



CHIEF CORONER

GUIDANCE No. 26

ORGAN DONATION

1. The purpose of this guidance is to help coroners with decision-making in situations that concern organ and tissue donation. It is intended to assist coroners on the law and procedures to be followed when dealing with post mortem organ and tissue donation, with a view to providing greater consistency of approach across all of England and Wales.
2. It is also hoped that the guidance will provide the National Health Service Blood & Transplant (NHSBT), staffed by specialist nurses for organ donation (SNODs); clinical leads in organ donation (CLODs); eye banks, staffed by ocular tissue donor co-ordinators (ocular co-ordinators); transplant surgeons; intensive care physicians; police officers and others, with a clear understanding of the relevant law and procedure and an understanding of the role of the coroner.
3. SNODs are responsible for promoting and facilitating the entire donation process by working in conjunction with all staff in critical care areas to support and maximise organ and tissue donation.
4. This guidance is designed to better enable all those concerned to discharge their different and independent functions, and to use limited resources to best effect. The premise of the guidance is that allowing organ and tissue donation to go ahead where possible is in the wider public interest.

Legal basis for the involvement of a coroner.

5. In England, removal of organs for the purpose of organ donation requires consent in accordance with the *Human Tissue Act 2004*, either from the deceased before death, or from next of kin after death.
6. In Wales, under the *Human Transplantation (Wales) Act 2013* there is deemed consent unless the deceased has opted out.
7. Whether death occurs in England or Wales, while inquiries are made on behalf of the coroner, the coroner has the right and duty in law to keep possession of the body. She has authority over the physical control of the body (*R v Bristol Coroner ex parte Kerr [1974] QB 652*) and there can be no interference without the coroner's authority.

8. Thus, when a death is reportable to a coroner in England and the consent of the deceased or family members has been given for organ or tissue donation, or in Wales there is deemed consent, the relevant coroner must be asked whether she has any objection to that donation taking place.

Human Tissue Act 2004

Section 11

- (2) *Where a person knows, or has reason to believe, that –*
- (a) *the body of a deceased person, or*
 - (b) *relevant material which has come from the body of deceased person, is, or may be, required for purposes of functions of a coroner, he shall not act ... except with the consent of the coroner.*

Human Transplantation (Wales) Act 2013

Section 14

- (2) *...where a person knows, or has reason to believe, that –*
- (a) *the body of a deceased person, or*
 - (b) *relevant material which has come from the body of deceased person, is, or may be, required for purposes of functions of a coroner.*
- (3) *The consent of the coroner is required before the person may act ... in relation to the body or material.*
9. If there is no consent for donation, then the coroner's objection or otherwise is irrelevant: the donation cannot proceed.

However, it may well be that the coroner is approached for a view before any discussion with the family of the deceased, in order to save the family the distress of consenting to donation only to have the coroner object. This is perfectly acceptable.

10. Though there is often colloquial reference to the coroner's consent, and although the Human Tissue Act and the Human Transplantation Act make reference to acting with the consent of the coroner, the coroner cannot consent to organ or tissue donation, the coroner can only object or raise no objection. If the coroner does object, the donation cannot proceed.

The coroner's jurisdiction

11. If the coroner is not going to make inquiries into the death, she does not have the right or duty to take control of the body and so does not become involved in the question of organ donation.
12. Section 1 of the Coroners and Justice Act defines those deaths that the coroner has a duty to investigate as follows.

Coroners and Justice Act 2009

Section 1 (2)

...the coroner has reason to suspect that -

- (a) *the deceased died a violent or unnatural death,*
- (b) *the cause of death is unknown, or*
- (c) *the deceased died while in custody or otherwise in state detention.*

13. So, if the death does not fall into one of these three categories and therefore the treating clinicians, having considered the matter carefully, are not going to report it to the coroner, it will not be necessary to contact the coroner on the question of

organ donation. Any question of donation will be determined on the basis of consent in accordance with the *Human Tissue Act 2004*, either from the deceased before death, or from next of kin after death.

The decision maker

14. Where the coroner is involved, the decision about whether to object to donation is a judicial decision. Only the sitting coroner, be that the senior coroner for the area in which the deceased lies, an area coroner or one of the assistant coroners for that area, can make this judicial decision.
15. A coroner's officer cannot make the decision. For a coroner's officer to purport to make the decision would be unlawful.

*The Coroners (Investigations) Regulations 2013
Regulation 7*

A coroner may delegate administrative, but not judicial functions, to coroner's officers and other support staff.

However, the usual route for communication of the coroner's decision is through his or her coroner's officer.

16. Similarly, no police officer, regardless of rank, can make the decision regarding organ donation, nor can they countermand the decision of the coroner. For a police officer to purport to make the decision would be unlawful.
17. If a police officer has concerns about the coroner's decision, they may make representations to the coroner. A more senior police officer may be asked to make representations. Ultimately, it is open to the police to seek a judicial review of the decision in the High Court.
18. It might be that a coroner will seek transfer of the death investigation to another coroner at a later date, because, for example, the events leading to death took place in a different coroner area. Even if that is the case, the coroner in whose area the body lies at the time of donation is the coroner who must make the decision about whether to object to donation.

Timing of approach to the coroner

19. The jurisdiction of the coroner only arises once death has taken place, so the coroner has no power to make a decision about organ donation until the donor has died. However, to wait until death has occurred would frustrate almost all donations, as it usually takes several hours to notify, assemble and prepare the retrieval teams, the transplant teams and the recipients.
20. Coroners will appreciate that, if there is a question of organ or tissue donation, the first contact made with them is likely to be before death. The coroner should consider the referral as soon as it is made. Where a death is likely, the coroner should be fully engaged with those treating the person and the family¹ so as to ensure that any donation decisions can be made.

¹ Although this would be a matter for the individual coroner, typically this discussion can be facilitated through the treating clinicians or other appropriate persons

21. Once they are provided with the necessary information about an imminent death, the coroner should give an indication as to whether she will object to organ donation.
22. This indication can be taken as the coroner's decision as at the moment of death, unless in the meantime new, relevant information has come to light about the circumstances of the death, in which case the coroner should be contacted again. When a SNOD is aware that an imminent death is reportable to the coroner and therefore authority is needed to go ahead with donation, if this is in office hours she should contact the coroner's office immediately. It is of great assistance to the coroner to have the first report made in office hours, when the coroner's office is staffed, resources are easily accessed, and contact can more readily be made with others.
23. Office hours for each coroner's office vary and SNODs & ocular co-ordinators should acquaint themselves with these for each office. Hours are often around 8am to 4pm.
24. Coroners tend to begin the day's sitting in court at 10am, and so contact should be made well before then if that is possible; if it is not possible then preferably before lunch when they are likely to rise to consider the morning's reports of death.
25. The vast majority of coroner's officers do not work on a shift basis, they work during the office hours advertised and then are on call. After a night on call, there may still be a working day ahead.
26. Coroners are available for urgent matters as defined by regulation 4 of The Coroners Regulations. In some areas, the coroner is on call without coroner officer support.

*The Coroners (Investigations) Regulations 2013
Regulation 4*

A coroner must be available at all times to address matters relating to an investigation into a death which must be dealt with immediately and cannot wait until the next working day.

The regulation 4 duty is typically taken to arise in respect of homicides and major disasters. However, given the futility of a coronial decision when organs are no longer viable, senior coroners should make themselves or their assistants available out of hours to consider requests pre-investigation for organ and tissue donation.

27. Coroners will normally consider time critical requests for organ donations to proceed at any time of the day or night, but calls to the coroner's officer/coroner should not be made out of office hours that could reasonably have waited until the following day.
28. If a call has to be made out of hours, it is preferable for this to be done in the daytime if at the weekend, or early evening if on a weekday, rather than overnight.
29. A night time call is generally only appropriate if the fatal injury and death both occur out of hours, and the retrieval needs to take place out of hours during that same window of time (i.e. that same night).

30. SNODs and ocular co-ordinators should make themselves aware of the local coroner's protocols. It is often helpful for the local coroner, SNODs and ocular co-ordinators to meet to discuss procedure, and sometimes even to draw up a memorandum of understanding.

SNOD's report to the coroner

31. When a SNOD makes a call to the coroner's office, regardless of the time of day or night, they should give full details of the case at the first call.

32. This will vary on a case by case basis, but should always include name & telephone number of the SNOD; name of the deceased, date and place of death and date of birth.

33. The details should not simply describe the course of events in hospital, but also what prompted admission. The description should include such details as, for example, whether a collapse was witnessed and, if so, by whom, and exactly what was seen.

34. The SNOD should also give the treating consultant's view of the medical cause of death. It may be necessary for the consultant to come to the phone to discuss personally.

35. Finally, the SNOD should give the anticipated timeframe of organ retrieval.

Homicides

36. If there is any possibility that death may have been caused by another, hospital staff must inform the police. If this has not taken place by the time the SNOD becomes involved, the SNOD should ensure that it has been done before contacting the coroner's office.

37. When the SNOD telephones the coroner's office, they should give a synopsis of the police view on donation if that is known, but in any event, should always endeavour to provide the name and telephone number of the senior investigating officer (SIO).

38. The coroner's officer or coroner should ask the SIO if they have any concerns about donation going ahead. To enable such a conversation to take place, the SIO should make themselves readily available to speak to the coroner's officer. If the SIO does have concerns, it is best practice for the coroner and the SIO to have a direct conversation about this.

39. The coroner will take the SIO's views into account. It might be that the SIO seeks the completion of certain tasks, such as photographing (see next section) before donation takes place. And the coroner might also wish to speak to a pathologist before making a decision. However, the decision about whether to object rests solely with the coroner.

40. The fact of an ensuing prosecution is not necessarily a bar to donation. Many donations have been followed by procedurally successful criminal trials. The coroner should ask him or herself the following questions. Is there any legitimate reason why donation should not go ahead in this particular situation? Would donation hamper the subsequent investigation?

Coroners should bear in mind that if a donor organ is poorly functioning and likely to be responsible for death rather than any traumatic injury suffered (a potential defence to a murder/manslaughter charge), then it will be poorly functioning after transplant, a fact easily identifiable later.

41. Very occasionally, the coroner will raise an objection to any organ being donated, for example in the case of a baby found dead with no relevant medical history.

Restricted or partial donations, and actions before or after donation

42. Some donation decisions, for example regarding corneal material, are usually easier than others. In some cases, the coroner may raise no objection to donation, but in others she may object to donation of some or all organs or tissue, or may ask that other actions be taken before donation can take place.
43. For example, the coroner may allow for donation of heart valves following dissection of the heart by a pathologist, in which case the SNOD may be asked to liaise with the pathologist on call, or the coroner may ask that the pathologist is present at organ retrieval. The coroner may ask for swabs to be taken before donation can take place, or the impression of bite marks, in which case it is likely that the police will be closely involved with this process. In each case, these actions must be carried out before retrieval of organs/tissue can take place.
44. In any event, the SNOD should instruct the retrieval surgeon that incisions for organ retrieval must not encroach upon any endotracheal tube, site of neck surgery or neck ligature indentation.
45. The SNOD should instruct the retrieval surgeon to document clearly all findings, including external injuries, and have these photographed (usually by the police).
46. The coroner may ask that the retrieval surgeon provides a statement under section 9 of the *Criminal Justice Act 1967*. If so, the SNOD should communicate that request and ensure that the relevant statement is prepared.

After donation

47. It is often appreciated by coroners when SNODs and ocular co-ordinators write after transplant with details of the organ recipients (e.g. a fifteen-year-old boy received the heart), provided it is acceptable to the family of the deceased for such a letter to be in the public domain. One organ donor can save up to eight lives by donating heart, lungs, liver, kidneys, pancreas and bowel. Sight may also be saved by donating corneas, and many lives vastly improved by tissue donation. Some coroners may choose to read out at inquest a SNOD's letter describing the organ recipients, and to offer public thanks.

**HH JUDGE MARK LUCRAFT QC
CHIEF CORONER**

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