The Royal College of Pathologists' response to the Justice Committee inquiry into the Coroner Service: follow up

9 January 2024

- ## What progress has been made towards the goal of placing bereaved families at the heart of the Coroner Service?

The College thinks the Ministry of Justice has missed an opportunity to invest in and reform the Coroner Service by not accepting key recommendations from the Justice Committee in 2021. In particular, the introduction of a National Coroners Service would provide a consistent and high-quality service in England and Wales. Bereaved families will continue to experience a service that is fragmented, disjointed and inconsistent in its standards and delivery. It is vital that post mortem services, and the accurate investigation and certification of death, are seen as part of the wider patient safety landscape.

The College would welcome the introduction of service similar to the NHS Patient Advice and Liaison Service (PALS) or a charter to set out rights and responsibilities so that patients, relatives and coroners know what is expected of them, and what services should be delivered.

NHS bereavement services and the coronial services often are quite disparate. Pathologists have told us, from experience, that the coroner's office doesn't necessarily liaise with the bereavement office particularly effectively and consequently the information does not always get through to the pathologist in a timely manner.

There is a significant shortage of pathologists to carry out coronial post mortems which has a direct impact on the bereaved. This deficit has several causes. Coronial post mortems fall outside of consultants' hospital trust contracts and are rarely included in consultants' job plans. This means that pathologists have to schedule post mortems outside of their NHS work. Poor remuneration for pathologists conducting autopsies contributes significantly to the shortage of pathologists and there needs to be an increase in Coroner Service fees for pathologists to better reflect the cost of performing post mortem services. The shortage of pathologists to carry out post mortem examinations has a direct effect on services for the bereaved who are left to struggle in a flawed system.

Bereaved relatives who have contacted the College have reported that coroners and coroners' officers can be difficult to reach via telephone, with offices often only open part time. They also reported widespread use of voicemail or email-only contact.

- **What progress has been made by the Government in implementing those of the Committee's earlier recommendations which it accepted in September 2021.?**

The revival of the consultation on coronial investigation of stillbirths and publication of proposals for reform was accepted by the government. The College is disappointed that there is no proposal for reform and action, but rather a factual summary of responses received.

With wider post mortem services, there is a desire, in line with the Hutton report, to form a number of specialised centres of excellence for carrying out post mortem work which follows established good practice and policy in a number of other countries (e.g., Australia) where the policy has been remarkably successful. In some areas, for example Sheffield, there have been some conversations with the Coroner about moving towards a specialised centre of excellence but progress is slow.

There has not been progress towards a National Coroners Service, which was a key recommendation from the Justice Committee, and which the College supports.

Bringing the post mortem work into pathologists' job plans was accepted and discussed but there has not been any progress as far as our pathologist members have reported.

- **What progress has been made by the Government in responding to those of the Committee's recommendations which it was unable to address in September 2021?**

The Coronial service is fragmented with great unevenness and varying levels of delivery of service to bereaved families. The Government's response to the report provides no reassurance that these major flaws in the system will be addressed.

The refusal to publish the 2015 post-implementation review on the basis that it would have been is insufficient reason not to publish. The system suffers from the same problems today that it did in 2009 with very little change seen on the ground.

Where recommendations have been responded to as "requiring further work", no timescale has been included. Some of these changes require urgent implementation and this failure to provide any indication of the likely time to action leaves the service in limbo.

The current remuneration structure for coronial post mortem practice is unsustainable in terms of maintaining the necessary level of service when trying to balance NHS and coronial work. The standard fees paid for coronial post mortems are far too low to attract pathologists to do the work, do not reflect the complexity of the work involved and have not been raised in any significant way for over two decades.

We acknowledge that there is some work in the form of a government consultation taking place at the at the moment on pathologists' fees, but we still think that this is an important issue to raise. The fee structure needs to change significantly to address the issue of

difficulties in recruiting and retaining pathologists to do post mortems. The subsequent problems such as delays to the families need to be resolved.

Evidence of the inadequacy of the fee structure is in the sheer variety of case fees that pathologists are being paid across the country. Pathologists have told us that some areas are willing to pay up to seven times the case fee in comparison to other areas.

- **Given that the Government has rejected the Committee's recommendation to unite local coroner services into a single service, what more can be done to reduce regional variation and ensure that a consistent service operates across England and Wales?**

The College supports the introduction of a National Coroners Service to help ensure consistency across England and Wales through a single, reliable system. There is great unevenness in the coronial service, with independent coroners providing varying levels of service to the bereaved and their families. At the least, there is a need for a clear code of practice for coroners. The Chief Coroner should have the necessary powers and authority to set and enforce agreed standards in all coronial jurisdictions.

Due to the current lack of clarity over the purpose of the coronial service, there is no consistency in the level of reporting that is required of a pathologist, or what tests (such as toxicology) are asked for. This depends entirely on what is set out by the individual coroner and depends on their interpretation of what the purpose of their service is.

The College would be happy to work with the Chief Coroner and other stakeholders to develop national standards. The standards would need to be realistic and reflect the currently available levels of support and funding.

Improvements are needed in the service provided for the bereaved and in the quality of communications with relatives of the deceased. There are huge discrepancies in fees, governance, quality of information, level of questions being answered and quality of post mortem examinations. A National Coroners Service, coupled with a national post mortem service, would go a long way to addressing these points.

- **Whether more can be done to make best use of the Coroner Service's role in learning lessons and preventing future deaths. In particular (a) are Coroners across England and Wales making consistent use of their power to issue PFD reports? And (b) could the way PFD reports are being used to help prevent future deaths be improved?**

There is a much greater need to systematically collect, analyse and record data obtained from post mortems regionally and nationally so that trends and patterns can be identified both in hospital deaths and community deaths.

The College would advocate that a national approach to investigating deaths in future pandemics be adopted. This would address the public health interest to learn about the pathological effects of similar infectious diseases to help prevent future deaths and help treat the living.

- **How Coroners respond to the requirements of faith burials and funerary practices, especially in relation to early release of bodies and provision of non-invasive autopsies. Could more be done to ensure a consistent and satisfactory approach across England and Wales?**

Pathologists tell us that the approach of coroners may vary depending on the religion or culture of the bereaved person or their relatives, particularly where this relates to the prompt burial of the body. Concerns were raised by pathologists that the thoroughness of coronial investigations might be influenced by such factors.

There needs to be a consistent and satisfactory approach to provision of non-invasive autopsies across England and Wales which does not exist at the moment. The College has produced guidelines for post mortem cross-sectional imaging in adults for non-forensic deaths in conjunction with the Royal College of Radiologists about post mortem imaging. The College recommends that these guidelines on cross sectional imaging should be distributed by the Chief Coroner to the coroner service.

Post mortem CT scanning is still only available in a very small number of centres in the UK and people with experience and expertise in of interpreting those are therefore still limited as well. Families are not getting a fair and consistent approach when it comes to the availability of such services.

- **Whether there is evidence that inquests are taking too long to be completed, and if so why, and what can be done in response.**

A pathologist told us that one of the delays incurred in their region for completing the post mortem report and giving a final cause of death, was in delays of toxicology results as the toxicology service is very busy and they have struggled with capacity in the past. This is replicated across other regions as well with insufficient resources in areas like toxicology delaying completion of the report.

There is great variation across England and Wales coroner's areas regarding the requirement of pathologists to attend inquests. There has been a downward trend, particularly since the pandemic, with some pathologist now only rarely or never called to inquest. Whilst the reduced burden on pathologists is welcomed, pathologists can offer useful input at inquest for families and coroners.

The backlog of inquests may have been a driver for the communication breakdowns. The

College believes that having pathologists at an inquest can be helpful to the family in providing information.

Coroner's office staffing often seems to be a driver for delays. Members report issues with inadequate staffing and failure to retain staff; it seems that the job description for a Coroner's Officer has changed significantly away from an investigative role to a largely administrative one.

- **Whether the Coroners' Service has recovered from the challenges of the Covid-19 pandemic, and what lessons can be drawn from it.**

The College would advocate that a national approach to investigating deaths in future pandemics be adopted. This would address the public health interest to learn about the pathological effects of similar infectious diseases to help prevent future deaths and help treat the living.

The levels of delays are better than a year ago and certainly two years ago and the extreme challenges posed by COVID-19 have eased. However, COVID-19 highlighted issues in the system and encouraged the adoption of strict guidelines and parameters which have slipped since the end of the pandemic.

We need to know how to manage national pandemics better than we did. Pathologists had to manage large numbers of deceased people and need to have capacity for that if required.

The College has concerns that a nationally co-ordinated approach to the pathological investigation and analysis of the COVID-19 outbreak was severely lacking. Great reliance has been placed on the clinical cause of death. Studies worldwide have repeatedly shown that, when a post mortem examination is carried out, major discrepancies are identified between the certified clinical cause of death and the cause of death determined at post mortem examination.[1] One manifestation of this is that a clinical cause of death may fail to determine the difference between someone dying *with* COVID-19 and someone dying *of* it.

- **Whether there are any other changes to the way the Coroner Service operates that could be made to improve its effectiveness.**

Histopathologists, who are central to cancer diagnosis and treatment, are also the pathologists who carry out the majority of coronial post mortems. They are now faced with a diagnostic backlog but were already severely stretched prior to the pandemic. The College workforce survey published in 2018 showed only 3% of histopathology departments across the UK have adequate staff. According to latest College figures, there is a deficit of 580 consultant histopathology posts nationally.

One member of the Royal College of Pathologists told the College: *"We are an 8-consultant whole-time equivalent (WTE) department that's trying to make do with 3.8 WTE consultants. We're all exhausted ... Demand is higher than ever and there are complaints every week*

from various departments about how long it's taking to clear red flag cases. We send as much work out as possible but it's still not enough to stay afloat and we're about to drop down to 2.8 WTE consultants in a couple of months. I feel burnt out and I can't see it changing any time soon. I am seriously considering leaving the NHS."

Due to the lack of capacity of consultants to provide training it is a struggle to ensure the next generation of trainees have adequate training and support. There is a risk of a knowledge gap as the most senior pathologists come up to retirement. Training and investment in the future is essential in a service that is recognised as facing some difficulties.

The Chief Coroner has focused on training for coroners and coroners' officers. There needs to be strong leadership and job plans for coroners with the usual opportunities for training and development that are the norm in other professions. For example, continuing professional development, revalidation, case review, quality assurance and annual appraisals. The role of the Chief Coroner needs to be strengthened so that they have authority over all senior coroners and their staff to ensure such professional governance measures are followed nationally.

Many pathologists have commented that the need for coroners to come from a legal (rather than a medical) background has left a gap in coroners' medical understanding of cases. The focus on the requirement for legal qualifications is very appropriate, bearing in mind the way inquests are run and the legal nuances involved, however it should be acknowledged that there are gaps around medical knowledge and a solution to this should be sought.

The College suggests that a medical diploma/basic medical training for coroners should be introduced to fill this gap, or that there is independent medical advice available to the coroner. It may also support the service to have a named pathologist on call (with appropriate remuneration) for the coroner, to make communication easier and to allow clarification of any medical issues unfamiliar to the coroner. A national post mortem service would facilitate this.

The College does not think there can be fairness in the Coroners Service without equity of access to services. The service needs to be truly national. This will only happen when the role of the Chief Coroner is strengthened to ensure true oversight of and authority over the national coronial service.

References

[1] Roulson J, Benbow EW, Hasleton PS. Discrepancies between clinical and autopsy diagnosis and the value of post mortem histology; a meta-analysis and review. *Histopathology*. 2005 Dec;47(6):551-9

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About the Royal College of Pathologists

The Royal College of Pathologists is a professional membership organisation with more than 11,000 fellows, affiliates and trainees, of which 23% are based outside of the UK. We are committed to setting and maintaining professional standards and promoting excellence in the teaching and practice of pathology, for the benefit of patients.

Our members include medically and veterinary qualified pathologists and clinical scientists in
17 different specialties, including cellular pathology, haematology, clinical biochemistry, medical microbiology and veterinary pathology.

The College works with pathologists at every stage of their career. We set curricula, organise training and run exams, publish clinical guidelines and best practice recommendations and
provide continuing professional development. We engage a wide range of stakeholders to improve awareness and understanding of pathology and the vital role it plays in everybody’s healthcare. Working with members, we run programmes to inspire the next generation to study science and join the profession.