The Royal College of Pathologists
Pathology: the science behind the cure

Patient Safety Bulletin

A colleague casts an eye – the critical conclusions check

What happened and what were the issues/implications?

The sudden death of an infant just after a bath (who was alone with a parent) was reported to the coroner and, owing to some slight inconsistencies within the history, the police requested that the autopsy should be done by a forensic pathologist jointly with a paediatric pathologist. The external examination revealed unusual injuries to the face, although the parents of the deceased provided a plausible explanation as to what had caused them. There were no other injuries identified and the external examination, internal examination and ancillary investigations revealed no other significant findings. The cause of death was reported as unascertained.

The report was written and, in the discussion, the pathologists stated that the injuries to the face were consistent with the history given. Prior to the report being issued, it was sent to another pathologist for a review.

The review is known as a critical conclusions check (CCC) and is undertaken on the reports of all cases conducted by a forensic pathologist on the Home Office Register, by another independent forensic pathologist. The reviewing pathologist assesses the report to see whether it is internally consistent and to ensure that the conclusions drawn in the report from the described findings are reasonable.

The reviewing forensic pathologist drew the attention of the report writer to the fact that while the facial injuries were consistent with the explanation offered by the parents, it would not be possible to exclude non-accidental injury. At the reviewing forensic pathologist's suggestion that this point should be included in the final report, the report writer added it into the discussion of the case.

Several years later, as new information came to light, a review of the post-mortem findings and the report was necessary. The inclusion of the discussion regarding non-accidental injury, as suggested by the reviewing pathologist, subsequently became important in a Crown Court case.

What actions were taken?

Injuries in children always present difficulties in interpretation, with implications if the injury is either under- or over-interpreted. Fortunately, owing to the mandatory implementation of the CCC, no specific action was necessary in this case, other than considerable reflection on the difficulties in report writing in the medico-legal arena.

What did you learn?

Following this case, the report writer became much more aware of the need to fully explain all potential causes of an injury, even when a plausible explanation was presented, bearing in mind that the parents and carers of children are not always necessarily truthful about what happened to their own child. The report writer learnt that all avenues need to be explored.

The importance of the CCC was also highlighted – the simple acts of reading and commenting on and critiquing someone else's report is invaluable. This principle is applicable across the legal systems in all UK nations and internationally.

How was the learning shared?

Every month, the forensic pathologists take part in a local audit meeting. During this meeting, difficult cases, such as the one seen in this case study, can be discussed and the learning points shared. Along with the CCC, monthly audits are particularly valuable in maintaining standards in forensic pathology.

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