

A Study into Decision Making at the Initial Scene of Unexpected Death

**A report for the Forensic Science Regulator concerning the
2012 Audit of Forensic Pathologists Reports**

**Forensic Pathology Unit of the Home Office
January 2015**

A Study into Decision Making at the Initial Scene of Unexpected Death

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1. Executive Summary

The subject of this report is the result of a study following the Forensic Science Regulator's (FSR's) 2012 audit of Home Office Registered Forensic Pathologist's (HORFP's) post mortem reports (not yet published). The report concerns cases where HORFP have been asked to continue a post mortem examination (PM) initially commenced by a non-forensic pathologist. Analysis of data received from returned questionnaires submitted by police, coroners and pathologists in 33 such cases, has highlighted issues in respect of decision making at unexplained death scenes by those responsible for investigating deaths in the community. This study was initiated by the Home Office Forensic Pathology Unit (HOFPU) on referral from the FSR, and with the agreement of the Chief Coroner and the National Police Lead for forensic pathology as well as the Pathology Delivery Board (PDB).

Of the 33 cases provided to the study: one was omitted due to the fact that it was a road traffic death; 10 transpired to be homicides and a further 5 were suspicious deaths requiring further investigation. In 15 of the cases, from information available at the scene, it was considered that the death should have been treated as suspicious from the outset.

The study has highlighted what appears to be variations in quality of initial scene assessments. It is suspected that 'cognitive bias', rather than a full assessment, may influence decision making. This was noted especially in cases where the deceased had been using drugs, alcohol, or were elderly. This study found no evidence to indicate that financial constraints on the part of the police were a factor in the failure to use a HORFP.

Although the cases examined are examples of where the 'system worked' and homicides (which may otherwise have gone undiscovered) were identified as such, it is concerning that evidence uncovered in this limited study has identified cases where apparent and obvious indicators of suspicion were overlooked by those making decisions at the scene of unexplained deaths. It therefore seems reasonable to suspect that homicide cases may have been missed in the past, and could continue to be missed or forensic evidence lost. Action is required to address the shortfalls in the

adequacy of the assessment of death cases and the associated decision making process concerning the use of HORFP's.

This report makes 8 recommendations:

Recommendations

Recommendation 1. – That this report be circulated to the FSR; Chief Coroner; National Police Lead for Forensic Pathology and the Chair of the PDB for initial feedback.

Recommendation 2. – That the Home Office Forensic Pathology Unit continues to collect data and process it in the same manner as was conducted as part of the audit. Ethnic origins of deceased persons should be included in the requested data in case this is shown to reveal some significance

Recommendation 3. – The College of Policing (COP) should review current training for police joiners in respect of scene of death investigation, to include brief searching of bodies and scene protection. The Initial Crime Investigators Development Program (ICIDP) and Detective Sergeants courses should also be similarly reviewed.

Recommendation 4. – The National SIO course and the training of Inspector ranks should receive suitable training on relevant courses.

Recommendation 5. – Consideration should be given to open up the current Home Office run course 'Criminal Justice Training for Pathologists' to histopathologists engaged in autopsy practice and include an element on the 'Signs of Homicide'.

Recommendation 6. – That the Chief Coroner be approached to request that a direction be made to all coroners, that due regard be taken of the Royal College of Pathologists publication 'Standards for Coroners Pathologist's in post mortem examinations of deaths that appear not to be suspicious' concerning the standards of post mortem examinations by hospital pathologists (February, 2014).

Recommendation 7. – That forensic post mortem data be included within the Homicide Index in order that police forces can assess and monitor the relationship between

homicide and the use of forensic pathology.

Recommendation 8. - The PDB consider how to take forward the broader potential issue of cases of death that may have been suspicious but either did not have a PM; or where a PM was conducted by a non – forensic practitioner it was never passed on to a HORFP.

2. Background

Since 1944, the Home Office have maintained a 'Register' of forensic pathologists with sufficient qualifications, training and experience to assist the police and coroners in the investigation of the cause and surrounding circumstances of death in cases which appear to be unexplained; and where there may have been third party involvement. These cases are commonly referred to as 'suspicious'. HORFP's are also trained to make scene assessments and obtain evidence from the body at a post mortem examination. Police in England and Wales are directed by national practice advice (Approved Professional Practice: formerly the Murder Investigation Manual) to use HORFP's in all non-road traffic¹ related suspicious deaths.

There are currently 35 HORFP's who are subject to a Protocol, Discipline Code and a Code of Practice: all of which are monitored by the Home Office. Registrants work in 'group practices' in England and Wales and provide a 24/7 service to police and coroners for suspicious death cases. They are in the main private individuals; although some are employed by Universities or hold a NHS contract of employment. Forensic Pathology is a 'specialism' of pathology in its own right and the holder of the specialism will have the details of their qualification entered onto the specialist register of the General Medical Council (GMC) and hold a current GMC license to practise.

The FSR is responsible for quality standards relating to all aspects of forensic science and conducts an annual audit of the quality of HORFP reports. This process is conducted by the Forensic Pathology Specialist Group (FPSG); which is a 'working party' that advises the Regulator in the setting of standards for forensic pathology in England, Wales and Northern Ireland.

The process of the audit is that, a 'theme' is identified and HORFP's are asked to submit anonymised post mortem (PM) reports on the relevant subject area. These are then assessed by a panel made up of forensic pathologists, a coroner and police senior investigating officers (SIOs). The panel submit their feedback to a nominee of

¹ Practice advice on road death investigation states that the decision to have a forensic post mortem examination on a victim of a non-homicidal road death should be decided on a case by case basis.

the FPSG who in turn produces a report outlining the general quality of the material submitted and any issues identified.

For the FSR 2012 audit HORFP's were requested to submit reports of a case where a non-forensic post mortem examination had been commenced but ceased in favour of a forensic post mortem. This may have been due to mortuary staff or the non-forensic pathologist discovering injuries or other identifying issues which they felt would more appropriately be dealt with by way of a forensic post mortem.

A total of 33 cases were submitted for audit and all were reported upon by the panel. Initial analysis of the results were made by the FPSG, and the audit team took the view that **all** of the cases should have been deemed as warranting forensic autopsies from the outset; and that the decision not to have a forensic post mortem was a flawed one. It is important to note however, that within the context of the FSR's audit, the only information on which the panel had to rely upon was the HORFP's report.

It was therefore decided that further enquiry should take place into each of these cases and the FSR commissioned the HOFPU to conducted further investigations. Permission was further sought and granted to conduct this work from the Chief Coroner; National Police Lead for Forensic pathology and the Pathology Delivery Board (PDB). Final approval to go ahead with this study was received in November 2013 and the finalised questionnaires were sent to respondents between February and April 2014.

3. Methodology

Although this was a relatively small scale research project, various methods were considered to gain the necessary data. The basic research question was;

To examine the strengths and weaknesses of the decision(s) by those investigating unexplained deaths not to engage the services of a HOFP from the outset of each case.

Sub questions were

What influenced decision making in those cases where a forensic pathologist was not utilised but should have been?

What is the case for further research in the area of suspicious death and homicide investigation?

What can be implemented by way of policy to improve the initial investigation of unexplained death?

Detailed examination of each case file was considered but dismissed, as this would have posed a massive exercise beyond the resources of the HOFPU. It was therefore decided that the most targeted and efficient means of gathering the data was to send a questionnaire to the key decision makers in each of the 33 cases, and to request case.

A questionnaire with open questions would allow for both quantitative and qualitative analysis of the results, and so a bespoke questionnaire was designed for each of the three groups of:

- Police
- Forensic pathologist's
- Coroners

The draft questionnaires were quality assured by a member of Home Office Research and Development. These were then 'tested' using a small number of police Senior Investigators to ensure that the questions were clear and unambiguous. The coroner's questionnaire was quality assured by the office of the Chief Coroner who wished to

ensure that the message was clear and that the questions were in no way perceived to be a challenge to the coroner's judicial authority.

The questions were designed to elicit responses in order to test the initial circumstances of each case, the circumstances present at the time decisions were made and the rationale for particular decisions. The three questionnaires were in the main similar but differed, where appropriate, to reflect the differing roles of the respondents. Examples of the blank questionnaires can be found at **Appendix A**.

Questionnaires were emailed to respective recipients; in the case of the police, to the relevant Chief Constables, with an accompanying letter from the National Police Lead for Forensic Pathology. Hard copies of the questionnaire were sent via secure post where appropriate. In the case of coroners and pathologists, questionnaires were sent direct to the recipients.

A 'return by' date was set and reminders were sent at appropriate stages.

The returned questionnaires with accompanying documentation was analysed and case summaries were produced in respect of each case using all of the available information. A quantitative analysis of the data was then plotted onto an excel spreadsheet from which statistical data could be elicited.

Qualitative data was then available for comment to give depth to the statistical findings.

One of the cases (a road death, for which there is no national guidance in respect of post mortem examinations) was removed from the study. This left a final set of 32 cases, which were all post mortem examinations, the majority of which took place within a 12 month period from the audit date.

In considering the cases, actions by the police in making decisions at the scene of the death were mapped against practice advice in place in the form of the College of Policing Approved Professional Practice (APP). This Practice Advice was formerly known as the Murder Investigation Manual (2006). Any comments and statistical presentation in respect of decisions made by coroners and others are based on

subjective opinion on the part of the authors; and on the basis of the returned data. However, in order to obtain a broader range of views, two independent operational SIO's were also asked to consider the cases as well as an experienced investigator from outside of the civil police in the UK. It is accepted that there will be other information outside of the knowledge of this study as there was not a 100% return rate of questionnaires. The overall return rate of questionnaires was almost 80%.

4. Results

Return Rate

Table 1 sets out the return rate for all questionnaires for Police, Coroners and HORFP's

Discipline	No. returned	% return rate
Police	30	94
Coroners	20	63
HORFP	26	81

Table 1: Returned Questionnaires

The original review team considered that the number of homicides identified as a result of a forensic post mortem in the 32 cases was initially: 6 confirmed and 6 suspected cases. However, additional analysis of the data contained in the returned questionnaires showed that there were in fact 10 confirmed homicides and a further 5 treated as suspicious deaths². This represents 31% of the cases as confirmed homicide, but if the possible homicides are included it brings the percentage to 47%. In other words, almost half of the cases submitted fall in to the categories of either confirmed or possible homicide.

There were also a further 9 cases (28%), where the police were not initially involved in the investigation and did not attend the scene. Therefore they could not have had the benefit of assessing the scene at all. These included cases where for example, the deceased had been conveyed to hospital and died there. Of the cases where the police did attend the scene 65% (23 cases) should have been forensic cases from the outset.

In considering the overall circumstances of each case there were 10 (31%) instances where there was no reason to consider the death as suspicious from the information

² The assessment of whether a case was deemed to have been a 'possible homicide' was a subjective one based upon the available information and when an open verdict was recorded.

available at the scene. This included 3 of the confirmed homicide and 1 of the suspicious death cases requiring further investigation. This highlights how difficult it can be at some scenes in terms of the scene assessment and decision making process. Each Force has its own crime scene examination process to ensure skilled staff are available to conduct this assessment.

Table 2 is a breakdown of cases where decisions were made by parties to the investigation as to whether to treat the case as ‘suspicious’ from the documentation available. In some cases there is insufficient information available as to why certain decisions were made. Once again, it is emphasised, that this is a subjective view, formed from an assessment of the available documentation. Some gaps exist due to the failure of parties to return questionnaires. However, the data on which this table is produced is available for independent review.

Party to Investigation	Cases where the initial decision is ‘questionable’	% of cases
Police at the scene	10	31
Senior police (SIO)	8	25
Coroner*	11	34
Attending Doctor	5	16

Table 2: Decisions deemed as ‘questionable’

**In those cases where the coroner made the decision not to treat it as suspicious, most were on the advice of and in accordance with information provided by the police.*

Of the cases where questionable decisions were made by the first officers at the scene many appeared to have been upheld by supervisory officers in 9 cases (56%). Of the 10 confirmed homicides the failure to identify them as such was as a consequence of initial police decision making in 7 cases. Of the 5 suspicious deaths requiring further investigation, failure to identify them as such was as a consequence of police decision making in 2 cases. Therefore, of the 15 cases in these two categories, initial police decision making accounted for the potential to miss a homicide in 9 of them. This equates to 60% of cases identified as homicide or suspicious deaths requiring further

investigation, and in 28% of all the cases represented in the study. The overall number of cases where the decisions of the police were questionable was (as mentioned above) 15, representing 47% of the cases submitted for audit.

Drugs and/or alcohol were factors in 13 of the 33 cases, 6 of which were either homicide or suspicious deaths. One force visited by the HOFPU during the research period had identified (during their own in-force research) that alcohol and drugs were a feature of some death scenes which had influenced officers to make isolated decisions that the cause of death was not suspicious. Officers appeared to presume that death was as a result of alcohol consumption leading to injury through falling or some other cause due to intoxication. The presence of alcohol/drugs needs to form part of a broader assessment.

In addition to quantitative data some HORFP's made both specific and general comments regarding how they are utilised by police. These comments are not included for reasons of anonymity.

Case Summaries were produced for all the 32 examined cases but are not included within this report. Although these are anonymised as far as is practical to do so, the individual nature of each case could possibly lead to the case being identified and so these should not be published outside of the consultation group.

5. Discussion

It is worth noting that HORFP's are trained in the collection of forensic medical and physical trace evidence from the deceased, and in giving expert opinion in court as to the cause of death. In the case of *R v Clarke and Morabir* (2013)³ the Court of Appeal upheld a trial judge's direction that a non-Home Office registered pathologist was not competent to challenge the opinion of a HORFP.

One factor which appears from the data available to be a significant issue, is the lack or poor inspection of the body at the scene of death by the first attending officers. There is some evidence that even though there were visible marks indicating possible violence in many of the cases decisions were made not to treat the deaths as suspicious. In 5 cases there appears to have been no inspection of the body at all.

There may also be a tendency to treat the deaths of elderly people as less suspicious for understandable reasons. One senior police officer stated that in their experience what tends to happen at a scene is that the first attending officer makes up their mind as to whether the death is suspicious or not, sometimes believing the first account they are given. A 'cognitive bias' (Forensic Science Regulator, 2014; Kahneman, 2011) is then potentially adopted by the investigator with regard to any new evidence which comes forward and also when briefing senior officers and the coroner.

During the course of this study, 2 SIOs made comment that finance is a consideration when asking for a forensic post mortem. However, this would probably not be a consideration of the first attending officers. Cost is more likely to be an issue for more senior officers such as SIO's. At a recent focus group of 18 SIO's of Inspector to Superintendent rank, from all regions of England and Wales assembled to consider the future of the forensic pathology service, all stated that finance was not an issue in deciding to use a HORFP in unexplained death cases and neither had they experienced any pressure to reduce forensic PM's from senior budget holders.

³ *R v Clarke and Morabir* (2013) can be downloaded from <http://www.bailii.org/ew/cases/EWCA/Crim/2013/162.html>

However, one proposal recently put forward by a force was that all police cases should be conducted as 'special post mortem' examinations, attracting a fee of only £260 and if the outcome was that it was deemed to be suspicious, or a confirmed homicide, then a forensic case would be called. A direct quote from the source of this proposal stated that '*Due to the increasing costs and frequency of forensic post-mortem examinations, both Coroners and Police Forces are reviewing their approach to this issue*'. Clearly therefore the pressure to reduce spending may have some bearing on the use of HORFPs in some areas.

Understandably costs and budgets are a factor in decision making and a major issue for all public bodies in the current climate. Nevertheless an over emphasis on cost saving by the agencies involved in death investigation could potentially lead to suspicious death/homicide cases being missed if cost becomes a key factor in decision making around whether or not to call for a forensic PM.

The use of non-forensic post mortem processes is particularly concerning in the light of a report by the National Confidential Enquiry into Patient Outcomes and Death (NCEPOD, 2006), which found that many non-forensic PM examinations were inadequate. This was a comprehensive piece of research into the quality of coroners' autopsies following general disquiet about the standard of non-forensic PM examinations. These concerns were first highlighted by the Broderick Report in 1970 when discrepancies were found between clinical and PM diagnoses. Although this research is over 9 years old, the report was recently referred by the Pathology Unit to relevant personnel within the Royal College of Pathologists in order to establish whether its findings are still current. The unanimous view was that, if anything, the situation had worsened since the 2006. One of the reasons given was the fact that the autopsy element of histopathology training was no longer compulsory leading to a reduced number of non-forensic pathologists willing or able to conduct coronial work.

The NCEPOD auditors reviewed 1,877 autopsy reports and supporting documentation in a one week period in 2005 in England, Wales and Northern Ireland. The report concluded that there was no improvement in the discrepancies identified since the 1960s (Harvard, 1960); that half of the cases produced findings which were unsuspected before death; that at least one third of death certificates were likely to be

incorrect. In 16 cases where the body was found in a decomposed state, the bodies were not examined and evaluated properly. A common denominator in these cases was that the deceased were either known alcoholics or drug users or found hanging from the neck.

The following factors were also identified;

- One in four autopsy reports were judged to be poor or unacceptable.
- In one third of mortuaries, the mortuary technician opened the body and removed organs before the pathologist actually inspected the body.
- In one in seven cases the brain was not examined.
- Histology was not taken when it was judged that it should have been in many cases.
- In a fifth of cases, the cause of death was adjudged to have been questionable.
- There was generally a poor quality of examination of the body and organs.
- Communication between coroners and pathologists was poor and there was insufficient information passed to the pathologist by the coroner.

The report quotes;

'If one quarter of all surgical procedures undertaken on the living were deemed, by peers, to be poorly or unacceptably badly done, there would be a public outcry. The fact that there is no public outcry is a manifestation of the fact that families are unaware of the variable quality of the autopsy procedure'.

When questioned about this, a common response from pathologists and coroners was *"what do you expect for £87.70?"* (the fee then payable for a non-forensic 'routine' autopsy which is now £96.60).

The report was a comprehensive piece of work; however it did not review the actual post mortem examinations, but was rather a review of the paperwork only, and so reliance on this report as empirical evidence of the poor quality of non-forensic post mortem examinations should perhaps be treated with some caution.

Undoubtedly many histopathologists conduct PM's to a high standard, but reliance on a non-forensic PM is risky and potentially unlikely to identify a complex murder. More concerning is the fact that evidence uncovered in this limited study has identified cases where obvious indicators of suspicion were overlooked by both police and non-forensic pathologists. It therefore seems entirely reasonable to suspect that a number of homicide cases may have been missed in the past and will continue to be missed in the future unless action is taken to address the shortfalls in the adequacy of police assessment of death cases, including the decision making process concerning the use of HORFP's.

An examination of the literature has revealed some historic research into this area that tends to show that the problem is not new and also highlights that some action is required to ensure change now. Although there is clearly difficulty in placing too much emphasis on data gleaned from research carried out many years ago it does underline the fact that the issues highlighted are not merely confined to contemporary practice.

The only other study into the quality of post mortem examinations and the investigation into the cause of death, known to the author of this report, is '*The Incidents of Unnatural Deaths Which have been Presumed to be Natural in Coroners Autopsies*' conducted by Home Office forensic pathologist Professor Hugh Johnson in 1969 (Medicine Science and Law 1969 9:102).

Johnson attempted to estimate the frequency of unnatural deaths discovered at autopsy by reviewing 28,108 autopsy cases over a 5 year period between 1963 and 1967. The pathologists engaged in this review had the back up of full laboratory facilities. All of the autopsies were carried out by members of the Department of Forensic Medicine at the London Hospital Medical College. Of these cases, 5,038 were identified as being unnatural and these were used for the purpose of the study.

Johnson's review relied on the coroner's officer's report and the autopsy report. The 5,038 cases were selected because there was an indication of something present at the death scene (or other information) which indicated the possibility that the death could be unnatural. Of these cases 263 were discounted as being unnatural by the coroners officers report due to information supplied by the deceased's relatives, the attending doctor, police officer, or indeed the view of the coroners officer themselves.

These 263 cases were examined in detail.

Of these 263 cases 174 were poisoning cases (although not necessarily criminal poisoning), 34 were head injury cases, 14 had other injuries to the body, 11 asphyxia cases, 1 hanging, 1 cut throat, 1 electrocution, 18 homicides and 9 criminal abortions. This represented over 5% of all of the identified unnatural deaths from the original total number of cases.

Johnson comments that although there was information which would bring these cases into the unnatural category they were missed as potential homicides even though in some cases there were visible injuries. He identified that the main reasons were that the body had not been properly examined at the scene either by the attending doctor or the police officer, or because in some cases no examination had taken place at all. In other cases, no investigation appeared to have taken place at the scene of the death. There were also examples of deliberate deception and concealment of information by relatives in the deaths identified as being criminal. In many cases assumptions had been made that because the deceased were either old or had been ill that death was due to natural causes.

According to Johnson;

'...the overall picture is one of lack of suspicion, inadequate examination of the body and circumstances at the scene and an astonishing capacity for self-deception on the part of those investigating those deaths.'

There was at the time of the study (1963 – 1967) no formal training for police officers in death investigation and almost all coroners officers were at that time serving police officers, who tended to be at the end of their police service or of ill health and other limiting factors.

Johnson speculated that there may be a reliance on the part of the police on the opinion of the attending doctor but as could be seen from this study that reliance was misplaced.

In all Johnson's study showed that 27 criminal cases were missed.

He quotes;

'Whilst misdiagnoses of natural deaths is regrettable, it seldom has any far

reaching consequences unless such cases are treated as unnatural deaths as due to natural causes can be much more serious. Cases of major crime can be overlooked and not investigated, and also problems of insurance, pensions and civil litigation may stem from incorrect or incomplete causes of death'

There are even older studies which tend to suggest that this problem is not a new one. *The Detection of Secret Homicide* (Harvard, 1960) was a study of the Investigation of Sudden and Unexplained Death. This book claims to be the first academic work to examine those instances where homicide is not initially identified but subsequently transpires as such. It concludes that the high detection rate for murder may have produced a false sense of security as many homicides are missed each year. At the time of the study the only missed murders subsequently identified as such were due to the offender reoffending, which raised suspicion regarding previous deaths.

Harvard states that those cases without an adequate medico-legal investigation of the person who has died a violent death or a sudden death of unexplained cause are fraught with danger. He also states that even the most competent physician if he attempts to certify the cause of such deaths on the basis of the available clinical history and external examination of the body is likely to be proven wrong by a medico-legal post mortem in one out of every three cases.

However, it is important to note that when this research was carried out many murders of the day were by means of poisoning and the profile of murders is considerably different today. Clearly it is to the advantage of the offender to disguise the homicide to appear as a natural death and the number of such cases will never be known from the examination of statistical data.

Harvard looked at margins of error in recorded cases of sudden death between the diagnosis of the certifying doctor and the outcome of the post mortem examination. He also looked at cases where a death is certified as natural and through some other reason facts emerge which casted doubt on the original death verdict. This raises another issue as to the reliability of many GP certificated deaths, however this is outside of the remit of the present study. Harvard relies on a study conducted in 1958

where 1404 cases were examined and the attending doctor had certified death as natural causes. Upon subsequent autopsy of the bodies 19% uncovered factual errors in the doctors diagnosis and there was discrepancy of opinion in 47% of cases. He also refers to another study in 1939 of infant deaths in Newcastle, where one third of the diagnoses of the cause of death were incorrect upon post mortem examination (Spence, 1941).

In 1942, the advisor to the Home Office on toxicology, Dr Roche Lynch reported that of eight exhumations he had examined seven were homicide that had been missed due to inadequate investigation (Roche, 1942).

In a study in San Francisco over 100 post mortem examinations on cases certified by doctors revealed the wrong cause of death in 45% of the cases Turkel (1953).

A report of the Medical Examiner of New York in 1950 estimated an annual average of 50 cases where homicide is identified following a decision of the attending doctor that death was due to natural causes.

Although it is not the intention to go into any particular category of 'victim' of homicide as being particularly difficult to identify at the scene, there is however some more contemporary research into the likelihood of missing child homicide which is much more difficult to detect in a young infant (Brookman and Nolan, 2006; Vaughan and Kautt, 2009; Pasquale-Styles, Tackitt and Schmidt, 2007).

6. Conclusion and Recommendations

In conclusion, the findings of this limited study of cases, originally identified by the FSR's audit process, have highlighted the potential for professionals involved in death investigation to 'miss' homicides by conducting limited scene assessments and not utilising the advice and expertise of a HORFP early on in the investigation process. The historical studies cited in this report also show that concern over the incorrect identification of causes of death is not new.

The prevailing situation poses an obvious threat to the criminal justice system due to factors such as inadequate training, cognitive bias and financial pressures.

However, more extensive and detailed research is required to investigate this area further. In the meantime, a number of recommendations are put forward for consideration to address the findings of this report.

It has been agreed that prior to publication of this report it shall first be forwarded to those referred to in recommendation 1, and then to the members of the FPSG and the PDB before wider publication. The recommendations are as follows:

Recommendation 1. – That this report be circulated to the Forensic Science Regulator; Chief Coroner; National Police Lead for Forensic Pathology and the Chair of the Pathology Delivery Board for initial feedback.

Since the study, the Forensic Pathology Unit within the Home Office has started to collect cases (on the same basis as the original audit), where a HORFP have taken over from a non-forensic pathologist. To date, there have been an additional 150 cases reported since January 2014. These have not been enquired into as yet. However it is recommended that all of these cases, and future ones, be treated in the same manner as the 32 audit cases; namely, that questionnaires be submitted to each of the coroners, police and HORFPs. The expected benefit of this is that it will in time raise awareness and will hopefully drive up the standard of death investigation at least in terms of first attendees.

Recommendation 2. – That the Home Office Forensic Pathology Unit continue to collect data and process it in the same manner as was conducted as part of the audit. Ethnic origins of deceased persons should be included in the requested data in case this is shown to reveal some significance

It would appear that junior officers attending scenes of death may in some cases (as highlighted in this report) be in need of training as to how to conduct scene of death investigations. It is suggested that the guiding principle should be to start on the basis that the death is suspicious unless the evidence shows otherwise.

Recommendation 3. – The College of Policing should review current training for police joiners in respect of scene of death investigation, to include brief searching of bodies and scene protection. The Initial Crime Investigators Development Program (ICIDP) and Detective Sergeants courses should also be similarly reviewed.

Senior Investigating Officers should be made aware of the issues in respect of failure to use the services of a HORFP, and the fact that non-forensic pathologists may be ill equipped to identify a homicide. Valuable trace evidence may be lost in the process of washing and evisceration as part of the non-forensic process. An article to this effect has already been published in the Homicide Journal (Jones, 2014).

Recommendation 4. – The National SIO course and the training of Inspector ranks should receive suitable training on relevant courses.

Currently there is no specific training offered to non-forensic pathologists in the identification of suspicious death. An opportunity to do so is the current course run by the Home Office namely: 'Criminal Justice Training for Pathologists'. This course, which is currently delivered for paediatric pathologists, could be introduced for histopathologists.

Recommendation 5. – Consideration should be given to open up the current Home Office run course 'Criminal Justice Training for Pathologists' to

histopathologists engaged in autopsy practice and include an element on the 'Signs of Homicide'.

Recommendation 6. – That the Chief Coroner be approached to request that a direction be made to all coroners, that due regard be taken of the Royal College of Pathologists publication 'Standards for Coroners Pathologist's in post mortem examinations of deaths that appear not to be suspicious' concerning the standards of post mortem examinations by hospital pathologists (February, 2014).

Recommendation 7. – That forensic post mortem data be included within the Homicide Index in order that police forces can assess and monitor the relationship between homicide and the use of forensic pathology.

Recommendation 8. - The PDB consider how to take forward the broader potential issue of cases of death that may have been suspicious but either did not have a PM; or where a PM was conducted by a non – forensic practitioner it was never passed on to a HORFP

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