PE1699/C
Crown Office and Procurator Fiscal Service submission of 11 October 2018

1. Public Petition PE1699

On 23 July 2018 Amanda Digby lodged a public petition with the Scottish Parliament entitled 'Release of murder victim bodies for funeral arrangements'.

The petition calls on "the Scottish Parliament to urge the Scottish Government to change post mortem examination protocols to allow for the deceased to be released as early as possible to enable families to make funeral arrangements for their loved ones".

Petition background information

The petition further states:

"In Scotland a murder victim's body must be released by the Procurator Fiscal before any funeral arrangements can take place. In some cases this may result in the body being required to be kept for a long period of time. Primarily, this is to allow the defence the opportunity for a second post mortem to be carried out.

This system differs from the coroner system operating in England and Wales. Under that system, if no-one has been charged and the Police do not expect to make an arrest within 28 days, the coroner will arrange for a second post mortem to be carried out by an independent pathologist. This second post mortem will allow the coroner to release the body and retain the report for use by the defence if, in due course, an arrest is made and charges brought."

Ms Digby asks why the post mortem examination cannot be carried out independently as it is in England and Wales, so as to allow for the release of a body for burial or cremation.

2. Role of the PF in the investigation of sudden, accidental, unexplained and suspicious deaths

The Procurator Fiscal and COPFS

The Lord Advocate has responsibility for the investigation of any death in Scotland which requires further explanation. The Lord Advocate also has responsibility for the investigation and prosecution of crime in Scotland. These are "retained functions" of the Lord Advocate, functions exercised by the Lord Advocate before devolution; and which have been retained by the Lord Advocate since devolution. They are exercised by him independently of any other person.

The Lord Advocate's responsibilities in relation to the investigation of deaths are undertaken on his behalf – and subject to his direction - by procurators fiscal employed by COPFS. All accidental, sudden, unexplained or suspicious deaths in Scotland must be reported to the Procurator Fiscal, who is responsible for deciding what further investigation, if any, is required. Death reports to the Procurator Fiscal are usually made by a Doctor or by the Police. Once a death has been reported to the Procurator Fiscal, the Procurator Fiscal has legal responsibility for the body of the deceased.

The position of the Coroner, in England & Wales, is quite different. The Coroner has functions only in relation to the investigation of deaths; and has no responsibility in relation to the investigation and prosecution of crime.

COPFS Specialist Investigative model

The Crown Office and Procurator Fiscal Service is organised into distinct specialist functions:

- High Court
- Local Court
- Operational Support
- Specialist Casework

The circumstances of an individual death will determine which specialist Unit is responsible for the investigation of the death.

Where a death is sudden, accidental or unexplained the death may be described as "non-suspicious". Where there are circumstances surrounding the death which suggests that criminal conduct may have caused or contributed towards the death, the death may be described as "suspicious".

Within the Specialist Casework Function, COPFS has a national High Court team and specifically a specialist Homicide Team. The Homicide Team deals with suspicious death investigations across Scotland, instructing Police Scotland and working with criminal justice partners including pathologists and forensic experts. The team will investigate the circumstances of the death, arrange any post mortem examination, liaise with the defence where an accused person has appeared before the court, including in relation to any defence post mortem examination and report the circumstances of such cases to Crown Counsel. In such cases, Crown Counsel's authority for the release of a person's body may be required.

Also within the Specialist Casework Function, COPFS has the Scottish Fatalities Investigation Unit (SFIU). SFIU is a specialist unit responsible for investigating

all sudden, accidental and unexplained deaths or “non- suspicious deaths”. SFIU will investigate the circumstances of the death, arrange any necessary post mortem examination and authorise release of the deceased’s body to nearest relatives.

Depending on the circumstances, a death may be investigated by one of the other specialist functions of COPFS – the Road Traffic Fatalities Investigation Unit, the Helicopter Incident Investigation Unit or Health and Safety Division.

3. The Crown post mortem examination process in non-suspicious and suspicious deaths

Non-suspicious deaths

Where a death is brought to the attention of the Procurator Fiscal and the Procurator Fiscal is satisfied that the death is due to natural causes and that there are no elements of criminality or negligence, the Procurator Fiscal will discuss the position with the deceased’s own Doctor or, if the deceased died in hospital, the Doctor concerned, with a view to that Doctor providing a certificate as to the cause of death. If a satisfactory certificate is provided and there is no reason for further investigation, the death investigation will be closed and the body released.

If no certificate is provided, or if the Procurator Fiscal is not satisfied that the death is due to natural causes, or if negligence may be a factor, the Procurator Fiscal may instruct appropriate post mortem examination. The post mortem examination will be carried out by one pathologist. In deciding whether to instruct a post mortem examination the Procurator Fiscal will seek to confirm the views of the nearest relatives where possible. If there is an objection to a post mortem examination from nearest relatives, careful consideration will be given to whether the examination is, indeed, essential. A post mortem examination may be necessary in order to establish the cause of death (something which is required in every death), notwithstanding the views of the nearest relatives.

In the case of non-suspicious deaths the Procurator Fiscal will ensure that there are arrangements in place for the deceased’s body to be released to the nearest relative as soon as possible. In the case of non-suspicious deaths, the deceased’s body would only be retained by the Procurator Fiscal in exceptional circumstances such as where there is a difficulty in identifying a nearest relative.

Suspicious deaths

A post mortem examination will always be required in suspicious deaths where the body of the deceased has been recovered. The post mortem examination is designed both to establish the cause of death and to ensure that all available

evidence is ingathered to assist with any criminal investigation, including identifying those persons responsible for the death, and determining whether or not there is a basis for criminal proceedings.

A post mortem will always be carried out in any case where the potential subsequent charge would require the fact and cause of death to be corroborated, such as in the case of a homicide. In such a case, the post mortem will be carried out by two independent pathologists working together. The Procurator Fiscal will select and instruct the pathologists to perform the post mortem examination.

In relation to both non-suspicious and suspicious deaths a post mortem examination will take place as soon as possible after the report of a death to the Procurator Fiscal and will often take place within a few days of death.

4. Structure within which pathology services provided

COPFS has contracts in place covering the whole of Scotland for the provision of Pathology Services, (post mortems).

These contracts are with both academic intuitions and the NHS. The contracts for the services are with: Aberdeen University, Dundee University, Glasgow University, NHS Highlands, NHS Lothians, NHS Ayrshire and Arran and NHS Dumfries and Galloway.

The contracts cover Post Mortems for deaths by “view and grant”, one doctor or two doctor post mortems. “View and grant” is a non-invasive investigation which is sometimes sufficient to enable a cause of death to be certified. The precise kind of post mortem depends on the individual circumstances of the fatality. As will be apparent from the description above of the processes applicable to non-suspicious deaths, not all post mortems relate ultimately to prosecutions.

The contracts provide for the undertaking of 6,958 Post Mortem Examinations instructed by COPFS per annum across Scotland. These examinations include both suspicious and non-suspicious deaths.

In January 2016 a Code of practice and performance standards for forensic pathologists dealing with suspicious deaths in Scotland was published by COPFS and the Royal College of Pathologists. A copy of the Code of practice is enclosed at **Annex A.** The Code of Practice is largely based on the code of practice now adopted for forensic pathologists in England and Wales and ensures that common standards of practice apply throughout Scotland, and, indeed, the UK.

5. Release of the body to nearest relatives in suspicious deaths and the Defence Post Mortem Examination Process

Article 6 of the European Convention on Human Rights protects the right to a fair trial. An accused person has the right to investigate and test the evidence against them. The accused's right to test the evidence against him may require the instruction of a defence post mortem examination. Failure to observe the accused's rights or failure to properly test the evidence may result in an unfair trial and an acquittal. The case of HMA v Hemphill 2001 SCCR 59 provides an example of an acquittal in a murder case as a result of a defence failure to properly test the pathology evidence against an accused person.

Where criminal proceedings against an accused person have commenced the Procurator Fiscal will ascertain from the accused's representatives whether they wish to instruct a post mortem. The body will not, in such cases, be released until the defence indicate, in writing, that they do not require a defence post mortem or that they have completed their examination. If it is necessary to retain a deceased person's body for this purpose, nearest relatives will be advised and the circumstances explained to them.

Where all potential suspects are in custody and the defence agree to the release of the body, again in writing, the Procurator Fiscal will release the body for burial or cremation. If the defence decline to agree to the release of the body or in the event of any other difficulty, Crown Counsel's instructions will be obtained prior to the release of the body.

In cases where it has been ascertained that a homicide has been committed but where criminal proceedings have not commenced or where not all potential suspects are in custody, or where the death is a suspicious death but it has not been ascertained that homicide has been committed, the Procurator Fiscal is required to report the case to Crown Counsel within two weeks of the date of the Crown's post mortem. The report will include consideration of whether the body can be released to the nearest relatives.

If the body is not released immediately, the Procurator Fiscal is required to review the case on a regular basis. COPFS policy is that a body should be retained for longer than one month from the date of the post mortem only in exceptional cases**.** Exceptional cases might include cases where the commencement of criminal proceedings against an accused person is imminent or the nearest relatives cannot be confirmed. Should such a case arise, the Procurator Fiscal will report the circumstances fully to Crown Counsel and, if Crown Counsel instructs that the body should be retained, will ensure that the nearest relative is informed of the reasons for the continued retention of the body.

Should the Committee wish information on any logistical challenges faced by the defence in making arrangements for a defence post mortem examination,

COPFS would suggest that the Committee may wish to seek evidence from defence representatives.

6. Review of Post Mortem Examination Protocols

COPFS recognises the impact on bereaved families of the post mortem examination process and, in particular, of any delay in the return of the body of their loved one for burial or cremation. In consultation with the Law Society of Scotland, the Faculty of Advocates, and Forensic Pathologists, COPFS has accordingly reviewed the post mortem examination protocols described above.

The review recognised the right of accused persons to examine and test the evidence against them, including pathology evidence, and the resultant right to instruct a defence post mortem examination. The review recognised the professional obligation on the defence to ensure that an accused's defence is properly investigated and conducted and that any failure to meet this professional obligation may result in a successful appeal against conviction.

However, the review also recognised that in all but exceptional cases, a second invasive post mortem examination of the deceased's body may be of limited evidential value. The review noted that, in all but exceptional cases, the evidence of the Crown post mortem examination could be properly tested and challenged by the defence through a defence pathologist's expert examination of the post mortem findings, including samples where relevant, and opinion as opposed to a second invasive post mortem examination.

The review concluded that a complementary Consultation Protocol, supporting effective consultation between pathologists instructed by the Crown and defence may deliver further improvements. Effective consultation would support an informed defence decision as to whether a second invasive post mortem examination was required and may reduce not only the number of required defence examinations but also delays in the return of deceased persons to their families, reflecting the views of families.

Following positive discussions with Forensic Pathologists, the Law Society of Scotland and the Faculty of Advocates, the Consultation Protocol is now finalised and about to be published. **A copy of the Protocol is enclosed at Annex B.**

COPFS has also reviewed its approach to the release of bodies in cases where criminal proceedings have not commenced or not all suspects have appeared before the court. As stated above, COPFS policy is that a body in such a case should only be retained beyond one month in exceptional cases. The review has identified that current guidance should be supplemented and improved to ensure that bodies are not retained for any longer than is necessary in such cases.

COPFS intends to monitor the impact of the reinforced guidance and the Consultation Protocol. COPFS will monitor both the timelines in relation to release of bodies in suspicious deaths and the number of post mortem examinations instructed by the defence. The performance will be monitored by the COPFS Pathology Board.

7. England and Wales model

The Committee has been referred to the approach adopted to a second post mortem examination in England and Wales.

The two systems are not directly comparable. In England and Wales, a first post mortem examination is instructed by the Coroner. By contrast with the Procurator Fiscal, the Coroner has no prosecutorial function. The first post mortem examination in England & Wales is conducted by a single doctor only. If no person has been charged and the Police do not expect to make an arrest within 28 days, the Coroner will arrange for a second post mortem to be carried out by a second pathologist.

By contrast, in Scotland, the first post mortem examination is conducted by pathologists instructed by COPFS. In the case of a suspicious death, as described above, the post mortem examination is conducted by two independent pathologists and corroborated expert opinion evidence is therefore available as to cause of death. If proceedings have not been commenced within one month, the body will, under the reinforced guidance described above, be released to nearest relatives unless there are exceptional circumstances.

The COPFS policy reflects the conclusion of the recent review that, in all but exceptional cases, the evidence of the Crown post mortem examination can be properly tested and challenged by the defence through a defence pathologist's expert examination of the post mortem examination records, including physical samples where relevant and provision of a further expert opinion as opposed to a second invasive post mortem examination.

The approach in Scotland therefore offers an opportunity, other than in exceptional circumstances – where retention of the body is justified for particular reasons - for a body to be returned to nearest relatives without the impact of a second post mortem examination and without further delay at the end of a month. As described above, COPFS intends to monitor the impact of the Consultation Protocol and its reinforced guidance with a view to ensuring that bodies are released as soon as they properly can, consistent with the obligations on the Crown as regards the investigation of deaths and the prosecution of crime.

Code of practice and performance standards for forensic pathologists dealing with suspicious deaths in Scotland

January 2016

Unique document number	G066
Document name	Code of practice and performance standards for forensic pathologists dealing with suspicious deaths in Scotland
Version number	2
Produced by	RCPath forensic pathologists in Scotland and staff at the Crown Office and Procurator Fiscal Service, Scottish Fatalities Investigation Unit
Date active	January 2016
Date for review	January 2019
Comments	This document replaces the first version of this document, published in 2007. In accordance with the College's pre-publication policy, this document was on The Royal College of Pathologists' website for consultation from 2–30 September 2015. Six items of feedback were received; the authors considered them and did not need to amend the document. Please email publishing@rcpath.org if you wish to see the responses and comments. **Dr Lorna Williamson** **Director of Publishing and Engagement**

The Royal College of Pathologists
4th Floor, 21 Prescot Street, London E1 8BB
Tel: 020 7451 6700
Web: www.rcpath.org

The Crown Office and Procurator Fiscal Service
25 Chambers Street, Edinburgh EH1 1LA
Tel: 01389 739 557
Web: www.copfs.gov.uk

Contents

1 Introduction

1.1 General

This code of practice and performance standards has been developed for forensic pathologists in Scotland dealing with suspicious deaths. The code is also relevant for neuropathologists, paediatric pathologists and any other pathologist (including NHS pathologists) involved in the investigation of suspicious deaths. It has been introduced to ensure that common standards of practice exist throughout the whole of the United Kingdom. It is based very largely on the code of practice now adopted for forensic pathologists in England and Wales, that document having been developed and accepted by the Home Office Forensic Science Regulator in Forensic Pathology and The Royal College of Pathologists (hereinafter referred to as 'the College'). It allows pathologists to demonstrate high standards of professional performance using valid and acceptable criteria.

The general principles of performance standards for pathologists are applicable throughout the whole of the United Kingdom. In Scotland the investigations into sudden, unexpected, unexplained or suspicious deaths are led by the Procurator Fiscal. It is the Procurator Fiscal who takes the final decisions about those investigations including whether a death should be treated as suspicious and whether there should be a one- or two-doctor autopsy.

The document is divided into sections, each dealing with a specific aspect of the activity of the forensic pathologist, and each section commencing with a statement of the standard of practice expected of a forensic pathologist. New recruits to the profession will be expected to display competences derived from these standards. The document then goes on to expand, where necessary, upon the way in which these standard should be maintained during delivery of the service.

The code of practice is consistent with Recommendation R(99)3 of the Council of Europe on the Harmonisation of Medico-Legal Autopsy Rules, adopted by the Committee of Ministers in February 1999.[1]

1.2 Importance of the code of practice and performance standards

Adherence to this code of practice and performance standards will be an essential requirement in the provision of these services. If there are occasions on which forensic pathologists decide to depart from these codes, they must be able to justify their reasons to colleagues, to the Crown Office and Procurator Fiscal Service (COPFS), the criminal justice system and, if necessary, to the College. There may be occasions when a departure from these standards is unavoidable or even desirable. In such instances, the reasons for any significant departure should be discussed beforehand with the Procurator Fiscal and recorded.

In the context of the Scottish 'double doctor' system, this code will apply equally to both pathologists' involvement in the case.

1.3 The duties and responsibilities of the forensic pathologist

Among the duties and responsibilities of the pathologist, the following elements are considered particularly important.

- **Personal expertise:** keeping up-to-date with the latest methods and thinking by, for instance, actively pursuing relevant continuing professional development (CPD) programmes.

- **Standards:** accepting the use of agreed documented procedures and participating in appropriate schemes of peer review and audit.

- **Integrity of evidence:** ensuring that the integrity of evidence is not compromised.

- **Ensuring the fair presentation of findings:** presenting findings and evidence in a balanced and impartial manner, and confining opinions to those based on personal skills and experience, referring to the work of other experts in the field where appropriate.

- **Understanding the Scottish criminal justice system**: recognising the importance of the disclosure of information to relevant parties.

- **Service provision:** the pathologists will address and, where possible, meet customers' needs, including timeliness, providing relevant information and communicating effectively with police officers and others in the investigative process including complying with COPFS contracts and local service delivery agreements.

2 Professional standards in forensic pathology

2.1 Introduction

The General Medical Council (GMC) is responsible for maintaining the Medical Register in the United Kingdom. First and foremost, the forensic pathologist is a doctor, bound by the principles that govern this Register. While the responsibilities of the forensic pathologist may differ somewhat from those of the majority of medical practitioners, both the Scottish Government and the College advocate the principles of good practice summarised in the GMC's publication, *Good Medical Practice.*[2] This document forms the base against which should be judged every action taken by a doctor. The GMC has also published on the responsibilities of expert witnesses.[3]

The responsibilities of forensic pathologists in respect of all aspects of their work – including audit, clinical governance, quality assurance, CPD, revalidation and research – are the same as those of any medically qualified clinical pathologist. However, they also have responsibilities to the criminal justice system, including the need to offer impartial evidence, the integrity of which is not compromised, and the need to present such evidence in a manner that is acceptable to others involved in the criminal justice system. The forensic pathologist is an independent and objective investigator whose primary duty is to the court and they must not act in any way that fails to acknowledge that duty.

The Scottish Government and the College share responsibility for setting the standards that underpin high-quality pathology services. Forensic pathologists must ensure that the service they provide is of high quality and conducted in accordance with COPFS contracts or local service delivery agreements that demonstrates a commitment to quality, transparency and accountability. It is recognised that not all deaths occur in circumstances where all the steps in this process are required, but the absence of a step does not constitute an argument for ignoring the principles inherent within the code.

The standards set out in this code must be applied by the forensic pathologist, regardless of the party instructing that individual. All pathologists have a duty to consider and investigate explanations for a death consistent with the innocence of an accused person. Where such an explanation cannot be excluded, it must be brought to the attention of the pathologist's instructing party.

2.2 The code of practice

This code sets out what is expected of the forensic pathologist in the performance of each step in the process of investigation of a suspicious death, from the initial contact from the Procurator Fiscal/police regarding that death to the presentation in a court of evidence

relating to the death. It provides a framework within which clinical audit and performance review can be carried out to assure the quality of performance of individual forensic pathologists, as well as to facilitate the collection of evidence for the revalidation process.

2.3 Mortuary facilities

It is recognised that forensic pathologists may have to perform autopsies within mortuaries where they have no formal contract of employment with the providers. Forensic pathologists should be satisfied that the mortuaries in which they work are fit for purpose and have facilities equivalent to the standards set out in Scottish Health Planning Note 20: Facilities for Mortuary and Post-mortem Room Services (Health Facilities Scotland) and the documents produced by the Health Services Advisory Committee and the Advisory Committee on Dangerous Pathogens on safe working and the prevention of infection in the mortuary and post-mortem room.
If pathologists are not satisfied with any aspect of a mortuary, they should make these concerns known to those instructing them, such as the Procurator Fiscal and Police Scotland.

2.4 Peer review

It is important that forensic pathologists regularly consult and discuss their cases with forensic colleagues, and all pathologists must have arrangements in place so that this can be done. The value of review by peers cannot be overstressed. Forensic pathologists must not work in isolation from colleagues, either within the discipline of forensic pathology or from other clinical disciplines.

2.5 Assistance from other specialists

Practitioners must have in place adequate arrangements whereby they can consult with experts in other medical specialities who may be asked to assist or advise in appropriate cases. They will be expected to have full and easy access to departments of all other branches of pathology, including secure specimen storage, to a department of radiology and to a forensic science laboratory. They should have adequate provision of modern information technology (IT), including internet access.

2.6 Keeping up to date

Practitioners should have ready access to a comprehensive medical library, including appropriate journals. They have a duty to keep up to date and must be able to advise the legal authorities on the current literature.

2.7 Departure from the standards

Where pathologists become aware of an unjustifiable departure from these standards, whether by themselves or by another practitioner, that departure must be brought to the attention of the pathologist's instructing party.

2.8 Record keeping

The maintenance of adequate records is vital and full notes must be kept of briefings and conferences, as well as of all work carried out, tests performed and results obtained. Pathologists' records should be retained in accordance with agreements with the Procurator Fiscal and material should not be destroyed without the consent of the Procurator Fiscal. In particular, records should remain available to the Procurator Fiscal even after individual pathologists have moved on.

Records must be properly indexed and archived in secure storage. There may be occasions (such as at the scene of the discovery of the body or during the autopsy) in which the

pathologist may dictate notes to a recorder. In such circumstances, the original media, as well as any transcript made from them, must be retained.

When recording information gained or generated at any stage of the investigation, it is important to remember that all such material is potentially disclosable to the other parties involved in a legal action.

3 Initial contact with the pathologist

3.1 Standard

The forensic pathologist must be readily accessible to the Procurator Fiscal and police in accordance with whatever conditions are set out in an appropriate contract or local service delivery agreement.

At the initial contact with the police or Procurator Fiscal, the pathologist will determine:

a) that if not already directly contacted by the Procurator Fiscal, the latter has been notified of the death and has authorised the attendance of the pathologist

b) the nature of the case and, if known, the issues surrounding it

c) the need for the pathologist to attend the scene of discovery of the body following discussion between the Procurator Fiscal, senior investigating officer (SIO) and crime scene manager (CSM)

d) if attending the scene, its location and an agreed time of arrival, bearing in mind the possible requirement of others to attend beforehand

It may be relevant for the pathologist to document these issues and record the timings.

3.2 Code of practice

It is the responsibility of pathologists to ensure that, when on call, they can be contacted at all times. Adequate arrangements should be in place for pathologists to be available to provide cover during off-duty and leave periods. Maintenance of these arrangements is the responsibility of the pathologist. Those involved in a rota system should give adequate advance notice of any changes in such arrangements.

It is also the responsibility of pathologists to ensure that the relevant Procurators Fiscal have available to them full contact details. Even when not on duty, it is helpful if such details are known in case there is some emergency, such as an incident involving mass fatalities, in which the attendance of as many pathologists as possible may be required.

There should be no unreasonable delay in responding to a call, particularly where examination of the body at the scene is required. The Procurators Fiscal and/or police must be made aware of the time required to travel to a particular incident; this will vary from situation to situation depending on the distances involved. If there is to be an undue delay, arrangements should be in place, and adequate resources available, for the provision of a suitable deputy.
On occasion, the pathologist can reasonably expect the police to make arrangements for travel, for example to avoid the pathologist having to drive a long distance. Provision of rapid transfer by the police may also be appropriate in some cases.

4 The briefing

4.1 Standard

The briefing may occur before the attendance at the scene and / or before the post-mortem examination depending on the circumstances of the case.

At the briefing, the pathologist will liaise with the Procurator Fiscal, the SIO, the CSM and other experts present, e.g. a forensic specialist advisor, and in the light of available information, determine:

a) where necessary, health and safety issues in relation to the scene of discovery of the body and the personnel involved in the examination of that scene

b) what evidential issues are raised by the circumstances of death and how these issues are best approached

c) what risks of contamination are posed by the circumstances of the case and what measures are required to prevent such contamination

d) the plan for their examination of the scene and body

e) the best location for the autopsy and, if possible, an approximate time of arrival at that location.

The pathologist should make a full and dated record of the briefing.

4.2 Code of practice

Pathologists must ensure that they obtain such details of the circumstances of the death as are available. This should be briefed by either the Procurator Fiscal, the SIO or another officer delegated for this task by the SIO. This briefing should be carried out at the first available opportunity, and should certainly be done before the pathologist carries out any detailed examination of the body or the scene of the incident. The briefing should include any version of the circumstances emanating from witnesses, together with any possible explanation advanced by a suspect.

Adequate and appropriate briefing is essential if pathologists are to obtain the maximum information from their examination. The act of carrying out the autopsy will alter the condition of the various parts of the body and, if pathologists do not learn of possible explanations for their findings until after the examination is completed, there is a risk that the best evidence to confirm or contradict the explanation may not be available.

Pathologists will not assume that any one of explanations that have been advanced for the death is necessarily correct. They will, however, in due course consider any explanations in relation to their own findings in order to come to properly reasoned conclusions.

It is important that pathologists record any briefing given to them in sufficient detail, including the date and time, to enable the practitioner themselves (or some other individual) to recall and understand any matter that they may have had in mind when conducting the examination. The absolute importance of proper notes is stressed throughout this code.

5 Scene of the discovery of the body

5.1 Standard

The pathologist will, in liaison with the Procurator Fiscal, the SIO, the CSM and any other experts present:

a) agree the plan for examination of the scene

b) enter the scene only by the agreed route of access, using the protective clothing agreed as appropriate to the circumstances of the case

c) determine whether any special techniques or procedures may be needed during the examination of the scene and body

d) determine, in consultation with the CSM and forensic scientist (if present), what specimen recovery will take place at the scene and, in due course, take where appropriate such samples

e) ensure that all production labels necessary to ensure the chain of custody of samples removed for evidential purposes are signed at the time

f) ensure the protection of any trace evidence that is not to be collected prior to removal of the body from the scene

g) advise on the route of removal of the body from the scene and, if necessary, supervise the removal of the body by the funeral director or other appropriate person

h) bring to the attention of the CSM, and be prepared to give advice upon, any health and safety issue (where this lies within the pathologist's area of expertise)

i) where appropriate, record all medical data that assists in attempts to determine the time of the death

j) ensure that if it is necessary to manipulate the body during the examination, such manipulation is adequately recorded.

Pathologists must record full details of the scene and the body, and must document both their own actions and those of others that may be significant to the pathologist's examination.

5.2 Code of practice

5.2.1 Scene management

With advances in resuscitation, bodies are often immediately and quite properly removed from the scene of discovery and transferred to a local hospital. When a body is still *in situ*, however, careful consideration must be given to the need for a forensic pathologist to attend the scene. Even when a body has been removed, examination of the scene may provide useful evidence, even though the autopsy may already have been carried out.

The police 'murder investigation manual' documentation on homicide investigation instructs that the pathologist should be informed without delay in cases of sudden or suspicious death. On receiving notification of a suspicious death, the pathologist should develop a plan for scene management, in consultation with the Procurator Fiscal, the SIO and/or the CSM. This will often but not invariably involve the attendance at the scene by the forensic pathologist. It is recognised that with advances in forensic scientist examination at scenes, there may be competing aspects of scene examination. Nevertheless, forensic pathologists still have a

potential role in the management of most scenes, even where they do not actually attend. When a scene has not been attended, photographs, video recordings and other imaging techniques should be made available in the subsequent briefing of the forensic pathologist.

5.2.2 Action at the scene

Prior to or on arrival at the scene, the pathologist should be briefed by the Procurator Fiscal, the SIO or a senior deputy, ideally with other appropriate experts present. Pathologists should record the facts given to them at this briefing. Reference should be made to the notes on 'The briefing' given in section 4.

The scene will be under the control of the CSM and the pathologist's approach to the body and the examination of other aspects of the scene should be undertaken only after consultation `with this officer and other scenes-of-crime experts who may be present. Such discussions must include route of access to the scene and the prevention of contamination.

Where there has been no briefing before the scene visit, all of the issues described in section 4, 'The briefing', will need to be considered before entering the scene. Attendance at the scene itself may require reconsideration of decisions made at the briefing.

5.2.3 Importance of notes

Pathologists should always record their actions and observations at the scene.

5.2.4 Photography

The pathologist should advise that adequate photographs of the body are taken. If this has already happened, consideration should be given to the need for any additional photographs.

5.2.5 Position of the body

The positions of the body and that of each of the limbs and of the head should be recorded, together with the relationship of the body to adjacent objects such as furniture and other articles. The state of the clothing should also be noted.

5.2.6 Assessment of the time of death

Except where the body has been exposed to fire or is decomposed or skeletal, recording of the ambient temperature and, if possible (given the position of the body), the deep temperature of the body should be considered. However, it is recognised that the latter is invasive and may interfere with the proper collection of other, potentially more important forensic evidence at the scene. The pathologist must be able to justify his/her decision.

The genitalia and anus should be examined and swabs taken before a thermometer or thermo-couple is introduced. If, for some reason, it is not practical to measure the body temperature at the scene, it may be recorded as soon as practicable upon arrival of the body at the mortuary. The degree, location and fixation of rigor mortis and hypostasis should be noted.

5.2.7 Other aspects of scene examination

Detailed examination of the scene of discovery of the body is usually undertaken by the forensic scientists and scene-of-crime officers (SOCOs). However, the forensic pathologist may be required to inspect other aspects of the location and note any findings. The requirement is clearly a matter for discussion with the CSM, SIO and the Procurator Fiscal.

It may be appropriate for the pathologist and a forensic scientist to jointly examine the scene, including features such as the distribution and appearance of any bloodstains. Although the forensic scientist's report will contain detailed comment on such matters, it is the pathologist who should be directly responsible for giving an opinion upon the nature and possible cause of wounds that may be the source of the blood. The distribution of blood from any injuries

may need to be taken into account by the pathologist in reconstructing the way in which injuries were likely to have been inflicted.

5.2.8 Involvement of other specialists

Occasionally, it may be appropriate to seek advice from other specialists, such as forensic entomologists or anthropologists. The pathologist should consider whether the circumstances of the incident indicate the need for other specialist advice and must make the SIO aware of that. The decision to instruct other specialist advice is for the Procurator Fiscal.

5.2.9 Prevention of contamination at the scene

Only the minimum number of personnel required for efficient and safe examination of the scene should enter that scene. Where it is likely that minute traces of evidence may be important, e.g. in the use of low copy number DNA, consideration should be given as to whether the forensic pathologist has a role at all in terms of actually entering the scene prior to the taking of samples for such trace evidence. Appropriate protective clothing, as determined by the CSM, should be worn. Changes of gloves may be necessary during the investigation, particularly if productions are taken during the examination.

5.2.10 Taking of specimens at the scene

It is essential that no specimens be taken from the body until there has been consultation between the pathologist and the CSM. SOCOs and forensic scientists, if present, may also need to be consulted. Where the taking of certain samples is not considered necessary, these should be omitted only after discussion with the above parties and confirmed with the police and the Procurator Fiscal.

Tapings will often be taken from exposed surfaces of the body and possibly from the clothing, this normally being done by an appropriate person. If, for some reason, no tapings have been taken at the scene, consideration should be given to them being taken in the mortuary when the body is first unwrapped.

On occasions, it may be advisable to remove some or all of the clothing at the scene, again in consultation with the CSM and scientists.

All specimens should be taken using appropriate equipment. If clothing is to be cut, sterile instruments should be used.

When deciding what material will be relevant in any particular case, discussion with the Procurator Fiscal, the forensic scientist(s), SOCO and CSM should decide what is appropriate and where and by whom the samples should be taken. The taking of samples from the following areas should be considered:

a) tapings from exposed body surfaces and uppermost surfaces of clothing (where that clothing is such that it is considered likely that trace evidence will be shed on manipulation). If clothing is not to be cut away, the manipulation of the body required to remove clothing may dislodge or contaminate trace evidence

b) combings of head hair, beard and moustache hair and pubic hair

c) plucked hairs from the above sites, each sample being representative of the range of hairs present at those sites

d) where objective evidence of chronic drug use is relevant to the case, a pencil thickness of head hair, plucked from the occipital scalp

e) a swab or swabs from the mouth and teeth

f) tapings from the hands where any foreign material is recognised; tapings must be taken before fingernail scrapings or cuttings

g) scrapings from underneath the fingernails of each hand, or fingernail cuttings or nail swabs. Sampling from hair and hands where the death may be related to firearms or explosives must be made using only a 'Gunshot residues and explosives sampling kit' approved by the relevant forensic science laboratory

h) swabs from any moist areas on the body surface where the possibility exists that such moist stains have arisen from a person other than the body. Where there is a possibility of sex-related crime, swabs will be taken from those areas considered most likely to be productive of semen or saliva (face, neck, nipples and hands)

i) a swab or swabs from the perianal skin, taken before a swab or swabs from the anus

j) a swab or swabs from vulva and high and low vagina, taking care to avoid contamination of the latter from the initial swabbing of the former. These swabs must be taken after swabbing of the perianal skin and anus (to avoid leakage during the course of the vulval swabbing)

k) a swab or swabs of injuries that may have resulted from contact with another individual where the skin from that individual may have been shed, e.g. swabbing of the skin of the neck in postulated manual strangulation.

In each instance, when appropriate, control swabs must be taken. Multiple swabs from a single area must be numbered in the order of their taking.

5.2.11 Removal of the body

When a scene has been assessed, the pathologist will often supervise the packaging and subsequent removal of the body. If trace evidence has not been collected at the scene, the hands may be placed in bags before the body is removed. If the head is to be similarly placed in a bag, it must be remembered that any open head wound is likely to shed blood into the bag during transit. This may obscure details such as the direction of dried bloodstains and render difficult the collection of trace evidence. It is often advisable to examine the head for such material at the scene.

On arrival at the autopsy room, the body should remain undisturbed, still in its wrapping or body bag, until the pathologist arrived to undertake the examination, unless any different action has previously been agreed with the Procurator Fiscal and SIO or designate for some specific purpose.

6 The autopsy

6.1 Standard

At the mortuary, the pathologist will:

a) ensure that the body is that for which the pathologist has authorisation to conduct an autopsy and has been properly identified as agreed with the Procurator Fiscal

b) if trace evidence was not taken at the scene, ensure that as far as practicable there is no opportunity for contamination of the body from any fixture, fitting or person at the mortuary

c) take, or supervise the taking of, any necessary trace evidence not taken at the scene

d) ensure that any manipulation of clothing once removed from the body takes place over the body wrapping, so that any evidence shed from the clothing will not be lost

e) make an examination of the body in a manner that both addresses all evidential issues that may be raised by the case and, if possible, ensures that the dignity of the deceased and ethical issues relating to the deceased and the family are accommodated

f) be able to justify all examinations having regard to the context of the case and remembering that, in a criminal investigation, there may be interested parties other than the family. One party's needs must not be accommodated to the detriment of other parties subject to the primacy of the criminal investigation

g) note any significant features of the body that reveal something out of the ordinary, whether or not they appear immediately relevant to the cause of death

h) note if relevant parts of the body have been examined and no abnormality found, because the negative finding may be equally significant

i) where there are findings of apparent significance that can be demonstrated visually, ensure that photographs are taken so that others can see them for themselves at a later date

j) retain any material relevant to the cause of death and/or that may assist in the resolution of issues (whether for inclusion or exclusion of possibilities) that foreseeably may arise during the investigation of the death, including those that can be anticipated at trial

k) ensure that all production labels necessary to ensure the chain of custody of samples removed for evidential purposes are signed at the time of the post-mortem examination

l) in the light of the information provided by the SIO and Procurator Fiscal, summarise for the SIO and Procurator Fiscal the salient autopsy findings, their interpretation and their significance in the context of the apparent circumstances

m) complete the medical certificate of cause of death as soon as practicable.

Pathologists must record full details of the autopsy and must document their own actions as well as the actions of others that may be significant to their examination.

6.2 Code of practice

The Scottish Government and the College recommended that all pathologists follow the appropriate guidance published by The Royal College of Pathologists.

6.2.1 Approach to the autopsy

Having equipped themselves as far as they can with information about the likely issues to be resolved, pathologists will be ready to embark upon the actual examination. They will need to note any significant features of the body where their findings reveal something out of the ordinary, whether or not this appears immediately relevant to the cause of the death. They will also need to record carefully the fact that they have examined relevant parts of the body and found no abnormality, because a negative finding may turn out to be as significant as one that is positive.

Techniques employed during the dissection, or during any subsequent investigation, should as far as practicable be accepted and well-established procedures. Pathologists must be able to defend the use of any novel or unorthodox technique both to their colleagues and to the wider criminal justice system.

Wherever possible, and particularly where it is relevant to the investigation, the forensic pathologist should have access to the medical history of the deceased before the autopsy is commenced. Where such records are not forthcoming, the pathologist will need to decide in consultation with the Procurator Fiscal whether it would be sensible for the autopsy to be postponed until the information becomes available.

6.2.2 General considerations

Autopsies should only be conducted in mortuaries that have adequate facilities and safety procedures (see below). Where mortuary facilities are deemed to be inadequate, the pathologist should consider whether the examination should be performed at that location and, if necessary, discuss that matter with the Procurator Fiscal or the police. The location should have modern autopsy equipment, including accurate weighing apparatus for both organs and for the whole body. There should be access to equipment for radiological examination and to a radiologist's opinion in due course.

The examination should not normally be conducted without the assistance of skilled mortuary technical staff. The pathologist should brief the anatomical pathology technician (APT) on the nature of the case and their tasks. An experienced APT or similar person can assist with the dissection at the discretion of the pathologist, but must be under the control and supervision of the pathologist at all times. Technical staff may, for instance, open the head under the pathologist's supervision.

Continuity of identity from the scene of discovery should be carried out at the start of the examination and the formal identity should be confirmed to the pathologist if the identity is known. If unknown, it should be identified by reference to where and when it was found.

In suspected homicides, the Procurator Fiscal, the SIO (or an appropriately designated officer) will normally be present throughout the autopsy so that they can appreciate the autopsy findings and answer any questions that may arise about the circumstances of the case.

Appropriate SOCOs and CID should also be present. It is essential that all personnel present in the autopsy room should be subject to full precautions to protect them from infective hazards and to avoid any contamination of the body or clothing. The number of individuals in the autopsy room should be kept to a minimum.

6.2.3 Needs of relatives

The autopsy must be carried out in a manner consistent with medical ethics and respecting the dignity of the deceased. Proper consideration must be given to the needs and wishes of relatives and others who may wish to view the body. If practicable, consideration should be given to close relatives being given an opportunity to see the body before the autopsy, but only after relevant trace evidence has been taken. Before such a viewing is undertaken, there should be discussion between the pathologist, the Procurator Fiscal, the SIO and the family liaison officer (FLO) so that the relative is fully informed, for example, of any features that might cause distress. If the viewing is to take place after the autopsy, the pathologist should consider whether any dissection, which may render viewing of the body by relatives distressing, may be postponed to a time when all such viewings have been made.

6.2.4 Involvement of other specialists

Pathologists must consider whether they have the appropriate expertise to perform an autopsy in the circumstance of that case and request the attendance of an appropriate expert if necessary. Pathologists must cooperate in an appropriate manner with such experts.

If investigation of the case requires the assistance of other specialists, for example a paediatric, cardiac or neuropathologist, it is the responsibility of the pathologist to make appropriate recommendations to the SIO and Procurator Fiscal. If that expert cannot attend,

the pathologist must seek advice from the expert to determine what material might be required for later examination and interpretation, and ensure it is recorded and/or preserved in an appropriate manner.

6.2.5 Photography

It is the duty of the pathologist to ensure that adequate photographs are taken of the whole body and of all wounds or other abnormal features before commencement of dissection. This process may also involve consideration and discussion of quasar or other imaging. Photography in the mortuary should only be carried out under the supervision of the pathologist. Pathologists may take their own photographs, both at the scene and in the mortuary, but the report must indicate that such photographs exist.

Where there are findings of apparent significance that can be demonstrated visually, these should normally be photographed so that others will be in a position to see for themselves at a later date. It will be particularly important to record the condition of the body in situations in which the examination will itself interfere with the finding and thus prevent anyone else from assessing the significance of the finding.

Where a photograph is to record detail (e.g. an injury), it should incorporate a scale.

Copies of all photographs taken during the post-mortem examination and relevant locus photographs should be provided to the pathologists as soon as possible after the examination to facilitate the preparation and timely submission of the post-mortem examination report to the Procurator Fiscal.

6.2.6 Radiology

Radiological examination should be part of the examination of all cases of suspected non-accidental injury in children, in all sudden infant deaths and in all appropriate deaths involving firearms or explosives. It can also be of considerable assistance in the examination of badly burnt or decomposed bodies and may be appropriate in other instances. The pathologist will be responsible for advising on the need for such examination and the assistance of a consultant radiologist where necessary.

6.2.7 Autopsy notes

Comprehensive contemporaneous notes are essential and should be taken of every procedure undertaken. Such notes may be written or dictated. Where appropriate, notes should be accompanied by diagrams.

Notes must include the time, date and place of the autopsy. If not otherwise recorded, it is good practice to record the names of all those present at the autopsy, with an indication of the role of each one in the mortuary.

6.2.8 Removal of clothing

Any clothing on the body must be removed carefully, preferably without cutting, and placed in appropriate bags with due care to avoid contamination. This should be done after trace evidence has been removed from the accessible areas of the body, particularly the hands (unless they are bagged). Although detailed examination of the clothing is a matter for the forensic scientist, the pathologist should check it for damage such as cuts, which may influence the conclusions to be drawn from the examination of the body. Any such manipulation of the clothing should take place over the wrapping material so that any shed evidence is not lost. In some instances, tapings should be taken from the surface of the clothing before removal; this is usually done by a forensic scientist or SOCO. It is important in some instances that serial photographs should be taken as each garment is removed.

Adequate notes must be made of the procedure and the findings.

6.2.9 Collection of trace evidence from the body

The pathologist must ensure, if all samples have not been taken at the scene, that there is no opportunity for contamination of the body from any fixture, fitting or person at the mortuary. Samples should be taken after discussion with the Procurator Fiscal, the SIO and appropriate experts. Only where these discussions indicate that samples are not considered necessary should they be omitted; such discussions should be documented.

Where samples may be of value, reference should be made to the list of samples noted in paragraph 5.2.10, 'Taking of specimens at the scene'.

Clearly, in some cases the autopsy is not carried out until after a period in hospital, in which case the collection of some or all specimens may be pointless.

6.3 Autopsy procedures

6.3.1 Measurements

Metric measurements should be used. Imperial measurements are still felt to be more readily understood by the court, especially in the case of larger measurements such as body height and body weight. If the imperial equivalents are not stated in the report, the pathologist must be prepared to provide them when giving evidence.

6.3.2 External examination

The description of the body should include age, sex, build, height, ethnic group, weight, nutritional state, skin colour and special characteristics such as scars, tattoos, etc. Notes should also include the length, colour and distribution of hair and beard; the presence or absence of petechiae in the face and neck and the appearance and length of the fingernails.

The presence (or absence) and distribution of hypostasis should be recorded.

If not already dealt with at the scene, rigor mortis should be systematically tested for if potentially of relevance to the case.

Signs of treatment should be recorded. Medical devices should not be removed from the body before the autopsy.

6.3.3 Examination of injuries

All injuries must be described by shape, exact measurements, direction, edges and angles. The location relative to anatomical landmarks and, if appropriate, the height above the heel should be measured.

In cases of multiple repetitive injury, it may be appropriate to describe groups of injury.

In the case of closed injuries, such as bruising, the colour should be noted. Local skin incision may be appropriate in the assessment of bruising.

Skin reflection may be necessary in some parts of the body, but unnecessarily mutilating dissections and destructive examinations should be avoided. Any dissection that does take place must be of such type that the body can adequately be reconstructed. All dissection carried out at autopsy must be justified in the context of the case. There should be a low threshold for the examination of subcutaneous tissues for evidence of bruising, particularly in dark-skinned individuals where bruising may not be apparent at the skin surface.

It is often important to dissect the face from the underlying facial skeleton. If the whole dissection is performed skilfully and carefully, the face can be replaced with little significant distortion.

6.3.4 Internal examination

Pathologists should adhere to the appropriate guidance as published by The Royal College of Pathologists. The standard of internal autopsy dissection must be comprehensive. In addition to the forensic aspects of the examination, careful attention must be paid to any features that may be relevant to natural disease or medical intervention.

Incisions should be appropriate in relation to the nature of the case.

The state of body cavities should be described and the amount of fluid or blood in each cavity should be measured.

All organs must be dissected and accurately and adequately described with weights of major organs. Other measurements should be recorded as appropriate.

The appearance and approximate volume of the contents of the stomach and bladder should be recorded. It may be useful to discuss the potential value of the stomach contents with the SIO and Procurator Fiscal.

Examination of the generative organs must not be omitted.

6.3.5 Collection of internal specimens at autopsy

Pathologists must ensure that all necessary samples are taken for toxicology and are properly preserved. They may need to discuss with an experienced toxicologist what specimens may be required. Pathologists should also be aware of the effect on samples of any medical intervention, such as blood transfusion or the administration of drugs prior to death, on specimens taken at the autopsy. These should be discussed in the autopsy report.

Blood should be taken from a peripheral vein, preferably the external iliac or femoral, and the site of collection should be recorded in the pathologist's notes.

Control samples, for example for DNA examination, should be collected and retained according to the instructions given by the responsible forensic science laboratory.

In addition, pathologists must consider whether other types of microscopic or other laboratory examination will be necessary, and whether samples for these purposes should be taken at autopsy. In some circumstances, pathologists will decide that tissues or organs need to be retained for later examination. In such instances, they must make appropriate arrangements, including informing the Procurator Fiscal responsible for the body.

6.3.6 Post-mortem histology

A histological examination should be made, by the pathologists themselves, of the major organs (assuming that they are not heavily decomposed) in all suspicious deaths. Histology is of value in confirming, evaluating and sometimes revising the course of natural disease processes that may have contributed to the cause of the death. Other samples should be taken for histological examination depending on the circumstances of the case, e.g. for the purposes of ageing injuries. The reasons behind any decision not to undertake a histological examination must be adequately recorded, in order that the pathologist may be in a position to defend this decision if required.

6.3.7 Health and safety issues

The pathologist has a role in advising on health and safety in the post-mortem room. However, it is recognised that other professionals present will be expected to follow their own guidelines and the pathologist cannot be held responsible for any breaches in adherence to those guidelines by others present. The pathologist is expected to set an example in matters of health and safety.

All those involved will be expected to take very serious account of the pathologist's directions, particularly when dealing with a recognised or potential high-risk case.

Any autopsy room used for the examination should be fit for purpose and should reach accepted safety standards and hold (or at least be working towards) UKAS or equivalent accreditation. A properly trained APT should be in attendance.

The Health and Safety Executive's (HSE) view is that any autopsy where infective disease cannot safely be excluded should be treated as a high-risk case, and this will include a high proportion of suspected homicides. The pathologist should take careful account of local standard operating procedures**.**

6.3.8 Retention of material after autopsy

Retention of material, particularly organs, removed at autopsy may cause considerable distress to bereaved relatives, and the pathologist must consider very carefully whether such material needs to be retained and for what purpose.

The Procurator Fiscal shall make provision, so far as possible, for the preservation of material which in their opinion bears upon the cause of death for such period as the Procurator Fiscal thinks fit. Blocks and slides will be preserved as part of the medical record.

It is important to allow families of those who have had a post-mortem examination instructed by the Procurator Fiscal the opportunity of authorising the use for purposes such as education and research of any organs or tissues retained as a result of the examination, provided these are no longer required for the Fiscal's purposes. The Human Tissue (Scotland) Act 2006[4] provides that tissue samples retained should become part of the deceased's medical record once the Fiscal has indicated that they are no longer required for his or her purposes, and can be used for diagnostic purposes and audit without the authorisation from the nearest relative, and for research, education and training provided those uses have been properly authorised and provided also that ethical approval is in place.

The Act also allows for the possibility that whole organs no longer needed for the Fiscal's purposes could be used for education, training or research provided proper authorisation has been given for these uses. The Act extends the hierarchy of relatives to include someone who had a long-standing professional relationship with the deceased person.

The Act also sets out the basis on which organs retained from a post-mortem examination instructed by the Fiscal can continue to be kept in existing holdings.

6.3.9 Non-invasive examinations

The College and COPFS do not consider the use of non-invasive examination methods, by themselves, sufficient in cases involving violent or suspicious deaths.

7 The pathologist's autopsy report

7.1 Standard

The pathologist will:

a) produce a formal report that will record:
   i. the relevant information the pathologist received in advance of the autopsy
   ii. all investigations made either personally or by submission to a laboratory for report
   iii. conclusions and an explanation for those conclusions; where unusual features are found but are concluded not to be relevant, the pathologist must explain why the finding has been discounted

iv. the reasoning underlying why, where findings are susceptible of alternative explanations, one explanation is favoured

v. the reasoning that supports conclusions, detailing all material drawn upon to support that reasoning, including reference to pertinent and current literature

vi. all samples that have been retained by the pathologist

b) comply with the requirement that the taking of samples at autopsy, the findings of the post-mortem examination and the cause of death and related issues be corroborated by a second pathologist, and that the report be signed by both

c) produce the report within the timescale agreed by contract or local service delivery agreement taking into consideration the complexity of the case. This will depend on the investigations and expertise required.

d) consider additional information revealed by investigations after the provision of a report and, where necessary, produce a supplementary report incorporating that information and drawing further conclusions

e) ensure that the detail within any report reflects standards contained in relevant and current guidance.

7.2 Code of practice

7.2.1 General comments

In general terms, the report or statement must be clearly laid out, section by section, in an easily read format. The following sections are recommended:

- report preamble
- history (see below)
- scene examination
- external examination
- internal examination
- supplementary findings and additional investigations (histology, etc.)
- commentary and conclusions
- cause of death
- note on retention of samples, tissues and organs and list of samples retained.

The essence of the report of an expert witness is that it should be easily read and unambiguous. The commentary or conclusions section must be intelligible and easily understood by non-medical people, so as to render it suitable for presentation in court. The report should be clearly divided into sections and, where appropriate, sub-sections. The language should be as straightforward and as simple as possible, whilst nevertheless retaining complete accuracy and balance and being sufficiently detailed to allow other medical experts to fully comprehend the abnormality or injury being described.

It should be remembered that decisions with serious legal implications may be based partly, or even solely, on the pathologist's report. It must be sufficiently detailed to allow these decisions to be made. In view of this, it must be written in a fair and impartial manner, having taken into account all the relevant issues of the case.

7.2.2 Report preamble

The report preamble must set out the full name, age, etc. of the deceased, together with the date, time and place of the autopsy. The pathologist's name, qualifications and appointment must be stated.

In order to properly identify all the circumstances surrounding the autopsy, the report should also make reference to the authority of the Procurator Fiscal instructing the autopsy and include the persons identifying the body to the pathologist.

7.2.3 History

The pathologist should record and may wish to summarise in their report the information that they were given before the autopsy was performed, and should identify the sources of such information. The inclusion of background information, such as the deceased's duration in hospital and/or the treatment given prior to death, can be of considerable assistance to those reading the report, whether they are lawyers preparing a case for court or medical colleagues who may be asked to comment.

Much of this information is likely to have been provided to the pathologist during their initial briefing; it will also come from the deceased's medical history. Proper recording of this information is essential and reference should be made to section 4, 'The briefing', and paragraph 5.2.3, 'Importance of notes', above.

7.2.4 The scene of the death

The record of the scene visit must include a note of the date and time of arrival at the scene, a note of the location and a general description of the locus and the body, and must state which pathologist(s) attended at the scene.

A note must be made of recordings taken (e.g. environmental and body temperatures) and of any samples, etc. taken prior to removal of the body.

7.2.5 External appearance of the body

The record should commence with a note of the state of the body as received in the mortuary and a description of the presence of any bloodstaining, etc. An inventory must be made of the clothing as it is removed from the body. Within this section should be a note of the height, weight and build of the individual. The presence and extent of rigor mortis should be tested for and noted if relevant. The position of hypostasis should be recorded. The limitations of any conclusions drawn from body temperature, rigor mortis or hypostasis should be made clear in the report.

Mention should be made of the hair, eyes, ears, nose, mouth, scars, tattoos, fingernails, etc., even if these are normal. Negative findings, e.g. the absence of petechiae in various parts of the face in suspected strangulation, are just as significant as positive ones.

7.2.6 Injuries

Injuries, no matter how trivial, must be described in detail using recognised terms, with measurements given. The position of injuries must be described with reference to appropriate anatomical landmarks and in some instances with reference to the height above the heel. The description must include the type of injury and an indication as to whether it is of recent origin. A numerical identification system may be particularly useful where reference is to be made to specific injuries in other parts of the report. It may be helpful to record the injuries on an outline body chart, as this may assist the pathologist and others in any subsequent discussion of the case.

A separate section of the report dealing specifically with injuries is the easiest way of recording these findings, including both external and internal features. It may be best to describe the major injuries first and/or to group injuries according to type or anatomical location.

7.2.7 Internal examination

The internal examination must follow the appropriate guidance published by The Royal College of Pathologists. For ease of reading, the report should be divided into sections, each with an appropriate subheading.

Particular attention should be given to those organs that are diseased or injured. Also included would be the presence or absence of skeletal injuries, e.g. skull fractures. Where features out of the ordinary are found and the pathologist concludes that they are not relevant, the reasons for discounting these findings must be explained.

In addition to a full description of all the major organs, their weights should be recorded. Descriptions should be objective.

7.2.8 Supplementary examinations

Included in this section would be the results, (if available), of toxicological analyses, X-rays, neuropathology, histology and the results of any other tests or examinations that were carried out.

Where test results or any other finding included in the report are the work of another person, it must be made clear who made the finding or produced the results.

The pathologist must ensure that all tests which he or she performs or commissions, whatever the result subsequently obtained, are listed and revealed to those instructing the pathologist.

7.2.9 Commentary and conclusions

In this section, the pathologist should attempt to explain in easily understood language the cause and mechanism of death, as well as other relevant findings. This must be set out clearly and in a comprehensive manner to allow interpretation of the information by the police and Procurator Fiscal. The opinions expressed must be fair and unbiased and under no circumstances should be written to assist one side rather than the other. No information that may have a significant bearing on the death should be excluded, for instance in order to shorten or simplify the report. When giving opinion, the pathologist must state clearly where that opinion is based on their own work and where it relies heavily on the work, pathological findings, test results, etc. of others.

A good, well thought out commentary will be invaluable in many circumstances in allowing the Crown Office to decide whether to proceed with a prosecution. This may have significant ramifications, e.g. in facilitating the release of a prisoner in custody or preventing a potential miscarriage of justice. There may also be financial implications if a decision is taken not to proceed with a case.

Where relevant, comments should include details such as the amount of force likely to have been used, the type of weapon, the direction of injuries and the probable rapidity of death. In circumstances in which an assessment of the likely time of death is required, it must be given with adequate and defensible margins.

The conclusions reached following an examination should be clearly set out in the report giving the reasons for reaching these conclusions. It is also necessary to give some indication of the reliability of such conclusions, and possible alternate explanations or opinions should also be given. Where features out of the ordinary are found and the pathologist concludes that they are not relevant, the reasons for discounting these findings must be explained.

From the scientific findings, the pathologist may be able to construct a picture of the sequence of events that occurred. The pathologist should clearly state the evidence and rationale on which the conclusion was based. However, the pathologist must not engage in unfounded speculation or conjecture. Should the findings suggest more than one picture of the sequence of events, then all the relevant scenarios must be stated.

7.2.10 Cause of death

This should be given in the usual manner as prescribed by the Registrar General, i.e. 1(a) .... , due to 1(b)…., II….etc. Since this system may not be familiar to lawyers and others who will read the report, it may be important to elaborate on this information, for instance in the conclusion section of the report and, if appropriate, when giving evidence in court.

If, having considered all the evidence, no cause can reasonably be found for the death, then the pathologist must record it as ‘unascertained’, ‘undetermined’ or similar.

7.2.11 Retention of samples

The report must clearly indicate what material has been retained and submitted for further scientific examination, e.g. blood samples, swabs, etc. It is essential to include a list of any organs, such as the brain, retained for further examination. If no organs are retained, a simple statement to this effect in the report is necessary.

7.2.12 Final check

Before the report is signed and issued, the pathologist must check it for errors such as typographical and grammatical mistakes. Simple mistakes, such as the substitution of ‘left’ for ‘right’ or ‘millimetres’ for ‘centimetres’, may significantly alter the interpretation of a finding by the reader. Furthermore, a poorly presented report with multiple errors gives the impression of a lack of care or interest in the completion of the report and, by inference, in the conduct of the autopsy and in the interpretation of the findings.

7.2.13 Time of submission of the report

The report must be submitted to the Procurator Fiscal in accordance with contractual arrangements. In some instances, it is appropriate to submit a preliminary report, detailing as far as possible the expected timing of the pending final report. If there is to be a significant delay, the reasons for this should be given and explained. Normally, delays should only be those occasioned by the need for time-consuming special investigations, such as toxicology, neuropathology or cardiac pathology. Routine histology should not be a reason for significant postponement of a final report. However, it is preferable that the report should be as detailed and comprehensive as possible, even if this does cause some delay in its completion. In most instances, this will be more helpful to the user than the issue of multiple supplementary reports or statements.

7.2.14 Disclosure of information

The overriding duty of the pathologist is not to mislead the Court, and to ensure that all findings are disclosed to the Procurator Fiscal. Disclosure to the defence is dealt with in section 9.

8 Conferences and other subsequent action

8.1 Standard

The pathologist will:

a) attend any request for precognition or consultation by the Procurator Fiscal or advocate depute to discuss the pathologist's report or other issues involved in the case

b) explain clearly all findings and their interpretation in the context of the case

c) consider alternative explanations, test alternative hypotheses, draw conclusions and give advice based on the facts of the case and established scientific principles

d) state what is required before additional conclusions can be drawn and demand that those requirements are fulfilled before any additional conclusions are drawn

e) identify, clarify and summarise areas of agreement and disagreement

f) seek feedback to determine whether those involved understand the concepts discussed at precognition/consultations

g) advise the Procurator Fiscal/advocate depute of any significant change in their opinion on the cause and mechanism of death

h) make themselves available to speak to nearest relatives where appropriate.

8.2 Code of practice

8.2.1 Attendance at consultation

COPFS has a policy of consulting with expert witnesses as part of the preparation of most High Court cases. Accordingly, the case investigator will usually meet with at least one of the two authors of a joint report to discuss the findings, clarify any unfamiliar or unusual terminology or findings and also to establish the opinions which are to be given by that pathologist based on those findings. COPFS may also wish to seek the pathologist's opinion on any defence which is known, or to discuss the content of any defence post-mortem report.

On occasion, the advocate depute who is prosecuting the case may be present at the consultation or may seek to hold a separate meeting with the pathologist. The COPFS member of staff will record the content of the consultation and then send a written note of the meeting to the pathologist. The pathologist will be asked to read this and to highlight any inaccuracies or misunderstandings found in the written note. The pathologist will then be invited to sign the final copy record of the consultation.

8.2.2 Availability for consultation

There may be cases where the Procurator Fiscal/advocate depute needs to discuss an aspect of the case – this may be because new information has come to light or for other reasons. In these situations, pathologists may be asked to make themselves available for consultations (either in person or over the telephone) with the Procurator Fiscal/advocate depute, either prior to the trial commencing or prior to leading their evidence.

8.2.3 Change of opinion

In order for cases to be processed fairly, professionally and effectively, pathologists must advise the Procurator Fiscal/advocate depute of any significant change in their opinion on the cause and mechanism of death.

9 The pathologist and the defence

9.1 Standard

The pathologist will:

a) make a reasonable attempt to attend any additional autopsy made by a pathologist retained on behalf of any person charged in relation to the death (the 'defence pathologist')

b) make available to that defence pathologist a copy of any locus or autopsy report if requested, unless otherwise instructed by the Procurator Fiscal

c) ensure that the existence of all the material in the pathologist's possession and any report arising from any further pathological investigation is, on request, and with the knowledge of the Procurator Fiscal, disclosed to any defence pathologist

d) where necessary, advise the Procurator Fiscal and the police on any necessary measure which should be taken to preserve the body.

9.2 Code of practice

Although this code has been written primarily from the standpoint of the pathologist acting for the prosecution, practitioners should also be aware of the needs of lawyers who may be called upon to defend an accused person.

Where a second autopsy is to be carried out, pathologists acting on behalf of the COPFS should, if requested, share all the information that they have obtained, whether or not they have concluded that it provides an explanation for the death. The initial autopsy may have caused changes to the body that will obscure findings made during the course of that examination. It may also prevent the observation of other significant features. There is also a clear responsibility to avoid any interference with the body unless it is necessary to reach a proper understanding of the death.

In order to facilitate an autopsy examination conducted on behalf of the defence, pathologists acting on behalf of the COPFS must ensure that all pathological specimens retained following the first autopsy have been preserved under the best possible circumstances. These specimens must be made available to the defence pathologist. If they are retained after any defence examination, possession of these productions must remain with the pathologist acting on behalf of the COPFS unless otherwise directed by the Court or by agreement with the Procurator Fiscal.

If, during the second autopsy, a previously unrecognised finding is discovered by the defence pathologist, this should be recorded as appropriate and discussed with the pathologist who carried out the first autopsy.

Forensic pathologists acting on behalf of the COPFS will themselves, on occasion, be called on to act for the defence. While the circumstances may be different, in that the pathologist will usually be examining a body on which an autopsy has already been performed, as far as possible the same high standards must be applied to any examination undertaken.

10 Attendance at court

10.1 Standard

The pathologist must:

a) ensure that they are well prepared prior to attendance at court to give evidence

b) ensure that appearance and behaviour conform to acceptable professional standards

c) deliver evidence in an audible and understandable manner

d) give evidence consistent with the contents of the written report

e) deal with questions truthfully, impartially and flexibly

f) identify questions that are unclear and clarify them before offering a response

g) give answers to technical questions in a manner understandable by those who have no technical or scientific training

h) differentiate between facts and conclusions drawn from those facts, and ensure that any such conclusions lie within their field of expertise

i) consider additional information or alternative hypotheses that are presented and, where warranted, modify conclusions already drawn

j) where it appears that a lawyer has misunderstood or is misstating evidence, ensure that the court is made aware of that misunderstanding or misstatement.

10.2 Code of practice

Pathologists must ensure that they are appropriately prepared prior to attending court to give evidence. The evidence must be objective and fairly presented and attention must be drawn to any areas of speculation. Proper and objective consideration must be given to any interpretations or conclusions fairly raised by the defence, particularly if they are supported by their own expert opinion.

The role of expert witnesses is not to provide evidence that supports the case for the prosecution or for the defence. Opinions must be objectively reached and have scientific validity. Witnesses must make it clear which part of their evidence is fact and which is opinion. The evidence on which that opinion is based must also be available.

Facts may emerge during the course of an investigation, and sometimes even during the course of the trial, which may make the pathologist modify a previously held opinion. Pathologists have a duty to give any new facts due consideration and ensure that their evidence remains objective and unbiased. If previously held conclusions can no longer be substantiated, any change of opinion must be promptly and clearly stated, irrespective of any possible embarrassment. Delay will not only potentially harm the administration of justice but will reflect adversely upon the reputation of the pathologist.

11 References

1. Brinkmann B, Mangin P. Recommendation R(99)3. The harmonisation of medico-legal autopsy rules and its explanatory memorandum. *Forensic Science International* (Special issue), 2000;111 (issues 1–3):5–29.

2. General Medical Council. *Good Medical Practice.* London: General Medical Council, 2013. www.gmc-uk.org/guidance/good_medical_practice.asp

3. General Medical Council. *Acting as a Witness in Legal Proceedings*. London: General Medical Council, 2013. www.gmc-uk.org/guidance/ethical_guidance/21188.asp

4. Human Tissue (Scotland) Act 2006. www.legislation.gov.uk/asp/2006/4/contents

FORENSIC PATHOLOGIST CONSULATION PROTOCOL

A Code of practice and performance standards for forensic pathologists dealing with suspicious deaths in Scotland has been published by the Royal College of Pathologists and the Crown Office and Procurator Fiscal Service. The Code is supplemented by the following consultation commitments on the part of forensic pathologists:

- Pathologists instructed by the Crown should be available, if required, to consult with the pathologist instructed by the defence to ensure that the latter is content that all appropriate examination has been undertaken by the Crown;

- That, if available, the Crown pathology report should be made available to the pathologist instructed by the defence to inform this consultation. A draft report may similarly be made available provided it contains all significant facts.

- That the Crown examination photographs should be made available to the pathologist instructed by the defence to similarly inform the consultation.

- That the pathologist instructed by the defence should consider whether or not a further physical post mortem examination is required or whether, following consultation with the Crown pathologist, a physical examination is of limited value and the pathologist instructed by the defence can provide an expert opinion based upon the available records and samples from the first post mortem examination.