4. Overview and discussion

The purpose of the coronial autopsy

What is the purpose of the coronial autopsy examination? Statutorily, it is to determine the medical cause of death; but as detailed in the Introduction it can and does have layers of additional significance in the clinicopathological depiction of the final events of a person. Schedule 2 of the Coroners Rules simply provides for the overall structure but not the detailed content of the autopsy report, so that there is no specific answer to the question of how much information is meant to be set out in an autopsy report. The original schedule of items to be included in a report does not, for example, include a clinicopathological correlation. Viewing the study autopsy reports and the wide range of detail and commentary included within them, one can draw up an algorithmic approach which includes a five point grey scale of incremental quality. The range of purposes of the coronial autopsy may be (although not mutually exclusive):

A1: To consider and exclude homicide.

A2: To consider and exclude unnatural death.

B1: To provide an acceptable - though not necessarily correct - medical cause of death for registration purposes.

B2: To provide the correct medical cause of death and accurate data for national statistics.

B3: To provide an account of sufficient, accurate detail to address any concerns from the next of kin and to be useful to them.

B4: To provide detailed information for medical audit and explanation of events following medical interventions.

B5: To provide the basis for a publishable case report.

Under section 19 of the Coroners Act, the autopsy may provide a cause of death that renders an inquest unnecessary. This is the commonest situation in coronial autopsy practice (although there are no published data on the proportion of section 19 versus section 20 coronial autopsies). Thus the purpose of the autopsy might be defined as fulfilling levels A1, A2 and B1 in the above list.

Within the study data, examples of all these levels of quality were observed (with the exception of the first (A1), as homicide cases were excluded), and this exemplifies the lack of standardisation of the process. In the RCPath Guidelines, the purpose of all autopsies is to address all questions that may be posed by interested parties regarding a death and ultimately satisfactorily explain how the patient died[3]. The parties include, in principle, not just the coroner, but the family, any clinicians involved in the deceased's care, the hospital or general practitioner and the pathologist. That implies that all autopsies should be undertaken at least down to levels B3 and B4 in the above list. But perhaps level B2 is what most interested parties, most of the

time, would wish to see. The fundamental conclusion of this study is that there is a very wide range of reporting standards in coronial autopsy reports whereas a nationally agreed - and funded - standard is desirable. The figure of 18% (310/1,691) of all cases where the advisors questioned the accuracy of the given cause of death, indicates the need for a proper discussion of what level of quality product do the professions, government statistics, and the public want from coronial autopsy reports. Since coronial autopsies are the basis of 22%[4] of all causes of death for ONS purposes, this is an important question.

NCEPOD and other inquiries (e.g. The Shipman Inquiry) do not believe that sufficient consultation has been undertaken to review the purposes of the coronial autopsy in its broadest contexts. The system for coronial autopsies has continued for decades, unmodified, unaudited and using old 'Rules'. Because it lies outside the governance of the NHS - which has seen extraordinary commitment to raising standards through guidelines and target imperatives across all aspects of medical practice - it has been seen as separate and not worthy of inspection. This has to change, and is changing. In particular, the impact on families of autopsy diagnoses needs to be taken more seriously. Families wish to know how their relatives have died, and be given more information than they currently receive. There needs to be a national discussion and consensus on what the coronial autopsy is for, when it should be ordered, and what level of quality is expected from it. The system of death certification and the coroner service is currently in the process of reform, there having been two recent reviews[1,2]. There is an opportunity now to make statutory provisions for improvements. The distribution of cases amongst pathologists, i.e. should there be more specialisation of autopsy practice, as is happening with diagnostic surgical pathology, needs to be re-examined. NCEPOD has consistently called for the most appropriate pathologists to examine particular cases, and this is discussed further below.