

## Forensic Pathology Specialist Group (FPSG)

Note of the meeting held on 9<sup>th</sup> November 2017, at the Home Office, 2 Marsham Street, Westminster, London, SW1P 4DF.

# 1. Welcome and Apologies

1.1 The Chair welcomed all to the meeting. A full list of attendees is available at Annex A. Apologies were received from Nigel Meadows and Caroline Browne.

# 2. <u>Minutes of the Last Meeting</u>

2.1 The minutes of the meeting held on 17 May 2017 were agreed to be an accurate reflection of the discussions held.

# 3. <u>Matters Arising from the Previous Minutes</u>

Imaging Standard

3.1 At the meeting held on the 17 May, members had been presented with a draft guidance document on the use of Post Mortem Computed Tomography (PMCT) as an adjunct to suspicious and homicide death investigations. The Forensic Science Regulator (the 'Regulator') confirmed that they would work with the FPSG and relevant stakeholders to progress guidance in this area.

# Action 1: Jeff Adams to contact David Baily and other relevant stakeholders in regards to developing a PMCT imaging standard.

3.2 All other matters arising were either complete or agenda items for the current meeting.

#### 4. Codes of Practice and Performance Standards

- 4.1 Members were provided with a draft copy of the Code of Practice and Performance Standards for Forensic Pathology in England, Wales and Northern Ireland. This document had been presented at the previous FPSG meeting and feedback had been solicited. The Group discussed the substantive comments that had been provided on the document.
- 4.2 One substantive comment had opined that there was not sufficient reference to children in the document. Members discussed that the document could only include as many references to children as was practicable, and that care would be needed to avoid a potential overlap with paediatric pathology.

Action 2: Nat Cary to collate information on children that could be added to the Code of Practice and send this to Jeff Adams.

4.3 Additional feedback highlighted that the document did not contain information on organ donation, or the discussions to be had between the senior investigating officers, the Coroner, the Pathologist and the organ donation teams. The Group supported the appropriate harvesting of organs for donation, and members heard that East Midlands forensic pathology practice and local police had a standard operating procedure (SOP) for organ donation in this context.

#### Action 3: Guy Rutty to share a SOP on organ donation with Jeff Adams.

- 4.4 A comment had been received in support of non-invasive examinations in cases of suspicious death. The Group confirmed it agreed with the current wording in the document, in addition to its previous guidance, that full, invasive examinations are appropriate for suspicious deaths, although the Codes allow for deviation in exceptional cases. It was noted that this document also covered road traffic incidents, which presented a different set of circumstances, and the document may need to be redrafted to reflect this.
- 4.5 The Group discussed a comment that had been received supporting stylised comments in the reporting of causes of death. However, the Group supported the current reporting system, suggesting that the flexibility to allow stylised comments in such cases can lead to more subjective and variable findings.
- 4.6 Members discussed further feedback concerning a lack of clarity surrounding peer review, the definition of a "complex case" and assessment of mortuary standards.
- 4.7 Members requested clarification in regards to a section of the document stating that where injuries are impressed into the skin, a three dimensional record (e.g. by casting) might be appropriate. The Group discussed that such records can be useful in criminal justice work, and suggested further information, including on 3D printing, be added to the document.

# Action 4: Jeff Adams to update the Codes of Practice and Performance Standards based on the FPSG discussion.

## 5. Royal College of Pathologists Guidance

5.1 The Group discussed draft guidance documents produced by the Royal College of Pathologists on drowning and deaths due to drugs. These documents had been authored by histopathologists, with relatively little input from forensic pathologists. It was the opinion of the Group that as a result, these documents did not address all the issues as well they could. Members heard that the representative from the Department of Justice, Northern Ireland had written to the President of the College on this matter. The Regulator offered to write to the College to offer assistance to the College on future publications.

Action 5: The Regulator to write to the President of the Royal College of Pathology to offer assistance in the authorship of future guidance documents where forensic pathology expertise would be useful.

### 6. Report Requirements

- 6.1 The Group heard that new legal guidance had been published by the Regulator concerning expert report content<sup>1</sup>. It was confirmed that this guidance applied to both prosecution and defence witnesses in England and Wales. The Group discussed concerns relating to the use of experts from outside of England and Wales who may not be aware of this reporting structure. It was confirmed that such experts must comply with the expert report guidelines, as set out in the Criminal Procedure Rules and Criminal Practice Directions.
- 6.2 Members enquired if the FSRU could provide a pro forma containing the necessary declarations relevant to forensic pathologists, for inclusion in expert witness statements.

#### Action 6: Jeff Adams to circulate an expert report pro forma to FPSG members.

## 7. Audit 2017

- 7.1 The Group heard that the process was underway to establish payments for the forensic pathology auditors. The wording for the audit, based on discussions at the previous FPSG meeting, would be circulated once financial approval was granted.
- 7.2 The Chair enquired if coroners would be involved in the audit. The FSRU representative confirmed this was the intention, and he had approached the Coroners' Society in this regard.
- 7.3 It was emphasised that the audit only applied to England and Wales, however an invitation to Scotland and Northern Ireland to participate voluntarily would, as usual, be extended.

#### 8. Audit 2016

- 8.1 The 2016 audit report had been circulated to the relevant stakeholders and would be published in the near future.
- 8.2 The Group discussed recurring feedback on audits. These included requests for a standard template for audits; however the members agreed that templates were overly restrictive, although they supported checklists detailing items that should be included in an audit report. It was suggested that adding numbering to injuries was helpful, and this should be added to the Regulator's guidance.

Action 7: Jeff Adams to add that careful confederation should be given to numbering injuries in a systematic manner to audit guidance.

8.3 Other recurring feedback concerned critical conclusions checks and the need for a 14 day report. The group supported the current system in both cases.

<sup>&</sup>lt;sup>1</sup> Available from: https://www.gov.uk/government/publications/expert-report-content.

#### 9. Audit 2012

- 9.1 The FSRU had been in discussion about a document concerning indicators of suspicion. The Royal College of Pathologists had indicated that several revisions were required to the document.
- 9.2 The FPSG had previously discussed the provision of training for forensic pathologists, including attachments to forensic departments. The College was supportive of such training, and the group discussed how trainees might be supported financially.

Action 8: Jack Crane and Jeff Adams to discuss potential alterations to the 'Indicators of Suspicion' document.

Action 9: Guy Rutty and Paul Johnson to discuss training of forensic pathologists with Jeff Adams.

#### 10. Excited Delirium

- 10.1 The Group heard that the guidance on the use of the term 'excited delirium' had been agreed with the Royal College of Pathologists and the British Association in Forensic Medicine (BAFM). This wording made it clear that excited delirium should not be cited as a cause of death. It will be discussed at the Death Investigation Group of the College in November.
- 10.2 It was suggested that the guidance might benefit from citing further sources of information regarding excited delirium.

Action 10: Guy Rutty to suggest potential additions to the document.

#### 11. Deaths in Custody Review

11.1 Members heard that the *Independent Review of Deaths and Serious Incidents in Police Custody*<sup>2</sup> contained two recommendations relevant to the Group. Firstly, that excited delirium should not be cited as a cause of death (see Section 10 above), and secondly that urgent consideration should be given to the mandatory video and audio recording of post-mortem examinations in contentious Article 2<sup>3</sup> deaths. Members expressed their concern at mandatory filming of autopsies.

## 12. Forensic Toxicology Integrity

12.1 The Group was updated on an ongoing case of serious malpractice within a forensic toxicology provider.

## 13. External Quality Assessment

13.1 Members were presented with a proposal for an external quality assessment (EQA) scheme to be established in forensic pathology. The EQA would involve material from

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<sup>&</sup>lt;sup>2</sup> Available from:

 $<sup>\</sup>underline{\text{https://www.gov.uk/government/uploads/system/uploads/attachment\_data/file/655401/Report\_of\_Angiolini\_R} \\ eview\_ISBN\_Accessible.pdf.$ 

<sup>&</sup>lt;sup>3</sup> Article 2 of the European Convention on Human Rights provides for the independent investigation of deaths where there has been state involvement.

closed cases and was primarily intended as an educational tool. It was suggested that the BAFM could administer the scheme. The Group was supportive of the scheme, although it reiterated the important of using material from closed cases, so not to affect ongoing court cases.

# Action 11: Naomi Carter to add the EQA scheme to the agenda of the next BAFM meeting.

### 14. AOB

Forensic Anthropology

14.1 The Group heard that the Regulator had published a consultation on a standard for forensic anthropology<sup>4</sup>. The deadline for comments was 4 December 2017.

# Action 12: The Secretariat to circulate a link to the forensic anthropology consultation to FPSG members.

FPSG Membership

14.2 Members were informed that this would be the final meeting of Jack Crane and Nat Cary, and the Chair thanked them for their service on the group.

# 15. Date of the next meeting

15.1 The next meeting of the Regulator's FPSG had not yet been decided.

<sup>&</sup>lt;sup>4</sup> Available from: https://www.gov.uk/government/consultations/code-of-practice-for-forensic-anthropology.

# Annex A:

# Present:

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Patrick Gallagher	Chair
Gillian Tully	The Forensic Science Regulator
Jeff Adams	Forensic Science Regulation Unit, HO
Mark Bishop	Crown Prosecution Service
Martin Bottomley	National Police Chiefs' Council
	Homicide Working Group
Naomi Carter	Forensic Pathologist – British
	Association in Forensic Medicine
Nat Cary	Forensic Pathologist - Royal College
	of Pathologists
Jack Crane	Forensic Pathologist - Department of
	Justice, Northern Ireland
David Green	The Crown Office and Procurator
	Fiscal Service
Dean Jones	Forensic Pathology Unit, HO
Paul Johnson (by telephone)	Forensic Pathologist - British
	Association in Forensic Medicine
Philip Lumb (by telephone)	Forensic Pathologist – British
	Association in Forensic Medicine
Guy Rutty	Forensic Pathologist – Responsible
	Officer for Pathology Delivery Board
Marjorie Turner	Forensic Pathologist - Crown Office
	and Procurator Fiscal Service
Thomas Vincent	Home Office Science Secretariat