1. Introduction

The Royal College of Pathologists

The Royal College of Pathologists (RCPath) is a "professional membership organisation... concerned with all matters relating to the science and practice of pathology"[30]. The RCPath has previously outlined a number of problems with the current coronial system[24], some of which are discussed here.

First, the RCPath contend that there is often a lack of adequate information presented to pathologists before the autopsy, and that in most cases the pathologist will not have the patient's medical records, a finding which has been supported by previous research[31].

Second, the RCPath has expressed the view that performing many autopsies in a short space of time can lead to an inadequate amount of time being spent on problematic cases. Attitudes of pathologists have also been highlighted as a problem, as they may be under pressure to provide a cause of death quickly, leading to inadequate investigations into the cause of death. These findings have been replicated by the Shipman Inquiry[32], which also highlighted the issue of histology, whereby the coroner may not allow for histology to be taken, even where the pathologist feels it is necessary. Following The Royal Liverpool Inquiry[33] and the Bristol Royal Infirmary Inquiry[34] there has been a 'sea change' in the attitude of most coroners to retaining tissues for analysis, with increasing restriction. The attitude of government toward all autopsy tissue retention also changed and the specific regulations governing tissue retention at a coronial autopsy were amended with effect from June 2005 (see 'Tissue retention' in the 'Results' section).

Third, the RCPath has highlighted a lack of audit leading to a possible fall in standards. They argue that it is important to have a baseline overview of what is actually done at autopsy.

In the late 1990s, the RCPath commissioned the development of practice guidelines for autopsies of all kinds (i.e. coronial as well as consented hospital autopsies) which was published in 2002. The minimum data set applicable to all autopsy examinations includes:

- Demographic details;
- Type of autopsy;
- Clinical history;
- External description;
- Internal organ examination;
- Histological report (if histology is taken);
- Summary of findings;
- Clinicopathological correlation;
- Cause of death[24].

These guidelines are for 'best practice' and have no direct influence on how coronial autopsies are performed. The RCPath recognises that in addition to providing a cause of death, autopsies that are conducted within and outside the coronial system are useful to gain further understanding of disease, to evaluate the effects of treatment and to identify other information about the deceased which may be relevant to the death. Autopsies may incidentally be used for audit of clinical care, teaching, and are occasionally used in research.

Role of the RCPath

The RCPath is a professional and advisory body; it is not a regulatory body that has powers to enforce standards of practice in any area of pathology. It produces best practice guidelines, across all areas of pathology, that derive from expert groups which are then subject to consultation with the membership and other relevant bodies, to arrive at a consensus. These guidelines are not binding upon practitioners, but are incorporated into specialist practice development and reviews (e.g. cancer networks). It has a Professional Standards Unit (PSU) that can become involved in investigating pathologists and departments where allegations of substandard practice have been made, usually at the invitation of medical directors of trusts and other hospitals. It organises a Continuing Professional Development (CPD) scheme for pathologists, which is voluntary, to document practice and continuing education in the specialist fields. This can be part of the regular appraisal of pathologists by their employers.

However, coronial autopsy practice is, by definition, privately contracted work that lies outside the National Health Service (NHS). Whether the pathologist is employed by a hospital trust, a medical school, or is an independent practitioner, the standards of practice in performing coronial autopsies do not come under the clinical governance prescriptions of the NHS. Thus this activity is essentially unaudited (the autopsy reports belong only to the coroner and may not be disclosed without the consent of the coroner[27]), is not part of the annual appraisal (as long as the time taken doing coronial autopsies does not conflict with agreed job plans), and does not come under CPD inspection. Further, the RCPath PSU has specifically indicated that, for the moment, coronial autopsy practice is not within its remit for investigation.

Initiating this study

In 2004, NCEPOD received a proposal from the RCPath, which called for a study to examine the quality of coronial autopsy reports. It will be the first of its kind to audit the quality of the product of coronial autopsies: the autopsy report. NCEPOD hope that the findings from this study will be useful to coroners, pathologists and other key stakeholders, particularly during the proposed coronial reform[35]; and that the results of the study will be used as a baseline for future quality audits, be that on a local, national or international level.