Information about post-mortem examination for relatives

We appreciate that this is a very difficult time for you. You may have been told that the coroner has asked for a post-mortem examination to be performed on your relative, or you have been asked to consider giving your consent to a post-mortem. This leaflet aims to give you some information about the procedure, however, please ask the person who gave it to you if you have further questions or anything is unclear.

Why are post-mortem examinations performed?

There are two types of post-mortem (autopsy) examination. The first can be ordered by a coroner, for example if a death has occurred unexpectedly, immediately after surgery or as a result of an accident. Families do not have the right to object to a post-mortem ordered by the coroner to determine the cause of death however they do still have choices about what happens to any tissue removed during the examination.

The second is a 'hospital' or 'consented' post-mortem. In this instance a death certificate (medical certificate of cause of death MCCD) can be issued but there are still unresolved questions surrounding the death. These might relate to more precise disease classification, the extent of the medical condition or the effects of any treatment. Unexpected diseases might also be uncovered during the post-mortem. This type of post-mortem can only occur if consent is given by the person in the closest relationship with the deceased (the definitions and 'ranking' of relationships are listed on the consent form).

It is not necessary to wait for the PM report for funeral arrangements to proceed after a consented PM as the MCCD is already available. If the option 'information from post-mortem may be available later' has been marked on the MCCD the registrar will write to the issuing Dr after 2 months to ask if there are new findings in which case an addendum note can be added to the register. The original cause of death remains on the certificate.

The extra information about why someone has died can help families come to terms with the death. Occasionally there may be implications for other family members for example in hereditary diseases.

Who performs the post-mortem examination?

Post-mortems are carried out by pathologists. Pathologists are doctors who have specialised in diagnosis. The examination is either performed by a consultant or by a junior pathologist (supervised by a consultant) assisted by an anatomical pathology technologist. The team who treated the patient may be present during the examination or may attend the post-mortem at the end to hear the findings. Other doctors in training and medical students may also be present. You can nominate a representative to be present on your behalf if you wish.

Where is it done?

Hospital post-mortems are performed in the mortuary located within the hospital.
When a coroner requests a post-mortem they usually ask that the body is moved to a different location, for example the mortuary at Newton Street in central Birmingham.

When will it happen?

If the post-mortem is carried out at the coroner's request, it will usually take place within a week of the patient dying.

A hospital post-mortem usually is carried out between 24–48 hours after the consent form has been signed.

What happens during post-mortem examination?

The body of the deceased is treated with respect at all times. During the procedure organs are removed, weighed and dissected. Photographs and X-rays may be taken.

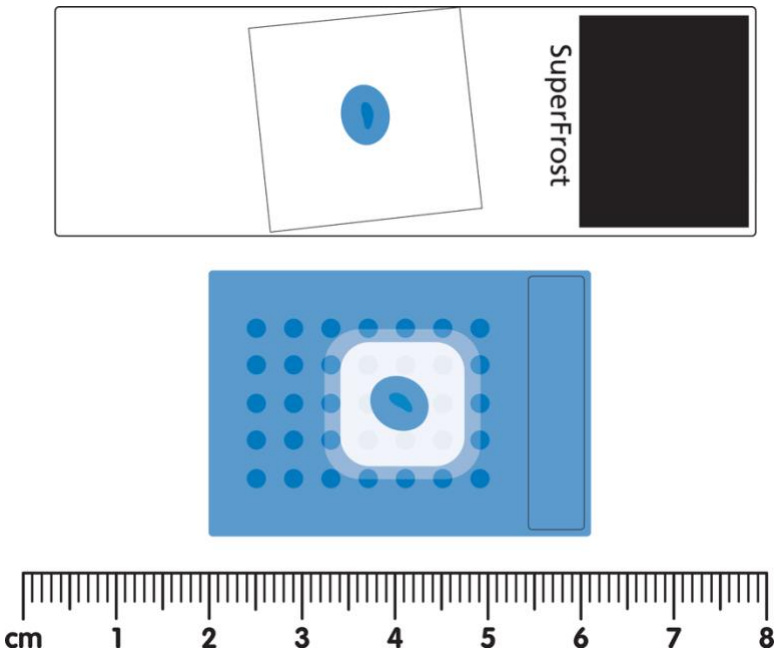
Post-mortems can be full or limited

In a full post-mortem examination all areas are examined. This gives the maximum possible information about the deceased. An incision (cut), like that used in surgical procedures, is made down the front of the body centrally to allow access to the chest and abdomen. The brain is examined via an incision around the back of the head within the hair. Unless there is a risk of infection, the family are still able to view the deceased after the post-mortem. No incisions are made on the face, arms or legs.

In a limited post-mortem only one area of the body, or even only one organ, is examined. Sometimes this can be performed through making an incision on an existing surgical scar. This type of examination will limit the information available from the examination.

Why do tissue samples need to be taken and what happens to them?

Only limited information can be gained from naked eye examination therefore it is often necessary to take small samples of tissue to investigate. These samples, known as biopsies, are similar to tissue samples taken when diagnosing illnesses in living patients. These are made into 'cassettes' and 'slides'. The pieces of tissue in the cassettes are approximately thumb-nail sized. The small pieces of tissue left over after making the cassettes are disposed of.



The slides are examined by the pathologist to characterise diseases as accurately as possible. After this has been done you can opt to have the slides and cassettes disposed of respectfully or you can give consent to them being stored for future use. These uses might relate to the deceased and their family exclusively, for example if a question arose after the illness of another family member, or if a new test becomes available. Other uses would be audit/quality control, education and research. The tissue is a very valuable resource for teaching junior doctors and medical students and also researching the causes and potential treatments of diseases.

Why is a request being made to retain a whole organ?

Sometimes the questions relating to a death mean that it is necessary to retain a whole organ for examination. This usually applies to the brain, for example in suspected cases of CJD, or the heart. Expert second opinions may be requested to confirm the diagnosis. If consent is given for the retention of a whole organ, you will have choices about what happens to the organ once the examination is complete. These include returning the tissue to the body (please note that this may delay funeral arrangements), storing it for future uses as outlined above under the section on tissue samples, or requesting that it be respectfully disposed of by the hospital.

How will I find out about the results?

After the examinations are complete the pathologist writes a report. This can take **up to 8 weeks**. In coroners cases this report belongs to the coroner. The coroner may issue a Medical Certificate of Death or may hold an inquest. The contents of the report will be discussed at the inquest.

In hospital cases a copy of the report is sent to the consultant who was caring for the deceased and also to the GP. A meeting can be arranged for you to discuss the results of the post-mortem.

Unfortunately even after the most thorough investigations, some questions may remain unanswered. In this situation many families take some comfort in knowing that there was a thorough investigation and some information of potential benefit to future patients may have been gained.

Contact numbers

Heartlands Hospital

Bereavement: 0121 424 1476
Cellular pathology: 0121 424 3884

Queen Elizabeth Hospital Birmingham

Cellular pathology: 0121 371 3326
Bereavement: 0121 371 2450

We aim to get this leaflet to you before a consent discussion regarding PM. Please use the space below to write down any questions you may have and bring this with you. You will also have a specified period to change your mind if you consent to an examination.

Accessibility



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