The use of personal health information in the coroner's inquiry

ABSTRACT – A pathologist appointed by the coroner may feel that his or her role is to review the medical notes, perform a post-mortem examination and then interpret the findings in the light of clinical information and any other information received from the coroner, and include in the clinico-pathological summary a cause of death. We believe that such an approach is not in accordance with the legal position relating to coroners' inquests. The coroner has no automatic right to see the medical notes (and neither does the coroner's pathologist); where there is, or may be, dispute as to the circumstances leading to death, the proper way for information in the medical record to be presented at the coroner's inquest is for the maker of any note to give oral evidence. Where the cause of death requires interpretation of the clinical history or knowledge of any circumstantial evidence, a pathologist should refrain from giving a cause of death; such a task is for the court, having heard all the evidence – medical or not – relating to the death.

It is no secret that the anomalies and ambiguities inherent in the legislation relating to the coroner system[1] and the discretion allowed to individual coroners by that legislation can, at the inquest into a hospital death, make the procedure troublesome, even for the experienced lawyer[2]. The coroner's pathologist – experienced or otherwise – may be equally troubled if expected, as part of a post-mortem report or during an inquest, to interpret his or her findings in the light of clinical information obtained from the clinical record or by personal inquiry but not separately introduced as evidence. This paper explores the existing law relating to the use of health records, by both pathologist and clinician, in the coroner's inquiry and asks which health professional is better placed to formulate a cause of death.

There is uncertainty as to the information that should, or may, be passed directly and unsolicited from the doctor to the coroner as a report of a death that might require the holding of an inquest. There is no statutory duty upon the doctor to report any death to the coroner and the existence of a common law duty is uncertain[3]. The doctor in a position to certify the cause of death may discharge any obligation by completing the death certificate in such a way that any need for referral to the coroner is clear to the Registrar of Births and Deaths, the person whose statutory duty it is to report to the coroner[4]. Should the death certificate mention a cause of death that, although true to the best of his knowledge and belief[5], deliberately does not make clear the need for referral – perhaps from a misguided desire to spare the family a post-mortem examination or inquest[6] – the doctor risks obstructing the coroner through giving a certificate that facilitates disposal. Were the doctor to give a frankly false cause of death, then charges under the Perjury Act 1911 section 4(1)(b) and the Births and Deaths Registration Act 1953 section 37 might follow.

International codes of medical ethics protect medical confidences after the death of the patient as they do during life[7,8]. However, guidance on confidentiality from the Department of Health does not address this particular issue[9]. It might be argued that the doctor who reports a death that has occurred in circumstances that require the holding of an inquest need give no further information regarding that death before an inquest is held; it could not be argued that failure to disclose clinical information on the grounds of confidentiality was obstructing the coroner because, having reported that the death occurred in circumstances requiring the holding of an inquest, the doctor cannot be said to have demonstrated any intention to obstruct the coroner in holding an inquest[10]. The possibility of such an argument raises the question of what is the power of the coroner to 'seize', or order the production of, the clinical record.

The existing law is plainly stated in R v Southwark Coroner ex parte Hicks: 'A coroner has himself no power to order the production of documents. His final right is to apply to the High Court for a subpoena *duces tecum* ordering their production, but normally that is not necessary. A request will be enough and the maker or custodian will either produce them or bring them to the hearing'[11].

Similar informal arrangements may be made with regard to a coroner providing any consultant who has been involved in the patient's care prior to death with a copy of the post-mortem report[12]; although not regarded as 'the better view'[13], a coroner may exercise discretion as to whether that report is released before it is put in evidence at an inquest. The inference may be drawn from existing legal comment that evidence in a medical inquest may 'be tailored'[14] and a coroner might argue that it would be better for medical witnesses to present evidence regarding treatment without any benefit of hindsight afforded by prior knowledge of the post-mortem report. However, it appears absurd to deny the attending clinician access to a copy of the post-mortem report when that clinician may be

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entitled to attend the post-mortem examination either as the representative of the hospital[15] or when information has been sworn that the clinician is responsible for the death[16]. The existence of the subpoena *duces tecum* perhaps mitigates against an unlikely tit-for-tat situation where a health service body refuses a coroner access to the medical record in advance of the inquest when the coroner has refused to release a post-mortem report.

'It is said that at common law every person who is able to give evidence is bound to attend at the coroner's court'[17] and section 11(2) of the Coroners Act 1988 states 'the coroner shall, at the first sitting of the inquest, examine on oath, concerning the death all persons who tender evidence as to the facts on the death and all persons having knowledge of those facts whom he considers it expedient to examine'. Where an inquest is concerned with complex medical issues and where, in these increasingly litigious times, it is unlikely that there will be no dispute regarding those medical issues, it would appear that the medical record (however obtained) should not be admitted as documentary evidence; instead it would be more proper 'to have oral evidence from the person who made the note'[18]. It may be advisable for clinicians to be aware of this dictum and to be sure, where a death occurs in circumstances that might give rise to litigation, that the coroner is informed of their desire to be notified of, and to be present at, the inquest into that death (also being sure to supply a telephone number or address for the purpose of notification)[19]. Where the clinician feels that he or she may be regarded as a 'person whose act or omission or that of his agent or servant may, in the opinion of the coroner, have caused, or contributed to, the death of the deceased' then he or she should be sure to attend the inquest and should realise that he or she is 'entitled to examine any witness . . . either in person or by counsel or solicitor'[20].

What is the position of the coroner's pathologist against this obscure and unsatisfactory background? Knowledge of the medical record is essential, if only to determine the techniques that will be employed in the post-mortem examination. A coroner's pathologist who is employed by the health service body which holds those medical records usually will not experience difficulty in obtaining access to them; an external or independent pathologist may be less fortunate. Where access to the health record is not allowed it can only be good sense to decline to perform the post-mortem examination.

It has been recognised for many years that a 'post-mortem examination made by a skilled pathologist will often give no result unless it is supplemented by clinical evidence'[21]; to what extent, and in what manner, should the pathologist draw upon the medical records when formulating the report for the coroner and an opinion as to the cause of death? In the light (or darkness) of the background described above, we are more and more inclined to the view that, where the death involves complex medical issues and may lead to an inquest or raises the possibility of litigation, the pathologist's report should be confined to the objective evidence afforded by the post-mortem examination, not make any comment upon the clinical history and not give an opinion as to the cause of death. This may be contrary to the views expressed by the Royal College of Pathologists[22] and, for example, the National Confidential Enquiry into Peri-Operative Deaths[23] but we feel that our expertise does not extend beyond the field of pathology and that, should a death occur in circumstances where other disciplines are involved, expert evidence from those disciplines should be called at the inquest.

This might be regarded as abdication of responsibility but consideration of the recent case of R v HM Coroner for Kent (Maidstone district) ex parte Philip Johnstone justifies the cautious approach. In that case a pathologist gave, in preliminary and supplementary post-mortem reports, a cause of death – neuroleptic malignant syndrome – which might be said to have led the family of the deceased to conclude that death had resulted from a reaction to drugs, leading them to take professional advice on that basis. At the inquest, held before a jury, where the pathologist was called last, after nursing and clinical staff, his evidence was that the cause of death given in the report was not intended to convey that the death was drug-related and that he would prefer to use another term – acute exhaustive mania. The inquest was then adjourned and, when resumed, counsel for the family applied for adjournment to enable another pathologist to make a report and attend to give evidence. That application was rejected and the inquest was concluded, the jury having found that death was caused by acute exhaustive mania due to natural causes. Applications were granted for judicial review, at which both verdict and inquisition were quashed and a fresh inquest was ordered. In an affidavit the pathologist swore: 'My provisional cause of death given after my post-mortem examination required to be refined at the Inquest after hearing further evidence. It will be appreciated that even after considering the Toxicology Report when writing my Supplementary Report I had yet to hear and evaluate the clinical evidence'.

It appears to us that to give a cause of death that might be changed later when evidence from other sources is given at inquest might deprive a family, if not the coroner, of the opportunity to prepare adequately for that inquest. The consequent inability to explore issues may give rise to understandable dissatisfaction, if not distress, to family members, and further delay should it be necessary to adjourn the inquest. We believe it would be better for the pathologist to refrain from giving an opinion as to cause of death until all the available evidence has been heard. It cannot be denied that the pathologist can rarely be certain that evidence will not become available at a later date which may change an opinion as to cause of

death, and that to adopt this approach might increase, rather than alleviate, potential delay and distress within the existing coroner system. Where, however, an opinion as to cause of death turns not upon objective pathological findings alone but upon an interpretation of such findings – or, indeed, the absence of any finding – in the light of evidence which should be regarded as outwith pathological expertise, then it appears obvious that such evidence must be considered before a cause of death is formulated. In such circumstances the best opinion as to cause of death may lie with the clinician rather than the pathologist. Were the pathologist to regard this view as heresy, might it not also appear heresy to the clinician that a public interpretation of the clinical course may be given at an inquest by a pathologist?

The pathologist called upon at inquest to comment upon matters outside his or her field of expertise should acknowledge lack of expertise in those fields and decline to answer. Where clinical evidence or evidence relating to the circumstances of the death is necessary in order to interpret post-mortem findings and arrive at a cause of death, we feel that it is more appropriate for this evidence to be elicited and explored by the coroner at inquest rather than through the pathologist's interpretation of what is written in the medical record; that record may not represent the whole story and the pathologist's interpretation of it may be flawed. Indeed, it might be said that the pathologist's formulation of a cause of death prior to inquest usurps the function of the coroner. It is for the coroner to determine the cause of death, having heard all the evidence, it being 'the primary purpose of an inquest . . . to establish the cause of death'[11]. Should a coroner find this approach unacceptable in a pathologist then it is within his or her discretion not to employ the pathologist in similar cases (or, indeed, in any case) in the future. It is ironic that should all pathologists adopt this approach, so that none is prepared to formulate a cause of death upon the basis of clinical information prior to inquest, the coroner might use his power to direct the clinician under whose care the patient died to perform the post-mortem examination[24]. Our approach seems to us no more unreasonable than would the stance of a clinician so directed in refusing to make the examination on the grounds that he or she was not 'a pathologist with suitable qualifications and experience'[25].

Such an approach may inconvenience clinicians in requiring them to attend coroners' inquests, may increase the burden of decision-making upon coroners and may increase the financial burden upon local authorities (upon whom coroners' expenditure devolves). The pathologist who is prepared to facilitate an inquiry without appropriate expertise takes an ill-advised and possibly inadequate part in a system which, it has been said, 'may nowadays be thought to lack any very clear or cogent role'[26]. Our approach would define and support the roles of the pathologist and the clinician in a system the function of which should be to 'establish as many of the facts about a death as the public interest requires'[27].

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