3. Results of study

Results of study

This section presents and discusses the results of the study. Where areas of potential improvement have been identified, recommendations are made. Where practicable, the results have been presented in the order by which a case is investigated: from the information that is available to the pathologist prior to autopsy, the autopsy process itself including facilities available during the autopsy, and to production of the final written autopsy report. Accordingly, this chapter contains information from both assessment forms and the organisational questionnaires.

Alongside the results, there is also discussion of the main issues that have emerged. References are made to existing guidelines or legislation, where they exist, and to the relevant literature. There are also illustrative vignettes which depict particular cases that highlight certain issues. Inevitably, many vignettes illustrate what the advisors consider to be poor practice and indicate generic means of preventing such events in future. However, some cases have been included where the advisors considered that good practice was evident. The recommendations for remedial action are placed at the ends of each section.

Finally, in the 'Overview and discussion' section, the emerging themes are drawn together and some over-arching recommendations are proposed. Because the coronial and death certification systems of England and Wales are currently awaiting new legislation and reform[1], these recommendations could have a broader application than just intended for coroners and pathologists.