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CARLA VALENTINE

*Past
Mortems*

LIFE & DEATH
BEHIND
MORTUARY
DOORS



SPHERE



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The First Cut

Anorexic. Dentist.

They were two words I'd never seen written together before but there they were, in black smudged ink, on the 97A:

'Anorexic dentist'.

I took a sip of my coffee while perusing the rest of the paperwork. I enjoyed this part of the morning: the calm before the storm. The mortuary's senior technician, Jason, was happily hunched over the latest edition of the *News of the World* with a cup of tea. As a veteran technician, he had seen it all, and he appeared less interested in the information we received on the day's cases than in the plot of *EastEnders* or the latest football scores.

The 97A is the form faxed to the mortuary from the local Coroner's Office which simultaneously requests and gives permission for the post-mortem of the deceased. Although these forms have different names in different areas, one thing

remains the same all through the UK (except Scotland), and that is the Coroner gives permission for an autopsy to take place (in Scotland it's the Procurator Fiscal).

The role of the UK Coroner is constantly misunderstood because of the abundance of TV shows and crime books which continually hit our shores from the US. In America, although it varies from state to state, a coroner is another term for what we'd call a pathologist: a doctor who carries out autopsies. They're often elected in the US and in smaller states may even be the neighbourhood mortician or GP. In the UK, they are independent judicial officers appointed by the local government as a sort of overseer of all deaths in the area, and they must be qualified barristers or solicitors. Some also have a medical degree.

The term coroner comes from 'crowner', a position that has existed here formally since the year 1194. The Crowner had two roles: to oversee deaths in the area, and to be informed of any treasure that may have been discovered by a lucky serf and decide if it really was going to be 'finders, keepers' or if it belonged to someone else. This means that our Coroners sometimes have the unusual responsibility of investigating long-forgotten objects or money found buried in the garden and declaring them 'Treasure Trove'; that is, valuables of unknown ownership which become the property of the Crown. (In 1996 'Treasure Trove' became the Treasure Act.) Basically, 'whatever you find buried under your patio, be it a body or a bag of gold coins, you call the Coroner'.

I always imagine them as Grim Reapers in suits with Filofaxes and mobile phones, aware of all the deaths in their jurisdiction and poised to move all the relevant participants around like pieces on a chessboard, in order to

begin the death investigation: the police, the pathologists, their Coroner's Officers, mortuary staff and more. You see, UK Coroners don't carry out autopsies, they only decide when one is required using various legal criteria, then sign a form to state that fact. After that, they watch the chess game unfold. It's the pathologist who carries out the autopsy or post-mortem – the two terms are interchangeable – and we, the anatomical pathology technologists, who assist.

So what are the criteria for a post-mortem examination in the UK? Essentially, you don't need one if (a) you have seen a doctor within two weeks of your death, and (b) the doctor knows the cause of death was natural.

Hospital patients don't tend to need Coronial post-mortems because the likelihood is that they will have seen a doctor every day they've been there. The same goes for patients in hospices and similar facilities. But nearly everyone else will. Perhaps a man passed out while running on a treadmill in the gym? Perhaps a woman collapsed at a bus stop? Perhaps unidentifiable remains were found in the park by the clichéd man walking his dog? These will all be Coronial cases that will come into the mortuary from the local area. In fact, a person may be eighty years old and die in her sleep but if she hasn't seen a doctor within the last two weeks she will still need a post-mortem. 'Old Age' doesn't tend to be written as a cause of death on death certificates any more thanks, in part, to Harold Shipman, the notorious serial killer whose victims were usually pensioners. After he was brought to trial in 1999 more than 250 victims were attributed to him and this caused a cultural shift in GP practices and death certification as well as a huge rise in post-mortem requests.

Our forms, the 97As, arrived around eight thirty in the

morning with a flurry of beeping, buzzing and swooshing as the sheets were spewed from the mouth of the ancient fax machine and on to the floor of the small mortuary office. On the pages were some details of the deceased and the salient features of the case – whatever the assigned Coroner’s Officer had been able to find out in the first few hours after the death. Sometimes there were reams and reams of difficult-to-read lines, especially if medical notes were included. There might be information on prior illnesses, previous drug use, where and how the body was found, family members, charts, height and weight, and whether or not the deceased preferred one lump or two in his tea. In other cases there might be just a few words or lines, like this one:

Anorexic dentist
 45 yrs
 Bedridden 2 wks
 Son Of a Bitch

‘Bloody hell, that’s harsh!’ I said to Jason, so loudly that he nearly spilled his cuppa as he lifted it towards his lips.

‘What is it, hun?’ he asked, his eyes flying to me and away from the pages of his newspaper. He always called me ‘hun’ and I didn’t mind. His huge, muscular, tattooed form belied a very gentle and protective nature.

‘The poor bloke’s dead and they’re calling him a son of a bitch!’

I stomped across the office to wave the 97A in front of his perplexed face. He halted my hysterical form-flapping to get a good look at the info, and after a beat of silence and a confused expression, he roared with laughter. His massive

shoulders heaved, his face reddened, and he even wiped a tear from his eye. 'Son of a bitch ...' He repeated it a few times, the words barely audible through his laughter.

When he calmed down, I discovered the reason. Although I'd read the form that way, it actually stated:

Anorexic dentist
45 yrs
Bedridden 2 wks
S.O.B.

And S.O.B. meant 'shortness of breath'. No wonder Jason was in hysterics. I was going to have to get used to acronyms if I was to make it in this game.

As there was only one 97A that day, and therefore only one post-mortem or PM (another acronym - *you'll* have to get used to them too), Jason said today would be my first attempt at making the incision into the deceased myself. As a trainee APT (anatomical pathology technologist - another one!) this is the first stage in learning the art of evisceration - the medical term for removing the organs, which sounds marginally better than 'disembowelling'.

Though I was only a trainee, I had the hang of the basics by now - the paperwork, signing in new bodies, carrying out viewings, small procedures like removing stubborn jewellery or false teeth - but it was time to start some proper training. It was time to do my first full incision and open the deceased. I really wanted to, I was so incredibly excited, but at the same time I was terrified. I'd wanted to do this job for so long, but now that I was about to take the plunge I suddenly had no confidence in myself. What if I messed up? What if I was

no good at it and my whole life was a lie? I couldn't even cut paper straight without drawing a line with a ruler first; how was I going to cut *skin* straight? And I absolutely, positively couldn't sew any sort of fabric, so how was I going to sew a person together? Considering I'd never really been interested in paper crafts or textiles at school, the idea of trying out these little-used skills on a human being was beginning to freak me out.

To keep myself calm, I decided to focus on the things I did know, the tasks I carried out every single morning after arriving at work around seven thirty, and I realised it was only a few weeks ago I hadn't known how to do them either. I was learning quickly and I needed to stop stressing out. Everyone has to start somewhere.

So I took charge. Jason followed to observe as I headed into the small, bright post-mortem room and pulled on some latex gloves, taking a deep breath as I did so. I located the body bag of the anorexic dentist in the fridge by his name written on the door (the fridge being otherwise known as a temperature-controlled storage facility but, eager to avoid yet another acronym, we just called it a fridge). I gently slid his tray out and on to the hydraulic trolley, then I hesitated, thinking I'd made a mistake. The tray was so light it didn't seem like there was anyone actually in the bag. However, on closer inspection I could discern the curve of the top of a head pressing against the white plastic and a sharper point, much lower down, which looked like it could be a bent knee. Satisfied he was definitely in there, I took another deep breath and turned the trolley a full 180 degrees to position the tray over the stainless-steel holder jutting from the post-mortem room walls. Via this set-up the tray the deceased rests on in

the fridge also becomes the dissection bed, cradled in the strong steel arms of the holder.

Sometimes the difficult manoeuvre would be done without a hitch; just the gentle glide of the turning trolley then the muted squeak of the trolley's mechanism as it lowered the tray down on to its holster.

This wasn't one of those times.

A combination of my earlier anxiety and Jason watching me intently meant I was just too nervous. There was a crash of metal on metal as I missed the turn by a couple of inches and slammed into the jutting arm with the trolley. It was nothing that would damage the deceased or even the equipment, only my ego, which was feeling more and more like it would need its own post-mortem by the end of the day: cause of death – extensive bruising.

'Don't worry about it, hun, we all do that sometimes,' Jason reassured me. 'It's a really small PM room.' I had no idea how he could be so infinitely patient with me especially since sometimes, as a newbie, I felt like all Three Stooges rolled into one.

With no real damage done, I eventually got the tray with the body bag in position on the hoist and slowly unzipped it. Jason let me carry out the entire process as though he wasn't there, which on this occasion was absolutely fine. Normally it would take two APTs to remove the patient from the bag in a well-rehearsed and carefully choreographed manoeuvre that looks like it's anything but. It involves tipping the deceased to the side, using legs and arms like levers and fulcrums, so that the plastic can be slid beneath the body on one side; the whole thing is then repeated on the other side, and the bag can be gently pulled out and folded away. But this man was

so thin I could move him on my own, with one arm, while I worked the bag out with the other, as easy as holding a baby's legs aloft while sliding a nappy out from under its bottom. I concentrated on carefully removing the man while taking deep breaths to steady my nerves.

And then I got a good look at him.

I'd never seen anything like it: he resembled a knotted white twig with a few extraneous branches and hairy bark. From the front I could see the shape of his pelvic bones clearly through his meagre flesh, and when I gently rolled him away from me to view his back, every single groove of his tailbone – or sacrum and coccyx – was visible too. Where his bones had been forcing their way through his paper-thin skin during those last bedridden weeks, angry pressure sores had formed. They were deep red and wet in appearance with yellow-green infected parts, oozing pus. At the sight of them, imaginary pain involuntarily shot through me. It was so unexpected it took my breath away for a second and left me feeling winded.

His hair was long and very dark, almost black, matted to his head and upper back in some places, yet wild in others. His nails were overgrown and yellowed and, taken with the hair and the emaciation, it seemed there was more than just anorexia going on here; I was very much reminded of Howard Hughes and other recluses with psychological problems, and wondered if the same fate had befallen the dentist. But I couldn't just keep standing there musing because Jason reminded me I had a job to do by handing me a clipboard with a paper form on it. I used the form to make notes about the man's appearance; his sunken cheekbones, matted hair, bedsores and more. I noted down as much as I could, every

mole, every wrinkle, every 'is that a birthmark or a bit of dirt?', and I realised it was for two reasons. On the one hand, it was my first external exam alone so I didn't want to miss anything and look incompetent to the pathologist who'd be arriving shortly. On the other, the longer I took over the examination the longer it would be until I had to make that terrifying first cut.

Jason saw right through me and, after I'd circled the body a third time like a hungry vulture, he was having none of it. 'You don't have to mark down every wrinkle on his ballsack, hun,' he said, handing me a PM40, the mortician's main blade.

It was time.

I bent down over my patient and tried to concentrate on his neck and clavicle, the natural curve where I would begin the incision. But all I could see was the harsh light from the overhead lamp reflecting off my blade like a strobe as my hand shook.

Just then, that overhead light reminded me of something and I zoned out again. (See what I mean? Poor, patient Jason.) When we were children, my best friend Jayne and I would put make-up on each other, as many young girls do. At that moment, I had a sudden memory of lying back all those years ago with my eyes shut tight to the light above and feeling it warm my eyelids, feeling the soft stroke of the brush on my skin as Jayne applied the make-up, and thinking, 'This must be what a corpse feels like' – which is probably something most young girls *don't* do. I was specifically thinking of scenes I'd sometimes see in films or on TV where the deceased gets 'beautified' in the funeral home for the big day. In my defence, I had just seen *My Girl*, the wonderfully

poignant Macaulay Culkin film from 1991. Dan Aykroyd plays a funeral director who employs the vivacious Jamie Lee Curtis to apply make-up to the dead. She made it look like so much fun, even glamorous, and it left a kind of positive impression on me, although the ending of the film certainly did not. Even now I feel traumatised if I see a mood ring or a willow tree.* With this mental image of myself as the corpse, feeling the gentle touch of the make-up brush, I suddenly imagined the anorexic dentist could feel me. Not my touch yet, but certainly my hyperventilating and my hesitating. I was sure that he wouldn't want a blonde, uncertain neophyte waving a knife above him like a sushi chef so I firmly told myself, 'Carla – get on with it.'

And I did.

I'd seen technicians make this incision many times before and I executed it almost perfectly. Starting on the right side behind the ear I slid the blade down the side of his neck, altering the angle slightly as it travelled over the clavicle and down in a 'V' to the breastbone, the skin parting with the ease of butter beneath the sharp steel. I repeated this from the left side, a slightly more awkward angle when using the right hand, and when I reached the point of the 'V' I took the blade in a straight line down his abdomen, just circumnavigating his belly button slightly. I stopped abruptly at the pubis leaving a fairly neat 'Y' shape, which is why we call it the 'Y-incision'. There were a couple of slight deviations in the skin, but I defy anyone to cut open a human being for the first time with a blade that could take off your own finger and

* If you haven't seen *My Girl* I highly recommend it, not only because it's wonderful but also because otherwise that last sentence will make no sense.

not falter just a little bit. Anyway, slightly wonky lines aren't visible after they've been stitched back together during the final reconstruction.

I was quite proud of myself. I stood there breathing a sigh of relief, admiring my handiwork for an inordinate amount of time, until Jason spoke.

'Come on, Edward Scissorhands, we've still got the rest of the PM to do.'

The next stage, at this point of my training, was to relinquish the blade and observe Jason for the rest of the process. Autopsy technicians tend to learn evisceration in stages, a bit like driving. For your first driving lesson you don't get in the car, gun the engine then start parallel parking and doing five-point turns, and it's the same with autopsies. It all happens step by step.

Once the incision has been made in the chest, and the breastbone – the sternum – has been removed, there are a few different methods for systematically removing the organs for examination. The most common is often called the Rokitsansky Method, though in fact it was Maurice Letulle who created what is also known as the en masse procedure in which, as the name suggests, organs are removed in one large mass. This was to be the way I would carry out an evisceration for much of my career so I watched carefully as Jason proceeded.

First, some exploration, as he used his non-cutting hand to feel behind each lung for possible pleural adhesions – parts of the lung that may be stuck to the chest wall. They can be caused by previous trauma or diseases such as tuberculosis or pleurisy. The best-case scenario was that the lungs, pink,