

The Coroner's Autopsy: Do we deserve better?



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As a bereaved parent, Michaela Willis explained that she looked at the issue of on behalf of family members rather than as an academic. She explained that when her son died 13 years ago, his heart was retained at the Bristol hospital in which he died. She had been closely involved with the issue, with the Bristol Heart Children's Action Group.

The key issue in improving deficits revealed by the NCEPOD report in the coronial autopsy process is to improve communication, suggested Ms Willis. She argued that it was vital to improve communication between the coroner and the pathologist and communication with the family. It was also important to agree on the purpose of a coronial autopsy, she told the meeting.

Coronial autopsy reports should be fit for purpose, regardless of quality, Ms Willis said. Further issues to address were whether a coronial autopsy is necessary, for whose benefit it is being performed and why – simply to establish cause of death was not unnatural or to gather additional information of use for education or to improve understanding of disease processes.

"There is a distinction between needing to know and wanting to know," Ms Willis noted. She suggested that for coronial autopsies beyond the specific remit, families should be engaged in the process and consent given. Alternatively, the remit of the coroner should be extended, if that is the will of Society.

Considering the scope of a coronial autopsy, Ms Willis said that she agreed that normally a complete autopsy should be performed, with all organs, including the brain being examined. However, she considered that the scope was influenced by the purpose of a coronial autopsy. As things stand, it is set out in the Coroner's Act that a coroner's autopsy is 'to inform the coroner's investigation, when it is the coroner's duty to investigate the cause and circumstances of death, where it is not known.'

What would constitute an autopsy for the coroners' purpose? Ms Willis suggested an autopsy that answers how the deceased came to their death, in cases where unnatural death is suspected. She noted that for most causes of death, the standard of proof required is only the 'balance of probability.'

Ms Willis considered that it was important to distinguish between a coronial autopsy and a hospital autopsy in order to answer the question regarding the purpose of the coronial autopsy. She suggested that the purposes of a hospital autopsy included education, to gain a deeper understanding of the disease process and to answer questions for the family of the deceased. She noted that many of the families who called the National Bereavement Partnership helpline were upset because they did not know why someone had died. "If find it difficult that they are unable to get an answer," she said.

If the coronial autopsy is to also to include purposes related to education, gaining a deeper understanding of disease and to answer questions for the family, she suggested that this was a question for the State to decide what it would be acceptable to proceed with, without the agreement of the family. "If we think the duty of the coroner is too limited, and the coroner should be gathering information beyond 'the

balance of probability' then the Coroners' Act should be changed," she said.

Commenting on the NCEPOD finding that one in four autopsy reports were judged to be poor or unacceptable, Ms Willis said: "I find that really scary. Whose problem is it? Who is going to take some ownership of this? Whose responsibility is it? Who is going to change it?" She said that public trusted doctors and expected to receive a high quality service. She asked whether the coroner was failing in his/her obligation to investigate and communicate with the pathologist on the quality of the service/report required.

If families understood there was a variation in quality, she believed they would be shocked. "The first feeling that I got when I read the report, was 'these autopsies are quick and dirty.' 'Let's just get them in and get them out, and give them an answer,'" she said. She asked those attending the meeting whether that was what they would really want for their loved one. It was really important for people's future health to be able to understand why someone had died, she noted.

"In the case of my son, I would never have pursued a public enquiry had someone spoken to me earlier. But sitting down and talking to the pathologist, going through the five-page post-mortem report, it made the most incredible difference to me actually understanding why our son had died. Had I only have had one page, with very little information, I don't know what I would have got from that. But I certainly knew that my subsequent children weren't going to be affected. And it was really important for me to know that."

Considering the recommendations made by the report on quality issues and tissue retention, Ms Willis considered that they represented good practice and common sense. She was disappointed that the report showed that in one third of mortuaries the pathologist failed to inspect the body before the APT commenced opening it and removing the organs, and considered this was a matter for professional guidance. She also considered that professional guidance should require autopsy reports to clearly indicate whether or not tissues were retained.

The finding that histology should have been taken – but was not - in order to determine the cause of death in one in 16 cases was a quality issue, Ms Willis said. She considered that the coroner should oversee this issue. She considered the finding that the cause of death was questionable in nearly one in five cases was an issue for audit.

Outlining the views of family members, Ms Willis said: "We want autopsy practice to be better to serve education, provide a deeper understanding of the disease process and to answering questions for the family. If families were in possession of the facts, understanding the potential value of the autopsy, many would agree to what constitutes a hospital autopsy."

In conclusion, Ms Willis suggested: "Engage the families, engage the public and see what they want."