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Injury Examination and Medico-Legal Report

Practical 01 / Clinical or documentation case

Aim

Describe injuries objectively and write a simulated medico-legal injury report.

Principle

Observed findings, reported history and expert opinion have different evidential weight. Wound terminology and reproducible location help a later reviewer understand the report.

Materials and Requirements

- Fictional clinical record and de-identified injury images
- Body chart, scale and institutional training form

Procedure

1. Check the purpose, identity, authority and consent process with the supervisor. Prioritise required clinical care.
2. Verify the simulated request, examinee identifier, date, time, place and examiner role. Explain the examination scope and record the permitted parts before beginning the model assessment.
3. Record the patient's account in their own words where useful and mark who supplied each history item.
4. Create a brief time line separating the examinee's reported event, attendance and treatment from verified events in the chart. Record a direct quotation only where wording matters.

Continue with step 5 on the next page.

Procedure Continued

Injury Examination and Medico-Legal Report

5. Describe every represented injury by type, side, site relative to landmarks, measurements and observed features. Mark findings on a diagram.
6. On the model or photograph number lesions in a consistent anatomical order. Record exact position, shape and measured dimensions using the supplied scale and mark each number on the body chart.
7. Compare simulated symptoms with objective findings and state which regions could be assessed. Describe the margins, surrounding change and any supplied imaging without assigning unsupported timing or intent.
8. Record investigations, treatment and limitations. State only an evidence-supported opinion and mark any part that is deferred.
9. Review the record against the mock form and state the supported medical interpretation and its limits. Date the entry and identify pending results and who will review them.

Precautions

- Do not estimate bruise age from colour alone.
- Use only authorised images and records. Preserve privacy and chain of custody.

Observations and Interpretation

Injury Examination and Medico-Legal Report

Observations and Record

Item	What to record	What it tells you
History	Source, date and patient account	Separates reported events from examination
Injury	Type, size, site and diagram	Documents observable facts
Opinion	Supported inference and limitations	Preserves uncertainty for later review

Worked Example

A teaching image shows a superficial linear abrasion 2.0 cm long over the left forearm. Record the actual site and appearance. Shape alone does not identify a unique object or exact time.

Result and Interpretation

Produce a completed fictional report with time, observations, diagram and a limited opinion.

Viva Questions and Answers

What distinguishes a laceration from an incision as a description?

Laceration refers to tearing and can show bridging tissue. Assess an actual wound in context.

Why use fixed landmarks?

They make later location and comparison more reliable.

Medical Certification of Cause of Death

Practical 02 / Clinical or documentation case

Aim

Complete a fictional cause-of-death statement with the causal sequence and relevant contributing conditions.

Principle

Part I records the sequence that led to death from the immediate cause back to the underlying cause. Part II records other significant contributing conditions outside that sequence.

Materials and Requirements

- Institutional practice form modelled on the applicable MCCD form
- Fictional authorised hospital case
- Chronology worksheet

Procedure

1. Review the available clinical record and determine whether certification can proceed through the authorised pathway in the scenario.
2. In the fictional record verify identity, date and location of death, the responsible certifier and whether relevant history and records are available. Identify scenarios requiring an authorised referral.
3. Identify the immediate disease or complication and work back through antecedent conditions in plausible causal order.
4. Begin with the condition directly leading to death and ask what caused it. Continue until the underlying disease or injury that initiated the chain is reached where evidence supports it.

Continue with step 5 on the next page.

Procedure Continued

Medical Certification of Cause of Death

5. Test the sequence by reading the lower line as the cause of the line above. Use specific disease terms and include a documented context needed to understand the sequence.
6. Record approximate intervals if supported. Use separate lines for linked conditions and add unrelated contributors in Part II.
7. Enter the approximate duration from onset to death on each applicable line. Add significant conditions that contributed outside the direct causal chain in Part II and review the timing for plausibility.
8. Check legibility and specificity. Refer uncertain, unexpected or medico-legal scenarios to the appropriate process.
9. Compare names, dates, diagnosis and durations with the records. Present a legible teaching certificate or document why the responsible clinician needs further evidence before completion.

Precautions

- Use approved local forms and pathways for real cases.
- Do not certify a cause beyond the information or authority available.

Observations and Interpretation

Medical Certification of Cause of Death

Observations and Record

Item	What to record	What it tells you
Part I top line	Immediate disease or complication	First condition in the written chain
Part I lower lines	Antecedent and underlying conditions	Explains what initiated the chain
Part II	Other significant contributors	Adds context outside the direct chain

Worked Example

In a fictional authorised natural-death record, aspiration pneumonia arose after a documented acute stroke with dysphagia. Record the clinician-supported sequence in Part I and add a separate contributing disease only if supported.

Result and Interpretation

Provide a coherent training certificate and explain why a mode of dying alone, such as cardiac arrest, gives insufficient cause information.

Viva Questions and Answers

What is the underlying cause?

The condition or event that initiated the sequence leading to death.

Where do other contributing conditions go?

Part II when they contribute outside the Part I causal chain.

Post-Mortem Report Interpretation and Case Log

Practical 03 / Clinical or documentation case

Aim

Review a set of supervised or simulated post-mortem reports and document evidence and limitations.

Principle

A post-mortem opinion integrates circumstances, identification, examination and ancillary results. A single finding may be nonspecific and cause and manner are distinct questions.

Materials and Requirements

- Fifteen fictional or authorised teaching summaries
- Case review log and anatomical diagrams

Procedure

1. Record authorisation, identifiers, chronology and the type of examination from each supplied report.
2. Create fifteen numbered rows and record case source, authority, identity status and date in each. Establish which examinations and ancillary results are included in the teaching pack.
3. Summarise external and internal findings objectively from the records and state which samples or ancillary reports were available.
4. Read the narrative before assigning an opinion. Enter significant external and internal findings by site and system, then mark collection, investigation or treatment details provided by the case.

Continue with step 5 on the next page.

Procedure Continued

Post-Mortem Report Interpretation and Case Log

5. Separate reported circumstances from examination evidence. Mark any missing view, incomplete examination or pending ancillary result in a dedicated field and retain the original observation language.
6. Review 15 varied reports in the log, including natural cardiovascular, respiratory, infection and metabolic cases, accident or injury cases, and cases with pending or uncertain evidence.
7. Compare the different case groups and state how the evidence supports or weakens each reported sequence. Use the natural, injury and complex practice sheets alongside the main log.
8. For each, state what supports the opinion and what remains pending. Practise one concise explanation for an examiner.
9. Submit the entire teaching log for review, explaining one supported opinion and one pending opinion. Document feedback, the review date and any follow-up that could resolve uncertainty.

Precautions

- Use records or authorised observation only.
- Avoid causal overstatement and preserve dignity and confidentiality.

Observations and Interpretation

Post-Mortem Report Interpretation and Case Log

Observations and Record

Item	What to record	What it tells you
Case log	Case number, scenario and records available	Tracks distinct cases
Findings	External, internal and ancillary results	Supports a structured report review
Opinion	Cause basis and uncertainty	Separates evidence from inference

Worked Example

A fictional unexpected death is reported before toxicology is available. Record descriptive findings and explain why the final opinion may remain pending.

Result and Interpretation

Complete a dated 15-case teaching log with reviews by case. Actual institutional certification requires faculty sign-off.

Viva Questions and Answers

Why distinguish provisional and final opinions?

New evidence can affect the final supported conclusion.

Does one finding settle manner of death?

The relevant circumstances and authorised investigation must be considered.

Identification Age Estimation and Skeletal Spotters

Practical 04 / Spotter and viva

Aim

Document observations relevant to age or identity using supplied anonymised records and replica specimens.

Principle

Age estimation uses several indicators and their uncertainty. Bone development and dental milestones vary among individuals and populations. Skeletal identification is multidisciplinary.

Materials and Requirements

- Skeletal replicas and authorised dental or maturation teaching images
- Fictional age-assessment request
- Locally adopted reference chart

Procedure

1. Record who requested the assessment and collect supplied documentary evidence and history.
2. Verify the reference method and the supplied source of age or identity information. Use a fictional case code and note information that comes from documentation or observer report.
3. Identify bone, side and developmental markers. For a fetal or skeletal teaching record document the method and measurements provided.

Continue with step 4 on the next page.

Procedure Continued

Identification Age Estimation and Skeletal Spotters

4. On dry replicas and supplied films orient and identify the structure before reading fusion or development. Locate the matching projection and record open, partially fused or fused features where interpretable.
5. For a supplied measurement confirm the scale, unit and anatomical landmarks. Take two independent readings on the replica or image when feasible and investigate disagreement before averaging.
6. Compare independent indicators with the adopted reference and explain variation or conflicting findings.
7. Compare the findings with an age-appropriate reference population and state the expected range. Identify how image quality, developmental variation or missing records affect precision.
8. Write an estimated range and confidence limits where supported and state why definitive individual identification needs additional evidence.
9. Report the finding, reference, estimated range and limitations in separate fields. Identify any additional documentary or specialist evidence necessary for an individual identification decision.

Precautions

- Use approved images and consent procedures. Do not arrange radiation solely for a student exercise.
- Protect identities and avoid unsupported ancestry or identity claims.

Observations and Interpretation

Identification Age Estimation and Skeletal Spotters

Observations and Record

Item	What to record	What it tells you
Evidence source	Document, dental or skeletal feature	Distinguishes provenance
Measurement	Method and units	Supports repeatability
Conclusion	Estimated range and uncertainty	Avoids unjustified precision

Worked Example

In a training case, dental appearance and bone maturation are consistent with overlapping ranges. Give the evidence and range rather than treating the mean of the two as an exact birthday.

Result and Interpretation

Present the range, reference population and method limits.

Viva Questions and Answers

Why indicate a range?

Biological development varies and methods have limited precision.

Is a bone tag enough for individual identification?

Individual identification requires corroboration by authorised evidence.

Poisoning Assessment and Exposure Documentation

Practical 05 / Clinical or documentation case

Aim

Recognise a time-sensitive poisoning scenario and produce an objective exposure and examination record.

Principle

Symptoms, vital signs, exposure history and concerning syndrome patterns guide urgent assessment. Similar clinical findings can have different causes.

Materials and Requirements

- Fictional exposure cards and photographs of labelled inert exhibits
- Simulated clinical chart
- Local emergency and poison-information pathway

Procedure

1. In the simulation check immediate threats to airway, breathing, circulation and alertness and call for supervised clinical help.
2. Establish scene safety and whether the scenario involves contamination. Call for assistance and state what protective equipment and support the treating team's protocol requires.
3. Record the reported product, route, time, estimated amount if known, symptoms and relevant co-exposures.

Continue with step 4 on the next page.

Procedure Continued

Poisoning Assessment and Exposure Documentation

4. Derive a timeline from the patient or witness, available label and transport record. Enter what is confirmed and what is estimated and avoid handling a real unknown product in the skills exercise.
5. Review vital trends, mental state and supplied examination or laboratory findings. Consider alternative explanations for apparent intoxication.
6. Record vital signs and consciousness by time, then compare trends and the supplied ECG or laboratory results. Review plausible medical, metabolic or trauma-related explanations with the supervisor.
7. Identify the urgent concern and rehearse a focused message to the treatment or poison-information service. Include suspected exposure, time, current findings and support already given.
8. Prepare the medico-legal note with uncertainty, care given by the team, disposition and any authorised specimen request.
9. Complete a dated simulated clinical and medico-legal record. Note the source of each history item, authorised specimens and responsible team for results, review and disposition.

Precautions

- Use inert exhibits and supplied case records.
- Keep treatment within the emergency team and local protocol. Do not induce vomiting or improvise an antidote.

Observations and Interpretation

Poisoning Assessment and Exposure Documentation

Observations and Record

Item	What to record	What it tells you
Exposure reported	Product, route, time and information source	Separates known and uncertain data
Clinical assessment	Vitals, mental state and focused observations	Prioritises urgent care
Medico-legal record	Date, findings and action	Preserves chronology and objectivity

Worked Example

A fictional drowsy patient is said to have consumed alcohol. Escalate altered consciousness and consider other medical causes such as hypoglycaemia or trauma based on supplied findings.

Result and Interpretation

Present a time-linked report and state the urgent clinical priority and any evidence still required.

Viva Questions and Answers

Can smell alone establish a diagnosis?

History, examination and appropriate tests are needed.

What has priority over evidence paperwork?

Immediate clinical assessment and patient care.

Evidence Labelling Chain of Custody and Expert Reports

Practical 06 / Skills laboratory simulation

Aim

Document sealed mock exhibits, maintain chain of custody and explain the limits of expert interpretation.

Principle

Traceability requires unambiguous identifiers and recorded transfers. A resemblance or group match is not an individual identification. Specialist laboratories establish designated conclusions.

Materials and Requirements

- Inert replicas and empty sealed teaching containers
- Mock identifiers, forwarding form and delivery log
- Supplied blood group and DNA report examples

Procedure

1. Use a labelled photo or inert exhibit to record category, identifier and externally observed features. Keep firearm or sharp exhibits in authorised specialist custody.
2. Assign a case code and item number to each authorised model item or photograph. Record received condition, orientation and visible identifiers without reproducing operational details of a weapon.
3. Complete a mock label with unique ID, source, collector, date and condition. Follow the case-specific laboratory form and packaging demonstration.

Continue with step 4 on the next page.

Procedure Continued

Evidence Labelling Chain of Custody and Expert Reports

4. In the packaging simulation check that exhibit ID and label agree, then document packaging and seal condition using the supplied workflow. Keep an observed discrepancy visible in the record.
5. Log each transfer and verify any seal discrepancy. Review the supplied DNA or ABO/RhD record without attempting individual identification from a blood group.
6. Enter date, time, item number, sender, receiver and purpose on each mock handover. Check that times are sequential and each seal or custody issue has a recorded response.
7. Summarise the supplied lab result and indicate its material source and testing scope. Compare class-level information with results requiring additional authorised interpretation.
8. Give a short simulated expert statement describing findings, evidence and limitations without assuming how an injury occurred.
9. Present one concise statement using observed facts and explicitly qualified opinions. Explain how a documented uncertainty or custody gap affects confidence without speculating about events.

Precautions

- Use inert material and do not operate or dismantle exhibits.
- Record facts without reconstructing harm or inferring details unsupported by the record.

Observations and Interpretation

Evidence Labelling Chain of Custody and Expert Reports

Observations and Record

Item	What to record	What it tells you
Exhibit	Identifier, observed features and seal status	Supports traceability
Transfer	From, to, date and purpose	Documents custody
Opinion	Observed facts, method and unresolved questions	Limits conclusions to the evidence

Worked Example

A mock sealed package arrives with a label that does not match the forwarding form. Hold the training transfer and refer the discrepancy through the evidence protocol.

Result and Interpretation

Complete two documented mock transfers and give an objective training opinion about the supplied evidence.

Viva Questions and Answers

What is chain of custody?

The documented history of handling and transfer of identified evidence.

Does a matching ABO result identify a person?

Many people share a group. Individual identification needs much stronger evidence.

Trauma-Informed Medico-Legal Care and Record Review

Practical 07 / Communication role-play

Aim

Demonstrate a trauma-informed, objective approach to fictional survivor and accused-person records under supervision.

Principle

Clinical care, consent, privacy, safeguarding and objective documentation apply within the appropriate legal pathway. Examination findings cannot determine consent or disprove an account.

Materials and Requirements

- Fictional survivor and accused-person records
- Approved local protocols, consent forms and safeguarding pathway
- Standardised communication role-play

Procedure

1. Use separate fictional record packs. Identify each person's clinical needs and the supervising team's authorised role.
2. Prepare separate case records and obtain supervisor guidance on scope, referral routes and immediate health needs. Establish a private environment and offer an interpreter or chosen support person.
3. Explain examination and evidence options with separate consent, the ability to decline and limits of confidentiality as applicable. Offer appropriate support and establish safety.
4. Explain clinical care, examination, history and evidence steps individually. Record which components were accepted, declined or deferred and check consent again before any change to scope.

Continue with step 5 on the next page.

Procedure Continued

Trauma-Informed Medico-Legal Care and Record Review

5. Ask what the person needs now and use open, non-judgemental questions. Explain limits of confidentiality in advance and identify the trained service for urgent care or safeguarding concerns.
6. Review anonymised written findings and record reported history separately from observations. Use the approved form and trained examiner pathway for safeguarding or evidence.
7. Enter reported narrative, observed findings, care and referral separately using the fictional records. Label and transfer any model evidence with the approved chain-of-custody checklist.
8. Present an objective summary for each case and explain how restricted handling, referrals, follow-up and mandatory processes are managed by the team.
9. Summarise immediate support, follow-up and how the person can obtain help. Document who received the clinical or safeguarding handover and the reason any part was deferred.

Precautions

- Do not perform a two-finger or virginity test. Genital findings cannot determine a person's prior sexual history or consent.
- Follow current institution-approved legal and child-safeguarding requirements with a qualified supervisor.

Observations and Interpretation

Trauma-Informed Medico-Legal Care and Record Review

Observations and Record

Item	What to record	What it tells you
Consent and privacy	Choices, support and relevant confidentiality limits	Supports autonomy and safe care
Documentation	Attributed history and objective findings	Avoids prejudicial inference
Disposition	Care, safeguarding and authorised evidence pathway	Maintains continuity

Worked Example

A fictional survivor agrees to care and declines evidence collection. Respect the choice, document it appropriately and continue care through the supervising team.

Result and Interpretation

Demonstrate supportive language and neutral documentation. Use written vignettes rather than practising an intimate examination.

Viva Questions and Answers

Does absence of injury rule out sexual violence?

Absence of injury does not resolve whether an event occurred.

What if a survivor declines part of the process?

Respect and document the choice while offering clinical care and appropriate support.

Custody Examination Dying Declaration and Court Simulation

Practical 08 / Communication role-play

Aim

Recognise medical roles in custody assessment, simulated dying declaration and communicating evidence in court.

Principle

Clinical priority and independent objective documentation remain central. The authorised officer or clinician follows the applicable local legal and institutional procedure.

Materials and Requirements

- Fictional custody and court cases
- Approved role cards and de-identified note format
- Supervisor or examiner

Procedure

1. Identify authority, requested scope, consent and urgent clinical issues in the fictional case. Document privacy and any limits.
2. Verify the simulated referral, permitted purpose and independence of the medical role. Offer privacy where appropriate, assess urgent care needs and obtain and document consent in the scenario.
3. Record objective examination and patient account separately. Escalate safeguarding concerns through the designated pathway.

Continue with step 4 on the next page.

Procedure Continued

Custody Examination Dying Declaration and Court Simulation

4. Begin with an open history and confirm current symptoms and access to care. Record demeanour, vital findings and each represented injury separately from the person's reported account.
5. In a role-play, assess and record the patient's clinical ability to communicate as taught and refer the declaration process to the authorised route. Use nonleading questions and exact words where required.
6. Document alertness, orientation and ability to understand and communicate using the case prompts. Escalate the request to the designated authority and preserve the exact volunteered words according to the exercise.
7. Record all relevant times, who was present, communication aids and changes in clinical status. Mark any limitation that affects the reliability of the observed assessment.
8. Practise answering a court question within the stated expertise and identify what remains unknown.
9. In court simulation refer to the contemporaneous record. Distinguish observation and professional inference, answer only within scope and state which questions require other evidence.

Precautions

- Follow institutional and current legal guidance for real cases.
- Maintain neutrality. Never use leading statements to fill a record gap.

Observations and Interpretation

Custody Examination Dying Declaration and Court Simulation

Observations and Record

Item	What to record	What it tells you
Custody case	Identity, scope, findings and priority	Supports independent assessment
Declaration scenario	Date, clinical state and recorded statement	Preserves accurate attribution
Court response	Observation, inference and limitation	Stays within professional competence

Worked Example

In a simulation the person is difficult to rouse and cannot give coherent answers. Document the observed state and alert the clinical and authorised team rather than assuming capacity.

Result and Interpretation

Produce a fictional custody note and brief oral explanation that distinguish clinical facts and legal conclusions.

Viva Questions and Answers

Why quote a significant statement accurately?

It preserves what was said and avoids inserting the examiner's inference.

What if information is missing?

State the gap and avoid guessing.

Post-Mortem Case Records Natural Causes

Practical 09 / Clinical or documentation case

Aim

Use five fictional natural death records to practise concise post-mortem summaries.

Principle

The immediate cause and underlying disease are supported by the case history, examination and ancillary findings. The certifying clinician decides whether enough evidence is available.

Materials and Requirements

- Five teaching records in the observation table
- Case log with space for finding, opinion and pending information

Procedure

1. For each record, list the principal findings and identify the main organ system.
2. Work through the five case cards in order. Enter a case code, clinical course, organ involved and the principal examination finding, using a new row for each record.
3. Review the pattern of the evidence before assigning a cause. For example, compare coronary pathology with evidence of recent myocardial injury, or pulmonary vessel findings with the documented venous source.
4. Draft an immediate cause and an underlying condition only where the supplied facts support them.
5. Draft a short sequence showing the immediate disease and the preceding condition where support exists. Identify a coexisting condition separately if its role has yet to be established.
6. State one further report or history item that would help strengthen the opinion.
7. Select a targeted next source such as relevant histology, charted laboratory results, prior cardiovascular history or medication timing. Explain why it would strengthen or change the opinion.
8. Ask the instructor to review each entry and record any revision.
9. Compare the five sequences for plausible timing and clear language. Correct unsupported causal statements after review and note whether each case is provisionally supported or pending.

Precautions

- Teaching summaries are fictional and deliberately brief.
- Use stated evidence to support each opinion.

Observations and Interpretation

Post-Mortem Case Records Natural Causes

Observations and Record

Item	What to record	What it tells you
Case 01	Coronary thrombosis and recent myocardial necrosis	Acute myocardial infarction with coronary disease
Case 02	Lobar consolidation with acute inflammation	Pneumonia pattern
Case 03	Large cerebral haemorrhage and known chronic hypertension	Intracerebral haemorrhage with relevant history
Case 04	Large pulmonary embolus and documented deep-vein thrombus	Pulmonary embolism arising from venous thrombosis
Case 05	Ketosis, markedly elevated glucose and supportive medical records	Diabetic ketoacidosis pattern

Worked Example

For Case 01, record the recent myocardial injury and the supporting coronary finding. Review prior symptoms and histology before offering a provisional causal sequence.

Result and Interpretation

A supported opinion connects the anatomical and clinical evidence. Document the difference between established findings and provisional causal conclusions.

Viva Questions and Answers

Why review the clinical history in Case 05?

Biochemical findings are interpreted with investigation timing and the disease history.

What is an underlying cause?

The disease or injury that initiated the sequence leading to death.

Post-Mortem Case Records Injury and Exposure

Practical 10 / Clinical or documentation case

Aim

Record five fictional injury or exposure findings and explain the limits of a cause opinion.

Principle

Anatomical injury, clinical events and investigation records support the medical opinion. Scene information may be essential for reconstructing circumstances.

Materials and Requirements

- Five teaching records in the observation table
- Case log and records of agreed simulated investigations

Procedure

1. For each case record the source of the reported circumstances and list objective positive findings.
2. Make a separate record for each numbered case. Enter the reported situation, its source and objectivity of the anatomical finding, and indicate whether the hospital or scene account is incomplete.
3. Identify the injury or physiological pattern that may explain the death, using concise medical language.
4. Summarise the main injury or complication in clinical terms and relate it to the observed condition. Where more than one process is plausible, keep the alternatives visible.
5. List findings or reports needed to distinguish other causes or clarify circumstances.
6. Record the relevant gap for each case, such as incomplete treatment chronology or conflicting reports. Explain what a further verified record would help distinguish without reconstructing unverified events.
7. For the submersion example compare environmental and medical possibilities using the provided records. Describe why location alone is insufficient to settle the medical cause.
8. Draft a provisional report with factual observations and an opinion field. Review it with faculty.
9. Present one supported and one deferred case and record faculty feedback. Keep dates, observations, provisional opinions and pending materials in separate entries.

Precautions

- Use case information with dignity and neutral wording.
- Do not infer intent from an anatomical finding.

Observations and Interpretation

Post-Mortem Case Records Injury and Exposure

Observations and Record

Item	What to record	What it tells you
Case 06	Major blunt chest injury with haemorrhage after reported collision	Correlate injuries with medical and scene records
Case 07	Significant head injury after a reported fall	Record injury and verify chronology
Case 08	Post-trauma open limb injury and later sepsis in hospital records	Assess the link between injury and infection
Case 09	Widespread thermal injury and documented intensive care	Consider complications and treatment timeline
Case 10	Recovery from water with nonspecific anatomical findings	Review circumstances and exclude alternatives

Worked Example

In Case 10 the circumstances suggest submersion, but the available findings are nonspecific. Document the information and state what remains to be reviewed.

Result and Interpretation

Give a cause opinion only to the extent supported by investigation. Record mechanism and circumstances separately where evidence allows.

Viva Questions and Answers

Why record a hospital timeline in Case 08?

It connects the original injury, subsequent management and development of infection.

Can a single finding establish drowning?

A conclusion depends on the circumstances, examination and exclusion of relevant alternatives.

Post-Mortem Case Records Pending and Complex Opinions

Practical 11 / Clinical or documentation case

Aim

Complete five fictional records in which timing, competing disease or pending tests affect the opinion.

Principle

Some findings are nonspecific or incidental. A provisional report can preserve accurate observations while deferring an opinion until evidence is reviewed.

Materials and Requirements

- Five teaching records in the observation table
- Pending-report checklist and case log

Procedure

1. For each case list established findings, received records and missing information.
2. Use one row per card and record what was observed, what was reported and which records are still missing. Mark where preservation or documentation affects assessment.
3. Identify the leading possibility and whether the available evidence supports a provisional causal opinion.
4. Compare the likely explanation with one competing possibility for each record. Show how the available data either support a limited interim opinion or leave both possibilities open.

Continue with step 5 on the next page.

Procedure Continued

Post-Mortem Case Records Pending and Complex Opinions

5. For the pregnancy-associated case identify relevant maternal history and clinical chronology. Record what would distinguish a pregnancy-related process from a coincidental condition using the supplied classification.
6. Write the specific review or ancillary result needed and the service responsible for it.
7. Assign each pending item to the simulated responsible service and write the expected decision it informs. Note when review was requested and whether further records have been received.
8. Close the classroom record with a dated status and verify it with the supervisor.
9. Read the dated status back to the supervisor and update the status when results arrive. Preserve the provisional wording and reason for any later revision.

Precautions

- Treat absence of a report as a limitation and use accurate dates.
- Keep fictional conclusions distinct from real medical certification.

Observations and Interpretation

Post-Mortem Case Records Pending and Complex Opinions

Observations and Record

Item	What to record	What it tells you
Case 11	Unexpected death with toxicology pending	Keep the exposure opinion open
Case 12	Decomposition limiting evaluation	Document preservation and examination limits
Case 13	Sudden collapse with organ findings of uncertain relevance	Request clinical, family and ancillary information
Case 14	Death during pregnancy with signs consistent with thromboembolism	Review obstetric and medical records for classification
Case 15	Severe chronic disease with a possible treatment complication	Review treatment timeline and differential

Worked Example

In Case 15 both chronic pathology and a possible treatment complication are recorded. The exact chronology and relevant results have yet to be provided.

Result and Interpretation

Record both findings and the reason for keeping the final opinion pending. Identify which information will be reviewed and by whom.

Viva Questions and Answers

Is a pending opinion an incomplete observation record?

Observed findings can be complete even while a causal conclusion awaits evidence.

What helps an examiner understand uncertainty?

A clear statement of the missing evidence and the competing explanations.

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