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

Email: president@rcpath.org

Bridget Dolan QC
Serjeants' Inn Chambers
85 Fleet Street
London
EC4Y 1AE

25 July 2019

Dear Ms Dolan

Regulation 28: Report to prevent future deaths following the inquest into the death of Private Geoff Gray. Response on behalf of the Royal College of Pathologists

Firstly, the Royal College of Pathologists would like to express our condolences to the families, friends and all those affected by the tragic deaths of Private Geoff Gray, Private Sean Benton and Ms Cheryl James.

The Royal College of Pathologists (the College) works to ensure the highest quality of pathology services are provided by its members to facilitate the highest quality of care possible is provided to the public and all those who use pathology services.

The issues raised by HH Peter Rook QC, assistant coroner for the coroner area of Surrey, are extremely serious and have been reviewed by the College. Following this review we have the following response:

While the College has been provided with various documents including the relevant regulation 28 report, some transcripts of court proceedings and the record of the inquest, the College representatives were not present in court nor had access to all the relevant material relating to the case including the various pathologists reports. All the specific details of the case are therefore not available for review by the College and therefore the College response is somewhat general in nature.

The College has discussed the issues raised and its responses with the Medicolegal division of the Coroners Society of England and Wales and with the Forensic Pathology unit of the Home Office both of whom support the College views and responses.

The College document quoted "Royal College of Pathologists - Standards for Coroners' pathologists in post-mortem examinations of deaths that appear not to be suspicious February 2014" is currently being updated. While this does not and will not alter the College responses shown below this and all regulation 28 reports and similar feedback to the College is and will be born in mind when updating this and other documents and in College teaching and training material so that members and other interested parties can learn from these tragic events.

The College will deal with the issues raised by the assistant coroner in order.

The MATTERS OF CONCERN are as follows:

1. I instructed Professor Jack Crane as an independent expert in forensic pathology. He told me that the practice in Northern Ireland is that every firearms death, whatever the circumstances, will be subject to a forensic post-mortem.

The type of post mortem conducted by a pathologist is decided by the coroner dealing with the case in conjunction with other parties investigating the death. College guidance states "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" (1) &

while a pathologist should "ensure he or she has the appropriate expertise to make the post-mortem examination and, if not, to advise the Coroner to seek an appropriate expert to conduct or advise on the procedure" (1) the final decision as to the type of post mortem examination ordered and funded by the coroner and other investigating parties is purely at the discretion of the coroner and those parties. The College and its members therefore are not able to action this suggestion themselves. If any such rule was proposed the College would hope to be actively involved in those discussions as a major stakeholder and would involve itself in any relevant consultation process. The College would highlight however that any such rule would require the appropriate manpower, logistical support and funding issues be addressed adequately if it were to be achievable.

2. Both Professor Crane and Dr Robert Chapman, the forensic pathologist who conducted the post-mortem told me that that there is no specific guidance to either pathologists, and as I understand it to coroners, that urges them to give particular consideration to the nature of the post-mortem examination in cases of death by firearms, even when that death is of a child.

Please see the College response to point 1 above.

3. It is of concern that where assumptions of suicide lead to cursory post-mortem investigations this creates a risk that homicides will go undetected. The higher the possibility that homicides will be distinguished from self-inflicted deaths, the greater the deterrence to those who might have reason to try to make a murder look like a suicide.

The type of post mortem conducted by a pathologist is decided by the coroner dealing with the case in conjunction with other parties investigating the death. A standard coroners post mortem aims to provide the cause of death "on the balance of probability" the burden of proof required in a coroners court. If such a standard coroners post mortem is deemed to be appropriate by the coroner dealing with the case in conjunction with other parties investigating the death they must be clear that all that is required is the provision of the cause of death "on the balance of probability". If in depth investigation, complex assessment, complex ancillary studies and interpretation and so forth are required because the case might be suspicious or because this information may be required for other investigative purposes then a standard coroners post mortem is not suitable and a full formal forensic post mortem is appropriate.

4. The use of a forensic post-mortem, or at very least something more than a basic 'routine' examination in all cases of sudden death by gunshot may, by enhancing the quality of investigations and ensuring that assumptions of suicide are properly tested, reduce that risk.

Please see the College response to point 1 above.

Action Points

In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

1. I consider that the Chief Coroner and the Royal College of Pathologists, should review the issues raised by Geoff Gray's case and those of the other deaths of trainees at Princess Royal Barracks
and consider whether there is a need for any amendments to their current guidance to suggest that in cases of death from gunshot wounds, even should the initial evidential inquiries point towards self-infliction, fuller consideration should be given to the nature of the post-mortem examination to be carried out.

The type of post mortem conducted by a pathologist is decided by the coroner dealing with the case in conjunction with other parties investigating the death. College guidance states "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" (1) & while a pathologist should "ensure he or she has the appropriate expertise to make the post-mortem examination and, if not, to advise the Coroner to seek an appropriate expert to conduct or advise on the procedure" (1) the final decision as to the type of post mortem examination ordered and funded by the coroner and other investigating parties is purely at the discretion of the coroner and those parties. The College and its members therefore are not able to action this suggestion themselves. If a rule that all firearms deaths were conducted as forensic post mortems was proposed the College would hope to be actively involved in those discussions as a major stakeholder and would involve itself in any relevant consultation process. The College would highlight however that any such rule would require the appropriate manpower, logistical support and funding issues be addressed adequately if it were to be achievable.

2. Where the circumstances are deemed not to require the extremely invasive and costly procedure of a forensic autopsy, consideration might nevertheless be given to whether a 'routine' coronial autopsy should be enhanced by (i) photography, (ii) x-ray or CT imaging, (iii) the clear recording of the presence or absence of projectiles (iv) drawing body maps (v) the identification of
likely wound tracks, (vi) hand swabbing; (vii) recording of any damage to clothing and (vii) the preservation of clothing for potential chemographic analysis by others.

The type of post mortem conducted by a pathologist is decided by the coroner dealing with the case in conjunction with other parties investigating the death. A standard coroners post mortem aims to provide the cause of death "on the balance of probability" the burden of proof required in a coroners court. If such a standard coroners post mortem is deemed to be appropriate by the coroner dealing with the case in conjunction with other parties investigating the death they must be clear that all that is required is the provision of the cause of death "on the balance of probability". If in depth investigation, complex assessment, complex ancillary studies and interpretation and so forth are required because the case might be suspicious or because this information may be required for other investigative purposes then a standard coroners post mortem is not suitable and a full formal forensic post mortem is appropriate. In the view of the College there is no place for this suggested "enhanced" quasi forensic post mortem in cases which might seem to fall into this suggested category as in such cases only a full formal forensic post mortem with all the associated appropriate support and funding would adequately address the issues and therefore be suitable.

3. If such steps are not taken at the very outset of investigations because of early assumptions regarding suicide it increases the risks of relevant information being lost and potential homicides going undetected.

Please see the College responses to Action points 1 & 2 above and the other College comments attached.

Reference:
1 – Royal College of Pathologists - Standards for Coroners' pathologists in post-mortem examinations of deaths that appear not to be suspicious February 2014.

Yours sincerely

J.E. Martin

Professor Jo Martin MA MBBS PhD FRCPath
President