**FORENSIC SCIENCE REGULATOR**

# FORENSIC PATHOLOGY SPECIALIST GROUP

## AUDIT OF THE WORK OF FORENSIC PATHOLOGISTS BASED IN ENGLAND, WALES & NORTHERN IRELAND

REPORT OF THE 2017 ANNUAL AUDIT

**FORENSIC PATHOLOGY SPECIALIST GROUP**

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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 2017 is the seventh exercise in this series and followed the format used for previous exercises.

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 were also invited to take part. In this year's audit, 3 pathologists from Northern Ireland 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 for audit. One was to be a case in which he/she had to take over an examination which had already been started by a non-forensic pathologist because a death which had initially appeared non–suspicious was reclassified as suspicious.

5 The second case, was the next suspicious death (of whatever nature and irrespective of outcome) investigated immediately following the first case.

6 The request to submit material was made in late December 2017. It had been anticipated that the Northern Ireland practitioners would not have any cases to fill the first selected case studies as they do all of the Coronial autopsies for the province and hence will not have taken over a non-suspicious case from a histopathologist. The Northern Ireland pathologists were therefore asked to submit 2 suspicious death post-mortems they had undertaken.

### Service provision

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

## Audit protocol

8 The protocol agreed by the FPSG[1] 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.

9 For this exercise five (5) experienced forensic pathologists formed the team which examined the reports for their technical quality and six (6) senior investigating officers (SIOs) were available to scrutinise the material from their own viewpoint. The coroners were also invited to comment and the submitted cases have been spread amongst a number of coroners, to ease workload.

10 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 thus 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.

11 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.

12 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.

13 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, a coroner and two of the SIOs. Accordingly, each pathologist auditor received between 29 and 31 case reports for scrutiny; each SIO assessed about 23 cases. A coroner was assigned one case from each of the participants.

14 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*[2] issued jointly by the Forensic Science Regulator and the

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1 *Protocol: Forensic pathology audit* Forensic Science Regulator 2014.

2 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.

Royal College of Pathologists (in partnership with the Home Office and Department of Justice in Northern Ireland).

15 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.

16 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.

17 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 practise.

**Re-assessment**

18 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 1 (one) such report was identified for further consideration. This report was subsequently scrutinised by all five pathologist auditors.

19 Within the re-scrutinised report, the auditors concluded that no significant issues were identified that warranted further action. However, the participant will receive the additional comments within their feedback document.

**Structure of the report**

20 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.

21 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 comments were made regarding the structure of reports and their use of vague terminology. 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.

## AUDIT RESULTS

### Introduction

22 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.

23 The overall standard of the reports submitted for this year's audit was **good to high.**

A number of comments received were very complementary of the style, detail and standard of the reports. These were from both the forensic auditors, SIO's and coroners who were giving a layman's perspective.

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.

24 The general approach to a post mortem examination will be broadly similar whatever the cause of the death. However, the first case requested relates to a forensic pathologist taking over a post mortem already commenced as non-suspicious. This could have highlighted a potential area of concern that cases were not being correctly assessed at the outset or not being appropriately stopped by the histopathologist during the 1st post mortem.

All the cases submitted were initially stopped because of concerns during the 1st post mortem or due to further police investigations requiring a second forensic autopsy.

Assessing the cases submitted, 29 cases (83%) were of a nature that suggested that a coronial post mortem was the appropriate first action. The remaining 6 cases should possibly have been started as a suspicious investigation. The 2nd post mortem conducted by the forensic pathologist concluded that 69% were confirmed as still non-suspicious, 29% could not be confirmed as suspicious or non-suspicious and 2% confirmed as being a suspicious case.

25 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.*

26 Although differing styles and formats were evident, all reports submitted complied with the statutory declarations and legal requirements expected as an expert witness.

27 As per previous audits, 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, as far as I am aware, 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. I am unaware of any outcome on these discussions or if they now form part of, the soon to be issued, the revised code of practice.

However, a number of comments were received from coroners on the use of vague definitions within reports and some form of clarity on definitions would prove useful.

### *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.*

28 Timeliness of reports being issued is covered within paragraph 52.

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.*

29 All essential information was included.

### *Code of Practice - 7.2.4 History*[3]

*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.*

30 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.

31 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

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[3] 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.

in hospital the treatment notes had usually been made available. In 4 cases (10.5%) within the 2nd case submitted, it was noted that GP notes had not been seen or available.

32 Case histories were satisfactory, many being detailed and very informative. In 10 cases (13% 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.*

33 It would appear to be normal procedure not to invite a forensic pathologist to the scene, but to supply them with detailed police pictures or third party briefings. The exception to this is within 1 forensic practice, where it seems to be normal police procedure to invite the pathologist to all or most scenes.

### *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.*

34 Descriptions of the external appearance of the body were good, many being very detailed. Fifteen (15) case reports (19.7% of the total) contained brief descriptions of the external appearance although all were considered adequate in the circumstances.

The higher number within this year's audit is contributed to the majority of the brief descriptions being within the post mortem case taken over by the forensic pathologist.

### *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.*

35 Most Injuries were well recorded, with very detailed descriptions in several case reports. Where body diagrams were used to assist the report, although very useful, clearer cross referencing and correlation with the main report could be improved.

***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*.

36 The internal examination in both series of cases was generally very well described. 16% were stated as needing greater detail and 10% classed as detailed.

***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.*

37 Appropriate supplementary examinations had been carried out in 90% of the cases.

In one case, in the 1st routine hospital autopsy, no toxicology or histology had been undertaken. This action severely hampering the investigation by the 2nd forensic pathologist and was recorded by the auditing SIO as;

**Would these conclusions offer information potentially useful to a police investigation?**

"No. The lack of examination in the first PM has seriously affected the information police may have found useful."

***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.*

38 Commentaries in general were entirely satisfactory, many involving a thorough, well-argued and detailed discussion of the various issues.

As per previous audits, some were well set out and, in the words of more than one auditor, 'a very complex case that overall covers the issues and is a very good example of forensic pathology work'.

'The conclusions offer clear information to lines of enquiry for the police. Whilst falling short in actually mitigating 'foul play', the nature of the report and the full explanations given to each conclusion is of great assistance and would have structured outstanding tasks required of the police if not already completed'.

39 Eight case reports (10.5% of the total) included a commentary which was considered brief, although adequate in the circumstances.

40 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. All 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.*

41 The cause of death had been recorded in the prescribed manner in all cases.

42 The majority were agreed by the auditors as satisfactory or fine. In some cases, comments were made on the recorded cause of death. These were the auditors' opinion, provided to further clarify the given cause of death. In two cases the coroners stated that they would call the pathologist to the inquest for further clarity.

### *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.*

43 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. No comments or issues were raised during this audit.

### *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.*

44 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

- Simple spelling mistakes.
- Syntax errors
- Double space the lines to make it easier to read

45 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. 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*

46 The issuing of reports, prior to a Critical Conclusion Check (CCC) having been undertaken was identified. In two cases, CCC's were undertaken later and confirmed acceptance of the reports. However, this is considered to be poor practice and places an unfair burden on the reviewer if subsequent changes are required.

47 It seems clear from the foregoing paragraphs that the quality of these checks is still failing to pick up typographical errors.

48 I note that the Code of practice and performance standards for forensic pathology was due for a review 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.

49 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'.*

50 Overall, timeliness of the reports within this audit did not appear to be a significant issue. However, the auditors considered that 3 reports did not meet the standard of being issued as quickly as possible, this represented 4% of the total cases audited.

In 1 of these cases, over 4 months elapsed from when the final analytical reports had been received by the pathologist and 6 months after the PM, before the report was issued. In the other, over 5 months after the PM when no neuropathology or toxicology were required.

Timeliness has been identified in previous audits as an issue, and although small within the context of this audit it has become raised again by coroners and SIO's.

All future audits should look at this issue in greater detail and request the dated preliminary report along with the dated final report and dated supplementary reports to examine if this is an greater area of concern than seen within this limited audit.

***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*

51 No comments in this area within this year's audit.

***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.*

52 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.*

53 Some comments were made, both, by the pathology and SIO auditors on the length of some reports within the commentary/conclusion section. One auditor expressing if the reader would be able to clearly understand the issues because of the detail and length.

However, this view was not fully supported by other auditors of the cases but is given as general comment and could be a discussion point for consideration.

**Comments made by the coroner**

54 Last year we had no coroner input, and 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

55 Fortunately, in this years' audit, the coroners' comments were co-ordinated by Jacqueline Lake, the Senior Coroner for Norfolk, who managed to provide a coroner comment for all cases submitted

56 I would like to record my thanks to Jacqueline and all the coroners who provided comments for her and their support to this audit.

A sample of Coroners comments

"Likely to call the pathologist as a witness to explore signs of dehydration, as well clinicians."

"Excellent report.

Detailed, well written and easily accessible comments and very well presented and laid out.

The inter relationship between the various medical conditions is complex but the Summary and Conclusions sections pull these together well.

This would be helpful at Inquest."

**"**A helpful report in a difficult case.

Neuropathology reports are always difficult to read, but a very good explanation of the findings is given here.

I note that the toxicology report comments that the site of collection of the blood sample is unspecified.

The case does emphasise the need to recover blood samples collected on hospital admission when it becomes apparent that their analysis might inform the investigation of the death.

There is no mention in the report of the results of the very limited toxicology screen that would usually be done when a patient is admitted as "? Overdose".

It may have been helpful to comment on the relevance of the relatively long death – post mortem interval in respect of the post mortem alcohol results and the unavailability of admission blood samples.

The question arises as to whether a "SFR report could be admitted as evidence in isolation at an inquest…". [4]

**Comments made by the police senior investigating officers (SIOs)**

57 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. In this year's audit we had 5 SIOs who took part,

[4] The reference to SFR (streamlined forensic report) is to a toxicology report rather than the report of the forensic pathologist.

providing many useful comments, the overwhelming majority of which were positive.

### The layout and format of the report

58 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.

59 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.

60 However, some comments were received from both SIO's and coroners in the use of vague terms, such as;

- I think that a heavy impact ….. ? better to say in my opinion, on the balance of probabilities
- In the context of this case, it suggests that ….. as above

Also, the use of definitions, as used by one practice, was thought to be useful by one coroner.

## RECOMMENDATIONS

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

1. Review the Critical Conclusion Check (mentioned last audit)
2. Issue the new Code of Practice (20xx) to incorporate current legal, guidance and procedure rules, where applicable.
3. 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 usefulness from the SIO and Coroner input, where interim and final can be examined.
4. Perform the next audit against the new Code of Practice.

## CONCLUSIONS

62 This was the seventh 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 Northern Ireland. The reports submitted for this exercise were generally of a high standard and provided clear indication that standards are being maintained.

63 The issue of taking over a non-suspicious post mortem did not raise any major issues within the audit. Assessing the cases submitted, 29 cases (83%) were of a nature that suggested that a coronial post mortem was the appropriate first action. The remaining 6 cases should possibly have been started as a suspicious investigation.

The 2nd post mortem conducted by the forensic pathologist concluded that 69% were confirmed as still non-suspicious, 29% could not be confirmed as suspicious or non-suspicious and 2% confirmed as being a suspicious case.

64 Within this audit, I planned to use 6 SIO's. Case studies were sent to all 6, unfortunately 1 SIO, due to pressure of work, was unable to provide written comments. Overall this increased number of SIO's works extremely well and if they are available, should be continued.

65 Looking back on the annual audits, standards are being maintained. The Code of Practice 2012 is due to be reviewed and reissued and the next audit should be based on the new code, with the criteria being set on cases meeting the new code.