

## Chapter 9. The Coroner

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## 1. Introduction

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- 1.1 Post mortem examinations can be carried out under two different legal powers. The most commonly used nationally is that under the jurisdiction of the Coroner (Coroner's post mortem examination or CPM). The other power lies under the Human Tissue Act 1961 (hospital post mortem examination or HPM) and will be covered in Chapter 10. In an HPM the surviving relatives should decide whether it takes place. In a CPM it is the Coroner who decides and the surviving relatives have no right to object. A CPM is required by law in certain circumstances.
- 1.2 Coroners are appointed and paid by local authorities. They are accountable to the Courts for their decisions by way of judicial review. They are also answerable to the Home Office and to the Lord Chancellor's Department for their conduct and administration.

## 2. Deaths Requiring an Inquest

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- 2.1 Coroners must hold an inquest where there is reasonable cause to suspect that the death reported was:
- unnatural;
  - due to violence;
  - sudden and of unknown cause;
  - in certain other circumstances not directly relevant to this Inquiry.
- 2.2 Where Coroners must hold an inquest they are also empowered to request a post mortem examination.

## 3. Function of the Inquest – the Scope of the Proceedings

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- 3.1 The function of an Inquest is to determine certain facts:
- the identity of the deceased;
  - the cause of death;
  - the circumstances surrounding the death and its cause.

- 3.2 Inquests can help allay rumour or suspicion, draw attention to the existence of circumstances which if unremedied might lead to further deaths, advance medical knowledge and preserve the legal interests of the deceased person's family. It is not, however, the function of an inquest to establish either criminal or civil liability.

## 4. Deaths Reportable to Coroners

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- 4.1 Coroners must be informed in the case of a death:
- of any person not attended during his last illness by a registered medical practitioner;
  - for which a certificate of cause of death cannot be obtained;
  - occurring in circumstances where the deceased was seen neither after death nor within 14 days before death by the certifying doctor;
  - the cause of which appears unknown;
  - which is unnatural, suspicious or related to trauma;
  - during an operation or before recovery from the effects of an anaesthetic;
  - related to industrial diseases or industrial poisoning.

## 5. Decisions Open to the Coroner

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- 5.1 Following notification of a death, the Coroner may decide that:
- the circumstances require neither a post mortem examination nor an inquest and inform the Registrar of Births and Deaths accordingly – the Pink Form A Procedure;
  - a post mortem examination is required. The Coroner makes the decision and may override the wishes of the surviving relatives. After the examination the Coroner may decide that an inquest is unnecessary if satisfied that the death was due to natural causes, in which case the cause of death identified by the examination will be notified by way of the Pink Form B Procedure;
  - an inquest is required with or without a post mortem examination.

## 6. Coroner's Limited Right to Possession of the Body and Retention of Body Parts

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6.1 Where a death has been referred to the Coroner, until an inquest has been held or the Coroner has decided no inquest is necessary, the Coroner has the right to possession of the body. This overrides the right of any other person until his duties have been completed.

6.2 Under Rule 36 of the Coroner's Rules 1984 the Coroner has the right to possession of a body only to carry out the function of the Coroner.

‘The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely:

- who the deceased was;
- how, when and where the deceased came by his death;
- the particulars for the time being required by the Registration Act to be registered concerning the death.

Neither the Coroner nor the Jury shall express any opinion on any other matter.’

6.3 There is no power to possess the body for research, medical education or therapeutic purposes under the Coroner's jurisdiction, which is a narrow one.

6.4 Rule 9 of the Coroner's Rules 1984 governs the circumstances in which body parts may be retained on behalf of the Coroner.

‘A person making a post mortem examination shall make provision, so far as possible, for the preservation of material which in his opinion bears upon the cause of death for such period as the Coroner thinks fit.’

6.5 Again there is no power to preserve body parts for research, medical education or therapeutic purposes. Preservation is only allowed of material bearing on the cause of death. Once the process is completed, while it can be appreciated that in some cases it would be appropriate to preserve material for further examination of experts in a civil case, it is difficult to see how a Coroner could validly think it fit to preserve large quantities of material any longer.

## 7. Background to our Inquiry

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- 7.1 Our Inquiry began at a time when the new HM Coroner for Liverpool, Mr Andre Rebello, was opening inquests into cases many years old which did not appear originally to have been properly investigated. Some surviving relatives were alleging that they had felt pressured into agreeing to an HPM on the basis that if they did not agree there would be a CPM anyway. There appeared to be a general ignorance among surviving relatives of the Coroner's process and some claimed not to have understood the cause of death. In the light of what was emerging from the van Velzen years (see Chapter 8), we were interested to see if Professor van Velzen's practice with regard to CPM had differed from that at HPM and whether there had been compliance within the limited scope of the Coroner's process. If there had been failures we were interested to see how the previous HM Coroner for Liverpool, Mr Roy Barter, had reacted.

## Pressure on Parents, Using Mention of CPM, to Consent to HPM

### 8. Parents' Account

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- 8.1 A number of parents gave evidence to the Inquiry to the following effect. When they were asked to 'consent' to an HPM they were put under pressure by references to a CPM. They were made to feel that a CPM would be carried out anyway and so there was little point in objecting to an HPM.
- 8.2 The mother of Samantha gave us a graphic example of the pressure she felt. Samantha had two operations and died within 48 hours of the second. The death was, therefore, clearly reportable to the Coroner and a CPM was in the end performed, finding the cause of death as cardiac and liver failure, due to chromosomal abnormality syndrome, congenital cardiovascular malformation and malformation of the liver. Samantha's mother, however, was asked to 'consent' to an HPM within five to ten minutes of Samantha's death. She protested that Samantha had been through enough and she would not consent to an HPM. At this point the treating clinician said that if she objected there would be a CPM anyway. Despite this pressure she continued in her objection. The CPM was appropriate but the pressure and reference to a HPM were not.
- 8.3 The mother of Simone reported a similar experience. Simone suffered from a congenital heart defect. She underwent surgery at 10 and 16 months of age. Following the later operation her condition deteriorated and she died three days after the operation. Her death was not reported to the Coroner and this case constitutes one of those now formally opened by Mr Rebello ten years on. Simone's mother said in

evidence to us that Mr Franks, Consultant Cardiothoracic Surgeon, made it clear that if she did not sign the post mortem consent form then he would ask for a CPM. She told the Inquiry,

‘He came in and placed a piece of paper in front of me and said, ‘Can you sign that?’ I said, ‘What is it?’ He said, ‘It is for a post mortem.’ I said, ‘You do not need one. You have been working on her for over 6 hours. You know what she has died of. Leave her alone. You have done enough.’ He said, ‘If you do not sign it, I am going to get it done anyway. I will get the Coroner to get it done.’ Basically, he was adamant that he was going to get that consent form signed.’

Simone’s mother reluctantly signed the form.

## 9. Clinicians’ Account

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- 9.1 Mr Franks disputed in his evidence that he made any reference to a CPM, saying in his witness statement dated 7 June 2000,

‘I deny categorically that the threat of a Coroner’s post mortem was ever used by me as a stick to ‘persuade’ parents to consent to a hospital post mortem. I have never done that and would regard that conduct as completely unacceptable.’

- 9.2 Other clinicians, against whom the parents made no complaint, maintained that they never applied pressure in this way. Dr Arnold, Consultant Paediatric Cardiologist, said in his witness statement dated 19 June 2000,

‘I believe that the circumstances in which the Coroner should be notified of the death of a child are quite straightforward and I have never used the ‘threat’ of a Coroner’s post mortem as a stick to get parents to consent to a hospital post mortem. Indeed, I have never leaned on parents in obtaining their consent to a hospital post mortem: usually one can tell right away whether parents are likely to agree or not.’

- 9.3 Dr Peart, Consultant Paediatric Cardiologist, expressed a similar view.

‘I have never held the threat of a Coroner’s post mortem over parents’ heads if they did not agree to a hospital post mortem. In my view a Coroner’s post mortem would be undertaken for two reasons, firstly where there was a legal request – usually in the situation of a death either on the operating table or within 24 hours of surgery – and secondly where the clinician had no idea as to why the child had died, for instance where the clinician was unable to sign a death certificate giving a cause of death. Outwith those situations, if I wanted a post mortem then my role was to discuss it with the parents. If the parents did not agree, then a post mortem would not take place.’

- 9.4 Dr Ratcliffe, Consultant in Paediatric Intensive Care, said in her witness statement,

‘I have always been clear about the distinction between the legal requirement for a Coroner’s post mortem and a hospital post mortem ... I would be very clear during my discussions with families that a post mortem examination was not required by the Coroner for legal reasons and that I was in a position to sign a death certificate.... I can confirm therefore that I have never used a Coroner’s post mortem as a threat to obtain consent to a hospital post mortem, and indeed I have no knowledge of this happening at Alder Hey, although I am aware that it did take place at institutions where I have worked previously.’

- 9.5 The final sentiment, that it was known to happen but not at Alder Hey, was also apparent from discussion at the Clinicians’ Seminar, arranged by the Inquiry and which took place at Alder Hey on 23 May 2000. There was again anecdotal evidence of the practice but individual clinicians denied that they had followed it. There are no grounds at all for suspecting that Dr Ratcliffe’s own evidence was not entirely honest on the point.

## 10. Coroner’s Officer

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- 10.1 Further anecdotal evidence of the practice came from DC Carl Thompson who served as a Coroner’s Officer in the Liverpool Office from 1992 to 2000. In his witness statement dated 30 June 2000 he said he was aware that doctors sometimes approached families to obtain consent for an HPM, telling the family that a death certificate would be issued at a later stage. He considered it to be unacceptable practice and explained that in cases not reportable to the Coroner a death certificate should be presented to the family before consent for any HPM was requested. In this way parents could object to an HPM and yet still hold a death certificate. He was not specifically aware of this unacceptable practice at Alder Hey.

## 11. Conclusion – ‘A Clouded View of What is Required’

- 11.1 We are satisfied, having weighed the evidence carefully, that pressure was sometimes applied at Alder Hey in mentioning a CPM at a time when parents were considering whether or not to object to an HPM. The parents’ evidence was compelling and supported in part at least by the evidence of clinicians and the Coroner’s Officer. They were aware of such a practice generally, although not admitting it at Alder Hey, and we regard this as substantial if not complete corroboration of the parents. We find that Mr Franks had a mistaken view of what was required in the reporting of deaths to the Coroner and our reasons are to be found below.
- 11.2 A clouded view of what the Coroner’s jurisdiction requires of clinicians has emerged generally in the course of our Inquiry. We have indicated in Chapter 10 how surprised we were to find the ignorance of the medical profession of the Human Tissue Act 1961. There was a similar confusion and lack of precision in the mind of clinicians as to when a death is strictly reportable to the Coroner. Dr Marco Pozzi, Consultant Cardiothoracic Surgeon, said in his witness statement,
- ‘I have never been given a document setting out the particular circumstances in which I have a legal obligation to report a death to the Coroner. Even now, all I know is if a child dies in theatre or does not wake up from anaesthesia, I have to report it to the Coroner.’
- 11.3 Professor van Velzen himself, having undertaken numerous CPMs, appears to have had a genuine misapprehension of what was required of him and what material he could retain. Of course what he in fact did went well beyond any genuine misapprehension, but he said in his preliminary evidence to the Solicitor to the Inquiry,
- ‘I was never fully instructed about how to go about Coroner’s post mortems.’
- 11.4 There is nothing wrong with obtaining an HPM ‘consent’ under the Human Tissue Act 1961 to the retention of material beyond the Coroner’s process for research, medical education or therapeutic purposes so long as the Coroner is notified and agrees. There is nothing wrong with returning to parents to ask for an HPM if the Coroner declines jurisdiction or decides not to carry out a CPM. What is unacceptable is for relatives to feel pressured into ‘consenting’ to HPM by reason of the suggestion of a CPM.

## Systems and Procedures

We were interested to find out if there are cases where CPMs should have been performed but were not. We explored carefully the Coroner’s systems and procedures.

## 12. Cases of 'Despair'

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12.1 DC Thompson has extensive experience as a Coroner's Officer. Before his appointment in Liverpool in 1992, he spent six years as a Coroner's Officer in the Wirral. He explained that when there had been a death at Alder Hey, which was reportable to the Coroner, the usual procedure was for the senior doctor concerned, in his recollection invariably a consultant, to telephone the office to report the death. As the Coroner's Officer he then completed *pro forma* Form 97, which records basic information regarding the death. If the death followed an operation, the reporting doctor explained its nature. The doctor outlined what the operation involved, the probability of survival and the medical background of the child. Often the doctor indicated that he was happy to sign a death certificate and that the operation had really been one of 'despair', meaning that the child would probably have died anyway and the family had no concerns regarding the treatment.

12.2 DC Thompson's practice in cases of 'despair', acting on instructions from the Coroner, was to indicate to the reporting doctor that there was no need for any CPM and that a death certificate could be issued. He said,

'That, however, was dependent upon my being satisfied that there was nothing in the circumstances reported to me that was of concern. If there was anything at all which was reported with which I was unhappy, then I would insist that a Coroner's post mortem would have to be carried out.'

## 13. The Problem

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13.1 How was DC Thompson to be 'satisfied' that there was nothing 'of concern' in the report to him? He was completely reliant on the accuracy of the information given to him by the reporting doctor. He had no training, no particular medical knowledge and yet he was required to make a 'judicial' decision concerning the performance of a post mortem examination. He was required to make no positive inquiry of the surviving relatives themselves to see if they had any concerns about the treatment. That they had not, he took completely on trust from the reporting doctor.

13.2 If satisfied DC Thompson then completed a Pink Form A, which the Coroner himself had to sign. This form was confirmation that a death had been reported but no post mortem examination performed. The reporting doctor was asked to initial the medical certificate of death. The Registrar of Births Marriages and Deaths then knew that the death had been reported to the Coroner. The Registrar agreed to the issue of the death certificate and expected Pink Form A from the Coroner's office in due course.

## 14. Clinicians' Knowledge and Use of the Practice

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- 14.1 The above practice was not unique to Liverpool and was well known to the clinicians at Alder Hey. Both Dr Pozzi and Dr Peart were well aware of it, Dr Peart stating,

‘I am not aware of circumstances where a Coroner’s post mortem has been used as a threat to induce consent to a hospital post mortem but I am aware that there were circumstances where the Coroner waived his right to a post mortem.’

## 15. Mr Franks' Memory

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- 15.1 Mr Franks' memory of exactly what the practice involved differed, slightly but significantly, from that of DC Thompson. He remembers that the Coroner only authorised the issue of a death certificate without a CPM in the following circumstances:

- when the doctor was able to write a death certificate;
- when there was ‘no problem or discontent on the part of the relatives’;
- *and* there was going to be an HPM in any event.

- 15.2 Mr Franks said he did not have such a discussion with the Coroner's Officer

‘... unless I was sure that I had a formal consent to post mortem because otherwise there could be a change of mind.... My usual practice was therefore to speak to the Coroner if I was in any doubt as to the circumstances regarding my duty to report but then I would have left it to the Coroner to decide whether there should be a Coroner's post mortem. His questions however, were usually the same, “Could you write a death certificate and would there be a post mortem examination giving the opportunity to modify the death certificate?” If the answers to those questions were in the affirmative then the Coroner would generally say that the death did not need to be formally reported but he would *see the post mortem report and file it on that basis*’. [emphasis added]

## 16. Contrast DC Thompson

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- 16.1 DC Thompson's recollection is different. He is clear that in making the decision to perform a CPM he never offered the reporting doctor the opportunity of performing an HPM instead, only for a copy of the report to be sent to the Coroner.

- 16.2 We prefer DC Thompson's evidence. Mr Franks seems to have a mistaken view of the role of the Coroner and the rules governing the Coroner's procedures. It is illogical, in the case of a reportable death, for a Coroner to state that a CPM is unnecessary, but that an HPM should be performed. It is not surprising that, despite looking, we have found no evidence of HPM reports being sent to the Coroner. Mr Franks' evidence is confused. Whether he was sure that a death should be reported is not the issue. The real question, to be addressed by the Coroner, is whether a CPM should be performed, the death having been formally reported. There is the clear potential for mistake, or even abuse, in the procedure designed to provide the information upon which the decision is to be made.

## 17. Views of Clinicians

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- 17.1 At the Clinicians' Seminar one consultant expressed his confidence in the Coroner's Officers, but Dr Pozzi disagreed in his evidence.

'The communication has been with an Officer who, from my point of view, had very little understanding of what the problem was and who seemed to have difficulty spelling the name of the pathologist. We could tell these people just about what we wanted and we could decide almost whether or not we wanted a Coroner's post mortem report by putting the emphasis on the severity of the disease and their happiness to produce a cause of death.'

- 17.2 Dr Pozzi exposed the lack of transparency of the system and his views were echoed in those of Dr Ratcliffe. She said,

'I now accept that on the face of things, that system is not transparent in that if the reporting doctor wished to put a history in terms such as to persuade the Coroner's Officer that a post mortem was not necessary, then due to the Coroner's Officer's lack of knowledge there would be the potential for that to happen. This problem is exemplified by the fact that in many cases I would be telephoning to report the death to the Coroner and yet I would not have been directly involved with all the treatment. For example, I would not have been party to cardiac surgery, yet would have often dealt with that patient in intensive care and may not have had any knowledge of any untoward events in theatre. Having said that, I have no evidence of the system having been abused in this way.'

- 17.3 In relation to Dr Ratcliffe and Dr Pozzi there is no issue as to their honesty or any suggestion of any abuse of the trust placed in them. We found them to be caring clinicians and open in their approach.

## 18. Conclusion

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18.1 DC Thompson himself recognised the problem.

‘I personally was aware of the inherent dangers of taking at face value what had been said to me by the reporting doctor and authorising the issue of the death certificate without a Coroner’s post mortem. However, it was clear to me that this way of dealing with things was how Mr Barter wanted us to proceed.’

18.2 Failure to carry out a CPM in cases where such an examination should be performed leads to lack of proper scrutiny of medical practice. Transparency and openness are lost.

## The Coroner’s Non-delegable Duties

### 19. Rule 4 – ‘Ready’ at all Times

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19.1 We have outlined in the previous section how the Coroner’s Officer regularly decided whether a post mortem examination should be carried out. Under Rule 4 of the Coroner’s Rules 1984,

‘A Coroner shall at all times hold himself ready to undertake either by himself or by his deputy or assistant deputy any duties in connection with inquests and post mortem examinations.’

19.2 This imposes a personal duty on the Coroner, and both Rules 5 and 6, which deal with the arrangements for post mortem examination, are specific in referring to the Coroner as the one directing or requesting the examination. The wording of the Rules clearly lays the responsibility on the Coroner personally, and not on his Officer, of taking decisions regarding the authorisation of a post mortem examination.

### 20. Role of Coroner’s Officer

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20.1 The standard text, *Jervis on Coroners*, states,

‘The Officer is not the Coroner, and he must never appear to assume more than transitory responsibility for what is being done, ordered or arranged. He must report to, and receive instructions from, the Coroner, though he may know from experience the likely sequence of events in certain fairly common and well-defined circumstances.’

## 21. Pink Forms Revisited – the Coroner's Decision

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- 21.1 While the Coroner did in fact sign the Pink Form A personally, this amounted to little safeguard when the Officer was the one in direct communication with the clinician. DC Thompson said that on occasions Mr Barter asked for more information before signing the Pink Form A but he had never ultimately refused to sign one. The present Coroner for Liverpool, Mr Rebello, supervises the officers much more closely. DC Thompson said,

‘The practice to which I have referred above however, whereby I am able to authorise the issue of a death certificate without the necessity for a Coroner’s post mortem subject to being satisfied with the information given to me by the reporting doctor, is a practice which continues. The difference now is that my contact with the Coroner is much closer. Mr Rebello personally authorises all post mortems whereas Mr Barter was more remote than that. Provided that there were no queries he was more than happy for post mortems to be authorised on his behalf and he did not expect to be consulted all the time. Now, however, I am obliged to check matters with Mr Rebello. I am no longer able to agree that no Coroner’s post mortem should be performed without specifically referring to Mr Rebello first. Previously the only effective control was that ultimately Mr Barter would sign the pink form A in each case.’

## 22. Stacks of Pre-signed Forms

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- 22.1 Improper delegation of his duty by Mr Barter led to other undesirable practices. We obtained evidence that there were stacks of pre-signed blank Pink Form B (authorising issue of death certificate where no inquest was ordered) and Form Cert E (releasing the body for cremation). Mr Barter explained that he wished to help grieving families in any way he could, particularly by issuing promptly those documents enabling funeral arrangements to proceed. Pink Form B and Form Cert E were pre-signed to avoid delays. Pink Form A was not pre-signed, as in such cases the death was registered on the basis of the cause of death given by the medical practitioner and not on the contents of Form A which simply confirmed the Coroner had no further interest in the death. The upshot of having these pre-signed forms was that Coroner’s Officers were able to take decisions whether to hold an inquest or not without being obliged first to refer to Mr Barter.

## 23. Training of Coroner's Officers – Misplaced Confidence

- 23.1 The lack of personal control of the previous Coroner is all the more concerning because of a similar lack of training in Coroner's Officers generally. DC Thompson maintained that he had received no formal training. Essentially he learnt the job through sitting next to one of the other Coroner's Officers. In oral evidence Mr Barter suggested that the decision whether to carry out a CPM was basically a simple administrative decision. He considered that an experienced Coroner's Officer was perfectly competent to know when a post mortem examination was needed and said he had every confidence in his senior Coroner's Officers. However, he accepted that ultimately he was responsible for the decisions reached, that there was no written instruction or training of Coroner's Officers and the job was learned 'hands on'.

## 24. Conclusion

- 24.1 In our view it is quite wrong to suggest that the decision whether to carry out a Coroner's post mortem is 'a simple administrative decision'. The decision is one to be taken by the Coroner personally, after all proper enquiries. No doubt the Coroner's Officers can assist, but it is not their decision to take.

## Further Illustrations

### Sean

- 25.1 Sean was born in 1996. He had been diagnosed as suffering from a congenital heart defect (double outlet right ventricle, hypoplastic left ventricle with hypoplastic aortic arch). He underwent a repair of the aortic arch a week after birth and at 15 months a Fontain procedure. He died on the operating table during this second surgery. Before the operation Sean's parents were told differing prospects of success – 80 per cent but then 50 per cent. His father gave us clear evidence that after death he was approached by the surgeon, Mr Franks, for consent for an HPM which he gave, limited to the heart and lungs,

'I specified that Sean's heart only be looked at, because I figured that because he died during open heart surgery, that was the reason for his death.... We were stunned he had died, and we wanted to know why he had died, and that is what we thought we were consenting to, to help the hospital and to help ourselves to discover why.'

- 25.2 Precisely why Mr Franks asked for an HPM is a matter of some speculation when it was so obviously wrong. A CPM was clearly indicated because Sean had died during surgery but the parents did not then know this. Sean's mother said,
- ‘I did not even realise that a Coroner could and should have done the post mortem.... Mr Franks should have stepped back and said, “I am very sorry, but at this point I do have to hand over to the Coroner”, for want of a better phrase.’
- 25.3 His father said,
- ‘I do recall Mr Franks saying to me words to the effect that, ‘you can have a Coroner’s post mortem if you want, but obviously we know why he died, so we will just do a hospital one because it will be quicker’. They are not his words, but that was the general tone.’
- 25.4 Mr Franks said, in a supplementary statement dealing specifically with Sean, that the death had been reported to the Coroner, who had been happy for a death certificate to be issued subject to the performance of an HPM. We have established that the death was reported to the Coroner on the following day. The Coroner’s officer completed the Form 97A,
- ‘Elective admission to correct complex congenital heart condition (high risk but essential to preserve life). Surgery commenced 09:00 21/10. Baby died on table at 20:00 same day. Natural causes, family happy to accept certificate.’
- 25.5 There is no evidence of any HPM report having being sent to the Coroner. A Pink Form A was issued, confirming that a death certificate could be issued without a post mortem examination, and the cause of death was recorded as 1(a) heart failure and 1(b) complex congenital heart disease.

## 26. Conclusion

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- 26.1 This is as clear a case as any where a CPM should have been performed. On the basis of the actual death certificate the Registrar of Births and Deaths was not even aware that there had been surgery, let alone that death had been on the operating table. The comment on Form 97A, ‘high risk but essential to preserve life’, might well be correct; but it begs the question whether Sean had the quality of surgery and care that is owed to us all, even a critically ill baby. Only a CPM independent of the hospital could have provided open and transparent evidence upon which to decide whether to hold an inquest.

- 26.2 The parents gave evidence in their initial questionnaire,
- ‘Had we truly understood the situation as to the events around Sean’s death we now know that we would not have signed any consent form, nor allowed anyone else at Alder Hey to touch him, and also most significantly we would have wanted the Coroner to be involved as Sean died during an operation.’
- 26.3 Sean’s parents understandably feel that the sole reason for the HPM was to enable the hospital to retain Sean’s heart for the collection at the ICH. We now know that Professor van Velzen made no distinction between CPMs and HPMs, so that the parents’ concern on this score is unlikely to be accurate. However, this sort of suspicion is precisely what comes out of secrecy and disregard of proper procedure. The present Coroner is now investigating and an inquest is expected soon.

## Sarah

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- 27.1 Sarah was born in 1991 and died at the age of 5 weeks following surgery on the previous day. The death was correctly reported to the Coroner, but Form 97A reveals only the scrappiest manuscript note. It records simply that an operation for transposition of the great arteries had been performed and that Sarah had died at 0300 the following day. The cause of death was recorded as 1(a) heart failure and 1(b) transposition of great vessels and coarctation, with a note ‘PHos’ (apparently ‘per hospital’).
- 27.2 Even though a death certificate could be issued without post mortem examination, an HPM was performed. Mr Franks, the surgeon involved, commented specifically on the case and suggested that a CPM was carried out, but there is no copy of any post mortem report on the Coroner’s original file, and the post mortem report copied to us indicates clearly that Professor van Velzen performed an HPM. When Sarah’s parents gave oral evidence to the Inquiry her father rightly questioned how it could be that the Coroner did not request a post mortem examination when Sarah had died within hours of surgery.

## 28. Conclusion

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- 28.1 As with Sean, an HPM was carried out when it was indicated on behalf of the Coroner that there was no need for a CPM. Had the parents objected to an HPM, there would have been no investigation at all into the death. This would have been highly unsatisfactory. In each case, as with many others, a CPM was surely indicated.

## Information for Parents

### 29. Information Irrespective of 'Consent'

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- 29.1 While as a matter of law consent to a CPM is not required, nevertheless surviving relatives should be informed of the purpose of the procedure, what it involves and, most importantly, the findings and conclusions. We found little evidence of any detailed discussion in the case of CPM. The general experience of parents was that they were told it had to be performed and that 'this was the law'. Inevitably those 'discussions' often took place at the most difficult of times, immediately after the death and when parents were most vulnerable. Some clinicians limited 'discussion' of a CPM to a bare minimum precisely because 'consent' was not required. This reflects the difficulties of some clinicians in discussing post mortem examinations generally.

## Gareth

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- 30.1 Gareth, who died following surgery for a congenital heart defect in 1993, is a typical case where the parents were given inadequate information. They gave evidence to us of Mr Franks' explanation that a CPM was required.

'He came out saying something along the lines of, 'You know there is going to have to be a post mortem', basically saying we did not have any choice in the matter, no option. I think we appreciated that ourselves, from our own knowledge, but at no time did he come out and explain the post mortem procedure, or why it was necessary. We were not really given any time to consider it... We were just told, 'it is going to happen.'

- 30.2 The lack of proper explanation led the parents to suspect something had gone wrong with the treatment. That was not the case and the upset and suspicion could easily have been avoided.

## 31. Clinicians ‘Slightly Defensive’ When Coroner Involved

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- 31.1 Clinicians generally felt that they had to be more circumspect in cases where the Coroner was involved. Dr Arnold, Consultant Paediatric Cardiologist, said in his witness statement dated 19 June 2000,

‘In relation to Coroner’s post mortems I would confess that I had always felt our attitude in this regard has been slightly defensive in terms of being very careful in relation to what is said to parents given that a Coroner’s inquiry is underway, particularly when an inquest is being arranged. With the benefits of hindsight I do not think that that was helpful, and there should be more liaison between clinicians and the Coroner.’

- 31.2 Circumspection in discussing the presumptive cause of death before a CPM is easily to be understood, but there is no reason why a full explanation of the procedure and the reason for the examination cannot be given. Dr Ratcliffe agreed. She made no distinction in the way she worked with parents in a CPM or an HPM. She explained to parents that a CPM was required by law in certain circumstances and was explicit as to what the examination involved. We received written evidence from some parents who appreciated this explicit but sympathetic approach and they had specific praise for Dr Ratcliffe.

## 32. Examples of Poor Communication

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- 32.1 In some cases there was practically no communication. The mother of Lindsay, who died in 1991, did not know that a CPM had been performed until she attended the funeral parlour. The mother of Craig, who died in 1986, was told of the need for a CPM, but the subsequent report suggested that when the discussion took place the examination had already been performed. The parents of Philip, who died in 1989, knew that as a result of their son’s death there would be some investigation, but understood this to be ‘an internal inquiry’. They did not appreciate that a CPM had been performed, even when the treating clinician came to see them to discuss Philip’s death some six to eight weeks later.

## 33. Conclusion

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- 33.1 If parents want a full discussion of what is involved in the Coroner’s process, they should have it. Some parents, however, do not want to go into such detail. We appreciate that it is upsetting. Whereas Parliament has given the surviving relatives the responsibility for making the decision to have an HPM and they have to be told

upsetting information to inform their decision, no such considerations apply to CPM. It is wrong to force them to listen to the detail if they do not want to hear it. Sympathetic enquiry can be made of what they want to know and the information suited to their wishes.

- 33.2 While there is no statutory requirement, good practice clearly dictates that surviving relatives be told the results of a CPM as soon as is reasonably practicable, and in writing if requested. Results of examinations have not been communicated as a matter of routine in all past cases. Lindsay's mother did not receive the report until she requested a copy in November 1999, more than eight years on. There was no system at Alder Hey or at the Coroner's Office to ensure that parents who wished to do so received copies of reports in an appropriate setting. Given the basic human need for grieving parents to understand the cause of death of their child, it was wrong not to have ensured proper counselling of parents in the light of the reports. If parents have to 'endure' post mortem examination irrespective of consent in the case of CPM, then the least society can do in return is to communicate and counsel properly to help them understand and, in so doing, to help in the process of grieving.

## The Use of Organs Retained at CPM for Research

### 34. The Extent of the Power to Retain Material at CPM

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- 34.1 We have already set out the basic extent of the power in the above description. Section 11(5)(b)(i) and (ii) of the Coroner's Act 1988 defines precisely the extent of the Coroner's jurisdiction which is to determine who the deceased was, how, where and when he came by his death, and no more.
- 34.2 Paragraph 6 of 'Practice Notes for Coroners', a document issued by the Coroners' Society of England and Wales and approved by Council of the Society on 19 November 1998 states,

'It is long recognised that the Coroner's ability to direct that an examination be made is limited to the purposes laid down in the Coroners Act 1988, viz, to establish a cause of death and how that cause of death arose. Although a post mortem may offer the opportunity for wider research or investigation, the Coroner has no power to authorise any such extension to the examination to be made, and those wishing to avail themselves of this opportunity will have to resort to consent under the Anatomy Act 1984 or Human Tissue Act 1961, obtaining appropriate consent in each case.'

- 34.3 The Coroner therefore has no power to direct or request the removal of tissue or organs for any purpose other than to establish the cause of death. Mr Barter himself confirmed that this was his understanding too. His pathologists had his authority to remove and examine only those organs which they felt necessary to identify the cause of death. He had never been asked permission for the retention of organs for the purpose of teaching or research. If he had, he would have refused, he had no power to grant the request. If a family were to have said they had no objection to the use of organs for research, then he would not have been concerned. It would have been a matter for the hospital and the family to resolve directly. He concluded,

‘It is clear ... that the pathologist’s authority to remove organs is only to establish the cause of death, and that authority would be breached if entire organs were being preserved and being kept in a collection without my knowledge or authority. It would appear from what knowledge I have that what was done was in breach of Coroner’s rules.’

We concur in this statement of principle and the conclusion.

- 34.4 The Department of Health Circular, HC (77)28, gives further guidance at paragraph 7,

‘The provisions relating to the removal of tissue for therapeutic use and for medical education and research apply when a post mortem examination is ordered by a Coroner as they apply to any other post mortem examination, save that their removal requires also the consent of the Coroner.’

## 35. Conclusion

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- 35.1 If there is an intention to remove tissue/organs over and above what is necessary to identify the cause of death, then the consent of the Coroner and of the parents is required at the outset of the CPM. If there is an intention to use the material legitimately removed to identify the cause of death later for research or educational purposes, that consent is also better obtained at the outset.
- 35.2 Rule 9 of the Coroner’s Rules 1984 can be conveniently restated at this point,

‘A person making a post mortem examination shall make provision, so far as possible, for the preservation of material which in his opinion bears upon the cause of death for such period as the Coroner thinks fit.’

- 35.3 There is no evidence that Mr Barter ever made a decision under Rule 9 so as to indicate the disposal of such 'material'. As a result, hearts continued to be delivered to and stored at the ICH after the Coroner's process was over and without the 'consent' of the parents under the Human Tissue Act 1961. This continued even after Dr Ibrahim wrote to Mr Barter in 1988 pointing out the position (see Chapter 8, Part 1, paragraph 24.2).

## 36. Research

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- 36.1 There is no doubt that research was carried out on organs retained at CPM. Dr Gould identified in his report of the internal inquiry at Alder Hey (paragraph 9.2) that organs had been taken for research from at least 63 CPMs. In only one of those cases had there been any diagnostic histology. Mr Dearlove, an experienced MLSO within the Department of Pathology at Alder Hey, said that for the purposes of research there was no distinction made between tissue or organs removed at CPM and HPM. Professor van Velzen conceded this himself. He had no qualms in undertaking research on organs even if they had not been clinically reported. He argued that the decision to retain was not originally made to further opportunities for research, but the wholesale removal of organs was to carry out thorough routine reporting of histology,

'Most organs that we took as a whole, we took as a whole for routine reporting need.... Whether or not we wanted to do research from those later is relatively immaterial.'

- 36.2 We have already rejected Professor van Velzen's contention in our detailed findings in Part 2 of 'The van Velzen Years'. The nature of the fundamental flaw in the research has been exposed in Part 9. However, one aspect of the research material is particularly relevant to organs obtained at CPM. A research paper was rejected for lack of 'control' cases, or cases of death in 'normal' children as judged in the context of the paper. Professor van Velzen said,

'So we then added the very few kidneys that we had from children who had died in *car accidents* and it was only in that period that we *started collecting those as a whole.*' [emphasis added]

- 36.3 This is a specific example of the use of organs from CPM for the furtherance of research. We reject as extraordinary the alternative explanation put forward by Professor van Velzen, that he needed to take all the internal organs following a car accident to see if there was any underlying health problems that had made the child 'vulnerable to having an accident'! These were the clearest instances of organ retention well beyond what was required to establish the cause of death at CPM.

36.4 Both Professor van Velzen and Dr Howard apparently believed that it was legitimate to undertake research on organs taken at CPM without the need for further HPM ‘consent’. Both conveniently ignored that the initial removal and retention of organs was in excess of that required to identify the cause of death. Moreover, diagnostic histology following the examination was never undertaken in the vast majority of cases. Professor van Velzen explained in interview with the Solicitor to the Inquiry that, once research had been undertaken on an organ, the material would be returned to the containers and a note made confirming what had been done. He said this would ensure the information was available ‘as and when’ diagnostic histology was undertaken. When he attended the Inquiry in Liverpool, Counsel to the Inquiry pressed the point,

‘How can you square doing limited histology for your research purposes using stereology, using considerable technical time, consumables, manpower and skills... how can you do that on the one hand and yet have parents not knowing the real cause of death of their children, and waiting for weeks and months?’

36.5 Professor van Velzen’s response was,

‘I can only say that what we did was in that sense inexcusable, but that we were driven by the requirement to perform, as formulated by the Dean, to have research output and that in the balance of things, we made this judgment call. Looking back on it, it was unwise.’

36.6 The response is as relevant to all organ retention as it was to CPM retention and ‘unwise’ is a clear understatement.

## Post Mortem by Independent Pathologist

### 37. CPM

37.1 Under Rule 6 (1)(c) of the Coroner’s Rules 1984 it is stated, in simplified form,

‘In considering what legally qualified medical practitioner shall be directed or requested by the Coroner to make a post mortem examination, the Coroner shall have regard to the following consideration:

- if the deceased died in a hospital, the Coroner should not direct or request a pathologist on the staff of, or associated with, that hospital to make a post mortem examination if:
  - that pathologist does not desire to make the examination, or
  - the conduct of any member of the hospital staff is likely to be called in question, or

- any relative of the deceased asks the Coroner that the examination be not made by such a pathologist ...

unless the obtaining of another pathologist with suitable qualifications and experience would cause the examination to be unduly delayed.’

- 37.2 There is no evidence that Mr Barter had Rule 6 (1)(c) at the forefront of his mind. Quite rightly he wished to ensure that an expert in paediatric pathology investigated the death of any child, but he seemed unconcerned that Professor van Velzen was routinely reporting on deaths at his own hospital. He emphasised the point of theory that the pathologist performing the post mortem examination would be ‘wholly independent’ in the sense of someone instructed by him and owing a duty to him as Coroner. Of course, if that were the only consideration there would be no need for the Rule.
- 37.3 In the ordinary course of events Mr Barter may well have felt entitled to rely upon Professor van Velzen’s independence, expertise and integrity. However, time has shown this assumption to be unsafe. Mr Barter was not to know it initially, but the real problem surrounding the application of Rule 6 (1)(c) arose out of his reliance on the Coroner’s Officer to authorise CPMs. There is no evidence that the Coroner’s Officers were trained to consider Rule 6 (1)(c). In practice they did not and, as the duty to authorise and arrange CPMs had been delegated to them by Mr Barter, there was therefore no proper application of Rule 6 (1)(c).

## 38. HPM/CPM Interface

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- 38.1 The lack of true independence was even more evident in at least three cases of HPM where Professor van Velzen undertook the examination and the child had been under the care of his partner, a consultant haematologist at Alder Hey. He should have declined as his independence was compromised.
- 38.2 Further questions arise with regard to transparency as a result of the practice prevailing in ‘cardiac’ deaths, whether at HPM or CPM. There is inevitable overlap between HPM and CPM in the light of our earlier findings and the practices of Mr Barter and Mr Franks. Dr Audrey Smith, Honorary Research Fellow at the University worked in the ICH. She had originally been appointed as a technician in 1966 but her expertise increased so that that her work on the heart collection became recognised both nationally and internationally. The usual practice at Alder Hey was to examine the heart following post mortem examination through Dr Smith in conjunction with the cardiac surgeon(s), rather than through the pathologist himself who, at best, prepared a brief report on the macroscopic findings. Essentially, therefore, the pathologist provided the heart ‘unopened’ for further examination. Dr Smith was eminently well qualified to undertake a ‘morphological’ examination but she was not a pathologist. In any cardiac

case it was essential not just to carry out a morphological examination but also to marry up the pathological findings of the heart with those in relation to the other organs and systems. This wider pathological examination was not performed as a matter of routine in the van Velzen years, nor could it have been without routine histological examination. Again, transparency and openness in cardiac deaths were sacrificed.

## Preliminary Reports – Inaccurate Causes of Death?

### 39. The Parents’ Position, as Exemplified by Professor van Velzen

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- 39.1 Many parents stated in written and oral evidence that they found it difficult to accept that the Coroner could have been unaware for so long that post mortem histology was not being completed. When the Solicitor to the Inquiry asked Professor van Velzen if he had made the lack of histology explicit to Mr Barter he replied by asking rhetorically, ‘But how much more explicit do I need to get?’ He continued that each report was clearly headed as a ‘preliminary’ rather than a ‘final’ report. However, those ‘preliminary’ reports were so long and complex that recipients, including Mr Barter and even clinicians, appear to have accepted them as if final reports. At the very least clinicians often took the view that the reports contained sufficient information to enable them to counsel parents properly, although the approach was a practical compromise, as against theoretically proper, in the absence of histology.

### 40. The Coroner’s View

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- 40.1 Mr Barter gave evidence that histology was only ever indicated in a relatively small proportion of cases and it was only in those cases that he expected histology to be done. He said that Professor van Velzen had completed histology on all those cases where histology was awaited.

### 41. Professor van Velzen’s Weakness

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- 41.1 It is certainly relevant to note that Professor van Velzen was given every opportunity in his oral evidence to allege that he had specifically told Mr Barter that post mortem reports were not being completed because of the failure to perform histology, but he singularly drew back from making such an allegation when pressed.

## 42. Resolution

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- 42.1 In order to resolve whether Mr Barter knew, or should have known, that the reports were essentially incomplete, we again scrutinised the Coroner's procedures. DC Thompson explained that once a CPM had been performed the pathologist telephoned and gave the cause of death. While he was aware that part of the post mortem process might entail histology, he did not inquire of the pathologist whether histology was to be done. This issue lay with the pathologist. If the pathologist made no mention of histology he simply arranged for the death certificate to be issued. When the post mortem report arrived he checked that the cause of death was in accordance with that given over the telephone and if so he simply filed the report. Nobody actually read the report in any detail and the practice was merely to look at the name and the cause of death as a cross check. Dr Khine indicated in evidence that the Coroner's Officer might ask if histology was to be performed, but Mr Barter stated that the duty lay with the pathologist to draw this matter to the attention of the Officer.
- 42.2 If Professor van Velzen did not tell the Coroner's Officer that he intended to do histology then the Coroner did not expect histology to be performed and accordingly did not chase him for it. According to the evidence of DC Thompson the report itself was only scrutinised if the death was to be the subject of an inquest. Even if it was made clear on the face of the report that histology was awaited this fact was probably not appreciated as the system ran in practice. This effective disregard for the actual content of the report must be condemned. What was the purpose of a detailed, even if incomplete, report if it was not to be read in full? Inevitably some cases where histology was to be performed were not noted as such. We examined Coroner's files where the 'tick box' for histology was not completed, implying that this was not to be performed, and yet supplementary histology reports were in fact provided.
- 42.3 There was also another way in which the failure to perform histology might escape scrutiny. The correct procedure, if the pathologist indicated that histology was to be done, was for Pink Form B to be completed. A death certificate could then be issued and Pink Form B sent to the Registrar. Eventually the Office of Population Census and Surveys sent a form to the Coroner's office, for completion by the pathologist, to indicate whether, once histology had been performed, the cause of death had changed. It should then have been the pathologist's duty to complete that information, albeit the form when completed would have to be signed by the Coroner. However, there was no system in place to chase histology in such circumstances, let alone to obtain the information from the pathologist. Indeed, from Mr Barter's point of view, a cause of death had been established and a death by natural causes recorded. The only further involvement on his part was through his administrative staff, who processed the financial aspects and should have expected a claim in due course from the pathologist to cover the cost of histology. The staff did not chase the pathologist for histology, but merely checked when a financial claim was submitted that histology had indeed been done.

- 42.4 Our inspection of the Coroner's files did not support Mr Barter's claim in evidence that in *all those cases where histology was awaited* histology was in fact done. We identified cases where promised histology did not materialise and where the form from the Office of Population Census and Surveys still remains on the file to this day, many years later. In one such case the cause of death given in the post mortem report was 'myopathy', but it was noted that 'possible causes such as septicaemia or metabolic disease are under investigation'. Despite this clear indication that the cause of death was not a final one there was no further correspondence or documentation on file.

## 43. Conclusion

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- 43.1 There can be no other conclusion than that there was no proper system for clarifying the cases in which histology was required, or what tissues or organs would be preserved for examination and for pursuing that histology from the pathologist.

## Coroner's Knowledge of Incomplete Histology

While Mr Barter did not have effective systems there is some evidence that at various times the problems with the performance of histology did come specifically to his attention.

## 44. Coroner 'Extremely Patient'

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- 44.1 The manuscript notes made for the University Review on 1 June 1993 record Professor Carty as confirming that there was no routine post mortem histology service. She specifically referred to one case where the Coroner 'would not issue a death certificate until he had a histology report' and notes that in that case there had been a delay of several months before it had been produced. In her written report for the Review, dated 26 May 1993, Professor Carty referred to this case and wrote that 'the Coroner had been extremely patient'. There is no direct evidence but Mr Barter may have been put on notice at this stage of the problem regarding the provision of histology.

## 45. 'Unprocessed Tissue' Remaining

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- 45.1 In November 1995 Professor Carty wrote to Mr Barter (see below) referring specifically to 'unprocessed tissue' from Coroner's post mortems. The use of the phrase 'unprocessed tissue' is significant. If causes of death had already been attributed (as they had) Mr Barter must surely have appreciated that, for there to be 'unprocessed tissue' in such circumstances, meant that tissue over and above that required to identify the cause of death must have been taken in breach of the Coroner's Rules. Alternatively, histology had not been carried out as envisaged, in support of the above analysis. Mr Barter did not raise the point with Professor Carty, nor did he then chase the histology. Instead, his response through his Coroner's Officer was to indicate that in each of the cases in question death by natural causes had been confirmed and so there was no need for the histology.

## The Importance of Histology

### 46. Differing Perceptions

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- 46.1 The former and present Coroners have different perceptions of the importance of histology. Mr Barter said,
- 'In my view histology can do no more than fine tune the cause of death. It might more particularly specify the cause of death under 1(a), (b), or (c), but in 30 years' experience I never had a case where what was initially reported as a natural death turned out to be an unnatural death following performance of histology.'
- 46.2 Mr Rebello stated in contrast,
- 'The microscopic findings on histology are an important check on the macroscopic findings to assist in making the report complete and I am therefore surprised that the reports were not finalised properly.'

### 47. The Importance in SIDS Cases

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- 47.1 The importance of histology in SIDS cases cannot be understated and has been considered at some length already in Part 9 of Chapter 8. Professor van Velzen accepted in evidence that a true diagnosis of SIDS can only be made once histology has been undertaken, the diagnosis being one of exclusion. Dr Davidson, the present Medical

Director at Alder Hey, stated that if there had been no histology in a SIDS case then 'I'd hope the Coroner wouldn't be happy in that situation, because I wouldn't be.' Dr Davidson is, of course, medically qualified and Mr Barter is not. Nevertheless the point is clear.

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## 48. A SIDS Illustration

- 48.1 After a CPM following Katy's death in 1990 the cause was formally registered as SIDS. However, the parents did not accept it. The mother had been up all night with Katy. She had been coughing, was off her feeds and was basically unwell. Common sense suggested that SIDS was unlikely to be a true cause of death.
- 48.2 Katy's parents did their utmost to have the death certificate changed and even met with Dr Heaf, Consultant Paediatrician, Mr Butler, the Chief Executive, and Professor van Velzen. These efforts were eventually successful and the death certificate was altered to record the cause of death as 'bronchospastic syndrome'. It is extraordinary that histology was not performed bearing in mind the significance of the clinical history and this failure effectively invalidated the whole post mortem procedure.

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## 49. Conclusion

- 49.1 On several occasions SIDS was accepted by the Coroner as a proper cause of death despite the lack of histology. It exemplifies the Coroner's lack of medical knowledge in a relatively routine matter. In failing to insist on histology Mr Barter must have recorded an inaccurate cause in a number of cases.

## Coroner's Knowledge of Widespread Organ Retention?

'The news that there had been widespread retention of organs came as a complete shock to me. I had no idea what had been kept, and did not know that the Myrtle Street basement even existed.' (Mr Barter, witness statement, 18 May 2000.)

### 50. The Documentary Evidence

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- 50.1 Despite Mr Barter's clearly stated position we have noted that over the years various letters were sent to him which might have prompted him to make enquiries to a greater or lesser extent.

### 51. Dr Ibrahim's Letter

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- 51.1 On 16 February 1988 the locum Consultant Histopathologist, Dr Ibrahim, wrote to him enclosing 'a copy of the new Anatomy Regulations 1988'. The letter has been set out in Part 1 of 'The van Velzen Years' but is worthy of repetition,

'The current practice regarding heart (heart/lung) specimens from Coroner's autopsies is to study them histologically and then to discuss them at regular sessions with cardiac surgeons and physicians. In fact, most of these specimens from both Coroner's and Hospital autopsies over the last 35 years have been properly preserved and filed with the relevant data. In the light of the new Anatomy Regulations, I am not sure if the authority for possession of these specimens has been sought from the relatives of the deceased. I therefore wonder if it is possible to ask the relative for such a consent. If a consent is withheld then we have to dispose of the specimen properly after we have studied it microscopically.'

- 51.2 Dr Ibrahim asked for Mr Barter's advice, but the files disclosed to the Inquiry do not contain a copy of any response. Dr Ibrahim recalled hearing nothing further. Mr Barter denied having received the letter, which was correctly addressed.
- 51.3 Dr Ibrahim's letter, if received by Mr Barter, can only have alerted him to the existence of the heart collection. It also highlighted the possibility that the heart and lung specimens might have been preserved without appropriate consent in Coroner's cases. At the very least, the letter should have rung alarm bells and prompted further enquiry by Mr Barter.

## 52. Ownership of Post Mortem Tissue – 1994

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- 52.1 Other correspondence with Mr Barter included a letter again considered in ‘The van Velzen Years’ (see Part 7, paragraph 9.1). On 9 May 1994 Margery Clark, who was by then working in the legal department but had previously been Professor van Velzen’s personal assistant, wrote to Mr Barter seeking clarification on the ownership of ‘post mortem tissue’. She wrote,

‘We should be grateful if you could give a definitive ruling on the legal ownership of such tissue once the post mortem examination and all subsequent tests have been completed. Do you retain authority for its disposal (or otherwise) at your discretion or, in law, does this revert back to the next of kin of the deceased? Usually this tissue is ultimately disposed of by the hospital where the patient was treated or by the pathologist who performed the post mortem examination. We have not experienced any problems in the past over this issue, but the potential is always there, and for this reason we are anxious to establish the correct position in this respect.’

- 52.2 Mr Barter replied on 13 June 1994,

‘I do not know a definitive answer to the question raised in your letter. It is often necessary for a pathologist to retain possession of tissue samples etc for some time after the autopsy, either because they may be needed for further examination or because some person properly interested in the death wishes to have his own examination carried out. Having said that, I think that any tissue that remains after all necessary examinations have been carried out belongs to the person entitled to possession of the body. In over 25 years’ experience I have never had a legal representative ask for the return of such material, and I cannot visualise any circumstances in which it would be likely.’

- 52.3 Readers will have formed their own conclusion of the correspondence around this time and later in 1995. There is nothing on the face of the letters exchanged so far as Mr Barter is concerned to tell him of wholesale organ retention.

## 53. Disposal of Tissue – 1995

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- 53.1 The final piece of relevant correspondence consists in a letter from Professor Carty to Mr Barter and a response from DI Whalley, Coroner’s Officer, on behalf of Mr Barter. In her letter of 22 November 1995 Professor Carty wrote,

‘There are a number of Coroner case post mortem tissues in the laboratory which have not been processed, list attached, and we would like to transfer the heart and lungs of these post mortems, many of whom were cardiac patients, to a museum in the Institute of Child Health, here at Alder Hey, which specialises in the teaching of cardiac surgeons. The remainder of the unprocessed tissue would remain at the Myrtle Street laboratory and would be the responsibility of Professor C Foster at the Royal Liverpool University Hospital. We are informed that none of the tissues are required for medico legal or forensic purposes. I would be grateful if you could let us know, as soon as possible, if this is acceptable to you and could you also let us know if there are any other procedures which we should follow.’

- 53.2 The significance of the phrase ‘unprocessed tissue’ has been considered above and should again have alerted Mr Barter to the failure to provide histology reports. In fact, the list referred to by Professor Carty was returned under cover of a letter from DI Whalley dated 28 November 1995. He advised that there was only one Coroner’s case which was subject to inquest and where the post mortem had not revealed a natural cause of death. In the remaining cases ...

‘the Coroner has no objection to the tissue being disposed of in accordance with your normal procedures.’

## 54. Conclusion

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- 54.1 Professor Carty’s letter did not refer specifically to ‘organs’ other than the heart and lungs, and no inference can be drawn that Mr Barter knew from this letter of the true contents of the containers at Myrtle Street. Specific reference was made to the heart and lung collection, just as in Dr Ibrahim’s letter of 16 February 1988. To this extent he was put on specific notice of the retention of heart and lungs. Mr Barter said that he was unaware of the general organ retention at Myrtle Street and the weight of evidence on this specific point cannot cause us to disbelieve him. Furthermore, there is no evidence in the light of Professor Carty’s letter, to suggest that he would or should have known, that whole organs were retained at Myrtle Street awaiting histology. If Mr Barter had applied his mind to it he would have been entitled to assume that the appropriate blocks had been taken.

## Recommendations

We believe that the irregularities and difficulties revealed by our Inquiry in Liverpool point to one conclusion only. The Coroner's system, in which a legally qualified person makes decisions requiring medical expertise with little or no independent advice, will always be liable to error. Where 'unnatural death' and death following operative treatment are to be considered, specialist medical knowledge is more important than legal knowledge. Our Terms of Reference, however, are not to consider the Coroner's jurisdiction further than to make recommendations within the existing system.

### 55. Recommendations for Clinicians

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- The Department of Health, the Royal Colleges and medical schools shall instruct members of the medical profession in the precise terms and provisions of the Coroner's Act 1988 and in particular the circumstances in which it is obligatory to report cases to the Coroner.
- Clinicians shall give the following basic information to the next of kin when a Coroner's post mortem examination is to be performed.
  - The nature of the examination, including the need to open the body and to remove and weigh organs.
  - The need for samples and possible retention of organs.
- Clinicians wishing to retain organs or samples after the end of the Coroner's process for the purposes currently allowed under the Human Tissue Act 1961 shall follow the Recommendations in Chapter 10.
- Clinicians shall not mention to the next of kin the possibility of an examination under the Coroner's jurisdiction unless the death is reportable to the Coroner.
- Clinicians requesting a hospital post mortem examination after the Coroner has declined to authorise an examination shall make it clear to the next of kin that there is no compulsion remaining for such an examination.
- Clinicians shall explain the contents and implications of a Coroner's post mortem report to the next of kin as if the examination had been carried out as a hospital post mortem examination on their own recommendation.

## 56. Recommendations for Coroners

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- The Coroners' Society shall instruct Coroners that:
  - in the proper exercise of their judicial discretion, the decision to order a post mortem examination is not to be delegated to Coroner's Officers and Deputy Coroners must be available at all times;
  - organs are not to be retained unless relevant to establishing the cause of death and only when specified by the pathologist in writing.
- The Home Office and the Coroners' Society shall ensure all necessary medical education for Coroners.
- The Home Office and the Coroners' Society shall ensure all necessary training of Coroner's Officers and ancillary staff.
- Coroners shall be introduced, their function and procedures explained and the next of kin invited to express any specific concerns and requests.
- If a decision is made to authorise a post mortem examination Coroners shall ensure that the next of kin are advised of:
  - the reasons for authorising the post mortem examination;
  - their right to ask the Coroner that the examination be carried out by a pathologist independent of the hospital in which the deceased died;
  - the place and time of the examination and the identity of the pathologist;
  - the nature of the examination, including the need to open the body and to remove and weigh organs;
  - the need for samples and possible retention of organs;
  - their option to delay the funeral, while the pathologist fixes and examines any organs, to enable the return of the organs to the body for burial or cremation;
  - their option for a funeral without the return of the organs, in which case they shall be invited to consent to respectful disposal by the Coroner;
  - their option to make their own arrangements for respectful disposal of the organs.
- If a decision is made not to authorise a post mortem examination, Coroners shall notify the next of kin of that decision and give sufficient reasons for the decision.
- Coroners shall ensure the expeditious examination and recording of samples and organs.

- Coroners shall establish efficient systems for securing final post mortem reports following histological examination.
- Coroners shall ensure that all existing retained organs, tissue, blocks, slides, photographs and X-rays are specified within any preliminary and final post mortem reports.

## 57. Recommendations for Pathologists

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- The Royal College of Pathologists shall instruct all practising histopathologists that they shall not retain samples and organs beyond those reasonably incidental to establishing the cause of death unless there is also written consent properly obtained under the Human Tissue Act 1961.