



Human Tissue Authority

Code of practice 3 Post-mortem examination

Section: The hospital post-mortem examination

An independent statutory regulator sponsored by  Department of Health

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The hospital post-mortem examination

Introduction

82. Following a death where a medical certificate of cause of death (MCCD) has been issued, the treating clinician may wish to request a PM examination to investigate further the cause of death, to improve knowledge of the disease or effectiveness of the treatment given. Where it can be issued, it is not acceptable to withhold the issue of an MCCD in order to refer a death to the coroner. Occasionally, a family may request a PM examination following the death of a relative.

83. Consent must be given before the PM examination is undertaken to ensure proper compliance with the HT Act.

84. Model consent forms for hospital PM examination are available on the HTA's website www.hta.gov.uk/guidance/model_consent_forms.cfm . In Northern Ireland, HSC Trusts and other relevant organisations should use the standardised consent forms agreed with the DHSSPS www.dhsspsni.gov.uk/index/hss/hoi-home/hoi-postmortem.htm . The forms are not prescriptive due to local variations in practice and may be adapted as necessary, providing they comply with the HT Act and the codes of practice. Consent forms are part of the consent process and should be supplemented with further discussion and more detailed explanation where necessary.

85. Consent must be sought for standard, limited, minimally invasive and non-invasive PM examinations. For further information on the consent requirements relating to images, refer to the [code of practice on Consent](#) .

86. Where consent has not been given by the person in life, consent for a hospital PM examination may be given by the deceased person's nominated representative (if there is one), a person in a qualifying relationship (see the [code of practice on Consent](#)) or, in the case of a child, those with parental responsibility. During the PM examination, tissue or whole organs (e.g. the heart) may be preserved for a range of scheduled purposes. If this happens, it must be in accordance with the provisions of the HT Act and consent given.

87. While consent to the PM examination and consent to the removal, storage and use of organs and tissue (including blocks and slides) are two separate decisions, they may be recorded on the same consent form. In most cases, a decision to withhold consent for the removal, storage and use of tissues for histological examination is likely to render the PM examination so uninformative that the pathologist decides it should not proceed.

88. A signed copy of the consent form should be included in the medical record.

Who may seek consent?

89. Anyone seeking consent for hospital PM examinations should have relevant experience and a good understanding of the procedure. They should have been trained in dealing with bereavement and in the purpose and procedures of PM examinations and they should have witnessed a PM examination. This may include a member of the medical team involved in the care of the patient prior to their death, and may also include someone closely aligned to pathology such as an APT or a specialist nurse.

90. It is usually the responsibility of the deceased person's clinician to raise the possibility of a PM examination, knowing the medical problems and the unresolved aspects that merit investigation. However, there may be several options for who actually discusses the PM examination with the relatives and obtains consent, and a team approach is common. Every hospital should have an effective and reliable procedure in place and responsibility for obtaining consent should not be delegated to untrained or inexperienced staff. Where a procedure is already in place, the establishment should review it to ensure it meets requirements of this code (see also [code of practice on Consent](#)).

91. Due to the small number of hospital PM examinations which are carried out, staff seeking consent may not have the opportunity to carry out this task on a regular basis and therefore there is a risk it may not be undertaken effectively. The establishment should provide staff members with a documented consent procedure, ensuring that the information provided to relatives and the manner in which consent is obtained are consistent.

92. Wherever possible, it is good practice for consent to be obtained by a person with whom the relatives have established a relationship. If the consultant in charge has not had close dealings with the patient's family during the last illness, relatives may find it helpful to have someone present whom they know and trust.

Example – Some Trusts use trained bereavement officers or APTs to seek consent for PM examination, supported by the treating clinicians and pathologists. By nominating a small number of trained people and ensuring that they are regularly involved with seeking consent for post mortem, the Trust can manage ongoing training effectively.

93. Whichever approach is taken, the hospital should have a named individual who can provide support and information to the bereaved if a PM examination is required.

94. Before the discussion with relatives, the responsible clinician should consider obtaining advice from a pathologist on which, if any, tissue is likely to be retained, for how long and for what purpose. Thereafter, the pathologist undertaking the PM examination should be available for a discussion with the deceased person's relatives if they wish.

95. Although healthcare professionals may recognise the need to obtain a speedy decision in order to maximise the benefit from a hospital PM examination, it is important that they do not convey to relatives any sense of being rushed. Before the PM examination, relatives may want to

spend as much time as possible with the family member who has died and it is important to try to ensure that they have this time. However, if more information or better results might be obtained from an early examination, this should be explained.

96. Consent may be given over the phone or by email. In these cases, checks should be made to ensure that the appropriate person has consented (see [paragraphs 99–100](#)). The content of the telephone conversation should meet the requirements of [paragraph 39](#) and be documented. Pathologists must satisfy themselves that the consent was appropriate and valid before proceeding with a PM examination.

97. Once a decision has been made to proceed with the PM examination and consent has been given, the family should be given the opportunity to change their minds or to change the scope of the PM examination. The time relatives have to reflect on their decision and the point up to which they may withdraw their consent should be clearly stated and should not be less than 12 hours. The HTA recommends 24 hours.

98. The pathologist conducting a hospital PM examination may feel that the conditions imposed by relatives with particular religious or cultural needs call into question or limit the value of the PM examination. In such cases, the pathologist should advise relatives of these limitations or, if necessary, that the investigation will not be carried out because it would be uninformative. This eventuality should be explained to relatives at the time of discussion. However, pressure should not be exerted on them as this would render invalid any consent given.

Who may give consent?

Consent -- Adults

99. Appropriate consent in the HT Act, means:

- i. the consent of the deceased person (if a decision to, or not to, consent was in place immediately before death)
- ii. where (i) above does not apply, the consent of a nominated representative appointed by the deceased person to deal with this issue
- iii. where (i) and (ii) above do not apply, the consent of someone in a 'qualifying relationship' to the deceased person immediately before that person died

100. There should be inclusive discussion where possible. Whilst it may be legally possible to carry out activities with the consent of the highest-ranking qualifying person (where no decision was made by the deceased person and there is no nominated representative) consideration should be given to the possibility of this causing distress and resentment in other family members if there is disagreement. See the HT Act www.opsi.gov.uk/acts/acts2004/ukpga_20040030_en_1 and the [code of practice on Consent](#) for further guidance.

Consent – Children

101. Consent may be given by:

- i. the child immediately before they died (if competent to reach a decision to consent); this would, however, be rare in practice and options ii. and iii. below are therefore more likely to apply
- ii. a person with parental responsibility for the child immediately before the child's death; or
- iii. in the absence of a person with parental responsibility, a person in a 'qualifying relationship' to the child at that time (see the [code of practice on Consent](#)).

102. A person who has parental responsibility will usually, but not always, be the child's parent.

103. Consent should always be obtained from the parents in case of pregnancy loss, regardless of gestational age.

104. Asking parents to agree to a PM examination of their baby or young child can present particular difficulties. The Stillbirth and neonatal death society (Sands) has published detailed guidance on communication with women or couples regarding all areas of pregnancy loss which may be found in [Pregnancy loss and the death of a baby: guidelines for professionals](#). It should be noted that this document is not available to view online but may be purchased through the Sands website www.uk-sands.org . The Department of Health's video [Respect for the dead: care for the living guide to the post mortem procedure](#), is also a useful aid when discussing this topic www.dh.gov.uk/en/Publicationsandstatistics/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4090087 . The Department of Health, Social Services and Public Safety (DHSSPS) (Northern Ireland) has also produced a [Careplan for women who experience a miscarriage, stillbirth or neonatal death](#) www.dhsspsni.gov.uk/hoi-careplan.pdf .

105. Guidance from the Royal College of Paediatrics and Child Health on [The future of paediatric pathology services](#) should be followed when conducting paediatric PM examinations www.rcpch.ac.uk/Publications . For further information, refer to the section on fetal tissue in the code of practice on Consent.

106. Women who have been the victim of a violent attack which has resulted in the loss of their unborn child need expert support to help them decide whether or not to consent to a PM examination of their baby, as this can not be authorised by the coroner. A multi-agency

approach, including liaison with the police, will be necessary.

Information to be given to relatives after a hospital post-mortem examination

107. Relatives should be told when the results are likely to be available and given the option of an appointment that will allow them to discuss the results with the clinician responsible for the deceased person's care, the pathologist or other specialist clinician where that would be helpful.

Example – In one Trust where consent is delegated to specialist nurses, the family are offered the option of receiving the results in writing. The results letter is drafted by the nurse, and shared with the pathologist and clinician before the final version is sent to the person who gave consent. The letter contains details of how to contact the clinician for a meeting if there are any further questions.

108. There may be occasions where the deceased person expressed a specific wish before death that information should not be shared with relatives and this should be respected as far as possible.

109. Care should be taken regarding the possible disclosure of information, such as genetic information or HIV status, which the deceased person may not have wished to be disclosed, or which may have significant implications for other family members. Healthcare professionals will have to make a decision, based on individual circumstances, about whether it is appropriate to disclose medical history or any other sensitive information about the deceased that the family may not be aware of. In making decisions, healthcare professionals will have to have regard to their duty of patient confidentiality and may have to consider the provisions of the Data Protection Act 1998 (www.opsi.gov.uk/Acts/Acts1998/ukpga_19980029_en_1). In certain circumstances, it may be necessary to share sensitive information with the family if the results of the PM examination have the potential to affect them or other relatives. For further guidance see GMC guidance on confidentiality (www.gmc-uk.org/guidance/ethical_guidance/index.asp) and the Department of Health's guidance on confidentiality (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253) which deals with disclosing information after a patient has died. See also the Welsh Assembly Government's guidance on confidentiality.

110. Some relatives will not want to know the results of the PM examination or will not want to discuss them in detail. Their wishes should be respected. However, they should be offered the opportunity to discuss the results at a later date.

111. Although in general, information about deceased patients should be treated in confidence, in these circumstances the relatives' legitimate wish for relevant information should be met with proper care and sensitivity, subject to any expressed wishes of the deceased person and any legislative restrictions on disclosure.

112. For parents who have suffered pregnancy loss or the death of a baby, the pathology results may raise many issues which it is important for them to discuss as a couple. These issues may require further discussion with other healthcare professionals, such as a genetic specialist. Parents should be offered the chance to have such a meeting. If they do not feel ready to take up that offer immediately, they should be provided with contact details so that they may contact them again at a later date. They should also be told who to contact (and how) if they have questions later on, and given details of national and local support organisations.

113. Subject to the parents' agreement, the report should also be given to the deceased child's GP or treating clinician, and to the mother's GP in the case of a neonatal death or stillbirth.