

# 11. Pathology

## Introduction

Of the 560 patients in this study population who died, 16% (91/560) had an autopsy. Autopsy reports were received from 48% (44/91) of these cases. Since there are only 44 reports to consider, analysis and comment are necessarily limited. The observations on quality are based on standards indicated in the Royal College of Pathologists *Guidelines for Autopsy Practice*<sup>42</sup> which are intended to apply to both consented and coronial autopsies.

Most of the observations on autopsy quality are similar to those in previous NCEPOD reports. For coronial autopsies, there is the issue over the difference in expectations of what information an autopsy is intended to provide, between clinicians and the coroner. Under the Coroners Act 1988, coroners are only required to determine how the person came by their death, i.e. what is the cause of death. Clinicians would like to know more about the underlying disease, its complications and the impacts of treatment in order to audit the care of their patients. Another point made in the last report<sup>43</sup>, that the formulations of causes of death could be significantly improved, pertains again in the current data set.