

Standards for Coroners' pathologists in post-mortem examinations of deaths that appear not to be suspicious

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Comments	<p>This is a new document.</p> <p>In accordance with the College's pre-publications policy, this document was on The Royal College of Pathologists' website for consultation from 13 March to 13 April 2013. Fifty-three items of feedback were received and the authors considered them and amended the document as appropriate. Please email publications@rcpath.org if you wish to see the responses and comments.</p> <p>Dr Suzy Lishman Vice-President for Advocacy and Communications</p>

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Scope and purpose

These guidelines apply to the conduct of a post-mortem examination performed under the authority of a Coroner and where a death is not deemed to be suspicious.

The guidance also applies to the conduct of a post-mortem examination performed as a second examination following an original investigation under the authority of a Coroner and where a death is not deemed to be suspicious, for example at the request of a family or other authority.

These guidelines set out what is expected of the Coroner's pathologist in the performance of each step in the process of the pathological investigation of a death that has been reported to the Coroner but that appears not to be attended by suspicious circumstances, from the initial authorisation from the Coroner's Office to the pathologist, to attendance at the inquest.

The Royal College of Pathologists is responsible for setting the standards that underpin high quality pathology services.

The guidelines will ensure that investigations into a death are reliable; will be congruent with relevant legal and regulatory codes; and will provide a framework against which clinical audit and performance review of pathologists can be set. The standards specified can be used to assure the quality of performance of individual Coroners' pathologists, as well as to facilitate the collection of evidence for the revalidation process.

These guidelines have been developed by the College to allow Coroners' pathologists to demonstrate high standards of professional performance based upon expert consensus.

Stakeholder involvement

The guidelines were reviewed by the Histopathology Working Group of the Human Tissue Authority, which includes representatives of the following stakeholder groups:

- Human Tissue Authority (HTA)
- British Medical Association's Central Consultants and Specialists Committee (CCSC) Pathology Subcommittee
- Association of Anatomical Pathology Technology (AAPT)
- Institute of Biomedical Science (IBMS)
- Home Office
- Coroners Society of England and Wales
- Ministry of Justice (MoJ) (on occasion)
- INQUEST.

The guidelines were modified after review by Fellows of the College.

General standards

The College advocates the principles of good practice published by the General Medical Council (GMC) in *Good Medical Practice*.¹

A Coroner's pathologist must be on the GMC Medical Register, have a licence to practise and adhere to the standards set out in *Good Medical Practice*.¹ They should be appropriately qualified and have experience in autopsy pathology.

The Coroner's pathologist's primary duty is to the Coroner and he or she must not act in any way that fails to acknowledge that duty.

A Coroner's pathologist must understand and work within the legal framework in which authority to perform a post-mortem examination is given under the Coroners (Investigations) Regulations 2013.²

The responsibilities of the Coroner's pathologist regarding audit, clinical governance, quality assurance, continuing professional development (CPD), revalidation and research are the same as those of any medically qualified clinical pathologist.

Coroners' pathologists must ensure that the service they provide is of high quality. It is advised that services are conducted in accordance with a formal agreement made between the Coroner and the pathologist that demonstrates a commitment to quality, transparency and accountability. The College does not specify the format of such an agreement, which is a matter for Coroners, but advises that it refers to these standards.

The College recognises that a Coroner's pathologist may have to perform post-mortem examinations within mortuaries where he or she has no formal contract of employment with the providers. The Coroner's pathologist should be satisfied that the mortuaries in which he or she works are licensed under the oversight of the Human Tissue Authority and meets standards specified in its published codes of practice.² If a pathologist is not satisfied with any aspect of a mortuary, he or she should make those concerns known to the Coroner and to the Designated Individual responsible for the licensed premises, without delay. It is also possible to raise issues directly with the Human Tissue Authority.

A Coroner's pathologist should not work in isolation from colleagues, either within the discipline of pathology or other clinical disciplines.

1 Before the post-mortem examination

Upon receipt of authority from a Coroner to conduct a post-mortem examination, the pathologist will examine the information passed from the Coroner's Office and decide:

- what health and safety issues are raised by the case and, in particular, consider whether the mortuary is equipped to a standard that allows proper investigation of the death and, if not, advise the Coroner to seek a more appropriate mortuary
- whether, where the death has occurred in the pathologist's own hospital, it is appropriate that he or she makes the post-mortem examination and, if not, to advise the Coroner. Such a decision must take due account of any potential conflicts of interest which should be disclosed to the Coroner
- whether he or she has the appropriate expertise to make the post-mortem examination and, if not, to advise the Coroner to seek an appropriate expert to conduct or advise on the procedure. If that expert cannot attend, the pathologist should seek advice from the expert to determine what material might be required for later examination and interpretation, and ensure it is recorded and/or preserved in an appropriate manner
- what issues – pathological or other – are raised by the circumstances of death and how these issues are best addressed. Where these issues require the use of other investigations, such as radiology or the retention of human material, there must be discussion with the Coroner to seek agreement
- if, in advance of any post-mortem examination, discussion with the Coroner indicates to the pathologist that the Coroner will not permit investigations necessary for the reliable

elucidation of the death, the pathologist should decline to make that post-mortem examination. This is a matter for clinical judgment.

- whether it is appropriate to delegate any part, or all, of the post-mortem examination to a trainee pathologist. If so, the agreement of the Coroner should have been sought and appropriate supervision should be ensured by the pathologist. Training departments may choose to seek generic approval from a Coroner in this matter.
- whether it is inappropriate to delegate any part of the evisceration to an anatomical pathology technologist (APT).

In some circumstances, a pathologist may be asked to be involved in a post-mortem examination which is linked to a post-mortem investigation using imaging. The guidance from the College in respect of imaging should be followed.³

Where the information is insufficient to allow these decisions to be made, the pathologist will seek further information from the Coroner's Office before beginning any post-mortem examination.

Where the pathologist is unhappy to make the post-mortem examination (for example, where the police appear to be interested in the case, but are unwilling to seek the services of a forensic pathologist), the pathologist must be under no pressure to make the examination. He or she should advise the Coroner of the reasons for declining the request to make the post-mortem examination.

Where it is known that there are clinical case notes related to a death that has involved an episode of care in hospital immediately preceding the death, the notes should be obtained under the authority of the Coroner and read by the pathologist prior to the examination. This is to ensure that the pathologist is fully aware of any aspects of care that may have a bearing on the death. If such case notes are not readily available, the pathologist or Coroner should arrange for a clinical summary to be prepared by the consultant in charge of the case and arrange for this to be available prior to the examination. Where the history provided by the Coroner indicates that relevant additional information may be gathered from other sources, such as GP records or ambulance records, these should be requested from the Coroner and, when available, should be read to decide if there are issues that are relevant to the cause of death. Clinical judgment should be exercised in deciding whether to delay starting an examination before such records are available.

All discussions, decisions and associated reasoning must be documented by the pathologist.

2 The post-mortem examination

The pathologist will:

- work to the standards specified in the codes of practice from the Human Tissue Authority so far as they apply to a Coroner's post-mortem examination⁴
- make himself/herself fully familiar with, and work within the procedures specified in, the licensed premises for the conduct of an examination, including procedures required for the documentation of any tissue retained
- ensure, by having systems in place to communicate with the Coroner, that no examination is made before all interested persons who have expressed a wish to be present or represented at the post-mortem examination are, in fact, present or represented, unless this would result in unreasonable delay

- ensure that any personnel who may assist at the post-mortem examination are fully aware of the nature of the case
- agree with the anatomical pathology technologist (APT) the precautions to be taken in making the post-mortem examination and the extent of the examination
- ensure that the body is that for which the pathologist has authorisation to make a post-mortem examination
- ensure that no evisceration takes place before the pathologist has made a full examination of the external surface of the body
- make the examination of the body in a manner that both addresses relevant issues that may be raised by the death and ensures, so far as is possible, that the dignity of the deceased, and ethical issues relating to that deceased and their family, are accommodated
- keep a full awareness that “there must be an ever-present readiness to keep in mind the possibility that death might not have been natural”.⁵ The role of the pathologist includes consideration of the possibility of concealed homicide or negligence in care and the examination must be conducted in such a way that the opportunity to detect evidence of such a possibility is not missed
- perform an examination according to the clinical context of the case, which reflects standards and datasets contained in relevant and current guidance issues by the College
- be able to justify all examinations (or the omission of any part of an examination), having regard to the context of the case. The extent of the examination made should ensure that the cause of death is reliably established
- note any features of the body that reveal something out of the ordinary, whether or not they appear immediately relevant to the cause of death
- note the fact that parts of the body have been examined and no abnormality found, because the negative finding may be significant
- ensure, when the circumstances are such that others may wish to view findings of apparent significance at a later date, for example in describing a post-operative finding of relevance to the cause of death, that photographs are taken before the post-mortem examination interferes with the findings and prevents those others from having the same opportunity to assess their significance. This is a matter for clinical judgment. Photographs should be stored as part of the post-mortem record in a way that complies with information governance requirements
- recommend and seek agreement from the Coroner to retain that material which is relevant to the cause of death and/or which may assist in the resolution of issues that it is foreseeable may arise during the investigation of the death, including those that can be anticipated at inquest. This is a matter for clinical judgment
- where any part of the examination or evisceration has been delegated to a trainee pathologist or APT, be available promptly to provide advice or assistance, or to take over the conduct of the post-mortem examination
- ensure that arrangements are in place for the appropriate preservation and correct labelling of specimens, and for their prompt submission to the appropriate laboratory
- be available should it be required to advise the APT of any precautions necessary in further handling or viewing of the body.

At any point during an examination, should any finding raise a suspicion of the death having been caused by a criminal act, the pathologist must cease the examination immediately and make his or her concerns known to the Coroner.

3 Preliminary report to Coroner

The pathologist will:

- liaise with the Coroner or Coroner's officer, either in person or by telephone, secure email or fax:
 - to relate the major findings of the post-mortem examination, including the anatomic cause of death where available
 - to recommend and seek authority to retain material to conduct further investigations as required, to assist in full interpretation
 - to advise HM Coroner of any issues which appear to be raised by the death which would be addressed better by other clinicians or experts
- provide information to the Coroner regarding what human material has been retained after the examination and the reason for its retention, using the procedures specified in the licensed premises
- produce a written record of the above and arrange for a copy to be sent to the Coroner.

4 Further investigations

The pathologist will:

- ensure that the proper preservation and safe transport of any item retained, or processed, by the pathologist conforms with systems set out in any management or contract agreement drawn up between the Coroner and the licensed premises in relation to delivery of the service
- consider whether other expertise is required in the processing or examination of material and, if such is required, advise the Coroner
- where such material is submitted to another expert, ensure that there is proper preservation of that material and that full information regarding the findings at post-mortem examination, and any other information required, are made available to that expert
- ensure that the processing of all material is performed in a laboratory with Clinical Pathology Accreditation (CPA).

5 Production of report

The pathologist will:

- produce a formal report that will detail:
 - the source(s) of information the pathologist received or reviewed in advance of the post-mortem examination that justify decisions and actions taken at the post-mortem examination and source(s) of information used later in the interpretation of results to formulate a cause of death. While some Coroners do not allow such information to be transcribed directly into the report, the sources used should still be cited

- a schedule of all material retained as part of the examination and the purpose for retention
 - all investigations and the results of investigations made either personally or by submission to another laboratory for a report
 - conclusions and the reasoning that supports those conclusions, detailing all material drawn upon to support that reasoning, including reference to pertinent literature. Where unusual features are found but are concluded not to be relevant, the pathologist should explain why the finding has been discounted
 - the reasoning underlying why, where findings are open to alternative explanations, one explanation is favoured
- ensure that the detail within any report reflects standards and datasets contained in relevant College guidance
 - advise the Coroner, where a cause of death can be determined only from the clinical details, when there is a need for statements to be obtained from relevant clinicians
 - resist any pressure to formulate a cause of death where pathological findings do not allow such formulation or where investigations considered necessary to a proper formulation are not permitted by the Coroner
 - report, if requested by the Coroner, on whether an opinion can be formed as to whether the anatomic cause of death may be regarded as natural. The actual decision is a question for the Coroner to determine based upon such advice, the Coroner taking into account the full circumstances of the death⁶
 - produce the report as quickly as is possible with regard to the complexity of the case. The format of the report should be part of a formal agreement between a Coroner and the pathologist. A specification for the expected general turnaround time for production of reports should be part of a formal agreement between a Coroner and the pathologist
 - if a significant delay is anticipated in the production of a report, communicate this to the Coroner or Coroner's officer so that the family and any interested persons may be informed
 - if additional information is revealed after the provision of a report which impacts on the reliability of the original cause of death, produce a supplementary report incorporating that information and drawing further conclusions.

6 Attendance at inquest

The pathologist will:

- ensure that the Coroner has been made aware in advance of what evidence the pathologist feels he or she must hear, in order to give an accurate formulation of cause of death
- ensure that he or she is well prepared, prior to attendance at court to give evidence
- be willing to consider, and prepare, means of presenting evidence that minimises distress to those present in court
- ensure that documentation relevant to the case is brought to court
- ensure that appearance and behaviour conform to acceptable professional standards
- deliver evidence in an audible and understandable manner
- give evidence consistent with the contents of the written report

- deal with questions truthfully, impartially and flexibly
- identify questions that are unclear and clarify these before offering a response
- give answers to technical questions in a manner understandable by those who have no technical or scientific training
- differentiate between facts and conclusions drawn from those facts, and ensure that any such conclusions lie within his or her field of expertise
- consider additional information or alternative hypotheses that are presented and, where warranted, modify conclusions already drawn
- make clear how firm is any additional conclusion, and what further information or investigation will be required to modify that conclusion further
- be prepared to stay in court to hear further relevant evidence
- where it appears that the Coroner or any legal representative of any interested person has misunderstood or is mis-stating evidence, ensure that the Coroner is made aware of that misunderstanding or mis-statement
- where it is apparent that material which hitherto has not been considered relevant is now relevant, or where there is a change in relevance of findings, ensure that the Coroner is made aware of such change
- never lose sight of the principle that the pathologist's overriding duty is to the Coroner and not to any particular interested person.

7 Disposal or retention of retained material on completion of the Coroner's involvement

On completion of the Coroner's involvement, the pathologist will act upon or delegate responsibility for acting upon the wishes of the family in relation to the disposal or retention of any retained material according to procedures specified in the licensed premises in which the material is held.⁴ Where no wish is expressed, the pathologist will ensure that material is disposed of according to procedures specified in the licensed premises in which the material is held.⁴

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