MAGISTRATES COURT
TASMANIA

MAGISTRATES COURT *of* TASMANIA

CORONIAL DIVISION

Record of Investigation into Deaths (Without Inquest)

Coroners Act 1995
Coroners Rules 2006
Rule 11

I, Simon Cooper, Coroner, make the following findings in relation to human remains retained following coronial autopsies between 1966 and 1991 at the R.A. Rodda Museum, Hobart, Tasmania.

Background

1. During 2016, the Coroners' Office was contacted by the Curator of the R.A. Rodda Museum of Pathology ("the Museum") at the University of Tasmania. The curator wrote that she "would welcome the opportunity to discuss with the Coroner ***three*** specimens that we hold in our collection that had apparently been retained after a coronial *post mortem* examination without the consent or approval of a coroner or the families involved" [emphasis added]. The three specimens were said to have been sourced from coronial autopsies in 1982 and each were bone specimens.
2. The request was passed on to the Division's Long-Term Missing Persons working group. This working group was established in 2014 to systematically work through bone specimens held by Tasmania Police (or elsewhere) and connect them to long-term missing persons.
3. Further investigation revealed that potentially up to 482 individual samples of human remains had been retained by the Museum, between 1966 and February 1991, by forensic pathologists and hospital pathologists conducting autopsies.
4. Following an exhaustive investigation, the precise number of samples of human remains retained by the museum after coronial autopsy was ultimately determined to be 177.
5. The museum is part of the Faculty of Health at the University of Tasmania. It is located in Collins Street, Hobart. Established in 1966 by Dr Roland A. Rodda, Professor of Pathology, the Museum contains a comprehensive collection of a range of specimens, including:
    - Pathology specimens;
    - Historical objects;
    - A parasite collection; and
    - Medical equipment, documents and teaching resources.

6. The compilation of specimens began in 1966, with specimens being retained from autopsy and surgery for both teaching and research purposes. The collection is described as rich, varied and of great current and potential interest to existing users, University stakeholders, medical historians and the general public. It has been used since its establishment in the training of medical students in the area of pathology, and continues to this day to provide a history of disease in Tasmania.
7. It appears at this stage that now dead Forensic Pathologist, Dr Royal Cummings, was the person who provided the large majority of coronial specimens to the museum. However, it also appears that his predecessors and successors also engaged in the practice. It also appears that pathologists may have actively sourced specimens from coronial autopsies to give to the museum, as well as providing specimens that had been originally retained for forensic purposes under the *Coroners Act* 1957. It was identified that the practice of providing specimens to the museum finally ceased as recently as 1997, with the last specimen from a coronial autopsy having been provided in 1991.

The jurisdiction of the Coroner

8. Coronial findings in each relevant case were completed after the death in accordance with the former *Coroners Act* 1957. During the currency of that *Act*, in coronial cases under investigation where the body came under the control of the coroner, the coroner would invariably issue a burial warrant under section 51. This allowed the body to be released from the mortuary to the funeral home into the care of the family for burial arrangements. Under the 1957 *Act* the term "*body*" includes "*a portion of a human body*". There was no jurisdiction for a coroner to authorise removal or retention of any part of a dead body for any purpose other than investigating the manner and cause of death of that person. Similarly, any part of a dead body that had been removed and retained for legitimate coronial purposes should have been subject to a burial warrant by a coroner in consultation with the family and replaced in the body prior to burial. I note that there was no time limit for the issue of a burial warrant.
9. The coroner retains jurisdiction to issue burial warrants in respect of the specimens in question, pursuant to the *Coroners Act* 1957, section 51. This provision applies by virtue of the savings and transitional provision of the *Coroners Act* 1995, section 72. The coroner, under section 51, is not mandated to direct the burial warrant to the next of kin or any specified family member. However, the reality is that the release of the body from the mortuary, and from the coroner's control, should have been (and

certainly always is now) undertaken in consultation with relevant family members organising burial or cremation. I think it is reasonable to state that the expectation of families is (and would have been) that the body of their loved one is complete. The fact parts had been retained without knowledge or approval would come as a surprise to many, indeed most, members of the community. Now, if for legitimate forensic purpose retention of a body part is necessary, the current practice is to advise family of the retention of any body parts by the pathologist and to order disposal of those parts in consultation with the family when the forensic purpose has been served.

10. The coronial jurisdiction was and is limited by statute to determining particular matters – relevantly, the identity of the deceased, how death occurred and the cause of death. The same limits are therefore placed on the forensic pathologist conducting the *post mortem* examination. Body parts sourced or retained from the *post mortem* examination cannot be used for medical research or education, at least not without the knowledge and consent of relevant family members. This is the case notwithstanding that the motivation of the pathologist may have been benevolent.
11. Under the 1957 *Act*, body parts should be properly the subject of a burial warrant by the coroner once forensically examined for coronial purposes, even if the body itself has already been the subject of an earlier burial warrant. There is no evidence, at all that burial warrants issued for any of the specimens in question, or that the original coroners were even aware of the disposition of the specimens to the museum.
12. Therefore, I consider I have jurisdiction to issue burial warrants in respect of the specimens, the existence of the specimens (that is human remains or body parts) having been formally reported to the Division.

The historic practice of retention of body parts

13. The practice of retaining organs from autopsy attracted significant national and international attention in 1998 following the Bristol Royal Infirmary Inquiry and autopsy practices at the Royal Liverpool Children's Hospital in the United Kingdom.
14. In Australia, public inquiries in a number of states including the Walker Inquiry in New South Wales raised concerns regarding retention of organs at autopsy.
15. In response to these concerns the Federal Minister for Health initiated a report from the Australian Health Ethics Committee (AHEC) titled 'Organs retained at Autopsy: Ethical and Practical Issues'. The report made recommendations about what should be done about organs currently held by institutes as a result of autopsies. The Australian Health Ministers Advisory Council subcommittee on autopsy practice issued a final

report in April 2002 which set out guidelines, principles, procedures and a national code of practice for autopsy procedures to provide informed consent and procedures for handling and disposal of organs after autopsy to address the community's concerns and expectations regarding the practice of organ retention. Suffice it to say the body parts retained by the museum were not handled in accordance with those guidelines.

16. It is apparent that following the Walker Inquiry, the relevant minister and department were made aware of the practice in Tasmania, but no action was taken. I also observe that that inaction included not advising the Coronial Division of the practice.

The current situation

17. The belated discovery that human remains were removed at autopsy and not returned to the body has been a source of pain and anger for many families. The Coronial Division, while addressing the issue, has endeavoured to not make that pain and anger worse.
18. At my direction, in 2018, the relevant remains were removed from public display in the Museum to a more secure location within the University with limited access. Following this, records were reconciled as it was ultimately determined, as I have mentioned, that 177 specimens had been retained without authority, following coronial autopsies.
19. In February 2022, a manual search was commenced for the matters within Coronial records to identify if any of the matters were existing coronial cases. It took nearly 12 months to search through our records and not all records were able to be found or identified due to our records of matters in the 1980-1990 period being poorly recorded. It is I think worth remembering that this inquiry took place in addition to the normal day to day work of the Division, with little additional resources.
20. Births, Deaths & Marriages (BDM) were contacted in March 2022 to help identify what records are being held by BDM to assist in the process. This was an onerous task for BDM, and they also had to manually search records in an endeavour to identify some of these matters. I express my gratitude to that agency for its assistance. Valuable assistance was also provided from the office of the State Forensic Pathologist.
21. Where matters were able to be identified as coronial cases, State Archives were then contacted, and those original files returned to the Coronial Division. This was also, necessarily, a very lengthy process.
22. In August 2023, the complicated task of collating, auditing and reconciling the existing coronial files, forensic pathology files and university records in order to account for all the coronial specimens then held by the museum commenced.

23. I considered it was essential to ensure that every reasonable step be taken that could be taken to accurately identify from whom the specimens had been taken and also identify whether those people had living relatives, and if so, who they were.
24. To that end, on 3 April 2024 a Media Release was issued at my direction in relation to the specimens being held at the Museum asking for any enquiries in relation to this be directed to the Coronial Division. In response only one enquiry from the general public was made and was not a match to any of the names provided.
25. Advertisements were placed (again at my direction) in the public notices section of the Mercury, Advocate and Examiner newspapers on 25 January 2025 with a list of names of those deceased persons asking their families to contact the Coronial Division.
26. The Court also communicated with media in relation to the matter and advised them to refer to the list on the Court's website which was being constantly updated rather than publish and name individuals, which they have done. This was done to attempt to minimise additional harm or trauma for families of the deceased. I am grateful for the assistance of the media.
27. The Court also provided support to access counselling services for the families who have come forward through EAP Converge International.
28. As a result of the advertisements the Coronial Division was contacted by a number of families, and as they have, the names of deceased persons were gradually able to be removed from the list on the Court's website.
29. In some cases multiple attempts were made to different persons to identify the relevant family members required.
30. Eventually, around 100 matters were able to be identified from the original 177 reported. Those human remains unable to be identified or for which family members could not be identified were respectfully disposed pursuant to the *Act*.
31. All remains identified and with identified family members were disposed of in accordance with the family's knowledge and to the extent possible, wishes.

Conclusion

32. The retention of human remains without family or coronial approval, or even knowledge, is an historic practice out of keeping with, and offensive to, contemporary standards and values. It is inconceivable to my mind that it would ever happen again

although the fact that the practice continued for as long as it did and ended only comparatively recently is also almost equally inconceivable.

33. The circumstances of these matters are not such as to require me to make any comments or recommendations pursuant to Section 28 of the *Coroners Act* 1995.
34. I express my sincere thanks to the team who worked on this challenging and difficult investigation. The investigation was largely completed without any additional resources being made available to the Coronial Division. In particular, Ms Jane McLeod, the manager of the Coronial Division, Coroner's Associate Sergeant Darren Orr and Coronial Liaison Officer Ms Jodie Richardson, are worthy of special recognition. All three took on a heavy workload, over and above their already onerous jobs.

Dated: 8 September 2025 at Hobart, in the State of Tasmania.

Simon Cooper
Coroner