The Royal College of Pathologists
Pathology: the science behind the cure

Best practice recommendations

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

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Contents

Foreword

Best practice recommendations (BPRs) published by the Royal College of Pathologists should assist pathologists in providing a high standard of care for the deceased. BPRs are systematically developed statements intended to assist the decisions and approach of practitioners and patients about appropriate actions for specific clinical circumstances. They are based on the best available evidence at the time the document was prepared. It may be necessary or even desirable to depart from the advice in the interests of specific patients and special circumstances. The clinical risk of departing from the BPR should be assessed and documented.

A formal revision cycle for all BPRs takes place every 5 years. The College will ask the authors of the BPR to consider whether the recommendations need to be revised. A review may be required sooner if new developments arise or changes in practice necessitate an update. A full consultation process will be undertaken if major revisions are required. If minor revisions or changes are required, a short note of the proposed changes will be placed on the College website for 2 weeks for members' attention. If members do not object to the changes, a short notice of change will be incorporated into the document and the full revised version will replace the previous version on the College website.

This BPR has been reviewed by the Professional Guidelines team. It was placed on the College website for consultation with the membership from 22 October to 19 November 2024. All comments received from the membership were addressed by the authors to the satisfaction of the Clinical Director of Quality and Safety.

This BPR was developed without external funding to the writing group. The College requires the authors of BPRs to provide a list of potential conflicts of interest. These are monitored by the College's Professional Guidelines team and are available on request. The authors of this document have declared that there are no conflicts of interest.

1 Introduction

1.1 Scope and purpose

These guidelines apply to the conduct of a post-mortem examination performed under the authority of a Coroner or Procurator Fiscal, 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 or Procurator Fiscal, 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 pathologist during each step in the process of the pathological investigation of a death that has been reported to the Coroner or Procurator Fiscal but that appears not to be attended by suspicious circumstances. It spans from the initial authorisation from the Coroner's or Procurator Fiscal's Office to the pathologist, to attendance at the inquest or fatal accident inquiry.

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, are congruent with relevant legal and regulatory codes, and provide a framework against which clinical audits and performance reviews of pathologists can be set. The standards specified can be used to assure the quality of performance of individual pathologists as well as facilitate the collection of evidence for the revalidation process.

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

1.2 General standards

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

A 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, be on the GMC specialist register, and have experience in autopsy pathology.

The pathologist's primary duty is to the legal authority instructing the autopsy (Coroner or Procurator Fiscal) and they must not act in any way that fails to acknowledge that duty.

A pathologist must understand and work within the legal framework in which authority to perform a post-mortem examination is given. In England and Wales this is under the Coroners (Investigations) Regulations 2013. In Scotland this is under the common law and as recognised in s48(5) of the Scotland Act 1998. In Northern Ireland this is under the Coroners Act (Northern Ireland) 1959.[2–4]

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

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/Procurator Fiscal 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/Procurators Fiscal, but advises that it refers to these standards.

The College recognises that a pathologist may have to perform post-mortem examinations within mortuaries where they have no formal contract of employment with the providers. In England, Wales and Northern Ireland, the Human Tissue Authority (HTA) licenses mortuaries and provides codes of practice to adhere to. The pathologist should be satisfied that the mortuaries in which they work are licensed under the oversight of the HTA and meets standards specified in its published codes of practice.[5] If a pathologist is not satisfied with any aspect of a mortuary, they 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 HTA. In Scotland any concerns regarding mortuary facilities should be raised with the mortuary management.

A pathologist should not work in isolation from colleagues, either within the discipline of pathology or other clinical disciplines. It is important that pathologists regularly consult and discuss their cases with colleagues. There should be a process for auditing standards of practice in place. It is good practice for complex cases to be subjected to discussion or peer review before a final report is issued.

2 Methods

This best practice recommendation was devised and revised, drawing on the expertise of experienced autopsy pathologists across the UK.

3 Recommendations

3.1 Before the post-mortem examination

Upon receipt of authority from a Coroner or Procurator Fiscal to conduct a post-mortem examination, the pathologist should examine the information passed from the Coroner's/Procurator Fiscal'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/Procurator Fiscal to seek a more appropriate mortuary
- whether, where the death has occurred in the pathologist's own hospital, it is appropriate that they make the post-mortem examination and, if not, to advise the Coroner/Procurator Fiscal. Such a decision must take due account of any potential conflicts of interest which should be disclosed to the Coroner/Procurator Fiscal
- whether they have the appropriate expertise to make the post-mortem examination and, if not, to advise the Coroner/Procurator Fiscal 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/Procurator Fiscal to seek agreement
- what published guidelines may be applicable to the case, e.g. RCPath Autopsy guidelines series
- if, in advance of any post-mortem examination, discussion with the Coroner/Procurator Fiscal indicates to the pathologist that the Coroner/Procurator Fiscal 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. In most training departments there is generic approval from the Coroner/Procurator Fiscal to support such training

- the role of the anatomical pathology technologist (APT). It is standard practice for an APT to perform an evisceration after discussing the case with the pathologist and an external examination by the pathologist. In complex cases the pathologist will discuss the role of the APT.[6]

In some circumstances, a pathologist may be asked to be involved in a post-mortem examination that is linked to a post-mortem investigation using imaging. The guidance from the College in respect of imaging should be followed.[7]

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

Where the pathologist is unwilling to make the post-mortem examination, the pathologist must be under no pressure to make the examination. They should advise the Coroner/Procurator Fiscal 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/Procurator Fiscal 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. In England and Wales, Medical Examiner (ME) scrutiny of the death may provide a useful summary. However, the pathologist should make their own study and interpretation of the clinical notes from treating clinicians and other healthcare professionals. If such case notes are not readily available, the pathologist or Coroner/Procurator Fiscal 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/Procurator Fiscal 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/Procurator Fiscal 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.

If a discussion has been had with a clinician or Coroner/Procurator Fiscal, the fact of the discussion should be recorded in the autopsy report. The content of the discussion should be included where relevant, at the discretion of the pathologist.

3.2 The post-mortem examination

The pathologist should:

- work to the standards specified in the codes of practice from the HTA so far as they apply to a Coroner's post-mortem examination[5]
- make themself 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/Procurator Fiscal, 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 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, as far as is possible, that the dignity of the deceased, and ethical issues relating to that deceased and their family, are accommodated
- be aware that "there must be an ever-present readiness to keep in mind the possibility that death might not have been natural".[8] 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, giving due regard to the later reconstruction and viewing of the deceased, which reflects standards contained in relevant and current guidance issued by the College

- be able to justify all examinations (or the omission of any part of an examination), considering the context of the case. The extent of the examination made should ensure that the cause of death is reliably established
- be available promptly to provide advice or assistance, or to take over the conduct of the post-mortem examination, in cases where any part of the examination or evisceration has been delegated to a trainee pathologist or APT
- 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 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. This prevents any interference from the examination hindering others from assessing the significance of the initial findings. 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 and GMC guidance on medical photography[9]
- recommend and seek agreement from the Coroner/Procurator Fiscal to retain material that is relevant to the cause of death and/or that may assist in the resolution of foreseeable issues that may arise during the investigation of the death, including those that can be anticipated at inquest or fatal accident enquiry. This is a matter for clinical judgment and includes the retention of material for future genetic testing where a familial condition is suspected (which is lawful under the Coroner's obligations for prevention of future deaths, provided appropriate consent is given for onward retention, see section 3.7)
- 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 their concerns known to the Coroner/Procurator Fiscal.

3.3 Preliminary report

The pathologist should:

- liaise with the Coroner, Coroner's officer or Procurator Fiscal, either in person or by telephone or secure email:
  - to relate the major findings of the post-mortem examination, including the anatomic cause of death where available
  - 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 the Coroner or Procurator Fiscal of any issues that appear to be raised by the death that would be addressed better by other clinicians or experts
- provide information to the Coroner/Procurator Fiscal 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/Procurator Fiscal
- provide a 'freedom from infection' letter as required.

3.4 Further investigations

The pathologist should:

- ensure that processes are in place for the proper preservation and safe transport of any item retained, or processed, by the pathologist, and that this conforms with systems set out in any management or contract agreement drawn up between the Coroner/Procurator Fiscal 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/Procurator Fiscal
- ensure that there is proper preservation of material submitted to another expert and that full information regarding the findings at post-mortem examination, and any other information required, is made available to that expert

- ideally ensure that the processing of all material is performed in a laboratory with United Kingdom Accreditation Service (UKAS) accreditation, or equivalent standards.

3.5 Production of report

The pathologist should:

- produce a formal report that will detail:
  - the source(s) of information the pathologist received or reviewed in advance of the post-mortem. While some authorities do not allow such information to be transcribed directly into the report, the sources used should still be cited and at least a summary of such information included in the report
  - a description of the macroscopic findings
  - 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 them, detailing all material referenced, such as 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 conclusions should be written in plain language, or with medical terminology explained for a non-medical reader
  - the reasoning underlying why, where findings are open to alternative explanations, 1 explanation is favoured
- highlight any issues regarding clinical treatment or care identified by the post-mortem examination for the Coroner/Procurator Fiscal to consider for further investigation
- ensure that the detail within any report reflects standards and datasets contained in relevant College guidance
- advise the Coroner/Procurator Fiscal, 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 and other subsequent investigations do not allow it
- 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 death[8]
- produce the report as quickly as is possible with regard to the complexity of the case, without any unreasonable delay. The format of the report should be part of a formal agreement between a Coroner/Procurator Fiscal and the pathologist. A specification for the expected general turnaround time for production of reports may be part of a formal agreement between a Coroner/Procurator Fiscal and the pathologist
- communicate any significant delays anticipated in the production of a report to the Coroner/Procurator Fiscal so that the family and any interested persons may be informed
- produce a supplementary report incorporating additional information impacting the reliability of the original cause of death, if this is revealed after the provision of a report, and drawing further conclusions.

The post-mortem report belongs to the instructing authority (Coroner or Procurator Fiscal), and a copy of the report should only be issued to others with the explicit consent of the Coroner or Procurator Fiscal (for example to the GP, hospital clinicians, or inherited cardiac conditions team).

3.6 Attendance at court

The requirement for a pathologist to attend court for an inquest (in England, Wales or Northern Ireland) or Fatal Accident Inquiry (FAI) (in Scotland) is variable according to local practices of the legal authority.

In Scotland the vast majority of non-suspicious deaths do not require any court attendance. The pathologist may be required to attend a Sheriff's Court, Crown Court or the Court of Sessions in cases with a medico-legal aspect such as road traffic deaths, industrial disease, or health and safety. FAIs can be mandatory or discretionary,[10] and the pathologist may be called to give evidence.

The pathologist should:

- ensure that the Coroner or Procurator Fiscal has been made aware in advance of what evidence the pathologist feels they must hear, in order to give an accurate formulation of cause of death
- ensure that they are 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 their appearance and behaviour conform to acceptable professional standards
- deliver evidence in an audible and understandable manner, being mindful that the majority of people in court are not medically trained
- 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 their field of expertise
- consider additional information or alternative hypotheses that are presented and, where warranted, modify conclusions already drawn
- clarify the strength of any additional conclusions and specify what further information or investigations will be required to modify that conclusion further
- be prepared to stay in court to hear further relevant evidence
- ensure that the Coroner/Procurator Fiscal is made aware of any misunderstanding or misstatements by the Coroner/Procurator Fiscal or any legal representative
- ensure that the Coroner/Procurator Fiscal is made aware of any material that was previously deemed irrelevant but is now considered relevant, or where there has been a change in the relevance of findings
- never lose sight of the principle that the pathologist’s overriding duty is to the Coroner/Procurator Fiscal and not to any particular interested person.

3.7 Disposal or retention of retained material on completion of the Coroner's/Procurator Fiscal's involvement

In England, Wales and Northern Ireland, 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.[5] Where no wish is expressed, the pathologist should assure themselves that the processes are in place to ensure that material is disposed of according to procedures specified in the licensed premises in which the material is held.[5]

In Scotland any retained material becomes part of the deceased's medical record[11] and should be retained securely according to procedures specified in the premises in which the material is held.

4 References

1. General Medical Council. *Good Medical Practice.* Accessed November 2024. Available at: https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/good-medical-practice
2. HM Goverment. *The Coroners (Investigations) Regulations 2013.* Accessed November 2024. Available at: https://www.legislation.gov.uk/uksi/2013/1629/made
3. HM Goverment. *Scotland Act 1998.* Accessed November 2024. Available at: https://www.legislation.gov.uk/ukpga/1998/46/section/48#:~:text=(5)Any%20decision%20of%20the,independently%20of%20any%20other%20person
4. HM Goverment. *Coroners Act (Northern Ireland) 1959.* Accessed November 2024. Available at: https://www.legislation.gov.uk/ukpga/1998/46/section/48#:~:text=(5)Any%20decision%20of%20the,independently%20of%20any%20other%20person
5. Human Tissue Authority. *Code of Practice – Code B: Post-motem examination.* Accessed November 2024. Available at: https://www.hta.gov.uk/guidance-professionals/codes-practice-standards-and-legislation/codes-practice
6. Association of Anatomical Pathology Technology. *Practical Autopsy Standards for Anatomical Pathology Technologists.* Accessed November 2024. Available at: https://www.aaptuk.org/downloads/Practical_Autopsy_Standards_for_Anatomical_Pathology_Technologists_(2).pdf
7. The Royal College of Pathologists. *Guidelines for post-mortem cross-sectional imaging in adults for non-forensic deaths.* Accessed November 2024. Available at: https://www.rcpath.org/profession/guidelines/autopsy-guidelines-series.html
8. The Shipman Inquiry. *Death Certification and the Investigation of Deaths by Coroners.* Accessed November 2024. Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/273227/5854.pdf
9. General Medical Council. *Making and using visual and audio recordings of patients.* Accessed November 2024. Available at: https://www.gmc-uk.org/professional-standards/professional-standards-for-doctors/making-and-using-visual-and-audio-recordings-of-patients
10. HM Goverment. *Inquiries into Fatal Accidents and Sudden Deaths etc. (Scotland) Act 2016.* Accessed November 2024. Available at: https://www.legislation.gov.uk/asp/2016/2/contents/enacted
11. HM Goverment. *Human Tissue Act (Scotland) 2006.* Accessed November 2024. Available at: https://www.legislation.gov.uk/asp/2006/4/contents