2. Aim of study and method

Aim of the study

The aim of this study was to assess the quality of coronial autopsy reports, and indirectly the quality of autopsies, requested by coroners under the England, Wales, Northern Ireland, Guernsey, Jersey and the Isle of Man coronial systems.

The specific objectives of the study were:

- To assess the quality of coronial autopsy reports in conjunction with the written information relating to the death as presented to pathologists by coroners;
- To obtain a baseline overview of the standard to which coronial autopsy reports are currently being reported, and indirectly, the standard to which they are being performed;
- To assess how issues raised by a death are being addressed in the coronial autopsy;
- To highlight the variations in practices and explore reasons for these variations (e.g.: coroners' requests and expectations; pathologists' workloads; mortuary facilities);
- To evaluate the correctness of pathologists' Office of National Statistics (ONS) cause of death formulations in terms of structure and content;
- To make recommendations regarding quality of autopsy reports.

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Method

Peer review of individual autopsy reports and information from organisational questionnaires were used to inform the study. The two components of the study are described in the following sections.

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Peer review of autopsy reports

Twenty one currently practising coroners and 'autopsy-active' (>50 autopsies per year) pathologists (herein referred to as advisors) were selected specifically for the study to assess the quality of individual autopsy reports, along with the written documentation that was supplied to NCEPOD by the coroners' offices (referred to as 'supporting documentation'). For each case, the advisors completed an assessment form (with free text additions) developed specifically for this study. A copy of the assessment form is available as an Appendix. The assessment form was based on previous NCEPOD autopsy assessment forms, the Coroners Act 1988[1], and the 2002 Royal College of Pathologists' Guidelines for Autopsy Practice[2].

Before the full scale study commenced, the advisors attended a training session arranged by NCEPOD, where they were provided with a written Advisor Manual (available as an Appendix) and training. This enabled the group to discuss and practice the assessment process for a sample of individual cases using the assessment form.

During the study, the advisors met regularly in small groups and each case was initially reviewed by one advisor only. This individual review was then followed by a short presentation of each case to the multidisciplinary team for discussion from all advisors.

It is important to acknowledge the limitations of this methodology and its possibility to impact on the findings. The advisors could not duplicate the autopsy and did not have access to any clinical notes of the deceased. They are commenting on the autopsy reports and related information. Thus there may be underestimation of the deficiencies in the present system.

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Organisational questionnaire

An organisational questionnaire was disseminated to all mortuaries where coronial autopsies were performed in the participating countries. The organisational questionnaire was designed to gather information about the mortuary facilities available to pathologists when performing coronial autopsies. A copy is provided as an Appendix.

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Sample

The study sample comprised all coronial autopsy cases where the autopsy was performed during a one week (7 day) retrospective period in early 2005, in England, Wales, Northern Ireland, Guernsey, Jersey and the Isle of Man. The date was chosen to exclude any weeks with a bank holiday and the date was notified retrospectively to avoid bias in the study week. It was also before the implementation (in June 2005) of the important changes to the Coroners Rules 1984 that placed greater restriction on the taking of material for histology and toxicology etc.

NCEPOD allowed 11 weeks from the chosen study week before the data were requested from coroners' offices. This was to ensure sufficient time for the majority of autopsy reports to be completed and submitted to the coroner concerned. The data were accepted until the end of January 2006.

The only exclusion that applied to the study was suspected homicide cases. Paediatric cases were included in the sample population.

Based on 2003 data published in 2004, it was estimated that on average 2,300 coronial autopsies would be performed per week[3]. Taking into account a 1.6% decline in autopsy rate (based on the average rate of decline in coronial autopsies between 1993 and 2003) and the excluded homicide cases, it was anticipated that the study sample would consist of approximately 2,260 coronial autopsy cases.

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Case identification & data collection

Cases were identified by coronial staff from all coroners' offices in the participating countries. The following data were requested from coroners' offices for each case included in the study:

- The autopsy report.
- Supporting documentation. This referred to any documents that were issued to the pathologists by the coroner prior to the autopsy taking place. This may include (but was not limited to):
    - written instruction to the pathologist to perform an autopsy;
    - coroner's summary report;
    - police report (e.g. sudden death report, scene examination);
    - ambulance service forms;
    - clinical summary or copies of medical notes (if available on the coroner's file).

NCEPOD were unable to take cognisance of any oral information provided to the pathologists, e.g. by the attendance of a coroner's officer at the autopsy who passes oral information to the pathologist.

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Data analysis

All data were anonymised on receipt by NCEPOD and a unique number was given to each case and each mortuary. All identifiers pertaining to the deceased, next of kin, pathologist, coroner, hospital and mortuary were removed from the data before being reviewed by the advisors.

Data from both the assessment forms and the organisational questionnaires were abstracted by NCEPOD researchers and analysed using Microsoft Excel and Access to inform the study.

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References

1. Coroners Act 1988.
2. The Royal College of Pathologists. *Guidelines on autopsy practice.* Report of a working group of The Royal College of Pathologists 2002, Royal College of Pathologists, London.
3. Allen, R. Home Office, Deaths Reported to Coroners England and Wales 2003, 30 June 2004.