Is it the right body ? Coroners' investigatory duties after inaccurate post-mortem reporting.

written by Meelis Magland | 12 September 2017

***R (Heinonen and Sawko) v Senior Coroner for Inner South London* [2017] EWHC 1803 (Admin)**

It is often distressing for a bereaved family to contemplate their loved one being subject to a post-mortem examination, even in the context of a wish to have the cause of their death explained. When the resultant autopsy report contains an inaccurate physical description of the deceased, that thereafter remains unexplained, it is unsurprising that a family would seek further investigation of the matter by the Coroner.

However, in a case that provides a clear reminder of the high hurdle claimants must surmount to establish that a coroner's decision is unreasonable (in the *Wednesbury* sense), the Administrative Court has upheld this Coroner's refusal to open an investigation under s.1 CJA 2009, even though significant discrepancies between the description of the body examined and the deceased's physical characteristics remained unexplained and further avenues that might have more firmly established the identity of the body had not been explored.

> ***"I hope that an apology and some explanation as to how it came about will be forthcoming, I have no power so to order. I can merely express a hope that that will happen in due course". – Andrews J***

Simona Heinonen was only 27 when she died in hospital from a rare type of progressive brain stem tumour. Her family were critical of her care and concerned whether her death may have been due to the ingestion of stomach fluids. The Coroner conducted preliminary inquiries before deciding whether to open an investigation under s.1 CJA, including requesting a post-mortem under (1)(b). The autopsy report noted features consistent with of aspiration pneumonia and concluded that death was due to brain stem glioma and pneumonia. No issue was taken with the thoroughness of the post-mortem examination or the pathologist's conclusions from a medical point of view. However, whilst the autopsy report described the body examined as being of a female of similar age to Simona, it also recorded that she was tall, had grey eyes, light brown long hair and a "healed right frontal scar of 1cm in diameter". These physical attributes did not match Simona, who was 162 cm tall, had short dark brown hair and brown eyes. She had a right frontal scar but it was linear, not circular, and was 3.5 cm, not 1 cm, long. She also had a 10cm scar from a previous operation, which was not mentioned at all.

On learning of the family's concerns about the autopsy report, the Coroner contacted the pathologist who had said he was "confident" the post mortem was of the right body. The Coroner was satisfied from the medical evidence that this was not a violent or unnatural death and so considered that an

investigation under s.1 CJA 2009 was not required. The claimants wanted the Coroner to "remove the considerable doubt" whether the subject of the autopsy was actually Simona. They felt that "a repeat histology of the brain and spinal tissue and DNA test of that same tissue would remove such doubt." The Coroner offered the family the opportunity to organise a second autopsy themselves and to have access to the retained tissue samples to arrange for their own DNA testing but, having ended his enquiries, would not take those steps himself. The family were not appeased and felt this effectively amounted to trusting the pathologist's word that he had carried out the autopsy on the right person. The family wanted further investigation by the Coroner, at his expense; when this was refused an application was brought for Judicial Review.

In the High Court Mrs Justice Andrews considered that the inaccuracies in the physical description recorded by the pathologist were *"a genuine cause for concern"*. As she put it: *"Any parent in their position who had gone through the incredibly traumatic events of the weeks over which they observed their daughter's condition deteriorate, and then saw her pass away in the circumstances described in the papers, would be grieving and extremely upset. It can only have added to the weight of their distress to have seen on the face of the post-mortem report a description of somebody which was patently not a description of their daughter"*

Nevertheless the judge considered that the Coroner's decision was unimpeachable. Whatever criticisms might be made of the accuracy of the patient's description in the autopsy report, it did not support a suggestion that the subject of the autopsy had died from anything other than natural causes. A coroner would only have a continuing jurisdiction to investigate this death under s.1 CJA 2009 if there was reason to suspect the cause of death was "violent or unnatural" or unknown. He was entitled to rely upon the professional medical opinion of an experienced neuro-pathologist in these respects.

Despite the inaccuracies in description, a reasonable coroner was also entitled to accept the pathologist's assurances and be satisfied regarding the identity of the post mortem subject. The issue was not whether another Coroner might have acted differently, and inquire further into identity, but whether this Coroner's decision, that he now knew enough, was one he could reasonably come to. Although the discrepancies had still not been explained, the pathologist had told the Coroner that he relied on both the improbability of a second young woman with the rare condition of a brain stem glioma being in the mortuary and the wrist tags naming Simona being in place. It was highly improbable that the hospital had made an error and mixed up two bodies and far more likely that the error lay in the descriptions in the post-mortem report.

Furthermore, since he made the decision under challenge, more information had been provided to the Coroner from the hospital regarding how the body had been received and identified which confirmed his view. He had now been told that Simona's hospital nametags had been in place and checked when the family were with her and those wristbands remained present throughout the post-mortem process; they were still there when the funeral directors came to collect her body from the mortuary.

It might of course have been preferable, and eased the family concerns, had the Coroner obtained that additional information before coming to his initial decision; but this new information made the judicial review challenge academic. If all the information that had now come to light were placed before the Coroner and he was required to remake his decision he would still reach exactly the same decision, for exactly the same reasons.

Finally, the judge noted that the court would not grant judicial review where there was a viable alternative remedy available to the Claimant. One could fully understand the views of the family that they should not have to undergo the expense of carrying out DNA tests just to prove that the hospital

had got it right. But checking the DNA would have put to rest any residual doubts over identity and the family did not need a court order to obtain those tests.

This case is a stark reminder, if one were needed, of the need to treat bereaved families with sensitivity taking great care over documents relating to their loved one's death. Simple everyday carelessness, such as misspelling or mispronouncing the deceased's name, can be upsetting to some families, who feel this is indicative of failing to consider the deceased as a person who is due proper attention. More fundamental errors of description can be even more upsetting – and the failure to offer an explanation as to how the erroneous description came about in this case can only have added to the family's distress.

The judge rather forcefully expressed her views about the continued absence of an explanation from the pathologist:

> *"I hope that an apology and some explanation as to how it came about will be forthcoming, I have no power so to order. I can merely express a hope that that will happen in due course".*