
9.3	Nova Scotia	Medical Examiner system	Government of Nova Scotia	Fatalities Investigations Act 2001 [49]	2022	Yes
9.4	Newfoundland and Labrador	Medical Examiner system	Office of the Chief Medical Examiner	Fatalities Investigations Act [50]	2019	Yes
9.5	British Columbia	Coronial system	BC Coroners Service	Coroners Act 2007 [51]	2024	Yes
9.6	Québec	Coronial system	Government of Québec	Coroners Act [52] Public Health Act [53]	2023	Yes
10	Cayman Island	Coronial system	Cayman Islands Judicial Administration, Coroners Court	Coroners Act 2021 [54] Births and Deaths Registration Law [55]	2021	Yes
11	Channel Island	Coronial system	The Bailiwick of Guernsey (Government, Bailiwick of Jersey)	Inquests and Post-Mortem Examinations (Jersey) Law 1995 [56]	2023	No
12	Gibraltar	Coronial system	HM Government of Gibraltar. Laws of Gibraltar.	Coroners Act [57]	2007	No relevant data or records were located during the search[b]
13	Guyana	Coronial system	Cooperative Republic of Guyana. Ministry of Legal Affairs.	Coroners (Amendment) ACT 2016 [58]	2012	No relevant data or records were located during the search[b]
14	Hong Kong SAR (China)	Coronial system	The Hong Kong Judiciary The Coroners Court	Coroners Ordinance [59] Births and Deaths Registration Ordinance 2019 [60]	2024	Yes
15	Isle of Man	Coronial system	The official Isle of Man government website	Coroners of Inquests Act 1987 [61] Civil Registration Act 1984 [62]	2020	Yes
16	Israel	Ombudsman system	Ministry of Justice	Ombudsman of the Israeli Judiciary [63]	2023	No
17	Ireland	Coronial system	Government Ireland Department of Justice	Coroners (Amendment) Act 2019 [18]	2024	Yes
18	New Zealand	Coronial system	Government of New Zealand Ministry of Justice	Coroners Act 2006 [14]	2023	Yes
19	Singapore	Coronial system	Singapore Statutes online.	Coroners Act 2010 [64]	2024	No
20	Trinidad and Tobago	Coronial system	Ministry of the Attorney General and Legal Affairs. Judiciary Trinidad and Tobago.	Coroners Act [65] Birth and Death Registration Act [66]	2016	Yes
21	Turks and Caicos Islands	Coronial system	The Judiciary of the Turks and Caicos Islands	The Coroners Ordinance [67]	2014	No relevant data or records were located during the search[b]
22	United Kingdom	Coronial system				Yes
22.1	England and Wales	Coronial system	The Government of the United Kingdom. Ministry of Justice.	Coroners and Justice Act 2009 [68]	2024	Yes
22.2	Scotland	The crown office and procurator fiscal service (COPFS)	The Government of UK; The Crown Office and Procurator Fiscal Service (COPFS)	The Crown Office and Procurator Fiscal Service (COPFS) is Scotland's prosecution service and death investigation authority [69]	2024	Yes
22.3	Northern Ireland	Coronial system	Department of Justice Northern Ireland	Coroners Act (Northern Ireland) 1959 [70]	2024	Yes

Table 2: (continued)

S/No.[a]	Country and regional jurisdiction	Type of system in the country	Source	National legislation as per the jurisdiction	Legislation last update, year	Coroner or equivalent officers has jurisdiction to investigate perinatal deaths (in hospitals) (Y/N)
23	United States	Coronial and Medical Examiner system [71]				
23.1	Alaska	Medical Examiner system	The Alaska State Legislature	2016 Alaska Statutes. Title 12 – Code of Criminal Procedure. Chapter 12.65 - Death Investigations and Medical Examiners [72]	2023	No relevant data or records were located during the search[b]
23.2	Alabama	Coronial System and Medical Examiner system	The Alabama Legislature	Code of Alabama. Title 15, Criminal Procedures, Chapter 4: Coroner's Inquest [73]	2023	When death was unattended by medical staff[c]
23.3	Arizona	Medical Examiner system	Arizona state Legislature	2023 Arizona Revised Statutes. Title 11 – Counties. Article 12: County Medical Examiner [74]	2023	No relevant data or records were located during the search[b]
23.4	Arkansas	Coronial system	State of Arkansas. Laws and Statutes	Arkansas Code of 1987 (2023). Title 14 – Local government (§§ 14-1-101 – 14-387-706) Subtitle 2 – County Government (§§ 14-14-101 – 14-28-103) Chapter 15 – Officers (§§ 14-15-101 – 14-15-1106) Subchapter 3 – County Coroners (§§ 14-15-301 – 14-15-309) [75, 76]	2014	No relevant data or records were located during the search[b]
23.5	California	Coronial System and Medical Examiner system	California Legislative Information California State Coroner Association	California Government Code (Gov, Chapter 10. Coroner [27460–27530]) [77]	2023	Yes-when the cause of death is unknown. or when death was unattended by medical staff[c]
23.6	Connecticut	Medical Examiner system	General Statute of Connecticut	2019 Connecticut General Statutes. Title 19a – Public Health and Well-Being. Section 19a-406: Powers and duties of Chief Medical Examiner [78]	2023	No relevant data or records were located during the search[b]
23.7	Colorado	Coronial system	State of Colorado Colorado Coroners Association	Colorado Revised Statutes. Title 30 – Government – County. County Officers. Article 10 – County Officers Part 6 – Coroner [79]	2023	Yes
23.8	Delaware	Medical Examiner system	Delaware code online. Government of Delaware.	2023 Delaware Code. Title 29 – State Government. Chapter 47. Forensic Science – § 4704. Duties of Medical Examiners [80, 81]	2024	When death was unattended by medical staff[c]
23.9	District of Columbia	Medical Examiner system	Council of District of Columbia	Code of the District of Columbia. Chapter 14. Chief Medical Examiner [82]	2024	Yes
23.10	Florida	Medical Examiner system	Florida Department of Law Enforcement [83]	No information was found	N/A	No relevant data or records were located during the search[b]
23.11	Georgia	Coronial System and County Medical Examiner System	Georgia Bureau of Investigation Division of Forensic Sciences	2023 Code of Georgia. Chapter 16 – Coroners (§§ 45-16-1 – 45-16-80) [84, 85]	2023	No relevant data or records were located during the search[b]
23.12	Hawaii	Coronial system and Medical Examiner system	State of Hawaii [86]	No information was found	N/A	No relevant data or records were located during the search[b]

Table 2: (continued)

S/No.[a]	Country and regional jurisdiction	Type of system in the country	Source	National legislation as per the jurisdiction	Legislation last update, year	Coroner or equivalent officers has jurisdiction to investigate perinatal deaths (in hospitals) (Y/N)
23.13	Idaho	Coronial system	Idaho Legislature	Title 31. County And County Law. Chapter 28: Coroner [87]	2023	Yes
23.14	Indiana	Coronial system	Indiana Coroners Association [88]	No information was found	N/A	No relevant data or records were located during the search[b]
23.15	Illinois	Coronial system and Medical Examiner system	Illinois Coroners and Medical Examiners Association [89]	No information was found	N/A	No relevant data or records were located during the search[b]
23.16	Iowa	Medical Examiner system	Iowa Legislature	2015 Iowa Code TITLE XVI - Criminal Law and Procedure. Section 691.5 - State Medical Examiner [90]	2015	No relevant data or records were located during the search[b]
23.17	Kansas	Coronial system	Kansas Legislature	Kansas Statutes. Chapter 22a District Officers and Employees. Article 2 District Coroners [91]	2023	No relevant data or records were located during the search[b]
23.18	Kentucky	Coronial system	Kentucky Legislature	Kentucky Revised Statutes Chapter 72 Coroners, Inquests and Medical Examinations [92]	2024	No relevant data or records were located during the search[b]
23.19	Louisiana	Parish-based Coronial system	Louisiana State Coroner Association	Louisiana Laws Revised Statutes. Chapter 36 Coroners [93, 94]	2023	Yes
23.20	Maryland	Medical Examiner system	Maryland Government	Code of Maryland Regulations. Title 10 – Maryland Department of Health Part 4. Chapter 10.35.01 - Medical Examiner Cases [95]	2023	No
23.21	Maine	Medical Examiner system	Maine Legislature	2023 Maine Revised Statutes. Title 32: Professions and Occupations [96]	2023	No relevant data or records were located during the search[b]
23.22	Massachusetts	Medical Examiner system	The 193rd General Court of the Commonwealth of Massachusetts	Chapter 38: Medical Examiners and Inquests [97]	2024	Yes
23.23	Michigan	Coronial system and Medical Examiner system	Michigan Legislature	Michigan Compiled Laws Chapter 52 - Coroners Act 181 of 1953 – County Medical Examiners (52.201 – 52.216) [98]	2024	No relevant data or records were located during the search[b]
23.24	Minnesota	Coronial system and Medical Examiner system	Minnesota Legislature. 2023 minnesota Statutes	Minnesota Statutes Chapters 370–403 – Counties, County Officers, Regional Authorities Chapter 390 – Coroner; Medical Examiner [99]	2023	When death was unattended by medical staff[c]
23.25	Mississippi	Coronial system and Medical Examiner system	Mississippi Legislature. Mississippi Legislative Bill Status.	2020 Mississippi Code Title 19 - Counties and County Officers Chapter 21: Coroners [100]	2020	Yes
23.26	Missouri	Coronial system	Official website for the Revised Statutes of Missouri	Revised Statue of Missouri. Chapter 58: Coroners and Inquests [101]	2024	When death was unattended by medical staff[c]
23.27	Montana	Coronial system and Medical Examiner system	Office of County Coroner	Montana Code TITLE 7. Local Government. Chapter 4. Officers and Employees Part 29. Office of County Coroner [102]	2023	Yes

Table 2: (continued)

S/No.[a]	Country and regional jurisdiction	Type of system in the country	Source	National legislation as per the jurisdiction	Legislation last update, year	Coroner or equivalent officers has jurisdiction to investigate perinatal deaths (in hospitals) (Y/N)
23.28	North Carolina	Coronial system and Medical Examiner system	Office of Chief Medical Examiner	Chapter 130A – Public Health Article 16 – Postmortem Investigation and Disposition. § 130A-394 – Coroner to hold inquests [103]	2023	No relevant data or records were located during the search[b]
23.29	North Dakota	Coronial system and Medical Examiner system	State of North Dakota	Chapter 11-19.1. Medical County Coroner [104]	2023	Yes
23.30	Nevada	Coronial system	Nevada Legislature.	Nevada Code. Chapter 259 – Coroners [105]	2023	No relevant data or records were located during the search[b]
23.31	New Hampshire	Medical Examiner system	New Hampshire Statutes Office of The Chief Medical Examiner	New Hampshire Revised Statutes. Title LIX - Proceedings in Criminal Cases. Title 611-B- Office of the Chief Medical Examiner [106, 107]	2022	Yes
23.32	New Jersey	Medical Examiner	New Jersey Legislature	2023 New Jersey Revised Statutes. Title 40A - Municipalities and Counties Section 40A:9–46 - Medical Examiners [108, 109]	2023	When death was unattended by medical staff[c]
23.33	New Mexico	State Medical Investigator	New Mexico Legislature. 49TH LEGISLATURE – State of New Mexico	Title 7: Health; Chapter 3: State Medical Investigator's Office; Part 2: Policies of the Office of the Medical Investigator [110]	2023	When death was unattended by medical staff[c]
23.34	New York	Coronial system and Medical Examiner system	The New York State Senate	Chapter 11: County (CNT) Article 17-A. Coroner, Coroner's Physician and Medical Examiner County [111]	2017	No relevant data or records were located during the search[b]
23.35	Nebraska	Coronial system	Coroner's Office. Douglas county, Nebraska [112]	Nebraska Legislature [113]	2023	No relevant data or records were located during the search[b]
23.36	Ohio	Coronial system and Medical Examiner system	Ohio State Coroners Association [114]	Ohio Revised Code Chapter 313 – Coroner [115]	2023	No relevant data or records were located during the search[b]
23.37	Oregon	Medical Examiner system	Oregon State Legislature	Oregon Revised Statutes Volume: 04 –Criminal procedure, Crimes. Title 14. Chapter 146- Investigations of deaths, injuries, and missing persons [116]	2023	No relevant data or records were located during the search[b]
23.38	Oklahoma	Medical Examiner system	Oklahoma senate online	Oklahoma Statues. Title 63. Public Health and Safety. §63–935. Responsibility of Examiner [117]	2023	No relevant data or records were located during the search[b]
23.39	Pennsylvania	Coronial system and Medical Examiner system	Pennsylvania State Coroners' Association Coroner's Statutes	Coroners Act: The County Code at 16 P.S. §§ 1214 and 1231–1260 [118]	2018	Yes
23.40	Rhode Island	Medical Examiner system	Rhode Island General Assembly	Rhode Island General Laws Title 23 - Health and Safety Chapter 23-4 - Office of State Medical Examiners [119]	2023	No relevant data or records were located during the search[b]
23.41	South Carolina	Coronial system and Medical Examiners system	South Carolina Legislature	South Carolina Code of Laws Title 17 - Criminal Procedures Chapter 5 - Coroners and Medical Examiners [120]	2023	When death was unattended by medical staff[c]

Table 2: (continued)

S/No.[a]	Country and regional jurisdiction	Type of system in the country	Source	National legislation as per the jurisdiction	Legislation last update, year	Coroner or equivalent officers has jurisdiction to investigate perinatal deaths (in hospitals) (Y/N)
23.42	South Dakota	Coronial system	South Dakota Legislature	South Dakota Codified Laws Chapter 23-14: Coroner's Inquest [121]	2023	No relevant data or records were located during the search[b]
23.43	Tennessee	Medical Examiner system	Office of the State Chief Medical Examiner	Section 38-7-103 - Chief Medical Examiner- Deputies and Assistants- Duties and Authority [122]	2023	Yes
23.44	Texas	Medical Examiner System	Texas Constitution and Statutes	Tex. Crim. Proc. Code Ann. art. 49.23. Chapter 49– Inquests upon dead bodies. Subchapter. B. Duties performed by Medical Examiner [123]	2023	Yes
23.45	Utah	Coronial System and Medical Examiner System	Utah State Legislature [124]	No relevant data could be located	N/A	No relevant data or records were located during the search[b]
23.46	Vermont	Medical Examiner system	The Vermont Statutes Online	Vermont Statutes. Title 18 – Health. Chapter 9: Laboratory Services; Chief Medical Examiner; Autopsies [125]	2024	No relevant data or records were located during the search[b]
23.47	Virginia	Medical Examiner system	Virginia's legislative information system	Virginia Code Title 32.1 - Health § 32.1-282. Medical examiners [126]	2024	No relevant data or records were located during the search[b]
23.48	West Virginia	medical examiner system	West Virginia legislature	Chapter 61. Crimes and their punishments. Article 12. Postmortem Examinations. §61-12-3. Office of Chief Medical Examiner established [127, 128]	2017	No relevant data or records were located during the search[b]
23.49	Washington	Coronial system and Medical Examiner system	Washington state legislature	Chapter 68.50. RCW Human Remains. Section 68.50. 010 Coroner's jurisdiction over remains [129]	2021	Yes
23.50	Wisconsin	Coronial system	Wisconsin State Legislature	Wisconsin Statutes & Annotations. Chapter 59 – Counties. Subchapter 4- County Officers. Section 59. 34 Coroner, Medical Examiner duties [130, 131]	2023	No relevant data or records were located during the search[b]
23.51	Wyoming	Coronial system	State of Wyoming Legislature	Title 35- Public Health and Safety. Chapter 4 – County Coroners. Article 1- In General. WY Stat § 7-4-104 [132]	2022	When death was unattended by medical staff[c]
24	Virgin Island (U.S)	Medical Examiner system	U.S Virgin Island Department of Justice [133]	No relevant data could be located	2023	No relevant data or records were located during the search[b]

[a]S/No stands for serial number, which sequentially numbers the countries and regional jurisdiction listed in alphabetical order. [b]In some countries, certain states or provinces did not have relevant data on Coroner's or Medical Examiner's investigation on reportable deaths that could be accessed through government websites. [c]Perinatal deaths that took place without the involvement of medical professionals or those that occurred in non-hospital settings are excluded. Table 2 shows data from 24 high-income countries with a Coronial or equivalent System, including 20 with a Coronial system, 2 with a combination of Coronial and Medical Examiner system, 1 with Medical Examiner system and 1 with an Ombudsman system. All 24 countries had amended their national legislation since its establishment, the vast majority (n=16) in the past decade. Within Europe, Ireland and the United Kingdom have given Coroner's jurisdiction into investigating perinatal deaths. In other regions, five Canadian provinces, four Australian states and 22 US states had laws in place allowing Coroners or Medical Examiners to investigate perinatal deaths (either neonatal death or stillbirth).

officers [164]. Today, this position is held by qualified lawyers who work under the Crown Office and Procurator Fiscal Service [69, 164].

Australia, Canada, New Zealand (NZ), and the US inherited England's Coronial system and subsequently developed their own legislation [12, 164]. In NZ, the

Table 3: The role of Coroners in high-income countries where perinatal deaths are investigated by Coroners or equivalent authorities as per national legislation (n=12).

S/No.[a]	Country and regional jurisdiction	Qualification of a Coroner or equivalent officer	Appointment of a Coroner or Medical Examiner	Types of perinatal death cases reported to Coroner or equivalent officer	Role of a Coroner or equivalent officer as specified in the national legislation or Coroners Act relating to investigation of perinatal death in hospitals
1	Antigua and Barbuda	Magistrate	The Governor General	– Investigation into stillbirths is done only upon the advice of a medical officer. – No further information on death from live births was found in the national legislation.	A Coroner may investigate the cause of a stillborn child's death only if a medical practitioner is certain that such an investigation would yield relevant information.
2	Australia Australia has no single national Coroners System. Each state or territory has its own legislation governing Coroner's death investigation processes. The National Coronial Information System (NCIS) is a data repository containing information on deaths reported to a Coroner in Australia from 2000.				
2.1	Western Australia	Magistrate	Governor on the recommendation of the Attorney General	Live births where cause of death is unknown [134]	A Coroner can investigate if the child was born alive and cause of death is unknown.
2.2	New South Wales (NSW)	Lawyer	Governor on the recommendation of the Minister	– Live births where cause of death is unknown – Stillbirth was due to suboptimal management of the birth [135]	– In NSW, a Coroner cannot investigate stillbirths, unless it was caused by suboptimal care during delivery. – A Coroner cannot investigate if a baby dies due to prematurity or congenital abnormality – A Coroner may investigate if the child is born alive, and the cause of death is unknown.
2.3	Tasmania	Magistrate	The Governor	Live births where the cause of death was sudden and unexpected [136]	– A Coroner does not have the jurisdiction to investigate stillbirths as they are not reportable deaths. – A Coroner may initiate an investigation into the death of a newborn baby who initially showed signs of life after birth but died suddenly and unexpectedly, provided they receive such reports.
2.4	Queensland	Magistrate	The Governor	Death from live births without any limit set out in the legislation [137]	– A Coroner cannot investigate how the baby came to be stillborn. – A Coroner can only direct an autopsy to determine if the baby was born alive. A Coroner's investigation must stop if the autopsy confirms stillbirth.

Table 3: (continued)

S/No.[a]	Country and regional jurisdiction	Qualification of a Coroner or equivalent officer	Appointment of a Coroner or Medical Examiner	Types of perinatal death cases reported to Coroner or equivalent officer	Role of a Coroner or equivalent officer as specified in the national legislation or Coroners Act relating to investigation of perinatal death in hospitals
3	Bahamas	Attorney	The Governor General with the advice of the Judicial and Legal Service Commission	– Stillbirths where the cause of death is unknown. – No further information on death from live births was found in the national legislation.	– In instances where a medical practitioner is unable to establish the cause for a stillbirth, a Coroner may investigate and, if necessary, hold an inquest or undertake an inquiry to determine the cause of death.
4	Canada Two types of death investigation systems exist in Canada: Coroners' Systems and Medical Examiner's Systems. Canada does not have a single federal authority. Each province and territory has their own system and legislation governing investigation of unexpected or unexplained deaths. The Canadian Coroner and Medical Examiner Database serves as a centralised repository for standardised Coroner/Medical Examiner data in Canada.				
4.1	Ontario	Medical practitioner	The Lieutenant Governor in Council	– Neonatal deaths. – Stillbirths where the cause of death is suspicious [138].	– A Coroner must investigate the circumstances of a death that is reported to him/her. – Coroners may investigate if there are concerns related to care or injury and where questions have been raised about antenatal care or management of labor and delivery. – A Coroner must submit a medical certificate after the medical cause of death is established.
4.2	Nova Scotia	Physician or pathologist with forensic pathology training or experience	The Governor in Council or Minister	All neonatal deaths and stillbirths where the cause of death is suspicious or unclear	A Medical Examiner may investigate for further inquiry into the cause of death when the cause of stillbirth or neonatal death is unclear, suspicious, or believed to have been caused by negligence, misadventure, or accident involving the attending physician.
4.3	Newfoundland–Labrador	Registered medical Doctor	The Lieutenant Governor	Stillbirths and neonatal deaths where maternal injury has occurred [139]	The Medical Examiner must provide the underlying medical reason for a stillbirth in the certificate of death. This includes detailing the chain of events leading up to the event of death, as well as any other factors that might have contributed to the death.
4.4	British Columbia	Appointed on a merit-based process	The Lieutenant Governor in Council	Child who died during or after pregnancy due to circumstances that are related to the pregnancy or because of misconduct, malpractice, or negligence	There is no jurisdiction for a Coroner to investigate all stillbirths [140]

Table 3: (continued)

S/No.[a]	Country and regional jurisdiction	Qualification of a Coroner or equivalent officer	Appointment of a Coroner or Medical Examiner	Types of perinatal death cases reported to Coroner or equivalent officer	Role of a Coroner or equivalent officer as specified in the national legislation or Coroners Act relating to investigation of perinatal death in hospitals
4.4	Québec	Ex officio a justice of the peace	The Government	– Stillbirths where cause of death is unknown – No further information on death from live births was found in the national legislation.	A Coroner's death certificate must include information about the cause of death and any contributing factors, as well as whether or not an autopsy was conducted and whether or not causes of the stillbirth included in the certificate take the autopsy's findings into consideration.
5	Cayman Island	Magistrates	The Governor in Cabinet	Live births where the cause of the death is unknown.	A Coroner may investigate in cases where a child is born alive, and the cause of death is unknown or unclear.
6	Hong Kong SAR, China	Barrister, Solicitor or Advocate	The Chief Executive or Chief Justice	– Stillbirths where there is a doubt as to whether the still born foetus was alive or dead at the time of birth or there is a suspicion that the still birth might not have been a still birth but for the wilful act or neglect of any person. – No further information on death from live births was found in the national legislation.	A Coroner may investigate all reportable deaths including stillbirths where there is a doubt as to whether the still born foetus was alive or dead at the time of birth or there is a suspicion that the stillbirth, before issuing a permit for burial or cremation.
7	Isle of Man	Lawyer	The Chief Registrar on the orders of the Lieutenant Governor.	Live births where cause of death is unclear	– If there is a suspicion of a child being born alive, the registrar must report such death to a Coroner who has jurisdiction to investigate such deaths. – After reviewing the circumstances surrounding the stillbirth, a Coroner may decide to authorise an autopsy to gather more information. If there is sufficient evidence to suggest that the child was born alive, a Coroner may proceed with an inquest to further investigate the cause of death. – Alternatively, if a Coroner finds that the child was not born alive, they can issue a certificate to the registrar indicating that no further investigation or inquiry is necessary.

Table 3: (continued)

S/No.[a]	Country and regional jurisdiction	Qualification of a Coroner or equivalent officer	Appointment of a Coroner or Medical Examiner	Types of perinatal death cases reported to Coroner or equivalent officer	Role of a Coroner or equivalent officer as specified in the national legislation or Coroners Act relating to investigation of perinatal death in hospitals
8	Ireland	Lawyer or a Doctor	The Minister for Justice in Dublin and by local authorities in other parts of Ireland	– All stillbirths – All neonatal deaths	Coroner's Role in perinatal death investigation: – Investigates deaths of stillborn children when cause of death is unknown or uncertain. – If unable to obtain a medical certificate or natural cause, investigates circumstances surrounding the child's death. – A Coroner can also request a postmortem examination of a stillborn child. – Holds an inquest if unable to determine cause of death. – Can consider factors related to mother's health and circumstances contributing to child's death. – Consults with family members of the stillborn child if possible. – A Coroner is mandated to notify the relevant registrar of the circumstances surrounding the stillbirth within 30 days after investigation.
9	New Zealand	Barrister or Solicitor	The Governor General on the advice of the Attorney General	– Stillbirth only when doctor or nurse is unable to determine whether a newborn was stillborn. – No further information on death from live births was found in the national legislation.	– A Coroner does not have the authority to investigate stillbirths though they may direct a post-mortem examination to determine if the infant was stillborn. In such a case, a Coroner's role is to authorise the release of the child for burial. – If a doctor or nurse is unable to determine whether a newborn was stillborn, and if the death falls under the category of reportable deaths, they must report the matter to a Coroner for investigation. A Coroner will then examine the circumstances and cause of the death.

Table 3: (continued)

S/No.[a]	Country and regional jurisdiction	Qualification of a Coroner or equivalent officer	Appointment of a Coroner or Medical Examiner	Types of perinatal death cases reported to Coroner or equivalent officer	Role of a Coroner or equivalent officer as specified in the national legislation or Coroners Act relating to investigation of perinatal death in hospitals
10	Trinidad and Tobago	Magistrate	The Government	– Stillbirths without any limit set out in the legislation – No further information on death from live births was found in the national legislation.	A Stillborn child cannot be buried if a Coroner has ordered an inquest.
11	United Kingdom The Coroner service in England and Wales is governed by the Coroners and Justice Act 2009. In Scotland, death investigations are conducted by Crown Office and Procurator Fiscal Service on behalf of the Lord Advocate. Since September 9 2024, all deaths in any health setting that are not investigated by a Coroner are reviewed by NHS Medical Examiners.				
11.1	England and Wales	Coroners must satisfy the judicial-appointment eligibility qualification on a 5-year basis, which requires five years of legal practice or part-time judicial practice. Coroners appointed before 2013 could be lawyers or doctors.	Coroner appointments are governed by the Coroners and Justice Act 2009. All Coroner appointments are made by the local authority	– Stillbirths cases where there is doubt as to whether child was stillborn. – Death from live births that is prior to the 24th week of pregnancy or after it.	Coroner's Authority and Stillbirth Investigation: – A Coroner cannot investigate all stillbirths. – In cases of unknown or suspected cause of death, an autopsy may be ordered before burial. – *"A child who is born showing signs of life, whether that is prior to the 24th week of pregnancy or after it, has had an independent life and that child's death must be investigated if section 1 Coroners and Justice Act 2009 is engaged."* [13] – A postmortem examination can be requested by a Coroner. – If a live birth is suspected, an investigation should be conducted and resolved through an inquest. – A Coroner's investigation must be sensitive, empathetic, and thorough. – Written testimony or inquests in writing should be considered to minimise family stress. – In neonatal death cases, both birth and death must be registered. – If the child is stillborn, further investigation by a Coroner may be halted.

Table 3: (continued)

S/No.[a]	Country and regional jurisdiction	Qualification of a Coroner or equivalent officer	Appointment of a Coroner or Medical Examiner	Types of perinatal death cases reported to Coroner or equivalent officer	Role of a Coroner or equivalent officer as specified in the national legislation or Coroners Act relating to investigation of perinatal death in hospitals
11.2	Northern Ireland	Barristers or Solicitors	The Judicial Appointments Commission	– Death from live births without any limit set out in the legislation – Fetus capable of being born alive.	A Coroner is authorised to conduct an inquest if the fetus had a reasonable chance of surviving birth.
11.3	Scotland	The Lord Advocate	The Scottish Government	Sudden unexpected and unexplained perinatal deaths.	It is the duty of a Procurator Fiscal to investigate all reportable deaths including: – Sudden and unexplained perinatal death. – Circumstances suggesting medical staff negligence or neglect, or if medical staff have questions about the circumstances of a death.
12	United States – In US, a medico-legal officer can be a Coroner or Medical Examiner. Each state sets its own standards for death investigation and professional and education requirements. – A Medical Examiner is a physician certified by the American Board of Pathology in Forensic Pathology and experienced in Forensic Sciences. – Most US states do not require Coroners to be physicians or forensic pathologists, but state law often mandates specific training for death investigation. – Due to the varying requirements across jurisdictions, some Coroners may rely on forensic pathologists or other medical professionals to carry out the medical examination of bodies. – Coroners are either appointed or elected. Medical Examiners are mostly appointed. Within the US states, criteria for fetal death varies in different jurisdiction. Further definition of stillbirth is available in Table S2 in supplementary file.				
12.1	California	Licensed physician in some counties or a Sheriff	The Department of Justice. Sheriffs are constitutionally elected officials.	All fetal deaths after 20 weeks of gestation where cause of death is unknown, or death is unattended by a physician.	– The law requires a Coroner to register a fetal death after 20 weeks of gestation unless it is the result of a legal abortion. – A certificate of fetal death must be completed by a Coroner within three days of the fetus's examination. This must include timing of the fetal death, the direct reasons of the death, any conditions that may have contributed to the death, and any extra medical and health data that may be needed. – A Coroner shall, within three days after examining the body, deliver the death certificate to the attending funeral director.
12.2	Colorado	High school diploma or its equivalent or a college degree	The Coroner's office is an independent agency and does not work for the law enforcement agency.	Infant deaths that are sudden and unexplained.	– A Coroner may investigate sudden, unexplained, or unnatural death of a child or of an infant. A Coroner must investigate all reportable deaths that are

Table 3: (continued)

S/No.[a]	Country and regional jurisdiction	Qualification of a Coroner or equivalent officer	Appointment of a Coroner or Medical Examiner	Types of perinatal death cases reported to Coroner or equivalent officer	Role of a Coroner or equivalent officer as specified in the national legislation or Coroners Act relating to investigation of perinatal death in hospitals
					unexplained or unexpected throughout the county. – A Coroner must conduct all appropriate investigations with law enforcement to determine the cause and manner of death.
12.3	District of Columbia	Physician licensed to practice medicine in the district	The mayor with advice and consent of the Council	Fetal deaths related to maternal trauma.	A Chief Medical Examiner, Medical Examiners, and Medico-legal Investigators are authorised to determine a fetal cause of death in cases of trauma to the mother, including drug misuse and extramural births.
12.4	Idaho	No information available	The district Judge	– Stillbirths where the cause of death is suspicious. – No further information on death from live births was found in the national legislation.	– When a county Coroner receives notification of a reportable death, and there is reason to believe that the child's death or stillbirth was not caused by a recognised medical condition, they must investigate the cause.
12.5	Louisiana	Licensed physician	No information available	– Spontaneous fetal death (stillbirth) – No further information on death from live births was found in the national legislation.	Only a Coroner or Physician can authorise for the burial of the fetus.
12.6	Massachusetts	Physician who is a diplomat of the American Board of Pathology with certification in anatomic pathology	The Governor for a term of five years	Fetal death when death occurred before birth or if the fetus is at least 20 weeks' gestation or weighs at least 350 g.	A Medical Examiner may investigate fetal deaths regardless of the duration of pregnancy.
12.7	Mississippi	Physician Licensed to practice medicine in Mississippi and be certified in forensic pathology by the American Board of Pathology	The Commissioner of Public Safety	– Stillbirths where the cause of the death is suspicious. – No further information on death from live births was found in the national legislation.	A Medical Examiner and Coroner must investigate when the cause of stillborn is medically believed to be from the use, by the mother, of any controlled substance such as drugs (example: opiates, opium derivatives, hallucinogenic substances, stimulants, and others)
12.8	Montana	A Coroner must attend 40-h class on death investigation, and 16 h of advance training every two years. A Medical Examiner must be a Physician	County Coroners are elected public officials	Fetal deaths where the cause of death is unknown.	A Coroner is responsible for investigating and determining the cause and manner of death as well as any surrounding circumstances for any unusual, medically questionable, or unidentified death, including any fetal death.

Table 3: (continued)

S/No.[a]	Country and regional jurisdiction	Qualification of a Coroner or equivalent officer	Appointment of a Coroner or Medical Examiner	Types of perinatal death cases reported to Coroner or equivalent officer	Role of a Coroner or equivalent officer as specified in the national legislation or Coroners Act relating to investigation of perinatal death in hospitals
12.9	North Dakota	Licensed physician or registered nurse	The Board of County Commissioner.	Stillbirth and fetal death where cause of death is unknown	– When the cause of fetal death is unclear, the county Coroner may investigate it. – A Coroner must gather medical records from the deceased fetus's last known physician or physician assistant. – A County Coroner must also file the medical certification within 10 days after taking charge of the case.
12.10	New Hampshire	Licensed Physician and certified by the American Board of Pathology	The Governor	Fetal deaths caused by intrauterine trauma	A Medical Examiner can investigate fetal deaths where the death is suspected to be the result of intrauterine trauma affecting the fetus that has reached at least 20 weeks' gestation or weighs at least 350 g.
12.11	Pennsylvania	No specific particulars detailed	Elected at the Municipal election	– Stillbirths without any limit set out in the legislation – All sudden and unexplained infant death – No further information on death from live births was found in the national legislation.	– A Coroner investigates the circumstances surrounding any stillbirth or reportable death that occurs within the county, regardless of the cause of death, to decide whether an autopsy or inquest is needed. Details relating to infant death: – A Coroner must conduct an autopsy for the sudden unexplained death of a child under three years old. – Investigation includes demographic information, witness interview, infant medical history, biological mother's prenatal history, incident scene investigation, and scene and body diagrams.
12.12	Tennessee	Licensed Physician and Pathologist certified by the American Board of Pathology with a certificate of competency in forensic pathology.	The Tennessee Medical Examiner advisory council	Fetal deaths occurred due to maternal trauma or acute drug use	– A Medical Examiner may investigate death of a fetus that is more than 20 weeks' gestation or is at least 350 g resulting from maternal trauma or acute drug use. A county Medical Examiner has the responsibility to investigate the circumstances of the death.

Table 3: (continued)

S/No.[a]	Country and regional jurisdiction	Qualification of a Coroner or equivalent officer	Appointment of a Coroner or Medical Examiner	Types of perinatal death cases reported to Coroner or equivalent officer	Role of a Coroner or equivalent officer as specified in the national legislation or Coroners Act relating to investigation of perinatal death in hospitals
12.13	Texas	– Medical Examiner- Licensed Physician – Coroner- Justice of Peace + training in investigative procedures	Medical Examiners are appointed, and Coroners are elected by the commissioner's courts	Fetal death where cause of death is unknown	– A fetus cannot be buried unless a Coroner or Medical Examiner signs a certificate attesting to the fact that an autopsy was performed or that one was not necessary. – A Medical Examiner or a Coroner must issue a signed certificate providing the cause of fetal death.
12.14	Washington	Forensic pathologist certified from the American Board of Pathology Licensed physician qualified to sit for the American Board of Pathology forensic pathology exam	The County Legislative Authority	– Stillbirths without any limit set out in the legislation – Premature births without any limit set out in the legislation – No further information on death from live births was found in the national legislation. Note: "Fetal death" means any product of conception that shows no evidence of life, such as breathing, beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles after complete expulsion or extraction from the individual who gave birth that is not an induced termination of pregnancy and: (a) Has completed 20 or more weeks of gestation as calculated from the date the last menstrual period of the individual who gave birth began, to the date of expulsion or extraction; or (b) Weighs three hundred 50 g or more if weeks of gestation are not known [141].	– A County Coroner or Medical Examiner has the jurisdiction to investigate stillbirth or premature births. Role of Coroners in fetal death cases: – If fetal death is due to natural causes, a Coroner, Medical Examiner, or local health officer must determine whether to certify the report of death. – If the death is due to unlawful or unnatural causes, the Coroner or Medical Examiner must attest to the cause, place, and date of death and note on cause of death is pending investigation. A Coroner or Medical Examiner must return the report of fetal death within two calendar days to the funeral director or funeral establishment or person having similar duties

[a]S/No stands for serial number, which sequentially numbers the countries listed in alphabetical order. Table 3 shows variations in the qualifications and appointment processes for Coroners across the 12 high-income countries. Most countries employed Coroners with legal expertise (n=8), while some had medical or legal backgrounds (n=4). In some US States, Coroners had a college diploma or equivalent. In most countries (n=11), Coroners were appointed by a governor general, governor in council, chief executive or by the Government. However, some US States elected Coroners through municipal elections, highlighting a divergence from traditional appointment processes. Of the 34 jurisdiction (in 12 countries) explored, 18 jurisdictions restricted their reporting to death from live births; 10 restricted their reporting to only stillbirths; six reported both if the cause of death was unknown, suspicious or due to injury; and 1 country reported all perinatal deaths including those where cause of death is known.

Table 4: General characteristics of included documents as secondary sources.

S/No.[a]	Author/s and year	Title of the article	Type of evidence source	Country/region	Type of perinatal death investigation discussed in the study	Study method
1	A Quaile (2018)	More rigorous investigating needed to improve maternity safety	Peer reviewed academic journal article [142]	UK	·Stillbirths ·Neonatal deaths	Not applicable
2	The Lancet (2019)	Progress on investigating stillbirths	Editorial article- Lancet 2016 Series [143]	UK	Stillbirths	Not applicable
3	I Gill, T Parmar, H Walsh, P Downey, JFA Murphy (2014)	Neonatal referrals to the Coroner service: a short survey on current practice	Peer reviewed journal article [144]	Ireland	·Stillbirths ·Neonatal deaths	Cross-sectional telephone surveys
4	Scott Justice (2010)	Why did baby die?	Readers panel under the reflections section in Nursing Standard journal [145]	UK	·Stillbirths ·Neonatal deaths	Not applicable
5	I Freckelton (2013)	Stillbirth and the law: Options for law reform and issues for the Coronial Jurisdiction	Peer reviewed journal article [146]	Australia	·Stillbirths ·Live births	Not applicable
6	N Aladangady, P Chisholm (2021)	When should a neonatal death be referred to the Coroner?	Academic journal article [147]	UK	Neonatal deaths	Integrative review study
7	M Dubus, KS Mun, V Vasu (2021)	Variation in referral of neonatal deaths to Coronial services in the UK	Peer reviewed journal article [148]	UK	Neonatal deaths	Cross-sectional online surveys
8	VW Weedn (2022)	A model Medical Examiner Law	Peer reviewed journal article [149]	US	·Stillbirths ·Infant deaths ·Unexpected or unexplained infant deaths	Integrative review: various considerations for policy-makers were explored
9	A Haigh, K Haigh (2019)	Coroners' investigations of stillbirths	Peer reviewed journal article correspondence [150]	UK	Stillbirths	Not applicable
10	S Gould (2011)	Are perinatal deaths adequately scrutinised?	Peer reviewed journal article [151]	UK	Perinatal deaths	Not applicable
11	Judiciary NI (2013)	Attorney General for Northern Ireland v Desmond - 2015 NI 14 In the matter of an application by the attorney general of Northern Ireland for judicial review	Coroner's case [152]	Northern Ireland	Stillborn child	Case law
12	Judiciary NI (2019)	In the matter of an inquest into the death of baby Karl Lee Morton	Coroner's Case [153]	Northern Ireland	Stillborn child	Case law
13	Judiciary NI (2022)	The Inquest touching upon the Death of Baby Jaxon McVey	Coroner's Case [154]	Northern Ireland	Stillborn child	Case law
14	S Cullen, E Mooney, P Downey (2021)	A review of findings from placental histology in cases of stillbirth following the amendment to the Coroner's Act	Peer reviewed journal article [155]	Ireland	Stillbirths	Retrospective chart review

Table 4: (continued)

S/No.[a]	Author/s and year	Title of the article	Type of evidence source	Country/region	Type of perinatal death investigation discussed in the study	Study method
15	A Livesey (2005)	A multiagency protocol for responding to sudden unexpected death in infancy: Descriptive study	Peer reviewed journal article [156]	UK	Infant deaths (aged 3 days to 8 months)	Postal questionnaire and semi-structured interview
16	Department of Justice, Ireland (2018)	Minister Flanagan publishes the Coroners Amendment Bill 2018	Press release from the Government of Ireland [157]	Ireland	Perinatal deaths	Not applicable
17	Judiciary NI (2017)	Re Baby L [2017] NI Coroner 11	Coroner's case [158]	Northern Ireland	Stillborn child	Case law
18	The Law Reports, Queen's Bench Division, UK (2004)	In re Organ Retention Group Litigation	Coroner's case [159]	UK	Stillbirths	Case law
19	S Ormond-Walshe (2006)	Hit and miss? 156 NLJ 1308	Changes in a draft bill for reform of the Coroner and Death Certification Service [160]	UK	Infant deaths	Coronial law
20	S Chonat, R Lakshman, M Clements, R Iles (2007)	Variations in practice among paediatric consultants when referring unexpected neonatal deaths to a Coroner	Peer reviewed journal article [161]	UK	Neonatal deaths	Cross-sectional email surveys
21	State of Coroners court of New South Wales (2018)	Inquest into the death of Manusiu Amone	Coroner's case [162]	Australia	Neonatal death	Case law
22	Ministry of Health, NZ CSU-2010-HAM-000021, NZCorC 87 (2012)	Summary of recommendations on death of baby Adam Barlow	Coroner's case [163]	New Zealand	Stillborn child	Case law
23	J Moore (2016)	Coroners' Recommendations and the Promise of Saved Lives	Book [164]	New Zealand. Also briefly mentions England, Canada, Australia, Scotland, Ireland, and the US	·Stillbirths ·Neonatal deaths	Integrative review of Coroners law across New Zealand and other various countries
24	Queensland Nurse (2008)	Systems failures highlighted during inquest.	Peer reviewed journal article [165]	Australia	Neonatal death	Not applicable

[a]S/No stands for serial number, which sequentially numbers the literatures included as secondary sources. Table 4 outlines secondary sources containing peer-reviewed journal articles (n=11), academic articles (n=1), editorial pieces (n=1), perspective and opinion pieces (n=1), Coroner's case law (n=8), a statement from the Government of Ireland on Coroner's investigation in perinatal deaths (n=1), and book chapters. Twenty-three records focused on the Coroner's role, and one addressed the Medical Examiner's role. The records discussed Coroner's roles either relating to stillbirths (n=9), neonatal deaths (n=9) or both (n=6). The jurisdictions mentioned in records include Australia (n=3), Ireland (n=3), New Zealand (n=2), UK (n=15), US (n=1). The records were published between 2004 and 2022.

Coroners Ordinance of 1846 was replaced by the Coroners Act of 1858 (NZ) [14, 164]. As per the current jurisdiction, the Coroners Act 2006 (NZ) governs NZ's Coronial law [14]. In contrast to NZ, Australia does not have a unified National Coronial System. Instead, each state or territory has laws governing its Coronial processes [16, 164]. The Medical Examiner's system was first introduced in the US, starting in Massachusetts in 1877 when the state replaced the traditional Coroner's office with physician-led Medical Examiner positions [12].

In Ireland, while the first documented reference to a Coroner date back to 1264, the office could have existed as early as 1212 [167]. The Coroners Act of 1962 updated Ireland's Coronial legislation, consolidating and updating previous laws governing Coroners' roles [167]. This act has since undergone amendments, with the most recent revisions being in 2019 and 2024 [18].

Establishment of Coroner's role in perinatal death investigations

The UK parliament enacted the Births and Deaths Registration Act of 1874 in 1926 to regulate stillbirth registration and made it an offence to cremate a dead body until a registrar's certificate or Coroner's order had been issued [167]. In March 2019, the UK government proposed a consultation to consider empowering Coroners to investigate all stillbirths [142, 150]. However, this proposal is yet to be implemented [150]. In Ireland, the Coroners Act 1962 was amended on 23rd of July 2019 to require mandatory reporting of all perinatal deaths [18]. This change gave Coroners more authority to investigate all perinatal deaths and conduct inquiries if deemed necessary [18]. No information was found on when perinatal death investigations were first included in the legislation in other high-income countries.

(RQ2) Who are Coroners and what expertise is required for this role in high-income countries with national legislation in English?

A Coroner is a judicial law officer responsible for investigating deaths that are sudden, unexplained, or unexpected or suspected to be caused by external factors involving injury, poisoning, or violence as specified by national law [12]. In this review we highlight that the appointment process for Coroners varies globally, influenced by regional laws and regulations. In some high-income countries, Coroners may be appointed by local authorities, committee members, or by the Government [71]. In several US jurisdictions, Coroners are elected public officials who are directly answerable to voters and have significant authority over death investigations [77, 102, 118, 123].

The qualifications and requirements for Coroners also vary widely, with some jurisdictions allowing little to no training, while others mandate specific educational backgrounds or certifications. In our review, we found that in most high-income countries, Coroners possess either legal or medical qualifications, often holding positions such as magistrates, lawyers, barrister, or doctors. In contrast to the more rigorous qualification requirements found in most high-income, some states within the US do not necessitate a Coroner to be legally or medically qualified. For instance, in Montana [102], Coroners must complete a 40-h death investigation course and receive regular training ensuring they possess the knowledge and skills for the position. In Colorado [79], the minimum educational requirement for Coroners is a high school diploma or college degree. Notably, however, California has a more nuanced approach, where Coroners can be licensed physicians or sheriffs in certain counties, depending on local regulations and needs [77].

(RQ3) What titles or designations are applied to Coroners in high-income countries with national legislation in English?

In a Coronial system, a Coroner investigates deaths, while in a Medical Examiner system, a trained medical professional performs this role [12]. The title of a Coroner is determined by the jurisdiction [12]. A Medical Examiner, who assumes the duties of a Coroner, is typically either a licensed physician or a trained pathologist with expertise in forensic pathology [12]. Medical Examiners are expected to bring their medical expertise when analysing a deceased person's cause of death [12, 149].

This review identified two main systems for investigating perinatal deaths: the Coronial system and the Medical Examiner system [14–16, 18, 47, 71]. Of the 24 countries, 20 countries were identified with Coronial system [14, 16, 18, 26, 28, 41, 43–46, 54, 56–59, 61, 64, 65, 67, 68] with Medical Examiner system [24]. Canada and US have adopted both the Coronial and Medical Examiner systems across various states and provinces [47, 71]. Israel used Ombudsman system [63]. While UK has Coronial system [68], Scotland employs the Procurator Fiscal system where the Lord Advocate has responsibility to investigate any death which requires further explanation [69]. A statutory Medical Examiner system was set to be launched across England and Wales on September 9, 2024. In line with the new law, any deaths occurring within any healthcare setting that are not investigated by a Coroner will be reviewed by the NHS medical examiners. However, it is to be noted that a Medical Examiner system had not yet been established in the UK at the time of the review [168]. Upon conducting our initial searches, we identified that other European countries employed distinct medico-legal death investigation

practices, which differed from both Coronial and Medical Examiner system. Due to the scope of this review, it was not feasible to comprehensively document all European countries with unique practices, which were instead excluded during the initial search phase.

(RQ4) What is the role of a Coroner (or equivalent authorities) in investigating perinatal deaths in high-income countries with national legislation in English?

Primary and secondary sources revealed significant variations in Coroner's jurisdiction for perinatal death investigations across high-income countries. Certain jurisdictions, such as Australia, Hong Kong, UK, and US, restrict investigations to deaths from live births, stillbirths, or cases with suspicious causes [16, 59, 68, 71]. In contrast, Ireland allows Coroners to investigate all perinatal deaths [18].

Although Coroners jurisdiction for perinatal death cases may vary across regions, their role in investigating perinatal deaths is similar across high-income countries. Globally, Coroners represent both the state and the public interest, responsible for clarifying ambiguities surrounding perinatal deaths [164]. A Coroner's inquest is a detailed examination of the facts related to a perinatal death, conducted in a Coroner's court and subject to regional laws, generally held in public [162, 164, 169]. Throughout the investigation, Coroners are responsible for maintaining all inquest records and ensuring transparency and accountability [164, 166].

In some high-income countries such as Australia, New Zealand and Ireland, Coroners have additional responsibilities following an inquest. This includes identifying public health and safety issues and making targeted recommendations for policy changes within relevant organisations or public bodies [16, 146, 166]. The primary objective of these recommendations is to improve safety protocols, reduce incidents, and ultimately prevent future tragedies, when possible, by fostering enhanced public health outcomes [166].

Discussion

In this review we analysed legislation on Coronial or its equivalent system in 83 high-income countries. We identified 24 high-income countries with established Coronial system and legislation available in English and found 12 countries having specific laws addressing perinatal death investigations. Findings from the databases and comparative law approach, address the four proposed research questions and indicate that only a small number of high-income countries provide comprehensive information on the Coroner's role in perinatal death investigations, while most countries lack relevant documentation. Based on the results presented in the tables, several further interrelated issues were identified in relation to Coroners' investigations of perinatal death cases, which are discussed in detail below.

Complexity in statutory language

In most high-income countries, the Coroner's jurisdiction to conduct perinatal death investigations is determined by regional statutory law. However, the Coroner's role in perinatal deaths within these laws are limited by how clearly the law defines their role, often constrained by the general or specific nature of the statutory language. These laws often contain broad terminologies, lack uniform definitions, and clarity (both nationally and regionally) on the type of perinatal deaths included in the Coronial jurisdiction. This can lead to inconsistent interpretations of the legal language, affecting a Coroner's jurisdiction to investigate all perinatal deaths. For example, the Queensland's Coroners Act 2003 mandates that: "a Coroner must cease investigating a death if an autopsy ordered by the Coroner determines that the body is that of a stillborn child" [36]. However, the statute does not define 'stillborn' and does not clarify Coroner's role in cases involving deaths from live births. Similarly, in Louisiana, 'spontaneous fetal death' is referred to as stillbirth in the statue [93], while states like California, the District of Columbia, and North Dakota do not specify fetal death as stillbirth in their statutes [77, 82]. Other states such as Pennsylvania and South Carolina use the term "stillbirth" without providing further clarification on its definition or how Coroner's role in stillbirth cases differs from deaths following live births [118, 120]. Comparable situations are observed in other high-income countries included in this review like Canada, Hong Kong, and New Zealand [14, 15, 48, 49, 59].

Lack of clarity and uniformity in statutory language cause inconsistency in how perinatal deaths are handled across jurisdiction in high-income countries as well as within different states or provinces within the same country [144, 147, 148]. These inconsistencies can create uncertainty regarding whether a perinatal death falls under the Coroner's jurisdiction among families, healthcare professionals, and Coroners themselves [147, 148]. For example, lack of clarity on the type of perinatal deaths encompassed by the Coroner's jurisdiction can lead to inconsistent reporting by healthcare professionals, create uncertainty about whether to conduct investigations by Coroners, and cause irregular analysis of perinatal death patterns [146–148]. Studies from the UK and Ireland revealed that inconsistent approaches to documenting and investigating perinatal deaths are a direct result of ambiguous reporting guidelines, highlighting the need for clarity and standardisation [144, 148]. A study on clinician and

Coronial system reported *"Failure by doctors to recognise reportable cases may create administrative difficulties and unnecessary distress for bereaved relatives and medical colleagues"* [170]. Due to such ambiguity in statutory interpretation, Coroners and healthcare professionals must also be familiar with the specific laws of their region [170] and understand the different interpretations applied to various circumstances in perinatal death cases. This can be challenging for newly qualified junior doctors who are not appropriately exposed to the complexities of the Coronial system [166, 170].

Furthermore, potentially ambiguous and inconsistent language can create a gap between how families understand these laws and what is stated in Coroner's jurisdiction for perinatal death cases. Most families who experience a perinatal death often find themselves navigating the Coronial system with little or no understanding of its procedures or what to expect [146, 152, 169]. As the investigation continues, family members or parents are left to navigate various hopes and expectations of what the Coronial process might achieve [171]. Family members often struggle to comprehend the complex medico-legal aspects of causes of deaths when the legal language used is inaccessible or unfamiliar to the public [166]. A research study in Ireland highlighted the need for a clear and concise guide such as booklet to help bereaved parents understand the complexities of perinatal death review processes, including Coroner procedures, inquests, investigations, parental rights, and support services [172]. This underscores the importance of establishing clear and accessible guidelines that will inform and support families.

Inconsistencies in statutory law

In most high-income countries (e.g., Australia, Canada, UK, US) included in this review, the Coronial jurisdictions have separated stillbirths and live births into distinct categories. The ambiguities surrounding stillbirths involve fundamental issues around the definition of "born alive", the criteria for determining when human life begins, and expert evidence [146]. The definitions of "live birth" and "separate existence" are applied differently in such cases, highlighting complexities in understanding and proving the status of a stillborn infant within Coronial law [146, 173]. Furthermore, the varying definitions of stillbirth across different countries worldwide creates inconsistencies and obstacles when making international comparisons [174]. ultimately hindering the development of a standardised Coronial law that can be applied specifically to stillbirth cases. Moreover, The complexities surrounding medical terminology and the differing roles of Coroners in dealing with stillbirths vs. live births can pose challenges for policymakers seeking to establish a unified approach to this issue [146, 148]. Coroner's investigations into perinatal deaths should focus on understanding policy and legal complexities, rather than trying to redefine medical definitions of "live birth" and "stillbirth".

Resources strain and inconsistent scope

Various stakeholders in recent studies have expressed resource constraints in the Coronial process [146, 150, 166, 171]. In countries such as Ireland and the UK, the Coroner service experiences multiple management challenges, including being under-resourced and understaffed [166, 171, 175]. The demands on the Coroner's service are growing, with increasing complexity in investigations, a greater role expected of Coroners in preventing preventable deaths, and inquests under scrutiny in the media [171, 175, 176]. This results in unmanageable workloads, delays in investigation process and timelines, and emotional distress to family members [166, 175]. A recent study by Voicing Loss in the UK noted that the complexity of staff management arrangements, high turn-over of Coronial staff, limited facilities for hearings, severe shortage of pathologists and pressures on local authority finances also prevent effective delivery of the Coronial process [171]. In cases where changes are necessary to prevent similar incidents in the future, delays in investigations can occur potentially missing the window of opportunity for reform before systems and institutions evolve [150]. This highlights the need for proactive measures to address these challenges and ensure that perinatal death investigations prioritise both the investigation process and the emotional well-being of families involved.

Medical inquests can be time-consuming involving large volumes of complex documents and intricate medical science issues [166]. Unlike routine inquiries, which typically focus on specific questions, medical inquests often require extensive hearings that span several days or even weeks, involving testimony from many witnesses [166]. While Coroner's investigations aim to address the questions of how and why an event occurred, sometimes, the answers to these questions are already known [161]. Further investigation could put unnecessary pressure on Coroners, healthcare professionals, services such as administration and management, and families involved [150, 161]. Also, in most Coronial inquests, the cause of death (how) may be identified, but the underlying reason for the death (why) may not always straightforward and can be unclear [166]. This is particularly relevant in perinatal death cases. This ambiguity often leads to varying levels in the scope of an inquest, with some inquiries covering broad

circumstances, while others focus narrowly on the immediate causes [166]. As a result, bereaved families may feel helpless and waste of time specially if their concerns are not fully explored [166].

In this review, we have discussed previously the varying qualifications of Coroners among high-income countries and within jurisdictions. Other studies also have reported the lack of a uniform system or national standards for Coroner or Medical examiner Offices, or common measures to evaluate their performance [164, 177]. Coroners often deal with complex medical documents, such as ICU notes, pathology reports, radiology findings, test results, necessitating an understanding of medical records to conduct thorough and accurate death investigations [166]. A study from Australia found that Coroners felt limited by their inadequate training, which hindered their ability to contribute effectively to death and injury prevention efforts [164]. The study pointed out that Coroners in New Zealand lacked specialised training in key areas like epidemiology and statistics, which are vital for conducting health and safety assessments [164]. Notably, no specific training for investigating perinatal deaths was found across the reviewed countries, despite the sensitivity and importance of these cases.

If investigations were extended to every perinatal death, autopsies might become mandatory in some countries especially if an inquest is held [150, 169]. Also, consultant obstetricians may need to testify as an expert witness, providing detailed accounts of fetal development and any relevant medical events leading up to the pregnancy loss, through both written reports and live testimony at inquests [150]. A public consultation report in Ireland, based on questionnaire responses from Coroners, bereaved families, and other relevant stakeholders, showed that most participants felt it was unnecessary to report all perinatal deaths to Coroners [178]. They cited inconsistencies in guidelines for post-mortem examinations and believed that certain types of perinatal deaths, such as those with clear medical causes or known structural or genetic abnormalities, should not require mandatory reporting [178]. For instance, fatal fetal anomalies and stillbirths from natural causes were seen as exceptions [178]. Additionally, participants from the survey suggested that perinatal deaths occurring just before viability (at 21–22 weeks) should not automatically be referred to Coroners, allowing parents to decide whether to consent to a post-mortem examination [178].

Recommendations

Need to clearly define which type of perinatal deaths should be included under Coroner's jurisdiction. In Attorney General for Northern Ireland v Desmond [152], we note that the judgment discusses whether Coroners in Northern Ireland have jurisdiction to conduct an inquest into the death of a stillborn child. The court considers various arguments, including: right to life and non-discrimination, statutory interpretation of the Coroners Act and Rules, policy issues surrounding the definition of personhood and the distinction between life in the womb and outside. The court ultimately upholds the Coroner's interpretation that there is no express statutory jurisdiction to conduct an inquest into a stillborn child, and therefore dismisses the application for judicial review. The court notes that had the legislature intended to confer such a jurisdiction, it would have expressed it clearly in primary legislation. In Canada and the US, regional legislation governing Coroners' Courts for perinatal death varies significantly by state/territory. This inconsistency may arise to differing referral criteria for perinatal deaths. To prevent over-reporting or under-reporting of potentially investigable cases, each jurisdictions need to established clear guidelines for determining which perinatal deaths warrant a Coroner's inquiry. Without standardised national guidelines, hospitals or clinicians may apply their own subjective interpretations, leading to inconsistent reporting of similar cases. This can result in unfair outcomes for bereaved families, who may face disparate responses depending on the jurisdiction.

While it is not realistic to achieve uniform definitions and consistent language globally, Coronial law within a country can, however, aim to apply a coherent and consistent framework to guide the public and healthcare professionals in Coronial investigations of perinatal death. This includes providing clear legal and policy guidance on the scope of the Coroner's role. Clearly defined rules can help guide those without legal expertise in understanding when and how a Coroner becomes involved in perinatal death cases. It is advised that these changes be evidence-based, grounded in medical consensus, informed by emerging clinical knowledge, and designed to support bereaved parents. Perinatal death is an extremely difficult experience for everyone involved, particularly for bereaved parents. Having clear and consistent guidelines and procedures in place can support bereaved parents to navigate and avoid additional distress from the process.

A competency framework for the role of Coroners is needed and implementation at national level would be important. For an example, in the United States, each state establishes its own guidelines for determining which types of deaths warrant investigation and sets distinct professional and educational standards for Coroners and Medical Examiners responsible for conducting these investigations.

These varying standards can have significant public health implications as differences in death reporting and cause-of-death data collection may compromise the accuracy of mortality surveillance, making it challenging for public health officials to track trends and make informed decisions [71]. Coroners need regulatory standards, including legislative requirements for specific qualifications, continuous professional development, and access to expert epidemiological advice for context-specific guidance and recommendations. Training on perinatal death cases could be beneficial for Coroners, enabling informed decisions and tailored investigations. Regular updates to medical knowledge and best practices are crucial. While some studies suggest specific qualifications or backgrounds are essential, there is no empirical evidence supporting their effectiveness. Further research is needed to provide conclusive evidence on this topic.

It would be beneficial for both the public and healthcare professionals to have a dedicated national Coroners website that provides information about Coroners and their specific roles, along with relevant national legislation. A comprehensive guidebook outlining the Coroners' roles, investigation processes covering aspects such as what to expect, timelines, and an overview should be made accessible at both Coroner's offices and hospitals, written in clear, easy-to-understand language. A separate guidebook for healthcare professionals detailing referrals and other Coronial processes would also be advantageous. This information should be available in both online and print formats.

Enhancing hospital perinatal death review process: We have addressed the issue of resource limitations in the Coroner's process leading to frequent and prolonged delays in investigations. Therefore, it is important to enhance internal investigations, such as the perinatal death review process in hospitals, by incorporating multidisciplinary experts and actively engaging parents in the review. This should occur before the Coroner's inquiry over all perinatal deaths, especially in cases where the cause of death is known. A Perinatal death review approach has been successfully implemented in several high-income countries, yielding positive outcomes [177, 179]. Research indicates that families often seek legal representation due to a lack of understanding regarding the adverse event [166]. Some research suggests that involving bereaved parents in internal review process, includes current information about the nature and significance of postmortem examinations, may *"increase professionals' capacity to understand parents' perceptions of the counselling process"* [169]. Further evidence-based studies are needed to explore various ways for parents to participate in the death review process.

Strengths and limitations

Our review represents a pioneering effort to comprehensively examine the Coroner's role in perinatal death investigations across high-income countries with Coronial or equivalent systems. A notable strength of this study is its use of comparative law methodology. This method yielded valuable information on national legislations that may have gone unnoticed if we had relied solely on electronic databases. The recommendations outlined in this review could be actionable for experts involved in perinatal death investigations and may inform improvements to existing systems. We believe that this study will be beneficial to law enforcement agencies and countries where there is a lack of clarity in perinatal deaths investigations, particularly those with poorly established Coronial system. By comparing and contrasting findings on legal status for perinatal deaths across high-income countries, we hope to shed light on the overlaps and differences between various systems and provide a more nuanced understanding of best practices in Coroner's perinatal death investigation.

This study has some limitations to be considered. This review was confined to high-income jurisdictions with legislation available in English and English-language publications, which may have precluded the inclusion of relevant studies from low- and middle-income countries having Coronial or equivalent systems or those published in languages other than English. And this review was unable to locate comprehensive documentation of legislation for some high-income jurisdictions like Alaska, Florida, Illinois, and Indiana.

Conclusions

While not all perinatal deaths are preventable, every perinatal death can be reviewed, and each offers opportunities for learning for healthcare systems. Therefore, having a clear and established guideline for Coroner's investigations can provide valuable support to bereaved parents throughout the inquiry process. The study calls for more comprehensive research on how Coroner's investigations of perinatal deaths affect all stakeholders and highlights the need for clearer understanding of the Coroner's role, supported by structured guidelines and legislation. By comparing and contrasting the legislation surrounding perinatal deaths, identified challenges and areas for improvement in Coronial system. While the findings from this review may provide a basis for discussions aimed at enhancing Coronial laws related to perinatal death investigations, further research is needed to

address the concerns of families regarding the process and its implementation.

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