CHIEF CORONER

GUIDANCE No. 32

POST-MORTEM EXAMINATIONS INCLUDING SECOND POST-MORTEM EXAMINATIONS[1]

EXECUTIVE SUMMARY

This is the first Guidance in twenty years on the use of post-mortem examinations and second post-mortem examinations. Home Office Circular (No.30/1999) is considered superseded by this Guidance. Whilst there has been a general decrease in the number of post-mortem examinations carried out which the Chief Coroner welcomes, there remains a wide regional variation. This Guidance is intended to promote consistency in coronial practice.

While a coroner has legal control over the body of a deceased person, it is for the coroner to decide whether to commission a first or subsequent post-mortem examination and it is for the coroner to decide whether to permit a second examination of the body on the instruction of an interested party. Despite there being a widespread misconception (particularly in homicide cases), there is no automatic right to a second post-mortem examination and requests should be scrutinised rigorously by the coroner on a case by case basis.

[1] Work on this Guidance has been a lengthy task. Many have contributed. The Chief Coroner would particularly like to thank Dr Fiona Wilcox and Karen Harrold for their work on a first draft of this Guidance. He would also like to thank His Honour Sir Peter Thornton and Jonathan Hough QC for their comments and observations, both Deputy Chief Coroners HHJ Alexia Durran and Derek Winter, Eve Naftalin, the Chief Coroner's Legal Adviser and James Parker, Head of the Chief Coroner's Office.

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Part 1: Introduction to post-mortem examinations

1. The primary purpose of this Guidance is to assist coroners with decisions as to when to permit or commission second post-mortem ('PM') examinations. It is intended to be a practical guide for decision making and to promote broad consistency in coronial practice. The Guidance will also deal with first PM examinations more generally. While a coroner has legal control over the body of a deceased person, it is for the coroner to decide whether to commission a first or subsequent PM examination and it is equally for the coroner to decide whether to permit a second examination of the body on the instruction of an interested party.[2] These powers are to be exercised with proper regard to the rights and interests involved.

2. The Home Office (which then had responsibility for coroner law and policy) issued a Circular (No.30/1999) on 24 June 1999 titled 'Post Mortem examinations and the early release of bodies'. It was addressed to Chief Constables and to coroners. It was principally concerned about the delay in the release of a body following a suspected homicide. Many of the core principles in the 1999 Circular feature in this Guidance, but this Guidance seeks to take account of various statutory changes since, including the Coroners and Justice Act 2009 and the significant advances in facilities available. Amongst those the Chief Coroner has consulted on this Guidance are the Forensic Science Regulation Unit within the Home Office, and the Royal College of Pathologists. The Home Office Circular from 1999 is to be considered superseded by this Guidance. Coroners should refer to this Chief Coroner's Guidance when considering whether to arrange or permit a second PM examination.

3. A PM examination is not a requirement of death investigation by the coroner, although sometimes it is only a pathologist who can advise on the specific medical cause of death. The general trend over the last twenty years has been a decrease in first PM examinations arranged by coroners, from 59% in 1997 to 39% in 2018 of all deaths reported to coroners.[3] In general terms, this trend is to be welcomed, since PM examinations may cause distress to bereaved families and may also delay the release of bodies to bereaved families which in itself can be distressing.

4. There remains a wide regional variation in the extent to which coroners arrange PM examinations, ranging from 22% of the deaths reported in North Lincolnshire and Grimsby to 63% in North Yorkshire (Eastern) region. In comparison to similar jurisdictions internationally, the proportion of PM examinations out of total annual deaths in England and Wales is substantially higher than in other countries.[4] It is worth registering a note of caution on how these statistics may develop in coming years. As the pilot schemes show, once there are Medical Examiners in post there may be a reduction in the number of deaths reported to coroners, as well as a reduction in the number of PM examinations arranged by coroners. As a result of these

[2] There are rare circumstances in which non-coronial PM examinations take place, for example hospital PMs. This Guidance does not address those.
[3] Coroners statistics published May 2018 by the Ministry of Justice https://www.gov.uk/government/statistics/coroners-statistics-2018.
[4] In his 'A review of forensic pathology in England and Wales', March 2015, Professor Peter Hutton puts it at 40% more than in comparable international jurisdictions.

changes, the percentage of PM examinations as a proportion of reported deaths may rise.

5. PM examinations are carried out, for the most part, by consultant histopathologists or, sometimes, by consultant Home Office registered forensic pathologists. Even if they work in their 'day' job for a hospital or NHS Trust, in their work for a coroner they are independent and answerable to the coroner for the purposes of accepting an instruction to conduct the PM. Clearly, they will be carrying out their professional work along the guidelines set by the regulator, and, in the case of Home Office registered forensic pathologists, by reference to the terms of their Home Office work. However their overriding duty is to the coroner, and ultimately to the court to give independent assistance by way of objective, unbiased opinion on matters within their expertise, including by way of written report.

6. The consent of next of kin is not required for a PM examination, however they must be informed of the date, time and place of the examination unless that is impracticable or would cause the examination to be unreasonably delayed. They are also entitled to be represented by a medical practitioner at the examination.[5] The Chief Coroner expects that in all cases, and especially in contentious cases, the family should be informed in advance that there will be a PM examination, and what that will involve, so they can arrange to be represented there if they so desire. The family, as at all times, must be dealt with sensitively.

7. There have been mass fatality and terrorist incidents following which forensic PM examinations were undertaken, usually starting with full and detailed scanning of the bodies with no second forensic examinations.[6] Policies were drawn up by the incident coroners based upon the availability of primary pathological evidence of fact gleaned from a combination of scanning, photography and sampling that could all be made available to any second pathologist instructed by a defendant or other interested person. The approach adopted meant that a second pathologist would be able to carry out a desktop review of the evidence of the first PM examination, set out any differences in interpretation of the results in their report including the medical cause of death and how that person came to die if applicable. This approach had the advantage that there was no need for further dissection of the body. These practices were influenced by the recommendations made by Lord Justice Clarke[7], including that there should be respect for the deceased and the bereaved. Although this approach may not be right in all cases, it should be kept in mind as a practical and sensitive way to enable review of a first PM examination without a full second PM examination, not just in mass fatality cases but as a possible model for many other types of case.

[5] The Coroners (Investigations) Regulations, SI 2013/1629, reg. 13.

[6] Westminster Bridge 22 March 2017 (6 deaths); Manchester Arena 22 May 2017 (23 deaths), London Bridge & Borough Market 3 June 2017 (11 deaths); Grenfell Tower 14 June 2017 (71 deaths) and Finsbury Park 19 June 2017 (1 death and the only one subject to a second PM examination), Shoreham air crash 22 August 2015 (11 deaths with all PM examinations solely by computed tomography examinations)

[7] The Thames Safety Inquiry, January 2000. Lord Justice Clarke carried out a formal investigation into the Marchioness disaster after the fatal collision between two vessels on the River Thames in London on 20 August 1989, which resulted in the drowning of 51 people.

(i) The coroner's legal control over the body of the deceased

8. Once a coroner's statutory duty to investigate a death is triggered, or during the coroner's preliminary enquiries into whether he has jurisdiction, the coroner has a right to control of the body of the deceased until his coronial functions come to an end.[8] That control commences when the coroner is made aware that a body is within that coroner's area.[9]

9. The coroner should retain the body for as long as necessary but must release the body for burial or cremation as soon as is reasonably practicable.[10] This will generally be immediately the PM examination has been completed. Decisions about the retention and release of a body should be taken with proper regard to all the relevant considerations and interests, including any representations from the bereaved family and/or representations from any other person (such as a person under criminal investigation) that the body should be retained for further examination. Weight may have to be given to Article 8 and/or Article 9 rights of the family.

10. During the period that the coroner has legal control of the body of the deceased, the coroner is the only person with lawful authority to arrange or permit a PM examination of the body of the deceased. A coroner's decision to arrange or permit a PM examination[11] (including a second PM examination) is a judicial decision made in the judgment of that individual coroner alone and is subject only to challenge by way of judicial review in the High Court.

(ii) Explanation by the coroner to the family of legal control over the body

11. Coroners, their officers and staff must explain to the family of the deceased that the coroner has legal control over the body. This is a statutory power which gives the coroner the ability to carry out his functions to investigate the death and ensures the preservation of the best evidence. It is an important independent safeguard for the integrity of the investigation.

12. At no point should the coroner, his officers and staff refer to the body of a deceased as the 'property' of the coroner, nor should they use other forms of insensitive or 'off-hand' language when explaining the coroner's legal duties. This is one of the issues which was rightly highlighted by Bishop James Jones in his Review of the Hillsborough families' experiences[12] and which can cause great and unnecessary distress to bereaved people. Coroners and their officers should also keep the bereaved family advised of the likely timescales for release of the body and any reasons for retaining the body. If a body cannot be released within 28 days of the death being notified to the coroner, there is a duty to notify the next of kin of the reasons.[13]

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[8] R v Bristol Coroner ex parte Kerr [1974] QB 652.
[9] Coroners and Justice Act 2009 s1(1).
[10] Coroners Regulations reg. 20(1) and 21(1). See also the Chief Coroner's advice dated 1st May 2014 on Release of the body for burial or cremation: the legal powers and duties of the coroner.
[11] CJA s14.
[12] 'The patronising disposition of unaccountable power: A report to ensure the pain and suffering of the Hillsborough families is not repeated', The Right Reverend James Jones KBE, 2017.
[13] Coroners Regulations reg. 20(2).

13. Similarly, police officers and police staff who come in to contact with bereaved people must also be careful not to misrepresent the coroner's position by describing the body of a deceased as the 'property' of the coroner. Senior coroners should make efforts to ensure their local police force understands this issue and should provide training on it as necessary.

14. At all times, coroners, their officers and staff must explain the legal position to families carefully and sensitively. This should be by telephone or in person, rather than solely by correspondence or email.

(iii) What is the purpose of a post-mortem examination?

15. The coroner has a specific statutory power, exercised under s14 of the 2009 Act, to arrange a PM examination. The statutory purpose of arranging a PM examination is either (i) to assist in the objective of ascertaining who the deceased was, and when, where and how the deceased came by his death (if the coroner's duty under section 1 to investigate is engaged before the PM examination is arranged); or (ii) in order to enable the coroner to make a decision on whether he should conduct an investigation under section 1.

16. Sometimes, the only way that a coroner can establish the medical cause of death or assist in answering the statutory question of how the deceased came by his death is through a PM examination.

17. There is no legal definition of what constitutes a PM examination. It can include any of the following: external examination of the body; toxicology tests; tests on organ and tissue samples from the body; CT or MRI scanning; and/or full internal invasive examination of the body.

18. It is usual practice that a PM examination will be carried out, subject to the availability of pathologists, within a few days of the death, and ideally within 24 hours. Often the coroner will receive a summary report from the pathologist on the provisional cause of death and then receive a full report a number of weeks or even months later once all tests (for example toxicology, histology) have been completed. In all cases the pathologist is required to send a report to the coroner "as soon as reasonably practicable"[14] expressing a view about the medical cause of death. PM reports should be provided to the coroner within three to four weeks, except where further reports are required from toxicologists or other experts.

19. In a non-homicide case, the pathologist is required to express a view about the cause of death on the balance of probabilities i.e. what the pathologist feels is more likely than not, given the information that is available to him or her at the time of writing the report, and taking into account what is found out during the PM examination.

[14] CJA s14(5).

(iv) A brief word on pathologists and their independence and duties[15]

20. A PM examination must be carried out by "a suitable practitioner"[16] who must be "a registered medical practitioner".[17] In practice and for standard PM examinations, this will usually be an NHS registered consultant histopathologist.[18] Most histopathologists are employed by health trusts or boards to carry out other pathology work (on the living). They are doctors who have undertaken many years of specialist post-qualification training in histopathology. They are regulated by the Royal College of Pathologists which oversees standards, training and continued professional development and the General Medical Council which is responsible for registration and oversees the revalidation process. All pathologists, even if employed by the local NHS Trust, are independent professionals.

21. A consultant histopathologist's work for the coroner is usually undertaken as private practice outside the consultant's NHS contract. Therefore, although they may be based in a hospital for their 'day job', for coronial purposes they are entirely independent, (mostly) paid for by the coroner and under a legal obligation to him or her.

22. Forensic PM examinations are carried out by forensic pathologists listed on the Home Office Register and known as 'Home Office Registered Forensic Pathologists'. This work and the associated court attendances represent their main activity and source of income. They are usually self-employed. Although their work is largely paid for by the police, they are independent practitioners. As independent pathologists they have a duty to the coroner, and ultimately to the court to be impartial and this overrides any residual loyalty to the person who has paid them for the provision of their report. There are approximately 35 forensic pathologists on the Home Office Register. The forensic pathologist's primary duty is to the court and they are independent in forming their opinion. Admission onto the Home Office Register requires further training and experience which is regulated by the Pathology Delivery Board.[19] The code of practice and performance standards is set by the Home Office, the Forensic Science Regulator, the Department of Justice (Northern Ireland) and the Royal College of Pathologists.[20]

23. The Royal College of Pathologists makes clear in its guidance for all pathologists that their primary duty is to the court. In its guidance for histopathologists it states that "the Coroner's pathologist's primary duty is to the Coroner and he or she must not act in any way that fails to acknowledge that duty."[21] In its guidance for forensic pathologists it states, "(the forensic pathologist)…has responsibilities to the criminal justice system, including the need to offer impartial evidence, the integrity of which is not compromised,

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[15] Information taken from Professor Peter Hutton's Report – A review of forensic pathology in England and Wales, March 2015, Peter Hutton.
[16] CJA s14(1).
[17] CJA s14(3)(a).
[18] Histopathologists are expert doctors who are responsible for diagnosing and studying disease in tissues and organs.
[19] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/115690/pdb-board-criteria-reg.pdf.
[20] https://www.rcpath.org/uploads/assets/5617496b-cd1a-4ce3-9ec8eabfb0db8f3a/code-of-practice-and-performance-standards-for-forensic-pathology-in-england-wales-and-northern-ireland.pdf.
[21] Standards for Coroners' pathologists in post-mortem examinations of deaths that appear not to be suspicious, Royal College of Pathology, February 2014.

and the need to present such evidence in a manner that is acceptable to others involved in the criminal justice system. The pathologist's primary duty is to the court and he must not act in any way that fails to acknowledge that duty."[22] The guidance also explicitly states that forensic pathologists must comply "with the obligations placed on expert witnesses and, in particular, their overriding duty to the Court (see for example Part 33(2) Criminal Procedure Rules)". The procedural rule concerns an expert's duty to give objective and unbiased opinion to the court which overrides any obligation to the person from whom the expert receives instructions or by whom the expert is paid.

24. The Chief Coroner remains concerned about the pathology service to coroners. There are a dwindling number of pathologists prepared to carry out PM examinations requested by a coroner and the service is severely under-funded. Local pathology services are seriously stretched, with the result that coroners are sometimes forced to wait for a PM examination to be performed which in turn delays the release of the body to family for burial or cremation as well as having an adverse impact on mortuary capacity. There is a lack of control and oversight of the pathology provision partly as no government department, nor the NHS, considers it has responsibility for this vital service. The proper recording of the cause of death leads to better mortality statistics and the lessons to be learned from all deaths.

Part 2: First post-mortem examinations

25. There is almost no guidance in the statutes or case law as to the form of PM examinations. The Schedule of the Coroners Allowances, Fees and Expenses Regulations 2013 classifies them into two categories (although with reference to fees only).[23] A ('standard') PM examination[24] is charged at a lower rate than a PM examination "involving additional skills."[25] The local authority on behalf of the coroner usually pays the fee to the pathologist. There are also imaging-based PM examinations and forensic PM examinations.

26. The type of death in practice dictates which of the PM examinations are requested by the coroner, but the position is not specified in any formal document and varies according to jurisdiction. The language about PM examinations used amongst coroners is also inconsistent. In the end it is a matter for the relevant coroner whether to commission a PM examination and if so, what type.

27. Following a death abroad, the body may have already been subject to a PM examination in that country. Once the body is repatriated and if the coroner is to hold an investigation and inquest, any PM examination requested by the coroner may technically be a second PM examination.

[22] Code of practice and performance standards for forensic pathology in England, Wales and Northern Ireland, Home Office, the Forensic Science Regulator, the Department of Justice (Northern Ireland) and the Royal College of Pathologists, September 2018.
[23] The Coroners Allowances, Fees and Expenses Regulations 2013, SI 2013/1615, Sch. para 6.
[24] £96.80.
[25] £276.90.

28. The following describes the general scheme and is a description of current practice, but it is a matter for each individual coroner which pathologist he wishes to instruct and the type of investigations to request in each particular case. Deaths resulting from the inflicting of stab injuries or gunshot injuries which may or may not be self-inflicted may be cases where the coroner will wish to give particular thought to the need for or scope of a PM examination. When dealing with the death of a child and particularly the death of a child under 28 days (a neonatal death) consideration must always be given to a post-mortem examination being carried out by a suitably qualified consultant paediatric pathologist. The anatomy, physiology and pathology in children differs markedly from that in adults with the younger the child the more important it is to have the correct expertise.

(i) Standard post-mortem examinations

29. Generally speaking, the standard PM examination is performed by a histopathologist and is usually undertaken for hospital and community deaths, suspected natural deaths and drug and alcohol deaths. Histopathologists are usually best placed to deal with hospital deaths as they have greater knowledge of hospital process and procedures and complex medical conditions. These are sometimes referred to as 'routine' PM examinations.

30. In 2018, almost all (95%) of PMs were arranged at a standard rate - this proportion has remained at the same level since 2010.

(ii) Standard post-mortem examinations involving additional skills

31. These standard PM examinations requiring additional skills are usually reserved for more complex cases (although not homicides) and are generally performed by a forensic pathologist who is not connected to the local hospital (and therefore is sometimes described as an 'independent' pathologist, although the Chief Coroner discourages the use of this term as all pathologists are independent). The pathologists in these cases must report to the coroner and may well be required to give evidence during an inquest. Examples of these are cases in which the body is very decomposed or cases where medical records have to be read and expert opinion sought.

32. There are also some specialist PM examinations which are undertaken which need particular expertise and can involve a number of specialists, for example paediatric or neo-natal specialists or neuropathologists. The additional expertise involved in this form of examination may be a good reason for not having any second PM examination.

(iii) Imaging based post-mortem examinations[26]

33. Some coronial jurisdictions have made use of scanning techniques to supplement (or supplant) traditional invasive autopsy. Guidance on the use of PM imaging for adults was issued by the previous Chief Coroner on 14th January 2016.[27] Section 14(2) of the Act makes clear that a coroner may specify the kind of examination to be made. The Chief Coroner encourages coroners to consider the use of less invasive forms of examination in

[26] The internationally agreed nomenclature is Post Mortem Computed Tomography (PMCT) or Post Mortem Magnetic Resonance (PMMR) examinations.
[27] Updated Chief Coroner Guidance No.1, The Use of Post-Mortem Imaging (Adults).

appropriate cases, especially where the bereaved family has a strong objection to invasive examination.

34. Post-mortem imaging may not be the appropriate technique to determine the cause of death in all cases. In addition, facilities vary across the country and are not present in every jurisdiction. The correct approach to be taken to a request by a bereaved family for less invasive examination was considered in the case of *Rotsztein v H M Senior Coroner for Inner North London* [2015] EWHC 2764 which laid down guidelines. Coroners are encouraged to refer to that case when they receive such a request.

35. Many families (particularly those belonging to certain faith groups) request PM imaging instead of more invasive autopsy.[28] Imaging based examinations have the further benefit that through detailed images the state of the body, both externally and internally, is permanently recorded for anyone to review in future.

(iv) Forensic post-mortem examinations

36. When a violent death occurs or the coroner is informed by the police that a homicide offence[29] is suspected in connection with the death of the deceased, the coroner can request a forensic PM examination of the body. A Home Office registered forensic pathologist is instructed by the coroner in consultation with the police.[30] The coroner is encouraged to maintain a continuous dialogue with the police.

37. The investigation of suspected homicide deaths involves two simultaneous but separate investigations, namely for the coroner to ascertain the cause of death for the purpose of answering the four statutory questions (i.e. who the deceased was, and how, when and where the deceased came by his death), and also as part of the on-going police investigation into the suspected homicide. In short, the coroner investigates the death and the police investigate the crime.

38. A forensic PM examination seeks to provide assistance, hopefully answers, for both those investigations. For example, the pathologist can preserve or retain material which bears upon the cause of death or the identity of the deceased[31] and is also obliged to advise the police as to any material which should be retained as evidence. The pathologist's duty is to the courts (i.e. the coroner's court and/or criminal court in which his/her evidence is presented). "The opinions expressed must be fair and unbiased and under no circumstances should be written to assist one side rather than the other."[32]

39. According to the Forensic Science Regulator's 'Code of Practice and Performance Standards', a full forensic standard examination should be ordered in any death where a crime is reasonably suspected. This Code applies to the work of all pathologists. Examples include deaths which have been deemed suspicious by the police; cases where it is clear before the PM

[28] It is to be noted that an imaging PM examination does not exclude certain invasive techniques such as angiography and ventilation.
[29] Defined in Sch. 1 para 1(6) CJA.
[30] Coroners Regulations reg. 12.
[31] Coroners Regulations reg. 14.
[32] Code of practice and performance standards for forensic pathology.

examination is undertaken that the Health & Safety Executive may be bringing a prosecution; non-natural deaths in custody (especially where the deceased was sharing a cell); cases of drugs of abuse administered by another; assisted suicide; elder abuse; and neglect of children. The purpose of this forensic examination is to gather evidence to the criminal standard in order to establish cause of death; to investigate the circumstances and mechanism of death; and to retain evidence, such as body fluids for toxicology and organs for further specialist examination.

40. During a forensic PM examination, the homicide investigation teams attend and take photographs of the procedure and a whole range of forensic samples are taken from the body. Certain body parts (such as the eyes, brain, ribs, spinal column) can be examined by a sub-specialty pathologist. This can include evidence for the identification of the perpetrator. The pathologist will take extensive notes. In suspected homicides, a possible outcome is that the PM examination report is used in evidence in the Crown Court. If someone is prosecuted for the death, the forensic pathologist will need to give evidence in the Crown Court and therefore may have to consider whether the cause of death can be shown to the criminal standard (beyond reasonable doubt).

41. Currently, there are on average 2,000 initial forensic PM examinations per year in England and Wales, which amounts to around 2% of all PM examinations (0.4% of all registered deaths).

Part 3: Second post-mortem examinations

42. A second PM examination is an examination by a different pathologist who considers the original report and carries out work to agree or challenge its conclusions. They are most commonly carried out by forensic pathologists.

43. A second pathologist can do various kinds of work, ranging from reviewing notes, photographs, scans and other material from the first examination and a visual examination of the body, to another fully invasive examination. There is a substantial benefit of carrying out imaging that more detailed review is possible at a later stage, particularly in a case of suspected homicide or where there may be state involvement in the death. Coroners should reflect on the value a scan, alongside the first examination, may bring to a forensic case where there may be criminal proceedings. There may be considerable benefit. A scan will preserve evidence which can then be reviewed by others, including a second forensic pathologist.

44. It is important to note that, where a body has been subject to a first invasive PM examination (whether standard, additional or forensic), the body will often have been substantially disrupted, with organs removed. Therefore it is important for all involved to consider carefully and realistically what benefits can be gained from a subsequent invasive examination.

45. On the other hand, if an interested party wishes to instruct a second pathologist in order to review a scan or other electronic or other material from the first PM examination, then provided it can be done within the specified timeframe (see paragraph 53), a coroner may have greater confidence in acceding to the request.

46. The vast majority of second PM examinations are requested in cases of potential homicide, mostly by a defendant's solicitors. However, sometimes bereaved families may want a second PM examination when they are concerned to verify the cause of death. Experience indicates that this sometimes happens when their loved one has died in prison custody or police detention, but examples are not limited to such situations.

47. Where such a request for a second PM examination is made to the coroner, it should be in writing, setting out the reasons why a second examination of the body is required (including reasons why a review of the material obtained at the first PM is not or may not be sufficient). It should identify the suggested forensic pathologist (who does not have to be Home Office registered) and their availability. Where the request is not by the bereaved family, the views of the family should be ascertained by the coroner's officer or family liaison officer.

48. There is no absolute right or entitlement for a suspect, defendant, the police or any other interested person to have a second PM examination. Whilst the body remains under the coroner's legal control, the decision whether or not to arrange a second PM examination (and in what form) remains a judicial decision for the coroner to make, taking account of the reasons in support of a request and any competing considerations. Reasons for a decision should be given to the person making the request and (if different) to the next of kin and any other interested person.

49. If the next of kin are dissatisfied with the result of the coroner's PM examination, there is usually no bar to them instructing another pathologist to carry out a further examination once the body of the deceased has been released back into their care.

(i) Home Office Circular No.30/1999

50. There has been hitherto little guidance given to coroners on when to allow or arrange a second PM examination. There is no legal guidance in the 2009 Act or in secondary legislation. Home Office Circular No.30/1999 was issued twenty years ago to address the problem that coroners felt themselves to be under an obligation to retain a body (in some cases for a number of months) in the expectation that an arrest would be made. In general, it set out a good practical approach.

51. The Circular states that if the police could not identify or charge a suspect then the coroner could order a second PM examination by another forensic pathologist no later than 28 days after the first PM examination, retain the report and give it to the representative of a subsequent defendant in the case. The Circular also allows prospective defendants to justify being able to take up to 28 days after an initial PM examination to decide on whether they wish to have a second PM examination.

52. This has resulted in an unsatisfactory situation in which a second PM examination of doubtful value, or the delay whilst the issue is considered and the body retained, inevitably causes further trauma to the family of a person who has been unlawfully killed. If a second PM examination is requested by a prospective defendant and permitted by the coroner then the defence team must ordinarily fund the examination, which can itself result in some delay whilst the Legal Aid Agency makes a decision.

53. It is not for the coroner or the police to raise with the suspect's or defendant's solicitor whether they require a further PM examination. It is for the suspect or defendant to decide whether to make a request for one. However, in order to assist the process, the coroner through the coroner's officer should notify them of the date and time when the body will be released from the mortuary for funeral. A period of notice should be given (say, 5 days), in which to raise any request for a further PM examination. Similarly, if a further PM examination is requested then the coroner, having given reasons, should give the same notice before release of the body (say, 5 days). Thus, a dissatisfied defendant would have the opportunity to seek an urgent stay of the coroner's decision to release the body. This approach would pay proper respect to the general wishes of families for the body to be released and also have the added advantage of the body being released well within the 28 day period, referred to in Regulation 20 of the Coroners (Investigations) Regulations 2013.

54. As set out above, Home Office Circular No.30/1999 is superseded by this Guidance which coroners should refer to when considering whether to order a second PM examination.

(ii) Why have a second post-mortem examination?

55. The vast majority of cases in which a request for a second PM examination comes to the coroner are suspected homicide cases. Either there is an identified suspect or there is a request from the police to hold a second PM examination where there may be a suspect identified but not yet charged. In the absence of a suspect, it is difficult to imagine many circumstances which would justify a second PM examination.

56. Although practice varies and many coroners interrogate carefully the reasons as to why a defendant is requesting a second PM examination, coroners are understandably very anxious to prevent prejudicing a criminal prosecution by refusing to allow a second PM examination.

57. As the 1999 Home Office Circular stated: "the interests of family, police, defendants and others will conflict, and the coroner's role includes balancing those competing interests… Any future defendant's loss of the opportunity to obtain evidence through a second post-mortem does not render a fair trial impossible so as to justify a stay of the proceedings. In any event, if a defendant who has been unable to obtain a second autopsy is convicted of the homicide of the deceased, it is impossible to know whether the lack of a second autopsy made any difference to the jury. The coroner cannot be expected to second-guess the future course of events, and must accordingly be entitled to release the body without first causing a second post-mortem to be made for the benefit of a future defendant."

58. This Guidance seeks to set out some considerations for coroners to assist in deciding whether to arrange a second PM examination. Whatever the position, the coroner should carefully scrutinise any request for a second PM and expect to be given reasons for the need for one. Equally, it will be expected that the coroner in granting or refusing a request should give reasons for the decision.

59. Another problem is that frequently the report of the first PM examination is not available before a decision has to be made on a request for a second examination. Coroners may feel they have little choice but to arrange a second PM examination. It is plainly unsatisfactory if a second PM examination (especially of an invasive kind) is carried out purely because there has been a delay in obtaining the results of the first examination. The best solution is for coroners to do everything within their power to ensure that a preliminary report or summary conclusions from the first examination are made available at a very early stage, so that an informed decision can be taken on whether a second examination is justified.

60. The Chief Coroner expects that the pathologist will produce a summary report to the coroner as soon as possible in order that the defence solicitor can make a decision as quickly as possible as to whether to make a request to the coroner to arrange a second PM examination.

Part 4: Determining the evidential value of a second post-mortem examination

61. There is no statistical analysis of how frequently second PM examination results differ from first PM examination results.

62. If the first PM examination has given apparently clear and conclusive answers to all the questions in relation to the medical cause of death and how the person came to die, and assuming that other relevant evidence has been gathered under the Police and Criminal Evidence Act 1984 (such as evidence of identification) and all of this evidence has been fully documented and retained, then in principle there should be no need for a second forensic PM examination. In the absence of good reason for a second examination, the body can be released back to the family after the first examination has been completed and interim reports submitted and considered (allowing for notification to prospective defendants as discussed above).

63. The primary evidence gathered as part of the forensic PM examination (including samples, swabs, x-rays, scans, photographs, hair, blood and other body fluids analyses) is all evidence of fact, not opinion, and can be made available to a prospective defendant's pathologist without the need for a second invasive PM examination.

64. A proper desktop review by a second pathologist is a more useful exercise where the body of the deceased has been subject to imaging (such as CT scanning in adults and MRI in children) either peri-mortem or post-mortem. Not only are the scan images preserved so that they can be considered by a second pathologist, but the scan images can be very useful for presenting evidence in all court proceedings.

65. In cases where the cause of death is not in issue, such as a stabbing which has been witnessed or on CCTV or in a road traffic collision case where the issue is likely to be the standard of driving, it is unlikely that a second forensic PM examination will be needed.

66. Difficulties can arise if the medical cause of death has not been clearly established and/or if the evidence is complex. For example, this may be the case in restraint deaths; in child abuse cases; or in cases where issues have

come to light after a histopathology examination (such as medical gross negligence manslaughter arguable on the basis of statements, reports and medical records).

67. In complex cases where the cause of death is unclear, further examination may be needed. Consideration should always be given to limiting this examination to a specific part of the body where appropriate, or to further toxicology testing rather than full dissection.

68. There is no place for blanket simple assent to a request for a second PM examination. The coroner should exercise careful judgment in respect of any request for a second PM examination and should expect proper reasons to be given, pointing as appropriate to the likely issues in the prospective criminal proceedings. The coroner's decision should be fully reasoned and recorded.

69. Under Rule 13 of The Coroners (Inquests) Rules 2013, which governs disclosure of a document held by the coroner at the request of an interested person, the coroner should disclose a PM examination report to a suspect under Rule 13(2)(a). The coroner may however refuse to provide the report where the document relates to contemplated or commenced criminal proceedings (under Rule 15(d)). Prior to disclosure the coroner would be well advised to consult with the police and/or CPS.

70. However, all the above considerations assume that the coroner is in possession of all the relevant information at the time he is asked to make a decision as to whether or not a second forensic PM examination should proceed.

71. In practice, it will sometimes happen that the coroner will not receive even a preliminary report before a decision has to be made whether to arrange a second PM examination, or that issues remain open after considering the preliminary report. In such cases, where a respectable argument can be made that a second examination may have some value (e.g. because the cause of death is not obvious or because there may be other contentious issues addressed by the pathologist), the coroner may feel obliged to allow a second forensic PM examination to proceed. However, if CT/MRI scans have been completed these can usually be promptly disclosed. In some cases, these could be considered by the coroner and defence, in conjunction with the interim pathology report and other evidence of the circumstances in which the death took place, and may avoid the requirement for a second forensic PM examination.

72. Occasionally there have been multiple PM examinations when multiple defendants have instructed different solicitors who have each requested, and been granted, a further PM examination. Requests for multiple PM examinations should be scrutinised extremely rigorously and coroners should require strong reasons to be given. Even in a case where there is a conflict between defendants, the coroner will often conclude that it is not an issue that an additional PM examination can resolve.

Part 5: Road traffic collision deaths

73. The Chief Coroner wishes to thank Elaine Gordon and Lucy Harrison from RoadPeace[33] for their work on this issue in memory of Gina Johnson and Peter Price. The Chief Coroner is particularly grateful for their work flagging the inconsistency of approach across the coroner areas. He hopes this Guidance will address those concerns.

74. Road traffic collision cases resulting in a death are often highly contentious. If there appears to be a genuine prospect of a prosecution for death by careless or dangerous driving then the police may indicate to the coroner that they would like the coroner to authorise a full forensic PM examination (which may amount to a second PM examination if the coroner has already authorised a PM examination).

75. Difficulties can arise when the police are still at the early stage of a criminal investigation and neither the police nor the CPS can give a clear indication as to whether anyone will be charged.

76. Often in road traffic collision deaths, the cause of death is not the issue, rather it is the causal link between the death and the manner and standard of the driving which is the important factor. In such a case, other than toxicology tests, there should be no need for a forensic or further PM examination. This may merit further discussion between the CPS and the coroner in individual cases.

77. Many families find the prospect of a second PM examination abhorrent, especially in those cases where the cause of death from external examination of a body may appear to be obviously due to multiple injuries. In these cases consideration, where possible, should be given to a CT examination (rather than more invasive examination) because of the usefulness in documenting skeletal injuries.

78. For all those reasons, second PM examinations in road traffic collision deaths should in practice very seldom be authorised by a coroner. It is the Chief Coroner's firm view that requests for such examinations should be examined very carefully.

Part 6: Conclusion

79. If a defendant is facing possible imprisonment for many years following a conviction for homicide, then it is of course important that their defence team can properly interrogate and test the evidence.

80. However, it is the Chief Coroner's view that in many cases a desktop review of the evidence of the forensic PM examination will suffice. It is for the defendant to satisfy the coroner that a second full forensic PM examination is required.

81. With regards to the suggestion that inability to carry out a second examination may prejudice a trial and threaten the success of the prosecution, that problem should rarely arise if the first PM examination has been well

[33] The national charity for road crash victims.

documented and all the findings are available for another pathologist to review.

82. Coroners should take care to explain to all families, particularly those whose loved one has died in the care of the state, that forensic PM examinations are independent and impartial. Coroners should ensure that families are notified in advance of the time, date and place of the PM examination so that they can instruct a medical practitioner to attend if they choose to do so.

83. In those limited cases where a second PM examination is arranged by a coroner then it should be undertaken as quickly as possible and usually within days of the first. Other than in the most exceptional circumstances, it should be performed well before the expiry of 28 days from death.

HHJ MARK LUCRAFT QC

CHIEF CORONER OF ENGLAND AND WALES

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