Forensic Science Regulator
Overseeing Quality

Forensic Pathology Specialist Group

Note of the meeting held at 14:00 hours on the 25th May 2016 at the Home Office, 2 Marsham Street, London, SW1P 4DF – Subject to changes

1.0 Introductions

1.1 The Chair of the Forensic Pathology Specialist Group (FPSG), Dr Patrick Gallagher welcomed the members to the meeting and asked members to introduce themselves. A full list of attendees is attached at the end of this note.

2.0 Apologies

2.1 Apologies had been received from Martin Allix, Russ Jackson, Gill Tully and Charlie Wilson.

3.0 Minutes of last meeting on 3 November 2015

3.1 The minutes of the meeting held on 3 November 2015 were signed off as an accurate reflection of the discussions held.

4.0 Matters arising from the previous minutes

Guidance on Individual Chemical Exposure

4.1 Members had provided comments on the Guidance on Individual Chemical Exposure and these comments had been fed back to Police National CBRN Operations Centre.

External Quality Assurance of Forensic Pathologists

4.2 A proposal had been put forward to set up an External Quality Assurance (EQA) system for registered Forensic Pathologists using digitalised historical materials and anonymised photographs. Funding had been identified for this project and a machine would be purchased to undertake the digitalisation. It was proposed that the EQA would be composed of ten cases including a combination of histology, photographs and laboratory case information.

Post Mortem Sampling Guidance

4.3 The guidance on collection of post mortem samples had been circulated to the FPSG and comments made on the use of proctoscopes had been incorporated. Further comments were welcomed before the document was published by the Forensic Science Regulator (FSR). The document was aimed at forensic pathologists but would also be of interest to forensic scientists.

Standardised Kits for Forensic Pathologists

4.4 Standardised kits for collection of samples at post mortem were discussed. Members were unclear if a national contract had been established to procure these kits and if so who had written the specification and who was responsible for the contract. It was noted that the kits were wasteful as they contained specialist items which were not always used and items which were not fit for purpose or were poor quality.

Action 1: Jeff Adams to further enquire on the contract and specification for standardised kits for collection of samples at post mortem.

DNA Decontaminant Fluids

4.5 The advice in the Post Mortem Sampling Guidance on the use of named DNA decontaminant fluids had been checked with colleagues in the Home Office, who had not suggested any modifications for the text.

Histology – Letter to Chief Coroner

4.6 A letter had been sent to the Chief Coroner expressing the FPSG view that histology was a necessary part of all post mortems, as it was not known at the outset of a case whether the histology details would be needed in court. The response to the letter was delayed because the Chief Coroner was fulfilling three major Criminal Justice System (CJS) roles.

Use of National DNA Database® for Identification

4.7 The Group heard that police guidance when dealing with deaths had been reviewed by the Forensic Pathology Unit (FPU) and guidance on the use of DNA samples and the National DNA Database® to identify bodies of the deceased had been incorporated. There would be updated guidance for the police and training for officers who attended scenes of sudden and unexplained deaths about the use of the National DNA Database®. The College of Policing was transposing the guidance into their format and it would then be issued for consultation to interested parties including pathologists.

Imaging Standards for Post Mortems

4.8 It had been decided at the previous FPSG meeting that standards were needed for the use of imaging as an adjunct in post mortems. The Royal College of Pathologists (RCPath) had already published a document with the Royal College of Radiologists on imaging for pathologists and the Forensic Science Regulation Unit had met with imaging and radiologist colleagues who would draft outline standards for forensic pathologists. RCPath and the British Association in Forensic Medicine (BAFM) would be invited to critically review the document. It was hoped that the document would be published with the professional backing of both Royal Colleges (Pathologists and Radiologists). In discussion, FPSG preferred a document specifically for forensic pathologists as opposed to coronial pathologists.

Action 2: Jeff Adams to arrange for the production of imaging standards for forensic pathologists.

Toxicology Reports – MG (prosecution case file related to the 2011 manual of guidance for prosecutions) form

4.9 Delays to the completion of pathology reports as a result of waiting for toxicology results had been discussed between the Pathology Unit, a delegation of forensic pathologists, the judiciary and the Crown Prosecution Service (CPS). As an outcome, a new 'MG' form, had been produced and agreed, which would be sent by the Senior Investigating Officer (SIO) in the case to inform the CPS as to the reason for the delay in the completion of the pathology report, thereby managing the expectations of the courts.

Two Recommendations in Hutton Report on Forensic Pathology

4.10 The Hutton Report recommended reducing the number of forensic pathologist autopsies. However, it had been decided not to amend the Code of Practice and Performance for Forensic Pathologists in line with this recommendation and the FSR had responded accordingly.

4.11 A further recommendation in the Hutton report was the establishment of an archive for forensic pathology records. The issue had been raised with the Home Office team reviewing Forensic Archive Ltd and a response was awaited. Possibilities were considered including a virtual cloud storage system, use of commercial secure storage sites, pathology group practices to store records or for the local police force to store them.

Use of the Term 'Excited Delirium'

4.12 Representatives of the FPSG had drafted a guidance note on the use of the term 'excited delirium' in post mortem reports which could be published by the FSR and Royal College of Pathologists. The Royal College of Pathologists Specialty Advisory Committee did not wish to prohibit the term, so the guidance stated that it could be used as a description of the state of affairs prior to death, however the medical event which led to death should be stated as the cause of death. The guidance would be circulated for comments, when it was completed.

Action 3: Secretariat to circulate the guidance note on the use of the term 'excited delirium', once complete.

Examination of a Foetus

4.13 The police guidance on examination of a foetus had been updated, as part of a new document, replacing Chapter 11 of the Murder Investigation Manual, recommending that during forensic autopsies of pregnant women, the foetus could be examined without the consent of the coroner. It was noted that in regards to autopsies undertaken for criminal investigation, police powers would allow for the examination of the foetus, however there was uncertainty whether the coroner had the power to request the examination of the foetus in cases which they oversaw.

Action 4: Jeff Adams to circulate the updated guidance on examination of a foetus to the FPSG.

Traumatic Head Injury in Children

4.14 The Group discussed the minutes of a meeting held at RCPath in 2012 regarding the 'triad', which related to non-accidental death of a child caused by shaking. The minutes contained factually inaccurate information and had been

removed from the RCPath website. However, details of the discussion were still available from the CPS website. It was requested that the document be removed from the CPS website.

Action 5: Mark Bishop of CPS to request removal of the document on traumatic head injury in children from the CPS website.

Second Post Mortems

4.15 The Chief Coroner had held discussions on guidance for second post mortem examinations. This issue would be transferred from FPSG to the Pathology Delivery Board to follow up with the Chief Coroner.

5.0 Code of Practice and Performance Standards for Forensic Pathology

5.1 The Code of Practice and Performance Standards for Forensic Pathology had been circulated to FPSG members and a number of issues had been raised. A table setting out those issues was provided to the Group.

5.2 The Code was published in 2012 and a number of issues had since been identified. It was therefore appropriate to begin a full review with the aim of issuing a new version in 2017.

5.3 One issue raised related to how to handle cases where a coronial autopsy had initially taken place and then a second forensic pathologist autopsy was requested. It was suggested that it was helpful to involve the original pathologist in the second autopsy. However, ideally the situation should be avoided by increased awareness by the police to identify which cases should be sent to the forensic pathologist in the first instance. It was suggested that the code of practice be circulated to all those on the pathology Register with a request for feedback. In addition, advice should be sought from Forensic Science Practitioners (FSPs) on trace evidence collection.

Action 6: Jeff Adams to circulate the Code of Practice and Performance Standards for Forensic Pathology to all on the pathology Register and seek advice from Forensic Science Providers on trace evidence collection.

6.0 Forensic Pathologists Audit Report, 2015

6.1 The 2015 audit of forensic pathologists was complete and approval was sought for the audit to be published, which was granted. The use of the term ‘consistent’ had arisen in the audit and it was agreed that if this term were to be used in pathology reports then it must be accompanied by an explanation.

Action 7: Jeff Adams to publish the 2015 forensic pathologists audit report.

6.2 FPSG members discussed the function of the critical conclusions check for the forensic pathologist reports and the requirement for its function to be applied consistently. The Group suggested that whilst the primary purposes of the critical conclusions check was to check for substantive errors, in situations where numerous typographical errors arose, these should also be flagged.

Action 8: Jeff Adams and Dean Jones to update the forensic pathology guidance to allow for typographical errors to be flagged during the critical conclusions check.

6.3 Delays in the provision of pathology reports were considered and the Forensic Pathology Unit noted that they received complaints about delayed reports on a weekly basis. Pathologists had previously attributed delays with the provision of their reports to the provision of other supplementary reports and statements, such as toxicology reports and police witness statements. However, further delays had been noted with the production of pathology reports after the toxicology reports had been submitted. It was suggested that there was a disparity in time taken to produce pathology reports between practices and amongst individuals within the same practices. In Scotland six weeks were allowed to produce a pathology report if toxicology was included, and ten weeks if neuropathology was included. However, the toxicology within Scotland was provided by a central function and therefore provided a faster service. A College of Policing Manual of Guidance for Prosecutors (MG) form would be used to notify the delays.

6.4 It was suggested that the Pathology Delivery Board should review delays with the provision of pathology reports and in addition consider delays in pathologists attending crime scenes and post mortems.

7.0 Forensic Pathologists Audit, 2016

7.1 Three recommendations had been put forward for the focus of the 2016 audit. These were:

- A body recovered from water,
- A body repatriated from abroad, and
- A suspicious death of a child under one year old.

7.2 As usual, the audit would involve a review of two reports on two areas of interest from each pathologist, but if necessary, two reports on the same area of interest could be submitted instead. It was suggested to take the first two topics for the 2016 audit; ‘a body recovered from water’ and ‘a body repatriated from abroad’. ‘A suspicious death of a child under one year old’ would be included in the 2017 audit. However, it would be necessary to ensure the auditing team had sufficient experience in paediatrics and it would be necessary for the topic to be clearly defined. The 2017 audit could also include cases transferred from coronial pathologists to forensic pathologists. This would allow a re-evaluation of the issues investigated in the 2012 audit.

Action 9: The 2016 forensic pathologists audit to be focused on bodies recovered from water and bodies repatriated from abroad.

Action 10: The 2017 forensic pathologists audit to cover a precisely defined case of a suspicious death of a child and cases transferred from coronial pathologists to forensic pathologists.

7.3 Four members of the 2016 audit team had been identified and a fifth was needed, who would be a forensic pathologist from the North West practice. Naomi

Carter offered to suggest a suitable colleague, who had been on the Register for at least five years and so would be eligible.

Action 11: Naomi Carter to provide a suggestion of a pathologist from the North West practice to become a member of the 2016 audit team to Jeff Adams.

8.0 Forensic Pathologists Audit, 2012

8.1 The Group heard there was a commitment to publish all the audit reports including the 2012 audit report, which covered deaths due to use of an illicit substance and cases transferred from non-forensic to forensic pathologists. However, it was first necessary to complete the follow-up work on the recommendations. Comments had been sought on the transfers of cases but no response had yet been received from the Royal College of Pathologists (RCPath).

8.2 A paper had been drafted and circulated to the Group on 'Indicators of Suspicion' which provided guidance to anatomical pathology technicians and coronial pathologists as to which cases should be transferred to forensic pathologists. The paper underlined the need to assemble a history, outlining the information given to the pathologist at his initial briefing, including the deceased's medical history, before the post mortem. It also included the need for a pathologist to examine the body externally before evisceration and that evisceration should not take place unless the pathologist was available. This paper would be circulated by email to FPSG members seeking their comments.

Action 12: Secretariat to circulate Indicators of Suspicion paper to FPSG seeking their views.

9.0 Revalidation of Forensic Pathologists

9.1 The FSR had agreed to provide independent oversight of the process for the revalidation of forensic pathologists. Previously, the FPU had provided a report to the FSR about the revalidation of forensic pathologists. It was agreed this year that the FPU would be asked to produce a similar report to be submitted to the FSR. In addition, this year appraisees were being invited to provide feedback on the appraisers.

Action 13: FPU to be asked to report on the revalidation of forensic pathologists.

10.0 Legal Obligations of Expert Witnesses

10.1 It was queried whether the legal obligations of expert witnesses paper should be circulated to all pathologists as while it was useful it was very lengthy. It was agreed that the executive summary should be circulated to all forensic pathologists with the location of the full document, as a recent audit had highlighted inconsistencies in approach to statements.

Action 14: Jeff Adams to circulate a web-link to the legal obligations of expert witnesses information paper to Home Office registered forensic pathologists.

11.0 Legal Requirements for Statements

11.1 The guidance on legal requirements for statements had been updated. One suggestion was to convert it to a template so that changes in legislation could be incorporated. Comments from FPSG members on both of these legal guidance documents (expert witnesses and statements) were requested.

11.2 FPSG commented that sections 9.1.21 and 9.1.23 in the paper appeared similar, and the word 'justified' in section 9.1.29 C appeared incorrect.

Action 15: FPSG members to send comments on the legal obligations of expert witnesses and statement guidance papers to Jeff Adams.

12.0 The Hutton Review of Forensic Pathology

12.1 The Hutton Review of forensic pathology had made a number of recommendations. An action plan of how to take forward the main recommendation of a National Autopsy Service would be drafted for Ministerial consideration by Simon Bramble. In line with the recommendations, the guidance for police on pathology had been updated and sent to the College of Policing for action and it would be issued in due course.

13.0 Legal Issues in Forensic Pathology and Tissue Retention

13.1 FSR guidance on legal issues in Forensic pathology and human tissue retention had been circulated to FPSG. FPSG members had no comments on this guidance.

14.0 Second Post Mortem – Role of the first Forensic Pathologist

14.1 The purpose and frequency of second post mortems requested by the defence were considered and it was queried whether there was any oversight of the qualifications of the second pathologists and how they interacted with the first pathologist. It was agreed that, ideally only Home Office registered forensic pathologists should undertake the second autopsy, and in many circumstances it might be possible for the two pathologists to discuss the photographs and the report from the first autopsy rather than undertaking a complete second autopsy. It was noted that the Chief Coroner had issued draft guidance which questioned whether a second post mortem should be considered a matter of routine. It was noted that coroners do authorise a second post-mortem but the post-mortem is not done under their instructions and so the coroners' rules do not apply. It was agreed, that when the Codes are reviewed in the future, consideration should be given to the inclusion of guidance in relation to second autopsies.

15.0 Court Evidence Given by Other Experts

15.1 Discussions were held in relation to medical experts giving evidence which amounted to forensic pathology in court, who were either (a) not forensic pathologists or (b) retired and so were not subject to the annual appraisal process, who might not be on the medical register and so were not subject to the same degree of scrutiny as practicing forensic pathologists. This was an issue for the courts and it was suggested that a letter should be written to the Lord Chief Justice asking whether potential issues could be addressed in the Criminal Practice Directions.

16.0 Medical Examiners System for Hospital Deaths

16.1 A new system was being implemented for medical examiners to conduct independent scrutiny of causes of death in England and Wales. A recent communication from RCPath gave the date for this to go live as possibly April 2018.

16.2 It was expected that the numbers of hospital and nursing home deaths requiring autopsies would increase. This was suggested as a possible forensic pathologist audit topic for the future. FPSG members could contact Jeff Adams to raise any concerns.

Action 16: FPGS members to raise any concerns on availability of pathologists to examine hospital and nursing home deaths.

17.0 AOB

17.1 AOB items were invited from FPSG members. No further items were raised.

List of Attendees

Present:

• Patrick Gallagher	(Chair)
• Jeff Adams	Forensic Science Regulation Unit, HO
• Jack Crane	Forensic Pathologist - Department of Justice, Northern Ireland
• Martin Bottomley	National Police Chiefs' Council Homicide Working Group
• Caroline Browne	Human Tissue Authority
• Nat Cary	Forensic Pathologist - Royal College of Pathologists
• Naomi Carter	Forensic Pathologist – British Association in Forensic Medicine
• Andrew Davison	Forensic Pathologist – British Association in Forensic Medicine
• Dean Jones	Forensic Pathology Unit, HO
• Trevor Rothwell	Consultant (by phone)
• Mike Taylor	HO Science Secretariat (Secretary)
• Marjorie Turner	Forensic Pathologist - Crown Office and Procurator Fiscal Service
• Emma Burton-Graham	HO Science Secretariat

Apologies:

• Martin Allix	Forensic Pathology Unit, HO
• Russ Jackson	National Police Chiefs' Council - Homicide Working Group
• Gillian Tully	Forensic Science Regulator
• Charlie Wilson	Forensic Pathologist - British Association in Forensic Medicine