

14. As a hospital pathologist I regard it as one of my duties to assist clinicians investigating deaths both individually, and as part of audit. For example, for many years regular monthly perinatal mortality meetings have been held to discuss all stillbirths and neonatal deaths at St Michael's Hospital and Southmead Hospital. I chaired the latter meeting for several years and assisted in the production of an annual report at St Michael's Hospital. Similarly, I contributed to the cardiac surgery clinico-pathological meetings, presenting post-mortem findings to the cardiac surgeons, cardiologists and others, until 1993 when Dr Ashworth took over. (I will come back to audit in some detail later).
15. As a pathologist I occasionally encounter cases in which death has occurred in hospital and the cause is not clear. On at least two occasions in recent years I have suggested to the Medical Director of the Children's Hospital that there should be an internal inquiry into such a death (these were not cardiac cases). In addition, I have pressed for a small group to take an overview of all deaths in the Children's Hospital and to ensure that proper review of every death has taken place in each clinical discipline.
16. Coroners' pathologists carry out a difficult, unpleasant and sometimes even dangerous (in terms of risk of infection) task on behalf of the State. That the law requires Coroners' post-mortem examinations to be carried out even without the consent of relatives reflects that in some circumstances the public interest overrides private interests.

J2 The functions of post-mortems and inquests in helping to establish the cause of death of a child or the adequacy of the surgical or other services provided.

17. The statutory role of the Coroner is limited to determining the cause of death, and does not extend to monitoring the adequacy of surgical or other services. The pathologist may mention minor deficiencies in treatment in his or her report, but it is

generally only major errors that might lead to an inquest (e.g. mis-matched blood transfusion, major equipment failure, or some surgical disaster). The Coroner's system is therefore best suited to recognising individual or repeated gross deviations from normal medical practice and calling for changes in procedures. It is not intended to carry out long-term monitoring of individual specialised clinical services, which is the function of clinical audit. The Coroner's Rules are interpreted differently by different Coroners, the most literal interpretation (that the post-mortem examination should only establish the basic cause of death) conflicts with the needs of clinical audit, the views of The Royal College of Pathologists, and what is generally recognised as good practice.

18. My approach has been to carry out Coroners' autopsies in the same way as hospital autopsies, aiming for the same standards, to provide as much information as possible for parents and clinicians.
19. It was my practice to give a simple cause of death (e.g. "Congenital Heart Disease, attempted repair") to the Coroner by telephone as soon as the examination of the body was concluded and I was satisfied that I had found nothing to indicate that death was unnatural. This enabled a death certificate to be issued and parents to make funeral arrangements with the minimum delay. Further examination of the heart could then take place after a period of fixation in formalin, and the description would be incorporated into the written report to the Coroner. At that time these reports did not routinely state that the heart had been retained; some contain statements such as "heart examined after fixation" or "heart and lungs retained in continuity". Tissue samples were processed for histology, and any written report added to the post mortem report at a later date. All reports were routinely sent to the clinicians who had been responsible for the child's care in hospital.
20. Over the years I have drawn attention to a number of serious and unsuspected findings in the course of performing post-mortems of all types for the Coroner, some of which have led to inquests. I do not recall attending any inquests on post cardiac surgery patients.