A RESPONSE TO THE HUTTON REVIEW OF FORENSIC PATHOLOGY

Prepared by

THE BRITISH ASSOCIATION IN FORENSIC MEDICINE

INTRODUCTION

In 2014 Norman Baker MP commissioned a review of forensic pathology in England and Wales, and Professor Peter Hutton was appointed to review and report on the forensic pathology service in England and Wales. Professor Hutton's report was submitted to the Rt Hon Lynne Featherstone MP, Minister of State for Crime Prevention on 6th March 2015 and was released for wider consultation on 29th June 2015.

This response of the British Association in Forensic Medicine has been prepared by a BAFM Working Group consisting of representatives of each of the six forensic pathology group practices. The BAFM response has also been circulated for consultation to the BAFM Northern Ireland and Scotland representatives. The BAFM Working group consisted of:-

Dr Jennifer Bolton – representing the North East Group Practice

Dr Charlie Wilson – Chair, President of the BAFM and representing the North West Group Practice

Dr Michael Biggs – representing the East Midlands Group Practice

Dr Andrew Davison – representing the Mid and South Wales and Gloucestershire Group Practice

Dr Nat Cary – representing the Greater London, South East and West Midlands Group Practice

Dr Russell Delaney – representing the West and South West Group Practice.

RATIONALE OF THE BAFM RESPONSE

From the outset, the aim of the BAFM Working Group has been to identify and respond to the issues raised by the Hutton Report which the Association considers to be crucial to the effective practice of Forensic Pathology in England and Wales. It was clear from the consultations between Prof Hutton and the Forensic Pathologists carried out prior to the publication of the report that there would be some aspects of

the report which would gain widespread support within the forensic pathology community, whilst others would cause equally widespread concern.

In responding to the Hutton Review, the Working Group had always intended to make a distinction between recommendations in the report which are considered to be of major importance and other matters of detail which, though important to forensic pathologists collectively and individually, are considered to be less important in the wider context of the review. It was therefore originally intended to set out the major areas of agreement and disagreement with the recommendations of the review in the BAFM response, and to append verbatim comments received from individual pathologists and group practices to the BAFM response. However, the Working Group received a total of 126 individual comments, amongst which, perhaps understandably, there was some duplication. Therefore for the sake of reader accessibility the comments and suggested corrections received will be cross referenced to the text and paraphrased. The original comments will be retained in the BAFM archive, for detailed inspection if desired[1].

Though the original terms of reference of the review were to examine the current model of delivery of *forensic pathology* in England and Wales with specific reference to the function, organisation and governance of the service, Prof Hutton quickly determined that he could not fulfil this remit without considering the wider death investigation system including *non forensic* autopsy practice. Clearly, this was a very significant departure from the original terms of reference and equally clearly, this has greatly increased the scope of the review and hence the amount of work required to complete it. BAFM accepts that this may well be why there are several inaccuracies and inconsistencies in the body of the report, some of which are relatively minor – nevertheless, whilst not wishing to detract from the major themes of the review, it is important that these are addressed and where appropriate corrected.

With this in mind, the format of this response will consist of three main sections:

In the first section, the consensus view of the BAFM to the major themes arising from the Hutton Review will be set out.

In the second section, comments and suggested corrections of a more minor nature will be cross referenced with the body of the report.

In the third section, the BAFM response to the individual recommendations set out in the executive summary and section 4.7 ‘Recommendations for change’ of the report will be discussed.

[1] The exception to this is a response to the review from the Trainee Representative to the RCPath Forensic Pathology Specialty Advisory Committee, which is included as appendix A.

SECTION 1.

The major recommendations

The BAFM considered the most important recommendation of the review to be that *"This report proposes that the solution for the future is to operate the forensic and coronial pathology services in conjunction with each other in a national death investigation service".*

There was universal support from the BAFM fellowship for a fully integrated national death investigation system in England and Wales. It is also the position of the BAFM that it would be logical for forensic pathologists to lead autopsy provision within any national death investigation system.

Though the BAFM is fully supportive of the concept of a national death investigation service, there are three major areas of concern to the BAFM arising from the Hutton report; these are:-

1. Funding.

The BAFM accepts that given the recently extended scope of the Hutton Review, it was not possible to produce details of how an integrated national death investigation service would be funded. However, in the absence of fully costed proposals it is impossible to assess how changes suggested by the review would impact the practice of forensic pathology in England and Wales, which is obviously a matter of considerable concern.

The BAFM understands that a costing exercise will be carried out, but it is clear that any funds allocated to a national death investigation system must consider not only the cost of implementing the system, but be ring fenced for the future in order to ensure its sustainability in the long term.

2. The professional status of forensic pathologists.

Prof Hutton has made much of the distinction between the practice of forensic pathology and routine Coronial autopsy pathology in England and Wales, a distinction which he asserts is unique to that jurisdiction. The simple fact of the matter is that Home Office registered forensic pathologists undergo specialist training and accreditation to achieve and maintain a very high skill set. It could be argued that since in England and Wales Home Office registered pathologists deal primarily with suspicious death cases, the distinction between routine and forensic autopsy practice has concentrated a level of expertise of suspicious death investigation in those pathologists that has underpinned the high quality of forensic pathology identified by the review. Consequently, it is the position of the BAFM that maintenance of the distinction between those who have the professional competency to carry out suspicious death autopsies and those who do not is crucial to the integrity of our profession.

It is also important to realise that maintenance of the professional status of forensic pathologists at least in part requires regular exposure to suspicious death cases in order to maintain competency. Put simply, a forensic pathologist needs to carry out a significant number of suspicious death cases regularly in order to remain 'match fit'. The review suggests on page 88 that to provide a national death service of the type envisaged by the review, the service would need 100-125 forensic pathologists. Given that the number of suspicious death autopsies in England and Wales has declined steadily for many years and fell below 2,000 for the first time last year, maintaining this number of forensic pathologists would mean that each individual would see less than 20 cases per year, which, in the view of the Home Office Forensic Pathology Unit and many forensic pathologists, is insufficient to maintain competence.

The review has clearly found that standards amongst Home Office registered forensic pathologists are high and that there is a high degree of user satisfaction amongst those in the police and wider criminal justice system who require the services of a forensic pathologist. The review also found that standards and user satisfaction were lower in the routine Coronial autopsy sector. The BAFM agrees that there is room for improvement in the provision of a routine non-forensic autopsy service, and that it would be logical for forensic pathologists to provide advice and support to those who provide that service. Nevertheless, it should be borne in mind that the original terms of reference of the review were to examine the provision of *forensic pathology* in England and Wales; it would therefore be perverse if the problems identified within the *non forensic autopsy service* were to have an adverse effect on the forensic pathology sector. In summary, the BAFM accepts the need for improvement in the routine Coronial autopsy service and would be supportive of appropriate measures being taken to achieve higher standards in that sector. However, any proposed reform of the routine Coronial autopsy service must not be made at the expense of diminution in the expertise and professional standing of forensic pathologists.

3. The governance and provision of funding for forensic pathology.

In several areas of the review it is suggested that Forensic Pathologists might be employed by the NHS. Forensic pathologists are very unusual amongst doctors in that the 'end user' is not a live patient, but the police, coroners and criminal justice system. The NHS has very little knowledge of, or vested interest in, forensic pathology. On the other hand, the Home Office has considerable history of working with and setting standards in Forensic Pathology. The HO understands the contribution forensic pathology makes to crime investigation and the Ministry of Justice has a vested interest in the role of forensic pathologists within the wider criminal justice system.

It is highly likely that when allocating funds, the NHS would, quite reasonably, favour front line patient services over forensic pathology, whose 'value added' to the NHS might be considered minimal. As a small specialty, forensic pathology would have

little influence or relevance within the wider NHS. Consequently, there would be a significant risk that in the NHS forensic pathology would be chronically underfunded.

The majority of forensic pathologists[2] therefore believe that governance of forensic pathology via the Home Office or Ministry of Justice is more appropriate.

[2] 3 out of 33 BAFM Fellows expressed a preference for governance of forensic pathology through the NHS.

SECTION 2.

Comments on the body of the report

1. In the preface, (page 7 paragraph 2) Professor Hutton states *"I am aware that this is not the only possible way forward, but it is the one that I believe is most possible. It can be accommodated by the training system, it meets the future needs of both the forensic and coronial systems, it accommodates the main concerns of all the interested parties and, very importantly, it is the most cost-effective."*

It is not possible to state that the recommendations of the review would be the most cost effective, because no cost analysis has been carried out.

2. In section 1.4 'The scope of forensic and non forensic pathology', (page 16, last paragraph) it states:-

"It should perhaps be noted at the outset that Britain is unique in making such a clear separation between the work and professional position of consultant forensic and histopathologists. In most of the developed world, forensic pathologists undertake a greater proportion of non-forensic work and histopathologists work more closely with them in an integrated service."

The view of BAFM regarding loss of the distinction between forensic and non-forensic autopsy pathology has been set out in section one above. We would merely point out that if outside of England and Wales there is no distinction between forensic pathologists and non forensic histopathologists, the sentence *"In most of the developed world, forensic pathologists undertake a greater proportion of non-forensic work and histopathologists work more closely with them in an integrated service"* seems rather illogical.

3. In section 2.2 the Brodrick Report (1971), page 19 paragraph 5 it states:-
"The report endorsed the Home Office practice of maintaining a 'Home Office List'. At the time the Broderick report was written, there were 25 pathologists on the list outside of London and about 15 within the London area. The small number of just 40 pathologists serving England and Wales was recognised as being '... '...particularly vulnerable to death, illness, retirement or withdrawal of any one of the men on the current Home Office list'

The report went on to acknowledge that the profession was declining."

Nevertheless, over 40 years later forensic pathology is still providing a high quality service with a similar number of practitioners….could it be that approximately 40

pathologists is the right number to manage the caseload of suspicious death in England and Wales?

4. In section 3.1 'Developments over the past decade', (page 26 paragraph 4) it states -

"The FSS employed 3 forensic pathologists in the Sheffield area. With the proposed demise of the FSS (it continued till March 2012), these three people emigrated from England and the practice deficit was filled by forensic pathologists from the North West, a situation that continues at present. Humberside and Yorkshire (South and West) is therefore part of the area now covered by the North West Group Practice.

In 2010 there were considerable difficulties in the provision of services in the West Midlands. This deficit was filled by forensic pathologists from the Greater London Group Practice: this arrangement remains in place today."

When the service to Yorkshire and Humberside was at risk due the collapse of the FSS, the situation was swiftly and effectively dealt with by other pathologists in the region. Likewise, following departure of pathologists from the West Midlands in 2010 the region was quickly and seamlessly absorbed into a neighbouring group practice. This could be seen as evidence that the group practice system works well and, contrary to concerns *"raised informally within the Home Office",* there is a degree of resilience. "Informal concerns" are not a sufficient reason to alter a system that provides a good service.

On Page 28 paragraph 2 it states -

"However, for of a variety of reasons, e.g. lack of infrastructure support from the NHS and Universities, limited opening hours, inconvenience of location, continued use of local authority mortuaries within coronial districts, difficulties of transferring bodies etc., these improved facilities did not meet expectations in relation to service delivery. Consequently, autopsy work did not become re-allocated to the refurbished centres and there has been no effective geographical rationalisation."

This may be true in some areas, but it is not true across the country as a whole. In Liverpool, Greater Manchester and South Yorkshire there are regional mortuaries providing 24/7 service. Nevertheless, the BAFM supports the centralisation of specialist forensic autopsy facilities.

5. In section 3.1.3 'Consultant appointments and fee structures' (Page 28 paragraph 3)

"There have been no employed posts advertised since 2009 when FSS recruited two pathologists from abroad".

This is incorrect. Two posts were openly advertised (and filled) in the East Midlands in 2013. An employed post was created in Cardiff. An employed status position in London and South East was also advertised recently.

Re Page 29, paragraph 3 *"The basis of the calculation has never been changed, but the original fee has been lifted for inflation. In addition to this, the pathologist would have a coroner's case fee and would get additional payment from toxicology reports, court appearances and second autopsies."*

The case fee lift has been lower than the headline rate of inflation since 2009.

Forensic pathologists do not derive income from toxicology reports; this comment should be removed from the report.

6. Section 3.1.4 'Audit and Quality Assurance', paragraph 1:-

"The definition of the two terms in the title of this section varies from publication to publication, but in this report, audit is meant primarily to represent the recording of the number of cases undertaken and quality assurance (QA) the standard to which the work is done."

This is confusing, audit in the context of medical practice is a specific activity with an ISO number designed to manage quality. It would be better to replace the word Audit with 'Collection of management data'.

Page 31 paragraph 2 bullet point 2, *The annual Forensic Science Regulator's (FSR) 'audit'*. - The inverted commas should be removed, this is the correct meaning of audit, in that it is a process designed to monitor and improve quality in a system.

7. Section 3.2.1 'Managerial arrangements', page 35 paragraph 1.

"Alternatively, at the conclusion of a case, all the materials could be stored with the police file as is normally the case with all other material for which there is no further immediate use."

On the surface, this appears to be reasonable but it has the potential to create a logistical nightmare when, as often happens, an apparently completed case becomes 'live' again due to, for instance, an appeal or new evidence coming to light. Clearly, all documentation needs to be securely stored, but several respondents have pointed out that it is actually quite common for material to be lost from police files and Coroner's files.

Finally, contemporaneous notes might be considered the intellectual property of the individual pathologist therefore they should remain in the possession of, or at least under control of, the pathologist.

8. In section 3.2.2 ‘Group Practices and the employment of Home Office Registered Forensic Pathologists’ (Page 35 Paragraph 5, bullet point one)

- *“....in fewer appointments being made and a loss of 50% of the trainees to other locations abroad and within the UK (but outside England and Wales) and.....”*

‘Loss’ needs to be defined– how does this compare with the NHS where hundreds, possibly thousands of doctors trained in the UK eventually leave to work abroad?

The number of trainees is in itself very small, therefore the number of trainees ‘lost’ may appear to be disproportionately large in percentage terms, particularly if one does not consider those who achieve gainful employment elsewhere in the UK to be ‘lost’.

One trainee who has recently trained in Northern Ireland has just been appointed to a post in England, so the movement of trainees is not simply a one way traffic out of England and Wales.

The reasons why a trainee may choose to work elsewhere are undoubtedly complex, and may not be simply due to a lack of posts.

Section 3.3.2 Paragraph 4, bullet point one

- *“....in allegations being made that forensic pathology operates as a ‘closed shop’ with decisions being led by self-interested concerns over income.”*

A review of this nature should be based on hard data and not innuendo. The above sentence should specifically name those who have made the allegations, or be removed.

The concept of a ‘closed shop’ operating in forensic pathology is disingenuous. In any walk of life, there will be a limit to the number of people who can be employed based on a finite amount of work available. Some individuals will be considered suitable to fill a post and others will not, based on many and varied criteria. This is not operating a ‘closed shop’ - it is selecting the most suitable individual for a post.

Section 3.3.2 Paragraph 5

“but it cannot be ignored in the sections below that there is a huge variation in the individual incomes from self-employed practice that was never envisaged when the remuneration formula was established”

It is not surprising or necessarily wrong that there is a variation in individual incomes. In any system there will be variation in workloads based on geographical location and other factors. For instance, there may be considerable variation in the workload of NHS consultants in the same specialties in different locations. The fee per case system does at least ensure that those pathologists who bear the brunt of the service work are fairly and equitably remunerated. Furthermore, a national fee per case has prevented the chaos that has been caused by a false internal market and competitive tendering within the NHS.

9. Section 3.2.5 ‘ Where the forensic autopsies are done’, (page 43 paragraph 4),
“These figures clearly demonstrate that there are a large number of locations in which forensic autopsies are undertaken. It implies that on many occasions, forensic pathologists must effectively be working alone, despite being part of a group. Although this will be inevitable on some occasions, the original intention of Group Practices, frequently emphasized by the Forensic Science Regulator, that there should be close daily professional contact between individual pathologists, is clearly not being achieved.”

This does not present an entirely accurate view of how the day to day delivery of a forensic pathology service actually works. Even in a large department, pathologists will usually be alone in the mortuary. Many of us have seen departments where personal relationships have broken down to form a toxic working environment in which there is very little contact and even less mutual support between consultants working in the same building. The group practice system allows close contact and professional support when it is needed.

Page 43 paragraph 5

“On no occasion did anybody from any constituency defer from the view that the geographical rationalisation of sites into bigger and better equipped units was to be encouraged.”

There is one factor that needs to be considered when encouraging ‘geographic rationalization’. The overseas units which were consulted in this review were based in Canada and Australia…..these are very different from the UK in terms of geography. Due to the size of these countries, bodies may have to be transported hundreds of miles across inhospitable terrain to centralised mortuaries. The UK is geographically small and densely populated. This has the advantage of pathologists generally being close to the scene of discovery of a body, facilitating attendance of the pathologist at the crime scene. In Canada and Australia, this is often not possible for practical reasons. The UK has the great advantage that it is rare for a pathologist to be more than 2-3 hours travelling time from the scene of discovery of a body. The police find scene visits by pathologists very useful, and scene visits are encouraged by the Code of Practice. Scene visits are one of the reasons why there is high user satisfaction with forensic pathology in the UK. Any geographical rationalisation of forensic pathology centres must ensure that it is still possible for timely attendance of a pathologist at police briefings and crime scenes.

10. Section 3.2.6 Concluding remarks, page 44 paragraph 2

“Although ‘missed homicides’ are a concerning issue, their number is marginal in their effect on workload.”

“Concerning issue” is is a massive understatement – also, considering the findings of the 2013 Home Office audit, it is by no means certain that the number of missed

homicides is actually ‘marginal’. We do not know the effect ‘missed homicides’ will have on workload until operation Grey being carried out by HOFPU is completed and its recommendations are known.

11. Section 3.3.1 ‘Serving the CJS’, (page 45 paragraph 4)

“In the future, greater pressure to progress cases more quickly within the CJS will mean that the longer delivery times will need to be reduced.”

This is quite correct, but speed should not be achieved at the expense of quality – a statement produced rapidly but of poor quality poses a significant risk to the CJS.

Page 45 paragraph 5

“The English court system is adversarial in nature which can tend, unfortunately, to mitigate against openness and the re-consideration of findings in the light of another opinion.”

This is simply incorrect – consider clause C of the expert witness declaration*:- “that in the event my opinion changes on any material issue, I will inform the investigating officer, as soon as reasonably practicable and give reasons.”* It may be correct that *‘winning is important for the support of a professional reputation’* amongst legal counsel, but for a pathologist not being candid, open and honest is a far greater risk to professional reputation.

12. Section 3.3.3 ‘The methodology and content of the forensic autopsy’ (Page 47 paragraph 1)

“Because of this there is a good case for greater agreement on what constitutes an adequate data set that all experts might accept whilst still reserving the right to come to different conclusions from the findings”

Data sets create a ‘tick box’ mentality that can easily diminish critical thought. Forensic pathology is a nuanced practice that needs to be adapted from case to case. Being constrained by a ‘tick box list’ of do’s and don’ts would significantly diminish, rather than enhance, the professionalism of forensic pathologists.

Page 47 paragraph 2

“In terms of meeting the needs of justice, it is for instance, difficult to see why, other than to meet the conditions of the Code of Practice, all the viscera have to be examined in detail when someone previously healthy (who occupied a passive role in the events), has died suddenly from decapitation in a terrible road accident.”

This shows a lack of understanding of how forensic pathology actually works – a complete and thorough post mortem examination is essential. In forensic pathology, rare things do happen (that is why such occurrences are rare and not impossibilities). Therefore to satisfy the court (on a balance of probabilities or stronger) it is absolutely essential to do a thorough examination. This is precisely why a properly conducted autopsy is considered to be the gold-standard in medical audit – studies of, for instance, post-operative deaths have consistently shown that the autopsy picks up unexpected findings not appreciated by clinicians, which have had a major contribution to the cause of death – doing a limited examination on the basis of what is expected from the circumstances of a case is fraught with danger.

Page 47 paragraph 5

- *"apparently more closely accommodating the attitudes and beliefs of certain religious and ethnic groups and.....*

The delivery of a forensic pathology service should be fair and equal for all, irrespective of ethnicity, religious beliefs, gender, disability, sexual orientation or anything else.

Page 49 paragraph 2

"The public's concept of what an imaging post mortem entails when the body may be subject to colonoscopy"

None of the respondents had ever heard of PM colonoscopy, or could envisage a scenario where this might be indicated.

13. Section 3.3.4 Sub-specialty forensic pathology, (page 50 paragraph 4)

"There is now a small cadre of paediatric pathologists who do have the appropriate legal training and there have been proposals to establish a supplementary Home Office Register for this specialist work. It has been discussed at the PDB on more than one occasion but has always failed as a concept on the grounds that the individuals concerned have not completed a full postgraduate training programme in adult forensic pathology. It is an issue of judgement whether or not this argument has validity when applied to a specialist domain of practice. The situation does however remain both unsettled and unsettling. At the very least there surely needs to be a national list of suitable paediatric pathologists kept, whether or not there is a new supplementary register."

The BAFM is quite unequivocal that a paediatric pathologist practicing alone would be extremely unlikely regularly to see enough cases of traumatic death to retain adequate competency in forensic pathology. The current 'double doctor' system with joint autopsies carried out by forensic and paediatric pathologists is fit for purpose and robust. This is not to say a list of appropriate paediatric pathologists should not

be kept, this is an excellent idea; furthermore, those on that list should be offered support and courtroom skills training. Paediatric pathologists carrying out forensic autopsies on suspicious death cases in isolation is quite another matter.

14. Section 3.4 'Second autopsies' (Page 54 paragraph 3.4.2)

"Everybody giving evidence to this review agreed that the current methodology surrounding second autopsies needed re-assessment with a view to change."

Though a significant proportion of the forensic pathology community agrees there may need to be a reassessment of the 2nd autopsy process, many still regard 2nd post mortems to be very useful. It is very interesting that the consensus view of forensic pathology trainees expressed support for the 2nd autopsy. It has been pointed out, quite justifiably, that the 2nd post mortem is the ultimate audit.

Page 55, Paragraph 3.4.3 'Professional views'

"The forensic pathologists themselves agree that the way the system operates at present is far from ideal, that it is unfair on relatives, and that second autopsies rarely affect the process of justice."

This should be changed to <u>some</u> forensic pathologists – by no means all agree with the above statement, or at least the comment about the process of justice.

"The problem would reduce dramatically if second autopsies became a critical desk-top review of the original autopsy."

The 'desk top autopsy' is an attractive option in principle, but the quality of photography at the first post mortem **must** be improved and standardised across police forces if this is to take place. At the moment, not all forces have adequately trained professional photographers. Evidence not accurately photographed is evidence lost.

One major advantage of the second post mortem examination is that when performed properly, it brings together the crown and defence pathologist, providing an opportunity to identify points of agreement and disagreements. This has the potential to reduce subsequent disputes in court and is, therefore, of considerable benefit to the CJS.

Page 55, paragraph 3.4.4

"The answer is to have professional agreement on what constitutes a comprehensive autopsy in a given situation."

This already exists in the Code of Practice, NB see comment re tick box mentality above

Page 56 paragraph 3, (bullet point two)

"Strengthening the critical conclusion check so that it is done by a second pathologist external to the group within which the autopsy was done"

There is no reason why critical conclusions checks need to be done outside the group practice. In fact, the critical conclusions check is one of the procedures that actively encourages daily contact between group practice members.

It is important to understand the differences between a critical conclusions check, peer review and professional audit.

15. Section 3.5.2 'Mass casualties', paragraph 2

"Such occurrences are another strong argument for strengthening the links between forensic and coronial pathologists and encouraging them to work together in larger centres. In mass fatality incidents, the non-forensic autopsy pathologist should conduct their work under the close supervision of a HORFP and it is suggested that one HORFP could oversee the work of up to five non-forensic pathologists. "

Many forensic pathologists who have been involved in mass casualties would prefer not to use histopathologists for this work, but instead supervise forensic pathology trainees. Recent retirees from the Home Office list are another group of pathologists who have the skills and experience required and who might therefore contribute to the response to a mass fatality incident. There are inherent risks to forensic pathologists having vicarious liability for the actions of histopathologists who have limited experience of forensic work and may not be suitably qualified or experienced.

"The NHS should have in place formal call out arrangements for such mass fatality incidents."

It is unclear why the NHS should have the responsibility for this if the response is primarily from forensic pathologists who, as described in section one above, have no governance within or financial relationship with the NHS. Would the NHS be responsible for the on call costs?

16. Section 3.6.2 'Training in forensic histopathology', (page 59 paragraph 2).

"Recruitment to the specialty, which is not done on a national basis, is healthy: there are typically three or four good applicants per post".

This requires some clarification; although there is not a national system to allocate trainees around the various training centres, of the kind that exists in the NHS, training posts are advertised nationally and open to any suitable candidate from the

UK or beyond. The posts are, however, appointed by the individual training centres as opposed to any national body.

From 2009 – 2014, only 40% of trainees funded by the Home Office have become established members of Group Practices in England and Wales.

However, several trainees have found employment elsewhere in the wider UK.

17. Section 3.7.2 Ethnicity and religion.

It is the position of the BAFM that forensic pathology should be fair and equal to all, irrespective of ethnicity, religious beliefs, gender, disability, sexual orientation or anything else.

18. Section 3.8.4 The present operation of the coronial system (page 78 bullet point 6)

- *"There is a huge reluctance to engage in anything contentious"*

This is another reason why the distinction between forensic and routine coronial pathology should be maintained – histopathologists should not be pressured into accepting cases that are outwith their skill set.

Page 78 bullet point 10

- *"Difficult to find a pathologist independent of the local trust"*

This is a problem which would be exacerbated if forensic pathologists were to be employed by or under governance of the NHS.

19. Section 3.9.2 'Missed homicides and acting on unexplained deaths' (page 81 pargraph 1)

"Some people giving their opinions to this review commented on the critical nature of the experience of the first law officer to arrive at the scene of an unexplained or un-natural death."

The BAFM agrees that this is absolutely vital. The review must take into account the findings and recommendations of operation Grey. Each unexpected or unexplained death should be considered suspicious at the outset, and that suspicion should only be de-escalated after a suitably qualified and experienced police officer has determined there are no suspicious circumstances.

20. Section 3.9.4 ‘Contractual arrangements’

The East Midlands Group Practice does currently have a formal contract with police forces in their area.

4.1 ‘The models of employment provision of forensic and coronial pathologists’
4.1.1 paragraph 2

“This has forced forensic practitioners down the self employed route”

This is not strictly correct. Many of the current cohort of self employed practitioners actively chose to be self employed even though other employed status posts were available, because the working environment was better than in the employed sector.

Paragraph 4.1.2 bullet point 1

“Two Group Practices have collapsed and their work has been taken over by an adjoining practice……”.

There has been a smooth transition of services after *‘collapse’* of the two group practices – one of which collapsed because of inappropriate employment of pathologists by a government agency (The FSS) that was disbanded. This transition of services actually demonstrated the flexibility of the Group Practice system.

“All practices now cover a wide geographical area……..”

The report seems to support centralization over a wide geographical area, so why is this considered to be a problem?

“Combined with the large number of widely distributed mortuaries, despite HORFP’s being members of a Group Practice, this has unintentionally promoted isolated working and has mitigated against a regular place of work.”

See comment re Section 3.2.5 above; it is also possible to become professionally isolated in a large department – isolation is largely a state of mind dependent on the individual practitioner and the dynamics within any group of professionals – it is not necessarily dependent on physical location.

Paragraph 4.1.2 bullet point 3

“Because HORFP’s were not offered an employed status route, self-employment has become the norm.”

As described above this is not true in all cases, many pathologists actively chose self employment over employed status

Page 86 Paragraph 2

"Now is a good time to review the Group Practice structure and whilst maintaining its strengths, to consider whether or not there need to be boundary changes (perhaps mirroring the possible changes in serious crime units), or modifications to the scope of work."

Group practice boundaries do not need to mirror serious crime unit changes –police reorganisation typically occurs more frequently than changes in forensic pathology provision. Geographic considerations are actually more important when forces require access to forensic pathology services. In the North West, provision of forensic pathology cover to one force is divided between two group practices with no operational difficulties at all. The group practice system has provided stability in the forensic pathology sector for almost a decade, and one could reasonably argue that the absence of the almost constant reorganisation that has caused so much disruption in other public bodies such as the police and NHS over that period has contributed to that stability. It is important to ensure that any boundary changes or modifications to the scope of work do not destabilise a functioning system.

In short, boundary changes should be implemented with caution, and then only with the full agreement of *all* of the group practices involved, the affected police forces and coroners.

21. Paragraph 4.1.3 'Coronial pathology' (page 86 bullet point 2).

- *"There are insufficient forensic pathologists to fill the coronial gap that will occur if the current projections become a reality".*

It is not the intended role of forensic pathologists to correct perceived failings in the routine Coronial autopsy service. The great majority of forensic pathologists support the distinction between forensic and routine coronial pathology. Many have no desire at all to engage in routine autopsies.

It is absolutely crucial to maintain the professional status of HORFPs. The high quality of the forensic pathology service must not be compromised by failings in the routine Coronial system.

The chronic underfunding that has brought the routine coronial service to crisis point would not be corrected by diverting resources from the forensic sector.

Paragraph 4.1.4 'Future funding patterns' (bullet point 2).

"The report can therefore come to no other conclusion (primarily in the public interest) than to recommend that in parallel to the funding provisions that exist at present:

- *a publically funded salaried service is introduced for forensic pathologists and.....”*

If this is not funded at a level that allows equivalence of terms and conditions with other countries such as Australia and Canada, there will continue to be recruitment problems and loss of trainees overseas.

22. 4.3 ‘The investigation of death’, paragraph 4.3.2 page 88 paragraph 2

“if the autopsy rate was to approach that of other countries, the service would need approximately 400-500 whole time equivalents of whom 20-25% (100 – 125) would be forensically qualified.”

These figures are seriously flawed. With a current suspicious death autopsy rate of less than 2,000 pa, a cohort of 100-125 forensic pathologists would be carrying out less than 20 cases per year. This is well below the caseload that is considered adequate to maintain professional competence and currency in forensic pathology. *“Clearly this is a radical suggestion, but the time is ripe for it. It is also probably the only way (when combined with the other proposals on regionalisation), that improvements can be made within a cost-effective envelope. Additionally, it solves the problem of how to maintain churn within forensic pathology by allowing the entry of younger consultants in the presence of a falling homicide rate. It is relevant to note the following points:*

- *In this model, forensic pathologists would not only be doing the traditional forensic cases, they would also be engaged in contributing on a regular basis to the coronial service.”*

With regard to ‘*maintaining churn’* within forensic pathology by allowing the entry of younger consultants in the presence of a falling homicide rate; the younger and less experienced consultants would be even more in need of exposure to a suitable case load in order to build and maintain professional competence. This model would be unacceptable to the great majority of forensic pathologists.

23. Section 4.3.3 ‘The possible consequences of change’ (page 89 paragraph 1)

“If a death investigation service was introduced, it would be an opportunity for the medical and legal professions to discuss what exactly a particular autopsy should consist of.”

There is no reason why there should not be *discussion* with the legal profession as to what a particular autopsy should consist of, however we should be wary of allowing the legal profession to set parameters that might restrict the effectiveness of the autopsy - only a pathologist has the skills and training to understand what is

required from a post mortem examination. We have clear cut guidelines on what constitutes an adequate autopsy, and for good reason.

Page 89 paragraph 3

"The question for debate is whether in those cases that come to autopsy, either forensic or coronial, is the objective just to find the main (and possibly additional contributory factors), or is it to diligently study all aspects of all the organ systems to histological level? This is perhaps best illustrated by a witnessed head injury in a previously fit young man inflicted either by accident (e.g. hitting the head in a car crash), or by a deliberate act (e.g. hit over the head with an iron bar in an attack). The cause of death is obvious, it is not a mystery. There may be additional findings such as airway obstruction secondary to unconsciousness producing the fatal hypoxia, and toxicology to reveal drug usage so a post-mortem is clearly needed. But is it really necessary to section and study all the organs for the sake of completeness?"

It is illogical to suggest that the overall accuracy of death certification can be improved by doing fewer and less thorough autopsies.

24. Section 4.4.2 'The Courtroom', page 92 paragraph 1

"The absence of timely case management in practice leads to the view that 'it will all be sorted out in court': one corollary of this is that there is slipshod pre-court preparation and the development of disagreements in court that should have been resolved between the experts at a much earlier stage."

The view that '*it will all be sorted out in court'* is inevitable if cases are rushed through so that there is no time for proper consultation between prosecution and defence experts – the key is *realistic* case planning at an early stage.

This paragraph refers to *'slipshod pre court preparation'* by whom? If there is no time for a case conference because of unrealistic timescales set arbitrarily by the court, then that is not the fault of the pathologist

25. Section 4.4.3 'Sub-specialty specialist opinions and second autopsies', page 92 paragraph 3

"In taking evidence for this review, nobody thought that the current process for second autopsies was satisfactory."

Many pathologists have grave concerns about abandoning the 2nd autopsy altogether and consider it to be a very valuable exercise.

SECTION 3

The BAFM response to the review both in general and in detail has been largely covered above. However, for completeness the BAFM response to the key recommendations for change in the executive summary of the review and reiterated in section 4.7 on pages 94-96 of the report are expressed as bullet points below:-

National Death Investigation Service

- There was universal support from the BAFM fellowship for a fully integrated national death investigation system in England and Wales.
- It is also the position of the BAFM that it would be logical for forensic pathologists to lead autopsy provision within any national death investigation system.

Regionalisation

- The BAFM supports the concept of concentrating forensic pathology services in regional centres.
- The BAFM agrees there are too many mortuaries in use in *some* parts of England and Wales.
- Any centralisation must take into account geographic factors and it should not necessarily follow proposed police force reorganisation into regional crime units.
- In more remote areas, a hub and spoke model of service provision should be considered.

Training

- Training is a matter for the Royal College of Pathologists, but the BAFM is supportive of enhanced training for routine autopsy pathologists.
- This might take the form of a diploma in autopsy pathology, similar to the diplomas in cytopathology or dermatopathology.
- The BAFM is concerned about the use of the term ‘wastage’ in this report and does not consider trainee colleagues who chose to work elsewhere in the UK as ‘wasted’.
- The BAFM entirely agrees that police officers likely to be first attenders at the scenes of unexplained deaths should receive a uniform standard of training in identification of signs which might give rise to suspicion.

Employment models

- The BAFM believes that any integrated death investigation system that is introduced should have the flexibility to provide for an employed status for

practitioners whilst also accommodating those who would prefer to be self employed.

- Remuneration of forensic pathologists should ensure equitable incomes between individual practitioners when taking into account workload.
- Terms and conditions for forensic pathologists working in England and Wales should also compare favourably with other jurisdictions, to prevent the loss of British trained pathologists to other countries. This may also attract overseas talent into the British system.

Group Practices

- The BAFM asserts that the group practice system has provided for a period of stability and quality improvement in forensic pathology provision over the past decade.
- The Group practice system has coped admirably when challenged by departmental closures and local staffing crises, demonstrating that it has the flexibility to cope with regional pathology provision.
- Clearly other models of service provision can be considered, but BAFM sees no reason why a group practice system cannot function within an integrated death investigation system.
- The position of the BAFM is that boundary changes to group practice areas should be implemented with caution, and then only with the full agreement of *all* of the group practices involved, the affected police forces and coroners.

Review of 2nd post mortem procedures

- The BAFM notes the opinion expressed in the review that 2nd post mortem examinations are *'an anachronism'* and *'not in the humanitarian interests of the deceased's relatives nor required for justice',* but would respectfully point out that a significant number of forensic pathologists and some in the legal profession do not entirely agree with this position.
- The BAFM recognises that there are differing views in the profession regarding the 2nd post mortem examination, and would therefore caution against abandoning the practice without widespread consultation.
- If the legal position should change to a point where 2ndpost mortem examinations are no longer carried out, then it is imperative that a high quality photographic record of the autopsy is made so the original procedure can be adequately reviewed. All police forces should have suitably trained photographers who are skilled and experienced in the specialist techniques of autopsy photography.

Reduction in the number of coronial autopsies

- There is general acceptance that fewer and higher quality coronial autopsies would be an improvement on the status quo.

- The BAFM has considerable concerns about suggestions within the body of the report that partial autopsies are acceptable in some circumstances. It is illogical to suggest that fewer and less thorough post mortem examinations can achieve the review's stated aim of improving the accuracy of death certification.

Review of the Codes of Practice

- The codes of practice are kept under regular review, which is right and proper.
- The BAFM considers the current Code of Practice to be fit for purpose and is concerned that overly prescriptive instructions pertaining to different types of case can lead to a 'tick box' mentality that is not conducive to a considered approach to the autopsy.
- The BAFM considers that the current arrangement of critical conclusions checking within group practices has been one of the most successful and valuable recommendations of the previous review, but critical conclusions checks cannot be a substitute for peer review, proper audit or the second post mortem examination.
- The BAFM sees no reason why critical conclusions checks may not be carried out by members of another group practice, but can see no practical benefit in making this a standard practice.

Sub-specialty and Paediatric Pathologists

- The BAFM is supportive of creation of a list of sub-specialty pathologists.
- The BAFM welcomes the suggestion that the HOFPU could provide CJS training and other support to sub specialty pathologists.
- The BAFM does not support the concept of stand-alone paediatric forensic pathologists and considers that in child deaths, joint post mortem examinations carried out by paediatric and forensic pathologists represent best practice.

Mass fatality incidents

- The BAFM sees little utility in a NHS based call out system for mass fatalities, since the call out to such an incident will typically be mediated via HM Coroner and the police. Nevertheless, the NHS has in place major incident plans, some casualties from a mass disaster may die after a period in hospital and some autopsies may be carried out in NHS facilities, therefore close co-operation between the clinical and post mortem response to a mass fatality incident is clearly desirable.
- The BAFM accepts that in very large mass fatalities the current cadre of Home Office pathologists may struggle to cope. However, the BAFM would caution against the use of non-forensic pathologists in these circumstances, favouring the use of trainee forensic pathologists, those who have recently

retired from the Home Office list and colleagues from elsewhere in the UK in the first instance.

- A reciprocal arrangement for the staffing of mass fatality incidents across the British Isles would be welcome.

Contracts with the police

- The BAFM does not have a position on whether or not formal contracts should be in place between pathologists and police, either nationally or locally, providing the terms of such contracts are not unfairly imposed and are mutually beneficial.

National Statistics

- The BAFM supports the proposal that the National Homicide Index could be modified to include forensic post mortem data in order that the ratio between forensic post mortems and homicide rates can be monitored.

Autopsy fees

- The BAFM is of the opinion that fees for routine coronial autopsies are unrealistically low and create a situation that is not conducive to good autopsy practice.
- The BAFM supports a fee per case structure for the forensic autopsy. The fee per case system has prevented some of the problems associated with the false internal market that exists in the NHS and works well within the group practice system.

The Law

- The BAFM supports the use of video links as a means of giving evidence for all experts.
- The BAFM is concerned that cases are being scheduled too quickly. The resulting pressure to provide an early statement is not conducive to thoroughness and there is also anecdotal evidence that fewer case conferences are being held in advance of trial dates.
- The BAFM recognises and strongly supports the practice of clarifying points of agreement and disagreement between expert witnesses well ahead of trial dates, as required by the Criminal Procedure Rules.

Retention of notes and other materials

- Clearly all case material must be securely stored, but the BAFM is concerned that material kept within a police or Coroner's file may be lost. There is no objection to copied material being held in police and/or Coroner's files, but original contemporaneous notes are considered to be property the pathologist, who should have the option to retain them in their possession.

Communication and societal change

- It is the position of the BAFM that the practice of forensic pathology should be fair and equal to all, irrespective of ethnicity, religious beliefs, gender, disability, sexual orientation or anything else.

Appendix A

Letter from Dr Brett Lockyer, Trainee Representative to the RCPath Forensic Pathology Specialty Advisory Committee.