6. Before the appointment of Professor Berry as Consultant (which I note from his statement took place in 1983), children's post mortem examinations were usually carried out by Dr Norman Brown or by Dr Burton, if she were available. Otherwise such post mortem examinations were carried out by the pathologist on the rota for the day.

7. After the appointment of Dr Berry children's post mortems were carried out by him at the Children's Hospital.

8. When I became Deputy Coroner, forms for use by the pathologist to record his findings at post mortem were provided by the Coroner. I do not remember how the design originated but I think that the form was taken from an Appendix to the Coroners' Rules in force in the 1960s. A similar form appears as Schedule 2 to the Coroners' Rules 1984 – see Mr Clifford's statement at WIT 0043 0061.

9. On the form there is a specific box in which the pathologist noted if further examination was to be carried out which might affect the cause of death. If the answer to the question "Is any further laboratory examination to be made which may affect the cause of death" was in the affirmative I knew that histological specimens had been taken: otherwise I assumed that none had been taken.

10. During the period 1974 to 1991 I took the view that deaths following operations to correct medical conditions were deaths arising from natural causes and as such only referable to the coroner if the cause of death was unknown, or unknown without a hospital post mortem examination.

11. However, I did require to be notified of deaths that actually occurred on the operating table. When such a death was so referred and the cause of death was known and was natural I dealt with the matter by way of Form A without a post mortem examination.