

State Coroner's Guidelines 2013

Chapter 4

Dealing with bodies

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4.1 Introduction

Coronial involvement in the early aftermath of a person's death can be very disempowering for families. They have virtually no control over the body once the death is reported to the coroner, as the coroner takes control of the body until it is no longer needed for the investigation or the coroner stops investigating the death. Coroners can generally accommodate the therapeutic needs of grieving families to see the body or give effect to the deceased's wishes regarding organ and tissue donation without compromising the coronial investigation. It is essential for the body and the deceased person's family to be afforded dignity and respect during the early stages of the coronial process.

This Chapter provides guidance to first response officers and hospitals about when a body may be released directly to the family's funeral director. It explains how suspected indigenous burial remains should be dealt with. It explains the steps to be taken to preserve evidence when a reportable death occurs in a health care setting. It provides guidance to police and government undertakers about how bodies are to be prepared and transported for coronial purposes. Finally, it clarifies the coroner's role in relation to therapeutic viewings, administering religious or cultural rites and facilitating organ and tissue donation or sperm removal while the body remains under the coroner's control.

4.2 Release to the family's funeral director from the place of death

Legislation

Coroners Act
Sections 12(2), 26(1) & (2)

In principle

It is appropriate for a deceased person's body to be released directly to the family's funeral director where it is impracticable for the body to remain at the place of death pending either the issue of a cause of death certificate by a treating doctor or the outcome of a coroner's preliminary investigation.

In practice

Guideline for first response officers attending an apparent natural causes death in the community

Chapter 3.4 *Triaging apparent natural causes deaths at the initial reporting stage* provides guidance to first response officers when making enquiries to locate a treating doctor who may be willing to issue a cause of death certificate for an apparent natural causes death in the community.

If the attending officers form the view a cause of death certificate is likely to issue; and the death is not otherwise reportable, the officers should advise the

family the matter is not a coronial matter and the family should contact a private funeral director to make any necessary arrangements.

The family should also be advised that it will be necessary for them or their funeral director to contact the deceased person's usual treating doctor to arrange to have a cause of death certificate issued. They should be advised that if a death certificate is not forthcoming the matter will become a coroner's case.

Queensland Ambulance Service (QAS) paramedics will usually have already attended and they should be asked to issue a life extinct certificate. If this has not happened the QAS should be called to attend and confirm that the apparently deceased person does not require emergency transportation to hospital. The first response officers should ensure that a life extinct certificate has issued before they depart the scene.

Officers should be alert to the possibility that because of advancing age, infirmity, an extreme grief reaction, or poverty on occasions the surviving family member(s) may not be competent to make the necessary arrangements. In such cases it may still be necessary to contact the government contracted funeral director to move the body to its premises so that an application under the Burials Assistance Scheme can be made or more capable relatives located.

If the death for any reason appears suspicious or unnatural it should be discussed with the shift supervisor or district communications room supervisor.

The officers who attend the scene should ensure the details of their attendance are entered on QPRIME in accordance with the QPRIME user guide.

If a cause of death certificate does not issue

On occasion, even when the family indicates they had been expecting the death and/or a doctor indicates he or she will issue a cause of death certificate, one is subsequently not forthcoming.

If this occurs, the funeral director who has possession of the body and who is not authorised to prepare the body for a funeral until a death certificate is issued will contact the coroner who will direct police to treat the death as reportable. This will require police to engage the government contracted funeral director to transport the body from the family's funeral director's premises to the local government mortuary and to prepare a form 1.

The Detective Inspector, Assistant to the State Coroner, may be contacted on 07 3292 5900 should first response officers require any further assistance.

Guideline for coroners – arrangements for bodies when impracticable for body to remain at hospital or nursing home pending outcome of coroner’s preliminary investigation

Chapter 7.4 *Investigating health care related deaths* explains the process by which doctors and nursing homes can report a death directly to the coroner without involving police. This is generally initiated by a phone call to the coroner who will decide whether the death is reportable and if so, how it is to be reported.

For those deaths reportable by Form 1A (the death is reportable but it may be appropriate for the coroner to authorise the issue of a cause of death certificate without autopsy), the body should generally remain in the hospital mortuary until the coroner completes his or her preliminary investigation. This is in case the coroner decides further coronial investigation is required and the body needs to be transported to a coronial mortuary for autopsy. However, it is not always practicable for the body to remain on site - hospital mortuaries may be at capacity from time to time and nursing homes and small hospitals generally have no storage facilities. Nursing homes often report resident deaths after the body has been released to the family’s funeral director.

When directing a nursing home or hospital to report a death via Form 1A in these cases, the coroner should clarify where the body is being held and if not released already, give permission for it to be released to the family’s funeral director. The coroner should ask for the funeral director’s contact details to be provided with the Form 1A so the coroner’s staff can notify the funeral director as soon as practicable of the coroner’s involvement. This ensures the body is not buried or cremated before the coroner’s preliminary investigation is completed. It also ensures the coroner is informed of the timing of the family’s preferred funeral arrangements which may be affected should the coroner require the body for further investigation.

Occasionally a death reported by Form 1A will require further investigation, including autopsy. Coroners should ask nursing homes and hospitals to advise families of this possibility at the time the death is reported so families can factor this into their funeral planning. Coroners should also be proactive in ensuring families and funeral directors are kept informed of the progress of the preliminary investigation, especially if an autopsy is likely. If an autopsy is required and the family is unable or unwilling to postpone funeral arrangements, it is generally acceptable for the funeral service to proceed and for the body to be transported from the funeral home for autopsy afterwards. Before giving permission for the service to proceed, coroners should seek advice from a forensic pathologist about whether delay occasioned by accommodating a funeral could compromise the autopsy.

4.3 Dealing with possible indigenous burial remains

Legislation

Coroners Act

Sections 12(2)(a), 14(3)(b), 26(2)(a), 'indigenous burial remains', 'traditional burial site'

Aboriginal Cultural Heritage Act 2003,
'Aboriginal human remains', Part 2, division 2 ss.15, 16, 17, 18

Torres Strait Islander Cultural Heritage Act 2003,
'Torres Strait Islander human remains', Part 2 division 2 ss.15, 16, 17, 18

In principle

Burials are highly significant to Aboriginal and Torres Strait islander people and interference with burial remains is of great cultural concern to their communities. When dealing with what may be indigenous burial remains, a balance must be struck between the need to ensure the death was not a homicide and the need to minimise unnecessary disturbance of indigenous burial remains.

As soon as it is established that remains are indigenous burial remains, the coronial investigation must cease and management of the remains should be transferred to officers from the Cultural Heritage Coordination Unit of the Department of Aboriginal and Torres Strait Islander and Multicultural Affairs and representatives of the traditional owners of the land where the remains were found.

In practice

The discovery of any skeletal remains must be reported to police in the first instance. The site is to be treated as a potential crime scene until the coroner is satisfied the death is not suspicious. The site must be secured but before it is disturbed by any forensic process, attending officers must first consider whether the remains could be indigenous burial remains. In doing so, police must have regard to section 8.5.15 of the QPS Operational Procedures Manual (OPM). The Cultural Heritage Coordination Unit has developed guidelines to assist police in identifying possible indigenous burial remains.¹ These guidelines set out a range of physical signs that may indicate a site contains indigenous human remains, for example the location of the site, its proximity to carved or scarred trees or stone arrangements, the presence of grave artefacts, how the remains are positioned and their condition.

In all cases of possible criminal activity, scene preservation and forensic examination requirements will have priority.

However, once the possibility of criminal activity is excluded and it is thought the remains could be indigenous burial remains, attending police are to contact the Cultural Heritage Coordination Unit whose officers will attend the site as a matter of priority to help investigating officers determine the antiquity and ethnicity of the remains for the coroner's consideration. Attending police retain responsibility for the site at all times and may arrange for a second forensic expert opinion (either on site or by review of digital images) if

¹ *General Information for Police: Aboriginal and Torres Strait Islander Human Remains*
www.datsima.qld.gov.au/resources/atsis/people/indigenous-cultural-heritage/hr-general-info-police.pdf.

necessary. Cultural Heritage Coordination Unit officers will liaise with Aboriginal or Torres Strait Islander elders at the appropriate time during this process.

The coroner's investigation must stop once the coroner is satisfied the remains are indigenous burial remains. Sometimes this confirmation can be made without having to remove the remains from the site. However, in cases where the on-site assessment is inconclusive, it will be necessary to transport the remains to a coronial mortuary for further specialist examination. In these cases the Cultural Heritage Coordination Unit officers may continue to advise and assist police with further site examination, evidence retrieval and controlled removal of the remains. Further specialist examination and analysis of the remains may involve input from forensic osteologists or physical anthropologists.

Once the coroner is satisfied the remains are indigenous burial remains, the Cultural Heritage Coordination Unit will take responsibility for liaison and reburial with the appropriate Aboriginal or Torres Strait Islander community. This guideline is to be read in conjunction with Chapter 6.2 *Release of bodies for burial or cremation* which explains the process by which indigenous burial remains are to be released.

These guidelines have been prepared with reference to the Cultural Heritage Coordination Unit publication *The Discovery, Handling and Management of Human Remains under the Provisions of the Aboriginal Cultural Heritage Act 2003 and Torres Strait Islander Cultural Heritage Act 2003*²

4.4 Preserving evidence when a health care related death occurs in a health care setting

This section is intended to help health professionals and first response police officers decide what steps need to be taken to preserve evidence when a health care related death has occurred in a hospital or other health care facility. Staff and police should consider the factors listed below. If in doubt about any aspect, health care staff or police should consult with a coroner or forensic pathologist.

Violent or suspicious deaths that just happen to occur in a hospital should be treated in the same way as any other violent or suspicious death.

In principle

When deciding what interference with a death scene in a health care setting should occur and what instruments, equipment and specimens should be seized, those managing the facility and the investigators must try to balance three competing priorities:

- the forensic needs of the investigation,
- the need for the hospital or health care facility to continue to treat other patients or residents, and
- the sensitivities of the family and their need to have contact with the deceased in the least distressing condition.

² www.datsima.qld.gov.au/resources/atsis/people/indigenous-cultural-heritage/hr-remains-guideline.pdf

The greater the likelihood that a crime has occurred or seriously deficient practice has contributed to the death, the greater the emphasis that must be given to the interests of the investigation. In these rare cases in which criminal or civil proceedings are likely, continuity of the chain of possession and strict proof of events leading to the death can justify an operating theatre or hospital ward being treated as a crime scene.

In most other cases, the needs of the facility to have free access to operating theatres etc should be given priority. In most cases, the cause of death and the factors that contributed to it can be established from witness statements, medical records and notes, instrument settings etc making the isolation of the scene unnecessary.

In all cases, the needs of the family to have contact with the deceased should be considered and the desirability of cleaning the body to make such viewing less traumatic should only be over ridden if the need to preserve evidence justifies it.

In practice

Preserving the death scene

(a) Scenes of homicides, etc resulting from an incident within a health care facility

Scenes of death that involve, or may involve homicides, suspicious deaths, suicides or accidents **resulting from an incident within the facility itself should be preserved** for examination by police in exactly the same way as if the death had occurred in the general community.

Careful scene preservation is in the best interest of the health facility. For example, thorough and independent scene examination in a suicide may deflect unjustified criticism of a psychiatric unit.

As in the community, if the patient has been removed elsewhere for treatment and dies, or is likely to die, the scene of the incident (not the scene of death) should be preserved for examination.

(b) Scenes of ‘adverse health events’

Deaths from “adverse health events” are rarely of sufficient complexity to warrant preservation of the scene for examination by police or other experts. The key question is whether examination of an intact scene might help understand what happened.

In most reportable deaths that occur in health care settings, scene preservation is unnecessary and undesirable because of disruption to the health facility. For example, operating theatres in which deaths have occurred generally do ***not*** require preservation for inspection by police.

However, medical equipment at (or from) the scene must be preserved for independent examination if this may help understand the cause or circumstances of a reportable death. Medical equipment still attached to the body raises special issues and is considered next.

Preserving medical equipment attached to the body

This includes items entering the body (e.g. canulae, lines, ET and NG tubes, catheters, drains) and devices attached to these (e.g. drip bags, syringes, drain bottles and bags, urine bags).

The general rule is that medical equipment attached to the body must remain in place for the pathologist to examine as part of the autopsy whenever a deceased has been undergoing medical or surgical treatment at the time of death, regardless of the health care setting.

The reason is that, even though such items are often irrelevant to the investigation, it is difficult to predict which will be needed and in which cases. Generally, it is just as easy for items to be described, removed, examined where necessary, and discarded in the mortuary as elsewhere.

Exceptions can be made to the general rule – if removal is documented in the medical records (a sketch is useful), or in a report to the coroner and pathologist **AND** if justified by the following:

- to attempt resuscitation or other medical treatment – **this is always an over-riding priority**
- to make the body safe to handle (e.g. removal of a needle)
- to meet the request of a family member wishing to view the deceased before autopsy without sightly equipment such as an NG tube or airway, unless a problem such as incorrect positioning may have contributed to death in which case the tube should be left in place.

The following questions should be considered before removing equipment, ideally in consultation with the coroner or an independent professional (e.g. senior nurse, anaesthetist or forensic pathologist):

- could the item itself have caused or contributed to death e.g. ET tube in the oesophagus, infusion pump delivering medication incorrectly?
- what are the alternatives to complete removal e.g. defer viewing until after autopsy when the deceased may be more presentable anyway or cut an NG or ET tube just inside the body leaving the tip in situ?
- could independent examination of the equipment, either in situ or after removal, assist the investigation e.g. to document the settings, or check for faults?

Preservation of other evidence in a health care setting

(a) *Preserving clothing and jewellery*

Examination of clothing and sometimes jewellery can assist the pathologist and police reconstruct events e.g. by inspecting knife or bullet holes. Clothing removed to allow resuscitation should be placed in a bag accompanying the body to the mortuary. Jewellery and other valuables removed at the health facility should be documented and

returned to the family in accordance with the facility's own procedures. However, in homicides, suspicious deaths and deaths in custody, items still on the body at the time of death should be left in situ for examination in the mortuary.

(b) *Preserving other non-medical items attached to the body*

Items such as a noose used for self-inflicted hanging or a knife still protruding from the body should be preserved in situ wherever possible. If removed to allow medical treatment or for safety reasons, the items should be documented in the medical records and preserved separately for the police and pathologist to examine e.g. in a bag accompanying the body.

(c) *Preserving trace evidence, blood stains, etc on the body*

Generally, vital resuscitation attempts irretrievably contaminate any trace evidence on the body, especially on the face. Cleaning the face to allow viewing by the family is therefore usually permissible. In alleged sexual assaults, however, the genital area should not be disturbed prior to forensic examination. Consult the coroner or a forensic pathologist if in doubt.

(d) *Preserving injuries*

Although medical treatment is always a priority, injuries possibly due to an assault should ideally be preserved intact for the pathologist to examine. For example, examination of penetrating injuries (e.g. knife and firearm wounds) is critical to the reconstruction of events, and surgical incisions should avoid such wounds where possible.

(e) *Preserving pathology samples to assist the coroner's investigation*

Some pathology samples may need to be preserved for transfer to the forensic pathologist, toxicologist or other expert for separate examination. Examples include blood (or other samples) taken at the time of hospital admission as these may offer the best evidence of intoxication with alcohol, drugs or poisons at the time of an incident, and anatomical pathology specimens relevant to the autopsy such as an excised bullet wound, traumatically ruptured spleen, or placenta in a peri natal death. Admission samples should never be disposed of in cases where there is any real likelihood that the patient may die.

(f) *Take blood samples when adverse reaction to anaesthetics or drugs may be involved*

Deaths that may be due to an anaphylactic reaction or other form of hypersensitivity to a drug, anaesthetic or any other agent are reportable. In such cases, blood should be taken from the body for testing within 4four hours of death for tryptase and any other testing that may shed light on the cause of death. Police should therefore immediately contact the coroner to obtain consent for this to happen. The blood should then be stored in clean glass vials and refrigerated

immediately. The Form 1 Police Report of a Death to the Coroner should note the location of these samples.

4.5 How should bodies and hospital records be transported to the mortuary?

Legislation

Coroners Act
Section 18

Hospitals and Health Boards Act 2011
Section 157

In principle

A deceased person's body is perhaps one of the most important items of evidence from a death scene.³ While it is important for the body to be managed in way that minimises the risk of diminishing its forensic value, it must be treated with dignity at all times while being examined at the scene, prepared for transportation and transported to the mortuary.

In practice

Transportation of bodies

Bodies can only be transported to designated mortuaries by government contracted undertakers acting under direction from police or the coroner.

Attending police are required to act under the Police Powers and Responsibilities Act and section 8.4 of the Queensland Police Service Operational Procedures Manual (OPM) when attending a death scene and arranging for the body to be transported.⁴

Occasionally families may wish to observe cultural or religious rites before the body is removed from the scene. Coroners should allow this to occur for non-suspicious deaths once the scene has been forensically examined, provided the ritual does not involve physical contact with or contamination of the body. Care needs to be taken to ensure these observances do not unduly delay transportation and consequently it is reasonable to impose timeframes on when and for how long the ritual can be performed.

Government undertakers must comply with any direction given by attending police or the coroner and must observe the requirements of the commercial arrangement under which they are contracted to transport bodies for coronial purposes.

³ Freckleton, I & Ranson, D *Death Investigation and the Coroner's Inquest* 2006, p.221

⁴ See particularly section 8.4.4 Pre-mortuary procedures and removal of bodies from scene and 8.4.22 Funeral directors

Transportation of hospital records with the body

Since 2010, the Queensland Police Service has used sealed body bags to transport bodies for coronial purposes. This alleviates the need for police to escort the body to the mortuary to lodge non-suspicious deaths. It is recognised that many health and aged care facilities are moving to electronic medical record systems. Coronial mortuaries have access to the Department of Health electronic medical record system and other clinical databases. However, there are some facilities which still maintain paper-based patient/client records. When a death occurs at a hospital, it is desirable for any of the deceased's paper-based hospital records to be transported with the body. While it is preferred that the original records be made available at this time, it may not always be possible for copies to be made by the hospital before attending police leave the hospital. Consequently, it is acceptable for hospital staff to:

- (a) give the paper-based medical records to attending police who will arrange for the government undertaker to deliver the records to the mortuary with the body; or
- (b) if the records can not be downloaded or copied prior to the attending police officers' departure from the hospital, give the records to the government undertaker so they can be transported with the body; or
- (c) if the records can not be downloaded or copied prior to the government undertaker's departure from the hospital, courier the records to the mortuary as soon as practicable.

These arrangements are consistent with the operation of section 157 of the *Hospitals and Health Boards Act 2011*.

4.6 When can families view the body prior to release from a coronial mortuary?

In principle

It is well recognised there are significant benefits for bereaved families who have the opportunity to view their loved one's body. Viewing the body helps the bereaved start the process of mourning by satisfying themselves of the reality of the situation. In the coronial context, it also helps ameliorate the disempowering effect of the body remaining out of the family's control during the early stages of the coroner's investigation. While ensuring the integrity of the coroner's investigation is paramount, families should generally not be prevented from view the body at a coronial mortuary unless the death is suspicious or the condition of the body could place the family at risk of emotional distress or trauma.

In practice

Arrangements for formal identification viewings are dealt with in Chapter 8 of these guidelines and section 8.5.5 of the QPS OPMs.

When is a viewing not appropriate?

Viewings may not be appropriate when the body has been assessed as not visually identifiable, for example due to the extent of traumatic injury or post-mortem changes. Coronial mortuaries do not provide cosmetic reconstruction

as this is done by funeral directors for funeral home viewings. In these cases, the family is to be advised the viewing is neither possible nor recommended because of the risk of psychological injury due to the body's condition, and should be referred to their funeral director for advice about what may be possible at the funeral home.

Infection risk doesn't necessarily prevent a viewing. Advice should be sought from the case pathologist about whether and if so how this risk can be managed to facilitate a viewing.

When can a viewing be conducted?

Family requests for viewings will generally be made through coronial counsellors or hospital social workers.

Before arranging a viewing, the counsellor or social worker should first inspect the body and clarify with the case pathologist or the coroner whether the death is suspicious and whether there is a risk of infection.

It may be preferable for viewings to be conducted after the autopsy because the body's appearance will be more suitable for viewing as it will have been cleaned and carefully sutured. However, these guidelines recognise there can be reasons for the family to view the body before the autopsy is performed. Families may wish to view the body before the autopsy for religious or cultural reasons, due limited family availability to attend a viewing or before the body is transported from a local mortuary to a coronial mortuary in another region for autopsy.

There is generally no need for counsellors or hospital social workers to seek coronial permission to arrange a therapeutic viewing unless there is a family dispute about who can see the body.

Viewings will not be permitted before autopsy if the death is suspicious.

Managing family conflict

Death often exacerbates pre-existing family tensions. This can result in dispute between family members about who should be allowed to view the body. Where these disputes arise, the counsellor or social worker should seek direction from the coroner before arranging the viewing. The coroner is to have regard to the family member hierarchy established by the Coroners Act and seek advice from the counsellor or social worker about reasonable ways in which the viewing could be conducted to meet the family's competing emotional needs, for example, whether it is feasible to schedule separate viewings.

How should a viewing be conducted?

Viewings should only be conducted by coronial counsellors or hospital social workers or nurses practising in emergency, intensive care and perinatal wards. These professionals are trained to provide support to bereaved families. Viewings are not to be conducted by mortuary or ward staff.

It is reasonable to impose a time limit on a viewing as families can find the process of leaving the body extremely difficult. Forty-five minutes is the recommended duration, though experience has shown many viewings do not take this long.

Children are not to attend a viewing without both an adult support person and a coronial counsellor or social worker present.

Families will generally be permitted to view, touch and hold the body, undertake memory making (such as hand and foot prints, taking locks of hair), dress the body or perform religious, cultural or social rituals that do not interfere with the body and provided the ritual is not unduly disruptive to the mortuary environment. For non-suspicious deaths, there is no need for the viewing to be supervised by police.

4.7 When can organ and tissue donation take place?

Legislation

Coroners Act
Sections 18A, 54AA

Transplantation and Anatomy Act 1979
Sections 22, 24, 25, 'tissue'

In principle

The mere fact a person's death is reportable does not preclude whole organ or tissue donation. Rather, over 50% of Australian donors are coroner's cases. Provided coroners are satisfied the retrieval won't compromise their investigation or the prosecution of any criminal charges that may be laid in respect of the death, there is no reason for coroners to withhold consent to organ and tissue retrieval. Facilitating organ and tissue donation is consistent with the coronial system's focus on respecting the wishes of the deceased and their families to the greatest extent possible, and pursuing public benefit from sudden death investigation.

In practice

The retrieval of organs and tissue for transplantation and other medical and scientific purposes is regulated by Part 3 of the *Transplantation and Anatomy Act 1979*. When a person's death is reportable under the Coroners Act, coronial consent is required before retrieval can proceed.

Whole organs - most organ donations occur when a person is declared 'brain dead' (when the brain is so badly damaged that it permanently stops functioning, usually because of bleeding in the brain, a stroke, infection or severe head injury). Organ donation may also be possible in much more limited conditions after cardiac death (after a person's heart has stopped beating). Commonly retrieved organs include the heart, lungs, liver, kidneys and pancreas. To remain viable, organs must be retrieved within up to 12 hours after the death, depending on the organ to be donated. Obviously the

retrieval must be performed in hospital and if the donor's death is reportable, before a coronial autopsy is performed.

Tissue - tissue donation may be possible after brain death or cardiac death. Commonly retrieved tissues are bone and musculoskeletal tissue, heart valve and pericardium, corneas and skin. The timeframe for tissue retrieval is within 24 hours after death, depending on the tissue to be donated. Tissue retrieval occurs mainly in major cities where tissue banks are found as regional mortuaries are not equipped to undertake tissue donation. If the donor's death is reportable and an autopsy may be necessary, this means retrieval usually occurs at the QHFSS mortuary in Brisbane.

The DonateLife website contains very useful general information about the organ and tissue donation process.⁵

Process for obtaining coronial consent for organ & tissue donation

If a potential organ donor's death is or may be reportable and an autopsy is likely, the treating intensivist or DonateLife donor coordinator will first discuss the case with the duty pathologist who will advise whether organ retrieval could compromise an autopsy. Depending on the circumstances of the death, it may be only certain organs need to be retained for forensic examination but others can be made available for donation. If the death is suspicious, input will also be sought from the investigating officer about whether organ retrieval could compromise a criminal prosecution. The treating intensivist or DonateLife donor coordinator will then contact the coroner to seek verbal consent for organ donation to proceed. Coronial consent should be given in all cases where the coroner is satisfied the retrieval will not hinder either the coronial investigation or a criminal prosecution. The coroner's consent is then documented under the *Transplantation & Anatomy Act 1979* as soon as practicable.

Forensic pathologists are available to provide on-site advice to the retrieval team during the retrieval if necessary.

If the coroner considers an autopsy is not necessary and the death is more appropriately dealt with by a Form 1A investigation, the coroner must expedite his or her consideration of the matter so as not to jeopardise organ and tissue retrieval timeframes.

Management of body following organ retrieval in hospital

Following retrieval, the body may be moved from the operating theatre to an appropriate bedspace or, if the family has already left the hospital, to the hospital mortuary without a police attendance or escort.

For non-suspicious deaths, families may spend time with the body and will generally be permitted to touch and hold the body, undertake memory making (such as hand and foot prints, taking locks of hair), dress the body or perform

⁵ www.donatelife.gov.au

religious, cultural or social rituals that do not interfere with the body. There is no requirement for this to be supervised by police. However, if there is a family dispute about who may view the body, the donor coordinators and/or social workers must first consult with the coroner who will consider the situation with reference to the matters outlined in section 4.6 above. Once the family has finished spending time with the body, the body may be moved to the hospital mortuary without a police attendance or escort.

Post-retrieval viewings will not be permitted for suspicious deaths. A suspicious death is one where at the time of organ retrieval, police are investigating the death as suspicious, regardless of whether there is a known suspect or not or whether charges have been laid in respect of the death. However, in the event police are not already in attendance at the hospital, the body may be moved from the operating theatre to the hospital mortuary without a police escort. There is no need for members of the treating team or the donor coordinators who complete the donor identification to remain at the hospital pending the police attendance.

Process for obtaining coronial consent for tissue donation – donor in coronial mortuary

Amendments to the Coroners Act which came into effect on 2 November 2009 enable persons acting on behalf of prescribed tissue banks to access Forms 1 and to conduct external examinations of deceased bodies in mortuaries to assess their suitability for tissue donation on a standing or ongoing basis rather than needing to seek the consent of the investigating coroner on a case by case basis as was required before the amendments.

In order to maximise opportunities for tissue retrieval, the State Coroner has entered into arrangements under s.54AA of the Act with the Queensland Bone Bank, the Queensland Eye Bank, the Queensland Heart Valve Bank and the Queensland Skin Bank to provide tissue bank staff with access to information from the Form 1 (Police report of a death to the coroner) and perform an external examination of the body in order to assess donor suitability before the family and the coroner is approached for consent to retrieval.

Access to the Forms 1 must be in accordance with these arrangements and the examinations must comply with guidelines issued by the State Coroner under s. 18A.

These are the arrangements and guidelines under which the Queensland Health owned prescribed tissue banks (Queensland Bone Bank, Queensland Eye Bank, Queensland Heart Valve Bank and Queensland Skin Bank) and their staff or persons acting for the prescribed tissue banks including Coronial Nurse Coordinators at Queensland Health Forensic and Scientific Services and staff members of Queenslanders Donate (hereafter all referred to as 'tissue bank staff members' will be authorised to access Forms 1 at the QHFSS mortuary at Coopers Plains, and the Gold Coast, Nambour and Toowoomba Hospital mortuaries and undertake external examinations of the bodies of potential donors.

Arrangements for accessing forms 1

Tissue bank staff members may access the front page of all Forms 1 to ascertain the type of death and the date of birth of the deceased. In cases where the Form 1 indicates the death is suspicious or is a death in custody or the deceased is less than two years old, no further inspection of the Form 1 is authorised without the consent of the investigating coroner.

In all other cases the form can be inspected to ascertain the other matters set out in s. 54AA(1)(c)-(f), namely a brief description of the circumstances of the death; the deceased person's previous medical information; and the name and contact details of the deceased person's available next of kin.

Tissue bank staff members may access the Forms 1 from AUSLAB or from police or mortuary staff when the body is lodged at the mortuary or from the coroner's office.

State Coroner's guidelines for external examination of potential tissue donors

In cases where, as a result of inspecting the relevant Form 1, a tissue bank staff member concludes the deceased person may be a suitable tissue donor and the staff member wishes to undertake an external examination of the body to further assess its suitability, the staff member must comply with the following guidelines:

Prior to the examination

1. The Australian Organ Donor Register must be checked to confirm the deceased did not object to donating tissue.
2. The deceased must meet the basic donor selection criteria of the prescribed tissue bank (e.g. time since death, age).
3. Agreement must be obtained from the case pathologist or on-call pathologist.
4. The deceased must have been formally identified, unless visual identification is imminent and may provide an opportunity to seek family consent.
5. The identity of the deceased must be confirmed by comparing the details on the mortuary tag with the case documentation.

During the examination

6. The dignity of the deceased person must be respected and maintained.
7. Interference with the body must be kept to a minimum.
8. The body should not be altered in any way or undergo any invasive process.
9. Items attached to the body (e.g. a noose, IV lines) must not be altered or removed without the pathologist's approval.

Immediately after the examination

10. The examination details must be recorded on a Queensland Health approved form, highlighting any abnormalities, especially any of forensic or coronial relevance.

11. A copy of the completed form should be placed in the autopsy file straight away.
12. If abnormalities are found, these should be discussed with the pathologist and agreement obtained that donation can proceed before seeking next of kin consent.

The coroner will be approached for written consent under the *Transplantation & Anatomy Act 1979* in appropriate cases after senior available next of kin consent has been obtained. Depending on autopsy scheduling, the retrieval may take place before or at the end of the autopsy. There is no reason for a coroner to withhold consent for tissue retrieval once satisfied the retrieval will not compromise the coronial investigation or any criminal prosecution.

Documentation of organ and tissue retrieval

Any abnormalities or other significant issues identified during organ or tissue retrieval will be documented for the case pathologist, who will convey this information to the coroner and include it in the autopsy report.

4.8 Removal of sperm and associated procedures for in-vitro fertilisation (IVF)

In principle

Coroners do not currently have power to order sperm removal for non-coronial purposes. The posthumous removal of sperm, a testis or other tissue and the removal of blood for IVF testing can occur without court approval under Part 3 of the *Transplantation and Anatomy Act 1979*.⁶

Coroners and forensic pathologists will help facilitate sperm removals performed by IVF organisations under Part 3 without delay.

Coronial consent to the removal of the tissue is required where a death is a reportable death. This may be given orally and if so given must be confirmed in writing within seven days.⁷

In practice

Sperm and testes must be removed from a deceased person and processing commenced within 24 hours of death to remain viable for IVF.

This guideline adopts the QHFSS procedures for managing IVF sperm retrieval from a deceased person whose body is under the coroner's control.⁸

The coroner must be notified of a person's intention to apply for authorisation for sperm removal for IVF.

⁶ Re Cresswell [2018] QSC 142 <https://www.sclqld.org.au/caselaw/QSC/2018/142>

⁷ *Transplantation and Anatomy Act 1979*, s.24

⁸ <https://www.health.qld.gov.au/healthsupport/businesses/forensic-and-scientific-services/forensic-services/death-autopsies/sperm-retrieval>

Pending authorisation the coroner and forensic pathologist should action any lawful, reasonable and non-invasive interim measures recommended by the nominated IVF organisation to prolong sperm viability. Given the extremely short timeframe in which these applications must be dealt with, it is hard to imagine a situation where the autopsy could not be delayed to accommodate sperm removal.

Once sperm removal is authorised, the coroner and forensic pathologist must make appropriate arrangements to enable the IVF organisation to carry out the order without delay and in a way that doesn't compromise forensic examination of the body. A record of the coroner's consent should be saved to the coronial file.