Care of the bereaved when postmortems are required

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**ABSTRACT** Teasdale, K. (2004) Care of the bereaved when postmortems are required. *Nursing Times;* 100: 36, 32–33. There are two kinds of postmortem – those undertaken by coroners and those undertaken in hospitals. The rules for consent depend on the kind of postmortem, and families must be offered much fuller information than before the Alder Hey Inquiry. As a result, nurses need to be clear about what is involved in a postmortem so that they can support families in asking the right questions and understanding the consent issues involved.

Bereavement is always distressing to family members. When the death is unexpected or its cause is uncertain a postmortem examination may be considered.

The inquiry into events at Alder Hey Hospital (House of Commons, 2001) showed that procedures for explaining postmortems and seeking consent were paternalistic and unsound. This led to a national review and the publication of guidelines on good practice related to postmortem (Department of Health, 2003a).

**Types of postmortem**

Coroners’ postmortems are carried out to determine the cause of death, and the family’s consent is not required for the examination, although it is required to retain organs/tissues for educational or research purposes. While their consent is not required, family members do need to understand what will happen in the postmortem and how it, or an inquest, may affect funeral arrangements.

Hospital postmortems are carried out to gain a fuller understanding of the illness or cause of death and to enhance future medical care. The valid consent of the family or those close to the deceased person is a legal requirement, even if the deceased has already given consent. Positive consent should be obtained from the mother for the use of her foetus or foetal tissue. Written consent must also be obtained if any tissue/organs are to be preserved from any postmortem for diagnosis, therapeutic purposes, medical education or research.

**Consent**

Although it is good practice to gain the patient’s consent to a postmortem this is a sensitive matter and staff should use their judgement in each case. Even then, the patient’s consent may not be binding if close family members do not also give their consent after the person has died. One of the main learning points from Alder Hey (House of Commons, 2001) is that those close to the deceased must be enabled to understand the reasons for postmortems, the processes involved and their rights.

The family must understand that consent for postmortem and consent for tissue or organ retention are separate decisions, so they may give consent for one but withhold it for the other. The discussion must also make clear the meaning of the term ‘human tissue’ (Box 1), the various purposes for its retention, and options to give or refuse consent for the retention of any particular organ or tissue and for any particular use.

It is important to recognise the complexities of modern family relationships, which include cohabitation and same-sex partnerships. When asking patients to nominate their next of kin, nurses should make it clear that this is more than a contact number and may be needed in consent issues. It should also be made clear that the nominated next of kin does not have to be a blood relative or spouse and may be a same-sex partner or even a close friend. All reasonable steps should be taken to contact the nominated next of kin or, failing that, a member of the family to seek consent. There may be more than one next of kin, but it is not necessary to trace them all if this is not practical. If no relatives can be traced and there is no evidence of an objection on the part of the deceased person, a hospital postmortem may legally be carried out, but the decision should be made by the chief executive or designated senior manager or clinician.

Discussions about postmortems (Box 2) should take place in an area with suitable privacy and comfort, and the family should not feel rushed, even if an early postmortem is needed when postmortems are required.

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**Box 1. Definition of human tissue**

‘Human tissue’ includes organs, parts of organs and tissue in various forms, such as frozen sections and samples fixed in paraffin wax. According to the DoH (2003b), in postmortems small pieces of tissue are removed – usually less than 1 cm² and up to 5 mm thick, though samples from the brain may be larger at about 2 cm². The tissue is chemically treated so that sections can be cut from them. Sections are 10 times thinner than a human hair and are placed on slides for examination with a microscope. These techniques are also used to examine tissue samples from living patients. Larger organs, such as the heart or brain, may need to be preserved with chemicals for some weeks before blocks can be taken. Families need to know this so they can decide how they are to be disposed of subsequently.

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**REFERENCES**


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**WEBSITES**

CRUSE Bereavement Care: www.crusebereavementcare.org.uk

SANDS (Stillbirth and Neonatal Death Society): www.uk-sands.org
Religious or non-religious ceremony. The same options (usually burial or cremation) may be chosen, accompanied by a religious or non-religious ceremony. The deceased’s executor (or next of kin if there is no executor) has responsibility for disposal of the body. The timing of burial or cremation so that any remainder of tissues or organs and for what purposes

Options for what will happen to the body or remains and any organs or tissue removed – including tissue blocks – after the examination

Whether organs or tissue can be retained without time limit for medical research and any uses the family wishes to exclude

The timing of burial or cremation so that any human material removed can be reunited with the body if the family wish

A leaflet explaining postmortem is available to give to families (DoH, 2003b). Consent and decision-recording forms have also been produced (DoH, 2003a).

**References**
