CORONIAL AUTOPSY STUDY
Advisor Manual

PURPOSE

This document aims to assist the Advisors in completing the Coronial Autopsy Study Assessment Form. It is designed to provide definitions for the questions asked in the Assessment Form, and to eliminate any ambiguities in the way they are interpreted.

ABOUT THE ASSESSMENT FORM & THIS MANUAL

The Assessment Form is a structured questionnaire, designed specifically for this study by NCEPOD. The Assessment Form is based on the 2002 The Royal College of Pathologists *'Guidelines on Autopsy Practice'*, and Schedule 2 of the Coroners Rules 1984. Schedule 2 outlines the statutory autopsy reporting requirements of the pathologist.

Many of the questions in the Assessment Form are dichotomous, which require simple 'Yes' / 'No' responses. Accordingly, the definitions for some of the straightforward dichotomous questions contained within the Assessment Form have been excluded from this manual.

Other questions on the Assessment Form are subjective and require consideration of the quality of certain aspects of the autopsy report. For example, Advisors are asked to grade the description of external appearances / identification features presented in the autopsy report as: 'Good', 'Satisfactory' or 'Unsatisfactory'. The point at which grades change from Good to Satisfactory to Unsatisfactory can be a grey area. Therefore, this document provides examples of each grade to guide the Advisors in their decisions.

Definitions marked throughout this document in quotations have been extracted from the following reference:

> Report of a working group of The Royal College of Pathologists (2002) Guidelines on Autopsy Practice, The Royal College of Pathologists, September 2002. Available at: http://www.rcpath.org/resources/pdf/main_document.pdf

SECTION A - SUPPORTING DOCUMENTATION

This section relates to information from the coroner's office that was presumably available to the pathologist at the time of the autopsy.

Additional information may have been sought by the pathologists prior to, during, or after the autopsy. However, this information cannot be assessed by the Advisors, unless it forms part of the 'supporting documentation' supplied to NCEPOD by the coroners.

2. What supporting documentation do you have alongside the autopsy report?

Possible responses	Definition
a. Formal written instruction from a coroner to a pathologist to perform an autopsy	Any document that explicitly requests or directs a pathologist to perform an autopsy.
b. Sudden Death Report (or equivalent police report / scene examination)	Any document prepared by the police that contains information about the deceased. This may be titled: 'Sudden Death Report' or 'Scene Examination'.
c. Coroner's summary report	Any document prepared by or on behalf of a coroner containing information about the deceased. This may include demographic details, next of kin or general practitioner details, and clinical history. This is usually titled: Coroner's Officer's Report.
d. Extracts from the deceased's medical records (from hospital or general practitioner)	Any documents that were clearly part of the deceased's medical records when he/she was alive. E.g. discharge summary, operation note, correspondence between health service providers etc.
e. Ambulance service form(s) (including certification of fact of death).	Any document prepared by an ambulance service.
f. None (go to question 5)	-
g. Other	-

3. Does the supporting documentation contain the following details?

Sub-question	Possible responses	Definition
a. General / treating practitioner contact details (or an indication that no such details exist)	Yes	Contact details must include the name of the practitioner and at least the address or a contact phone number; OR an indication that no such details exist
	No	None of the above
b. Information about the deceased's occupation (past or present)	Yes	-
	No	-
c. Date of birth of deceased (as opposed to only age in years)	Yes	-
	No	-
d. Specific clinico-pathological questions relating to the death. E.g. ?P.E.; ?M.I.; ?Ca.	Yes	The coroner or any other person has provided the pathologist with questions relating to the death. For example, a query about the cause of death - ?P.E.; ?M.I.; ?Ca.
	No	The supporting documentation requests that the pathologist establishes the cause of death, and does not contain additional clinico-pathological questions (like those above) relating to the cause of death.
e. Specific requests / investigational instructions, e.g. Do / do not take histology / toxiciology	Yes	Investigational requests or instructions are provided by the coroner to the pathologist. For example: 'Do not take histology', or 'Please take toxicology'.
	No	The supporting documentation requests that the pathologist establishes the cause of death, and does not contain additional investigational instructions (like those above) relating to the cause of death.

4 a. Overall, how would you rate this supporting documentation, presuming that no additional information was sought by the pathologist?

Possible responses	Example
Good	The supporting documentation provides good background information about the deceased. It may include many of the details outlined in question 3 above, as well as basic demographic data about the deceased.
Satisfactory	The supporting documentation provides some background information about the deceased and/or the circumstance of death.
Unsatisfactory	The supporting documentation provides very limited, useless or no background information.

SECTION B – REPORT PREAMBLE / DEMOGRAPHIC DETAILS

This section relates to all demographic and background details provided by the pathologist in his / her autopsy report. It may include much of the information that was provided by the supporting documentation, as well as additional background information / history that the pathologist has sought prior to the autopsy taking place.

The RCPath 2002 Guidelines state that:

> "All autopsy reports must include a clinical history to make clear the context of the autopsy. The history comprises a summary of present illness in chronological order, and the circumstances of death. The past history often explains the findings. It is the pathologist's responsibility to be satisfied that a reasonable account has been obtained, and mere references to notes or letters is not an adequate substitute. Absences of, or difficulty in obtaining, clinical information should be recorded. The source of clinical information (medical records, Coroner's Officer only, etc) should be recorded. Pre-mortem clinical and laboratory investigations should be quoted where relevant, including significant negative results." Page 20.

6 a. Is a history provided?

Possible responses	Definition
Yes	At least some history is provided, which may include past medical history, relevant background information or circumstances about the death. A reference to the supporting documentation is not adequate. E.g. 'History – see coroner's summary.'
No	No history, relevant background information or circumstances about the death is provided at all; OR The only comment provided about the deceased history is a reference to some other document, e.g. 'History – see coroner's summary.'

6 b. If yes, is it essentially identical to that provided by the supporting documentation?

The reasoning behind this question is to determine whether or not the pathologist has sought additional history about the deceased to that provided by the supporting documentation.

Possible responses	Definition
Yes	The history provided in the autopsy report is essentially identical to that provided by the coroner / supporting documentation. It is obvious to the reader that NO additional history (e.g. laboratory data, radiological results etc.) has been sought by the pathologist.
No	The history provided in the autopsy report contains information that was not provided in the supporting documentation. A 'No' answer to this question may imply that additional history (e.g. laboratory data, radiological results etc.) has been sought by the pathologist.
Not applicable	Question 6a (above) was marked 'Yes' but no history or relevant background information was provided by the coroner.

6 c. In your opinion, would have additional history been useful to make clear the context of the autopsy?

This question is to be answered where 1) a history is provided; and 2) the history is essentially identical to that provided by the supporting documentation.

Possible responses	Definition
Yes	Additional history to that provided in the autopsy report would have been useful to make clear the context of the autopsy.
No	Additional history would not have been useful to make clear the context of the autopsy because the history already provided in the supporting documentation (and therefore the autopsy report) sufficiently makes clear the context of the autopsy.

6 d. Does the history indicate clinical questions to be addressed at autopsy?

Possible responses	Definition
Yes	The history contains clinical questions that the pathologists might address during the autopsy. For example ?Pulmonary embolus ?Myocardial infarction ?Lung cancer.
No	The history does not contain any clinical questions.
Not applicable	In the Advisor's opinion, no clinical questions were apparent or sufficiently relevant to be included in the 'report preamble' or 'history' section of the autopsy report.

6 e. Overall, how would you rate the history as presented in the autopsy report?

Possible responses	Example
Good	The history provides sufficient background information about the deceased to make clear the context of the autopsy. It closely adheres to the guidelines specified by RCPath (quoted above).
Satisfactory	The history provides some background information about the deceased and makes the context of the autopsy somewhat clearer - compared to having no history at all. Some aspects of the guidelines specified by RCPath may be included.
Unsatisfactory	The history provides little background information about the deceased or the circumstance of the death. It does not make clear the context of the autopsy. It may leave the reader wondering where the deceased was at the time of death and in what circumstances they died.

SECTION C – EXTERNAL EXAMINATION

7. Were the following recorded?

Sub-questions	Possible responses	Definition
a. Deceased's height	Yes	-
	No	-
b. Deceased's weight	Yes	-
	No	-
c. Nourishment	Yes	The report includes a comment about the overall nourishment of the deceased, e.g. well nourished; slim; obese etc.
	No	No comment is provided about the deceased's nourishment. The deceased's height and weight is not a sufficient marker for nourishment.

8 a. Is there a description or mention of external appearances and identification features?

The RCPath 2002 Guidelines state that the external appearances and identifications features should (where possible) include:

> "External appearances – sex, age, weight (kg), height (cm); weight and height are essential for perinatal and paediatric autopsies and best practice for adult cases.
>
> "Ethnicity – e.g. Caucasian, African, Afro-Caribbean, Indian subcontinent, Chinese, Japanese, South American Indian; if uncertain, describe the skin and hair.
>
> "Measurements of significant surface features, scars, operation sites, bruises, etc. with a clear description of the site, including diagrams or photography if necessary. The presence or absence of injuries to the eyes, genitalia and anus should be recorded.
>
> "Infant/neonatal/fetal deaths required additional measurements, studies of dysmorphism, placental studies and X-ray." Page 20

Possible responses	Definition
Yes	A description of the deceased's external appearances and identification features is given. It may include some of the features identified in the RCPath quotation above.
No	No description of external appearances and identification features is given at all.

8 b. If yes, is the description of external appearances / identification features:

Possible responses	Example
Good	The external description is sufficiently detailed for the reader to imagine how the body appeared prior to autopsy. It closely adheres to the guidelines specified by RCPath (quoted above). It may detail identification features such as tattoos, old scars and/or injuries, which are all noted examples of identification features outlined in Schedule 2 of the Coroners Rules 1984. A good description may contain negative features – e.g. ‘there was no bruising’; ‘no petechial haemorrhages are evident’; ‘no significant external abnormalities were noted’.
Satisfactory	The external description provides some information about the appearance of the deceased. It may contain some of the features identified in the RCPath quotation above.
Unsatisfactory	The description provides little detail about the deceased’s external appearance. It provides no or little comment about negative findings.

SECTION D – INTERNAL EXAMINATION

9. Does the internal examination include mention or description of the following systems? If yes, please grade:

The Advisor is asked to document whether or not the autopsy report contains a description of each of the following systems.

a. Central nervous
b. Cardiovascular
c. Respiratory
d. Gastrointestinal / Alimentary
e. Genitourinary
f. Lymphoreticular (reticulo-endothelial)
g. Endocrine
h. Musculoskeletal

For each system marked 'Yes', the Advisor is asked to grade the description as 'Good', 'Satisfactory' and 'Unsatisfactory'. Examples are provided below.

Possible responses	Example
Good	The internal description is sufficiently detailed for the reader to understand how that particular system appeared during the autopsy macroscopically. A good description may contain negative features – e.g. 'no focal lesions were seen on sectioning the brain'; 'the tricuspid, pulmonary, mitral and aortic valves appeared unremarkable'.
Satisfactory	The pathologist has made some effort to describe the internal organs.
Unsatisfactory	Very little effort has been made to describe the internal organs. It provides no or very little comment about negative findings, implying a lack of critical observation.

10 b. If some organ(s) was/were NOT weighed, is there any documentation in the autopsy report indicating that the organ(s) were previously removed? For example due to organ donation or a previous autopsy.

Possible responses	Definition
Yes	The autopsy report explicitly states that some organ(s) had previously been removed. It may state the reasons for their removal (e.g. organ donation or a previous autopsy). The pathologist has made an effort to account for 'absent' organs that were not available to weigh.
No	The autopsy report does not account for 'absent' organs.
Not applicable	All organs listed in question 10a were weighed (i.e. brain, lung, heart, liver, spleen, kidney) and therefore this question is not applicable, because all organs were accounted for in the autopsy report.

11 a. Overall, the gross description of the internal organs is:

This question is asking the Advisor to make an overall decision about the gross description of the internal organs, considering his / her responses to question 9.

Possible responses	Example
Good	Overall, the autopsy report provides a sufficiently detailed gross description of the deceased's internal organs. It appears complete and comprehensive to the reader.
Satisfactory	Overall, the autopsy report provides some detail about the gross internal organs as they appeared macroscopically to the pathologist.
Unsatisfactory	Overall, the report does not provide a sufficient or relevant description of the gross internal organs.

12 a. Does the report state whether or not whole organs or major parts were retained?

The RCPath 2002 Guidelines state that pathologists should:

> "Record organs retained for further study or other purposes, with reference to the person giving consent, and a note of how ultimate disposal is to be effected". Page 21

Possible responses	Definition
Yes	The report states (or implies in its description of the organs) that whole organs or major parts were retained; OR The report explicitly states that no organs / major parts were retained.
No	The report does not state either of the above.

13 a. Does the report state whether or not histology samples were taken?

Possible responses	Definition
Yes	The report states (or implies in its description of the organs) that histology was taken; OR The report explicitly states that no histology was taken.
No	The report does not state either of the above.

14 a. Are any separate reports (i.e. whole organ retention or histology) included with the autopsy report?

Possible responses	Definition
Yes	Whole organ(s) or major parts, or histology was / were taken AND the report(s) is / are included with the autopsy.
No	Whole organ(s) or major parts, or histology was / were taken and the report(s) is / are NOT included with the autopsy.
Not applicable	Based on the evidence provided, it appears that the pathologist has not retained organs or histology sections and therefore no separate report should be available.

14 b. If the report(s) is/are included, is it

Possible responses	Example
Good	The whole organ or histology descriptions are focused on the issues raised by the death.
Satisfactory	The whole organ or histology descriptions are relatively unfocused on the issues raised by the death.
Unsatisfactory	The whole organ or histology descriptions are incomprehensible or contradictory.

15 a. If whole organ retention or histology did not occur, did the lack of tissue retention in any way detract significantly from the autopsy report in determining the cause of death?

This question is asking the Advisor to consider whether the inclusion of organ retention or histology could have assisted the pathologist in determining or fully elucidating the cause of death.

Possible responses	Example
Yes	The absence of an examination of tissue (other than macroscopic examination) detracted from the autopsy report in determining OR fully elucidating the cause of death.
No	The cause of death was justifiably determined from the information provided in the autopsy report. Tissue retention would not have impacted on the cause of death.
Would have been informative	Tissue retention may have assisted in elucidating particular features of death, but may not necessarily be required in determining the cause of death.
Not applicable	Tissue retention (whole organ or tissue retention for histology) did occur and therefore this question is not applicable.

16 a. Were other samples taken e.g. toxicology, virology / microbiology, immunology? (E.g. for screening of drug overdose, hepatitis, tuberculosis etc.)

Possible responses	Example
Yes	The autopsy report explicitly states or implies in the content of the report that ‘other’ samples were taken (e.g. blood).
No	The autopsy report explicitly states that no ‘other’ samples were taken.
Not stated / unknown	The autopsy report does not state whether or not ‘other’ samples were taken and the advisor is unable to deduce from the content of the report whether ‘other’ samples were taken.

17 a. If other samples were not taken, did the lack of samples detract significantly from the report in its account of answering the questions raised by death?

This question is essentially identical to question 15a, but is referring to samples other than tissue, e.g. blood.

18 a. Is a cause of death given?

Possible responses	Example
Yes	-
No	-
Unascertainable	In some cases, a cause of death is unascertainable or unascertained, in which case, this should be stated here. In general, an **unascertainable** death would be where the pathologist is unable to establish a cause of death. This may be because the cadaver is autolysed, or the pathologist only has part of the body to autopsy. It may also be because the death is caused by probable natural causes that cannot be proven (e.g. cardiac arrythmias or epilepsy with no pathological findings etc.) A cause of death can also be recorded as **unascertained** either because it is truly unascertainable (for the reasons above) or because the cause of death was unable to be established at autopsy and had not since been established at the time the autopsy report was prepared.

18 b. If yes, does it follow the usual manner prescribed by the Office of National Statistics (ONS)?

The Royal College of Pathologists Guidelines state that:

"The cause of death, for adults and children over 28 days of age, must be given in the standard form required by the Office of National Statistics (ONS).

"The underlying cause of death should be the lowest completed line in Part I, such that conditions placed above it are 'due to' that pathology. Part II includes pathology, unrelated to that in Part I, which contributed toward death, but should not be used as a basket for all the minor pathologies found at autopsy.

"For stillbirths and live-born children dying within 28 days of birth, there is a different standardised format for the cause of death. The form of the statement is:

1. Main diseases or conditions in fetus/infant.
2. Other diseases or conditions in fetus/infant.
3. Main maternal diseases or conditions affecting fetus/infant.
4. Other maternal disease or conditions affecting fetus/infant.
5. Other relevant causes.

"If the patient dies following an operation and that procedure was directly or indirectly contributory to the death of the patient, the fact and type of the operation must be included in the cause of death (under Part I or II, according to relevance) and the date of the operation given (date/month/year)

"If the autopsy is limited, it may not be possible to give an ONS cause of death, and this must be made clear in the report." Page 22

Schedule 2 of the Coroners Rules 1984 states that the pathologist shall note:

In my opinion the cause of death was:

I	(a) ……..I……..
Disease or condition directly leading to the death*.	Due to (or as a consequence of)
Antecedent causes. Morbid conditions, if any, giving rise to the above cause (stating the underlying condition last).	(b) …….. Due to (or as a consequence of) (c) ……
II	II
Other significant conditions contributing to the death but NOT related to the disease or condition causing it. **	……

Morbid conditions present but in the pathologist's opinion *NOT contributing to the death*

*this does not mean the mode of dying, such as (e.g.) heart failure, asphyxia, asthenia, etc. It means the disease, injury or complication which caused death.

** Conditions which did not in the pathologist's opinion contribute materially to the death should NOT be included under this heading, but under "Morbid conditions present but in the pathologist's opinion NOT contributing to death".

19 a. Does the cause of death take into appropriate account the clinical course and autopsy findings as presented in the report and in the supporting documentation?

This question is asking the Advisor to consider whether the cause of death 'makes sense' given the information contained within the autopsy report and the supporting documentation provided to the pathologist.

Possible responses	Example
Yes	The cause of death appears reasonable and / or justified given the information provided in the autopsy report.
No	The cause of death appears unreasonable and / or unjustified given the information provided in the autopsy report.

20 a. Does the report contain clinicopathological commentary, correlation and/or summary?

Possible responses	Example
Yes	The autopsy report provides some kind of commentary, correlation or summary that makes reference to the deceased's past medical history and/or circumstances of death and cause of death.
No	The autopsy report does not provide any commentary, correlation or summary.

21. In your opinion, what was the category of death?

Possible responses	Definition
a. Natural cause of death (in hospital)	This category can be used where the deceased was clearly under the care of a hospital at the time of death. If an Accident and Emergency Department received a patient that was 'dead on arrival', this case can be classified as 21 b 'Natural cause of death in community'. If a patient was alive when admitted to a hospital but was not in the active and ongoing care of a hospital for more than about one hour prior to death, the case can also be classified as 21 b 'Natural cause of death in community'.
b. Natural cause of death (in community)	Any natural death reported to the coroner where the deceased died in the community – i.e. not in a hospital, prison or police custody. This category includes deaths in nursing or residential homes. If the death occurred in prison or police custody, please specify in 'Other'.
c. Natural cause of death (location not stated)	Any natural death where the Advisor is not able to determine from the information contained within the autopsy report and supporting documentation where the death occurred.
d. Related to anaesthetic / medical intervention	The death occurred while the person was under the influence of an anaesthetic, or the death was a result of an anaesthetic, or the anaesthetic is considered to have substantially contributed to death; OR The death occurred during a medical intervention, or the death was a result of a medical intervention. Medical intervention means surgery, drug therapy, radiotherapy, interventional radiology, endoscopy etc.

e. ‘Mishap’ in hospital (e.g. fall)	The death occurred in hospital and was due to a mishap or accident, which was not directly related to a particular medical intervention, e.g. a patient fell whilst in hospital which directly contributed to the death.
f. Associated with a road traffic collision	The deceased was involved in a road traffic accident, which directly or indirectly caused the death.
g. Associated with fire	The death was directly or indirectly attributable to the effects of fire or smoke.
h. Industrial (e.g. asbestos-related cause of death)	The death was directly or indirectly caused by an industrial-related disease or workplace accident (e.g. mesothelioma).
i. Intentional self harm	The death occurred as a result of intentional self harming actions by the deceased. This category includes suspected suicide.
j. Associated with illicit drug overdose/poisoning	The death was caused by the presence of illicit drugs (drugs of abuse) or their effects. **i** above can also be marked where applicable.
k. Associated with alcohol	The death was caused by the effects of chronic or acute alcohol abuse.
l. Associated with immersion	The death was caused by immersion, or was related to immersion. This usually means immersion in water. **i** above can also be marked where applicable.
m. Maternal death	Direct and indirect maternal deaths.
n. Sudden infant death syndrome (SIDS)	The cause of death was attributed to Sudden infant death syndrome
o. Cause of death unascertained	‘Unascertained’ was noted as the cause of death.
p. Other, please specify:	-

22. My overall score for this autopsy report is:

Possible responses	Definition
a. Excellent	The autopsy report meets MANY of the specifications outlined in the Royal College of Pathologists 2002 Guidelines for Autopsy Practice. The autopsy report reads well and the cause of death takes into appropriate account the findings presented in the autopsy report. The autopsy report is a standard that you would expect of yourselves and/or your colleagues.
b. Good	The autopsy report meets MANY of the specifications outlined in the Royal College of Pathologists 2002 Guidelines. The cause of death takes into appropriate account the findings presented in the autopsy report. It may not be as detailed as an autopsy report that would be classified as excellent.
c. Satisfactory	The autopsy report sufficiently explains the cause of death given by the pathologist. It may meet some of the specifications outlined in the in the Royal College of Pathologists 2002 Guidelines. The autopsy report fulfils its main purpose of documenting the cause of death but lacks additional details that distinguishes a Good or Excellent autopsy report. There is obvious room for improvement.
d. Poor	The autopsy report does not sufficiently explain the cause of death given by the pathologist. It contains few, if any, specifications outlined in the Royal College of Pathologists' 2002 Guidelines. The cause of death may appear to be incorrect based on the information presented in the autopsy report. An Advisor considers that the autopsy report is at a standard below what would expect from his / her colleagues.
e. Unacceptable (laying the pathologist open to serious professional criticism)	The autopsy report does not sufficiently explain the cause of death given by the pathologist OR the cause of death is incorrect. It may be carelessly drafted. The Advisor considers that the autopsy report fell below an acceptable standard that the profession would expect, which indicates that the pathologist is likely to prepare misleading or incorrect autopsy reports in the future, if not addressed.

24. If you feel that this case is 'Cause for Concern' please indicate here.

Cases that have been marked above in question 22 as **e. Unacceptable** may be deemed a 'cause for concern'. For these cases, a letter will be sent from the Chief Executive of NCEPOD to the coroner who requested the autopsy identifying the specific case and pathologist implicated and explaining our concerns. The letter from NCEPOD will suggest to the coroner the manner in which he / she might like to respond. This process has been agreed by the NCEPOD Steering Group. A similar process has been in operation for two years with generic approval from the General Medical Council, and the responses received have always been positive in that it is felt that NCEPOD are dealing with concerns in the most appropriate manner.

25. Does the autopsy report meet the statutory requirements outlined in Schedule 2 of the Coroners Rules 1984?

To meet the requirements of Schedule 2, the following questions must be completed in the affirmative:

5 a, b, d, f, g, i, j, k, l, m, o, q, r, s, u
7c
8 a
9 a – h
17 a

If the autopsy report meets all requirements except **5 o** (other persons present at autopsy), mark as YES. This may be because no other person was present at the autopsy.

If the autopsy report meets all requirements except **5 q** (deceased identified by), but indicates **5 p** (mode of identification of cadaver), mark as YES.

If autopsy meets all requirements except **5 b** (age), but indicates both the date of birth and the date of death, mark as YES.

If the autopsy report meets all requirements except **5 d** (address), mark as YES. The pathologist is only required to note the address of the deceased on the autopsy report if it is known.

5m can be marked if the autopsy report states the jurisdiction for which the autopsy was performed (i.e. it does not need to explicitly state the coroner's name).

9 h musculoskeletal system can be classified as 'external features' for this purpose (the Coroner's Rules states the following must be included in the autopsy report: *'Body surface and musculo-skeletal system, including injuries'*). I.e. if the autopsy report does not contain a section on the 'musculoskeletal system', but includes a description of identification features, it would meet the statutory requirements outlined by the Rules.