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

RCPath response to Justice Committee inquiry into the Coroner Service

2 September 2020

Introduction

The College welcomes the opportunity to respond to this inquiry. There is still a need to enact many of the recommendations made in the proposals made by the Coroner reform: improving death investigation in England and Wales, 2006 policy paper and the later Hutton Review of Forensic Pathology in England and Wales (published November 2015), which found that the coronial post-mortem service was in 'considerable difficulty'. In our response to the Hutton review, the College called for the development of a national death investigation service.

In addition, there needs to be clarity over the purpose of the coronial service – is it here to differentiate between natural and unnatural deaths, or to discover the precise cause of death? To provide the definitive cause of death, or a cause of death? These questions are fundamental to how the service is run and the level of funding required. Without these questions being answered, the service will always struggle with levels of expectation exceeding what can be delivered.

The College recommends the following three key actions:

- Clear ministerial oversight of the coronial service.
- Stronger governance powers for the Chief Coroner over the service and senior and deputy coroners – consideration should be given as to whether the Chief Coroner should be given responsibility/accountability for the quality of coronial post-mortems examinations. This would, however, require the Chief Coroner to have financial control over the service otherwise there would be a shortfall between expectations of the service and the service provision possible to deliver at the funding level provided.
- The introduction of a National Coroners Service to provide a consistent high-quality service and equity of access across England and Wales.

1. The extent of unevenness of coroners services, including local failures, and the case for a National Coroners Service

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.

There is wide variation in the coronial service across England and Wales. For example, in Lincolnshire, there is no pathology provision, so bodies need to be transported to Nottingham for a post mortem to be carried out. In other jurisdictions, pathologists travel long distances to conduct post mortems. This can lead to delays in the post mortem being completed and affect the condition of the body. These issues can only add to the distress of relatives.

Pathologists have reported to us that they are often discouraged, by coroners, from further investigation beyond the initial post mortem, for example, taking samples of tissue to examine under the microscope (histology) or for further analysis by toxicology. These investigations can be crucial in determining the precise pathological cause of death and such restrictions can lead to pathologists feeling they are prevented from providing a professional service. There is a risk that pathologists will stop carrying out this work as they feel they are unable to fulfil their professional duties as a doctor.

A particular area of concern is centred on the use of unregulated post-mortem cross-sectional imaging (also known as post-mortem computed tomography [PMCT]). There is limited availability of this service, and a lack of clarity over who provides the service, who has access to it, and how it is paid for. In some cases, the body and/or the scan are not reviewed and/or interpreted with direct input from a pathologist. This increases the likelihood of suspicious deaths being missed or incorrect causes of death being provided. Information from imaging is limited and may not identify common causes of death. For example, a scan would not identify plaque rupture in an artery, which is a significant cause of heart attack.

There is also a significant discrepancy in the national rates of post-mortem cross-sectional imaging. For example, in Lancashire, all non-forensic post mortems are carried out by scans, with a reported 92% success rate in providing a cause of death. The College would like to see data to support this figure, which seems surprisingly high.

While PMCT (post-mortem cross sectional imaging) may remove the need for a traditional autopsy examination in up to 70% of deaths coming to coronial autopsy if ancillary testing such as angiography are available, in the remaining 30% of deaths some degree of traditional internal examination of the body is required. This figure is far higher if such ancillary tests, which themselves are invasive to a degree, are not available, which is the case in many areas of England and Wales[1,2]

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 is a significant shortage of pathologists to carry out coronial post mortems. 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. As pressures on the health service mount, the College has heard from members that NHS employers are less willing to support those pathologists who wish to provide a post-mortem service.

In response to the COVID-19 pandemic, cancer screening has been suspended, routine diagnostic work deferred and only urgent symptomatic cases prioritised for diagnostic intervention. Histopathologists, who are central to cancer diagnosis and treatment, are also the pathologists who carry out the majority of coronial post mortems. They will now be faced with this 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. [3] According to latest College figures, there is a deficit of 580 consultant histopathology posts nationally.

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. Given the lack of pathologists, some jurisdictions have opted to pay higher rates per case, leading to a variation in fees paid for post mortems. This has also contributed to discrepancies in the availability of the service between regions.

A short-term option to increase the number of autopsy-trained pathologists available would be to make post-mortem work part of pathologists' NHS contract or to significantly raise the fee paid for each post mortem. Some pathologists think that both of these measures are necessary.

2. The Coroners Service's capacity to deal properly with multiple deaths in public disasters

The College's members report that most local authorities have clear mass disaster plans and implement them well. In the case of the deaths of 39 Vietnamese migrants whose bodies were found in a lorry in Essex in October 2019, there was a thorough investigation and advice was acted on.

There were an estimated 1,870 road deaths in Great Britain in the year ending June 2019 (Department of Transport, Reported road casualties in Great Britain: provisional estimates year ending June 2019). Pathologists tell us there is huge variation between jurisdictions in the way road traffic deaths are investigated. In some areas, all are dealt with as routine coronial cases,

while in others they are conducted as forensic cases and the post mortems are performed by forensic pathologists on the Home Office Register. Further clarification on how these cases should be investigated is imperative, particularly as many such cases can now result in severe criminal charges. It is often not evident that such criminal charges will follow at the time that the autopsy is requested.

One area that needs closer attention is the investigation of hospital deaths. There needs to be defined oversight of hospital deaths to look for and identify patterns of deaths. This does not exist within the present system and would help reduce the risk of future serious care failings, such as those at Mid Staffordshire NHS Foundation Trust. Within this topic there is a major role for medical examiners, both in improving the accuracy of the certified cause of death and in identifying cases that need to be referred to the coroner. However, oversight of coronial cases from institutions is needed to ensure patterns are not missed.

3. Ways to strengthen the coroners' role in the prevention of avoidable future deaths

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.

Again, there is a role here for medical examiners to refer avoidable deaths to the coroner, but these cases need to be collated and examined nationally, with data reviewed by the NHS.

4. How the Coroners Service has dealt with COVID-19

The College has concerns that a nationally co-ordinated approach to the pathological investigation and analysis of the COVID-19 outbreak has been 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.[4] 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.

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 Committee may be interested to know that the College has established a database of information about deaths related to COVID-19. Using data extracted from anonymised post-mortem reports, from the small number of COVID-19 post-mortem examinations that have been done, the College's aim is to help inform the treatment of patients and support research to help develop new treatments. This initiative has the support of the Chief Coroner and the Coroners' Society of England and Wales.

The College will be able to comment more fully on how the Coroners Service has dealt with COVID-19 when further data is available.

5. Progress with training and guidance for coroners

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 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.

6. Improvements in services for the bereaved

Shortages in pathologists to carry out post-mortem examinations have a direct effect on services for the bereaved and their relatives. The current shortage of pathologists, particularly in respect of coronial autopsies, is of great concern. 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.

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, as well as widespread use of voicemail or email-only contact.

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.

The introduction of medical examiners has started to provide an opportunity for relatives to ask questions about the medical circumstances and cause of death and to raise any concerns they may have – this should be welcomed. Medical examiners should be further rolled out into the community as soon as possible to help improve the accuracy of death certification and help mitigate against avoidable deaths and poor practice.

7. Fairness in the Coroners system

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. Issues of regional variation in funding and remuneration for post mortems also need to be addressed.

Better communication with the Coroners Service is vital to improve fairness. There is also social disparity between people who are able to navigate the process of death investigation and understand the legal system, and those who can't.

References

[1] Roberts IS, Traill ZC. Minimally invasive autopsy employing post-mortem CT and targeted coronary angiography: evaluation of its application to a routine coronial service. *Histopathology*. 2014;64:211–217.
[2] Rutty GN, Morgan B, Robinson C, Raj V, Pakkal M, Amoroso J, et al. Diagnostic accuracy of post-mortem CT with targeted coronary angiography versus autopsy for coroner-requested post-mortem investigations: prospective, masked, comparison study. *Lancet*. 2017;390:145–154.
[3] The Royal College of Pathologists. *Meeting pathology demand: histopathology workforce census*. 2018. www.rcpath.org/profession/workforce-planning/our-workforce-research/histopathology-workforce-survey-2018.html
[4] 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

Spoken evidence session in parliament

Dr Mike Osborn, RCPath President-Elect and Chair of the Death Investigations Committee, gave spoken evidence on the Coroner system to the Justice Committee on 8 September 2020. The session can be watched here:
https://parliamentlive.tv/event/index/77c00429-81ca-413b-a0ea-199ce3be3098

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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.