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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.

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