D81 Body Donation and Death Reporting: Three Case Studies

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After attending this presentation, attendees will gain an understanding of how body donation programs interact with coroners and medical examiners in the state of California through three specific case reports.

The presentation will impact the forensic science community by raising awareness of body donation programs and role and their interactions during death reporting.

Each year over 1,000 individuals donate their bodies after death to the University of California (UC). These donations are made to one of five campus locations at Davis, Irvine, Los Angeles, San Diego, or San Francisco. Most of these deaths are from natural causes; typical for the aged donor population. They result from long-term illness such as cancers, heart disease, or pneumonia, but occasionally, the circumstances surrounding the death are not typical and require further inquiry or formal investigation.

Standard protocol for receiving a donor at UC includes death notification to the program personnel and confirmation of registration in the donor program. A medical and social history screening is performed during the notification phone call. If the donor meets the criteria for donation, the remains are then transferred to the program. A serology sample is taken and submitted for communicable disease testing. Simultaneously with the preparation of death certificates and burial permits, donor program personnel conduct a thorough external examination and photograph the remains; noting trauma, surgical history, identifying markings, and other significant findings. The following are three cases that required further investigation.

Case number one is a 70-year-old Caucasian female who died in a nursing home. The attending physician provided cause of death information, the local coroner provided a case number and the death certificate was accepted by the local health department. During preparation for scientific use, donor program personnel found a foreign object and reported the case back to the coroner.

Case number two is an 85-year-old female. This case was received after a residential death and was transported by a contracted mortuary service. Program personnel determined that there was no doctor to sign the death certificate, concluding that the decedent had not seen a doctor in a number of years. The case was referred to the coroner's office for follow up at which point, that office determined that the death was not caused naturally. Case number three, a 71-year-old Caucasian male, was received after his death occurred in his residence. The local coroner had responded to the death, but declined to investigate the case. Upon external examination by the donor program personnel, evidence of traumatic injury was identified and the decedent was returned to the coroner's office for investigation.

Of the estimated 4,500 deaths accepted for donation in the UC System since 2008, 1,142 of them have been assigned coroner case numbers. The vast majority of these are assigned case numbers due to required reporting circumstances such as an emergency room death, hospice death or similar circumstances. In some cases, donor program personnel identify atypical circumstances that result in reporting to obtain a referral number or initiate a full investigation. The UC Davis donor program reports approximately 30 cases per year for further investigation.

It is essential that donor program personnel be trained to recognize normal postmortem processes so that abnormal cases can be appropriately referred to local officials for full review or follow up. It is possible that whole body donors for scientific use, who account for less than one percent of the total annual deaths in the state of California, may not always be subject to the same postmortem reporting process as those who choose a more traditional disposition. Theoretically, this may be due to caretakers who want to facilitate the donors' disposition wishes or for other, less obvious, reasons such as incomplete information provided in the initial death report. Further analysis of donation data may reveal reporting patterns, or a lack there of, for decedents who do not follow a typical disposition path.

Body Donation, Death Reporting, Death Investigation

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