Southern Trust Policy on Consent for Hospital Post-Mortem Examination

December 2012
## Policy Checklist

<table>
<thead>
<tr>
<th>Name of Policy:</th>
<th>Policy on Consent for Hospital Post Mortem Examination</th>
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<tbody>
<tr>
<td>Purpose of Policy:</td>
<td>The purpose of this policy and its procedure appendix is to guide compliance with the Human Tissue Authority (HTA) requirement that Trusts have a policy on consent for hospital PM examination that complies with the Human Tissue Act 2004 and HTA codes of practice. This policy will ensure that where possible, the wishes of the deceased person and those close to them are known, understood and taken into account and to ensure that PM examinations are undertaken with appropriate consent.</td>
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<tr>
<td>Directorate responsible for Policy:</td>
<td>Medical Directorate</td>
</tr>
</tbody>
</table>
| Name & Title of Author: | HSC Bereavement Network  
Chair: Mrs Patricia Donnelly, Director Acute Services BHSCT  
SHSCT Representative: Mrs Anne Coyle, Bereavement Coordinator  
Released to all HSC Trusts by the Chief Medical Officer, DHSSPS in circular HSS(MD) 48/2012 on 14th November 2012 |
<p>| Does this meet criteria of a Policy? | Yes |
| Trade Union consultation? | Not Applicable |
| Equality Screened by: | Western Trust on behalf of the region |
| Date Policy submitted to Policy Scrutiny Committee: | 10th December 2012 |
| Members of Policy Scrutiny Committee in Attendance: | Vivienne Toal, Head of Employee Engagement &amp; Relations (Chair), Anne Brennan, Senior Manager, Medical Directorate, Anita Carroll, Assistant Director of Acute Services – Functional Support Services, Claire Graham, Head of Corporate Records (for Siobhan Hanna), John Graham, Trade Union Side representative, Carmel Harney, Assistant Director of Allied Health Professionals, Governance &amp; Workforce Planning, Marita Magennis, Head of Social Work and Social Care Governance, Stephen McNally, Director of Finance &amp; Procurement, Fiona Wright, Assistant Director of Nursing Services, Governance &amp; Workforce Planning |
| Policy Approved/Rejected/Amended | Approved |
| Policy Implementation Plan included? |  |
| Any other comments: |  |
| Date presented to SMT |  |
| Director Responsible | Dr John Simpson |
| SMT Approved/Rejected/Amended |  |
| SMT Comments |  |</p>
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<th>Policy Document – Version Control Sheet</th>
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<td><strong>Supersedes</strong></td>
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<td>Description of Amendments(s)/Previous Policy or Version:</td>
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<tr>
<td><strong>Originator</strong></td>
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<tr>
<td>Trust representative: Anne Coyle, Bereavement Coordinator</td>
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<td><strong>Scrutiny Committee &amp; SMT approval</strong></td>
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<tr>
<td>Date of Referral: Scrutiny Policy Committee Approval (Date)</td>
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<tr>
<td><strong>Circulation</strong></td>
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<td><strong>Review</strong></td>
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<tr>
<td>Responsibility of (Name): Anne Coyle</td>
</tr>
</tbody>
</table>
Title: HSC Consent for Hospital Post-Mortem Examination
Regional Policy

Appendix 1: Procedure for Obtaining Consent for Hospital Post-Mortem Examination
Appendix 2: Process Summary: Consent for Hospital Post-Mortem Examination

Operational Date: September 2012
Review Date: September 2014

Type of Document: Clinical
EQIA Screening Date: Equality Screened on 23 November 2010 - EQIA not required

Replaces (if appropriate):

Lead Author: HSC Trust Bereavement Coordinators
Chair of Bereavement Network Board: Dr Patricia Donnelly, BHSCT

HSC Bereavement Network Board Approval: 21st January 2011
HSCBN 01(P) January 2011

DHSSPS Approval: Issued to Trusts on 14th November 2012 in HSS(MD)48/2012

Trust Approval: Adopted as Southern Trust Policy at the SHSCT Policy Scrutiny Committee on 10th December 2012
Southern Trust Policy on Consent for Hospital Post-Mortem Examination

1.0 Introduction

This document has been developed to standardise policy and practice regarding consent for hospital post-mortem (PM) examination across all HSC Trusts. It defines accountability for Trusts to ensure they meet their responsibilities for obtaining valid consent in compliance with the Human Tissue Act.

2.0 The Purpose

The Human Tissue Authority (HTA) requires Trusts to have a policy on consent for hospital PM examination. The HTA regulates activities concerning the removal, storage, use and disposal of human tissue. Trusts require a licence from the HTA to carry out PM examinations and other licensable activities and are inspected by them. A regional procedure for seeking consent for hospital post-mortem examination is attached (see appendix 1) and a process summary (see appendix 2).

3.0 Scope of the Policy

This policy applies to:
- clinicians who will seek to obtain consent for hospital PM examination
- members of staff who support the consent process
- pathologists
- trust bereavement coordinators
- mortuary staff

4.0 Policy Objectives

- to comply with the Human Tissue Act and HTA codes of practice
- to ensure that where possible, the wishes of the deceased person and those close to them are known, understood and taken into account
- to ensure that PM examinations are undertaken with appropriate consent and within the stipulations of the consent
- to ensure that there is clear documentation of the family’s wishes on the retention, use and disposal of organs and tissue
- to ensure that organs and tissue are only retained with consent
- to promote good communication between all parties involved and ensure that the family are treated with sensitivity and compassion which acknowledges the loss they have experienced

5.0 Policy Statement

- The Southern HSC Trust is committed to ensuring that consent is obtained for all hospital PM examinations in compliance with the Human Tissue Act
- this policy should be read in conjunction with relevant legislation, policy, procedure, protocol and guidelines (see 8.0).
6.0 Roles and Responsibilities

6.1 The Designated Individual* (DI), appointed by the Licence Holder (the Trust), has the statutory responsibility under the Human Tissue Act to supervise licensed activities. They have a duty to ensure that suitable practices are carried out by those working under the licence, that the premises are suitable and that the conditions of the licence are complied with. (*Dr Grainne McCusker, Clinical Director Pathology and Laboratory Services)

6.2 Directors are responsible for ensuring that this policy is disseminated to all relevant staff and that training slots are made available in their directorate/division.

6.3 All staff involved with seeking consent and supporting the relatives must have knowledge of PM examinations and access training (every 3 years) in the process involved in obtaining valid consent for hospital PM examination.

6.4 Pathologists and Trust Bereavement Coordinators will offer training sessions which will include an overview of the legislative requirements under the Human Tissue Act and role of the Human Tissue Authority, the responsibilities of staff seeking consent, guidance on completion of consent forms and sensitive management of people who are bereaved.

6.5 Trust Bereavement Coordinators will maintain training records for audit by the HTA.

6.6 The DI will arrange for an annual audit of Consent Forms to be carried out to assess compliance with HTA requirements and to identify further training needs.

7.0 Policy Background

Following the Bristol Royal Infirmary Inquiry (1999) and the Alder Hey Inquiry (2001) which led to the Human Organs Inquiry (2001) and the publication of the O’Hara Report (2002) in Northern Ireland, the DHSSPS developed regional guidance, consent forms and accompanying information booklets for relatives on hospital consented post-mortem examination.

The Human Tissue Act was updated in 2004 and became law on 1st April 2006. The Human Tissue Act established the Human Tissue Authority (HTA) to regulate activities concerning the removal, use and disposal of human tissue. The HTA Codes of Practice 1, Consent and 3, Post-mortem Examination, give practical guidance to professionals carrying out activities which lie within the remit of the HTA (see 8.0).

8.0 Source/Evidence Base

- Human Tissue Act, 2004
- Code of Practice 1 - Consent (HTA, 2009)
- Code of Practice 3 - Post-mortem examination (HTA, 2009)
- Code of Practice 5 - Disposal of human tissue (HTA, 2009)
- Care Plan for women who experience miscarriage, stillbirth or neonatal death (DHSSPS, 2005)
- Good Practice in Consent for Examination, Treatment or Care (DHSSPS, 2003).
9.0 Alternative Formats

This document can be made available on request on disc, larger font, braille, audio-cassette and in other minority languages to meet the needs of those not fluent in English.
Appendix I

Procedure for Obtaining Consent for Hospital Post-Mortem Examination

1.0 Procedure

Post-mortem (PM) examination is important for informing relatives, healthcare professionals and other interested parties about the cause of death. Following a death which does not meet the criteria for referral to the Coroner, the treating clinician may wish to request a hospital PM examination to investigate further the cause of death, to improve knowledge of the disease or effectiveness of the treatment given. Occasionally relatives may request a PM examination.

2.0 Who may seek consent?

2.1 It is usually the responsibility of the deceased person’s clinician to raise the possibility of a PM examination however others in the team may be involved in the consent process.

2.2 The need for a hospital PM examination of a child must be discussed with the child’s consultant and consent must be obtained by an experienced clinician.

2.3 The person seeking consent should be a senior doctor/healthcare professional who has sufficient experience and is able to explain the purpose and procedures involved. They should have training in seeking consent for hospital PM examination. They should also have training in communicating with people who have been bereaved. Preferably, they should have witnessed a PM examination.

3.0 Who may give consent?

3.1 Adults

3.1.1 A decision to consent to or refuse a hospital PM examination can be made by a patient in advance (advance directive) or by a nominated representative who has been appointed by the person while competent. Advance consent can be verbal or written, but must be recorded and signed by two witnesses.

3.1.2 If no advance decision or nominated representative is in place, then the consent of someone in a ‘qualifying relationship’ must be obtained. The following list gives the order of qualifying relationships (highest first):

1) Spouse or partner (including civil or same sex partner)*
2) Parent or child**
3) Brother or sister
4) Grandparent or grandchild
5) Niece or nephew
6) Stepfather or stepmother
7) Half-brother or half-sister
8) Friend of long standing

*The Human Tissue Act states that, for these purposes, a person is another person’s partner if the two of them (whether of different sexes or the same sex) live as partners in an enduring family relationship. **In this context a child may be of any age and means a biological or adopted child.
3.2 Children

3.2.1 In the case of a child, consent can be given by a competent child*** before death or by a person with parental responsibility**** (nominated representatives do not apply in the case of children).

3.2.2 Ideally consent should be obtained from both parents and if either parent objects, the PM examination should not proceed.

3.3 Babies

3.3.1 In the case of a baby, the possibility of a PM examination should be discussed with the parents of all babies who die.

3.3.2 In circumstances where the baby has died in the womb, the mother’s signature is essential; however both parents can sign the consent form.

3.3.3 The clinician seeking consent needs to be aware of the burial or cremation arrangements provided by the Trust, should the parents choose this option.

*** Competent child
Those aged 16 years or over are presumed to be capable of giving consent for themselves – as are younger children who are deemed to have sufficient understanding and intelligence to enable him or her to understand fully what is proposed (sometimes known as Gillick or Fraser competence).

**** Parental responsibility
The person(s) with parental responsibility will usually, but not invariably, be the child’s birth parents. People with parental responsibility for a child include: the child’s mother; the child’s father if married to the mother at the child’s conception, birth or later; or if unmarried if he is named on the child’s birth certificate (with effect from 15 April 2002); a legally appointed guardian; the Health and Social Services Trust if the child is the subject of a care order; or a person named in a residence order in respect of the child. A father who has never been married to the child’s mother or, after 15 April 2002, whose name has not been included on the child’s birth certificate, will only have parental responsibility if he has acquired it through a court order of parental responsibility agreement with the child’s mother.

4.0 Discussing the PM examination with the family

4.1 People who are bereaved should be treated with respect and sensitivity at all times. They should be given support to help them take important decisions at a difficult time.

4.2 As a first step, a willingness to discuss the possibility of PM examination should be established or if the family are unwilling to discuss, a note to that effect should be made in the patient’s medical records.

4.3 Staff need to be aware that certain religious beliefs or cultural requirements will not allow relatives to consider PM examination.

4.4 Provisions must be made to ensure that people who have communication difficulties, or whose first language is not English receive the assistance they require to understand and provide valid consent.
4.5 The next of kin information recorded in the patient’s health records is used by staff to identify the person from whom to seek consent for hospital PM examination. However the named next-of-kin may not be the person in the highest ranking qualifying relationship under the Human Tissue Act. The staff member seeking consent therefore needs to ask the next of kin if they are the person in the highest ranking qualifying relationship. If they are not, information should be requested about who is the highest ranking person and reasonable efforts made to contact the person prior to the PM examination taking place. This information should be documented on the consent form.

4.6 There may be situations where it may not be possible to seek consent from the person in the highest ranking qualifying relationship. The Human Tissue Act allows for this person to be omitted from the hierarchy if they cannot be located, declines to deal with the matter or is unable to give valid consent; for example, because they are a child or lack capacity to consent. In such cases, the next person in the hierarchy would become the appropriate person to give consent.

4.7 Consent is only required from the highest ranking person in the qualifying relationship, however, if there is disagreement between family members of equal rank (e.g. son and daughter), they may need to be given more time and information to help resolve the position. If agreement is not reached the PM examination should not proceed.

4.8 Consent is only valid if proper communication has taken place. The discussion should include:

- honest, accurate, clear, objective information
- the opportunity to ask questions
- reasonable time to reach decisions
- privacy for discussion with other family members
- emotional/psychological support, if required
- an opportunity to change their minds within an agreed time limit
- a realistic timeframe for results and the way in which these will be communicated

4.9 Booklets are available for baby and child / adult PM examinations, to give written information to support the discussion with families.

4.10 Relatives should be provided with the name and telephone number of a nominated member of staff whom they can contact if they have further questions.

4.11 Relatives should be made aware that other professionals may witness the PM examination for education purposes, unless they have any objection.

4.12 The clinician should contact the pathology department, discuss the PM examination request and confirm the arrangements, including timing and place of examination. It is important for the family to know when they are making their decision about the post-mortem examination, when it will take place and when the body can be released so that they can make arrangements for the funeral.
5.0 Documenting consent

5.1 Two regional consent forms are available (in triplicate) for supporting discussions and recording decisions around consent for hospital PM examination and relatives wishes about use, disposal or return of tissue.

- **Consent for Hospital Post-Mortem Examination of Children over 28 days old and Adults.**

- **Consent for Hospital Post-Mortem Examination of a Baby: Use for intrauterine deaths of babies greater than 6 cms crown rump size (usually more than 12 weeks gestation) and neonates of up to 28 days of age.**

A form is also available to record **Consent for Histopathological Examination and Disposal of Early Miscarriages: Use for early pregnancy losses without fetal remains or with a fetus less than 6 cms crown rump size, usually first trimester.**

5.2 The doctor/healthcare professional seeking consent should explain the range of choices available, the potential uses for any material retained and the disposal options. It is important to avoid recording contradictory choices e.g. ticking both ‘return of organs’ and ‘hospital disposal’.

5.3 All decisions should be recorded, including refusal of consent and the form signed both by the person seeking and the person giving consent.

5.4 A detailed clinical history/summary and, if requested, the patient’s health records must be sent to the Pathologist and the three copies of the consent forms should be distributed or filed as follows:

- top copy, with signature in ink, must be sent to the Pathologist
- middle copy is given to the person giving consent as a record of the decisions he/she made
- bottom copy should be filed in the patient’s health records
- if consent is withdrawn during the discussion a line should be put through the form and all three copies filed in the patient’s health records.

5.5 In addition, details of the discussion should be recorded in the patient’s health records.

5.6 Before the PM examination begins, the Pathologist must check that it has been properly consented to either by the deceased person before they died, their nominated representative or an appropriate relative and that consent has been obtained by an appropriate person.
6.0 Information to be given to relatives after a PM Examination

6.1 The clinician who has requested the PM examination is responsible for ensuring the relatives are informed of the findings. He/she may be able to give the relatives preliminary information immediately following the PM examination and/or arrange for an appropriate clinician to meet them at a later stage when the pathologist’s full report is available. The clinician needs to explain results using terms that can be easily understood and also be sensitive to the level of detail the relatives wish to receive.
Appendix 2

PROCESS SUMMARY: CONSENT FOR HOSPITAL POST-MORTEM EXAMINATION

- Consent is necessary for hospital post-mortem examinations, but not for those requested by the Coroner.
- In all post-mortem examinations the family will require oral and written information and support from hospital staff.
- In the first instance, a doctor who has been involved in the patient's treatment and care will identify the value of requesting a post-mortem examination, whilst appreciating the sensitivities required when communicating with a recently bereaved family.
- The doctor seeking consent should be of senior grade, have attended training and may be supported by additional members of the medical/nursing team.
- It should be ascertained whether any decisions/advance directives regarding post-mortem examinations were made by the patient prior to death.
- When completing forms, be careful not to record conflicting decisions (e.g. ticking both ‘hospital disposal’ and ‘return of organs’).

Approach family and establish if willing to consider discussing the value of a PM Examination. Enquire if they are aware of any known wishes of the patient.

Not willing to consider

Willing to consider

Still willing to consider

Record decision in patient’s health records.

Outline the procedure and requirement for consent. Provide information booklet. Allow time for questions and decision-making and explain that consent can be withdrawn any time prior to PM examination taking place.

Inform mortuary/pathology of possible PM examination. Select appropriate consent form (Key 1) and take ‘qualifying person’ (Key 2) through it.

Decision to withhold

Decision taken by family to withhold consent at any time before PM examination commences

Decision to continue with consent process

Record decision in patient's health records and on consent form, and put a line through consent form.

Inform Mortuary/Pathology

Ascertain and record decisions at each section of the form, and advise when and how the results will be made available and explained.

Forward top copy of form to mortuary and provide qualifying person with middle copy; retain bottom copy in patient’s health records.

Proceed with PM examination and notify family of results, as agreed.

KEY 1: Consent Forms
a. Child over 28 days / Adult
b. Baby – usually more than 12 weeks gestation up to 28 days
c. Histopathological examination and disposal of early miscarriage - fetus less than 6 cms crown rump size

KEY 2: Qualifying Relationships
a. Spouse or partner (including civil or same-sex partner)
b. parent/child
c. brother/sister
d. grandparent/grandchild
e. niece/nephew
f. step father/mother
g. half brother/sister
h. friend of longstanding