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

The Royal College of Pathologists' response to the Chief Coroner's Annual Report 2016-2017

Introduction

The Royal College of Pathologists welcomes the Annual Report of the Chief Coroner, His Honour Judge Mark Lucraft QC.

The shortage of pathologists highlighted in the report, particularly in respect of coronial autopsies, is of great concern. We welcome the Chief Coroner's call for a national service. It is vital that post-mortem services are seen as part of the wider patient safety landscape - the accurate investigation and certification of death underpins the delivery of health services for the living and should be part of the NHS's core business.

The College has pressed for the introduction of medical examiners, and the announcement regarding their introduction from 2019 is a significant step forward.

The report helpfully addresses some of the tensions in the funding and funding structures which underlie some of the problems in recruiting pathologists to assist coroners, and we look forward to progress in this area. We will continue to work constructively with the Chief Coroner's Office, through our regular meetings and their representation on our Death Investigation Group.

The coroner service

The College supports the Chief Coroner's call for a national service that would be funded and run centrally. A national service would help ensure consistency across England and Wales, particularly regarding which tests are carried out to help determine the cause of death. It would also be beneficial to fund centrally the payments to pathologists who conduct post-mortems.

Training

The College welcomes the Chief Coroner's focus on training for coroners and coroners' officers. The College is currently undertaking a major programme to update its autopsy scenarios to provide guidelines as an aid for practising pathologists carrying out coronial post-mortems. The guidelines aim to set a standard at the level that would be expected of a consultant pathologist conducting a routine coronial non-forensic post-mortem on a non-suspicious death. The level of this guidance takes into account the facilities, funding and logistical support currently available generally within the coronial post-mortem service.

In 2016 we published *Sudden unexpected death in infancy and childhood: Multi-agency guidelines for care and investigation*. These guidelines were produced with contributions from all professional groups involved in the investigation of sudden unexpected death in infancy and childhood, and are based on the best current international research.

Medical examiners
The first Chief Coroner welcomed the proposed introduction of medical examiners and we are pleased the Chief Coroner thinks that the investigation of deaths in England and Wales will be greatly enhanced by the proper implementation of the medical examiner (ME) system.

The College was pleased by Lord O'Shaughnessy's announcement in October that a national system of independent MEs would be introduced from April 2019. We think the proposed phased approach will allow the many agencies involved to prepare and is a pragmatic solution to a complex scheme. It is important that the second phase follows quickly to ensure that the benefits of the ME network are applied in all healthcare settings.

As the lead college for MEs, we have long campaigned for their introduction and very much see the implementation as a key patient safety initiative which should foster a culture of openness. We valued the support of the Chief Coroner's Office and individual coroners in this process, particularly the contribution to our roundtable with leading representatives of patient groups, charities, local and central government, and health services which considered:

- Where this vital initiative sits within the overall patient safety landscape.
- How improved death certification could better inform public health planning.
- The practicalities of implementation to ensure that this initiative reaches its full potential.

MEs will be ideally placed to identify trends relating to deaths and highlight areas for further investigation, giving relatives the answers they deserve and improving care for future patients. Pilot studies have demonstrated that MEs ensure that death certificates are accurate, cases are referred appropriately to the coroner and, most importantly, that bereaved relatives have the opportunity to ask questions and raise any concerns they may have.

The College is represented on the Department of Health Medical Examiners Strategic Programme Board and is now focusing on supporting MEs in terms of training, continuing development and the creation of a professional membership community. We are keen to work with the Chief Coroner's Office on preparation and training for the ME system.

Post-mortem imaging
The College supports the Chief Coroner in his call to encourage the availability of post-mortem imaging. Evidence shows that post-mortem imaging, in conjunction with other non-invasive tests, can provide a cause of death in approximately three-quarters of adult deaths, and may allow a more limited standard autopsy in the remaining cases.

Reporting deaths to the coroner
We share the concern of the Chief Coroner about the lack of statutory or other clear criteria for medical practitioners reporting deaths to coroners. This has created uncertainty and inconsistency.

While we expect this situation to be improved by the introduction of a national system of MEs, we would welcome clear national guidance on when a death should be reported to a coroner.

Stillbirths
We agree with the Chief Coroner that consideration should be given as to whether stillbirths/near-term deaths should be reportable cases. The College thinks that the Secretary of State for Health's announcement in November that cases of stillbirth should be independently investigated is an important step in helping parents get answers and in enabling the NHS to learn where things may be done differently.

Longer term, we think that all cases of stillbirth should initially be reported to an ME for review; the ME would then decide which cases should be referred to the coroner for further investigation.

Pathology services
The College shares the Chief Coroner's concern about availability of pathologists to carry out post-mortems and deeply regrets the delays caused by insufficient pathologists available to do post-mortems. These concerns were also raised by Professor Peter Hutton in his *Review of forensic pathology in England and Wales* (March 2015) which found that forensic pathology services are of a high standard, but there were significant problems within the coronial post-mortem service and acknowledged that both forensic and coronial post-mortem services needed urgent attention.

There are several causes of this deficit. Members tell us that a significant reason is inadequate funding.

Coronial post-mortems fall outside of consultants' hospital trust contracts and are rarely included in consultants' job plans. This means pathologists have to schedule post-mortems outside of their NHS work. As pressures on the health service mount, we have heard from members that trusts are less willing to support those pathologists who wish to provide a post-mortem service.

A spot-check carried out by the College in 2015 found that a quarter of histopathologists who undertake coroner's post-mortems intended to give them up in the near future. It also found that over half of hospital departments and public mortuaries struggle to provide a post-mortem service.

Other findings included:

- 92% of consultants who didn't undertake autopsies did so at some point in the past. 50% of these gave up due to NHS workload pressure and 24% due to inadequate remuneration.

- 70% of trainees are continuing with autopsy training and 90% of those intend to undertake coronial autopsies as a consultant.

This combination of findings suggested that the main problem in providing the coronial autopsy service is that autopsy-trained pathologists give up coroner's work, rather than not providing enough new autopsy-trained pathologists. Based on this evidence, the College disagrees with the suggestion that post-mortem training should be mandatory. Members tell us that, if post-mortem training were mandated, they would be less likely to choose histopathology as a specialty and may move to another medical profession entirely. This would lead to significant problems in the histopathology workforce, which is already facing shortages. Cancer Research UK's report *Testing Times* highlighted that, year on year, the amount of histopathology requests received by each laboratory has been going up by around 4.5% on average.

A short-term option to increase the number of autopsy-trained pathologists available would be to make post-mortem work part of the pathologist's contract.

We strongly support the Chief Coroner's call for a national service, organised regionally, although we do not think that teams at these centres should necessarily be led by a forensic pathologist.

It is vital that post-mortem services are seen as part of the wider patient safety landscape - the accurate investigation and certification of death underpins the delivery of health services for the living and should be part of the NHS's core business.

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