Legislative Council

Hansard

Tuesday 18 August 2026

The President, Mr Farrell, took the Chair at 11 a.m., acknowledged the Traditional People and read Prayers.

[excerpt…]

QUESTIONS

Autopsy Practices in Tasmania – Compliance

Ms WEBB question to LEADER for the GOVERNMENT in the LEGISLATIVE COUNCIL, Ms RATTRAY

Noting the September 2025 Tasmanian coronial findings report in relation to human remains retained following coronial autopsies between 1966 and 1991 at the RA Rodda Pathology Museum, which cited the 2001 Walker review of retention of body parts following post-mortem examination in New South Wales, the subsequent Australian Health Ethics Committee report, Organs retained at autopsy: ethical and practical issues, and the 2002 Australian Health Ministers' Advisory Council Subcommittee on Autopsy Practice report, can the government please:

(1) Confirm whether current Tasmanian autopsy practices comply with national guidelines, principles, procedures and codes of practice, particularly regarding informed consent and procedures for handling and disposal of organs after autopsy, in line with community expectations regarding the practice of organ retention;

(2) Detail when and how Tasmanian autopsy practices may have been updated following the 2001 Walker and 2002 National Health Ministers reports to provide for strengthened regulatory requirements and oversight;

(3) Detail any current oversight and auditing processes undertaken of Tasmanian autopsy practices to ensure compliance with established requirements.

ANSWER

In response to the honourable member's question:

(1) I'm advised that current Tasmanian autopsy practices do comply with national guidelines, principles, procedures and codes of practice. If an autopsy requires tissue to be retained, the Coroners Act 1995 applies. Section 36 autopsies:

> (1) If a coroner reasonably believes that it is necessary for the investigation of a death, [they] may direct the State Forensic Pathologist or an approved pathologist, or a medical practitioner under the direct supervision of the State Forensic Pathologist or an approved pathologist, to perform an autopsy on the body.

(2) The coroner must direct the State Forensic Pathologist or an approved pathologist, or a medical practitioner under the direct supervision of the State Forensic Pathologist or an approved pathologist, to perform an autopsy on the body if directed by the Chief Magistrate to do so.

(3) A coroner may direct the State Forensic Pathologist or a pathologist or medical practitioner performing an autopsy to cause to be preserved for such period as the coroner directs any material which appears to the State Forensic Pathologist or the pathologist or medical practitioner to relate to the cause of death or the circumstances surrounding the death.

(4) The State Forensic Pathologist or a pathologist or a medical practitioner performing an autopsy may remove and retain such parts of the body as [they consider] necessary in order to determine the cause of the death or the circumstances surrounding the death.

The Coroners Rules 2006 apply to autopsy performance.

Rule 8. Performing Autopsy.

If a coroner under section 36 of the Act directs the State Forensic Pathologist, an approved pathologist or a medical practitioner to perform an autopsy –

(a) the State Forensic Pathologist, approved pathologist or medical practitioner is to perform the autopsy as soon as practicable after receiving the direction; and

(b) as soon as practicable after completing the autopsy, the State Forensic Pathologist, approved pathologist or medical practitioner is to notify the coroner –

(i) of any preliminary findings as to the cause of death; or

(ii) that the cause of death is still under investigation; or

(iii) whether any of the deceased person's organs have been retained and, if so, the reason for their retention; and

(c) within 28 days of completing the autopsy or such longer period as the coroner may allow, the State Forensic Pathologist, approved pathologist or medical practitioner is to notify the coroner of the autopsy findings; and

(d) the State Forensic Pathologist, approved pathologist or medical practitioner is not to notify any other person of the autopsy findings without the prior approval of the coroner.

The State Forensic Medical Services currently provides an interim post-mortem report (IPMR) to the CO, which gives the preliminary cause of death pending test results, notice of intention with reasons that it is necessary to retain tissue. Coroners' associates communicate with senior next of kin (SNOK) and provide an update on the autopsy, what is happening and why. Coroners' associates discuss with SNOK to obtain decisions for the consent for permanent retention

for investigation, research or other purposes, release of the body with permanent tissue retention, clinical disposal of retained tissue, release of body without postponing funeral, and subsequent return of tissue previously retained for separate funeral disposal, and return of the tissue to the body before release for funeral postponed until after completing the autopsy investigations and ancillary testing.

When samples for testing and tissue processing are completed, the coroner issues a certificate for funeral disposal based on the decisions of the SNOK and their controlled jurisdiction over the retained tissue ends. The mortuary can clinically dispose of the retained tissue, release the body with the returned tissue, release the body without retained tissue, and release the return tissue separately. Release of tissue previously retained by the coroner directly to an academic or other institution requires written consent of the SNOK for transfer and permanent retention for investigation, research or other purposes.

(2) At response, the recommendations from the reports of 2001 and 2002 arose from investigations of practices in New South Wales at the Glebe forensic mortuary in Sydney. Recommendations were accepted in New South Wales and were implemented by the then-director of Statewide Forensic Medical Services in Tasmania. Current procedures are supported by controlled documentation for interim post-mortem reports and retention procedures. These documents are on the Tasmanian Health Service pathology Q-Pulse controlled laboratory procedure document management system. Current practices have built upon the improvements of the previous 20 years and have adopted writing practices which are based upon those in the Coroners Court, Queensland, provided for in the Queensland Coroners Act 2003.

(3) In mid-2025, Statewide Forensic Medical Services and anatomical pathology services at the Royal Hobart Hospital commenced the process for the shared mortuary space located at the Royal Hobart Hospital to undergo National Association of Testing Authorities (NATA) accreditation. The mortuary having NATA accreditation will support the site obtaining Royal College of Pathologists of Australasia (RCPA) accredited training for registrars for both coronial and noncoronial autopsies. The NATA accreditation process is ongoing, with further inspection due in September 2026. In 2025, the Attorney-General referred the Coroners Act 1995 to the Tasmania Law Reform Institute for review to report on how the legislation governing coronial processes can be improved, including how it operates with SNOK.