14th July, 2021

Dear Mrs Hunt,

Thank you for your prompt response.

We agree in principle to this fee schedule, but wish to propose minor amendments/refinements to more accurately enable recognition of additional effort required for a small number of cases, which might fall outside the Leicester model as it stands. We have drawn from our own collective experience and from practice in other Coroners' jurisdictions. We suggest the Special Examination fee be applicable for the following categories;

- Post-mortem examination on a decomposed body (#1).
- Complex peri-operative & post-operative or other complicated medical deaths (#2).
- Deaths during or following an invasive medical/radiological procedure.
- Deaths in a care/nursing home where there are potential allegations of neglect, abuse or suboptimal care.
- Deaths during custody or deprivation of liberty (#3).
- Deaths from abroad.
- High risk infectious cases (#4).
- Death related to occupation (#5).
- Maternal deaths (#6).
- Bodies recovered from fire (#7).
- Bodies recovered from water (#8).
- Examinations requiring histology.
- Examinations requiring interpretation of toxicology results (#9).
- Non-forensic road traffic deaths and other civilian multiple mutilating trauma (#10).
- Special circumstances (including SUDEP, SACD, maternal deaths) (#11).
- Any other category, as deemed by a Coroner and/or a Pathologist, as requiring a Special Examination (#12).

#1 The degree of decomposition being more than trivial or minimal and sufficient to cause deviation from a standard autopsy protocol and/or require extra procedures (as outlined in the Leicester schedule).

#2 This would include the Leicester category of *death before recovery from an anaesthetic, or death immediately after induction of an anaesthetic*, also other cases requiring time-consuming review of a considerable body of medical notes/evidence and/or complicated medical interpretation or opinion, cases subject to NHS or other regulatory body investigation (eg SUI, WMAS, CQC etc), and where there are other complaints to be addressed and/or detailed explanations requested for the benefit of next-of-kin or other interested persons.

#3 For example deaths in Police custody or prison, and deaths whilst sectioned under The Mental Health Act (1983).

#4 To include suspected or proven hepatitis B, hepatitis A, HIV, TB, SARS-CoV-2 COVID-19, or other infectious pathogens (predominantly HSE Hazard Groups 2 to 4).

#5 To include suspected or proven scheduled prescribed industrial disease, and deaths at work, where there may be additional investigation by other organisations such as the HSE.

#6 To include the Leicester categories *unexplained death in a pregnant mother, death during labour and death of a mother within 28 days of delivery*, but extended to 12 months post-partum to encompass the NCEPOD/CMACE/CEMD definition of a late/delayed maternal death (ie more than 6 weeks but less than 12 months after the end of pregnancy).

#7 To also cover cases where death may ultimately not be attributed to burn injury and/or smoke inhalation.

#8 Where drowning is suspected and may, or may not, be confirmed pathologically.

#9 Where toxicology results require time-consuming interpretation and/or research for poly-pharmaceutical interactions, but not including, for example, negative results in a straightforward hanging case.

#10 Railway deaths may involve just as much effort as RTCs, and will inevitably involve a BTP investigation. Civilian deaths alongside the military, and aviation deaths exceptionally occur.

#11 Cases where there are published best practice guidelines & protocols, involving toxicology and/or histology, also ad hoc cases where the MCOD is initially unascertained.

#12 It is an important principle (supported by the RCPath & Chief Coroner) that it must be the individual Pathologist, invited to handle any particular case who, in consultation with HM Coroner, ultimately has the professional discretion to decide upon the nature/extent of an examination, tailored to the circumstances in hand – for example, taking toxicology samples and/or histology specimens & determining a case to be potentially hazardous to mortuary staff/funerary personnel are clinical decisions, not legal ones.

This is not exhaustive. Rare scenarios such as electrocution, brachytherapy/radioactive implant removal and poisoning with toxic substances hazardous to mortuary staff (cyanide poisoning) spring to mind but could be accommodated in the spirit of the above schema.

The anticipation is that the Pathologist's fee is independent of histology or other costs, which would be negotiated by the relevant provider (such as the histology & toxicology laboratories and post-mortem imaging services), and invoiced directly to the Local Authority without interlocution by the Pathologist.

We feel that the above suggestions are a more reasonable and proportionate compromise than the present scale of fees, mindful that the Cambridge & Sunderland (Deputy Chief Coroner) jurisdictions are paying the Specialist Examination fee for all autopsies, a number of areas similarly for all proven or unknown status COVID-19 infection cases. We believe that the Leicester jurisdiction pays the highest rate fee for all inquest appearances.

We look forward to your comments on these proposals.

With kind regards,

Yours sincerely,

Dr A T Warfield. Dr S E Trotter. Dr G Langman. Dr A Williams. Dr W Boyle.

[electronically verified, but not signed, to avoid further delay]