FORENSIC SCIENCE REGULATOR

FORENSIC PATHOLOGY SPECIALIST GROUP

AUDIT OF THE WORK OF FORENSIC PATHOLOGISTS BASED IN THE UNITED KINGDOM

REPORT OF THE SIXTH ANNUAL AUDIT

FORENSIC PATHOLOGY SPECIALIST GROUP

SIXTH AUDIT OF THE WORK OF FORENSIC PATHOLOGISTS – 2016

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INTRODUCTION

1 The Forensic Pathology Specialist Group (FPSG) advises the Forensic Science Regulator on matters involving forensic pathology. The Group is responsible for the oversight of standards, one of the initiatives taken to acquit this responsibility being a programme of annual audit of the casework carried out by forensic pathologists. The audit commenced in 2016 is the sixth exercise in this series and followed the format used for previous exercises determined by the previous co-ordinator Trevor Rothwell.

2 Practitioners operating in England and Wales are registered with the Home Office and are required to participate in the audit scheme. As in previous years, forensic pathologists in Northern Ireland and Scotland were also invited to take part. In this year's audit, 2 pathologists from Northern Ireland and 1 from Scotland took part.

3 This exercise focussed on two different causes of death. These topics were proposed by the audit team and agreed by the FPSG.

4 Each participating pathologist was asked to submit two specific case reports[1] for audit. One was to be the first case investigated after 1st October 2015 of a body recovered from water.

5 The second case, the examination of which was to have been carried out as close as possible to the above date, involved a body repatriated from abroad.

6 The request to submit material was made in late December 2016. It had been anticipated that not every practitioner might have suitable cases to submit and that the response might therefore be limited. In the event this proved to be the situation and following discussion with the lead auditor, some latitude had to be permitted in meeting the submission criteria. The date for a body repatriated from abroad was moved back 5 years and in a body recovered from water where it was not available to a pathologist an alternative was substituted. Even this latitude did not alleviate the issue of meeting the set criteria and in a couple of instances cases of exhumed or second post mortem examination (PM's) were accepted.

7 Within this year's audit, new pathologists to the Home Office Register were participating for the first time. They did not have cases that met the required criteria and were therefore asked to submit recent work, so that their standards could still be compared against the Code of Practice.

Service provision

8 The primary purpose of audit is to monitor the standard of the post mortem examination, a service performed by the pathologist for the coroner and the investigating officer. Audit can also offer some indication of the efficiency of the service being provided, for instance, on issues such as the timeliness of

[1] The term report is a general term and includes statements.

the pathologist's report and whether it contains the prescribed legal requirements.

Audit protocol

9 The protocol agreed by the FPSG[2] ensures that the composition of the auditing team reflects the range of service provision, for instance the employment status of the pathologists and their locations. Appointment to the team is designed to maintain balance between rotation of the membership and continuity of experience. Auditors are normally appointed for three or four audit exercises.

10 For this exercise five experienced forensic pathologists formed the team which examined the reports for their technical quality. A coroner, also very experienced in dealing with forensic pathology reports, was asked to scrutinise a sample of the material to assess its potential value from his perspective and four senior investigating officers (SIOs) scrutinised the material from their own viewpoint. Unfortunately, this year, the coroner was unable to provide his feedback, therefore the audit and the individual feedback to the participants will be missing this aspect of the audit.

11 The content and format of reports submitted for audit were exactly as supplied to the coroner and police service. However, the audit scrutiny itself is anonymous and all identifying information had to be redacted from case reports prior to circulation to members of the audit team. Responsibility for redaction lay with the audit co-ordinator who removed the names and locations of both the pathologist and the deceased.

12 During redaction other names, e.g. witnesses or officials, were usually replaced by initials. However, anonymisation was not always straightforward as some cases included reference to many different witnesses or toxicology reports which were incorporated into the reports as imbedded PDF's. Replacement of every name by a set of initials was found to lead to difficulty in reading the text, and thus to possible confusion. Accordingly, in a very few instances it was considered prudent to retain the names of certain witnesses, although not where this could lead to direct identification of the deceased. Some of the cases, this year were high profile and although redacted could still be identifiable.

13 Each case was coded with a unique reference number by the co-ordinator, who maintained the sole key to the code. The current audit protocol provides that this key can be broken only if identification of a case is deemed essential to prevent a potential miscarriage of justice, and then only with the agreement of the Chair of the FPSG. This provision was not required in the current exercise.

14 Encrypted case reports (76 in total) were submitted electronically to the co-ordinator and then, after appropriate redaction, circulated to the auditors. Initially each case was given to at least two pathologist members of the team and to one of the SIOs. Accordingly, each pathologist auditor received between 34 and 38 case reports for scrutiny; each SIO assessed about 20 cases. The coroner was assigned one case from each of the participants.

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2 *Protocol: Forensic Pathology Audit*; FSR-P-304; Forensic Science Regulator 2015.

15 The format of the audit was like that used in earlier exercises, in that the pathologist auditors assessed reports against the technical standards laid out in the latest version of the *Code of Practice and Performance Standards for Forensic Pathology*[3] issued jointly by the Forensic Science Regulator and the Royal College of Pathologists (in partnership with the Home Office and Department of Justice in Northern Ireland). An equivalent document, incorporating very similar technical standards, is used by practitioners operating in Scotland.

16 Auditors were invited to comment on the way in which the content of the report related to each aspect of the published standard, completing a separate pro-forma for each case assessed. The comments included on these *pro-formas* formed the basis of both this audit report and the feedback provided to participants at the end of the exercise.

17 The non-medical auditors also took note of the Code of Practice but primarily assessed the potential usefulness and comprehensibility of the report to the lay user. These assessments were recorded on simplified pro-formas. Completed forms from all the auditors were returned to the co-ordinator for collation and preparation of the final report.

18 At the end of the exercise each participant received a summary of the auditors' findings in relation to the cases which they had submitted. This information was confidential to the individual practitioner concerned, and is not to be released to the public domain. It is intended, however, to form one element of the evidence used in revalidation of the practitioner's General Medical Council licence to practice.

Re-assessment

19 If any member of the audit team considers that a report raises issues which would benefit from wider discussion, the protocol requires the report in question to be circulated to all the pathologist auditors to enable a broader assessment. In this exercise 2 (two) such reports were identified for further consideration. These were subsequently scrutinised by all five pathologist auditors.

20 In 1 report, no significant issues were identified during this process; however, the participant will receive the additional comments within their feedback document.

21 The other report was very brief and considered to be of a poor standard. This report, related to a case on "repatriation from abroad" where the participant did not have a suitable case to submit and sent a second PM case as an alternative.

22 Normally, an additional report from the participant that covered "repatriation from abroad" would have been requested. However, the participant did not have any suitable cases. The audit co-ordinator checked the feedback on the participants other submitted case and this was of a good standard, so after careful consideration and in conjunction with the lead auditor it was decided that this participant should receive a letter of advice, outlining the auditors concerns and areas that should have been included within their report. This

[3] Issued in 2012. Previous exercises used as a standard the version of the *Code of Practice* issued in 2004. There are few significant differences in the basic pathology requirements between the two versions.

will be in addition to the normal feedback the participant receives and must form part of their appraisal process.

Structure of the report

23 This present report, which retains anonymity and will be a public document, collates and summarises the findings, highlighting areas of particularly good practice as well as those which may require attention.

24 The primary purpose of audit of forensic pathology reports is to monitor the technical standards of the post mortem examination. However, during the assessment a number of other potentially significant issues were identified in which practices differ, such as compliance with the appropriate legal requirements. These issues are not necessarily central to the main thrust of the exercise, although they may influence the effectiveness of the service and its value to its users.

25 The various rules and guidance documents were comprehensively documented in Annex A by Trevor Rothwell in the 2015 report. This appendix has been updated to reflect the current percentages identified within this audit as the audit team considers that this is an area that still needs further clarity on what should be delivered or incorporated within the final case report.

AUDIT RESULTS

Introduction

26 The various aspects of case reports were assessed against the headings detailed in Section 7 of the 2012 Code of Practice *'The pathologist's autopsy report'*, and are recorded under these headings in this final audit report. The first part (7.1) of this section of the Code defines the content of the standard.

27 The overall standard of the reports submitted for audit was good and, continued the progress made from previous exercises of this series. Those deviations from best practice, as recommended in the Code of Practice, were noted. Many of these comments are of relatively minor importance; sometimes simply a matter of personal preference. They are, however, intended to stimulate discussion and to facilitate the raising of standards overall.

28 The general approach to a post mortem examination will be broadly similar whatever the cause of the death. Accordingly, although the audit involved two different modes of death, much of this report applies to both types of incident.

29 As in previous audit reports comments on each section of the pathologist's report are prefaced by a summary of the requirements of that aspect of the examination.

Code of Practice - 7.2.1 General comments

The report or statement must be clearly laid out, section by section, in an easily read format. There are several statutory declarations and other legal requirements to be complied with regarding the pathologist's status as an expert witness.

30 The reports submitted for audit were not consistent in the legal requirements which they incorporated; similar findings had been recorded in previous audits. This issue is updated in Annex A.

31 As per the last audit, one Home Office practice includes an outline of the standards employed during the post mortem examination and an explanation of the various 'comparative' terms used in the report. Although the provision of such information is sometimes used in reports issued by other forensic specialists it has not thus far been discussed by the FPSG in relation to forensic pathology. Within the recommendations in the previous audit, these issues were to be considered by the FPSG. The Group is unaware of any outcome on these discussions and have therefore kept them in, for completeness, see Annexes B and C.

Code of Practice - 7.2.2 Rapid interim account

The pathologist may agree with the coroner, the police or the CPS that a rapid briefing be provided within 14 days of the post-mortem examination.

32 Timeliness of reports being issued is covered within paragraph 62.

However, to enable meaningful analysis on rapid interim reporting, it is recommended that future audits should be structured to receive 14 day statements along with the final report to ensure compliance with this requirement.

Code of Practice - 7.2.3 Report preamble

The preamble should set out details of the deceased and of the autopsy.

33 The essential information was included.

Code of Practice - 7.2.4 History[4]

In this section, the pathologist is expected to summarise information provided before the autopsy is performed. The Code requires this information to be recorded in full, with an acknowledgement that where the information has been obtained from others, rather than being the pathologist's own observations or experience, the pathologist cannot vouch for its accuracy or veracity.

34 This section of the report summarises the information available to the practitioner before the post mortem examination is undertaken and the auditors, especially the investigating officers, stressed the importance of recording this information at the start of the report to set the scene. The history should explain why the post mortem examination was approached in a manner; it also enables the scientific findings subsequently described to be more readily interpreted in the circumstances of the death.

35 It is helpful for the pathologist to have read the deceased's medical history before the post mortem examination is started. Where the death had occurred in hospital the treatment notes had usually been made available. In 14 cases, however, it was noted that GP notes had not been seen or available. The larger number this year can be attributed to cases being repatriated from abroad and the medical history may not have been readily available.

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4 This section of the Code has been supplemented with guidance issued by the Forensic Science Regulator: *Information to be included in The 'History' Section of a Forensic Pathologist's Report*; FSR-G-210; 2013

However, of the remaining cases, 8 (10.5% of the total) GP notes were not examined.

36 Case histories were satisfactory, many being detailed and very informative. However, in 13 cases (17% of the total) the history was considered brief, although adequate for the circumstances.

Code of Practice - 7.2.5 The scene of discovery of the body

Under this heading pathologists are expected to note full details of the scene of discovery of the body. It is recognised, however, that in many cases the body may be removed for emergency medical treatment prior to death and the scene may therefore possess little of relevance to the pathologist.

37 Half the cases within this audit covered a body repatriated from abroad and therefore relied upon previous autopsy reports or details. Out of the remaining cases only 4 cases (10.5% of the 38) had visits been made to the scene of the incident and 2 cases had no scene description at all. However, it was noted in 15 cases (39.5%) that a scene visit was deemed not applicable.

38 Within one forensic pathology practice, it would appear to be normal police procedure to invite the pathologist to all or most scenes, whilst within the others, scene details are provided by detailed police pictures or third party briefings (46%)

Code of Practice - 7.2.6 External appearance of the body

The pathologist should record in detail the external appearance of the body, including its state on arrival in the mortuary, and the presence and distribution of bloodstaining. An inventory should be made of clothing as it is removed from the body.

39 Descriptions of the external appearance of the body were good, many being very detailed. Eight case reports (10.5% of the total) contained brief descriptions of the external appearance although all were considered adequate in the circumstances.

40 Specific descriptions of the genitalia or anus were not present in several case reports.

Code of Practice – 7.2.7 Injuries

Injuries, however slight, must be described in detail, using recognised terms and appropriate measurements. Their location should be noted in relation to anatomical landmarks. Where there are many injuries a clear numbering system should be employed in the report to aid identification. Lack of suitable numbering could render subsequent reference to the report more difficult, for instance when giving evidence in court.

41 Injuries were almost always well recorded, with very detailed descriptions in several case reports.

42 In two cases, descriptions of the injuries were listed without numbers, and one referred to photographic references.

43 Auditors noted that in some reports they might have been more ‘user friendly’, for instance at inquest or during a trial, if the injuries had been numbered sequentially and/or grouped under sub-headings, with each sub group

continuing the sequential numbering, rather than starting afresh at 1 within each group.

Code of Practice - 7.2.8 Internal examination

The internal examination must follow the Royal College of Pathologists' Guidelines on Autopsy Practice. Particular note must be made of diseased or injured organs. Report sub-headings may be useful in organising the information. Organ weights should be recorded.

44 The internal examination in both series of cases was generally very well described.

45 Where comments were made, these were generally attributed to or related to the 1st PM. Such as, 'it would be of value to include the organ weights from the first PM report' or 'clarify if the bladder had been opened at previous PM. Often in cases from abroad it has not been and urine can be obtained for toxicology'.

Code of Practice - 7.2.9 Supplementary examinations

The involvement of other specialists should be included under this heading, and the results of their examinations noted. Most cases will involve toxicological examination, and specialisms such as paediatric pathology, radiology, etc will be included where appropriate.

46 Appropriate supplementary examinations had been carried out in 86% of the cases. No histology or toxicology had been carried out in two cases (3% of the total). One of these was a badly decomposed body, where it was stated none retained, but the auditor considered that the liver was suitable, albeit limited for further examination.

47 In one case the clinician producing the toxicology report provided an opinion on the cause of death to the coroner, potentially usurping the role of the pathologist.

Code of Practice - 7.2.10 Commentary and Conclusions

In the Commentary and Conclusions section the pathologist should explain the cause and mechanism of the death, using language which is precise and accurate in medical terms but also readily comprehensible to the lay reader. It is primarily from the commentary and conclusions that the police and prosecuting authorities will have to assess the relevance of the medical evidence to their consideration of the case.

48 Commentaries in general were entirely satisfactory, many involving a thorough, well-argued and detailed discussion of the various issues. Like last years' audit, some were well set out and, in the words of more than one auditor, 'an enjoyable read'.

49 Thirteen case reports (17% of the total) included a commentary which was considered brief, although adequate in the circumstances.

50 This section of the report deals with interpretation rather than straightforward recording of the findings themselves. Accordingly, it may be inevitable that individual auditors highlight issues which they personally consider relevant, although other team members do not mention these issues. This demonstrates the importance of having cases scrutinised by more than one auditor, in order that the overall assessment of the material shall be fair and

objective. However, the comments received from the auditors will be in the final feedback to the individual pathologist concerned so that they can see any differing views.

Code of Practice - 7.2.11 Cause of death

The cause of death is normally expressed in the manner approved by the Registrar General, although it is often important to elaborate on the information for those who may be unfamiliar with the format.

51 The cause of death had been recorded in the prescribed manner in most cases.

52 Case study 2 “body repatriated from abroad” provided most comments ranging from ‘I would have waited for the toxicology/PM report from abroad before providing the cause’ to ‘this is a hard case for the pathologist to conclude and their conclusions are long and detailed’.

53 In two cases no certifiable cause of death was offered. Not offering a cause of death should be considered an unacceptable approach, unless the report is clearly a preliminary account of the investigation. Death certification is provided by a forensic pathologist as an expert opinion rather than an absolute statement and it is the responsibility of the expert to provide this information. In certain circumstances the report can state the cause of death in ‘unascertained’ but the reasons for this conclusion must be provided.

Code of Practice - 7.2.12 Retention of samples

Every report should record what materials or samples have been retained after the examination and where they are located. If these items are exhibited, the exhibit number must be noted in the report These samples may have been generated during the examination. There may also be ‘unused material’ – samples provided to but not subsequently examined by the pathologist.

54 During the post mortem examination the pathologist will usually generate samples, for example, blood, to be retained for further examination by the pathologist or others. Such samples will be assigned alphanumeric references recording their origin at the post mortem examination. Eight reports (10.5%) did not provided an exhibit list.

55 The recording of ‘unused material’ is considered in section 7.2.15.

Code of Practice - 7.2.13 Final check

Before the report is signed and issued the pathologist should have checked it for factual errors as well as typographical, format or grammatical mistakes.

56 During scrutiny of the reports a small number of format, typographic or grammatical errors were noted; this problem has been commented on during every exercise in the current series of audits. Examples noted this year

- Incorrect date. Date of death given as 2016 rather than 2014.
- Syntax errors
- Double space the lines to make it easier to read

57 While at least some of these errors may not in themselves be of any great note they reflect a lack of care in proof-reading. It is unfortunate that reports of audit exercises should continue to comment in this way. Such errors also call into question the validity and usefulness of the Critical Conclusions Check.

Critical Conclusions Check

The criteria for the Critical Conclusions Check are set out in the Code of Practice standards (sec 7.1). The pathologist must:

*c) have in place, for **all** cases involving violent or suspicious death, a critical conclusion check procedure, whereby another suitably qualified forensic pathologist (on the Home Office Register where the initial pathologist is registered) scrutinises the report to ensure that (i) the report is internally consistent, (ii) the conclusions drawn are justifiable from the information set out in the report and (iii) the report is capable of being understood without reference to other material*

d) ensure the report states a critical conclusions check has been performed but not make any suggestion of support from the person performing the check

58 Within all the cases submitted, twenty-four reports (31.5%) of the audit did not mention if a final critical conclusion check had been undertaken. As the check is only required for cases delivered to the Criminal Justice System it is possible that some if these reports did not require this. It was noted that two practices include a signed declaration by a named checking pathologist, whilst the other practices simply record that the report had been subject to such checking.

59 It seems clear from the foregoing paragraphs that these checks are either not taking place, or that they are not clearly stated within the report and fail to sometimes identify typographical errors.

60 he Code of Practice and Performance Standards for Forensic Pathology is due for a review starting in October 2015. The FPSG and/or the Pathology Delivery Board (PDB) may wish to review the nature of the Critical Conclusions Check, together with the responsibilities and duties of the checker and the possibility of a standard template for reports within that overarching code of practice.

61 The Critical Conclusions Check procedure is not a requirement outwith England and Wales, but similar provisions may apply.

Code of Practice - 7.2.14 Time of submission of the report

Pathologists must 'produce the report as quickly as is possible, after production of necessary analytical reports, with regard to the complexity of the case and within an agreed timescale, depending on the investigations and expertise required'.

62 Overall, timeliness of the reports did not appear to be a significant issue within this audit. However, the auditors considered that 5 reports did not meet the standard of being issued as quickly as possible, this represented 6.7% of the total cases audited. In 1 case, this exceeded 5 months from when the final analytical reports had been received by the pathologist.

Code of Practice - 7.2.15 Disclosure of information to the defence

The pathologist acting for the Crown must notify the police and the CPS of the existence of any unused material

63 The Crown Prosecution Service (CPS) guidance for expert witnesses [5] requires the pathologist to provide a **disclosure schedule** – a list of materials in the possession of the pathologist whether used or unused during the examination, any of which may be relevant to other interested parties. Such an index of unused material was missing, in 27.6% of reports submitted.

64 These requirements are quite specific and it is recommended that practitioners revisit the appropriate guidance, as discussed in Annex A.

Code of Practice - 7.2.16 Change of opinion

Where a pathologist wishes to change a view already expressed in a report this should be achieved by issuing a new report setting out the new position taken by the pathologist and the reason for the change of position. Pathologists must not issue a re-worded document without making clear why that has been done.

65 No Cases were identified as being a second report, changing the cause of death from the first report.

Code of Practice - 7.2.17 Views of others

Where, during an examination, another expert agrees with a finding of fact it is acceptable to state in the report that there was such agreement. However, the significance of findings can be subjective and accordingly it is not acceptable to state that the other expert agrees with their opinion.

66 As expected, many the cases from the "repatriated from abroad" category did refer to findings from the first PM undertaken abroad. All but one did agree with the original conclusions of the first PM.

Comments made by the coroner

67 The importance of having a coroner perspective on this audit is crucial in helping to maintain standards and providing feedback to ensure forensic pathologists meet these standards.

68 Unfortunately, this years' audit did not have feedback from a coroner.

69 For future audits it should be recognised that coroners are extremely busy and that the workload of the audit should be shared between 3 and 4 coroners, located at different areas within England and Wales.

Comments made by the police senior investigating officers (SIOs)

70 Comments made by the police auditors are always helpful in that they can offer a different perspective on the material through assessing its potential value to the investigator. The SIOs who took part in this latest exercise provided many useful comments, the overwhelming majority of which were positive, for instance:

'a clear, unambiguous statement, easily understood'

'I would find this statement most useful to a police investigation'

'The conclusions are clear and understandable'

'I find this report clear and considered in what would be a difficult case'

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[5] *Guidance Booklet for Experts. Disclosure: Experts' Evidence, Case Management and Unused Material* CPS 2010

71 There was, however, a small number of case reports in which the cause of death was not considered to be explained clearly enough for the non-medical reader, although it was conceded that the clinical detail was probably adequate.

72 In one report the SIO commented on the brain examination, stating it was particularly difficult to understand, but noted that its intended audience was the pathologist rather than the police. However, even the conclusion was not clear and the police auditor's did not understand what was being said. This final report was also issued more than 5 months after PM.

The layout and format of the report

73 Neither the layout nor the format of the pathologist's report are prescribed in the Code of Practice, and all practices develop their own 'house' style. Nevertheless, it is essential that the report be laid out in such a way as to be readily accessible, not only to clinical colleagues, but also to readers who may have no medical knowledge.

74 That being the situation, each member of the audit team was invited to comment on the way in which the report was laid out. There was overall agreement that the reports submitted for this exercise were well presented and easy to read. Those few instances where this was not entirely true have been noted in the foregoing paragraphs.

Consistency

Previous reports have included comments on consistency, but it is not clear if any further clarification or direction has been issued. Similar issues have arisen within this audit; this section has therefore been kept in the report for further consideration.

75 While the technical standards of the post mortem examination are carried out and reported to a high and consistent standard the same does not apply to the format of the report, especially regarding the various legal requirements. Practices are autonomous bodies; nevertheless, it could perhaps be argued that every report issued by a Home Office registered forensic pathologist should have a consistent format, including the appropriate statutory declarations.

76 The need for a pathologist's report to contain a summary of the 'Examination Standards' (as adopted by one Home Office practice and illustrated in Annex B) should perhaps be reviewed by the FPSG. Is it necessary, or appropriate, to document the various standards documents used for reference?

77 It may also be instructive to discuss whether explaining the descriptive words can offer significant assistance to the reader of the report. The difficulty of appreciating the strength of evidence was commented on by lay members of the audit team and the topic is explored in Annex C.

78 It may be important to reiterate that although broadly similar rules apply to those pathologists who operate outwith England and Wales, the different jurisdictions may impose their own requirements on the content and format of the pathologist's report.

RECOMMENDATIONS

79 It is suggested that the following recommendations flow from this audit exercise:

1. Examine the possibility of a standard template for reports to ensure consistency in recording the legal requirements to meet CPS guidance.
    - The template to include standard areas for;
        - Critical Conclusion Check and sign off,
        - Declaration & Self-Declaration,
        - Index of used and unused materials,
        - GMC number, Date of issue, & List of attendees.
2. Review the Critical Conclusion Check (mentioned last audit)
3. Review the Code of Practice (2012) to incorporate current legal, guidance and procedure rules, where applicable. Original review date of this code is stated as October 2015.
4. Review the audit terms of reference to include the 14-day rapid interim statement, along with the final report on the selected case criteria. This will allow an accurate measurement on the number of interim reports issued, their timeliness and useful from the SIO and Coroner input, where interim and final can be examined.

CONCLUSIONS

80 This was the sixth in the series of audits of the work of forensic pathologists carried out on behalf of the Home Office Forensic Pathology Specialist Group. Case reports were submitted by Home Office registered pathologists and by forensic practitioners operating within Scotland and Northern Ireland. The reports submitted for this exercise were generally of a high standard. However, 1 participant will receive a letter of advice and several areas of relatively minor, albeit important, concern were identified.

81 The criteria set for the 2 case studies created issues for some pathologists to meet. Subsequently, the criteria had to be relaxed and in some cases ignored. I am aware that we are looking at technical standards, rather than the actual individual case, but it would be better to ensure that all pathologists will have cases that can meet the criteria being set.

82 The lack of coronial input to this years' audit was a significant issue. The PM reports are on behalf of the coroner and police and their input is vital to this audit. Consideration should be given to expanding the number of coroners involved, to ease their workload and ensure that coronial input is received.

83 The use of 4 senior investigating officers works extremely well and this should be continued.

84 Looking back on the annual audits, steady progress has been made and the main issues seem to be around consistency of report style and meeting legal declarations. The FPSG may wish to consider if annual audits are still required and if they should they be replaced with bi-annual audits. However, if the Code of Practice 2012 is to be reviewed and reissued within the next year,

then an audit based on the new code should follow, with the criteria being set on cases meeting the new code.

Annex A

Statutory declarations and other legal requirements

(As noted in the text this is reproduced from an earlier report and relate to the period of that report rather than being a statement of the current requirements)

A.1 The following notes apply solely to evidence prepared for use in the Criminal Justice System as it applies within England and Wales, although no doubt similar requirements exist outwith this jurisdiction.

A.2 Throughout this paper the document issued by the pathologist to the coroner and investigating officer, and submitted for audit, has been referred to as a 'report' – a convenient term which will continue to be used. In legal terms, however, evidence may be adduced as a report or as a statement, with requirements which may apply to one format or the other. Most of the material submitted for audit was in statement form and would be expected to comply with the appropriate requirements.

A.3 The Criminal Procedure Rules (CrimPR)[6] govern the conduct of criminal trials and provide guidance for the involvement of experts, including the format and content of reports and statements which are offered in evidence. Certain legal requirements, including declarations relating to the status of the pathologist as an expert, must be complied with whenever evidence is prepared for use within the criminal justice system.

> *'1.2.2 In presenting expert evidence the witness's "duty is to furnish the Judge or jury with the necessary scientific criteria for testing the accuracy of their conclusions, to enable the Judge or jury to form their own independent judgment by the application of these criteria to the facts proved in evidence. …..*
>
> *1.2.3 This places the expert witness in a privileged position. The nature of the role requires that the witness comply with certain obligations'* [7]

The Code of Practice also prescribes compliance with the relevant legislation; the practitioner must:

> *'ensure the report meets the requirements set out in Part 33 of the Criminal Procedure Rules'* [8]

A.4 The current Code of Practice for Home Office registered forensic pathologists does not specify a format for the post mortem examination report. In consequence practices develop their own 'house' style, leading to considerable variation in the formats employed.

A.5 Relevant information for experts instructed by the prosecution is available from the Crown Prosecution Service[9]. More generic information on the

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6 Consolidated Criminal Procedure Rules 2010; Part 33 (amended in 2015; Part 33 became Part 19, but without significant change to the elements relating to expert witness evidence apart from indexing of the material)

7 *Legal Obligations* Forensic Science Regulator – Information FSR-I-400 (Issue 3) 2015 *(pp 1.2.2-3)*

8 *Code of Practice 2012* Sec. 7.1 (b)

9 *Guidance Booklet for Experts* CPS *ibid*

responsibilities of the expert witness, regarding disclosure, is available in a further CPS document[10]. An equivalent document has been produced by the Crown Office in Scotland [11] . The basic requirements for a forensic pathologist's witness statement were set out in a note circulated to all Home Office practices in 2007[12].

A.6 More recently the Forensic Science Regulator has issued comprehensive information on the various requirements (Legal Obligations[13]) from which the advice stated above has been quoted. The Regulator has also issued draft guidance based on these requirements (Draft Statement Guidance[14]).

A.7 These last documents from the Regulator set out clearly the requirements which should be complied with by any practitioner offering evidence within the Criminal Justice System in England and Wales. In summary, the information which must accompany every forensic pathologist's report includes:

> *A **declaration** that the pathologist understands and accepts the requirements that apply to expert witnesses.*
>
> *A summary of the **qualifications** which permit the practitioner to act as an expert in forensic pathology – effectively a 'mini-CV'.*
>
> *Confirmation that the practitioner understands and has complied with the obligations for **disclosure**.*
>
> *A **self-certification** document which indicates that the expert is not debarred from offering evidence.*

A.8 The nature and content of these requirements is specified in the documents quoted. It is important to note that the CPS guidance booklet warns that failure to comply with these instructions may result in professional embarrassment or even adversely affect the trial itself.

A.9 All reports submitted for the current audit were submitted unredacted. Accordingly, it might have been expected that when received by the co-ordinator they would have complied with all the legal requirements. That was not so; the inclusion of the various elements was extremely variable. Very similar findings have been found in all the audits of the current series and the inclusion of statutory declarations was considered in some detail in the 2012 audit[15]. Analysis carried out during the current exercise showed a similar variability to that observed in the previous audit.

A.10 It should be noted that the Forensic Science Regulator's guidance is just that; it is neither mandatory nor non-mandatory. Accordingly, the degree of variability observed in reports submitted for audit may not be entirely surprising. It seems probable that local CPS offices do not pursue strict

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10 *Crown Prosecution Service: Guidance on Expert Evidence'* CPS, 2014

11 *Guidance booklet for expert witnesses The role of the expert witness and disclosure* Crown Office and Procurator Fiscal Service, Edinburgh 2014

12 Home Office Forensic Pathology Council; Witness Statements – Basic Requirements Note distributed to HO practices on 9 Feb 2007

13 *Legal Obligations* FSR-I-400 *ibid*

14 *Draft Statement Guidance* Forensic Science Regulator – Guidance FSR-G-200 (Draft 0.20) 2016

15 *Audit of the work of forensic pathologists based in the United Kingdom* Report of the 2012 audit FPSG

adherence to the rules, and anecdotal evidence from individual pathologists appears to confirm this.

Declaration

A.11 The report must incorporate a declaration that the author believes the content of the report to be true 'to the best of his knowledge and belief' and that the witness understands and will comply with their duty to the court. Such a declaration was present in 89.5% of the reports submitted for audit (74% in the 2015 audit). The guidance advises that this declaration may be in a report attached to the pathologist's statement; it does not have to be integral within the text.

Qualifications

A.12 One element in these declarations refers to the employment and experience of the report's author. Relevant information was included in the majority (97%) of reports (89% in 2015), although the content of the summaries was extremely variable. Some only a couple of lines, others occupied more than a page.

A.13 It is essential that the pathologist provides adequate relevant information to reassure the user of the report that the expert possesses sufficient skill and experience to investigate the death. The extent of the information provided may need to be varied dependent on the destination of the report. Findings in the latest audit appeared to be like those in all the previous exercises of this series.

Disclosure

A.14 The Criminal Procedure Rules specify that an expert witness should include with their report a list of all 'unused material' which may consist of documents or physical samples. Such material may be relevant to experts instructed by other parties and it is essential that its presence is recorded.

A.15 The CPS Disclosure Manual [16] specifies the wording which should be employed. It confirms that the pathologist has complied with their duty to record, retain and reveal such material; that they have compiled a relevant index; and that they will ensure this is updated as and where necessary. Within this audit 21 reports did not list unused material (27.6%) of the reports.

Self-certification

A.16 The Criminal Procedure Rules require an expert witness to produce a self-certificate giving basic information about his or her status; the CPS Manual provides a template. This certificate should be completed 'in every case that you are instructed as an expert witness for the prosecution', and sent to the 'disclosure officer or investigating officer'. However, such self-certification may be submitted as a separate document; there appears no requirement for it to be incorporated in the pathologist's report itself. A self-certificate formed part of the report in (38%) of the reports submitted by Home Office registered practitioners (32% in 2015).

Importance of compliance

A.17 The CPS guidance indicates that the various declarations are necessary to comply with the requirements of the Criminal Procedures Rules and

[16] *Guidance Booklet for Experts,* CPS *ibid*

accordingly it is difficult to understand why they are not consistently included in reports. Every report submitted for audit had previously been submitted to a coroner; some had already been used in a criminal trial.

A.18 One must assume, therefore, that practitioners are in compliance with the requirements of those who routinely instruct them. Perhaps local CPS offices do not closely check the content of pathologists' reports. Nevertheless, it should be noted that scientific evidence – although not from a forensic pathologist – has already been disallowed in a criminal trial on the basis that the report did not adhere to the prescribed format.

A.19 It could be argued that all registered practitioners should adhere to a common format in this respect. The FPSG or the Pathology Delivery Board (PDB) may wish to review the situation, perhaps in conjunction with the CPS, to assess the practical importance and relevance of the legal requirements.

Annex B

Examination standards

B.1 It was noted during this audit exercise that one Home Office practice prefaces its reports with a reference to the standards to which the examination had been carried out. Thus, the introductory paragraphs of reports emanating from this practice routinely include the following information:

> *Autopsy examinations are undertaken in line with the following standards (application of which in whole or part is case dependent):*
>
> *Council of Europe Group of Ministers. Recommendation R (99) 3 of the Group of Ministers to Member States on the Harmonisation of Medico-Legal Autopsy Rules, 1999.*
>
> *Codes of Practice and Performance Standards for Forensic Pathologists in England, Wales and Northern Ireland. Royal College of Pathologists, 2012.*
>
> *Standards for Coroner's pathologists in post-mortem examinations of deaths that appear not to be suspicious. Royal College of Pathologists, 2014.*
>
> *Information to be included in the 'history' section of a forensic pathologist's report. Forensic Science Regulator, 2014.*
>
> *The use of time of death estimates based on heat loss from the body. Forensic Science Regulator, 2014.*
>
> *Legal issues in Forensic Pathology and tissue retention: issue 3 guidance. Forensic Science Regulator, 2014.*

B.2 No doubt these represent the relevant standards which govern the work of Home Office registered forensic pathologists, and there may be value in informing coroners and other users of the report of their existence. It should perhaps be made clear that this list is not exhaustive; it would be difficult, if not impossible, to set out every standard which might apply.

B.3 If standards are to be included in this manner then they should be accurately recorded; for instance, the list is considerably wider than stated in the above extract from a pathologist's report.

B.4 That there will be adherence to the standards is a clear implication to be drawn from setting them out in this way, and presumably future audits would need to assess material against these standards alongside the Code of Practice.

B.5 To date there has never been any requirement imposed on practitioners to list standards such as these in their case reports. Nor do the practitioners operating outwith the ambit of the Home Office, ie in Scotland and Northern Ireland, include such information.

B.6 It may be appropriate to discuss whether recommending the incorporation of this information would be a positive and useful step in assisting those who will need to use the pathologist's report.

Annex C

Reporting standards

C.1 One Home Office regional forensic pathology practice offers definitions for the 'standard terminology' used throughout its reports, including the following information:

> *Where the following terminology is used within this report, it should be interpreted as per the Istanbul Protocol [Chapter V, Section D, Para 187 (a) - (e)], United Nations: New York & Geneva, 2004, which has been modified to include non-trauma pathology:*
>
> *'Not consistent' The lesion could not have been caused by the mechanism / pathology described.*
>
> *'Consistent' The lesion could have been caused by the mechanism / pathology described, but it is non-specific and there are many other possible causes.*
>
> *'Highly consistent' The lesion could have been caused by the mechanism / pathology described, and there are a few other possible causes.*
>
> *'Typical of' There is an appearance that is usually found with this type of mechanism / pathology, but there are other possible causes.*
>
> *'Diagnostic of' This appearance could not have been caused in any way other than that described.*

C.2 This explanation of the terms used in the pathologist's report is based on a document relating to the investigation of torture[17], originally produced through the auspices of the United Nations. It is argued, probably with some justification, that terms such as 'consistent' have a meaning which is well understood by others in the profession, but which may be less clear to the man in the street – for instance the members of a jury.

C.3 The thought processes involved in science and the legal system are essentially different. The former relies on conclusions which may not be clear-cut; decisions in the legal system are usually black and white. Scientific findings, the significance of which may not be entirely clear, may be important in explaining the death and must, therefore, be presented in evidence to a court.

C.4 It is essential that scientific findings are presented in a balanced manner, not favouring either prosecution or defence; the pathologist's duty when giving evidence is to the court itself. This is reiterated in the introduction to the CPS guidance for expert witnesses[18]:

> *As an expert witness, you have an overriding duty to assist the court and, in this respect, your duty is to the court and not to the Prosecution Team instructing you.*

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17 *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* Professional Training Series No 8 United Nations Office of the High Commissioner for Human Rights, Geneva, 1999

18 *Guidance Booklet for Experts,* CPS *ibid*

It will be for the jury to decide which side has put forward the more convincing case. Accordingly, it is important that the words used are both neutral and readily understood without ambiguity.

C.5 In recent years there has been a few instances in which the presentation of scientific evidence has resulted in a miscarriage of justice. As a result, considerable attention has been paid not just to the science itself but also to the way the evidence is presented.

C.6 Scientific findings such as the amount of alcohol detected in a sample of blood may be expressed quantitatively as a number. This may be interpreted relatively readily to indicate the level of intoxication of a subject, for instance, through comparison with the 'drink-driving' legislation. Other findings, including many of those found during a post mortem examination, may be less susceptible to description in such objective terms. Qualitative evidence of this nature is certainly no less valuable, but may be potentially less easy to explain to a jury in a manner which is both comprehensible and fair.

C.7 In the past decade the most effective and unbiased way to present and interpret scientific findings in court has been extensively studied, involving lawyers and even parliamentarians as well as the forensic science community itself.

C.8 The importance of ensuring that scientific evidence is presented fairly to a court was highlighted in a report issued some ten years ago by the House of Commons Select Committee on Science and Technology[19]. The problems were also identified in research published by the US National Institute of Justice[20]. The Lord Chief Justice of England and Wales referred to the presentation of scientific evidence in a lecture given to the Criminal Bar Association[21]. Sophisticated statistical analysis has been employed in an attempt to render qualitative scientific findings more comprehensible and easier to interpret, as described in the paper by Evett[22].

C.9 The difficulties in ensuring that a fair and accurate perspective is placed on scientific findings offered to a court is now well recognised. Although the majority of studies have focussed on forensic science evidence, similar considerations will apply to forensic pathology and medicine.

C.10 One small step in this direction involves offering definitions for the terms used in scientific reports. The approach has been employed by a number of forensic science providers and one Home Office regional practice has adopted the procedure to offer some evaluation of its findings.

C.11 It must be said, however, that the explanations offered by this Home Office practice are not entirely unambiguous; for instance, the definition of 'consistent' depends on the possibly equally vague words 'could have been'.

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19 *Use of Forensic Evidence in Court* H of C Select Committee on Science and Technology 7th Report Sec 7: 140-142, 2005

20 *Focus Group on Scientific and Forensic Evidence in the Courtroom* McClure D. National Institute of Justice, Washington DC; 220692' 2007

21 *Expert evidence The future of forensic science in criminal trials* Criminal Bar Association Kalisher Lecture 14 Oct 2014

22 *The logical foundations of forensic science: towards reliable knowledge*. Evett I. Phil. Trans. R. Soc. B **370**: 20140263 2015

C.12 Proof, if such was needed, of the difficulties stemming from use of the phrase 'consistent with' may be found in an appeal in 2005 involving a registered forensic pathologist[23].

> *'… an expert is entitled to say what he has found is consistent with something and that has probative value. Whereas "inconsistency" is often probative, the fact of consistency is quite often of no probative value at all. …. We consider that there is a very real danger in adducing before a jury dealing with a case such as the present evidence of matters which are "consistent" with a conclusion, at least unless it is to be made very clear to them that such matters do not help them to reach the conclusion. If it is introduced in evidence, and particularly if it is given some emphasis, a jury may well think that it assists them in reaching a conclusion: for why otherwise are they being told about it?'*

C.13 As with the listing of examination standards dealt with in the previous Annex, there has never been any requirement imposed on registered practitioners – nor on those operating in Scotland or Northern Ireland – to include any such information in their reports. Nor, indeed, has there been any serious study of the possible advantages of attempting to define the terms in use. Nevertheless, it could be argued that any attempt to define the terms employed by forensic pathologists can only assist those who have to read and use their post mortem examination reports.

C.14 It may be that the FPSG or the PDB would wish to discuss whether the incorporation of additional pieces of information, such as examination standards and terminology, would assist those who have to use forensic pathologists' reports. Should the incorporation of additional information be deemed appropriate probably the nature and relevance of the specific phrases used should be reviewed. Whatever the outcome of such discussions, there would appear to be logic in all registered practitioners adopting the same procedures.

[23] *R-v-Puaca* Court of Appeal 2005 EWCA Crim 3001 pp 39-40