1. Introduction

Why autopsies are performed

The Coroners Act 1988[27] (the Act), sections 8, 19 and 20, prescribes that in England and Wales' coroners shall investigate the body of a person lying within their jurisdictions where they have reasonable cause to suspect that the deceased:

- has died a violent or an unnatural death;
- has died a sudden death of which the cause is unknown; or,
- has died in prison or in such a place or in such circumstances as to require an inquest under any other Act.

A coroner will request an autopsy if there is reasonable cause to suspect that the person has died a sudden death where the cause of death is unknown, i.e. a medical practitioner does not feel able to provide a natural cause of death, 'to the best of his knowledge and belief' or because they have not seen the patient for more than two weeks[1].

For the purpose of the investigation, a coroner will decide whether an autopsy is necessary and, if so, direct any qualified (i.e. fully registered) medical practitioner to make an autopsy of the body, and to report the results of the examination to the coroner in writing. For the format of that autopsy report, Section 10 of the Coroners Rules 1984[28] states that:

"The person making a post-mortem examination shall report to the coroner in the form set out in Schedule 2 or in a form to the like effect".

A copy of Schedule 2 is provided as an Appendix. It lists the information that should be contained within an autopsy report. (The equivalent Schedule in the Northern Ireland coronial system is similar to that of England and Wales. Minor deviations as noted in the Statutory Rules and Orders of Northern Ireland[29] are highlighted where applicable throughout this report). (The offshore islands also have their own equivalent of the Coroners Rules[4,5]).

What is the autopsy for?

The coronial autopsy examination should identify how the deceased came by his/her death in cases where an unnatural death is suspected. For natural causes of death, under existing legislation, the standard of proof required is only the 'balance of probability', rather than 'beyond reasonable doubt' as required under criminal law, and for certain categories of coroners' verdicts (suicide, unlawful killing). In summary, the purpose of the coronial autopsy is to assist the coroner in carrying out their duties in establishing who the deceased was, and how, when and where the deceased came by their death. In most cases, the level of diagnostic accuracy is expected to be 'probably true' rather than 'accurate beyond reasonable doubt'. It is important to recognise that under existing legislation, the purpose of the coronial autopsy is interpreted differently by coroners as well as pathologists. At the basic level, it is to identify or exclude unnatural or violent deaths (e.g. homicide) and provide a cause of death. At the other end of the

spectrum, others may consider that the purpose of the coronial autopsy is to confirm or refute clinical diagnoses, and/or to ensure that the autopsy report meets 'best practice' guidelines (discussed further under 'The Royal College of Pathologists' section).

The autopsy results may obviate the need for an inquest, as occurs in nearly 90% of cases (England and Wales) where the cause of death proves to be 'natural' rather than 'unnatural'. There is no statutory definition of what constitutes a natural cause of death, however, it is generally taken to be the consequences of old age or a disease that did not (for example) involve a third party, drug toxicity, industrial complications, trauma, self injury, or medical malpractice. Over the years there has been accumulated guidance on the types of death scenarios that should be reported to a coroner, with such lists printed in the books of medical certificates of causes of death, and recent advice from the General Registrar's Office[1]. The conditions described therein constitute the conditions considered potentially unnatural and are to be investigated by the coroner.

If an inquest is to take place, the resulting autopsy report may become part of the evidence. Often, but not always, this is supported by the presence of the pathologist at the inquest. The Act prescribes that at inquest, the coroner shall set out, so far as such particulars have been proved, who the deceased was and how, when and where the deceased came by his/her death.

The communication between coroners and pathologists is critical to the operation of the system for autopsies, and comes under scrutiny in several places within this report. The size of coronial jurisdictions and numbers of deaths reported varies hugely[2], and in the busier jurisdictions there are officers employed on behalf of the coroner in most aspects of referred cases. They apply the policies laid down by the coroner and do most of the communicating with pathologists.

There are approximately 700-800 pathologists in the UK who perform autopsies for coroners but there is no central register. The Royal College of Pathologists is the professional body that supports pathologists, and a summary of their work is provided in the next section.