

Guidelines on autopsy practice

Fire deaths

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Contents

Foreword.....	3
1 Introduction.....	4
2 The role of the autopsy.....	5
3 Specific health and safety aspects	6
4 Pre-autopsy preparation	6
5 Imaging.....	7
6 External examination	7
7 Internal examination	10
8 Organ retention	11
9 Histological examination.....	12
10 Toxicology	12
11 Other relevant samples	13
12 Clinicopathological summary.....	13
13 Examples of cause of death opinions/statements	14
14 Criteria for audit.....	15
15 References	16
Appendix A Summary table – explanation of grades of evidence	18
Appendix B AGREE II guideline monitoring sheet	19

Foreword

The autopsy guidelines published by the Royal College of Pathologists (RCPATH) are guidelines which enable pathologists to deal with non-forensic consent and Coroner's/Procurator Fiscal post-mortem examinations in a consistent manner and to a high standard. The guidelines are systematically developed statements to assist the decisions of practitioners and are based on the best available evidence at the time the document was prepared. Given that much autopsy work is single observer and one-time only in reality, it has to be recognised that there is no reviewable standard that is mandated beyond that of the FRCPath Part 2 exam or the Certificate of Higher Autopsy Training (CHAT). Nevertheless, much of this can be reviewed against ante-mortem imaging and other data. This guideline has been developed to cover most common circumstances. However, we recognise that guidelines cannot anticipate every pathological case type and clinical scenario. Occasional variation from the practice recommended in this guideline may therefore be required to report an autopsy in a way that that maximises benefit to the pathologist, Coroner/Procurator Fiscal and the deceased's family.

There is a general requirement from the General Medical Council (GMC) to have continuing professional development (CPD) in all practice areas and this will naturally encompass autopsy practice. Those wishing to develop expertise/specialise in pathology are encouraged to seek appropriate educational opportunities and participate in the relevant external quality assurance (EQA) scheme.

The guidelines themselves constitute the tools for implementation and dissemination of good practice.

The following stakeholders will be consulted for this document:

- Coroners Society of England and Wales
- Crown Office and Procurator Fiscal Service
- Coroners Service of Northern Ireland
- Human Tissue Authority.

The information used to develop this document was derived from current medical literature and a previous version of this guideline. Much of the content of the document represents custom and practice and is based on the substantial clinical experience of the authors. All

evidence included in this guideline has been graded using modified SIGN guidance (see Appendix A.) The sections of this autopsy guideline that indicate compliance with each of the AGREE II standards are indicated in Appendix B.

No major organisational changes or cost implications have been identified that would hinder the implementation of the guidelines.

A formal revision cycle for all guidelines takes place on a 5-yearly cycle. The College will ask the authors of the guideline to consider whether the guideline needs to be revised. A full consultation process will be undertaken if major revisions are required. If minor revisions or changes are required, a short note of the proposed changes will be placed on the College website for 2 weeks for members' attention. If members do not object to the changes, the short notice of change will be incorporated into the guideline and the full revised version (incorporating the changes) will replace the existing version on the College website.

The guideline has been reviewed by the Professional Guidelines team, Death Investigation Committee, Specialty Advisory Committee and Lay Advisory Group. It will be placed on the College website for consultation with the membership from 4 August to 2 September 2026. All comments received from the membership will be addressed by the author to the satisfaction of the Clinical Leads for Autopsy Adjudication.

This guideline was developed without external funding to the writing group. The College requires the authors of guidelines to provide a list of potential conflicts of interest; these are monitored by the Professional Guidelines team and are available on request. The authors have declared no conflicts of interest.

1 Introduction

Autopsies performed on bodies recovered from fires are not uncommon; in the year ending December 2024, there were 254 fire-related fatalities in England and, in the year ending April 2024, there were 42 fire-related fatalities in Scotland.^{1,2} However, they can be among the most difficult to investigate due to the destructive nature of fire obscuring findings and introducing artefactual features.

Bodies may be recovered from fires in a number of different scenarios. Most fire-related deaths are accidental, but less-commonly fire can be used as a method of suicide (self-immolation) or even homicide. Alternatively, death, due to either natural or unnatural

causes, can have occurred prior to the start of the fire. While the majority of autopsies performed on bodies recovered from fire can be performed by a non-forensically trained pathologist, there must always be a low threshold for suspicion of foul play.

More commonly, fire-related deaths occur in residential buildings, and death is due to the inhalation of products of combustion; however, fire-related deaths can also occur in places of work, vehicles or outside. In those who are recovered alive from fires and with a period of survival, death tends to occur secondary to complications of severe burns, with hypovolaemia, multi-organ failure, sepsis or respiratory failure the most common mechanisms.

1.2 Target users and health benefits of this guideline

The target primary users of this guideline are pathologists who perform medico-legal autopsies on behalf of the Coroner or Procurator Fiscal. The recommendations will also be of value to trainee pathologists, particularly those preparing for their examinations (e.g. Certificate of Higher Autopsy Training (CHAT), FRCPath Part 2 or the Diploma in Forensic Pathology). Additionally, the guidelines may also be of use to individuals involved with the investigation of fatalities in fires, such as anthropologists, the police, fire investigation officers, and Coroners and Procurators Fiscal to determine the information required for the post-mortem examination to be performed.

These guidelines do not cover the investigation of deaths that are deemed suspicious and it is imperative to maintain a low threshold for involving a suitably trained forensic pathologist when conducting post mortems on bodies recovered from fires.

For bodies recovered from aviation-related fires, please refer to *G172 Guidelines on autopsy practice: Aviation-related fatalities*.³

2 The role of the autopsy

The role of the autopsy is to determine the cause of death, as well as:

- to determine if the individual was alive when the fire was started and, if alive at the start, to determine why the individual was in the fire and unable to self-rescue
- to assess for the presence of any relevant natural disease or intoxication
- to document patterns of injury
- to assist with identification of the deceased, particularly in severely burnt bodies

- to identify any potential attempt to conceal a homicide.

3 Specific health and safety aspects

Care needs to be taken when handling bodies recovered from fires in case of bone fragments or foreign bodies with sharp edges, such as broken glass and pieces of metal. Pre-autopsy imaging (see also section 5 below), such as post-mortem computerised tomography (PMCT) can aid in identifying these hazards. Otherwise, the routine standard autopsy health and safety considerations apply.

[Level of evidence – GPP.]

4 Pre-autopsy preparation

Prior to commencement of the autopsy, the following information should be gathered:

- background information, including discovery of the fire
- when the deceased was last seen alive and how they seemed
- police report, to include relevant information and to confirm in their opinion whether the death seems non-suspicious
- fire service report, to include cause of the fire, point of origin/seat of the fire, the use of accelerants, approximate length of time of the fire, the position of the body in relation to the fire, structural damage to the building from the fire, and the use of water/hoses to extinguish the fire
- hospital admission records if recovered alive from the fire and there was a period of survival
- past medical history, especially cardiovascular disease⁴ and osteoporosis⁵
- drug and alcohol history
- smoking history
- family history, especially sudden cardiac death.

[Level of evidence – C.]

5 Imaging

Imaging-based post-mortem examination, such as PMCT, should never be undertaken without an expert external examination of the body having first been performed by an appropriately trained and experienced pathologist. The use of PMCT is fully covered in the *Guidelines for post mortem cross-sectional imaging in adults for non-forensic deaths*.⁶

If available, PMCT can be a useful adjunct prior to invasive autopsy for bodies recovered from fires. PMCT was found to improve detection of heat fractures, contractions and destruction of extremities, subcutaneous emphysema and post-mortem gas collections.⁷ PMCT can also identify penetrating and blunt force trauma, as well as foreign bodies, and can potentially identify attempts to conceal a homicide, as well as highlighting risks that could prove hazardous to the person performing the invasive autopsy. Additionally, PMCT can also assist with the formal identification of bodies recovered from fires by the use of forensic odontology.

PMCT should not be used as a replacement to invasive autopsy as it cannot be used to assess for signs of vitality or superficial thermal injuries.⁷

[Level of evidence – Grade C.]

6 External examination

Morphological findings of bodies recovered from fires can vary widely, ranging from no apparent injury to calcined skeletal remains, depending on a number of different factors:

- the sustained temperature of the fire
- the duration of application of heat
- the transmission of heat to the body
- the ambient temperature.

The approach to the external examination will need to be adapted depending on the level of destruction of the body but can be planned in advance with the relevant pre-autopsy information. It should be noted, that post-mortem height and weight measurements may not always be reliable if there is significant damage, disruption or tissue loss of the body and these should therefore be reported with caution.

1 Where possible, full documentation of clothing worn can be useful, as fabrics can have a
2 direct effect on propensity to burn.

3 **6.1 Classification of burns**

4 The severity of burns can be classified according to their depth or affected total body
5 surface area. While these classifications are useful in clinical practice to calculate fluid
6 resuscitation requirements and the probability of survival, their application in post-mortem
7 cases is less reliable due to fire damage continuing after death has already occurred.

8 **6.1.1 Depth**

- 9 • Superficial (previously referred to as 1st degree burns)
 - 10 – involves epidermis only
 - 11 – pink-red in colour
 - 12 – no blistering.
- 13 • Partial thickness (previously referred to as 2nd degree burns)
 - 14 – affect superficial layers of the dermis
 - 15 – blisters common
 - 16 – underlying wound is homogenously red or pink.
- 17 • Full thickness (previously referred to as 3rd degree burns)
 - 18 – affect epidermis and dermis
 - 19 – result in leathery, stiff, dry appearance.

20 **6.1.2 Total body surface area**

21 There are different methods for calculating this when considering children, adults and
22 people who are obese.

23 The rule of nines can be used for healthy weight adults; it only considers partial- and full-
24 thickness burns.

- 25 • Entire head 9%.
- 26 • Entire trunk 36% (front and back 18% each).
- 27 • Upper extremities 18%.
- 28 • Lower extremities 36%.

- 1 • Groin 1%.

2 **6.2 External findings in bodies recovered from fire**

- 3 • Singeing of eyebrows, eyelashes and hair.
- 4 • Soot around the eyes with 'crow's feet' sparing, which might suggest the individual
5 was alive at the start of the fire.
- 6 • Soot around mouth and nostrils.
- 7 • Eyes – the corneas acquire a white translucency and lenses become opaque.
- 8 • Areas of sparing and intact skin on the body can assist in determining the position of
9 the body during the fire.
- 10 • Shrinkage of tissues due to loss of fluid results in
 - 11 – leathery skin – care must be taken as this can alter pre-existing injuries, e.g. stab
12 wounds may assume a circular shape
 - 13 – protrusion of the tongue
 - 14 – petechial haemorrhages in the head and neck can occur due to shrinkage of the of
15 the soft tissues of the neck or heat rigidity of the thorax and continuing circulation
16 (vital sign)
 - 17 – pugilistic/boxers' attitude – shrinkage of the muscles and tendons results in a
18 characteristic pose (however, this can be affected by mechanical obstacles, such
19 as if the body is found under rubble). It includes arms abducted at the shoulder
20 joint and flexed at the elbow; hands clenched into fists; legs abducted at the hip
21 joint and flexed at the hip and knee joints; and feet contracted.
- 22 • Complete charring
 - 23 – prolonged exposure can cause the skin to split creating linear, artefactual injuries
24 with sharp edges that can be apposed
 - 25 – most often seen on extensor surfaces and around the joints
 - 26 – they often reach the subcutaneous tissue and sometimes muscle
 - 27 – tissue in the depths is often unburned.
- 28 • Skeletonised remains

- in cases where there are skeletal remains it is beneficial to involve an anthropologist for estimation of height, age and sex.

[Level of evidence – GPP.]

7 Internal examination

As discussed above, the approach to the internal examination, as well as the findings, will be impacted by the extent of destruction of the body. After the internal cavities are exposed to heat, the organs will shrink and become ‘puppet organs’ and eventually become spongelike.⁸

The organs and blood can take on a cherry pink colour due to the accumulation of carboxyhaemoglobin. This is dependent on the individual being alive at the time of the fire.

7.1 Specific organ systems to be considered

7.1.1 Respiratory system

- If present, the hyoid bone and laryngeal cartilages should always be carefully examined in the potentiality of a concealed homicide.
- Soot in the airways below the level of larynx can indicate the individual was alive at the time of the fire (vital sign); however, extensive destruction of the body can result in soot reaching these areas.
- Inhalation of hot gases can cause oedema, mucosal bleeding and patchy detachment of the mucosa of the mouth, nose and airways.
- Increased secretion of mucus.
- People with pre-existing lung conditions, such as asthma and chronic obstructive pulmonary disease, may have increased sensitivity to inhaled irritants and the development of inhalation injury.⁹

7.1.2 Gastrointestinal tract

- Haemorrhage within the tongue.¹⁰
- Oedema, mucosal bleeding and patchy detachment of the mucosa of the oesophagus.
- Soot staining of the gastric contents indicates the individual was alive at the time of the fire (vital sign).
- Rupture of abdominal wall and prolapse of the intestinal loops.

1 **7.1.3 Central nervous system**

- 2 • Post-mortem extradural haematomas can form due the application of heat leading to a
3 shift of fluid from diploe and venous sinuses. They are described as being chocolate
4 brown and having a crumbly/honeycomb appearance and there is often charring of the
5 overlying skull cap.
 - 6 – Care must be taken to distinguish these from an ante-mortem extradural
7 haematoma, which would indicate head trauma prior to death (please see
8 toxicology in Section 10).
- 9 • Subdural haematomas are more indicative of ante-mortem trauma.

10 **7.1.4 Bones**

- 11 • Bones are highly resistant to heat in gross structure, but at temperatures above 700 °C
12 combustion of organic substances results in calcination and they become
13 greyish/white and desiccate easily.
- 14 • Bones from osteoporotic individuals degrade quicker and more extensively than
15 healthy bone.⁵
- 16 • Fractures may have occurred prior to death, as a result of fire damage, post mortem
17 due to mechanical damage or due to rapid cooling during extinguishing of the fire.
 - 18 – Post-mortem fractures tend to be located more peripheral, involving the limbs.
- 19 • Skull fractures can range from fine cortical fractures of the outer table, resemble
20 gunshot wounds or can result in full destruction from the vertex to skull base.

21 **7.1.5 Cardiovascular system**

- 22 • The presence of cardiac disease will lower an individual's tolerance to carbon
23 monoxide poisoning.⁴
- 24 • Cardiovascular disease could account for death.

25 *[Level of evidence – C.]*

26 **8 Organ retention**

27 In most cases, organ retention is not required; however, some circumstances may require
28 specialist opinion. Consent for organ retention should be gained from the appropriate
29 investigating body.

1 [Level of evidence – GPP.]

2 **9 Histological examination**

3 Where possible, and guided by the local governing body (Coroner/Procurator Fiscal),
4 samples of the major organs should taken for microscopic analysis to assess for natural
5 disease that may have caused or contributed to death.

6 Depending on the degree of destruction of the body, the organs may show varying
7 degrees of coagulative necrosis.

8 Additional histology to consider:

- 9 • Skin, including evidence of vitality, including inflammatory reaction, fibrin, hyperaemia
10 and oedema.
- 11 • Respiratory system, including soot within the second and third order bronchi.
- 12 • Cautery/heat artefacts, including loss of ciliated border, basal vacuolisation of the
13 epithelium, elongated and palisading cell nuclei, swelling and coagulative necrosis of
14 epithelial cells, submucosal congestion and oedema, and protrusion of submucosal
15 glands.¹¹

16 [Level of evidence – D.]

17 **10 Toxicology**

18 If suitable fluids are available, samples should always be taken for toxicological analyses
19 of alcohol, prescription drugs and drugs of abuse. Ideally, peripheral blood should be
20 obtained and, if available, urine and vitreous. In cases where the body is very badly
21 burned, alternative sampling can be considered, such as liver and skeletal muscle,
22 although these only serve a purpose for screening and not quantification.¹²

23 Carbon monoxide is the major toxic product of combustion. Carboxyhaemoglobin levels
24 should always be measured in the peripheral blood as it can aid in determining whether
25 the individual was alive at the start of the fire. However, carboxyhaemoglobin levels can be
26 normal in the case of flash fires, where there is sudden combustion and depletion of
27 oxygen and the individual dies rapidly, as well as fires that occur in well-ventilated spaces.

28 A carboxyhaemoglobin level of above 3% in a non-smoker and 10% in a smoker is
29 considered abnormal; however, in healthy individuals, levels can often reach 50–60%

before the individual succumbs to its effects. This level may be significantly lower in those with underlying health conditions, such as cardiovascular disease⁴ or at the extremes of age. In the event that the body is badly destroyed and it is not possible to sample blood, the spleen can be considered as an alternative.¹³

In situations where an extradural haematoma is present and it is uncertain whether this represents an ante-mortem injury or is the result of a head haematoma, blood from the haematoma can be assessed for carboxyhaemoglobin and compared to the levels from the circulating blood.

The incomplete combustion of nitrogen-containing synthetic materials, such as polyurethane foams in furniture and nylon, can produce hydrogen cyanide. If available locally, testing for hydrogen cyanide should be considered.¹⁴

[Level of evidence – C.]

11 Other relevant samples

In cases of severely burnt bodies, samples for formal identification will often be requested by the investigating authority. Samples for DNA extraction include liver, spleen, heart, skeletal muscle, teeth and bone.

Although self-immolation as a means of suicide is rare, in these cases consideration should be made towards the retention of clothing to assess for accelerants used. If clothing is suspected of containing fire accelerants, they should be placed into nylon bags with a swan neck seal and should not be dried out prior to packaging.¹⁵ Advice on appropriate retention of these materials can be sought from your local toxicology service. However, careful consideration should be paid to the circumstances surrounding the death – these cases are perhaps best referred to a forensic pathologist.

[Level of evidence – GPP.]

12 Clinicopathological summary

This should include the relevant background circumstances of the death, the findings from the post-mortem examination, including limitations imposed by the degree of destruction of the body, and the results from any additional tests that were performed.

Interpretation of the findings should include significant positive and negatives to determine, on the balance of probabilities, whether death occurred before the onset of the fire or if it

1 occurred due to the effects of fire, such as inhalation of smoke and fire gases or burns.
2 Where death has occurred directly due to the effects of fire, any underlying natural
3 disease, drug toxicity or injuries may be relevant when considering incapacitation.
4 In some cases, the destruction of the body will be so severe that the cause of death will be
5 unascertainable.
6 *[Level of evidence – GPP.]*

7 **13 Examples of cause of death opinions/statements**

8 1a. Inhalation of smoke and fire gases

9 1b. House fire

10 2. Acute alcohol intoxication

11 or

12 1a. Severe burns

13 1b. House fire

14 or

15 1a. Inhalation of smoke and fire gases

16 1b. Car fire

17 1c. Road traffic collision (car driver)

18 or

19 1a. Multi-organ failure

20 1b. Burns

21 1c. House fire

22 or

23 1a. Unascertainable

24

25

14 Criteria for audit

The following standards are suggested criteria that might be used in periodic reviews to ensure a post-mortem report for coronial autopsies conducted at an institution comply with the national recommendations provided by the 2006 NCEPOD study:

- supporting documentations:
 - standards: 95% of supporting documentation was available at the time of the autopsy
 - standards: 95% of autopsy reports documented are satisfactory, good or excellent.
- reporting internal examination:
 - standards: 100% of the autopsy report must explain the description of internal appearance
 - standards: 100% of autopsy reports documented are satisfactory, good or excellent.
- reporting external examination:
 - standards: 100% of the autopsy report must explain the description of external appearance
 - standards: 100% of autopsy reports documented are satisfactory, good or excellent.

A template for coronial autopsy audit can be found on The Royal College of Pathologists' website (www.rcpath.org/profession/guidelines/autopsy-guidelines-series.html).

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Appendix A Summary table – explanation of grades of evidence

(modified from Palmer K et al. BMJ 2008; 337:1832)

Grade (level) of evidence	Nature of evidence
Grade A	At least 1 high-quality meta-analysis, systematic review of randomised controlled trials or a randomised controlled trial with a very low risk of bias and directly attributable to the target population or A body of evidence demonstrating consistency of results and comprising mainly well-conducted meta-analyses, systematic reviews of randomised controlled trials or randomised controlled trials with a low risk of bias, directly applicable to the target cancer type.
Grade B	A body of evidence demonstrating consistency of results and comprising mainly high-quality systematic reviews of case-control or cohort studies and high-quality case-control or cohort studies with a very low risk of confounding or bias and a high probability that the relation is causal and which are directly applicable to the target population or Extrapolation evidence from studies described in A.
Grade C	A body of evidence demonstrating consistency of results and including well-conducted case-control or cohort studies and high- quality case-control or cohort studies with a low risk of confounding or bias and a moderate probability that the relation is causal and which are directly applicable to the target population or Extrapolation evidence from studies described in B.
Grade D	Non-analytic studies such as case reports, case series or expert opinion or Extrapolation evidence from studies described in C.
Good practice point (GPP)	Recommended best practice based on the clinical experience of the authors of the writing group.

Appendix B AGREE II guideline monitoring sheet

The autopsy guidelines of The Royal College of Pathologists comply with the AGREE II standards for good quality clinical guidelines. The sections of this autopsy guideline that indicate compliance with each of the AGREE II standards are indicated in the table.

AGREE standard	Section of guideline
Scope and purpose	
1 The overall objective(s) of the guideline is (are) specifically described	Foreword, 1
2 The health question(s) covered by the guideline is (are) specifically described	1
3 The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described	Foreword
Stakeholder involvement	
4 The guideline development group includes individuals from all the relevant professional groups	Foreword
5 The views and preferences of the target population (patients, public, etc.) have been sought	Foreword
6 The target users of the guideline are clearly defined	1
Rigour of development	
7 Systematic methods were used to search for evidence	Foreword
8 The criteria for selecting the evidence are clearly described	Foreword
9 The strengths and limitations of the body of evidence are clearly described	Foreword
10 The methods for formulating the recommendations are clearly described	Foreword
11 The health benefits, side effects and risks have been considered in formulating the recommendations	Foreword, 1
12 There is an explicit link between the recommendations and the supporting evidence	2–12
13 The guideline has been externally reviewed by experts prior to its publication	Foreword
14 A procedure for updating the guideline is provided	Foreword
Clarity of presentation	
15 The recommendations are specific and unambiguous	3–12
16 The different options for management of the condition or health issue are clearly presented	3–12
17 Key recommendations are easily identifiable	3–12

Applicability		
18	The guideline describes facilitators and barriers to its application	Foreword
19	The guideline provides advice and/or tools on how the recommendations can be put into practice	3–12
20	The potential resource implications of applying the recommendations have been considered	Foreword
21	The guideline presents monitoring and/or auditing criteria	14
Editorial independence		
22	The views of the funding body have not influenced the content of the guideline	Foreword
23	Competing interest of guideline development group members have been recorded and addressed	Foreword