2. Aim of study and method

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.