THE
SHIPMAN INQUIRY

Chairman: Dame Janet Smith DBE

Third Report

Death Certification and the Investigation of Deaths by Coroners

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Presented to Parliament by the
Secretary of State for the Home Department and
the Secretary of State for Health
by Command of Her Majesty
July 2003

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THE
SHIPMAN INQUIRY
Chairman: Dame Janet Smith DBE

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10 June 2003

Dear Secretaries of State,

Shipman Inquiry – Third Report

As you know, in January 2001, I was appointed to conduct an Inquiry into the issues arising from the conviction of Harold Shipman, a general medical practitioner, for the murder of fifteen of his patients. In July 2002, I published my First Report, dealing with the extent of Shipman's unlawful activities.

I now submit my Third Report, which deals with death certification and the investigation of deaths by coroners. The Inquiry's Terms of Reference require me to recommend what steps should be taken to protect patients in future. When work began, it soon became apparent that the existing systems have failed not only to protect patients but also to meet the needs and expectations of the wider public and society in general. I have sought to make recommendations that will protect patients and will also meet these broader objectives. My proposals entail radical change and would require primary legislation.

Mr Tom Luce, Chair of the Coroners Review, was asked to co-operate with the Shipman Inquiry. He allowed me to see the Review's Report in draft at a time when my own Report was still in preparation. I am pleased to say that there are many issues upon which the Review and the Inquiry have reached similar conclusions and made compatible recommendations.

Policy decisions will be required before change can be effected. In Chapter Three, I have set out the history of events following the publication of the Brodrick Report in 1971, in which the issues of death certification and the coroner system were comprehensively reviewed. The recommendations were not implemented because the conflicting views of interested parties were never resolved by the making of a clear decision on policy. I urge you now to ensure that the work of the Review and this Inquiry do not meet the same fate.

GRO-C

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FOREWORD

In the First Report of the Shipman Inquiry, I disclosed my finding that Shipman had killed at least 215 of his patients over a period of 24 years. It was clear that the current arrangements for death registration, cremation certification and coronial investigation in England and Wales had failed both to deter Shipman from killing his patients and to detect his crimes after they had been committed. The failure of the existing system prompted Parliament to set up the Shipman Inquiry, with Terms of Reference requiring me to examine the present arrangements and to make recommendations for changes that would protect patients in the future.

The focus of the Inquiry has therefore been primarily on the protection of patients from the actions of a homicidal doctor. Yet, there are other important aims and objectives that must be served by a system of death investigation and certification besides the protection of patients, important though that is. The system must seek to protect the public from harm of other kinds and to expose the wrongdoing of others besides an occasional aberrant health professional. A sound system will advance medical science, through the better understanding of causes of death. It will assist in planning for the better use of the huge resources now expended on the National Health Service. It will serve the interests of private individuals by providing a proper understanding of the cause and circumstances of a death in which they have an interest. It will assist in the prevention of avoidable deaths and injuries in the future. My task has been to make recommendations for a system that will meet the needs and legitimate expectations of society.

In the course of the Inquiry's work, I invited views about how a new system might be devised. Many individuals and organisations responded to my invitation with interesting and constructive ideas for change. However, some respondents sought to persuade me not to propose any radical changes to the system just because one doctor had been able to evade the existing safeguards. I was urged to accept that the system was working reasonably well; a few minor changes was all that was needed. There would never, it was said, be another Shipman.

It seems to me that there are two reasons why those arguments should not prevail. The first is that we do not know that Shipman is unique. We know that he has killed more people than any other serial killer yet identified, but we do not know how many other doctors have killed one or more patients. Some such killings have come to light; others may remain hidden. If Shipman was able to kill for almost 24 years before he was discovered, who can say with confidence that there are not other doctors, still unknown, who have killed in the past? Who can say that there will be none in the future? If there is a risk that a doctor might kill in the future and if, as is now clear, the present system would neither deter nor detect such conduct, surely the system must be changed.

The second reason is that my investigations have satisfied me that the system is not working as well as it should. The evidence received by the Inquiry suggests that there is much dissatisfaction with the present arrangements. It is said that the existing system is fragmented, is not sufficiently professional, is applied to very variable standards in different parts of the country and does not meet the needs of the public, especially the bereaved. It is said that it does not satisfy the public interest in the discovery of the true causes of death in the population. It does not contribute, to the extent that it should, to the improvement of public health and safety. If these complaints are well founded, as I have found they are, then there are good reasons for radical change, quite apart from the need to ensure that, so far as possible, homicide does not go undetected.

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In July 2001, while this Inquiry was working on Phase One, Mr Tom Luce was appointed to chair a Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland (the Coroners Review). His Terms of Reference overlapped, but were not coterminous with, those of the Shipman Inquiry. He was asked to co-operate with the Inquiry. That he has done and I am most grateful for the openness with which he shared the Review's developing ideas with the Inquiry, by speaking at one of our seminars in January 2003 and by allowing me to read his Report in draft.

I also wish to express my gratitude to those individuals who have attended to give evidence and to take part in the seminars. I must mention particularly those who came from overseas to participate in the seminar relating to systems of death investigation and certification in other jurisdictions. I thank, too, all those who wrote to the Inquiry giving their views about the present system and their ideas for change and improvement. Many individuals and organisations have provided witness statements, records, reports and other documentary material, thus enabling the Inquiry to assemble a huge amount of evidence. All have been generous with their time and effort, for which I am very grateful.

I must also thank Counsel, Dr Aneez Esmail, Henry Palin and other members of the Inquiry team, who, as in Phase One, have worked with energy, determination and good humour and without whose support this Report could not have been written.

This Inquiry was set up in the wake of a tragedy that shocked the world. It is my hope that some good may now come from those tragic events and that in the future we will have, in this country, systems of death investigation and certification that will bring real benefits in the fields of public health and safety and will meet the needs and expectations of private individuals, especially the bereaved. It is my earnest hope that the recommendations of this Report, together with those of the Coroners Review, will lead to radical change.

Janet Smith
June 2003

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SUMMARY

Introduction

1. Following my First Report, which set out my finding that Shipman had killed at least 215 of his patients over a period of 24 years, it was clear that the arrangements for death and cremation certification and the coronial system, which are intended to protect the public against the concealment of homicide, had failed to fulfil that purpose. The Inquiry's Terms of Reference required me to examine the present systems, together with the conduct of those who had been responsible for operating them in the aftermath of the deaths of Shipman's victims. I was also required to recommend what steps, if any, should be taken to protect patients in the future.

2. In the course of Phase Two, Stage Two, I have received a wealth of evidence, both oral and written. I have heard from many witnesses who have experience of the day-to-day operation of the existing systems. I have heard evidence from some of the bereaved relatives of Shipman's victims about their experiences and their ideas for change. I have considered the history of the systems and read many reports, reviews and commentaries, which have been written about them over the years. I have been referred to a great deal of documentary evidence concerning the systems as they operate today.

3. In addition, I have had the opportunity of reading the responses to the Consultation Papers published by two recent Home Office Reviews, the Review into Death Certification, which reported in 2001, and the Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland, whose Report was published in June 2003. The Inquiry has carried out its own consultation process. In October last year, its Discussion Paper, 'Developing a New System for Death Certification', was published. Written responses were received from 154 individuals and organisations. A series of seminars was held in January 2003, at which the Inquiry's ideas for change were discussed by representatives of organisations with a particular interest or involvement in post-death procedures and with a number of individuals who have a special knowledge of those procedures. One of the seminars was attended by representatives of five jurisdictions whose systems of death investigation and certification had features that were of interest to the Inquiry. The Inquiry conducted a small feasibility study into the use of the forms which had been designed as part of a new system of death certification.

4. I have been able to set all that material against the background of the evidence, both lay and expert, which I had received during Phase One of the Inquiry, when I considered and reported upon the circumstances and aftermath of just under 500 deaths of Shipman's patients.

The Bereaved Relatives

5. The evidence about the present post-death procedures shows that the families of deceased persons are little involved in the processes of certification and investigation of a death. It also shows that the needs and expectations of the bereaved relatives are sometimes not given the consideration they deserve. Of course, it is not just families who are affected by a death. In speaking of 'relatives' and 'families', I am intending to indicate

anyone who is sufficiently close to the deceased person to have a proper interest in the cause of his/her death and any investigation into it.

6. The evidence also shows that the present procedures fail to tap a source of information about the deceased person and the circumstances of his/her death that would be of great value to the process of death certification and investigation.

7. Any changes contemplated for the future must seek to ensure that families are kept informed about, and are consulted and involved at all stages of, the post-death procedures. However, their involvement must be handled sensitively and not intrusively. The needs of those minority ethnic or religious groups whose members wish to arrange disposal of the body as soon as possible after the death must also be borne in mind in any proposals for change.

Certification of the Fact of Death

8. At present, there is no requirement that a doctor or any other health professional should certify the fact that a person has died. In my view, there should be a requirement that the fact that death has occurred should be confirmed and certified. The person who confirms the fact of death (who might be a doctor or an accredited nurse or paramedic) should complete a form, recording information about the circumstances of the death. Not only would such a form assist in the professional scrutiny of the circumstances of death, it would also form a valuable safeguard against any attempt to provide false information about the death.

The Immediate Aftermath of a Death in the Community

9. When a death occurs in a hospital, hospice or care home, there are professionals on hand who know what action to take. However, when a death occurs at home, the relatives, friends or carers of the deceased often do not know what to do or what is expected of them as their legal duty. At present, there is no single agency or authority with primary responsibility for responding to the occurrence of a death. The ambulance service might be summoned if it is thought that the deceased person might not be beyond resuscitation. The police might be called, especially when the death has occurred suddenly, even though there is no suspicion of criminal involvement. In other cases, relatives might contact the deceased's general practitioner. Depending on the circumstances and time of day, either the general practitioner or a doctor from the deputising service might attend.

10. It is clear from the evidence received by the Inquiry that the present arrangements for dealing with the aftermath of a death in the community are unsatisfactory, especially in relation to deaths that occur out of normal working hours. Different procedures operate in different parts of the country. There is confusion about what is expected of the police, ambulance and medical services. There is also tension between the services, each of which has justifiable concerns about the use of its resources in attending deaths where the deceased is clearly beyond medical help and where there is no suspicion of any criminal involvement in the death. All the services have what might properly be regarded as more pressing duties in relation to the living.

11. In my view, there should be a nationally agreed policy for dealing with the immediate aftermath of a death occurring in the community. There will always be a role for the police, ambulance service and doctors in dealing with the aftermath of a death. However, I consider that their roles should be secondary to, and supportive of, a service with primary responsibility for dealing with deaths in the community, whenever they occur. In my view, this service should be based in the coroner's office and the provision of such a service should be one of the duties of a team of well-trained coroner's officers.

Medical Certification of the Cause of Death

12. Since 1926, the law has required that, before a death can be registered and the body disposed of by burial or cremation, the medical cause of death must be certified by a doctor who has attended the deceased during his/her last illness or by a coroner after autopsy or inquest. The procedure for certifying the medical cause of death has remained virtually unchanged for over 75 years.

13. The current procedure has three very real advantages; it is speedy, cheap and convenient. However, it has a number of disadvantages. The most serious of these is that it is dependent on the integrity and judgement of a single medical practitioner. That medical practitioner, if s/he has attended the deceased during the last illness, must decide whether s/he should report the death to the coroner or whether s/he can properly issue the medical certificate of cause of death (MCCD).

14. One of the circumstances in which a death should be reported to the coroner is if the death is sudden and the cause is unknown. Many of Shipman's patients died suddenly in circumstances in which no honest doctor could have claimed to know the cause of death. Yet Shipman, who had killed them, was able to certify the cause of death, avoid a report to the coroner and thus also avoid any official enquiry into the death.

15. The fact that the system of certification of the cause of death depends on a single doctor does not give rise only to the risk of concealment of crime or other wrongdoing by that doctor. There may be occasions when a doctor knows that a death may have been caused or contributed to by some misconduct, lack of care or medical error on the part of a professional colleague. In those circumstances, it takes considerable courage and independence for a doctor (particularly a junior doctor) to refuse to certify a death, when s/he knows that, if s/he does refuse, the death will be subject to a coroner's investigation. Pressure might also be exerted by the relatives of a deceased person. They might try to persuade the doctor to certify a cause of death so as to avoid a referral to the coroner and the possibility of an autopsy. They might also seek to press the doctor to state on the MCCD a cause of death which is not the true one, but which will cause the family less embarrassment or difficulty than the condition from which the deceased actually died. Once again, it can be very hard for a doctor to withstand that sort of pressure.

16. Research has shown that, even when not subjected to pressures of that kind, doctors still have difficulty in recognising those deaths that should be reported to the coroner. The categories of 'reportable deaths' are not easy to interpret and the matter is complicated by the fact that different coroners operate different 'local rules' governing the deaths which

should be reported to them. Research has shown that there is likely to be a significant proportion of deaths that, under the present law, should be reported to the coroner but are not.

17. A further problem with the current system is that the quality of certification is poor. Doctors receive little training in death certification. In hospitals, certification is often done by very junior doctors (sometimes in their pre-registration year) with little or no help from their senior colleagues. The standard of certification among general practitioners appears to be rather better although since, in general, they certify relatively few deaths, some still experience difficulty on occasions. The fact that deaths are not being certified correctly has an obvious impact on the quality of the mortality statistics which inform public health policy.

18. The Inquiry has heard that some general practitioners never report a death to the coroner. It seems unlikely that this is because no death certified by them ever comes within the category of reportable deaths. It is more likely that the doctor does not know which deaths should be reported, or does know but is seeking to spare families the ordeal of a report to the coroner and a possible autopsy. It may be that the doctor has personal objections to the autopsy process. Research has confirmed that some doctors are willing to 'modify' what they believe to be the true cause of death in order to avoid a report to the coroner.

19. Once a doctor has certified the cause of death then, provided that s/he has completed the MCCD fully and in appropriate terms, there is no check on the truth or accuracy of what s/he states. There is no system of audit or review of those cases where a doctor certifies the cause of death and does not report the death to the coroner. The relatives of the deceased person will take the MCCD to the register office, the death will be registered and a disposal certificate issued. A burial can then take place without any further check or formality.

20. In my view, the present arrangements, whereby, in effect, doctors decide whether or not to report a death to the coroner, are not satisfactory and should not be allowed to continue.

Registration of Deaths

21. The death of every person dying in England and Wales must be registered. Except where an inquest is held, the informant (usually a close relative) must attend personally before the local registrar to give the particulars necessary for the death to be registered. In cases where there has been no autopsy, the informant takes with him/her a copy of the MCCD which s/he will have been given by the certifying doctor.

22. Registrars have no medical experience. Their role is essentially administrative. They are required to record details of births, marriages and deaths. The information received by registrars forms the basis of an important public record that is widely used for statistical and research purposes. It is vital that it is recorded meticulously and accurately. Registrars also have to deal with members of the public and to guide them through the formalities associated with the most important of all life events.

23. Registrars are accountable to the Registrar General, whose office, the General Register Office (GRO), forms part of the Office for National Statistics (ONS). The GRO provides

guidance to registrars on a range of matters, including the circumstances in which a death should be reported to the coroner.

24. In the case of the registration of a death, registrars are required to perform a function of a completely different nature from those referred to above. They have a statutory duty to report to the coroner deaths which fall within certain specified categories. In order to decide whether such a duty arises in respect of a particular death, they have to scrutinise the MCCD and assess, insofar as they are able, whether it provides an acceptable medical explanation for the death. They have to be alert to circumstances that might be mentioned in, or evident from, the MCCD and which might make a report to the coroner appropriate. The medical terminology used on the MCCD to describe the cause of death may be difficult to understand for someone without medical expertise. Some registrars told the Inquiry that they felt ill equipped to undertake this task. I can understand why that is so.

25. Registrars report comparatively few deaths to coroners. The main reason for this is probably that most obviously reportable deaths will already have been reported by doctors before the death comes for registration. However, another reason may be that the registrar has little opportunity to discover whether there are any circumstances that might render the death reportable. The MCCD itself contains very limited information. Sometimes, the informant or another member of a deceased person's family might volunteer information that suggests that the death should be reported. However, there is no requirement for the registrar formally to seek information relating to the circumstances surrounding the death. Nor is the registrar required to confirm the information given by the certifying doctor on the MCCD. If it appears to the registrar that there are circumstances that suggest that the death is reportable to the coroner, his/her duty is to make the report. However, the registrar is not required to make direct enquiries of the informant, with a view to ascertaining whether or not such a report is necessary.

26. Registrars are not trained or equipped to provide the only form of scrutiny to which MCCDs issued by medical practitioners are subjected. I have concluded that, in future, any information about cause of death provided by a doctor should be scrutinised by a person with a medical qualification, or at least by someone with special training in medical matters and ready access to expert medical advice. That person should also have the opportunity to cross-check the essential facts with a relative of the deceased or someone with knowledge of the circumstances of the death. In my view, the task of scrutinising a cause of death should no longer be that of the registrars. Theirs should be a purely administrative function.

The Tameside Registrars

27. Most of the deaths of Shipman's patients, including the deaths of those whom he killed, were registered at the Tameside register office. It was therefore necessary for the Inquiry to examine procedures and practices at the office, both generally and in relation to Shipman.

28. After Shipman's criminal activities were revealed, there were suggestions that the registrars at the Tameside register office should have noticed that they were registering

an excessive number of deaths which had been certified by Shipman. There are four registrars at the Tameside register office. Each is responsible for her own register of deaths. Some registration is carried out by deputy registrars. No registrar sees the complete picture of death registrations effected in the office as a whole. Nor is there any system (or any duty to operate such a system) for the gathering of statistics relating to deaths. The identity of the doctor who certified the cause of a death would not be significant unless some difficulty arose over the MCCD. Shipman usually took care to ensure that no such difficulty arose.

29. The Inquiry examined the numbers of Shipman-certified deaths registered by two current registrars and one former registrar. These three registrars had been responsible for registering the greatest number of deaths certified by Shipman. The numbers of deaths certified by Shipman were compared with the (very large) total numbers of deaths registered by the registrars during the same period. Also, the Inquiry looked at a number of short periods of time when the concentration of Shipman-certified deaths registered by each registrar was at its highest. The object was to see whether, during those short periods, the frequency of Shipman-certified deaths should have been noticeable.

30. That exercise having been carried out, I am quite satisfied that the frequency with which Shipman-certified deaths occurred would not have been noticeable to any registrar. Nor, in my view, were the clusters of greatest intensity particularly remarkable. Such research as the Inquiry team was able to carry out showed that clusters of deaths certified by an individual doctor occur with reasonable frequency. Nor was there any evidence from which I could reasonably infer that any of the registrars had noticed an excess of deaths certified by Shipman or that they had had any other concerns about him.

31. The close scrutiny to which the procedures in operation at the Tameside register office were subjected by the Inquiry resulted in questions being raised about some of the practices in operation within the office. One in particular – whereby registrars would contact doctors who had issued MCCDs stating unacceptable causes of death, rather than reporting the death to the coroner's office and leaving it to the staff there to sort out the problem – gave rise to particular concern. However, whilst there is no doubt in my mind that this constituted poor practice, I am satisfied that the Tameside registrars undertook responsibility for contacting doctors in these circumstances because the coroner's office put pressure on them to do so and because they believed that, in doing so, they would be assisting the bereaved relatives by ensuring that, in an appropriate case, the defective MCCD was amended or replaced as soon as possible so as to allow the registration to proceed.

32. I am quite satisfied that neither the practice I have referred to above, nor any of the other procedures in operation at the Tameside register office, had any adverse effect on the registration process in cases where Shipman had killed.

33. It is not surprising that some departures from accepted practice occurred at the Tameside register office. The registrars there had not received clear training or guidance on the points of practice that arose. They had little opportunity to meet registrars from other areas. Accordingly, they had little opportunity to discover and correct any shortcomings in their own practice, or to gain the necessary confidence to insist upon compliance with

correct statutory procedures by others. It is plain, moreover, from correspondence received from the GRO since the Inquiry hearings, that the departures from best practice about which the Inquiry has heard are not confined to Tameside. Indeed, such is the concern of officials at the GRO about variations in practice throughout the country, that they have now written to all registrars, giving guidance about good practice in relation to a number of matters that have been explored in the course of evidence given to this Inquiry.

The General Register Office

34. The GRO operates a telephone advice line, which a registrar can use if unsure whether a death should be reported to the coroner. However, the staff who operate the advice line have no medical expertise or specific training for the task and are reliant upon medical reference books and notes of past advice given or received. They have access to medical epidemiologists employed by the ONS but the evidence strongly suggests that most queries are resolved by GRO staff without recourse to medical advice.

35. The Inquiry identified two deaths in 1996, where registrars at the Tameside register office had sought advice from the GRO before registering the death. On both occasions, Shipman had killed the deceased person and certified that the death was due to 'natural causes'. When the deaths came to be registered, the registrars at Tameside were uncertain as to whether 'natural causes' constituted an acceptable cause of death. They were advised by staff at the GRO that it did and that the deaths could therefore be registered. In fact, it was agreed by all who gave evidence to the Inquiry that 'natural causes' should never be acceptable to the registration service as a cause of death. The expression does not explain what has caused the death. It asserts only that the death was due to a natural disease process.

36. No explanation was advanced for the giving of the faulty advice. No clear written advice on the acceptability or otherwise of 'natural causes' as a cause of death was promulgated by the GRO, whether for the benefit of registrars or its own staff. That deficiency has been rectified since the Inquiry hearings. It is clear that the situation did not arise very frequently in practice. However, it appears that there must have been some misunderstanding amongst staff within the relevant section of the GRO about the status of 'natural causes' as a cause of death. This is worrying, since the giving of poor advice by the GRO in turn disseminates poor practice elsewhere.

37. In my view, the problems are caused in large part by a system in which clerical staff without medical expertise are seeking to advise other clerical staff on matters which are essentially medical in nature.

38. Even had the advice of the GRO in both cases been correct, namely that the cause of death was not acceptable and the death should be reported to the coroner, I do not think that the outcome of either case would have been significantly different from what in fact occurred. Shipman would have been contacted and would have provided a more specific cause of death. That cause of death would have been duly registered. It is highly unlikely that any further investigation of either death would have followed.

Cremation Certification

39. Over 70% of deaths in the UK are now followed by cremation. In 1903, the year when the first Cremation Regulations came into force, there were 477 cremations within the UK. In 2001, there were 427,944. During that period of almost 100 years, there has been very little change in the system by which authority to cremate is granted.

The System

40. Once a death has been registered and a disposal certificate issued by the registrar, burial can take place without any further check or formality. If any suspicion arises in the future that the death was caused by an unlawful act, the body will (for a limited period at least) be available for exhumation and forensic examination. When cremation was first introduced, it was recognised that there would be no such opportunity to recover the evidence when a body had been cremated. It was therefore decided that additional safeguards should be implemented in cases where a disposal was to be by way of cremation. The attending doctor (usually the same doctor who had issued the MCCD) would complete a certificate (Form B), giving rather more information than that contained on the MCCD. A second doctor would carry out his/her own enquiry and complete a confirmatory certificate (Form C) and a medical referee, on behalf of the cremation authority which operated the crematorium, would examine the forms and satisfy him/herself that the forms were in order, that proper enquiry had been made and that the cause of death had been definitely ascertained. He or she would then grant authority to cremate. Form B and Form C doctors and the medical referee were to receive fees for their part in the procedure, paid by the deceased's estate. Currently, fees totalling just under £100 are payable to the three doctors involved in authorising a cremation.

41. When the system was first devised, it was intended that the Form C doctor (who was to be demonstrably independent and to occupy a prestigious public appointment) would carry out a personal enquiry. Form C contained questions about the nature and extent of the enquiry to be carried out. The doctor was asked whether s/he had seen and carefully examined the body of the deceased (questions 1 and 2), whether s/he had made a post-mortem examination (question 3), whether s/he had seen and questioned the Form B doctor (question 4) and whether s/he had seen and questioned any other medical practitioner who had attended the deceased, any person who had nursed the deceased during his/her last illness or who was present at the death, any of the relatives of the deceased or any other person (questions 5–8).

42. The form prescribed by the 1903 Cremation Regulations contained no requirement that any of the questions on Form C should be answered in the affirmative and that remains the position today. However, each crematorium produces its own cremation forms and every Form C seen by the Inquiry has contained an instruction to the effect that questions 1, 2 and 4 should invariably be answered in the affirmative. The Inquiry has discovered that some crematoria issue cremation forms which contain a note to the effect that one of questions 5–8 also must be answered in the affirmative. The origin of this requirement is not known but it seems that it has appeared on the forms of some crematoria for many years, certainly for as long as the current personnel at the crematoria can remember.

43. The significance of an affirmative answer to one of questions 5–8 is that it indicates that the Form C doctor has questioned someone (other than the Form B doctor) who has knowledge of the deceased and of the circumstances of the death and has therefore had the opportunity of comparing the information received from the Form B doctor with that from another source.

The History

44. Over the years which followed the introduction of the cremation certification procedures, concerns were frequently expressed about the value of those procedures and, in particular, about the value of the personal enquiry undertaken by the Form C doctor. There were suggestions that the examination of the deceased's body by Form C doctors was often perfunctory and that, sometimes, the Form C doctor did not even question the Form B doctor. From time to time, it was also observed that the importance of the questioning of a person other than the Form B doctor was being neglected. There was an ongoing debate as to whether the cremation certification procedure should be abolished or retained. There were some (chiefly the organisations responsible for running the crematoria) who contended that the certification procedures should be abolished as they were expensive and a disincentive to choosing cremation as a means of disposal. There were others (notably the Government Law Officers, the police, the British Medical Association (BMA) and the Association of Crematorium Medical Referees) who argued that the procedures constituted a valuable safeguard against the concealment of crime. No consensus on the way forward was possible and every attempt to strengthen the system and make it more effective failed. In 1965, a Committee chaired by Mr Norman (later Judge) Brodrick QC ('the Brodrick Committee') was set up to examine the system of death certification and coroners. Cremation certification was included in its Terms of Reference.

45. The Brodrick Committee reported in 1971. Members of the Committee concluded that the system of medical certification of the cause of death should be strengthened. If that were done, they recommended that the cremation certification procedures should be abolished in their entirety. Even if no immediate steps were taken to change the death certification system, the Committee nevertheless recommended that the Form C procedure, which they regarded as valueless, could be abolished immediately without risk. That recommendation – like all the recommendations of the Committee – was based on its conclusion that the risk of secret homicide, whether by the attending doctor or anyone else, was negligible. That conclusion, expressed four years or so before Shipman began his course of killing, has of course been proved wrong by the events which have followed.

46. After the Brodrick Committee had reported, the Home Office (which was responsible for cremation-related matters) and the GRO (which had responsibility for taking forward the recommendations relating to death certification) set about attempting to implement the recommendations. However, abolition of the cremation procedures was opposed by those organisations which had opposed it in the past. Meanwhile, the cremation organisations and the National Association of Funeral Directors pressed for abolition. Disputes arose also over the implementation of recommendations relating to death

certification. In 1984, plans for a Bill to implement those recommendations were shelved. Efforts to abolish the Form C procedure (the interim measure that had been recommended by the Brodrick Committee) also foundered in the face of opposition by the BMA. In November 1988, the Home Office took the decision to abandon its attempts to abolish Form C until the GRO had effected changes to the procedures for death certification. Despite further attempts over the years, those changes were never effected and, more than 30 years after the Brodrick Committee reported, the cremation certification procedures remain virtually unaltered. However, even had the recommendations of the Brodrick Committee been implemented in their entirety, including the recommendations for strengthening the system of death certification, the course of Shipman's killing would not have been affected because the system would still have been dependent on the integrity of a single doctor.

The Cremation Forms

Form B

47. The Inquiry heard evidence about the problems associated with the cremation certification procedures. The meaning of some of the questions on Form B is uncertain and ambiguous and there is no consistency of approach. Although a completed Form B provides much more information than a completed MCCD, it does not require what I regard as the two essentials for the investigation of any death, namely a brief medical history and an account of the circumstances of the death.

Form C

48. The Form C procedure does not operate as it was intended to do when the procedure was first devised. The Form C doctor, in the community at least, is generally not truly independent of the Form B doctor. The Form B doctor will usually choose the doctor who is to complete Form C; the relationship between the two doctors will often be close, sometimes social as well as professional. Many doctors regard the completion of Form C as a technical requirement only. They do not see themselves as carrying out an independent investigation into the cause and circumstances of the death. The doctors who gave oral evidence to the Inquiry admitted, when pressed about the matter, that they had never previously thought that they were in any way 'policing' their colleagues. Most had never thought that they were supposed to consider whether their colleagues might have concealed wrongdoing of any kind, whether deliberate or through lack of care. Yet this is the very purpose for which the personal enquiry by a second (Form C) doctor was designed and intended.

49. The doctor who gives affirmative answers to questions 1, 2 and 4 on Form C will have seen the deceased's body and examined it to a greater or lesser extent. That examination may have provided confirmatory evidence of the diagnosis of cause of death. More likely, the examination will have been too superficial to reveal anything of significance, or the cause of death will be one that would not give rise to visible signs, even on a thorough physical examination. Thus, the examination will have provided no independent evidence upon which the Form C doctor can rely. The Form C doctor will also have heard the account of

the clinical history and the reasons for the diagnosis of cause of death, as propounded by the Form B doctor. That account will not have been confirmed by inspection of the medical records. Nor, unless there is a local requirement to do so, will most Form C doctors have questioned anyone other than the Form B doctor.

50. There was no such local requirement at the Dukinfield crematorium. In the vast majority of cases, the doctors who completed Forms C for Shipman did not question anyone independent of him about the death. They trusted him as a respected colleague. He lied to them; they believed his account of the death and they confirmed his dishonest opinion of the cause of death. The Form C procedure, as operated, served no useful purpose as a deterrent to Shipman's activities or as a means of detecting those activities. The question is whether it would have been useful in either respect if there had been a requirement that the Form C doctor should question someone other than Shipman.

51. Had there been such a requirement, there would have been a real prospect that, in many cases, the lies which Shipman had told when completing Form B (knowing that the form would never be seen by the deceased's relatives or carers) would have been exposed. It is likely also that, had the Form C doctor spoken to some of the relatives of Shipman's victims, they would have expressed surprise, even concern, at the suddenness of the death. The fact that, on many occasions, Shipman had certified the cause of a sudden death on inadequate grounds would probably also have become clear.

52. The possibility that any of these consequences might follow a discussion between a Form C doctor and a relative or carer of a patient whom he had killed would, I think, have acted as a real deterrent to Shipman. If, despite the possible consequences, he had taken the risk of killing, I am confident that the chances of his being detected would have been increased. The kind of report that Dr Linda Reynolds made to the Coroner in March 1998 might have been made earlier and with much greater attendant detail. I cannot say when this would have happened, but I think it likely that, had relatives and carers been questioned, that would have led to Shipman's detection at some stage, whereas the system, as operated, never did.

The Role of the Medical Referee

53. The crematorium medical referee is an experienced doctor, but carries out what is essentially a paper exercise. He or she is required to examine the cremation forms and ascertain that they are in order and that the enquiry made by the doctors completing the forms has been adequate. Before authorising a cremation, the medical referee must be satisfied that the cause of death has been definitely ascertained. He or she may make any enquiry that s/he may think necessary and may, in certain circumstances, order an autopsy or refer a case to the coroner. In fact, very few cases are subjected to autopsy or referred to the coroner as a result of action on the part of medical referees.

54. There are two schools of thought about what the task of the medical referee should entail. Some medical referees believe that they are required to make an essentially clerical check to ensure that the forms have been properly completed and that the causes of death stated on Forms B and C are the same. They are not required, they say, to consider the content of the forms or to seek to discover whether the picture presented makes medical

sense. Other medical referees take the view that their statutory duty requires them to scrutinise the forms with a view to seeing whether the picture created by them hangs together and makes medical sense.

55. It is not entirely surprising that there should be variability in practice among medical referees. They operate in isolation from each other and receive no training and little guidance, save that which is provided locally. There are no monitoring or audit procedures. The Home Office has in the past had little direct contact with medical referees, save when attempting to resolve a specific difficulty or request for advice.

56. In my view, it is clear that a clerical check cannot be the task that was envisaged when the procedures were devised. It must have been intended that the medical referee should make a medical judgement about the content of the forms and the consistency of the stated cause of death with the information contained in them. Even so, the medical referee's task is very limited. The completed forms contain inadequate information to enable the medical referee to gain a clear picture of the events leading up to the death. Form B does not require the doctor to provide even a brief account of the deceased's medical history, nor much information about the circumstances of the death. The task of the medical referee does not involve any independent investigation. The system is based upon trust in the truthfulness and integrity of those taking part in the procedure. In particular, the medical referee is dependent on the integrity of the Form B doctor.

57. In summary, it seems to me that the role of the medical referee is of limited value, even when the duties are carried out, as they often are, most conscientiously. When the role is limited to that of a clerical check, it is completely without value.

The Role of the Home Office

58. It has been known for over 50 years that the system of cremation certification was not working as it was intended. As I have already explained, no significant changes to the system were made; in particular, no steps were taken to strengthen the system or to ensure that the procedures worked as had been originally intended. Given that the Home Office had responsibility for keeping under consideration the need for changes to cremation legislation, I have had to consider whether the Home Office has properly discharged that responsibility.

59. I have concluded that, given the view of the Brodrick Committee that the risk of secret homicide was negligible and that the cremation procedures should be abolished, it is not possible to criticise the Home Office, whether in the years before the Brodrick Committee reported, or in the period immediately afterwards, for any failure to strengthen the cremation certification procedures. In the period after the Committee reported, it was hoped and intended that abolition would be effected and I can well understand therefore why strengthening the procedures was not a priority.

60. However, I consider that those Home Office officials responsible for cremation matters over the years are to be criticised for their general lack of awareness of how the cremation certification system was operating throughout the country. The Home Office should have had a policy for the selection of medical referees; it should have provided training and

support for them once appointed. It should have maintained contact with them and ensured that they had contact with each other. Had the Home Office taken these steps, officials should have been aware that different practices were followed at different crematoria; they should have known that, at some crematoria, an affirmative answer was required to one of questions 5–8 of Form C and they should have found out why this was so. They might then have realised that a requirement that the Form C doctor should question someone other than the Form B doctor would strengthen the protective effect of the procedures. It is possible that they might have considered introducing such a requirement. However, in view of the fact that they believed that the cremation procedures were valueless, they might have rejected the idea. Even if they had proposed a significant strengthening of the Form C procedure, such a proposal would certainly have aroused strong objections. In the circumstances, I do not think that Home Office officials could have been criticised had they failed to pursue their proposal with all the vigour and determination that would have been necessary to overcome such objections.

61. In the circumstances, I do not consider that there is any ground on which the Home Office can be held responsible for the failure of the cremation certification system to detect Shipman's course of criminal conduct.

62. In my view, the cremation certification procedure, as presently carried out in most places, is of very little value. I am recommending a new system of death certification for all deaths, whether followed by burial or cremation. If that recommendation is implemented, the current cremation certification system will no longer be required.

The Hyde Form C Doctors

63. The Inquiry has considered whether those doctors who undertook the duty of completing most of Shipman's Forms C ('the Hyde doctors') should be criticised for their performance in connection with the completion of Forms C for Shipman's patients. I had to consider, in relation to each Hyde doctor, whether there were numbers or patterns of deaths or unusual – possibly recurrent – features of the deaths that should have been noticed and acted upon by him/her. I also had to consider whether, by checking what Shipman had written on Form B, the Hyde doctors should have noticed any unusual features, or inconsistencies between what Shipman had written and what he had told them.

64. When giving evidence to the Inquiry, the Hyde doctors related how, when they were to complete a Form C for Shipman, he would visit them in their surgery and would give a very full account of the deceased person's medical history and the events leading up to the death. Shipman was a plausible historian and gave a full and persuasive account of events. The Form C doctor would not see the medical records. However, s/he would see the Form B, examine the deceased's body and complete and sign Form C. It does not appear that the doctors always read Form B carefully, as some failed to observe strikingly unusual features or inconsistencies in the forms. I think that most of them carried out their examination of the body in a cursory way although, even had they made a careful examination of the body of a patient whom Shipman had killed, it would have revealed no cause for suspicion.

65. In my judgement, the general approach of the Hyde doctors to their Form C role, like that of a large proportion of doctors practising elsewhere in the country, was not appropriate. The purpose of the Form C doctor is that s/he should seek to reach an independent opinion as to the cause of death. Doctors should not merely accept and endorse the view of the Form B doctor. They should carry out a careful examination of the body and they should not adopt the practice of never making enquiries of third parties. However, I observe that the profession as a whole was never instructed to change the practices that were commonly adopted. It would not be fair to single the Hyde doctors out for criticism on account of their general approach to the task.

66. I considered the conduct of each of the Hyde doctors individually, applying the standard of the reasonable, competent and conscientious general practitioner. As a result of that exercise, I have been critical, to a greater or lesser extent, of six out of the ten doctors concerned. It is not possible to explain adequately the reasons for my conclusions about the performance of each individual doctor within the confines of this Summary. My analysis of their roles is set out in Chapter Fifteen. The poor performance of the six doctors I have referred to above is mitigated, although not entirely excused, by the generally low standard of Form C completion prevailing throughout the profession.

67. Even if, in the cases in which I have criticised a doctor for signing a particular Form C, the doctor had queried the propriety of Shipman's decision to certify the cause of death, I do not think that would have led to his detection. I think it likely that Shipman would have claimed that he had spoken to the coroner, who had approved the cause of death. Distrust of Shipman would not have been such as to cause the Form C doctor to verify the truth of that statement. However, if this had happened regularly, it would or should have attracted notice.

68. It is clear that the Form C procedure, as operated in this country for many decades, has been wholly inadequate as a safeguard against concealed wrongdoing by a Form B doctor. By wrongdoing, I mean, not only homicide, but also negligence and neglect. It is clear that any system which depends on the integrity of one doctor is open to abuse by that doctor, if s/he is dishonest.

69. It is a matter of regret that the Hyde doctors have still not changed their practice in relation to completion of Forms C, despite their knowledge of the way in which the system can be abused by an unscrupulous doctor.

The Dukinfield Crematorium Medical Referees

70. The Inquiry examined the work of the two doctors who were employed as medical referees at the Dukinfield crematorium during the years when Shipman killed so many of his patients. Dr Betty Hinchliffe was Deputy Medical Referee from the late 1970s until 1989, when she became Medical Referee, and Dr Jane Holme was Deputy Medical Referee from about 1989. Both retired in 1999.

71. Dr Hinchliffe and Dr Holme had worked in the field of child health for most of their professional careers and had very little experience relevant to their work as medical referees, especially in the care and treatment of the elderly. Both had little experience of

completing cremation forms. In my view, neither Dr Hinchliffe nor Dr Holme was adequately equipped by her professional experience for the work of a medical referee. This was not their fault. It was the fault of the system that permitted them to be appointed, despite their lack of relevant experience.

72. In oral evidence, Dr Holme told the Inquiry that she believed that her task was essentially to carry out a clerical check of the cremation forms. She did not consider that she should review the medical opinions expressed by the Form B and Form C doctors. She had never queried a cause of death. Nor had she ever ordered an autopsy or referred a death to the coroner.

73. By contrast, Dr Hinchliffe told the Inquiry that, in looking at the cremation forms, she assessed the whole picture and tried to fill in 'a little jigsaw puzzle'. In other words, she was suggesting that she exercised a degree of medical judgement. I regret to say that I was unable to accept that evidence for reasons which I have explained fully in Chapter Sixteen. I am satisfied that, like her colleague, Dr Hinchliffe carried out what was essentially a clerical check of the cremation forms only. Dr Hinchliffe too had never ordered an autopsy or referred a death to the coroner.

74. I am reluctant to criticise Dr Hinchliffe and Dr Holme for believing that their task was of an essentially clerical nature because this mistaken belief was not uncommon and there was no training or guidance by which such a mistaken belief could be corrected. However, I would have thought that the application of common sense to the words of the Cremation Regulations (particularly the power to order an autopsy) should have suggested to them that the task required the exercise of some degree of medical judgement and was intended to be more than a clerical exercise. I can only conclude that, like many of their colleagues, they never paused to consider the underlying purpose of the work of a medical referee, nor why, if that purpose were clerical in nature, the work had to be undertaken by an experienced medical practitioner.

75. Dr Hinchliffe authorised the cremation of the bodies of 176 of Shipman's patients; Shipman had killed 107 of those patients. The figures must be seen in the context of the total number (about 2000 a year) of deaths that Dr Hinchliffe processed. I am satisfied that neither the number nor the distribution of the deaths of Shipman's patients scrutinised by Dr Hinchliffe was so unusual that she should have found them noteworthy. Dr Holme dealt with only 31 deaths certified by Shipman over a period of eight years. There was nothing about the numbers to draw Shipman to her attention.

76. Had Dr Hinchliffe or Dr Holme undertaken an assessment of the whole picture presented by the cremation forms, they would have found some (in Dr Hinchliffe's case, many) Forms B in which the information provided by Shipman was inadequate or inconsistent. For Dr Hinchliffe, in particular, this would have meant that it was quite often necessary for her to speak to him to clarify the picture. She would have found it necessary to speak to him considerably more frequently than she had to speak to other general practitioners. Had Dr Hinchliffe assessed the whole picture, and had she had the benefit of a more appropriate medical background, she would have realised that there were unusual features among the deaths of Shipman's patients.

77. Whilst the performance of Dr Hinchliffe and, to a lesser extent, Dr Holme fell short of that which might have been expected from the best of their colleagues, I conclude that it is unlikely to have been significantly different from that of many other medical referees in England and Wales. In mitigation of their performance, they had not been given any formal training or even provided with a handbook of advice. The only instruction available had been provided by the previous medical referee. There was no contact with medical referees from other areas. Furthermore, the circumstances in which the task was performed, especially the pressure created by timing, encouraged the feeling that the job was a straightforward clerical exercise with the minimum of enquiry needed.

78. Even had Dr Hinchliffe or Dr Holme questioned Shipman, it is likely that he would have been able to proffer an explanation in any given case which would have satisfied them, just as it must already have satisfied the Form C doctor. However, had there been a repeated need to contact Shipman and to ask similar questions in relation to cases with similar characteristics, this might well have led to concerns about his competence to complete the forms, possibly about his competence as a doctor and possibly even as to his honesty. Repeated questions directed at him might have acted to deter him from pursuing his criminal activities. However, he might just have modified his form-filling techniques so as to ensure that his deaths passed through the system without question. Even had the medical referees exercised their power to order an autopsy, or referred a death to the coroner for him to do so, it would not have revealed evidence of criminal activity in the absence of toxicological tests.

79. In short, I doubt very much that, even if the medical referees had performed their duties in a more critical manner, the course of Shipman's killing would have been changed.

Coroners

The Existing Coronial System and Coroners' Jurisdiction

80. According to the Home Office, there are 115 coroners in England and Wales, of whom 23 are full-time. Coroners may have a legal or a medical qualification; the vast majority are legally qualified. The coroner service is funded by local authorities, who are also responsible for appointing coroners. The resources available to coroners (even full-time coroners) in terms of office and court premises, staff and office equipment vary widely. Part-time coroners combine their coronial duties with practice, usually as a doctor or solicitor, often discharging their duties from their practice premises. Some carry out their duties from home.

81. Until recently, there was virtually no training for coroners. Recently, the Home Office began to provide some training. However, it is not compulsory and some coroners do not avail themselves of it. Many coroners, particularly part-time coroners, have little contact with their colleagues and operate in virtual isolation. In the past, they have received little advice or guidance. There is no leadership structure. The only challenge to a coroner's decision is by way of judicial review which is rare; there is no appellate body offering regular guidance on the interpretation of the relevant statutory provisions. As a consequence of all these factors, there is considerable variability of practice and standards in different coroner's districts.

82. It would be desirable to achieve a measure of consistency of practice and of high standards. To achieve these ends, there is a need for leadership, organisation and structure in the work of coroners. Coroners must also receive continuing education and training.

83. Some functions of a coroner (such as the conduct of inquests) require legal knowledge and experience. Others (such as the judgement whether a death is or is not due to a natural disease process) require medical expertise. At present, there are few coroner's offices where both legal and medical expertise is available on a day-to-day basis. Usually, the available expertise is legal only.

84. A coroner can act only if and when a death is reported to him/her. In 2001, 37.8% of all registered deaths were reported to coroners; most reports (95.7% in 2001) were by doctors. Coroners receive no information about deaths that are not reported to them. They are dependent on others to report deaths. I have already drawn attention to the present unsatisfactory arrangements whereby doctors decide whether or not to report deaths to the coroner. I have also described the difficulty which registrars experience in identifying those cases which should be reported. As Shipman has shown, it is possible for a doctor to evade the coronial system almost completely. A way must be found to ensure that all deaths receive a degree of scrutiny and investigation appropriate to their facts and circumstances.

85. When a report of a death is made, the coroner must make a decision as to whether the death falls within his/her jurisdiction, i.e. whether the death falls within one of the categories of deaths in respect of which s/he is obliged by statute to hold an inquest. These categories comprise deaths where there is reasonable cause to suspect that the death was 'violent' or 'unnatural' or was sudden and of unknown cause or occurred whilst the deceased person was in custody. The coroner might decide that the death falls within his/her jurisdiction, in which case s/he will proceed to investigate the death in preparation for an inquest, or to order an autopsy which might make an inquest unnecessary. Alternatively, the coroner might decide that the death does not fall within his/her jurisdiction, in which case s/he will take no action to investigate the death.

86. In my view, there are grounds for concern about the soundness of the decisions taken by some coroners and coroner's staff as to whether the coroner has jurisdiction. These decisions are very important as they will determine whether or not an individual death is to be subjected to any 'official' investigation. If the coroner does not assume jurisdiction, burial can follow without any further check being made. If the deceased is to be cremated, the death is still unlikely to be subjected to any significant investigation.

87. In my view, many decisions on jurisdiction are taken far too informally. The person reporting the death (usually a doctor) is not required to put anything in writing or produce any extract from the medical records. The coroner should receive written information about the circumstances of the death and the deceased's medical history in order to inform his/her decision on jurisdiction.

88. The decision as to jurisdiction is, in general, taken on the basis only of what the reporting doctor says. The coroner or a member of the coroner's staff takes what the doctor says

completely on trust. In general, no attempt will be made to verify the accuracy of the information given by the doctor from any other source. Nor will any attempt be made to speak to a relative of the deceased. In my view, such decisions should be based upon a broader knowledge of the death. Information provided by the person reporting the death should be cross-checked with a member of the deceased's family or some other person with recent knowledge of the deceased. If appropriate, other enquiries should be made.

89. The evidence received by the Inquiry suggests that many decisions about jurisdiction are taken by untrained staff without the medical knowledge necessary to equip them to do so and without any proper understanding of the correct statutory tests to be applied. The evidence suggests that, on occasions, they are influenced, whether deliberately or not, by extraneous matters. Even when coroners themselves take the decisions, they may not have the necessary medical knowledge to understand the issues and may in any event be reliant on information taken by a member of staff with no understanding of those issues. In my view, decisions of this kind should be taken by medically qualified coroners or, in the more straightforward cases, by coroner's officers with some medical background and ready access to expert medical advice.

Greater Manchester South District

90. Shipman's practice in Hyde fell within the coronial District of Greater Manchester South. Once his activities became known, there was some public disquiet that they had not earlier come to the knowledge of the Coroner for the District, Mr John Pollard. It was therefore necessary for the Inquiry to examine the practices within his office and to ascertain whether the fact that Shipman's activities had not come to his attention resulted from any fault on his part or that of his staff.

91. The procedures within Mr Pollard's office have been subjected to close scrutiny by the Inquiry. As a result, concerns have arisen about practices in operation in the office. Those concerns relate in particular to the way in which decisions, particularly decisions on jurisdiction, were made. I have also expressed concern about the extent to which members of his staff were authorised to make decisions on his behalf. I am not critical of individual members of staff, who had received no training and were no doubt doing their very best to discharge their duties in difficult circumstances. Nor am I very critical of Mr Pollard himself. He too had little training and suffered from the disadvantages of lack of leadership and guidance which I have described. I do not think that the practices within his office were any different from those in operation in many other coroners' offices up and down the country.

92. Most importantly, I doubt that the practices in operation in Mr Pollard's office had any effect on the outcome of those few deaths referred to him where Shipman had killed. It is possible that, if the practices followed in the office had been better, the outcome might have been different in those cases (we do not know how many since records would not necessarily have been kept) in which Shipman spoke to the coroner's office and 'discussed' a death. For example, in the case of Mrs Kathleen Grundy, a coroner's officer or clerk/typist might have spoken to Mrs Grundy's daughter, Mrs Angela Woodruff, before giving 'permission' for Shipman to certify the death as due to 'old age'. However, the

practice in the coroner's office can have had no effect on the vast majority of the killings, which never came to the Coroner's notice at all.

Coroner's Officers

93. The functions of coroner's officers vary from district to district. Some fulfil an investigative role. Others are office-bound. Most are serving or former police officers. Others come from a variety of different employment backgrounds, including nursing and paramedic. Some are employed by the police and others by local authorities. Until recently, when the Coroner's Officers Association began to organise and fund it, no training for coroner's officers was available. Even now, those coroners whose officers are employed by the police cannot insist on their attending the training courses which are available.

94. The service provided by coroner's officers is currently of variable quality. For too long, they have been expected to perform tasks requiring the application of skills which they do not possess and in which they have not been trained. Coroners must have the support of a team of investigators, preferably drawn from a wider variety of employment backgrounds than at present. The coroner should be able to direct and manage their work and working conditions. The investigators will require appropriate training. Other staff will supply the necessary administrative support.

The Police as Coroner's Officers

95. Under the present system, the police are frequently summoned to the scene of a death which has occurred in the community. If it appears to the police officer attending that there are circumstances suggestive of criminal involvement in the death, a police investigation will be set in motion. If there are no such circumstances and if it appears to the officer that there is a doctor willing and able to issue an MCCD, police involvement usually ceases immediately. If, however, there appears to be no doctor willing and able to issue an MCCD, the death must be reported to the coroner.

96. In that event, the function of the police officer changes and, thereafter, s/he acts in the capacity of a coroner's officer. In that capacity, s/he will carry out a limited preliminary investigation of the circumstances of the death and complete one or more sudden death report forms, recording the information obtained. Police officers sometimes carry out this same function following the report of a death to the coroner by others – for example, doctors and registrars.

97. The Inquiry examined samples of sudden death report forms completed by officers of the Greater Manchester Police (GMP). These revealed very variable standards of investigation and reporting. It was clear that the officers often had no idea why the death had been reported to the coroner or what issues the coroner would have to decide. Thus, the information contained on the forms did not focus on the issues of real relevance to any subsequent coroner's investigation. It was accepted on behalf of the GMP that the standard of investigation and reporting of deaths on behalf of the coroner was very variable. An individual officer might complete such forms only once or twice a year. Procedures that are not practised frequently are unlikely to be conducted to as consistently high a standard as those that are performed often.

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98. Although I am critical of the standard of investigation and reporting by the GMP, I am satisfied that none of the shortcomings that I have identified resulted in Shipman escaping detection for killings which might have been revealed had officers acted differently. I should say also that I heard criticism of the standards of investigation and reporting by officers of other police forces besides the GMP.

99. It appears to me that there are several reasons why police officers should no longer be involved in the investigation of deaths that do not give rise to any suspicion of crime. First, they do not have the skills or expertise necessary for the job. It is clear that many enquiries to be made on a coroner's behalf will involve medical issues and I am satisfied that a police officer with no medical knowledge is not an appropriate person to undertake them. Such enquiries also involve dealing with the recently bereaved, which many police officers are not used to and find difficult. Furthermore, the task of attending such deaths is time-consuming and places a heavy burden on limited police resources. Understandably, perhaps, many police officers do not regard attendance at such deaths as an appropriate use of their skills or their time.

100. In my view, what is needed is a person specially trained to investigate non-suspicious deaths. The usual role of the police should be limited to the investigation of those deaths where there is some reason to suspect crime. My proposal will be that the investigation of non-suspicious deaths should be carried out by the coroner's investigators to whom I have already referred.

Coroners' Investigations and Inquests

101. Once the coroner decides that s/he has jurisdiction over a death reported to him/her, the coroner will carry out an investigation into the death. Only two of the deaths of Shipman's victims, those of Mrs Renate Overton and Mr Charles Barlow, were subjected to a coroner's investigation. For reasons which I have set out in Chapters Nine and Thirteen, both investigations resulted in the deaths being wrongly attributed to 'natural causes'. The fact that those investigations had failed to reveal that Mrs Overton and Mr Barlow had been unlawfully killed raised the possibility that there might be more general deficiencies in the methods of investigation adopted by coroners. The Inquiry examined some of the ways in which coroners investigate deaths and the investigative tools at their disposal.

102. At present, once a coroner accepts jurisdiction in respect of a death, a subsequent decision to order an autopsy is almost automatic, without any other preliminary investigation. This immediate resort to autopsy results from the legislation. In my view, it is undesirable. An autopsy should be conducted only when there is a positive reason to do so; the decision should not be taken 'by default'. The coroner should have available to him/her a wider range of investigative methods and should be provided with the necessary powers to enable him/her to make full use of those methods.

103. The evidence received by the Inquiry suggests that, sometimes, the autopsy is not the definitive source of information it is often thought to be. Some coroners' autopsies are seriously deficient. The pathologist may have inadequate information about the death. He or she may not have the medical records or the opportunity to speak to the clinicians responsible for the deceased person's care. Pressure of time may mean that the autopsy

is conducted too quickly and best practice may not be followed. Sometimes, coroners will not give permission for samples to be taken for histology, when the pathologist thinks it necessary. The pathologist may feel under pressure to find a natural cause of death. Sometimes, pathologists are tempted – or persuaded – to go beyond their expertise in ascribing a death to 'natural causes' when they do not have all the relevant information.

104. When available, the autopsy report is often viewed in isolation. The coroner is likely to know little about the circumstances of the death or the deceased person's medical history. He or she will have no witness statements and no medical records. In the absence of any wider evidential background against which to view the autopsy report, a coroner is almost bound to accept it at face value. Nor do most coroners have the medical expertise necessary to subject the report to any critical examination.

105. My overall impression is that there is in the minds of the coroners and some of the pathologists about whose practices I heard an expectation that, if a death is not immediately identified as 'suspicious', it will be found to be due to natural causes. It is easy to see how this attitude can become entrenched. The great majority of deaths will, in fact, be natural. However, if a coroner's investigation is to be effective, there must be an ever-present readiness to keep in mind the possibility that the death might not have been natural. Quite apart from any question of homicide, the coroner should bear in mind the possibility that neglect, accident or medical error might have caused or contributed to the death. Otherwise, the expectation that the death will be 'natural' may become a self-fulfilling prophecy.

106. Following autopsy, if the cause of death is not certified on the basis of the cause of death given in the autopsy report, some investigations will be undertaken prior to the inquest. The detailed evidence which the Inquiry received about such investigations came primarily from the Greater Manchester South District. That evidence suggested that investigations were unfocussed and lacked co-ordination by a person who understood the issues and had access to all the available information. A particular problem arose in the investigation of cases involving the possibility of medical error or neglect which might have caused or contributed to the death. Such investigations require particular expertise and the availability of specialist skills.

107. There is, in my view, an urgent need for a more focussed, professional and consistent approach to coroners' investigations; this is needed from the time that the death is reported, right up to the verdict at inquest. There needs to be clarity as to the purpose and scope of the enquiries that are made. Coroners themselves, who are to direct the conduct of an investigation, require training. Legal experience, particularly as a solicitor, should provide a sound basis for the conduct of an investigation into non-medical matters, but it is apparent from the evidence that medical knowledge and experience is vital for the proper conduct of many investigations, as well as for the proper evaluation of evidence and the taking of decisions.

108. In the course of the Inquiry, I have become aware of the widespread concern about the number of inquests held and the way in which many inquests are conducted. I have considered the issue of inquests only briefly because, in the event, no death of a victim of

Shipman was the subject of an inquest until after Shipman had been convicted of murder in January 2000.

109. In 2001, inquests were held into nearly 25,800 deaths in England and Wales; that figure represents 13% of all deaths reported to coroners and nearly 5% of all registered deaths. Inquests are held into a far larger proportion of deaths in England and Wales than in other jurisdictions which the Inquiry examined.

110. Although some jurisdictions manage without inquests altogether, I think there are positive reasons to have inquests, provided that they are thorough and well conducted. There are cases in which the holding of an inquest will result in positive public health and public safety benefits. Also, where issues of public concern arise, an inquest can expose failings or engender confidence.

111. At present, it is not easy for coroners to decide whether a particular death falls within one of those categories of death which by statute require an inquest. There is a general perception that the existing categories do not include all deaths that give rise to public concern. Equally, there is a feeling that some deaths which do fall within the categories give rise to no issue of particular public interest or concern. In short, the means of selecting those deaths where the public interest requires an inquest is not satisfactory and requires change.

112. In the modern era, the purposes of the public inquest should be to conduct a public investigation into deaths which have or might have resulted from an unlawful act or unlawful acts, to inform interested bodies and the public at large about deaths which give rise to issues relating to public safety, public health and the prevention of avoidable death and injury, and to provide public scrutiny of those deaths that occur in circumstances in which there exists the possibility of an abuse of power.

113. In many cases, nothing is gained by the hearing of evidence in public. Indeed, in many cases, such exposure amounts to an unwarranted invasion of privacy and only causes increased distress to the bereaved. In my opinion, the public inquest should be limited to those deaths about which there is a real public 'need to know'. In all other cases, the end product of a coroner's investigation would be a written report. I would confine inquests to deaths where the particular circumstances are such that the public interest requires a public hearing. I suggest that, apart from a few types of situation in which an inquest should be mandatory (such as cases of homicide not followed by conviction and deaths in custody), the coroner should have discretion to decide (after consultation with interested parties) whether a public inquest should be held in that individual case or group of cases. The decision should be subject to appeal, not only by relatives of the deceased, but also by anyone with a legitimate interest in the case. Coroners should receive guidance on the types of issue that will require a public investigation at inquest.

114. I also consider that the procedure by which coroners can make recommendations for future change should be continued, but strengthened.

The Death of Mrs Renate Overton

115. Following investigation of Mrs Overton's death during Phase One, I found that Shipman had deliberately given her an overdose of diamorphine (or possibly morphine), intending

to kill her. In the event, she survived, in a persistent vegetative state, for 14 months before her death in April 1995. I was concerned to investigate precisely how the post-death procedures had operated in her case. The detailed results of that investigation are set out in Chapter Thirteen.

116. I have found that the performance of Dr David Bee, the consultant pathologist who carried out the autopsy in Mrs Overton's case, was seriously deficient. His autopsy report provided no underlying cause of death and he should have made it clear that he was unable to do so. Instead, he gave an unfounded opinion that the death was due to natural causes. I have also criticised the then Coroner for Greater Manchester South District, Mr Peter Revington, for his decision, based on manifestly inadequate information, not to hold an inquest.

117. The events of this case vividly illustrate the shortcomings of the systems for the investigation of deaths in operation in the office of the Coroner for Greater Manchester South District at the material time and lend strong support to the conclusions which I have expressed above about the inadequacy of coroners' investigations generally.

Proposals for Change

118. It is clear from the evidence I have received that the current arrangements for death and cremation certification and the coronial system require radical change. I have set out my proposals for that change in the following section.

RECOMMENDATIONS

The Future of the Coronial System

1. The coronial system should be retained, but in a form entirely different from at present. There must be radical reform and a complete break with the past, as to organisation, philosophy, sense of purpose and mode of operation. (paragraphs 19.10–19.12)

The Aim and Purposes of the New Coroner Service

2. The aim of the new Coroner Service should be to provide an independent, cohesive system of death investigation and certification, readily accessible to and understood by the public. It should seek to establish the cause of every death and to record the formal details accurately, for the purposes of registration and the collection of mortality statistics. It should seek to meet the needs and expectations of the bereaved. Its procedures should be designed to detect cases of homicide, medical error and neglect. It should provide a thorough and open investigation of all deaths giving rise to public concern. It should ensure that the knowledge gained from death investigation is applied for the prevention of avoidable death and injury in the future. (paragraphs 19.13–19.14)

The Need for Leadership, Training and Expertise in the Coroner Service

3. The Coroner Service should provide leadership, training and guidance for coroners, with the aim of achieving consistency of practice and a high quality of service throughout the country. (paragraph 19.15)

4. The Coroner Service requires medical, legal and investigative expertise. (paragraph 19.16)

5. Many of the functions currently carried out by coroners (who, in the main, have a legal qualification only) require the exercise of medical judgement. Some of those functions (and others which I am recommending) require legal expertise. In the future, those functions should be carried out respectively by a medical coroner and a judicial coroner. Both the medical and judicial coroners should be independent office-holders under the Crown. (paragraphs 19.17–19.19)

6. The Coroner Service should have a corps of trained investigators, who would be the mainstays of the new system. The coroner's investigator would replace the coroner's officer but have a greatly enhanced role. More routine functions, at present performed by coroner's officers, would be performed instead by administrative staff. (paragraph 19.20)

Structure and Organisation of the Coroner Service

Central Organisation

7. The Coroner Service must be, and must be seen to be, independent of Government and of all other sectional interests. It should not be administered, therefore, from within a Government Department. Instead, it should be a body at 'arm's length' from Government,

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that is an Executive Non-Departmental Public Body (ENDPB). Such bodies are formed in association with, but are independent of, the Government Department through which they are answerable to Parliament. Ideally, the Coroner Service should be associated with both the Department for Constitutional Affairs and the Department of Health (in Wales, the National Health Service Wales Department of the National Assembly for Wales).
(paragraphs 19.21–19.25)

8. The Coroner Service should be governed by a Board. Among the Board's responsibilities would be the formulation of policy, the strategic direction of the Service and the promotion of public education about such matters as the work of the Coroner Service and bereavement services. Three of the members of the Board would be the Chief Judicial Coroner, the Chief Medical Coroner and the Chief Coroner's Investigator, each of whom would be responsible for leading his/her respective branch of the Service.
(paragraphs 19.26–19.30)

9. The Service should also have an Advisory Council, the function of which would be to provide policy advice on all issues. (paragraph 19.31)

Regional and District Organisation

10. The Coroner Service should be administered through a regional and district structure, with a regional medical coroner and at least one judicial coroner assigned to each region. There might also be a regional investigator. There would be ten regions in England and Wales, coinciding with the ten administrative regions. (paragraph 19.32)

11. Each region should be divided into between three and seven districts, each with a population of about a million. Each district office would have a medical coroner, one (possibly more than one) deputy medical coroner (who might work part-time), a team of coroner's investigators and a small administrative staff. The staff would operate a service outside the usual office hours. (paragraph 19.34)

12. The Coroner Service should have jurisdiction over every death that occurs in England and Wales and over every dead body brought within the boundaries. Jurisdiction should not depend upon a report being made or upon the need for an inquest. A death should be investigated in the district office most convenient in all the circumstances.
(paragraph 19.32)

Death Certification

13. There should be one system of death certification applicable to all deaths, whether the death is to be followed by burial or cremation. (paragraph 19.36)

14. There should be a requirement that the fact that a death has occurred should be confirmed and certified. (paragraph 19.41)

The New Forms

15. The basis for the certification system would be the completion of two forms. The first (Form 1) would provide an official record of the fact and circumstances of death. It would be

completed by the person (a doctor, an accredited nurse or paramedic or a trained and accredited coroner's investigator) who had confirmed the fact that death had occurred. The second form (Form 2) would be completed by the doctor who had treated the deceased person during the last illness or, if no doctor had treated the deceased in the recent past, by the deceased's usual medical practitioner. Form 2 would contain a brief summary of the deceased person's recent medical history and the chain of events leading to death. The doctor completing the form would have the option of expressing an opinion as to the cause of death. To be eligible to complete Form 2, a doctor should be registered in the UK and have been in practice for four years since qualification.

(paragraphs 19.40–19.48)

The Duties of Doctors

16. A statutory duty to complete Form 2 should be imposed:

    - in the case of a death occurring in hospital, upon the consultant responsible for the care of the deceased at the time of the death. The duty would be satisfied if the form were completed by a suitably qualified member of the consultant's clinical team or firm; and

    - in the case of a death occurring other than in a hospital, upon the general practitioner with whom the deceased had been registered. The duty would be satisfied if the form were completed by another principal in the practice. If, in the future, patients were to be registered with a general practice (rather than an individual general practitioner), the statutory duty would lie upon all principals in the practice until fulfilled by one of them. (paragraph 19.49)

17. The General Medical Council should impose upon doctors a professional duty to co-operate with the death certification system, requiring them to provide an opinion as to the cause of death on Form 2 in cases where it is appropriate to do so. A failure to co-operate should be a disciplinary matter. (paragraph 19.51)

The Role of the Coroner Service

18. All deaths should be reported to the Coroner Service, which would take responsibility for certification of the death and for deciding whether further investigation was necessary. Deaths where the doctor completing Form 2 had expressed an opinion as to the cause of death would be considered for certification by a coroner's investigator after consultation with the deceased's family. All other deaths would go for further investigation by the medical coroner. (paragraphs 19.58–19.65)

19. The Coroner Service would take primary responsibility for all post-death procedures. It would relieve other agencies of some of the responsibilities that they presently carry in connection with those procedures. (paragraphs 19.66–19.69)

Random and Targeted Checks

20. A proportion of all deaths certified by a coroner's investigator on the basis of the opinion of the Form 2 doctor should be selected randomly for fuller investigation at the discretion of the medical coroner. This process of random investigations would itself be the subject

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of audit. In addition, the Coroner Service should have the power to undertake targeted investigations, both prospective and retrospective. (paragraphs 19.70–19.73)

Registration

21. A new certificate of cause of death should be designed for completion by a coroner's investigator or, where an investigation has been undertaken, by the medical coroner. If, in the future, it becomes possible to register a death on-line, registration could on many occasions be effected by the informant (with assistance) direct from the district coroner's office. (paragraphs 19.79–19.81)

Further Investigation

Criteria for Investigation

22. Coroner's investigators should be trained to recognise the type of circumstances which make it appropriate for a death to be investigated by the medical coroner. The guidance given to investigators should permit flexibility and should be kept under constant review. (paragraphs 19.83–19.86)

The End Product of Further Investigation

23. In general, there should be an inquest only in a case in which the public interest requires a public investigation for reasons connected with the facts and circumstances of the individual case. There should be a few quite narrow categories in which an inquest would be mandatory. Otherwise, the decision whether the public interest required an inquest would be for the judicial coroner and would be subject to appeal. I agree with many of the views expressed in the recent Report of the Coroners Review relating to the outcome, scope and conduct of inquests. (paragraph 19.87)

24. In other cases, the product of the further investigation of a death would be a report (written by the medical or judicial coroner, occasionally by them both jointly) explaining how and why the deceased died. The report should be primarily for the benefit of the family of the deceased person, but should also be provided to any party or public body with a proper interest in its receipt. (paragraph 19.88)

25. Any recommendation made by a judicial or medical coroner, whether in the course of an inquest or a written report, should be submitted to the Chief Coroners. If they ratified it, they would then be responsible for taking it forward at a high level, first by submitting it to the appropriate body and then by pursuing that body until a satisfactory response had been received and action taken. (paragraph 19.91)

Procedures for Investigation

26. The framework for the investigative procedures to be followed once a death had been identified as requiring investigation would be for the Board of the Coroner Service to determine. In any individual case, the course to be followed would be a matter for the individual medical or judicial coroner to decide. (paragraph 19.92)

The Necessary Powers

27. The judicial coroner should be given powers to order entry and search of premises and seizure of property and documents relevant to a death investigation. The medical coroner should be given powers to order the seizure of medical records and drugs. The judicial coroner should hear appeals from decisions of the medical coroner in relation to those powers of seizure. (paragraph 19.95)

Investigation of the Medical Cause of Death

28. In cases where the medical cause of death is to be investigated, there should not be an automatic resort to autopsy. The medical coroner, who would have responsibility for establishing the cause of death, would have a variety of investigative tools at his/her disposal. If the medical coroner were considering ordering an autopsy, the family of the deceased person would be informed and an explanation of why the autopsy was considered necessary would be given to them. There should be an opportunity for family members to advance objections. If the medical coroner were to decide nevertheless that an autopsy was necessary, the family should have a right to appeal the decision to the judicial coroner. In a case where the medical coroner concludes that the cause of death has been established and no further investigation is required, but the family is of the view that there should be an autopsy, there should be a right to make representations to the medical coroner and to appeal to the judicial coroner. (paragraphs 19.96–19.97)

29. In general, the medical coroner should seek to establish the cause of death to a high degree of confidence. However, in an appropriate case, it should be open to a medical coroner, provided that s/he has satisfied him/herself that there is no other reason why the death should be investigated further, to certify the cause of death on the balance of probabilities. In some cases, it might be appropriate for the medical coroner to certify that the death was due to 'unascertained natural disease process'. However, such a cause should not be certified without toxicological screening of a blood or urine sample. The medical coroner should be permitted, in an appropriate case, to certify that a death was due to 'old age'. (paragraphs 19.98–19.100)

30. Disposal of the body of a deceased person whose death is being investigated by the Coroner Service should be permitted as soon as the body has been identified and a decision has been taken that it will not be required for further investigations. If the medical coroner is satisfied that the cause of death is known, but the investigation into the death is not yet complete in other respects, s/he should inform the family and the register office of that cause of death. If there remains any uncertainty about the cause of death, and that uncertainty cannot be resolved until the circumstances have been fully investigated, the medical coroner should, where possible, provide the register office with a provisional cause of death. (paragraph 19.102).

Investigation by the Judicial Coroner

31. Judicial coroners who have to conduct inquests should be relieved of the day-to-day responsibility for the pre-inquest investigation. They should direct the investigation, but responsibility for the collection of evidence should devolve onto a legally qualified person

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in the regional office. The judicial coroner should also have the assistance of that person or, in the more complex cases, counsel to the inquest, who would present the evidence and call the witnesses. (paragraph 19.105)

Criminal Cases and Deaths Investigated by Other Agencies

32. If criminal proceedings have been commenced, there should be no need for an inquest to be opened and adjourned, as is the present practice. If the proceedings resulted in a conviction, the medical coroner would usually need to do no more than write a report recording the fact of the conviction, the cause of death and the brief circumstances of the death. In a rare case, a public interest issue might arise, in which case an inquest would be appropriate. If the proceedings led to acquittal, the death would be referred to the judicial coroner for inquest. (paragraph 19.106)

33. If any other agency (such as the Health and Safety Executive) were to investigate a death, the medical coroner would take no action, other than that necessary to establish the cause of death. When the other agency's investigation was complete, its report, together with the result of the medical coroner's investigation into the cause of death, would be sent to the judicial coroner. The judicial coroner would then decide whether any further investigation was required or whether an inquest should be held. If no inquest were to be held, the judicial coroner would write a report. (paragraph 19.107)

Deaths Arising from Medical Error or Neglect

34. Deaths which were, or might be, caused or contributed to by medical error or neglect should be investigated by the Coroner Service. Doctors should not be treated any differently from others whose errors lead to death. At present, it appears that many cases of medical error and neglect are not reported to or investigated by coroners. The coroner's conclusions would not be determinative of civil liability. The Coroner Service should study the system of identifying and investigating cases of potential medical error being developed in Victoria, Australia, with a view to introducing something of a similar nature in this country. (paragraphs 19.108–19.109)

35. Cases of possible medical error or neglect should be investigated initially by the medical coroner. If, following that investigation, it appeared to him/her that the death might have been caused or contributed to by medical error or neglect, the case should be referred to the regional coroner's office for investigation by the regional medical coroner and judicial coroner. (paragraph 19.110)

36. Cases of medical error or neglect transferred to the regional coroner's office would be investigated under the direction of a legally qualified person. There should be a small team of coroner's investigators at every regional office who can develop expertise in medical cases. Appropriate expert opinions would be obtained. Further ideas for the investigation of more complex medical cases should be considered with a view to a proper system of investigation being devised. (paragraph 19.111)

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Pathology Services

Autopsies

37. All autopsies should be carried out to the standards recommended by the Royal College of Pathologists in its document 'Guidelines on autopsy practice', published in September 2002. The content of a properly conducted autopsy should be formally recognised, possibly by the production of a code of practice with statutory force. Pathologists should be provided with improved background information about the deceased person's medical history and the circumstances of the death so that they can interpret their findings in context. They should be free to carry out whatever special examinations they consider necessary for the completion of a thorough and accurate autopsy report, provided that there is proper medical justification for the conduct of those examinations. (paragraph 19.119)

Toxicology

38. Greater use should be made of toxicology in the investigation of deaths of which the cause is not immediately apparent. It should be the aim of medical coroners to move towards the use of toxicology in virtually all autopsies and in some cases where no autopsy is conducted. (paragraph 19.120)

Partial Autopsy

39. It should be possible for a medical coroner to authorise a partial autopsy. Any limitation would have to be very clearly defined and would have to be subject to the stipulation that, if the pathologist needs to go beyond what has been authorised, in order to reach a satisfactory conclusion as to the cause of death, s/he should be free to do so. (paragraph 19.121)

Retention of Organs and Tissues

40. Guidance on the issue of retention of organs and tissues following a coroner's autopsy will have to be provided for coroners by the Coroner Service. The medical coroner must have the power to order retention of organs and tissues if such retention is necessary for the purpose of his/her investigation. Families should have the same rights to object and appeal as in respect of an autopsy. (paragraph 19.123)

The Provision of a Unified Pathology Service

41. There are strong arguments to suggest that the criminal justice system and the Coroner Service would both be well served by a pathology service (including both forensic pathologists and those histopathologists who conduct most coroners' autopsies) which operated under the auspices of a Special Health Authority. If such a pathology service were to establish regional 'centres of excellence', this would fit well with the Inquiry's proposal for regional coroner's offices. (paragraphs 19.124–19.125)

A Statutory Duty to Report Concerns about a Death

42. There should be a statutory duty on any 'qualified' or 'responsible' person to report to the Coroner Service any concern relevant to the cause or circumstances of a death of which

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s/he becomes aware in the course of his/her duties. The duty should be to report as soon as practicable any information relating to a death believed by that person to be true and which, if true, might amount to evidence of crime, malpractice or neglect.
(paragraph 19.126)

43. All relevant employers should encourage their employees to report any concerns relating to the cause or circumstances of a death of which they become aware in the course of their duties. Employers should ensure that such reports as are made to them are passed on to the appropriate quarter without delay and without any possibility of the reporter being subject to criticism or reprisal. (paragraph 19.127)

Public Education

44. The Coroner Service should seek to educate the public about the functions of the Service and, at the same time, encourage members of the public to report any concerns about a death. (paragraph 19.128)

Audit and Appeal

45. There should be systematic audit of every function of the medical and judicial coroners and their investigators, save for those relating to the correctness of the decisions reached by the coroners. (paragraphs 19.129–19.131)

46. Any decision made by a medical or judicial coroner would be subject to judicial review. However, a quicker and cheaper means of appeal should be provided, whereby decisions of the coroners that are wrong in law, plainly wrong on the facts, fail to set out the facts found or fail to give reasons for the conclusions can be set aside. The Chief Judicial Coroner should decide such appeals, if appropriate with the Chief Medical Coroner acting as medical adviser. From his/her decision, there should be a statutory right of appeal to the Divisional Court on a point of law only. (paragraph 19.132)

Transitional Arrangements

47. In the short term, changes to existing systems should be made. In particular, the cremation certification procedures should be strengthened. A variety of steps could be taken to improve practices in coroner's offices. (paragraphs 19.134–19.140)

The Future

48. In 1971, the Brodrick Committee recommended wide-ranging changes to the current systems of death and cremation certification and coroner investigations. Hardly any of their proposals were implemented. As it happens, I do not think that implementation would have prevented the Shipman tragedy. But, in many respects, the systems would have been improved. Today, the systems do not meet the needs of society. There is a groundswell of opinion in favour of change. It is to be hoped that the proposals of the Coroners Review and of this Inquiry do not, as did those of the Brodrick Committee, end in stalemate. (paragraph 19.142)

CHAPTER ONE

The Conduct of Phase Two, Stage Two of the Inquiry

Terms of Reference

1.1 The Terms of Reference of the Inquiry relevant to the subject matter of Phase Two, Stage Two ('Stage Two') are as follows:

> **'... (b) to enquire into the actions of the statutory bodies, authorities, other organisations and responsible individuals concerned in the procedures and investigations which followed the deaths of those of Harold Shipman's patients who died in unlawful or suspicious circumstances;'**

and

> **'... (d) following those enquiries, to recommend what steps, if any, should be taken to protect patients in the future ...'**.

The Subject Matter

1.2 During Stage Two, the Inquiry examined the procedures and investigations which follow, or may follow, a death. Those procedures and investigations fall into the following categories:

- verification of the fact that death has occurred
- certification of the cause of death
- in a case where the deceased is to be cremated, certification for the purpose of cremation
- registration of the death
- reporting of certain deaths to the coroner
- investigation of reported deaths by the coroner, including medical investigation by means of autopsy and other forms of pathological examination.

The Inquiry's Approach

1.3 The Inquiry's Terms of Reference specifically required me to enquire into the conduct of those concerned in the events following the deaths of Shipman's patients. Nevertheless, it was plainly necessary for the Inquiry to obtain evidence of a more general nature, showing how the post-death procedures worked in other parts of the country and how those responsible for the operation of the procedures elsewhere carried out their duties. This evidence of the 'wider picture' was necessary for two reasons. First, it would provide me with a benchmark against which to judge the actions of the organisations and individuals responsible for dealing with the deaths of Shipman's patients. Second, it would assist me in judging whether it was the actions of those organisations and individuals

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which enabled Shipman to kill for so long without detection or whether he was able to do so because of inherent flaws in the procedures themselves.

1.4 Obtaining a true picture of how the various post-death procedures operate in other parts of the country was not an easy matter. Plainly, given the time and resources available to the Inquiry, there was no question of undertaking or commissioning large-scale research into the operation of post-death procedures throughout the country. There are no independent 'experts' who can provide an overview of practice countrywide. The procedures are operated by general practitioners, hospital doctors, crematorium medical referees, registrars, coroners, coroners' staff and pathologists, each of whom carries out the work in his/her own way, often isolated from others performing similar functions. There is no objective means (at least without considerable research) of assessing who are the 'best' and who are the 'worst' performers in their particular field.

1.5 The Inquiry team therefore decided that the only practicable way of gaining a general picture was to approach a number of practitioners and to obtain evidence from them about how they carried out their work and about their perception of the systems that they were required to operate. From that evidence, it was hoped that I would be able to gain an insight into the working of the various post-death procedures. Evidence was also obtained from many practitioners from the Tameside area.

1.6 Before the Stage Two hearings began, I visited the office of a local crematorium and spoke to the crematorium medical referee. I also visited a register office, where I observed a death being registered and spoke to the Superintendent Registrar and other registrars. I went to a coroner's office and met the Coroner. All the offices in question were entirely unconnected with Shipman. The object of my visits was to gain some impression of the day-to-day work undertaken at the offices by the personnel employed there. Insofar as the discussions which took place during the course of those visits informed my thinking, I have related them in the course of this Report.

The Evidence

Witness and Witness-Related Evidence

1.7 A total of 276 witness statements and about 36,000 pages of documents have been scanned into the Inquiry's image database in connection with Stage Two. That evidence comes from the following sources.

Families

1.8 When providing their Inquiry witness statements for Phase One, the relatives of Shipman's patients were invited to give their suggestions for changes in the existing post-death procedures, with a view to providing additional safeguards for the future. Many responded to this invitation and put forward thoughtful and constructive suggestions as to how the systems might be improved. I have considered those written suggestions and at the outset of the Stage Two hearings, I heard oral evidence from 12 relatives of patients whom Shipman had killed. I shall discuss that evidence further in Chapter Twelve.

Doctors Responsible for Completing Medical Certificates of Cause of Death and Cremation Forms B

1.9 In order to understand the processes of death and cremation certification, it was necessary for me first to gain a full understanding of the practice and procedures relating to the completion, by the attending doctor of a deceased person, of the medical certificate of cause of death (MCCD) and cremation Form B.

1.10 Witness statements were obtained from six general practitioners of varying seniority, dealing with their own practice when completing MCCDs and Forms B for their patients. They were asked about the training which they had received in completing forms, the way in which they approached the task and their interpretation of the forms. Four of the general practitioners were former colleagues of Shipman (Dr John Dacre in Todmorden and Dr Ian Napier, Dr Geoffrey Roberts and Dr John Smith at the Donneybrook Practice). The other two were young practitioners who had no connection with Shipman. Five of the general practitioners were or had been in practice in Hyde.

1.11 Dr Ian Morgan, a general practitioner and medical referee practising in Solihull, was also asked to provide a witness statement dealing with his practice with regard to completing MCCDs and cremation Forms B. He gave oral evidence about these issues. In order that I might also understand the practice in hospital, witness statements were obtained from representatives of two local hospitals, describing the procedures that are followed when a death occurs.

1.12 The information contained on MCCDs is collected by the Office for National Statistics (ONS) and used in the compilation of mortality and other statistics. A witness statement was therefore obtained from Dr Cleone Rooney, a medical epidemiologist at the ONS, explaining how the task of completing an MCCD should be undertaken.

Doctors Responsible for Completing Cremation Forms C

1.13 One of the issues I have had to consider was the role of the doctors who had confirmed the cause of death certified by Shipman in cases where he had killed and the deceased were cremated. I had to decide whether their conduct in signing Forms C in some or all of those cases should be criticised. I have also had to assess the value of the cremation certification system, both as it was intended by Parliament and as it operates on the ground. I needed to know how doctors went about the task of obtaining the information necessary in order to complete a Form C.

1.14 Six of Shipman's former colleagues provided witness statements about their practice in relation to the completion of Form C. Witness statements were also obtained from 16 general practitioners who had, at various times, signed Forms C at Shipman's request. Ten of these doctors gave oral evidence during the Stage Two hearings, when they were asked detailed questions about the forms they had signed for Shipman's patients. Those ten doctors were also asked about the Forms B they had signed for their own patients over the relevant period.

1.15 Dr Morgan's oral evidence (to which I have referred above) dealt also with his practice when completing Forms C, and this provided some context for the evidence of the Hyde Form C doctors.

1.16 I shall explain in Chapter Eleven how it became evident to the Inquiry that some crematoria imposed a requirement that one of questions 5–8 on Form C must be answered in the affirmative. Once the Inquiry became aware of that, a survey was carried out, with the assistance of the Cremation Society of Great Britain, in order to discover how many crematoria in England, Wales and Scotland had such a requirement and how the requirement had originated. Examples of completed cremation forms were obtained from each crematorium which was found to have such a requirement. Further witness statements were obtained from general practitioners practising in the area of the crematoria concerned, describing their experience of speaking to relatives and other persons in order to fulfil the requirement imposed by their local crematorium. Eight provided statements. A further witness statement was obtained from a doctor whose practice was to speak to relatives and other persons, for the purposes of completing Form C, but whose local crematorium did not require this to be done.

1.17 Dr John Grenville, a general practitioner who gave expert evidence in Phase One, provided a report expanding upon the evidence he had given on the issue of 'old age'.

Crematorium Medical Referees

1.18 Most of Shipman's victims were cremated at the Dukinfield crematorium. The cremations were authorised, in the main, by Dr Betty Hinchliffe, who was Deputy Medical Referee, then Medical Referee, at the crematorium, and by Dr Jane Holme, who was Deputy Medical Referee to Dr Hinchliffe. I have had to consider whether their conduct in authorising those cremations warranted criticism. It has also been necessary for me to assess the value of the role of the medical referee, both as it was intended by Parliament and as it is fulfilled in practice. Before making judgements of this kind, I had to have a picture of the way in which the task of the medical referee was approached by practitioners other than those at Dukinfield.

1.19 The Inquiry team identified three medical referees who were asked to provide evidence. Each of these had somewhat different experience. Professor M Memon is a medical practitioner with a special interest in community and public health medicine. He is involved with postgraduate medical training. Since Shipman's conviction, he has (with others) made a number of suggestions as to possible reforms which might be made to the cremation certification system. Dr Morgan, whom I have already mentioned, is a general practitioner and medical referee and has experience therefore of all aspects of the cremation certification process. Dr Gordon Pledger, Medical Referee at the Newcastle-upon-Tyne crematorium (one of those with a requirement that one of questions 5–8 on Form C is answered in the affirmative), has had a varied medical career. He retired from his position as Director of Public Health for Newcastle in 1992. He has been advocating changes to the cremation certification procedures since before Shipman's criminal activities came to light.

1.20 Dr Morgan and Dr Pledger gave oral evidence to the Inquiry. Before they did so, they examined a number of cremation forms relating to Shipman's patients. The object of this exercise was not that they should give 'expert' evidence, but merely that they should tell the Inquiry how they would have dealt with those forms, had the forms been among a batch

of cremation documents which they had to deal with at their crematoria. I shall refer in Chapter Sixteen to the outcome of that exercise. It gave me a helpful insight into the way in which those medical referees approached their task.

1.21 In addition, the Inquiry obtained evidence from a number of medical referees and crematorium staff at crematoria where there is a requirement that one of questions 5–8 on Form C is answered in the affirmative. A witness statement was obtained from one medical referee whose crematorium has recently ceased to impose such a requirement.

1.22 Most of the cremations of Shipman's patients were, as I have said, authorised by Dr Hinchliffe and Dr Jane Holme. Some were authorised by Dr Thomas Holme, Dr Hinchliffe's predecessor. He has since died.

1.23 Both Dr Hinchliffe and Dr Jane Holme gave oral evidence to the Inquiry. In addition to examining cases in which they had been involved where Shipman had completed the Form B, the Inquiry also looked at a number of deaths falling within two separate three-month periods, where Dr Hinchcliffe and Dr Holme had authorised cremations which had no connection with Shipman. This gave me a more comprehensive picture of their approach to their task and also enabled me to see examples of Forms B and C completed by a variety of doctors other than Shipman.

1.24 Witness statements were also obtained from a former medical referee and a deputy medical referee at the Stockport crematorium and a former deputy medical referee at the Dukinfield crematorium. They had authorised a few cremations of Shipman's patients and were asked about some of those specific deaths. They provided witness statements dealing with their general practice and with those cases in particular.

1.25 The Inquiry also carried out some very small-scale research into the performance of medical referees at crematoria other than Dukinfield. Crematorium forms, covering two periods of three months each, were obtained from four crematoria. The forms were examined and the notes (relating to topics which had been queried by the medical referee) made on the forms by the medical referee were examined. Thus, I was able to compare the types of query raised by Dr Hinchliffe and Dr Holme with those raised by medical referees elsewhere. This exercise also gave me an opportunity to examine Forms B and C completed by doctors outside Hyde.

The Home Office

1.26 At present, the Home Office has certain responsibilities in relation to cremation procedures. In particular, it has responsibility for keeping under consideration the need for changes to cremation legislation. I have had to consider whether, in permitting the cremation system to remain virtually unchanged for a century, the Home Office had properly discharged its responsibilities. This issue is of particular importance in the light of the fact that no fewer than 176 of the people whom Shipman killed are known to have been cremated. It was therefore necessary for me to have a detailed understanding of the history underlying the continued existence of the cremation procedures over the last 100 years.

1.27 Mr Robert Clifford, Head of the Coroners Section of the Animal Procedures and Coroners Unit, attended the Inquiry to give oral evidence. He had previously provided a witness statement setting out the history of the Home Office's attempts to implement the recommendation of the Committee chaired by Mr Norman (later Judge) Brodrick QC ('the Brodrick Committee'), made in 1971, that the cremation procedures should be abolished in their entirety. Mr Clifford had little personal knowledge of the events in question, since he only joined the relevant Section in 1995. However, the Inquiry requested, and was provided with, a very large quantity of Home Office documentation, from which it was possible to piece together the relevant history.

The Registration Service

1.28 Most of the deaths of Shipman's patients, including those whom he killed, were registered at the Tameside register office. I have had to consider whether the registrars who registered those deaths should have noticed that they were registering an excessive number of deaths that had been certified by Shipman. In order to be in a position to make a judgement about that matter, it was necessary for me to have a clear understanding of the practice and procedures followed when registering a death and of how registrars deal with various types of circumstances which might arise in the course of their work. This evidence was also of assistance when I came to consider whether the functions currently fulfilled by the registrars in the scrutiny of MCCDs are appropriate, or whether there should be changes to the system.

1.29 In order to identify registrars who might provide the Inquiry with evidence about the practice and procedures for registering deaths, the Inquiry team contacted Miss Ceinwen Lloyd, Branch Manager Births and Deaths at the ONS. She provided a number of names, among them that of Mrs Jane West, registrar for the Boston district and Training Officer for the Lincolnshire registration service. Mrs West provided a witness statement, together with documentation produced for the guidance of registrars. She gave oral evidence to the Inquiry and, as a Training Officer, was in a good position to inform me about practice in the registration service as it is taught to registrars and deputy registrars in her county. Mrs Susan Jones, a registrar from Blackpool, and Mr William Jenkins, former Deputy Head of the Registration Division of the General Register Office (GRO), also provided witness statements.

1.30 In relation to practice at the Tameside register office, I heard oral evidence from two current registrars, one former registrar and a former deputy registrar. In addition, witness statements were provided by the Superintendent Registrar, the Additional Superintendent Registrar, two current registrars, a deputy registrar and four former registrars. Their evidence covered a period of just less than 30 years.

The General Register Office

1.31 In relation to two cases where Shipman had killed, the GRO had given advice to registrars at Tameside that 'natural causes' was an acceptable cause of death. I have had to consider whether that advice was correct and, if it was not, how it came to be given. I have also had to consider whether the system for providing advice and guidance to registrars

is adequate to enable them properly to fulfil their responsibility for scrutinising MCCDs. To assist me in that task, I heard oral evidence from Mr David Trembath, Manager of the General Section of the GRO, and a member of his staff.

1.32 Miss Lloyd provided a detailed witness statement, dealing with registration practice, together with relevant documentation. She also provided a witness statement about the steps taken by the GRO to implement the recommendations of the Brodrick Committee relating to medical certification of the cause of death. Annexed to that witness statement were documents, setting out the history of events from 1971 until the early 1990s.

Coroners and Their Staff

1.33 Very few of the cases where Shipman had killed were reported to the local coroner, who was the Coroner for Greater Manchester South District, Mr John Pollard. I have had to consider why that was, and whether it occurred by reason of any fault on the part of the Coroner or his staff. I have also had to consider whether the fact that Shipman was able to avoid a report to the Coroner on so many occasions arose as a result of fundamental defects within the system itself. Since the coroner system is intended to provide a mechanism for investigating deaths occurring otherwise than as a result of a natural disease process, the fact that so many killings were able to go unreported to the Coroner is clearly a matter of great concern. Examination of the current coroner system was central to my consideration of the post-death procedures and to my recommendations for the future.

1.34 In general, coroners are appointed locally. There is no unified coroner service. Any leadership which is provided is given by the Coroners' Society of England and Wales. The Inquiry therefore began by approaching the Honorary Secretary of the Society, Mr Michael Burgess, HM Coroner for Surrey. He gave a witness statement to the Inquiry, in response to detailed questions put to him by the Inquiry team. Statements were also provided by the former Secretary of the Society, Dr John Burton. In addition, the Inquiry obtained evidence from Dr Nigel Chapman, one of the few coroners possessing a medical qualification, and from Mr Christopher Dorries, HM Coroner for South Yorkshire (West) and author of a textbook about coronial practice[1]. Mr Burgess, Mr Dorries and Dr Chapman gave oral evidence to the Inquiry. All hold full-time positions as coroners. The Inquiry also obtained a witness statement from Mr John Hughes, part-time Coroner for North Wales Central & North East Wales. In connection with the procedures which follow when a sudden death occurs at home, the Inquiry obtained witness statements from Dr Elizabeth Stearn, HM Coroner for London (Eastern District) and Mr Roger Whittaker, HM Coroner for West Yorkshire (Western District). A total of ten other coroners provided further information to the Inquiry dealing with the involvement of police officers in deaths reported to them. Similar information was obtained from two offices of procurators fiscal in Scotland.

1.35 Mr Pollard gave oral evidence to the Inquiry about the practice within the Greater Manchester South District office. In order to illustrate those practices, the Inquiry had obtained Mr Pollard's files relating to a number of cases unconnected with Shipman. For example, Mr Pollard was asked to produce all documentation relating to the last 20 deaths

[1] Dorries, CP (1999) 'Coroner's Courts – a guide to law and practice'. Chichester: John Wiley and Sons.

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referred to his office by registrars prior to 31st July 2002. That was one of a number of categories of documentation requested and obtained. Consideration of that documentation, and of Mr Pollard's evidence relating to its contents, provided me with a valuable insight into the decision-making process applied in his office, both before Shipman's arrest and conviction and more recently. Mr Pollard's predecessor, Mr Peter Revington, gave a witness statement to the Inquiry but was not fit enough to attend to give oral evidence.

1.36 I heard evidence from five members and former members of Mr Pollard's office staff. A further three members or former members of the office staff provided witness statements. I also heard evidence from one of Mr Pollard's current coroner's liaison officers, Mr Christopher Gaines, who has responsibility for the area which includes Hyde. Oral evidence was also given by two former coroner's officers, one of whom currently serves as Mr Gaines' deputy. A witness statement was provided to the Inquiry by a coroner's officer who briefly held that post in the late 1980s.

1.37 Additionally, I heard oral evidence from Mrs Christine Hurst, who has been the senior coroner's officer in Cheshire since 1998 and who, in her capacity as the Deputy Chairperson of the Coroner's Officers Association, has made a significant contribution towards the education and training of coroner's officers. The Chairman of the Association, Mr John Coopey, also provided a witness statement.

Funeral Directors

1.38 Funeral directors play a most important role in the post-death procedures. They have close contact with families and provide advice and practical support. They act as co-ordinators for the cremation certification process and liaise with doctors, registrars and coroners' offices as necessary. Doctors attend their premises to examine the bodies of deceased persons for whom they are to complete cremation forms. Funeral directors are in a unique position to see at first hand the manner in which the examination is carried out and the attitude of doctors to the completion of the cremation forms.

1.39 With these factors in mind, the Inquiry requested and obtained a witness statement from Mr Nigel Rose, who is a member of the Executive of the National Association of Funeral Directors and a director of a large firm of funeral directors. He gave oral evidence about his experiences of post-death procedures. Statements were also obtained from four funeral directors from the Hyde area, dealing in particular with procedures for death and cremation certification and with their knowledge of Shipman.

Pathologists

1.40 An important investigative tool available to the coroner is the autopsy. The Inquiry heard some evidence in Phase One about autopsies relating to specific deaths of Shipman's patients. In Stage Two, it was necessary to explore the adequacy of the 'routine' coroner's autopsy and the extent to which such an autopsy provides the 'gold standard' answer to the issue of cause of death which it is commonly assumed to do. In order to inform me about these matters, the Inquiry team obtained evidence from Professor Helen Whitwell,

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Professor of Forensic Pathology and Head of Department at the University of Sheffield, who had given evidence in Phase One. She gave further evidence at the Stage Two hearings. Dr Martin Gillett, a consultant histopathologist who performs many coroners' autopsies, also gave oral evidence.

1.41 One issue that I was anxious to explore was the extent to which non-invasive techniques of post-mortem examination might provide a viable alternative to the full invasive autopsy. The Inquiry team therefore obtained a statement from Dr Rob Bisset, a consultant radiologist from Manchester, who has pioneered the use of magnetic resonance scanning after death. This has been of particular value to the Jewish community, whose members are opposed to the invasive autopsy on religious grounds. The Inquiry team also obtained evidence from the Royal College of Radiologists.

Police

1.42 As I shall explain in Chapter Four, many deaths are reported to the police in their general 'public service' capacity, and not because it is suspected that there may be some criminal involvement in the death. Except in those cases where a death is reported to them because there is a suspicion of criminal involvement, the policy of most police forces in England and Wales is that their role ceases as soon as it becomes clear that the deceased's general practitioner is prepared to certify the cause of death. In cases where there is no suspicion of criminal involvement but where the general practitioner cannot certify a cause of death, the police may have some involvement in reporting the circumstances to the coroner, or in investigating on his/her behalf.

1.43 On the occasions when officers of the Greater Manchester Police (GMP) were called out to attend the deaths of Shipman's patients, they generally did so in their 'public service' role. Never, before Dr Linda Reynolds came forward in March 1998, was it suggested to them in connection with a 'Shipman death' that there was any suspicion of criminal involvement.

1.44 It was important that I fully understood the nature of the involvement of the police in attending deaths in their 'public service' capacity. Ten GMP officers of different ranks gave oral evidence to the Inquiry. Five of those officers had attended deaths where it is now known that Shipman had killed. Detective Chief Superintendent Peter Stelfox, from whom I had heard evidence in Stage One, gave oral evidence about Shipman-related cases, as well as in connection with the general issues arising from police involvement in 'non-suspicious' sudden deaths occurring in the community. The Inquiry also obtained witness statements from a further six officers.

1.45 In addition, evidence was obtained from twelve other police forces in connection with police attendance at deaths occurring in the community.

Ambulance Services

1.46 Ambulance crews from the Greater Manchester Ambulance Service NHS Trust (GMAS) attended about 80 of the deaths of patients whom Shipman had killed. The Inquiry heard oral evidence from nine ambulance personnel who had attended deaths of persons killed

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by Shipman. They explained the procedures followed when attending a death. I also heard evidence from the daughter of one of the victims. Mr Neil Barnes, who is the General Manager of Clinical Governance at GMAS, gave useful background evidence and explained recent discussions between GMAS and the GMP. Witness statements were obtained from a further seven members of GMAS staff. Evidence was also provided by ambulance services from 14 other areas.

Deaths Occurring 'Out of Hours'

1.47 During the process of gathering evidence, the Inquiry legal team became increasingly aware of the practical problems associated with deaths occurring outside normal general practitioner working hours. The Inquiry received written material from 16 organisations with a special interest in 'out of hours' services, in relation to the problems associated with 'out of hours' deaths. The Inquiry also obtained evidence on the same issue from the British Federation of Care Home Proprietors, from the National Care Homes Association and from four persons in positions of authority in nursing or care homes.

Evidence in the Case of Mrs Renate Overton

1.48 In addition to evidence from the sources identified above, I received evidence from paramedics, nurses, doctors, consultants, hospital management and administration staff, coroner's staff and a retired consultant pathologist relating to the death of Mrs Renate Overton. I also heard evidence from members of her family. Following investigation of Mrs Overton's death in Phase One, I found that Shipman had deliberately given her an overdose of diamorphine (possibly morphine), intending to kill her. In the event, she survived, in a persistent vegetative state, for 14 months before her death in April 1995. I was concerned to investigate precisely how the post-death procedures had operated in her case. The results of that investigation are set out in Chapter Thirteen of this Report.

1.49 As well as discovering what had happened in Mrs Overton's case, the evidence given in relation to her death also informed my general view of the extent to which the existing post-death procedures provide an effective means of investigating the circumstances of a death.

Documentary Evidence

1.50 The evidence to which I have referred above, whilst providing me with a good insight into the operation of the post-death procedures, and enabling me to place in context the detailed evidence about procedures and practices in Tameside, does not, of course, represent the whole picture. Viewed in isolation, it would represent only a small part of that picture. However, the evidence available to me has been a great deal more extensive than that which has been prepared specifically for the Inquiry.

1.51 In particular, I have been able to examine and consider documentation from the following sources.

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Departmental and Other Committees and Working Parties

1.52 The Committee whose work has been most relevant and significant to this Inquiry is the Brodrick Committee, which reported in 1971. However, there are a large number of reports of other committees and working parties dealing with topics which the Inquiry has considered and these have provided valuable background reading. Many of them are referred to in the course of this Report.

The Home Office

1.53 As well as the documentation to which I have already referred, and other material relevant to coroners, the Inquiry has had access to the responses of individuals and organisations to Consultation Papers issued by the Home Office Review into Death Certification, conducted in 2000–2001, and by the Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland ('the Coroners Review'), carried out between 2001 and 2003. Contained within those responses was a wealth of information and experience about the working of the post-death procedures. The responses to the first of these two Reviews, which became available shortly after this Inquiry started work, provided a particularly valuable insight into the working of the relevant systems at an early stage of our investigations.

1.54 Other Home Office work, including the recent Review of Forensic Pathology Services in England and Wales, has also provided valuable background information.

Academic and Professional Journals

1.55 With the assistance of the Medical Advisor to the Inquiry, Dr Aneez Esmail, the Inquiry team collected, from academic and professional journals, a large amount of published literature dealing with death and cremation certification and related issues. I have referred to some of this literature (in particular, to some of the research carried out over the years) in the course of this Report. Although the research projects conducted in the past have tended to be small in scale, they nevertheless provide some objective means of assessing whether the overall picture of the operation of the systems that I have gained from the rest of the evidence is likely to be correct. In that way, they have provided a valuable check on my preliminary views.

Other Sources

1.56 The Inquiry has also obtained a number of publications and other documentation from such sources as the Office for National Statistics, the British Medical Association, the Cremation Society of Great Britain, the General Medical Council, the Royal College of General Practitioners, the Royal College of Pathologists, the National Confidential Enquiry into Perioperative Deaths, the Department of Health and many other organisations. Material has been obtained about death investigation and certification systems in a number of other jurisdictions, both in the British Isles and further afield.

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The Inquiry's Own Consultations

1.57 Before the start of the Stage Two hearings, the Inquiry published a Discussion Paper, 'Developing a New System for Death Certification', which presented a 'working model' for a revised death investigation and certification system. The purpose of the Discussion Paper was to provide a focus, both for written responses and for discussion at a series of seminars held by the Inquiry in January 2003. The Inquiry received written responses from 154 individuals and organisations. The views expressed in those responses were considered and discussed at the seminars.

1.58 The seminars covered six different topics and extended over nine days. Participating in the seminars were representatives of a large number of the organisations involved in the day-to-day operation of the post-death procedures, together with a number of individuals with particular knowledge of those procedures. One seminar, lasting two days, was devoted to the systems of death investigation and certification in five other jurisdictions – those of Victoria (Australia), Ontario (Canada), Maryland (USA), Finland and Scotland. I shall discuss some of the views expressed during the Inquiry's consultation process in Chapter Seventeen of this Report. An account of the systems in operation in the five other jurisdictions to which I have referred is set out in Chapter Eighteen.

The Inquiry's Feasibility Study

1.59 Contained within the Discussion Paper were four sample forms, intended by the Inquiry for completion by the person verifying the fact that a person had died, by the doctor certifying the cause of death or reporting the death to the coroner, by a member of the deceased's family and by the funeral director responsible for the arrangements for burial or cremation. The purpose of producing the forms was to illustrate the nature and extent of the information which the Inquiry envisaged might be collected and recorded at various stages of the death certification process. The Inquiry sought views about the contents of the forms and who should complete them. One of the Inquiry's seminars was entirely devoted to discussion of the forms and any problems which might arise in completing them.

1.60 In a further attempt to identify potential problems with the forms and to ascertain how they might work in practice, the Inquiry commissioned a small feasibility study, to be carried out by the Department of General Practice and Primary Health Care at the University of Leicester. Thirty nine doctors and six relatives were asked to complete forms in relation to deaths which had occurred recently. They were then interviewed, their views on the forms canvassed and any problems with specific questions on the forms identified. The study team reported in March 2003.

1.61 As a result of points made by respondents to the Discussion Paper and by participants at the seminars, the Inquiry had already concluded that the number of forms to be completed after a death should be reduced and the forms themselves greatly simplified. The results of the feasibility study provided support for that view and also provided valuable pointers which were used when the Inquiry team undertook the task of redesigning the forms for inclusion in this Report.

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Costings

1.62 The Inquiry team considered whether attempts should be made to obtain evidence comparing the cost of any revised system that I might recommend with that of the present systems. A decision was taken not to do so. This was not because the Inquiry does not regard cost as an important and relevant issue; plainly, it is. However, the Inquiry did not have the necessary expertise to conduct the exercise itself. No steps could be taken to commission an external study until I had resolved what my recommendations would be. I could not do that until the evidence and consultation processes were complete. Since it was the Inquiry's firm intention to deliver this Report to Ministers in the early summer of 2003, there was obviously insufficient time for any detailed costings, based on my recommendations, to be prepared by any outside agency.

1.63 In any event, I doubted that any estimate of costings was likely to be of significant assistance at this stage. After all, assuming that my recommendations were to be adopted in their entirety, many details, together with the timing of the changes, remain to be decided. In consequence, any attempt at an estimate would necessarily be very speculative. In the light of all these considerations, it was decided that it would be inappropriate and impractical for the Inquiry to expend substantial resources on an attempt to obtain evidence about the potential cost consequent upon any recommendations I might make.

The Effect of the Evidence

1.64 All the material obtained from the sources which I have described above has, of course, been set against the background of the evidence, both lay and expert, received by the Inquiry during Phase One, when I considered and reported upon the circumstances and aftermath of just under 500 deaths of Shipman's patients.

1.65 In her Opening Statement at the start of the Stage Two hearings, Leading Counsel to the Inquiry said that, when I had before me all the material which the Inquiry had gathered and had heard the discussions at the seminars, I should be in the best possible position, not only to make findings in respect of the operation of the post-death systems in Tameside, but also to make wide-ranging recommendations for changes to those systems. I am confident that this is so.

Before the Oral Hearings

The Arrangements for the Distribution of Evidence

1.66 The arrangements for the distribution of evidence were the same for Stage Two as for Phase One. They are described at paragraphs 3.17 and 3.18 of my First Report. As in Phase One, all the evidence available to the Inquiry was released into the public domain by means of the Inquiry website.

The Public Meeting

1.67 On 21st March 2002, the Inquiry held a Public Meeting, at which I explained the arrangements for Stages One and Two of Phase Two.

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Representation

1.68 Before and after the Meeting, I granted leave to various individuals and organisations to be represented before the Inquiry during the Stage Two hearings and, for some, recommended funding for that representation at public expense. A list of participants in Stage Two and their representatives can be seen at Appendix A of this Report.

Salmon Letters

1.69 Before the Stage Two hearings began, the Solicitor to the Inquiry, Mr Henry Palin, sent letters (known as 'Salmon letters') to those persons and organisations whose conduct might be the subject of criticism by the Inquiry. The potential criticisms were clearly identified in those letters.

1.70 In the event that any further potential criticisms came to light at or after the hearings, these were the subject of further Salmon letters. Recipients of Salmon letters were given the opportunity to respond to the potential criticisms in writing, as well as in the course of their oral evidence at the hearings.

Broadcasting

1.71 I had given permission for the Stage One hearings to be broadcast in accordance with a protocol which had been prepared by the Inquiry and was designed to ensure that Inquiry material would not be misused. Those arrangements caused no difficulties in Stage One and I received no representations suggesting that they should be discontinued. I therefore gave permission to recognised organisations to broadcast during Stage Two, provided that they complied with a slightly amended protocol, clarifying the broadcasters' duties in respect of websites. During Stage Two, I received and granted two applications from witnesses that their evidence should not be broadcast.

The Oral Hearings

1.72 The oral hearings were held in the Council Chamber at Manchester Town Hall. The Stage Two hearings took place from 7th October to 19th December 2002 and on 29th January 2003.

1.73 The arrangements for the oral hearings, and for the publication of evidence, were the same as for the Phase One hearings. They are described at paragraphs 3.28 to 3.36 of my First Report. The only significant difference was that the public viewing facility at the Hyde Library had been closed before the hearings began. The local authority had required the premises for other purposes and the number of people using the facility had fallen. After consultation, in the course of which few objections to closure were raised, I decided that the public expense of setting up another facility could not be justified. The public gallery at the Town Hall remained open, of course, and transcripts and other documents were posted on the Inquiry's website after each day's hearings.

1.74 Volunteers from Tameside Victim Support attended to assist family witnesses at the start of the Stage Two hearings, but were not required during the remainder of these hearings.

I remain most grateful to Tameside Victim Support for all the assistance they have given during the course of the Inquiry.

1.75 In general, witnesses who gave oral evidence during the Stage Two hearings were called by Counsel to the Inquiry. However, in the interests of fairness, those witnesses who had received Salmon letters were given the opportunity of making an opening statement of their evidence in response to questions by their own counsel or solicitor, before being questioned by Counsel to the Inquiry. Some, but not all, recipients of Salmon letters availed themselves of this opportunity. Others chose to follow the usual procedure.

Submissions

1.76 At the conclusion of the Stage Two hearings, Counsel to the Inquiry produced written submissions relating to those areas of the evidence in respect of which criticisms had been levelled at individuals or organisations. Representatives of most of those individuals and organisations also made written submissions, as did the Tameside Families Support Group. I offered an opportunity to all those representatives to make representations that I should hear oral submissions, but received no such representations. The only topic on which I heard oral submissions was in respect of the death of Mrs Overton.

The Seminars

1.77 The seminars were held in the Council Chamber at Manchester Town Hall from 13th to 24th January 2003. Forty participants, some representing organisations with a particular interest or involvement in post-death procedures, took part in the discussions at the seminars. Those discussions were led by Leading Counsel to the Inquiry. Although structured, the discussions were significantly less formal than the oral evidence given during the usual Inquiry hearings.

1.78 Participants in the seminars had submitted written responses to the Inquiry's Discussion Paper in advance and expanded on those responses during the course of the seminars. Persons attending the seminars as observers were able to raise points through Counsel for the consideration of seminar participants. After the seminars, the Inquiry received a number of further responses, both from participants who wished to confirm or revise views previously expressed, and from people who had attended the seminars, or who had become aware of the discussions that had taken place, and wanted to contribute their own opinions.

1.79 I found the seminars, and indeed the whole consultation process undertaken by the Inquiry, extremely valuable in clarifying my thoughts and assisting me to formulate my recommendations for the future.

The Structure of This Report

1.80 In Chapters Two and Three of this Report, I shall seek to set out the history giving rise to the current procedures for death certification, death registration and cremation certification,

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together with the existing coronial system. By doing that, I shall try to set in context the detailed discussion of those systems that follows.

1.81 Deaths occurring in the community, especially those which happen out of the usual office and surgery hours, present special difficulties. In Chapter Four, I shall discuss the roles of the police, the ambulance services, general practitioners and deputising doctors in the immediate aftermath of a death in the community, in particular when the death occurs 'out of hours'.

1.82 In Chapters Five and Six, I shall describe the current systems for medical certification of the cause of death and registration of death, and shall set out my analyses of the strengths and weaknesses of those systems and my conclusions about them.

1.83 Chapters Seven, Eight and Nine will deal with the coroner system. In Chapter Seven, I shall discuss the jurisdiction of the coroner and way in which decisions are made as to whether deaths reported to the coroner fall within that jurisdiction. In Chapter Eight, I shall consider the role of the coroner's officer and the respects in which that role might be developed in the future. In Chapter Nine, I shall describe the way in which coroners undertake their investigations into the deaths that are reported to them. Chapters Seven and Nine also contain discussion about the procedures in operation at the office of the Coroner for Greater Manchester South District, whose geographical jurisdiction includes Hyde. Pathology is an important adjunct to the coroner's investigation and its role is discussed in Chapter Ten.

1.84 In Chapter Eleven, I shall describe the system of cremation certification as it operates on the ground and the respective roles of the Form B and Form C doctors and the medical referee. I shall also consider whether the Home Office is to be criticised for its failure to effect changes in the procedures for cremation certification.

1.85 Chapter Twelve will be devoted to a discussion of the position of bereaved relatives of a deceased person and the part that they can play in the investigation and certification of a death. I shall consider their needs and, in particular, the needs of relatives from minority groups, whose religion or culture make it particularly important that burial or cremation should take place as quickly as possible after death and who have particular objections to invasive post-mortem examinations.

1.86 In Chapter Thirteen, I shall deal with issues relating to the death of Mrs Renate Overton. In Chapters Fourteen, Fifteen and Sixteen, I shall set out the evidence about the procedures operated by the registrars at the Tameside register office, the doctors who signed cremation Forms C for Shipman and the medical referees at the Dukinfield crematorium. I shall consider whether those individuals should be criticised for the way in which they dealt with the deaths of Shipman's patients. In Chapter Fourteen, I shall also consider the quality of the advice given to registrars at Tameside by staff at the GRO in connection with two cases where Shipman had killed and attributed the cause of death to 'natural causes'.

1.87 Chapters Seventeen and Eighteen will give an account of the Inquiry's consultation processes and their outcome. Chapter Nineteen sets out my proposals for change.

1.88 It will be apparent from the contents of this Chapter that the Inquiry has received a wealth of evidence in connection with the issues considered during Stage Two. In this Report, I

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have not sought to set out that evidence in detail. The evidence is there to be read by all who wish to do so. Instead, I have recorded my observations and conclusions about the various systems, based upon all the evidence I have heard and read. I have sought to devise systems of death investigation and certification that will not only protect patients from a future Shipman but will also meet all the needs and expectations of the public, both collectively and individually.

CHAPTER TWO

Registration of Death, Medical Certification of the Cause of Death and the Coronial System: a Brief History

Introduction

2.1 The systems for registration of death and medical certification of the cause of death evolved in parallel. Both were the products of a growing awareness of the importance of collecting accurate statistics, including mortality statistics. It was quickly realised that information about causes of death could be used for the advancement of medical knowledge and the improvement of public health. It was also recognised that death certification could provide a safeguard against concealed homicide. In this Chapter, I shall trace briefly the origins of these systems, which have remained virtually unchanged over the last 75 years.

2.2 The coronial system has been in existence for hundreds of years, although the functions of the coroner are significantly more circumscribed now than they were in the twelfth century. Those functions are inextricably linked with the systems of registration and medical certification of the cause of death. Apart from where a death occurs in custody (when there are special requirements to report the death), the registrar is the only class of person with a statutory duty to report a death to the coroner. The coroner is the only class of person, apart from a registered medical practitioner, who can furnish the registrar with the documentation necessary for the registration of a death. If there is no doctor who can certify the cause of a death, the coronial system is the only route by which that death can be registered and by which burial or cremation of the deceased's body can lawfully take place.

2.3 Despite the interdependence of the coronial system and the systems for registration and certification of the cause of death, they have developed entirely separately. Different statutes govern them and different Government Departments are responsible for issues arising from them. Later in this Report, I shall consider the effects of this fragmentation of the various systems and I shall consider how the various systems presently in existence might be translated into one cohesive whole.

2.4 During the course of this Chapter, I shall refer to the holding of 'post-mortem examinations', meaning invasive examinations of the organs of the body, carried out after death. 'Post-mortem examination' is the term used in the relevant legislation. Many pathologists use the word 'autopsy' to describe the same procedure. In the course of this Report, I shall use both terms interchangeably.

Registration of Death and Medical Certification of the Cause of Death

The First Requirement to Register a Death

2.5 On 1st July 1837, the Births and Deaths Registration Act 1836 came into force. The aim of the Act was to **'provide the Means for a complete Register of the Births, Deaths and**

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Marriages of His Majesty's Subjects in England'. A General Register Office was set up, headed by a Registrar General. The Act allowed the medical cause of death to be provided and recorded when a death was registered. However, there was no requirement that this should be done. Following registration of a death, the registrar was required to deliver to the person having charge of the funeral a certificate stating that the death had been duly registered. If an inquest was held, the coroner could issue an order for burial before registration.

2.6 Burial of the body could take place before the death was registered. No penalties were prescribed for failure to register, provided that the fact that the burial had been carried out without a certificate from the registrar or a burial order from the coroner was notified to the registrar. Consequently, even after 1837, not all deaths were registered. For those deaths that were registered, a medical cause of death was not always provided. When it was, it tended to be unreliable. There was no requirement that the cause should be certified by a medical practitioner. Nor was there any consistency in the descriptions of cause of death used by different practitioners. Despite these shortcomings, the 1836 Act laid the foundation for the present system of collecting mortality statistics.

2.7 Over the ensuing years, various steps were taken to improve the reliability of the particulars of cause of death recorded on registration. Medical practitioners who had treated a deceased person during his/her last illness were encouraged to provide the family with a written statement of the cause of death for production to the registrar. Registrars were instructed to obtain details of the cause of death direct from medical practitioners, rather than from the person giving information about the death. Efforts were made to achieve some consistency of terminology among members of the medical profession. During the 1840s, the Registrar General distributed the first books of forms for use when certifying the cause of death. These forms became known as Medical Certificates of Cause of Death (MCCD). Despite their introduction over a decade before, more than 11% of deaths registered in England and Wales in the year 1860 were registered without an MCCD.

The Duty to Provide a Medical Certificate of Cause of Death

2.8 The Births and Deaths Registration Act 1874 introduced penalties for failing to register a death, as a consequence of which the number of unregistered deaths fell. However, there was still no requirement to register the death before disposal of the body. The Act required the registrar (after registration of the death or notification that the death had occurred and a certificate of cause of death had been completed) to issue a certificate stating that the death had been registered or notified to the registrar. Coroners were also given power to issue certificates authorising burial when an inquest was held. However, the person conducting the burial was not required to be in possession of a certificate from a registrar or coroner before proceeding. The only requirement was that, if no such certificate was delivered, notice of that fact had to be given to the registrar within seven days of the burial.

2.9 The 1874 Act imposed a duty on any practitioner registered with the General Medical Council (GMC) who had been in attendance during a person's last illness to deliver to the informant (i.e. the person giving information about the death to the registrar) a certificate

stating the cause of death to the best of his knowledge or belief. No certificate was required if it was known that an inquest was to be held. Penalties were imposed for failure to provide a certificate (except on reasonable grounds) and for giving a false certificate.

2.10 Since many medical practitioners did not meet the standards required for registration with the GMC, the 1874 Act, which imposed the requirement to certify the cause of death only on registered practitioners, did not have the effect of securing certification of the cause of every death. In many cases, registrars still had to rely on information supplied by the family of the deceased person, or by an unregistered medical practitioner.

2.11 Under Regulations issued by the Registrar General, registrars were directed to report to the coroner any deaths which appeared to be due to violence or were attended by suspicious circumstances; such deaths were not to be registered until the registrar had received notification of the coroner's decision that no inquest was necessary or had been informed of the finding of the jury at inquest. In 1885, the circumstances in which registrars were required to report deaths to the coroner were extended by the Registrar General to include deaths where the cause was unknown and sudden deaths.

The 1893 Select Committee

2.12 In 1893, a Select Committee of Parliament was appointed:

> **'... to inquire into the sufficiency of the existing Law as to the Disposal of the Dead, for securing an accurate Record of the Causes of Death in all cases, and especially for detecting them where Death may have been due to Poison, Violence or Criminal Neglect'**.

2.13 The Committee reported that the **'loose'** system of certification of death did not guarantee a record of the true cause of death; nor did it necessarily prevent the concealment of homicide. There was no requirement for the attending medical practitioner to see the body after death or to certify the fact of death. Deaths were frequently certified by medical practitioners who had not seen the patient for months. Sometimes, the certifying doctor had never attended the deceased. Certificates could be bought from practitioners and used for the purposes of fraud, or to conceal suicide or homicide. Registration of death was known to have taken place in cases where the deceased had been murdered, or was still alive, or in circumstances where it was not known whether or not s/he had died.

2.14 The situation was said to be even worse in the case of uncertified deaths, i.e. those deaths for which the cause of death had not been certified by a registered practitioner. In 1891, uncertified deaths accounted for 2.7% of the deaths registered in England and Wales. However, the proportion varied markedly from district to district. The Committee noted the striking trend whereby the deaths of adults of working age (and therefore self-supporting) were rarely uncertified, whereas the deaths of infants and elderly people, whose age rendered them **'as a class, a burden on their friends'**, were far more likely to go uncertified. It was suggested that, for those who were not economically useful, medical treatment, from a registered practitioner at least, was less likely to be forthcoming than for those who were in work. The Committee expressed the conviction that **'vastly more'** deaths occurred from **'foul play and criminal neglect'** than the law recognised.

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2.15 Where no registered medical practitioner had been in attendance upon the deceased before death and there was no medical certificate of cause of death, the registrar was constrained (unless the case was reportable to the coroner and the coroner proceeded to inquest) to take information on the cause of death from the informant. Such information was likely to be incorrect; it might even be deliberately misleading. This system was said by the Committee to be **'dangerously defective'** and to play into the hands of the **'criminal classes'**. The Committee reported that:

> **'... it seems impossible to come to any other conclusion than that an amendment of the present law is urgently required, and that if no legislation can be framed which would altogether put an end to foul play and criminal neglect as secret factors in our national death-roll, much may be done in the way of reducing the evil by the enactment of judicious checks'**.

The Recommendations of the 1893 Select Committee

2.16 The Report of the Committee makes interesting reading. Many of the issues discussed within it have been considered by this Inquiry, over a century later. For example, the Committee expressed concern about the competence of registrars, who have no medical expertise, to understand the medical terms used to describe causes of death and to determine whether or not a death should be referred to the coroner. The Report also criticised the **'very elastic fashion'** in which the phrase **'in attendance at the last illness'** had been interpreted in the past. It recommended that a single definition be adopted, namely **'personal attendance by the person certifying upon at least two occasions, one of which should be within eight days of death'**. I could give further examples but, instead, I shall confine myself to summarising the main recommendations of the Report.

2.17 The Committee was determined that uncertified deaths should, as a class, cease to exist and that, henceforth, **'... as far as may be, it should be made impossible for any person to disappear from his place in the community without any satisfactory evidence being obtained of the cause of his disappearance'**. It recommended therefore that no death should be registered without production of a certificate of the cause of death, in a prescribed form, signed by a registered medical practitioner or a coroner after an inquest. The Committee also recommended that the practice of permitting disposal to take place before registration or authorisation by the coroner should be stopped.

2.18 In order to deal with those cases where no attending doctor was available, the Committee recommended that registered medical practitioners should be appointed as public medical certifiers of the cause of death in such cases. When informed of a death, the certifier should be required to attend and examine the body and make such enquiries and examination (including post-mortem examination) as he may think necessary to enable him to form an opinion as to the cause of death. If satisfied that the death was due to natural causes, he should forward a certificate to the registrar. If the certifier was of the opinion that the death was due to accident, violence, poison or neglect, or that the circumstances were in any respect indicative of foul play, he should be required to report the case to the coroner.

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2.19 The Committee was concerned about the lack of any requirement for the certifying doctor to view the body of the deceased before providing a certificate. This gave rise to a risk of fraud or concealment of crime and also, the Committee recognised, to the risk that the 'deceased' might in fact still be alive. It was therefore recommended that, before giving a certificate of cause of death, the medical practitioner in attendance should be required personally to inspect the body; if he were unable to do so, the fact of death should be certified by two neighbours of the deceased and their certificate should be attached to the certificate of cause of death forwarded to the registrar.

After the 1893 Select Committee

2.20 No immediate step was taken to implement these important recommendations. In 1902, the Departmental Committee charged with preparing draft Regulations to be made under the Cremation Act 1902 observed that:

> **'... burial may take place either without any certificate of the cause of death or on the certificate of one medical man which may be in the vaguest and most uncertain terms. Unless, therefore, some definite ground of suspicion arises, there is no investigation of those cases where the cause of death is obscure, and where the ambiguity of the symptoms can be slurred over in a certificate which it is no one's business to question or criticise.'**

2.21 The Births and Deaths Registration Act 1926 prohibited the disposal of a body except following receipt of a certificate of the registrar or an order of the coroner. The person arranging the disposal was required to deliver notification to the registrar of the date, place and means of disposal. The form of the certificate of cause of death was prescribed; the Act required the certificate to be delivered by the medical practitioner to the registrar. To a large extent, these provisions implemented recommendations made in the 1893 Report. However, in two important respects, the intentions of the 1893 Committee were not adopted.

2.22 First, the 1893 Committee had intended that the qualification of the medical practitioner who was to issue the MCCD should continue to be defined by reference to attendance on the deceased during the last illness. The Committee had recommended that the phrase should be precisely defined: see paragraph 2.16. Following the passage of the 1926 Act, the duty to complete an MCCD continued to be imposed on the medical practitioner who had been in attendance during the deceased's last illness. However, the phrase was not defined in the Act. Second, the Committee had also recommended a requirement that either the certifying practitioner should inspect the body after death or the fact of death should be certified by two **'neighbours'** of the deceased. However, the 1926 Act imposed no such requirement.

2.23 The 1926 Act must be read in conjunction with the Registration (Births, Stillbirths, Deaths and Marriages) Consolidated Regulations 1927. They provided that a registrar would be under a duty to report a death if, on the face of the MCCD, it appeared that the certifying practitioner had not either seen the deceased within 14 days before death or seen the body after death. I shall refer to this rule as the 'either/or rule'. It appears that, even if the

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certifying doctor were unable to comply with either of these requirements, this would not affect the doctor's qualification to certify the cause of death. That qualification depended solely on the doctor's undefined **'attendance during the last illness'**.

2.24 It appears that the 'either/or rule' came about as the result of a legislative compromise. The passing of the 1926 Act followed several attempts to amend the law relating to the registration of deaths. Private Member's Bills were presented in 1923, 1924 and 1925. All failed. The Bill of 1925 contained a clause, which, if enacted, would have provided that, before a registrar could issue a disposal certificate, a certificate of the fact of death must have been supplied by a medical practitioner, who had examined the body and had satisfied himself that life was extinct. This was thought desirable by many as, at that time, the deceased's body was examined by a doctor after death in only about 40% of cases and there was concern in the country that people had been buried while still alive. However, the clause was opposed by the medical profession and was defeated in the House of Commons. When a further Private Member's Bill was presented in 1926, the clause was replaced by a proposal that a local authority could direct a medical practitioner to inspect the body to ensure that life was extinct. The clause containing that proposal was deleted during the committee stage. At the report stage, an attempt was made to re-introduce the clause from the 1925 Bill, requiring the provision of a certificate of the fact of death by the medical practitioner who was to certify the cause of death. However, this amendment was again opposed on the ground that it would impose an unreasonable burden upon doctors.

2.25 A compromise solution was proposed by the Government. There was to be no specific requirement that the certifying doctor should see the body after death. The MCCD was to be redrafted to require the doctor to state whether he had seen the deceased after death and how long before death he had last seen him/her alive. The registrar would then be required to refer to the coroner any death in which the doctor had not seen the body after death or had not seen the deceased within a **'reasonably short period before death'**. It was suggested that this provision would have two desirable effects. It would increase the number of cases in which a doctor saw the body after death and it would ensure that **'a large class of the more doubtful cases'** was reviewed by the coroner. On the basis of the proposed compromise solution, the amendment was withdrawn and, in due course, the Bill went through. At that time, the **'reasonably short period'** within which the doctor was required to have seen the deceased had not been defined. In 1927, it was decided that the period should be 14 days. The Regulations of 1927 were brought into force and the 'either/or rule' was established.

2.26 I do not think that the Members of Parliament who considered the effect of the compromise accepted in 1926 can have realised how the 'either/or rule' would work out in practice. It may be that requiring the doctor to state on the MCCD whether or not he had seen the body after death had the desired effect of increasing the proportion of cases in which that happened. However, the effect of the rule was that, provided the doctor had seen the body after death, it mattered not how long before death the doctor had last seen the patient alive. The provision, as passed, completely failed to ensure that 'doubtful cases', such as cases in which the doctor had not seen the patient for months before death, would be reported to the coroner. If the doctor took the trouble to see the body after death, it would

not matter when he had last seen the patient alive. He might be in no good position to certify the cause of death, although he could be quite certain that life was extinct. There was still no definition of **'attendance during the last illness'**. The sensible intentions of the 1893 Committee were thus frustrated. I shall return to the effect of the 'either/or rule' later in this Report.[1]

2.27 The 1926 Act also imposed controls on the removal of bodies into and out of England and Wales. Meanwhile, by the Coroners (Amendment) Act of the same year, coroners were given the power to direct a post-mortem examination if there was reason to believe that such an examination might render an inquest unnecessary.

2.28 The effect of the Births and Deaths Registration Act 1926 was to bring about a situation whereby registration of a death became virtually impossible without either an acceptable medical certificate of cause of death, completed by a registered medical practitioner, or a coroner's certificate issued after inquest or post-mortem examination. Disposal of a body could take place only on the authority of a registrar or coroner.

2.29 Despite these measures, I was told that there still remain a very small number of 'uncertified' deaths, even today. These usually occur when there is no doctor qualified to issue a medical certificate of cause of death (perhaps because the patient's usual general practitioner is on holiday or ill) and the coroner declines to order an autopsy or hold an inquest. I shall refer to these deaths again in Chapter Seven.

2.30 Registration is now governed by the Births and Deaths Registration Act 1953. In 1965, the Brodrick Committee was set up to examine the systems of death certification and coroners. It reported in 1971. The Report recommended a 'tightening up' of the procedures for medical certification of the cause of death. A new form of MCCD was proposed. For reasons that I shall explain in Chapter Three, its recommendations were never implemented. As a consequence, the systems for registration of death and medical certification of the cause of death remain much the same now as they were in 1927.

The Origins of the Coronial System

The Role of the Coroner in Early Times

2.31 The first real evidence of the existence of the office of coroner dates from the twelfth century. At that time, the Latin title for the office was '*custos placitorum coronas*' which, with time, was translated to 'crowner' and, thence, 'coroner'. Holders of the office were elected by the counties and, later, by the boroughs in which they resided.

2.32 The coroner had both financial and judicial responsibilities. From the earliest times, one of the coroner's most important duties was to enquire into unnatural, violent and sudden deaths. He was also required to keep a record of revenue due to the King in connection with the administration of justice; a violent or unnatural death might be a source of such revenue. For example, if it could not be proved that the victim of a violent death was English, it would be presumed that the deceased was Norman and a fine (the 'murdrum')

[1] The Inquiry is grateful to Mr Thomas Hennell for his research into the origin of the 'either/or rule'.

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was payable to the Crown by the local inhabitants. In the case of homicide or suicide, the weapon which caused the death was forfeit to the Crown as a 'deodand', as was any animal or object which caused a death by misadventure. The chattels of those committing homicide or suicide were also liable to forfeiture.

2.33 When a sudden death occurred, the coroner was required to attend the scene of death and view the body. Jurors, consisting of representatives from the local townships, were summoned to view the body with the coroner and to participate in the inquest. Although inquests were a common feature of life in thirteenth century England, it seems likely that many sudden deaths were concealed in order to avoid the various financial penalties consequent thereon.

2.34 During the fourteenth and fifteenth centuries, a series of changes to the legal system (in particular, the increasing role of the justice of the peace) resulted in a decline in the extent and importance of the coroner's functions. By the beginning of the sixteenth century, almost the only significant function left to the coroner was the investigation of unnatural deaths. The ensuing centuries saw dissent between coroners and justices of the peace about the ambit of the coronial jurisdiction. The justices contended that the coroners' jurisdiction was confined to the investigation of obviously violent deaths only. The coroners, who were paid by reference to the number of inquests held, asserted their right to investigate all sudden and unexplained deaths.

The Development of the Current Coronial System

2.35 The implementation of the Births and Deaths Registration Act 1836 had the effect of giving coroners a role in the drive to collect and record accurate statistical information about deaths by means of the new system of registration. Under the Act, coroners were required to notify the registrar of bodies **'found exposed'** which were reported to them. After an inquest had been held, the coroner was to give notice to the registrar of the particulars to be registered. Burial of a body was permitted upon receipt of a registrar's certificate or a coroner's burial order, issued after an inquest had been opened. However, burial without receipt of either such certificate was lawful, provided that notification was given to the registrar of the fact within seven days of the burial being carried out. Penalties were imposed upon persons who carried out burials of deceased persons without a certificate from the registrar or the coroner and who did not notify the registrar of the burial.

2.36 Also in 1836, an Act was passed, giving coroners power to compel the attendance of a medical witness at an inquest and to order the witness to perform an autopsy, if the cause of death remained uncertain. The effect of this measure was to increase the potential for the detection of cases of homicide. Over the years that followed, the number of inquests increased. The Coroners Act 1887 consolidated the laws relating to coroners and placed the emphasis upon their role in investigating the cause of, and the circumstances surrounding, deaths which were suspected of being violent or unnatural or which had occurred in prison or in such place or under such circumstances as to require an inquest. Coroners did, however, retain the duty to enquire into treasure trove, a vestige of their former role in protecting the financial interests of the Crown. In the following year, the Local Government Act 1888 abolished the practice of electing coroners, who were henceforth to be appointed by the local authority.

2.37 By 1901, coroners were being notified of about 60,000 deaths per annum, i.e. just over 10% of all deaths in England and Wales at that time. Inquests were held in just over two-thirds of those cases. Since the coroner had no power to order an autopsy without an inquest, almost one-third of deaths referred to the coroner were registered without further medical investigation. In a sizeable proportion of those (about 7500 in the year 1900), no MCCD had been completed, so that the death was eventually registered as 'uncertified'.

2.38 The Coroners (Amendment) Act 1926 introduced important reforms, some of which had been recommended by a Select Committee which had reported 16 years previously. The coroner was given the power to order an autopsy without having to proceed to an inquest in cases where there was no suspicion that the death had arisen as a result of anything other than natural causes. Also, in an attempt to introduce a higher standard of competence among coroners, a new requirement provided that future holders of the office should have medical or legal qualifications and not less than five years' standing in their profession. The number of circumstances in which a jury had to be summoned was reduced and the Lord Chancellor was given power to make rules of practice relating to procedure in coroners' courts and in relation to the conduct of autopsies.

2.39 As a result of the implementation of the Births and Deaths Registration Act 1926, and the consequent tightening up of the registration procedures, the number of deaths reported to coroners rose over the ensuing years. In 1926, there were just over 54,000 reported deaths; the number had risen to nearly 70,000 ten years later. Of those 70,000 deaths, less than half (almost 31,000) were followed by inquest. Over 12,000 autopsies were ordered by coroners in non-inquest cases.

2.40 In 1936, the Report of a Departmental Committee ('the Wright Committee'), chaired by The Rt Hon Lord Wright, was published. The Committee had been appointed following criticism of the conduct of some recent inquests. At the time of its deliberations, there were 309 coroners holding 354 coronerships; 13 coroners were engaged full-time and the rest part-time. The part-time coroners had little experience in the performance of their coronial duties and little prospect of gaining such experience. The Committee recommended a reduction in the number of coroners by means of the merger of smaller jurisdictions. It also recommended that those appointed to the post of coroner should be legally (not medically) qualified, preferably with experience as a deputy coroner and having undertaken a course in forensic medicine. They also recommended that deputy coroners be appointed by local authorities, not by the coroners themselves. The Committee proposed changes (including a restriction on press reports) to the conduct of inquests in the case of suicides. It was also recommended that coroners should have discretion to dispense with an inquest in certain cases (e.g. 'simple accidents', deaths under an anaesthetic or during an operation). Few of the recommendations of the Wright Committee were ever enacted.

2.41 The Brodrick Committee was set up in 1965 and gave detailed consideration to the arrangements existing in the coroner service. The Committee reported in 1971. The Committee recommended retention of the existing system whereby coroners were the recipients of reports of deaths that required investigation. The Committee envisaged the

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coroner becoming **'a principal agent in the certification of medical causes of death'**. Members of the Committee agreed with the Wright Committee that a service comprising full-time coroners only should, in time, replace the existing system whereby many coroners were employed part-time. The Committee recommended measures to compel the new county and metropolitan local authorities to submit for approval by the Home Secretary proposals for the organisation of a coroner service in their area. Any proposals for creation of part-time coroners' districts would have to be justified carefully and might be rejected. The Committee also suggested that measures should be taken to create panels of coroners who would be available for special inquiries as and when necessary. Panel members would also be available to give temporary assistance to coroners in other areas if required.

2.42 The Committee was anxious to bring to an end the system of local appointment of coroners. The Report therefore recommended that all coroners, deputies and assistant deputies should be appointed by the Lord Chancellor's Department, after consultation with the relevant local authority. The Lord Chancellor should also have power to remove a coroner for any incapacity or misbehaviour that rendered him unfit to continue in office. This would have had the effect of removing the restriction whereby a coroner could be removed only for misconduct relating to his office as coroner.

2.43 The Committee proposed that only persons with appropriate legal qualifications should be eligible to act as coroners. The Committee came to this conclusion because of the quasi-judicial decisions taken by coroners, even outside the formal context of an inquest. Members of the Committee felt that a lawyer would be better able to assess the value of evidence, both medical and factual, and would be more likely to command the confidence of the public because of his independence from the medical profession, on whose evidence the coroner frequently had to rely. The Committee also suggested that a medically qualified coroner might be assumed to have a specialist and up-to-date medical knowledge that in fact he did not possess. Consequently, the Committee came to the same conclusion as the Wright Committee, namely that possession of a legal, rather than a medical, qualification was to be preferred. The Brodrick Committee recommended that the use of police officers as coroner's officers should be phased out and that they should be replaced by civilian coroner's officers and, where necessary, secretarial staff. The Home Secretary should have a statutory duty to secure the provision of suitable and sufficient staff and accommodation for the coroner.

2.44 The Committee made a number of other important recommendations about the procedures for investigation by coroners, as well as the conduct of inquests. In 1976, a Working Party was set up to consider implementation of the recommendations. The Working Party reported in October 1977 and April 1980. As a result of its work, some of the recommendations were implemented.

2.45 However, there has been no substantial change in the way the coronial system is organised since the Brodrick Committee reported. There has been a significant reduction in the number of coroners' districts; as at February 2003, there were 129. But the majority of coroner appointments continue to be part-time; Home Office figures suggest that there are currently only 23 full-time coroners. They are still appointed by local authorities, which

retain responsibility for their remuneration and for the funding of their staff and office (if any). As I shall explain later in this Report, there have been moves to introduce more civilian coroner's officers, but it is still not unusual for coroner's officers to be serving police officers, employed and paid by the local police authority. The restrictions on the removal of coroners remain.

2.46 In the summer of 2001, the Home Office set up the Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland ('the Coroners Review'), chaired by Mr Tom Luce. The Coroners Review published a Consultation Paper in August 2002. In May 2003, it presented its final Report to the Home Secretary. I shall refer further to that Report and its recommendations in Chapter Nineteen.

CHAPTER THREE

The Origins of the Existing Cremation Certification System

Introduction

3.1 The system of cremation certification has been the subject of controversy for 100 years. Despite strong differences of view as to its value, the system has survived, virtually unchanged, during that time. Meanwhile, cremation has become the chosen method of disposal for the majority of people in the UK. In 1903, the year when the first Cremation Regulations came into force, there were 477 cremations in the UK; in 2001, there were 427,944. Over 70% of deaths in the UK are now followed by cremation.

3.2 In this Chapter, I shall set out the history of the procedures for cremation certification and the efforts that have been made over the years to change those procedures. Later in this Report, it will be necessary for me to consider the part played by the Home Office in the development and operation of the cremation certification system. For that reason, it has been necessary to research the history of the system, and the efforts by the Home Office to change it, in some detail. The Inquiry has had access to a large number of documents held by the Home Office, tracing its involvement with the cremation procedures over the last century.

The First Cremations

3.3 Until the late nineteenth century, cremation was virtually unknown in the UK. In 1874, the Cremation Society of England ('the Cremation Society') was formed **'to promote a more sanitary, reverent and inexpensive method of disposing of the dead'** than the traditional means of burial. Shortly afterwards, the Cremation Society purchased a plot of land at Woking, on which it intended to carry out cremations. The proposal met with fierce opposition from those living in the neighbourhood. Meanwhile, the Government refused to give any assurance that persons carrying out a cremation would not be prosecuted and convicted of an offence against public decency.

3.4 In February 1884, William Price[1] was indicted for attempting to burn the body of his child, instead of burying it; a second indictment charged him with attempting to burn the body with intent to avoid an inquest. He was acquitted on both charges. In giving his direction to the grand jury, the Judge, Mr Justice Stephen, expressed his view that, while the practice of burning the dead might be abhorrent to some, he could not declare it to be unlawful. He said:

> **'Though I think that to burn a dead body decently and inoffensively is not criminal, it is obvious that if it is done in such a manner as to be offensive to others it is a nuisance of an aggravated kind.'**

3.5 Those words provided the reassurance that the cremation movement had needed. Just over a year later, the first 'official' cremation took place at Woking. There were two more that year. Thereafter, the number rose steadily. The Cremation Society developed

[1] R v Price 1884 12 QBD 247.

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procedures designed to prevent cremation from being used to conceal crime. An applicant for cremation had to complete a detailed form of application and to obtain two medical certificates from different doctors, one of whom had attended the deceased. All three documents then had to be examined by another doctor, the 'medical referee'. If satisfied that the certificates disclosed no uncertainty or inconsistency, nor any grounds for suspicion, the medical referee would give the necessary permission to proceed with the cremation. If not satisfied that the certificates disclosed no uncertainty or inconsistency, nor any grounds for suspicion, the medical referee would cause further enquiries to be made, including, if necessary, an autopsy.

3.6 By 1900, four crematoria were in existence in the UK and the procedures at each of these were similar to those developed by the Cremation Society. In that year, there were 444 cremations within the UK. Then, as now, some of the crematoria were municipal concerns, owned and run by local authorities, while others were owned and operated by private companies.

Statutory Recognition for Cremation

3.7 In 1902, the practice of cremation received statutory recognition. The Cremation Act 1902 gave burial authorities (i.e. burial boards and local authorities having the powers and duties of a burial board) the power to provide and maintain crematoria. It also placed a duty on the Home Secretary to make regulations governing the maintenance and inspection of crematoria and the conduct of cremations, including regulations prescribing the forms of the notices, certificates and declarations to be given or made before a cremation was permitted to take place. A Departmental Committee was appointed to prepare a draft of the Regulations to be made under the 1902 Act.

The Report of the Departmental Committee 1903

3.8 In their Report, published in 1903, the Committee said:

> **'... the point which we have considered of prime importance has been to frame Regulations which, while avoiding unnecessary restrictions such as might discourage cremation or involve undesirable delay in the disposal of the body, would reduce to a minimum the risk of cremation being used to destroy the evidence of murder by violence or poison'**.

3.9 As I have described in Chapter Two, the system of registering deaths at this time was extremely unsatisfactory. The law permitted disposal of a body without prior registration of the death. Even if a death were registered, there might be no certificate of cause of death. If a doctor did provide a certificate, he might not have seen the deceased during the last illness, or indeed at all. Moreover, if the certificate of cause of death was vague and uncertain in its terms, it was unlikely to be questioned by anyone. The registrar, who was the only person who would examine it, was not medically qualified and was not therefore in a strong position to question a certificate, unless it gave rise to an obvious suggestion of violence or other suspicious circumstances. The Committee referred to cases where these weaknesses in the system had resulted in burials being used to

conceal evidence of murder. Its Report also drew attention to the possibility that the person giving the certificate of cause of death might himself be the murderer. Examples of killings by doctors were cited and the Committee observed that: **'... such instances ... cannot be disregarded'**. Its members were therefore anxious to devise a system which would detect or deter such crimes. However, their Report recognised that no Regulations could be framed so as to eliminate entirely the risk that cremation might be used for the concealment of crime.

3.10 The Report described the procedures already devised and operated by the Cremation Society. The Committee concluded that the second medical certificate required by the Cremation Society, which was intended to be provided by an independent doctor, did not achieve the safeguard that had been intended. Despite the requirement that the second doctor should make **'careful and separate investigation'**, it was recognised that, in some cases, no such investigation was made and that **'the certificate usually amounts to little more than a guarantee by another medical man of the good faith of the practitioner who signs the first certificate'**.

3.11 The Committee also expressed doubt that the wide discretion given to the Cremation Society's medical referees (who were practitioners of considerable distinction) could appropriately be extended to all practitioners who might fulfil the role of medical referee. Under the Cremation Society's procedures, the medical referee acted entirely on his own discretion in making or not making further enquiries about the death. The Committee felt that, while much must be left to the judgement of individual medical referees, there must be some uniformity of practice. It was also recognised that, as the number of crematoria increased, the medical referees appointed to them might not be of the same calibre as had previously been the case and would therefore require clear rules as to how to proceed. Accordingly, although the Cremation Society's procedures formed the basis of the Committee's recommendations, the Committee proposed a departure from those procedures in several important respects.

The Recommendations of the Departmental Committee

3.12 The Committee concluded that responsibility for deciding in each individual case whether cremation was to be allowed should lie with the medical referee. It decided that the medical referee should not, in every case, personally investigate the cause of death so as to reach an independent conclusion on facts that he himself had ascertained. Considerations of geography made it impracticable for one official to make a personal investigation in every case. The Committee therefore decided that the medical referee's role would have to be confined to the scrutiny of the medical certificates presented in support of the application to cremate. The medical referee should examine the medical certificates to ensure that they were satisfactory and, if not so satisfied, he should decline to allow cremation without an autopsy or a reference to the coroner.

3.13 The Committee observed that, if it were practicable for medical referees to conduct a personal investigation in every case, it might be possible to dispense with the second certificate. However, since it was not practicable, the Committee felt that the second certificate must be retained. Members of the Committee considered the situation where a

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doctor committed murder and subsequently completed the first cremation certificate. That certificate would certainly be good on its face and would therefore be accepted without question by a medical referee who was merely carrying out a scrutiny of the certificates presented in support of the application to cremate. Some further safeguard was required, particularly since cremation of a body precluded the possibility of recovery of the body for future inspection. They proposed that the additional safeguard should consist of an investigation by a second doctor. An independent investigation could not, of course, be guaranteed to reveal evidence of such a crime, but would, the Committee believed, reduce the risk of concealment.

3.14 The Committee therefore recommended that, before cremation was permitted, there should be a personal investigation by a doctor other than the medical attendant of the deceased. The investigation might be carried out by the medical referee. If that were not possible, it should be conducted by an independent medical practitioner. That practitioner should be nominated for the purpose by the cremation authority or should hold the appointment of medical officer of health, police surgeon, certifying factory surgeon or medical referee under the Workmen's Compensation Act. It was pointed out that the last three categories of medical practitioners had special experience of cases of death by violence. Physicians and surgeons on the consulting staff of the larger public general hospitals were added to the list of those recommended for eligibility to investigate and provide a second medical certificate. The intention was that the second certifier should be demonstrably independent and of good standing in the medical profession.

3.15 If the medical referee were not satisfied that the two medical certificates showed the cause of death definitely, and in terms such as to exclude the possibility of poison or violence as the cause of death, an autopsy should be held. This should be conducted, the Committee said, by a medical practitioner experienced in pathology, who had been appointed by the cremation authority. If the autopsy revealed a sufficient cause of death, the cremation should be allowed. If it did not, and the relatives still wished for a cremation, the case should be referred to the coroner for an inquest. Even if the cause of death had been definitely ascertained, the death should be referred to the coroner if there were any suspicious circumstances surrounding it.

3.16 The Committee requested that its proposed Regulations should be regarded as provisional. It recommended that, as the experience of cremation increased, the Regulations might require simplification or, if weaknesses emerged, more rigid rules might be needed. Looking to the future, the Committee said:

> **'We look forward to the possibility that ultimately the whole question of death certification and of the disposal of the dead may be brought in every district under the control of some public officer, either the Coroner or the Medical Officer of Health ...'**.

3.17 In other words, exactly 100 years ago, the Committee was advocating what has been called in the course of this Inquiry a 'one-stop shop', covering all the formalities of death and cremation certification.

The Cremation Regulations 1903

3.18 The Cremation Regulations 1903 reproduced, in virtually identical terms, the draft Regulations recommended by the Departmental Committee that had reported a short time before. Draft forms were prescribed. Those relevant for the purposes of this Report are:

- the Application for Cremation (Form A), to be completed by the person applying for the cremation, usually the deceased's executor or nearest surviving relative. The contents of this form had to be confirmed by statutory declaration
- the Certificate of Medical Attendant (Form B), to be completed by a doctor who had attended the deceased before death and had seen and identified the body after death
- the Confirmatory Medical Certificate (Form C), to be completed by a second doctor who was the holder of one of the public appointments referred to at paragraph 3.14
- the Certificate after Post-Mortem Examination (Form D), to be completed by a pathologist who was directed by the medical referee to conduct a post-mortem examination
- the Coroner's Certificate (Form E), to be completed by a coroner who had held an inquest on the body of the deceased and was satisfied that no circumstance existed which could render necessary any further examination of the remains or any analysis of any part of the body
- the Authority to Cremate (Form F), to be completed by the medical referee who was satisfied that all the requirements of the Cremation Act and Regulations had been complied with, that the cause of death had been definitely ascertained and that there existed no reason for any further enquiry or examination.

The Period from 1904 to 1930

3.19 Between 1904 and 1930, the 1903 Regulations were amended several times. However, the procedure for obtaining authority to cremate remained essentially the same as that devised by the Departmental Committee that had reported in 1903.

3.20 The Cremation Regulations of 1930 made a number of changes. The most important of these was the removal of the requirement that the second (Form C) doctor should be appointed by the cremation authority or hold one of the categories of appointment previously specified. By 1930, the annual figure for cremations in the UK had increased to 4533. Many of the 21 crematoria then in existence covered large geographical areas. It had become difficult to find sufficient doctors with the requisite qualifications to sign the number of confirmatory certificates required. Those who were eligible to sign Forms C were, it was said, inclined to claim a monopoly and to charge unduly high fees.

3.21 It was decided that the previous rule should be relaxed. At first, the Home Office proposed that each cremation authority should appoint a panel of suitable doctors (drawn from a wider pool of eligible candidates than previously), who would be authorised to complete Forms C. However, the cremation authorities opposed this idea and Home Office officials

were reluctant to impose upon them a requirement to operate a panel system. The counter-proposal put forward by the cremation authorities was therefore accepted, namely that the doctor completing Form C should be a registered medical practitioner of not less than five years' standing and should not be a relative of the deceased or a relative or partner of the Form B doctor.

3.22 By 1930, the Home Office had become concerned that the system of appointing medical referees had broken down. It was decided that the Department must exercise some control over appointments, in order to preserve the original purpose of the system as a precaution against the risk of Form B being carelessly or corruptly completed by the attending doctor. Accordingly, the power of appointment of medical referees and deputy medical referees was transferred from cremation authorities to the Home Secretary, who was to appoint **'such fit persons'** as may be nominated by the cremation authority. It is not clear whether the Home Office ever put in place any mechanism by which it could properly exercise its power of appointment. If there ever was such a mechanism, it cannot have been maintained for long. I shall return to this topic later in this Chapter.

3.23 After the passage of the 1930 Regulations, it was no doubt hoped that doctors would be more modest with regard to the fees charged for completing cremation certificates, particularly Form C. No step was taken at that time to exercise any control over those fees and they have continued to be a source of concern ever since. They have come to be known colloquially, and unattractively, as 'ash cash'.

The Period from 1930 to 1950

3.24 During the period between 1930 and 1950, considerable doubts were expressed about the value of the certificate given by the second doctor. Reports submitted by medical referees to the Home Office in 1935 suggested that doctors habitually completed Forms C without making the personal investigation that had been intended by the Regulations. As a consequence, some medical referees thought the form of little practical value. There were particular problems with the completion of Forms C by hospital doctors.

3.25 In 1935, as now, Form C (as prescribed by the 1930 Regulations) contained the following questions:

> **'1 Have you seen the body of the deceased?**
>
> **2 Have you carefully examined the body externally?**
>
> **3 Have you made a post-mortem examination?**
>
> **4 Have you seen and questioned the medical practitioner who gave the above certificate** [*Form B*]**?**
>
> **5 Have you seen and questioned any other medical practitioner who attended the deceased?**
>
> **6 Have you seen and questioned any person who nursed the deceased during his last illness, or who was present at the death?**

7 Have you seen and questioned any of the relatives of the deceased?

8 Have you seen and questioned any other person?

(In the answers to questions 5, 6, 7, and 8, give names and addresses of persons seen and say whether you saw them alone.)'

3.26 The prescribed form contained no requirement that any of the questions on Form C should be answered in the affirmative as a prerequisite to the giving of authority to cremate. Thus, for example, there was no requirement that the Form C doctor should examine (or even view) the body, speak to the Form B doctor or question anyone else with knowledge of the circumstances of the death.

3.27 The reports of the medical referees, submitted in 1935, suggested that there was no uniform practice in the completion of Forms C. Most doctors would at least view the body of the deceased and speak to the doctor who had completed Form B, before issuing the confirmatory certificate. However, an examination of the deceased's body was by no means universal and some doctors, it was said, signed Form C without discussing the death with the Form B doctor.

3.28 As for questions 5–8 of Form C, it appeared that some doctors invariably answered **'No'** to all of them. The practice among medical referees plainly varied as to the extent of information that they required to be given by the Form C doctor before authorising the cremation. The suggestion was made that some medical referees might be giving authorisation even in the face of negative responses to all eight questions on Form C.

3.29 In October 1935, following analysis of the reports, a letter was written on behalf of the Home Secretary to all medical referees, reminding them of the original purpose for which Form C was devised, i.e. **'... as a safeguard against cremation being used to conceal crime ...'** by ensuring that **'a personal inquiry'** was carried out in every case by someone besides the medical attendant of the deceased. The letter expressed the Home Secretary's view that, as a general rule, no Form C should be accepted unless the answers to questions 1, 2 and 4 were in the affirmative. Medical referees were enjoined to remember that Form C was **'an essential safeguard in the system of cremation devised in the public interest'**. Nothing was said in the letter about questions 5–8.

3.30 A Home Office memorandum of 1937 records an official's view that a committee should be set up to review the working of the Cremation Act and Regulations and to report on any changes that might be desirable. The author pointed to ambiguities in the wording of Form B and suggested that a footnote should be added to Form C, to the effect that answers to questions 1, 2 and 4 should generally be in the affirmative. Other changes were also proposed.

3.31 The memorandum went on to discuss the possibility of abolition of Form C. The author observed:

'There appears in some degree to have been a return to the system of the Cremation Society in 1902, and the value of certificate C seems nowadays to depend very largely upon the doctor giving it to do his work properly.'

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If Form C were abolished, it was suggested that more work and responsibility would be placed upon medical referees. The need to guard against the use of cremation to conceal crime was again noted. It was anticipated that, as the number of cremations increased, the knowledge and experience of the medical referees would increase also. The fact that the medical referees appointed to the new, local authority-owned crematoria were, in general, medical officers of health was also thought to be a positive step. The author of the memorandum believed that, if medical referees were given greater responsibility, they were likely to discharge it conscientiously. He pointed out that it was in their interests (as appointees of the crematoria) to do so, since **'nothing would be more detrimental to the interests of cremation than the occurrence of a case in which cremation had been used for the concealment of a crime'**.

3.32 In the event, no steps were taken to set up a committee at that time. It was not until ten years later, after the end of the Second World War, that it was decided that the time had come for a thorough review of the system of controlling cremation. This was thought appropriate, in particular, in the light of the desire, expressed in the Departmental Committee's Report of 1903, that the system devised by that Committee should be regarded as provisional only. In 1947, an Interdepartmental Cremation Committee was set up under the chairmanship of Mr Austin (later Sir Austin) Strutt, a Home Office official. In that year, there were no fewer than 61,160 cremations in the UK and representations were being made by the organisations responsible for running the crematoria ('the cremation organisations') that the Regulations should be relaxed. In particular, the Cremation Council of Great Britain (which incorporated the Cremation Society and the Federation of British Cremation Authorities) was pressing for the abolition of Form C, on the grounds that it served no useful purpose and, by adding to the complexity and expense of applying for cremation, served as a deterrent against that means of disposal. However, that view was countered by public concern which had been awakened by press coverage of a case where a doctor had been suspected of murdering his wife. Because she had been cremated, no proper investigation into the death could be conducted.

The Report of the Interdepartmental Committee

3.33 The Committee reported in 1950. It recommended the removal of the requirement that the particulars stated in Form A should be confirmed by statutory declaration. Some changes to Form B were proposed. In particular, it was recommended that it should no longer be necessary for the doctor completing Form B to have attended the deceased during his/her last illness, provided that the doctor had visited the deceased within 14 days and was able to certify the cause of death **'to the best of his knowledge or belief'**.

3.34 The Committee's Report summarised the arguments put for and against the abolition of Form C. On the one hand, the Director of Public Prosecutions (DPP), the Coroners' Society of England and Wales (the Coroners' Society), the British Medical Association (BMA), a number of medical referees and the director of a forensic science laboratory all advocated retention of the requirement for Form C. The BMA said that the completion of Form C was **'a public duty that the medical profession should be required to take seriously'**. The Coroners' Society saw Form C as an additional precaution and suggested that it should be **'revised and slightly strengthened'**.

3.35 In favour of abolition were the cremation organisations, the Society of Medical Officers of Health and other medical referees. They pointed to the **'perfunctory manner'** in which Form C was completed in the majority of cases and to the equally perfunctory way in which doctors carried out their examination of bodies before completing Form C. It was said that the charges levied by doctors for completing Form C were a deterrent to choosing cremation as a means of disposal. Those arguing for abolition also pointed out that, in almost 50 years, no case had occurred in which the enquiry necessitated by Form C had led to the detection of a crime.

3.36 The Committee nevertheless recommended that Form C should be retained. The Report proposed that any new Regulations **'... should be so worded as to make it a duty on the person giving the confirmatory certificate to answer the questions properly and effectively'**. The Committee also recommended that Form C should be redesigned, so as to combine the functions of both Form C and Form F (the medical referee's authority to cremate). The Committee proposed a return to the previous system, whereby doctors completing Forms C were required to hold a prestigious public appointment. It was recommended that the doctor completing the new-style Form C should be of clearly recognised status, such as a medical officer of health, and should be assisted by a panel of practitioners specially selected by the cremation authority. In the case of a hospital death, it was proposed that the new Form C should be completed by the Medical Superintendent of the hospital or his deputy. It was also recommended that fees for completing Forms B and C should be standardised.

3.37 The effect of the Committee's recommendations was that there would be no future need for a medical referee or deputy medical referee. The doctor issuing Form C would give authority to cremate, except in cases where the death had been referred to the coroner and the coroner had issued Form E. In such cases, Form E would operate as the authority to cremate.

3.38 The Report suggested that, if cremation became more common (e.g. if cremation followed, say, 50% of deaths), it might well be necessary to consider whether the procedures for burial and cremation should be more closely assimilated.

The Period from 1950 to 1952

3.39 After publication of the Interdepartmental Committee's Report, it fell to the Home Office to consider implementation of the proposals contained in the Report. The cremation organisations were disappointed at the proposal to retain Form C and the BMA was firmly opposed to the abolition of the post of medical referee. The BMA expressed doubts about the suitability of medical officers of health to complete the new Form C, having regard to their lack of recent experience of clinical practice. Doubts were also expressed about the desirability of creating a panel of Form C doctors. If a limited number of panel members were to be selected from the existing pool of doctors eligible to sign Forms C, it was said that this might lead to delay and difficulty in obtaining completed Forms C. On the other hand, if all or most of those practitioners already eligible to sign Forms C were to become members of the panel, no advantage would be achieved. The BMA also observed that relatives would prefer a private practitioner, rather than an official, to come to their home

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to make any necessary enquiries before completing Form C; this, of course, presupposed that the certifying doctor would question relatives as part of his investigation before signing Form C.

3.40 During 1950 and 1951, the Home Office held a number of meetings with the various interest groups to discuss possible implementation of the changes; the discussions with the BMA included consideration of the level of fees which should be paid to doctors signing Forms B and C. In early January 1952, Mr Howat, who was an official at the Department of Health for Scotland and had been a member of the Interdepartmental Committee, wrote to Mr Strutt. Mr Howat expressed concern at a proposal to agree fees with the BMA without securing the agreement of the BMA to implementation of the recommendations of the Committee. In his letter, Mr Howat said this:

> **'If Form C. is to remain, then our first task is to see that it is an honest certificate. I doubt whether its completion by doctors in the present climate is worth five shillings much less two guineas. To give two guineas to a doctor who walks into a room and looks casually (but sympathetically, of course) at a body in a coffin and then walks out, is to my mind just wickedness. I would therefore urge that before fees are further considered we should undertake the revision of Form C. and the preparation of a memorandum describing what the doctor should do about it. Having done that, we could consider again what is the true worth of the Form.'**

3.41 Mr Strutt's draft response to Mr Howat expressed the general feeling within the Home Office which, after **'considerable reflection and with great reluctance'**, he had accepted, that the procedural changes recommended by the Committee would not work well in practice. It had been decided that the existing arrangements should be preserved, for the time being at least. Mr Strutt expressed the view that, **'... if the present system is to be perpetuated in any revised Regulations we ought to do all we** [*can*] **to see that doctors giving Form C do so in the manner and as intended by the Regulations ...'**.

3.42 In the event, that draft response was never sent, since a Private Member's Bill, which included a clause empowering the Home Secretary to fix fees for doctors' certificates, was introduced and it was deemed appropriate to delay further discussions until the procedures relating to the Bill had been completed. That Bill became the Cremation Act 1952. It gave power to the Home Secretary to prescribe the fees charged by doctors for issuing Forms B and C, a power that has never been exercised. Instead, the fees charged are those recommended by the BMA. No action was taken pursuant to Mr Howat's suggestion of a memorandum, setting out the duties of doctors in relation to Form C.

3.43 Regulations also made in 1952 removed the requirement for a statutory declaration to confirm the contents of Form A. Instead, the form was to be countersigned by a person employed in one of a number of specified professions.

The Cremation Working Party

3.44 After 1952, the number of cremations continued to rise steeply. In 1957, 28.4% of deaths in Great Britain were followed by cremation. The cremation organisations continued to

press for simplification of the Regulations, in particular abolition of Form C. In 1958, the Home Office decided to set up a Working Party, charged with the task of producing draft revised Cremation Regulations. The Working Party, which began its work in 1959, included among its members representatives from some of the organisations actively involved in the day-to-day operation of the cremation procedures.

3.45 The most difficult issue facing the Working Party was what to do about Form C. The Working Party took evidence from a number of organisations, among them the cremation organisations, the Association of Clinical Pathologists, the Association of Crematorium Medical Referees and the BMA.

3.46 The Association of Clinical Pathologists recognised the possibility that either the deceased's medical attendant or the deceased's family might be criminally involved in the death of the deceased. The Association construed 'criminal involvement' as including concealment of negligence in the treatment of the deceased. They took the view that the purpose of the Form C investigation was to perform a cross-check of the accounts given by the deceased's family and the Form B doctor. The Association stressed that questions 5 and 6 (which ask whether the second doctor has questioned any other medical practitioner who has treated the deceased or anyone who has nursed the deceased or was present at the death) were **'essential if any check is to be made on the attending practitioner'**. The Association believed that no proper check was in fact being performed. It was said that, in some cases, examination of the deceased's body might involve merely looking at the face. The doctor completing Form C was frequently a personal friend of the Form B doctor and **'was naturally reluctant to act inquisitorially'**. The Association doubted whether, having been **'so badly abused'**, Form C could ever be **'restored to usefulness'**. Consequently, the Association suggested that Form C should be discarded and that the role of the medical referee should be strengthened by appointing better qualified medical referees with more time to devote to the task of actively investigating deaths. In addition, the Association suggested that registrars should be encouraged to obtain information from relatives and to communicate this, where appropriate, to the medical referee, thus providing an informal checking mechanism.

3.47 I note, in passing, an extract taken from the Association's memorandum to the Working Party, written in 1959, where it was said:

> **'It might be worthy of consideration as to whether the Referee could not be in some way associated with the Coroner thereby linking the two so that reference of cases could be easily and expeditiously employed. The whole might ultimately be linked with a medico legal service serving the Coroner in a capacity now occupied by individual pathologists, forensic scientists, serologists, etc. The Referee being a trained forensic pathologist.'**

The similarity of that suggestion, put forward 44 years ago, to the idea for an integrated coroner service that this Inquiry has been considering is striking.

3.48 The Association of Crematorium Medical Referees regarded Form C as a valuable safeguard. However, the Association was anxious to see complete independence, both

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social and professional, of the Form C from the Form B doctor. Representatives of the Association suggested that future regulations should make clear what degree of association between the doctors was and was not acceptable. The Association was not, however, in favour of the creation of a panel of Form C doctors, as recommended in the Interdepartmental Committee's Report of 1950. Their objections were based on practical grounds and on the assertion that it was to be expected that **'many practitioners would bitterly resent certain of their colleagues being called in to question the relatives of the deceased'**. The Association expressed the view that it was undesirable, except where a case was referred to the coroner, for Form C to be completed without interviewing the relatives. Concern was expressed that the practice of removing bodies to the premises of funeral directors before the attendance of the Form C doctor was having the effect of discouraging Form C doctors from interviewing relatives.

3.49 Having considered the evidence, the Working Party concluded that the existing system should be retained and Form C strengthened and improved. That conclusion essentially accorded with the submissions made to the Working Party by the BMA, which supported retention of the existing system, with a revised Form C.

3.50 The BMA had stressed the importance of ascertaining the cause of death accurately, not only to prevent the concealment of crime but also to ensure the quality of mortality statistics. A minute of comments made to the Working Party by the BMA representative, Dr John Havard, reads:

> **'... the purpose of the Cremation Regulations was not so much to ascertain the fatal disease from which the deceased had been suffering as to determine what caused death. It was only too easy to help an old and chronic invalid out of the world. Although the Form B doctor was in an excellent position to give an opinion as to the nature of the fatal illness, it was essential to confirm his opinion on the actual cause of death. At present the potential criminal was deterred by the knowledge that a second examination by an independent doctor with questioning of relatives, nurses etc. would take place in every** [*his emphasis*] **case.'**

3.51 In fact, even at the time when those remarks were made, the questioning by the Form C doctor of persons other than the Form B doctor was far from being standard practice. The evidence of the Association of Crematorium Medical Referees, whose members were inspecting completed Forms C on a daily basis, made that clear.

3.52 Revised Regulations were drafted, together with revised cremation forms. It was proposed that the revised Form C should be a more searching document than previously. It required a full external examination of the body of the deceased and asked a series of questions about that examination. The form asked the certifying doctor to describe any external marks on the body indicating recent violence or injury and to state an opinion as to their cause, in particular whether they were consistent with the cause of death as stated. The form also asked whether there were any skin puncture marks and, if so, whether they were consistent with the treatment stated on Form B. The form asked, as previously, whether the certifying doctor had consulted with any other doctor (other than the Form B

doctor) or with any person who had nursed the deceased or a relative. However, affirmative answers to these questions were not mandatory. Finally, the certifying doctor was asked whether there was any feature of the illness or death which he wished to draw to the attention of the medical referee. The revised form represented an attempt to ensure that Form C doctors carried out a more rigorous investigation. In particular, it was intended to ensure that they performed a careful examination of the body. However, it was destined never to come into use.

3.53 The draft Regulations were circulated in June 1962 and a period of consultation followed. This was protracted and produced the familiar division of opinion. The DPP and the police were in favour of retention of Form C, which they regarded as a deterrent against crime. The BMA and the Association of Crematorium Medical Referees also supported retention. On the other side, the cremation organisations criticised the newly designed Form C as unwieldy; they contended that its complexity was likely to lead to it being completed in an even more perfunctory manner than previously. They continued to press for abolition of Form C or, as an alternative, an amalgamation of Forms B and C, requiring the signature of one doctor only. No agreement was possible and it was necessary for a ministerial decision to be made. In February 1964, the Home Secretary announced his decision that Form C should be retained.

3.54 Later in 1964, the decision was taken to set up a Committee (the Brodrick Committee) to examine the systems of death certification and coroners. It was decided that, because of the close relationship between the procedures governing death and cremation certification, the latter should be included in the Committee's Terms of Reference. As a consequence, the attempt at a complete overhaul of the Cremation Regulations was scaled down.

3.55 The Cremation Regulations 1965 were of limited scope. They permitted Form A to be countersigned by a householder, in place of a member of one of the professions specified in the Cremation Act 1952. They also gave the coroner power to issue Form E after opening (rather than holding) an inquest. This enabled a body to be cremated before the inquest was concluded.

The Report of the Brodrick Committee

3.56 The Brodrick Committee was set up in March 1965. It reported to the Home Secretary six and a half years later, in September 1971.

3.57 In its Report, the Committee discussed the BMA paper 'Deaths in the Community', which had been published in 1964. In particular, the Committee dealt with the suggestion that homicides were passing undetected through the existing certification systems. That suggestion was based on a book, 'The Detection of Secret Homicide',[2] by Dr John Havard. Dr Havard was at that time Assistant Secretary (later Secretary) of the BMA and played a prominent part in its dealings with the Home Office over a period of several decades. I referred to comments made by him at paragraph 3.50.

[2] Havard, JDJ (1960) 'The Detection of Secret Homicide', Cambridge Studies in Criminology, Vol XI. Cambridge: Cambridge University Press.

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3.58 The Brodrick Committee took the view that:

> **'... the risk of secret homicide occurring and remaining undiscovered as a direct consequence of the state of the current law on the certification of death has been much exaggerated ...'**.

3.59 The Committee reached that view, having noted that:

(a) A review of 28,108 autopsies carried out on behalf of coroners in the five-year period 1963 to 1967 had revealed that 263 of these autopsies had resulted in findings of unnatural death, despite the fact that the initial report (from a doctor or coroner's officer) suggested that the death had been due to natural causes or did not state a contrary opinion. Of those 263 deaths, one proved to be a case of homicide and, in 17 others (all deaths of infants), violence appeared to have played a part in the death. The Committee was evidently reassured by the fact that those 18 cases were identified for further investigation by the existing system. The Committee did not comment on the fact that the review shed no light on the pattern of death among cases that were not reported to the coroner.

(b) An examination of all (more than 400) cases of homicide or suspected homicide investigated by the police in 1965 and 1967 had revealed that not one of those deaths had been prematurely or wrongly registered. Investigations into the deaths had begun in all the cases before the stage of certification and registration was reached.

(c) Of 20 exhumations ordered over a period of ten years, only one resulted in a criminal conviction for homicide and that had been treated as suspicious from the first; the body was exhumed for a second autopsy in an effort to obtain additional medical evidence. During that ten-year period, some 5,500,000 deaths and 2,350,000 burials had taken place. The Committee did, however, refer to a case which had occurred outside the period of their review and in which, as a result of evidence gained from autopsies conducted after exhumations, a woman who may have murdered four husbands was found guilty of murdering two of them.

(d) Records showed that, in 90% of cases, the doctor completing the MCCD saw the deceased's body after death. The coroner made an enquiry in 20% of deaths. In more than 25% of deaths, an autopsy was carried out. The Committee felt that these factors were powerful deterrents to a would-be murderer.

(e) The evidence of witnesses did not support the existence of a significant risk.

3.60 The Committee observed:

> **'We do not say that there is no possibility whatever of a homicide being concealed under the present procedure for certifying deaths. What we do say is that, balancing all the relevant factors and observable probabilities, there is no requirement to strengthen the present machinery of death certification simply in order more efficiently to prevent or detect secret homicide. So far as detection of homicide is a**

relevant objective, the present certification system has worked as satisfactorily as any modern community could reasonably expect. Advances in medical science (and forensic medicine) are likely to maintain that position. Our task, therefore, has been to make sure that, in the future system of death certification, an autopsy will be performed in all cases in which there is any doubt about the medical cause of death or suspicion about the circumstances in which the death occurred.'

3.61 The Report went on to consider the specific risk associated with concealment of homicide by the attending doctor. It referred to the general risk, which the Committee considered was **'extremely small'**, and observed:

> **'... there is no reason — to put it at its lowest — to think that the risk of homicide by doctors is higher than for any other profession. Apart from this the arguments call in question the quality and to some extent the morality of professional conduct. They also depend for much of their force on the assumption that relatives, friends and others with knowledge of or interest in the death are likely to remain silent if they are dissatisfied with the conduct of the certifying doctor.'**

3.62 It is easy now to see that the Brodrick Committee was wrong to conclude that the risk of secret homicide was negligible. That conclusion was to underlie its whole approach to the question of reform. Since the discovery of Shipman's crimes, we know that the risk of homicide by doctors is a real one, although it may occur only rarely. The Brodrick Committee had only the suggestion, made in the BMA paper, that homicides were passing undetected. They concluded, on the basis of the evidence they had examined, that the BMA suggestion was unduly alarmist. I do feel bound to observe that the research on which the Brodrick Committee relied could not, on careful analysis, have satisfied its members that the risk of concealed homicide was minimal. They examined only deaths that had come to the attention of the coroner or the police. They did not consider whether or not there might be concealed homicides that had never come to the attention of either agency, i.e. cases of the Shipman kind. They were also confident that the family of a deceased whose doctor had done something wrong would recognise this and express dissatisfaction. That confidence can now be seen to have been misplaced. None of the relatives of Shipman's victims expressed concern to an official body at the time of the relevant death. Those few who felt any such concern felt inhibited from making it known.

3.63 In any event, it was against the background of the conclusion that the risk of concealed homicide was minimal that the Brodrick Committee set about its examination of all aspects of the existing systems. Many of the criticisms of those systems made to the Committee were reiterated to this Inquiry more than 30 years later.

3.64 Having reviewed the arrangements for cremation certification, the Committee observed that the process of certification appeared to operate without undue difficulty or delay. Indeed, the Committee concluded that, if judged solely by the test of convenience to the public, the existing system could be said to be generally satisfactory.

3.65 However, those actively involved in the operation of the system expressed widely disparate views about its efficiency and value. The cremation organisations and the

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National Association of Funeral Directors took the view that the whole process should be simplified. They recognised that, if that were done, it would be necessary to have a **'stronger'** certificate than the existing MCCD; in particular, it would be necessary to have a certificate which required the certifying doctor to examine the body after death. Thus, they were content for Form B (with some modifications) to be retained. However, they saw little value in Form C, except where it was provided by an experienced hospital pathologist following an autopsy. They relied, as in the past, on evidence of the perfunctory manner in which many doctors carried out their enquiries before completing Form C. They maintained their contention that Form C should be abolished.

3.66 On the other hand, the BMA again contended that the involvement of three doctors in the cremation certification process was an essential safeguard against the destruction of evidence of crime or neglect. Its representatives argued that the existing requirement that the medical referee should be satisfied that the cause of death had been **'definitely ascertained'** provided a further safeguard. The BMA did not accept that doctors were failing to carry out proper enquiries before completing Form C. The BMA described Form C as the **'lynch-pin'** of the cremation certification process and **'a vital safeguard'**.

3.67 Representatives of the Association of Crematorium Medical Referees told the Brodrick Committee that they were generally content with the existing system. They supported the retention of Form C. They believed that the completion of Form C, by a doctor unconnected with the Form B doctor, encouraged greater care in the assessment of the cause of death. They also pointed out that interviews (conducted pursuant to question 6 of Form C) with those who had nursed the deceased, or who had been present at the death, could bring to light **'sources of dissatisfaction and anxiety'** which should be taken into account before completing Form C.

3.68 The Police Federation, the Coroners' Society and individual pathologists all stressed the need for safeguards against the concealment of crime to be contained within any system of cremation certification. However, they believed that Form C should be dispensed with and replaced by something better.

3.69 Views about the degree of care with which medical referees carried out their duties also differed. The organisations representing the medical profession and crematorium medical referees were adamant that, in general, referees carried out their duties conscientiously and provided a genuine safeguard against crime. However, representatives of the cremation organisations and funeral directors suggested that, in many cases, the issuing of the authority to cremate was virtually automatic on production of the appropriate documentation.

The Conclusions of the Brodrick Committee

3.70 The Brodrick Committee concluded that Form B, while far from perfect, served a valuable purpose in concentrating the attending doctor's mind on the need to describe the medical cause of death accurately and on the need to consider whether there was any factor or circumstance which would make it desirable that a further examination of the body should be carried out. The evidence which the Committee had received suggested that Form B was, in general, adequately completed by doctors, although doubts were expressed

about the thoroughness with which the physical examination of the body, if performed, was conducted.

3.71 As to Form C, research into practice at four crematoria in different parts of the country revealed the extent to which doctors had recorded on Form C that they had questioned persons other than the Form B doctor. For deaths occurring outside hospital, the percentage of deaths where the Form C doctor claimed to have seen and questioned a person who had nursed the deceased during the last illness or been present at the death varied between 52.6% and 89.6%. At one crematorium, there was no death in respect of which a Form C doctor had recorded having questioned relatives. It is highly likely, however, that some relatives had also given nursing care or been present at the death and had therefore been referred to in response to the preceding question. At another crematorium, relatives had been questioned in connection with 86.1% of deaths. There was little evidence of questions being asked of anyone other than nurses, those present at the death or relatives.

3.72 Because of the way in which the figures were presented, it is impossible to ascertain in what percentage of cases the certifying doctor had questioned a person falling within one of the four categories referred to in questions 5–8 of Form C. We now know (although it appears that the Brodrick Committee did not) that, at some crematoria, it has long been a requirement that the Form C doctor must have questioned someone other than the Form B doctor before authority for cremation is given. At other crematoria, no such requirement exists. That may account for the differences in practice between the four crematoria examined by the Brodrick Committee. I shall return to this topic in due course. Meanwhile, it is perhaps interesting to note that, in 1967 and 1968 (the years covered by the information), persons other than the Form B doctor were questioned in relation to deaths occurring outside hospital in more than 50% of cases at each of the four crematoria studied. In the absence of any requirement on the face of Form C to do so, the proportion today would be very significantly lower, negligible in some places.

3.73 The Committee observed that, in order for a completed Form C to be valid, and authority to cremate to be given, it was not necessary for any of the eight questions which Form C contained to be answered in the affirmative. It is true that the 1930 Regulations imposed no such requirement and no such requirement is contained on the form as prescribed. However, in practice, no standard version of Form C is issued and each crematorium produces its own. Over the years, some of these forms have come to include various explanatory marginal notes and other additional material. The Forms C issued by most, if not all, crematoria in England and Wales contain a note to the effect that affirmative answers should invariably be provided to questions 1, 2 and 4 (relating to whether the Form C doctor has viewed and examined the body and seen and questioned the Form B doctor). That would no doubt account for the fact that, at all four of the crematoria about which the Brodrick Committee had information, there was 100% affirmative response to those questions.

3.74 The Committee went on to observe that the Form C doctor, who knew nothing about the death, had two choices. Either he could complete Form C merely by reproducing the information provided by the Form B doctor or he could make extensive enquiries of his

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own. Members of the Committee concluded that most doctors chose the first alternative. They expressed concern about the failure to make enquiries personally, when coupled with the evidence that physical examination of the deceased by Form C doctors was frequently inadequate or non-existent. Thus, they observed, there was no independent element to the enquiry made by the Form C doctor.

3.75 The Committee concluded that, except where Form C was completed after an autopsy, it amounted to **'no more than a statement of confidence in the judgement of the Form B doctor'**. It will be recalled that this was a view that had been expressed by the 1903 Departmental Committee almost 70 years previously in relation to the Cremation Society procedures then in existence.

3.76 Information provided to the Brodrick Committee by crematorium medical referees demonstrated that they rarely used their powers to order an autopsy, to report a death to the coroner or to decline to allow a cremation for other reasons. The Brodrick Report recorded that, in 1966, there were 260,685 cremations (other information contained in the Brodrick Report and provided to the Inquiry by the Cremation Society of Great Britain suggests the figure may have been slightly higher). Out of that number, there were 136 cases where a medical referee ordered an autopsy, 171 cases where the death was reported by the medical referee to the coroner and 13 where a medical referee declined to allow a cremation. A small number of medical referees accounted for the vast majority of these cases; for example, the medical referee at Liverpool had referred 103 (out of the total of 171) deaths to the coroner in 1966.

3.77 The Committee concluded that, for most of the time and in most places, the giving of authority to cremate was little more than a formality following receipt of Forms B and C. Most medical referees did not have the time or the facilities to do more than satisfy themselves that the Form B doctor was in a position (having regard to the history of his dealings with the patient as disclosed on Form B) to diagnose the cause of death. The Committee observed that the system would have broken down long before if medical referees had taken a strict view of their responsibilities and had **'assumed that they were the first and last line of defence against undetected homicide'**. The Committee drew attention to the difficulties and anomalies of the role of medical referee, to which I shall refer later in this Report. In the Committee's view:

> **'It is hard to see that, in his present isolated role of "long-stop" against a threat which we believe to be virtually non-existent, the medical referee has a place within the integrated system of death certification and disposal which we have set ourselves to achieve.'**

The Recommendations of the Brodrick Committee

3.78 The Brodrick Committee proposed the wholesale abolition of the existing system of cremation certification. In doing so, the Committee pointed out that there was no evidence that the procedure had ever led directly to the exposure of a previously unsuspected crime. The effect of the recommendation was that all deaths not reported to the coroner would be dealt with alike, regardless of whether disposal was by burial or cremation.

3.79 Changes in the procedures relating to the certification of the medical cause of death were also recommended. In that regard, the Committee proposed that:

(a) The remit of the certificate should be extended to cover both the fact and the cause of death. In 1971 (as now), there was no official mechanism for recording the fact that death had been diagnosed.

(b) The certifying doctor should be fully registered. In 1971 (as now), a provisionally registered doctor could certify the cause of death and problems had been caused by such inexperienced doctors performing the task unsupervised.

(c) The certifying doctor should have seen the deceased at least once during the seven days before death. In 1971 (as now), the relevant period was 14 days.

(d) The certifying doctor should be obliged to inspect the body before certifying the fact and cause of death. In 1971 (as now), the doctor was not required to inspect the body after death if he had seen the deceased within the 14 days preceding death.

(e) The certifying doctor should issue the certificate only if **'confident on reasonable grounds that he can certify the medical cause of death with accuracy and precision'**. This was to replace the requirement (still applicable) that the doctor should state a cause of death which was true to the best of his knowledge and belief.

(f) A doctor who had attended the deceased in life, or was called to attend and found him/her dead, should, if unable to certify the cause of death, report the fact of death to the coroner. In 1971 (as now), there was no statutory duty on a doctor to make a report to the coroner in circumstances where a death was reportable. The effect of the Committee's recommendations would have been to impose such a duty.

(g) The doctor should follow up a report to the coroner by sending to him the certificate of fact and cause of death, containing as much information about the death as the doctor was able to provide.

(h) A new certificate of the fact and cause of death should be introduced, incorporating a number of changes.

I observe that, even if these changes had been implemented, the system of death certification would still have been dependent upon the integrity of a single doctor.

3.80 The Committee was satisfied that the changes in the procedures for the certification of the medical cause of death would achieve a significantly higher degree of certainty that the cause of death had been accurately established before registration of the death than had previously been the case. Thus, the changes would provide an adequate safeguard, even in a death followed by cremation, where the body would not be available for further examination in the future. The Committee urged that all the recommendations which it had made should be implemented at the same time and as soon as possible. The Report went on to say this:

> **'But if, for any reason, there is a likelihood that the changes may be deferred for a considerable period, we recommend that Form C ... should be abolished without delay. We have already indicated that** [*sic*] **the**

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> **reasons why we consider that this certificate may be abolished with complete safety and we believe that the existing Regulations (minus the reference to this certificate) can adequately protect the public interest until the introduction of the changes** [*i.e. the changes to the certification of the medical cause of death*] **which we have recommended in Part I.'**

3.81 The Report of the Brodrick Committee was presented to Parliament in November 1971.

The Period from 1971 to 1977

3.82 The reference in the Brodrick Report to the possibility that implementation of the recommendations relating to certification of the medical cause of death might be deferred for a considerable period proved prophetic. Despite the passage of over 30 years since publication of the Report, the systems of death and cremation certification remain virtually unchanged today. It is necessary to examine the subsequent history in order to understand why the recommendations contained in the Report never became law. Examination of the history may also help those who have to consider the implementation of the reforms that will be proposed in this Report and those that appear in the Report of the Coroners Review. The history demonstrates that there are competing interests that may never be reconciled. Progress towards implementation may depend upon a willingness to take a definite policy decision, regardless of objection from some quarters.

3.83 The first issue to be decided within Government was how to take forward the recommendations. They fell into two groups. The first group comprised those matters relating to medical certification of the fact and cause of death (or 'medical certification'); those were the province of the General Register Office (GRO). The second group consisted of topics that were within the responsibility of the Home Office, namely those relating to cremation procedures and coroners. The GRO, which fell within the remit of the then Department of Health and Social Security (DHSS), intended to implement the recommendations relating to medical certification by effecting amendments to the legislation governing the registration of births and deaths.

3.84 In June 1972, it was decided that the best way of dismantling the cremation certification system was to repeal section 7 of the Cremation Act 1902, which required the Home Secretary to prescribe the form of certificates to be given before cremation could take place. The existing Regulations could then also be repealed. It was suggested that a suitable clause might be inserted into the Bill by which the GRO intended to effect the amendments relating to medical certification. It was hoped that the Home Secretary would support the inclusion of the Bill in the Parliamentary legislative programme. The intention was to get a paper to the Home and Social Affairs Committee by the autumn and seek the Committee's authority to proceed.

3.85 The GRO prepared draft recommendations for changes to the registration legislation but the Home Office timetable slipped. It was not until August 1973 that the Home Office circulated a draft memorandum on the recommendations contained in the Brodrick Report.

3.86 Circulation of the memorandum provoked a response from the DPP, who was opposed to abolition of the existing cremation certification procedures without some alternative

safeguard. He had suggested that, if the cremation certification procedure were to be abolished, there should be a new type of confirmatory certificate in cases where a cremation was to take place. GRO and Home Office officials took the view that there was no reason to suppose that any proposed system for a second certificate would be effective in preventing the concealment of homicide.

3.87 In late May or early June 1974, a meeting took place between the DPP and officials from the Home Office and the GRO. At that meeting, there was discussion about the value of the various procedures carried out by the Form C doctor. In a subsequent memorandum, written by Mr Stotesbury (the Home Office representative at the meeting), he recorded that, at the meeting, the DPP had asserted that an important feature of the Form C procedure was that the second doctor could find out about the circumstances surrounding the death by questioning the Form B doctor, nursing staff and relatives. Mr Stotesbury pointed out that Form C allowed the second doctor to do this, but did not compel him to do so. He was sceptical about the value of questioning the Form B doctor and observed that a requirement that a third person must be questioned in every case would be **'a monstrous interference of** [*sic*] **privacy which Parliament would reject'**. In a letter to the DHSS, Mr Stotesbury observed that the requirement would add to the distress of relatives and might perhaps lead to further increase in the fees charged by Form C doctors. In the light of the recommendations made by the Brodrick Committee, Mr Stotesbury did not believe that insistence on the questioning of a third person (other than the Form B doctor) was politically viable. In response to that letter, Mr Yellowlees, then Chief Medical Officer, agreed with Mr Stotesbury's observations and expressed the additional concern that the questioning would take up a considerable amount of the Form C doctor's time and was likely to be considered by most doctors **'a wearisome formality'**. His view was that the questioning was likely to be conducted as perfunctorily (and, consequently, be as valueless) as the physical examination of the deceased carried out by the Form C doctor. The correspondence between Mr Stotesbury and Mr Yellowlees was shown to the DPP, who said that his views had been misunderstood. He had not suggested that it should be a requirement that the Form C doctor should make enquiries of the deceased's relatives or another third person. In a letter to the Home Office, he observed, **'The occasions when he** [*the Form C doctor*] **found it necessary himself to question relatives etc would, I should expect, be comparatively infrequent.'** However, he adhered to his previous view that, in cases of cremation, there should be a confirmatory certificate from a second doctor. The Hon Dr Shirley Summerskill MP, Parliamentary Under Secretary of State at the Home Office (herself a former general practitioner), shared the DPP's view. Efforts were therefore made to find a solution acceptable to all.

3.88 In May 1975, after discussions with the DHSS, the Home Office proposed that, for deaths occurring outside hospital only, a second medical certificate should be provided. The certificate would be given by a doctor who would see the MCCD, view the body and certify that he saw no reason to disagree with the medical cause of death as stated on the MCCD. The second doctor would be a member of a panel of experienced doctors, appointed for the purpose by the cremation authority. The DPP signified his agreement to that proposal. Doubts about the proposal were, however, raised by officials in the Scottish Home and

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Health Department. They pointed out that the Crown Agent (the Scottish equivalent of the DPP) took the view that the confirmatory cremation certificate was needed just as much for hospital deaths as for deaths in the community. A query was also raised as to who, following the abolition of the post of medical referee, would be responsible for scrutinising the new type of confirmatory certificate.

3.89 In August 1975, The Rt Hon Mr Roy Jenkins MP (later Lord Jenkins of Hillhead), then Home Secretary, announced, by way of written answer to an arranged Parliamentary question, that the Government accepted the Brodrick Committee's recommendations for a new system for medical certification and the abolition of the existing cremation procedures. He signified the Government's intention to introduce a confirmatory certificate as agreed with the DPP. He also made clear that most of the recommendations of the Brodrick Committee in relation to coroners were accepted. He indicated that the Government proposed to open discussions with various interested organisations and to consider what procedural reforms might be achieved, in advance of legislation, through the use of existing statutory powers.

3.90 The Home Office decided to deal first with the recommendations relating to coroners. To this end, a Working Party was set up and held its first meeting in January 1977. Its deliberations dealt only with coronial matters and did not extend to cremation certification. No progress was made on that aspect of the Brodrick recommendations.

The Period from 1978 to 1988

3.91 In August 1978, a meeting took place between officials of the Home Office and the GRO to discuss the introduction of legislation to implement the recommendations of the Brodrick Committee. A new DPP was then in post and Home Office officials intended to discover whether he would reconsider the requirement, insisted on by his predecessor, for a confirmatory medical certificate for cremations following deaths in the community. In October 1978, The Rt Hon Mr Merlyn Rees MP (later Lord Merlyn-Rees), then Home Secretary, in a written answer to a Parliamentary question, said that discussions subsequent to his predecessor's (i.e. Mr Jenkins') written answer, given more than three years previously, had revealed widely divergent views about the proposal for the new confirmatory certificate. He was considering whether any alternative arrangements could be suggested which might meet with more general approval.

3.92 By December 1978, it had been agreed that the recommendations relating to medical certification of the fact and cause of death should be progressed, with a view to presentation of a Bill in the 1979/80 Parliamentary session. Home Office officials suggested that the GRO should take the lead in relation to the proposed Bill, although the Home Office would assist as necessary on matters relating to cremation certification and coroners' functions. In the event, the GRO failed to secure Parliamentary time for its Bill.

3.93 In March 1979, the Home Office received notification that the DPP took the same view as his predecessor, namely that there should be a confirmatory certificate in cremation cases following deaths occurring in the community. It seemed, therefore, that there was going to be no easy way to carry forward the Brodrick Committee's proposal to abolish the

cremation certification procedure. In August 1979, a Committee (known as the 'Ad Hoc Committee'), representing the cremation organisations and the National Association of Funeral Directors, had a meeting with Home Office officials. The Ad Hoc Committee wanted the Home Office to implement, without further delay, the Brodrick Committee's recommendation that Form C be abolished. Members of the Ad Hoc Committee claimed that the costs associated with cremation were excessive and unacceptable and that, as a consequence, the rate of increase in the number of cremations was slowing down. They were perturbed to hear that the recommendation for abolition might not be implemented at all because of the DPP's objections. They had believed, following Mr Jenkins' Parliamentary answer in 1975, that the Government was committed to abolition.

3.94 Following the meeting, the Ad Hoc Committee lobbied members of the House of Commons and the House of Lords, pressing for a change in the law. The Committee also put forward a simpler and less expensive alternative to the existing cremation certification system. These steps led to a further meeting, in March 1981, attended by Mr Timothy Raison MP (later The Rt Hon Sir Timothy Raison), then Minister of State at the Home Office, Sir George Young MP (later The Rt Hon Sir George Young), then Mr Raison's opposite number at the DHSS, the Deputy DPP, representatives from the BMA, the Association of Chief Police Officers (ACPO), the GRO and members of the Ad Hoc Committee, together with various departmental officials. The meeting produced general agreement that the system of death certification should be improved. However, the division of opinion about the value of the certification system in general, and Form C in particular, remained. The representatives of the BMA and ACPO took the view that the system provided a valuable deterrent and should be retained in all cases. The Deputy DPP argued for its retention for deaths occurring outside hospital. The DHSS supported abolition of Form C, but wanted a requirement that Form B should be completed by a doctor of not less than five years' standing. The GRO stressed the need for medical certification to be strengthened, in accordance with the Brodrick Committee's recommendations, before any changes to the cremation certification system were made. There was little support for the alternative system which had been put forward by the Ad Hoc Committee. At the conclusion of the meeting, no agreement had been reached. Mr Raison suggested that Home Office officials should consider further the proposal that Form C should be dispensed with for deaths occurring in hospital.

3.95 In early 1981, a Private Member's Bill (later the Industrial Diseases (Notification) Act 1981) was introduced. The Bill sought to place a statutory requirement on doctors to report to the coroner deaths that might have been caused or contributed to by the deceased's former employment. This Bill was introduced by Mr Nigel Spearing MP and eventually resulted in the addition of the 'Spearing box' to the MCCD. The certifying doctor was to tick this box if he had any reason to believe that the death was or might have been caused by the employment followed at any time by the deceased. During the course of the Bill's passage through Parliament, there was general agreement among those involved that the Brodrick Committee's recommendations relating to medical certification of the fact and cause of death should be implemented without delay. In its final form, the 1981 Act enabled the Registrar General to make Regulations concerning the notification and certification of death and for the recording of the information relating to industrial diseases and matters related thereto.

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3.96 Later that year, Mr Raison wrote to Mr Geoffrey Finsberg MP (later Lord Finsberg of Hampstead), then Parliamentary Under Secretary of State at the DHSS, to enquire whether there was any prospect of a Bill being brought forward to implement the Brodrick Committee's recommendations. Mr Raison observed that the Home Office was particularly anxious to see the recommendations implemented since it was hoped that this would pave the way for abolition of cremation Forms B and C.

3.97 In November 1981, it became evident that the GRO Medical Advisory Committee disagreed with some of the Brodrick Committee's recommendations about medical certification of the fact and cause of death. In particular, the Medical Advisory Committee could see nothing to be gained by reducing the period within which the certifying doctor must have seen the deceased from 14 to 7 days preceding death. In addition, the Committee found the requirement that a certifying doctor should state the cause of death **'with accuracy and precision'** totally unacceptable. There were serious doubts, the Committee said, as to whether the requirement would be accepted by the medical profession as a whole.

3.98 On 10th November 1981, Mr Finsberg wrote to Mr Raison, informing him that the DHSS intended to ask the Registrar General to consult the medical profession on revised proposals, which reflected the views of the Medical Advisory Committee. The revised proposals omitted the provision that doctors should certify the cause of death **'with accuracy and precision'**. This suggestion caused dismay at the Home Office. Mr Raison wrote a letter in reply, pointing out that the effect of demanding **'accuracy and precision'** on the part of certifying doctors would, according to the Brodrick Committee, be to improve the accuracy of death certification. That would be a laudable aim in itself. In addition, if the terms of the declaration on the MCCD were to remain unchanged, as the DHSS was proposing, this would make it much more difficult to press ahead with abolition of the cremation certification procedures in the future. He urged that, rather than conceding the point at this stage, there should be consultation on the declaration, as on other aspects of the Brodrick Committee's recommendations. In a letter dated 16th December 1981, Mr Finsberg agreed to ask the Registrar General to include the issue within the package of consultations to be undertaken. He drew attention to the concern within the GRO that there were many doctors who, if required to certify the cause of death **'with accuracy and precision'**, might refuse to sign the certificate at all. If that happened in too many cases, he said, the system would be **'wrecked'**.

3.99 During 1982, the GRO and the Home Office carried out a consultation exercise in connection with the proposals. The GRO dealt with the medical profession and the Home Office consulted with the Coroners' Society and local authority associations. The medical profession took the same view as the GRO Medical Advisory Committee about the two issues to which I have referred, i.e. the period of time before death within which the certifying doctor should have seen the deceased and the terms of the declaration on the new MCCD. By December 1982, Home Office officials, like the GRO and the DHSS, had apparently accepted that those two recommendations of the Brodrick Committee would have to be abandoned. Those recommendations had, of course, formed an important part

of the Brodrick Committee's plans to strengthen the system of medical certification. The major recommendations still remaining were as follows:

(a) The certifying doctor should be fully registered.

(b) The certifying doctor should inspect the body before completing the new MCCD.

(c) The attending doctor should either certify the cause of death or report the case to the coroner.

(d) There should be a statutory requirement on the doctor to report a death to the coroner in an appropriate case.

It was decided to proceed with a Bill containing those provisions.

3.100 At about this time, two further areas of dissent emerged. The BMA objected to the proposal that only fully registered doctors should be entitled to complete the new MCCD. Representatives of the BMA contended that doctors with provisional and limited registration working in hospital should be permitted to certify, provided that the name of the consultant in charge of the deceased's care appeared on the MCCD. Furthermore, the BMA contended that there should be no requirement that a certifying doctor should have seen the deceased's body after death, provided that he had seen the deceased within the 14 days preceding death and provided also that a second doctor, who had shared the care of the deceased in life, had inspected the body after death and the two doctors had discussed and agreed upon the cause of death. This was a wholly new proposal, which would have catered for the situation where it was inconvenient or impossible for the attending doctor to view the body after death.

3.101 In March 1983, the then Registrar General expressed some concern that, if all the BMA's proposals were accepted, the new system would fall far short of the recommendations of the Brodrick Committee and might, as a result, be the subject of criticism. Despite those concerns, work on the proposed legislation continued on the basis of the BMA's proposals. Parliamentary time for the Bill was provisionally granted for the October 1983 session and preparations were made to instruct Parliamentary Counsel to draft the necessary Bill. However, a general election intervened.

3.102 Following the general election, tension arose between the DHSS and the Home Office in relation to implementation of the Brodrick Committee's recommendations. Mr David Mellor MP (later The Rt Hon David Mellor), then Parliamentary Under Secretary of State at the Home Office, was concerned about what he termed the 'scandal' of the charges levied by doctors for completing cremation Forms B and C. By that time, the combined cost of the two forms exceeded the death grant payable to a bereaved family. Mr Mellor wanted to see the cremation procedure simplified by the removal of the requirement for Form C. He saw the proposed changes to the medical certification of the fact and cause of death as a lever which could be used in future negotiations to simplify the arrangements for cremation certification.

3.103 Meanwhile, Mr John Patten MP (later Lord Patten of Wincanton), then Parliamentary Under Secretary of State at the DHSS, had decided to abandon the Bill which had previously been planned. Even after the concessions that had been made in relation to the original

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Brodrick recommendations, there was outstanding disagreement between the GRO and the medical profession about the detail of the proposed new system. There was concern that doctors might demand a fee for completing the newly designed MCCD, which would have considerable financial implications for the DHSS. It appears that there was not the political will to impose the Brodrick proposals, even as diluted by the agreed concessions. Mr Patten decided that, instead of proceeding with the Bill, his Department's efforts should be directed at effecting amendments to the existing MCCD by adding the 'Spearing box', together with a requirement that, for a hospital death, the consultant responsible for the deceased's care should be identified. Those changes did not require legislation and a new form of MCCD was introduced the following year.

3.104 In June 1984, Mr Patten and Mr Mellor met. Mr Patten indicated that there was no immediate question of a change in his decision to abandon the Bill. The future of the cremation procedures was discussed. It became clear that the DHSS was reluctant to enter into a battle with the BMA over the issues of certificates and fees. It was therefore agreed that the Home Office would initiate discussions with the BMA. Mr Mellor indicated his intention to take a **'tough approach'** to the negotiations.

3.105 A meeting between Mr Mellor, Home Office officials and representatives of the BMA took place in October 1984. At the meeting, the BMA maintained their previous stance that the involvement of the second doctor and the medical referee constituted important safeguards for the public. The BMA made the point that any change to the cremation procedures would have to be in the context of a complete revision of the medical certification system. The BMA prevailed and no step was taken to abolish Form C.

3.106 In 1985, the Regulations governing cremation were amended. The Cremation (Amendment) Regulations 1985 provided that, where a deceased was a hospital in-patient at the time of his/her death, and where a post-mortem examination had been carried out and the results were known to the attending doctor before he completed Form B, no confirmatory Form C would be required. A new question (8A) was added to the prescribed Form B. The question did not require the certifying doctor to state the result of the post-mortem examination. The intention was to reduce the number of cases in which a Form C would be required and thus to reduce the cost to the public.

3.107 The Regulations ran into difficulties. In order for the new provision to apply, the doctor carrying out the post-mortem examination had to be a registered medical practitioner of at least five years' standing. Many hospital post-mortems were performed by trainees, who did not fulfil that requirement. It soon became apparent that some doctors were taking no steps to inform themselves of the results of any post-mortem examination carried out before completing Form B. Thus, Forms C were being completed where there was in fact no need for a confirmatory certificate. Even when the Form B doctor had indicated on Form B that he was aware of the results of a post-mortem examination, Form C was often completed. As a consequence of these problems, the number of Forms C provided was not reduced to the extent that had been hoped.

3.108 In February 1985, Mr Johnson, an official at the Home Office, wrote to all medical referees. The Home Office had conducted a survey of the work of medical referees during the 12 months ending 31st March 1984. Completed questionnaires had been received from 186

crematoria, which had carried out a total of 360,842 cremations during the relevant period. Of these, 273,335 cremations had been authorised by the medical referee following receipt of Forms B and C; the remainder had been authorised following receipt of a coroner's Form E.

3.109 Medical referees were asked how frequently they had raised queries with the doctors completing Forms B and C. The results of the survey revealed widely differing practices. One medical referee reported that he had raised 7136 separate queries in connection with 2914 cremations. Another had authorised 701 cremations and raised no questions at all. Out of the 273,335 cremations authorised on the basis of Forms B and C, 1701 queries had been raised in connection with the cause of death. On 182 occasions, enquiries initiated by medical referees had resulted in the cause of death being changed. Medical referees had ordered autopsies in 93 cases and had reported 367 deaths to the coroner.

3.110 Many medical referees were critical of the poor standard of completion of Forms B and C. The majority view was that Form C served little useful purpose. Errors in Form B often went uncorrected by the Form C doctor and Form C still appeared to be merely a statement of confidence by one doctor in another. By way of an alternative system, medical referees favoured abolition of Form C, the introduction of a more detailed Form B and personal enquiry by the medical referee.

3.111 During 1987 and 1988, there were discussions between the Home Office, the DPP and the Solicitor-General about possible abolition of cremation Form C. Mr Douglas Hogg MP, who was by that time Parliamentary Under Secretary of State at the Home Office, was keen to abolish Form C. The discussions foundered since both the Law Officers were prepared to countenance abolition only if it were accompanied by an improved medical certificate of the fact and cause of death or by additional safeguards which were judged by the Home Office to be unworkable. The DHSS was also opposed to abolition of Form C in the absence of improved medical certification. The BMA remained implacably opposed to abolition. In November 1988, the Home Office took the decision to abandon its attempts to abolish Form C until the GRO had effected changes to the procedure for certification of the medical cause of death. However, that decision was not accompanied by any attempt to strengthen the Form C procedure, so as to ensure that it served the purpose for which it was originally intended, namely the exposure of concealed homicide. Despite the stance taken by the Law Officers, the Home Office continued to accept the view of the Brodrick Committee that the risk of concealed homicide was minimal.

3.112 In December 1988, the Department of Health (DoH) published a Green Paper, 'Registration: a Modern Service', dealing with reform of the registration service. The Green Paper included proposals that:

- A statutory duty should be placed on doctors to report to the coroner all unnatural deaths.
- The right to issue a medical certificate of the fact and cause of death should be restricted to a medical practitioner who had seen the deceased at least once during the 14 days preceding death and who had inspected the body after death.

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3.113 The total effect of the changes proposed was very much more limited than that which would have resulted from implementation of the entire package of recommendations contained in the Brodrick Report.

The Draft Cremation Regulations of 1989

3.114 Draft Cremation Regulations were circulated for consultation in June 1989. These had been under consideration for some time. Mr Robert Clifford, Head of the Coroners Section of the Animal Procedures and Coroners Unit (formerly the Animals, Byelaws and Coroners Unit) of the Home Office since 1995, gave oral evidence to the Inquiry. He said that he understood that Home Office lawyers had been advising for several years that the Cremation Regulations, which had been amended on several occasions since 1930, should be consolidated and revised. The proposed Regulations, as drafted, were mainly consolidating in nature, although they did contain some changes of procedure. The draft Regulations included a requirement that the Form C doctor must not have been concerned with the case or the treatment of the deceased during his/her last illness. A revised version of Form C was proposed. This required the certifying doctor to state (in response to questions 1, 2 and 4(a)) whether he had seen the deceased's body, made a careful examination of it and questioned the Form B doctor and, if not, why not. A note to the proposed Form C stated:

> **'For a cremation to be authorised without further enquiry, questions 1, 2 and 4(a) must be answered in the affirmative.'**

3.115 By Schedule 3 to the draft Regulations, where Form C had been completed, the medical referee, before giving authority to cremate, was obliged to satisfy himself that the answers to questions 1, 2 and 4(a) were in the affirmative or, if not, that there were satisfactory reasons why not. This provision, if implemented, would have given regulatory force to a requirement that existed at all, or virtually all, crematoria in the land. The draft Regulations contained no similar provision in relation to enquiries to be made of persons other than the Form B doctor, nor did the doctor completing Form C have to state why no such enquiries had been made.

3.116 The exercise of consulting on the draft Regulations raised the familiar arguments about the need to abolish the procedures for cremation certification, together with other specific objections to the proposals. No progress was made and the draft Regulations were never implemented.

The Period from 1990 to the Present

3.117 The 1988 Green Paper was followed by a White Paper, 'Registration: proposals for change', which was published by the DoH in January 1990. This White Paper repeated the two significant proposed changes to the system of medical certification that had been contained within the Green Paper. However, following publication of the White Paper, attempts to secure Parliamentary time for a Bill were unsuccessful and other events intervened, with the result that the amendments to legislation proposed in the White Paper never reached the statute book.

3.118 In 1993, spurred on by yet further pressure from the cremation organisations, the Home Office initiated another series of consultations in an attempt to obtain agreement to the abolition of Form C. Those consultations did not include the BMA, whose stance was by that time well known. Despite that omission, no clear consensus was reached and the matter was not pursued.

3.119 Throughout the mid-1990s, it remained an objective of the Home Office to effect amendments to the Cremation Regulations. Legal advice, by then well over a decade old, had been to the effect that the existing Regulations required consolidation and amendment. Overhaul of the Regulations would give the opportunity to up-date procedures and, it was hoped, might result in the abolition of Form C. In 1996, Home Office officials discussed the possibility of approaching Ministers to seek agreement for another consultation exercise. Mr Clifford told the Inquiry that the proposal never reached Ministers, as the Department could not afford the expenditure of the time and effort required to mount another major consultation exercise. In any event, it must have been recognised that such an exercise was unlikely to produce any consensus. If significant change were to have been effected, it would have required the political will to override the views of those who dissented from the Government proposals.

3.120 In November 1997, the Home Office became aware of a survey that had been carried out by the Home and Health Department of the Scottish Office three years earlier. The Department had inspected 24 sets of cremation forms submitted to each crematorium in Scotland during a calendar year. The forms were chosen at random by means of cremation numbers submitted by the crematoria in their annual returns to the Federation of British Cremation Authorities. The survey revealed many defects in the way the forms had been completed. This in turn gave rise to concern that the medical referees had, despite those defects, passed the forms and authorised cremation. Examples of the matters which gave rise to concern were:

(a) Forms B and C were in some cases signed by doctors who worked in close proximity to each other and could not be said to be truly independent.

(b) Some deaths which should have been reported to the procurator fiscal (the Scottish equivalent of the coroner) had not been.

(c) Questions in Form B were frequently left unanswered or misinterpreted.

(d) Forms C had not always been submitted when the Regulations required it. Conversely, in other cases (where there had been a hospital autopsy and the Form B doctor was aware of the results) Forms C were submitted (and presumably charged for) where there was no requirement.

(e) In some cases, none of questions 2–5 of Form C (the equivalent of questions 5–8 on the English version) had been answered in the affirmative.

3.121 In September 1995, following the survey, a letter was written to all medical referees and deputies in Scotland, drawing their attention to the concerns arising from the survey. The letter reminded referees that at least one of questions 2–5 should be answered in the affirmative unless the form was completed by a pathologist who had completed an

autopsy. At the conclusion of the letter, referees were reminded that they were **'the last line of defence against the possibility of suspicious circumstances'** and that they should ensure that no cremation took place unless the forms had been properly completed. The letter was later reproduced in a Health Bulletin circulated to all doctors in Scotland.

3.122 The Home Office recognised that a similar problem of poor completion of cremation forms might well exist in England and Wales. Consideration was therefore given to the possibility of carrying out a similar survey and, indeed, preliminary steps were taken to explore the possibility of funding for such a survey, to be carried out with the assistance of the DoH and the Office for National Statistics (ONS). No funding was then available. The survey project continued to be discussed but was overtaken by events. Mr Clifford told the Inquiry that the Home Office wished to clarify whether the existing procedures were being properly observed and, if not, whether the failure to observe them was having an adverse effect. It was not clear how it was intended that the presence or absence of such an effect was to be assessed. As matters turned out, however, the necessary evidence was indeed forthcoming. It was provided by Shipman.

3.123 In September 1998, Shipman was arrested and, in 1999, the Home Office became aware of the fact that many of his probable victims had been cremated. Immediately following Shipman's conviction, a Home Office official wrote to all medical referees, reminding them, in the light of the Shipman case, to be vigilant at all times. Referees were also reminded of their power to make their own enquiries and to refer cases to the coroner for further investigation.

3.124 In 2000, the Cremation (Amendment) Regulations were introduced in order to enable separated body parts to be cremated where the remainder of the body had previously been buried. This followed the discovery that a large quantity of organs and tissues removed during autopsies had been retained at the Bristol Royal Infirmary and the Royal Liverpool Children's NHS Trust (Alder Hey Children's Hospital). Organs and tissues were returned to the parents of the dead children concerned and arrangements for burial and cremation were necessary.

3.125 Meanwhile, shortly after Shipman's conviction in January 2000, the Home Office set up a Review into Death Certification. Under its Terms of Reference, the Review was to consider, among other things, improvements to the provisions for authorising cremation. The Review issued a Consultation Paper in July 2000 and reported finally in September 2001. I have taken account of its thought-provoking recommendations.

3.126 In February 2001, this Inquiry was set up, with Terms of Reference which include consideration of the ways in which the existing arrangements for death and cremation certification should be changed in order to provide improved protection of patients. In the summer of 2001, the Home Office set up the Coroners Review, to which I have already referred. The Coroners Review was given wide-ranging Terms of Reference, covering all aspects of arrangements for death investigation and certification. I shall refer to the recommendations of the Coroners Review in Chapter Nineteen.

3.127 In early 2003, after Mr Clifford had given oral evidence to the Inquiry, Home Office officials met representatives of the cremation organisations and medical referees to discuss ways

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in which cremation procedures might be improved in the short term, pending any changes to the law consequent upon the recommendations of this Inquiry and the Coroners Review. The Inquiry has been told that, following that meeting, a number of measures have been proposed. The Home Office is considering giving advice to cremation authorities, relating to the selection of nominees for the post of medical referee. Induction and guidance material is to be prepared and provided to medical referees. There are proposals for joint seminars between medical referees and coroners. In addition, the Home Office intends to explore the possibility of introducing a general requirement that Form C doctors should question a person other than the Form B doctor before signing the confirmatory certificate. I shall refer to this topic at greater length in Chapter Eleven.

3.128 At present, however, despite attempts over the years to effect change, the system of cremation certification remains more or less the same as when it was first introduced a century ago. In Chapter Eleven, I shall discuss how the system works in practice and my recommendations for the future.

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CHAPTER FOUR

The Functions of the Police, Ambulance Services, General Practitioners and Deputising Doctors in the Immediate Aftermath of a Death in the Community

Introduction

4.1 When a death occurs in a hospital, hospice or care home, there are professionals on hand who know what action to take. However, when a death occurs at home, the relatives, friends or carers of the deceased often do not know what to do or what is expected of them as their legal duty. Often, their first concern is to know whether or not death has in fact occurred. There is no single agency or authority with primary responsibility for responding to the occurrence of a death. The ambulance service might be summoned if it is thought that the deceased might not be beyond resuscitation. The police might be called, especially when the death has occurred suddenly. In other cases, relatives might contact the deceased's general practitioner and, depending on the circumstances and time of day, either the general practitioner or a doctor from a deputising service might attend.

4.2 The legal position is that there is no general obligation to report a death to the police. Of course, if it appears that the death was due to a criminal act or resulted from a road traffic accident or an accident at work, the police will be summoned. Nor is there any legal requirement that a doctor should confirm the fact that life is extinct. If a medical practitioner is willing and able to issue an MCCD, the relatives can register the death and arrange for the disposal of the body. If there is no medical practitioner willing and able to issue an MCCD, the death must be reported to the coroner.

4.3 Because the reactions of the bereaved to the death cannot be predicted or controlled, the public services and medical profession recognise that there must be a degree of flexibility in the ways in which they respond to calls from the families of the recently deceased. In this Chapter, I shall examine the functions of the medical and emergency services in the immediate aftermath of a death in the community. I have chosen to deal with the ambulance service first, then the police and, finally, the general practitioners and deputising services. However, it must be recognised that there are many occasions on which neither the police nor the ambulance service is called. There are also some deaths in which the police, the ambulance service and a doctor are all involved.

The Role of the Ambulance Service

The Greater Manchester Ambulance Service

4.4 The Inquiry's investigations into the role of the ambulance service have focussed mainly on the work of the Greater Manchester Ambulance Service NHS Trust (GMAS). This is because the area of Hyde is covered by GMAS.

4.5 Although precise figures are unavailable, it seems that between 1% and 2% of all calls received by GMAS relate to patients who are dead at the time of arrival of the ambulance.

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When called to attend a patient who appears to be dead, the GMAS crew will first determine whether resuscitation is possible, using criteria laid down in an established protocol. They will enquire of those present as to the circumstances of the collapse or discovery of the body. If they decide that resuscitation might be possible, the appropriate resuscitation procedures will be commenced and the patient will be taken to the nearest hospital with an accident and emergency department. If, however, in cases where the protocol applies, the paramedics confirm that the patient is dead, they do not take the body to hospital. They will ask Ambulance Control to contact the police if there is any suspicion of criminal involvement in the death. If there is not, Ambulance Control will attempt to contact the deceased's general practitioner to ascertain whether or not s/he is willing and able to issue an MCCD. If the general practitioner is willing and able to do so, the ambulance crew will complete their documentation and, after ensuring that the relatives present are able to cope with their difficult situation, they will leave. If the general practitioner cannot be traced or will not attend, arrangements will be made for Ambulance Control to contact the police.

4.6 Prior to 1993, ambulance personnel in Greater Manchester were not authorised to confirm that a patient was dead. When they believed that the patient had died, they had to summon a doctor to confirm that death had occurred. Whenever there was a delay in the arrival of the doctor (whether general practitioner or deputising doctor), the practice was for the deceased's body to be transferred by ambulance to the local hospital for confirmation of death and then to the hospital mortuary for formal identification procedures to be performed. This was recognised to be wasteful of resources and unnecessarily distressing for the bereaved family. Following a successful pilot scheme set up in 1992, a protocol covering the Greater Manchester area came into force in 1993. This protocol, which remains in force subject to minor changes, provides essentially that, when ambulance personnel are satisfied that an adult (but not a child) has died on private premises (as opposed to in a public place), they should call out the deceased's general practitioner or, if s/he is unavailable, the police. They are then free to carry on with their other duties. It is left to the discretion of the attending ambulance personnel whether or not they leave the scene before the police or doctor arrive. The ambulance crew are encouraged to depart the scene only if satisfied that the needs of the family do not require them to remain. In practice, the crew often remain at the scene until the arrival of the police or general practitioner.

4.7 This protocol appears to have worked well. I was impressed by the evidence of the ambulance personnel who came to the Inquiry. They appeared to know what to do and how to do it. They seemed able to provide a degree of sympathetic reassurance to the family of the deceased. They also appeared to me to complete their paperwork, on which their decisions and actions are recorded, to a high standard.

4.8 There have been discussions between GMAS and Greater Manchester Police (GMP) about the circumstances in which ambulance personnel might be required to remain at the scene of a death if there are potentially suspicious circumstances. Difficulties have arisen in defining such circumstances and in determining the period for which ambulance personnel should be required to await the arrival of the police. Such discussions have been suspended and await any recommendations of this Inquiry.

Ambulance Services in Other Areas

4.9 Although many ambulance trusts have adopted policies that permit the ambulance crew to confirm that death has occurred and to leave the scene when a delay in the attendance of a doctor or the police is anticipated, this is not the universal position. National training manuals provide that, where delay in the attendance of a doctor is likely in the case of a death at home, the deceased should be removed **'directly to hospital'**. Of 14 other ambulance trusts canvassed by the Inquiry, most – but not all – have a policy similar to that of GMAS. It follows, therefore, that, in some areas, where there is delay in awaiting the attendance of a doctor, the ambulance crew have to remain at the scene and, in some cases, they convey the body to hospital for the fact of death to be confirmed.

4.10 As I shall explain later in this Chapter, in some areas where paramedics have a protocol which allows them to confirm the fact of death in an adult, the ambulance service is, on occasions, called out specifically for that purpose. I shall consider later whether or not this is an appropriate use of its resources.

Police Attendance at the Scene of a Death

4.11 The Inquiry learned that policies relating to the attendance of the police at the scene of a death vary from area to area. Because of its involvement in the investigation of Shipman, the procedures of the GMP have been closely scrutinised. In some respects I shall be critical of their procedures and practices. I must stress that I do not think that the problems I shall outline exist only in the GMP; indeed it appears to me that they are probably widespread.

Initiation of a Report

4.12 Reports of death are usually made to the GMP by telephone. They are received by an operator in the Area Operations Rooms (AOR), who opens a computerised log, in which the progress of police involvement is recorded. Uniformed patrol officers are sent to the scene.

4.13 Many deaths are reported to the GMP, not because the person reporting believes that the circumstances of the death in question are suspicious of criminal involvement, but for other reasons. Detective Chief Superintendent (DCS) Peter Stelfox, GMP Head of Crime Investigation, said that these reasons include a misguided belief that there is an obligation to report. There is sometimes a request for assistance in gaining entry to premises, where there is concern for the occupant's welfare. On arrival, the police may find the occupant dead. Other examples involve requests for assistance in tracing next of kin and other relatives. The police have a valuable part to play in such cases. Sometimes, the police are asked for advice where people just do not know what to do. The police are called on in their general 'public service' role. In many such cases, the person finding the body could have chosen to contact the deceased's general practitioner or the ambulance service instead and, had they done so, it is quite likely that the police would never have known of the death because the general practitioner would have issued an MCCD.

4.14 On arrival, the police officers will seek to ascertain whether the person is in fact dead. If in doubt, they will summon an ambulance. If the officers find the person dead, but establish that no arrangements have been made for a doctor or paramedic to confirm life extinct, they will arrange this through the AOR.

Limitation of Police Involvement if a Doctor Will Issue the Medical Certificate of Cause of Death

4.15 Once a doctor or paramedic has been summoned to confirm the fact of death, GMP officers' next priority should be to assess what investigation, if any, is needed. However, on occasions, the officers will find that a doctor has already arrived at the scene or has promised to attend and to issue an MCCD. Once it is known that a doctor is prepared to issue an MCCD, police involvement ceases. The police do not regard themselves as having any further role to play, unless they remain involved for purposes such as contacting relatives or safeguarding property and premises.

4.16 The GMP Chief Constable's Order 98/47 and the GMP instruction manual (or blue book) both record in terms that if **'the deceased's own doctor will issue a death certificate, then our responsibility ends'**. The stated reasoning underlying the policy is that a doctor's preparedness to issue an MCCD means (almost by definition) that the death is natural and its cause is known. Certainly, no police officer would be expected to question the doctor's ability lawfully to issue. The doctor, as DCS Stelfox confirmed, 'outranks' the police officer. He said that he found it difficult to imagine circumstances in which a police officer might ask a doctor to explain his/her willingness to issue an MCCD.

4.17 DCS Stelfox was satisfied that the policy represents a perfectly logical course of action to take, in the absence of any trigger for suspicion. However, as he said, it would be dangerous for officers to adopt this approach as a matter of course, in circumstances where there might be some grounds for suspicion. It appears to me that good practice would require the attending police officer to make some brief enquiry and report as to the circumstances, even if s/he were told that a doctor was willing to attend to certify the cause of death.

4.18 The Inquiry obtained details of the policies and procedures of 12 police forces throughout the UK. The information obtained suggests that the practice in Greater Manchester is similar to that prevailing elsewhere. When the police are called out to a death and there is no obvious suspicion of criminal activity, police involvement (or in Scotland, involvement of the procurator fiscal) ceases as soon as it becomes known that a doctor is prepared to issue an MCCD. In some areas, written reports of the death are submitted to the coroner even where a doctor has certified the cause of death, but little, if any, forensic use is made of those reports.

Where There Is or Might Be No Doctor Who Will Certify the Cause of Death

4.19 If the GMP officer either knows that the doctor will not certify the cause of death or is uncertain of this, s/he is expected to assess the scene of the death, in order to establish whether there are signs of violence, unlawful entry or disturbance of property. The officer

should also obtain an account of the circumstances of the death or of the discovery of the body from anyone present.

4.20 The officer is also expected to carry out an examination of the deceased's clothing and of the exposed areas of the body. However, the evidence suggests that some officers are unwilling to undertake such examinations. Detective Chief Inspector (DCI) Kenneth Caldwell of GMP told me that attending police officers are very reluctant to touch and examine a dead body. This reluctance sometimes results in an officer failing to observe signs of violence that might suggest criminal involvement or at least an unnatural death. DCI Caldwell spoke of two cases in which uniformed officers had failed to detect such signs. In one case, obvious and unexplained injuries to the face and chest of the deceased were overlooked and the police internal report was endorsed to the effect that there were no visible injuries. In the second case, despite the presence of significant burns to the chest and face, the incident log was completed on the basis that there were no suspicious circumstances. In the event, it was found that the deceased in the first case had died of a self-induced drug and alcohol overdose. In the second case, the deceased had accidentally set himself on fire when smoking in bed. Either death might have been a case of homicide, in which case the consequences of overlooking such relevant evidence would have been very serious.

4.21 In the Northumbria police area, the attending officer is required, in all cases of sudden, non-suspicious deaths, to perform as thorough an examination as possible at the scene and again after the body has been stripped at the mortuary. However, this requirement represents the exception rather than the rule. In the event that no doctor will sign an MCCD, most forces seem only to require their officers to examine the bodies externally at the scene for signs of injury, perhaps requiring them also to loosen or even remove sufficient clothing to enable a thorough search for injuries to be made. In circumstances where it has been established that a doctor will certify the cause of death, there will usually be no examination of the body by the police. One police force advocates that only suitably qualified medical personnel should examine the bodies of deceased persons.

4.22 In Greater Manchester, if there is any ground for suspicion of criminal involvement, a supervising officer of the uniformed branch and an officer or officers from the Criminal Investigations Department are called. The scene is preserved and a criminal investigation is commenced. Some cases may initially be treated as suspicious, only for such suspicion to be eliminated within a short time.

Police Attitudes Towards Attendance at the Scene of a Death

4.23 It was clear from the evidence that officers of the GMP do not like attending the scene of a non-suspicious death, i.e. one that does not entail any criminal or road traffic investigation. In his witness statement, Detective Superintendent David Jones said that the attitude of police officers to attendance at non-suspicious deaths was influenced by the **'prevailing occupational culture surrounding such incidents, which created an unstructured, inconsistent and poor quality of response'**. I think this means that officers do not think they should have to attend such deaths and that, therefore, they do not do the work as well as they should. I also heard evidence on this topic from a small

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number of GMP officers. Police Sergeant (PS) Paul Walker told me in oral evidence that he had not liked attending such deaths when he was a junior officer because he found it difficult to deal with the recently bereaved. Police Constable Lawrence Thurston said that, over the years, he had become aware that many of his colleagues regarded attendance at such deaths as a burden, particularly in cases in which it was anticipated that the general practitioner would, in due course, issue an MCCD. I do not criticise the officers for their attitude and, indeed, regard it as understandable, as such attendance makes little demand on what are traditionally regarded as police skills and at the same time demands other skills which many police officers do not possess.

The Standard of the Initial Scene Investigation

4.24 The GMP accepted that their standard of initial scene investigation of deaths in which there is no visible evidence of violence or other obvious ground for suspicion can and should be improved. They intend to improve training. DCS Stelfox explained that, until now, the conclusions reached at the end of such initial investigations have been heavily reliant on the judgements made by the uniformed officers who first attend the scene. There has been no satisfactory audit of the appropriateness of those judgements, little supervision of the investigations and no examination of the reports submitted.

4.25 DCS Stelfox accepted that these investigation processes required improvement. However, he said that he was unaware of any case where there existed objective grounds for suspicion of criminal involvement which had been missed by an officer because the officer had instead concentrated his/her efforts on establishing whether there was a doctor who would issue an MCCD. The Inquiry has discovered several deaths to which the police were called but in which they did not undertake any investigation because Shipman said that he was willing and able to issue an MCCD. In some of those cases, Shipman had in fact killed the deceased. However, I would not expect a uniformed police constable, trained to observe 'conventional' signs of criminal activity, to have noticed any signs of suspicion in those cases. Detection of such crimes would require a completely different approach to investigation, one that examined the deceased's medical history and the circumstances of the death and sought to ascertain whether they were consistent with the cause of death suggested by the doctor. In my view, for reasons that I shall explain later, that type of investigation should not be undertaken by police officers.

Record Keeping

4.26 In cases attended by GMP officers in which it is established that a doctor will issue an MCCD, the only document that will normally be generated, apart possibly from a brief entry in the officer's pocket book, is an internal report form or log for the computerised Force Wide Incident Network. The reports are known as FWINs. They contain little detail. What has hitherto been considered important by the GMP is the fact that suspicion has been eliminated, rather than how it has been eliminated. In my view, it is highly desirable, when important decisions (such as the decision not to pursue a criminal investigation of a death) are taken, that the reasons for such decisions should be recorded. DCS Stelfox was of the view that it would be beneficial to the GMP if officers attending a death were required to record a brief written summary as to why suspicion had been excluded.

Attendance of a Doctor When a Death Occurs Outside Normal Working Hours

4.27 When a death occurs, or is discovered, during normal working hours, the deceased's general practitioner will usually attend to confirm the fact that death has occurred and will indicate whether s/he is in a position to certify the cause of death. However, this is rarely possible at night and at weekends, because of the increasing use made by general practitioners of deputising doctor organisations (both commercial organisations and general practitioner co-operatives). A deputising doctor will rarely know enough about the patient to be able to say whether the patient's general practitioner will be in a position to issue an MCCD. However, s/he will be able to confirm that life is extinct. In many areas, it appears that there is often delay in attendance by a deputising doctor, who might, understandably, give priority to the urgent needs of the living. As a result, the police are called out to an increasing number of deaths in which there is no suspicion of criminal involvement. Also, there is more frequent resort to the ambulance service with requests to confirm that death has occurred.

4.28 Two generations ago, relatives expected that the body of a deceased person would remain at home, at least for several hours, if not until the day of the funeral. Nowadays, expectations are different and most families wish and expect that the body will be removed from home without delay. Although there is no specific rule to this effect, in practice, once it is known that a doctor will issue an MCCD, the body can be taken to the premises of a funeral director. If the doctor cannot issue an MCCD, the death will be reported to the coroner and the body will usually be taken to a public or hospital mortuary to await autopsy.

4.29 There are no rules of general application throughout the country as to what should happen when a death occurs out of hours and it is not possible to discover whether the general practitioner will be prepared to issue an MCCD. Difficulty or delay in establishing whether the general practitioner will be prepared to do so may result in delay in the removal of the body. It appears that there is a wide variation in different parts of the country as to the practice relating to the confirmation of the fact of death and the removal of the body to a public mortuary or to the premises of funeral directors.

4.30 The Inquiry contacted a number of organisations with a special interest in 'out of hours' and deputising doctor services. These included Nestor Healthcare Group plc, a large public limited company operating 32 branches in England, Wales and Scotland, the National Association of GP Co-operatives and a number of small local co-operatives. Their evidence confirms that there is no consistent approach to the 'out of hours' death, whether expected or unexpected.

Guidance from the British Medical Association

4.31 In April 1999, the General Practitioners' Committee of the BMA issued guidance to members as to their duties in respect of attendance following a death. This guidance draws a distinction between what should happen in connection with an **'expected'** death and an **'unexpected'** (which the Committee appeared to equate with **'sudden'**) death, although these terms are not defined. The guidance presumes that doctors not only

understand the terms, but also recognise into which category a particular death falls. It appears that an **'expected'** death is one for which the general practitioner will be able to issue an MCCD and an **'unexpected'** death is one for which s/he will not.

4.32 The guidance suggests that where an **'expected'** death occurs at the patient's home, it is **'wise'** (although not necessary) for the general practitioner to attend as soon as the urgent needs of the living permit. When such a death occurs in a nursing or residential home, and the general practitioner who attended during the last illness is available, it is **'sensible'** (although not necessary) for him/her to attend **'when practicable'** to issue an MCCD. However, it advises that when an **'on-call'** doctor is on duty, whether in or out of normal working hours, it is unlikely that any useful purpose will be served by his/her attendance. This appears to apply whether the death occurs in the deceased's own home or in an institution. It is said that the doctor should advise those in charge that they should contact the funeral director if they want to have the body removed. He or she should also inform the deceased's general practitioner of the death, as soon as possible.

4.33 In the case of an **'unexpected'** or **'sudden'** death, the guidance suggests that, when the death occurs in the patient's own home, or in a nursing or residential home, the patient's registered general practitioner should attend to examine the body and confirm the death. It does not deal with the position of the **'on-call'** doctor in those circumstances. The guidance suggests that, **'in any other circumstances'**, i.e. where the death does not occur in the patient's own home, or in a nursing or residential home, it is usually wise, and especially so in the case of an **'on-call'** doctor, to decline to attend and to advise that the services of a retained police surgeon be obtained.

4.34 This advice assumes that the **'on-call'** doctor, who does not know the patient, can distinguish between an expected and an unexpected death without attending, presumably in reliance upon what the caller says. In the event that the **'on-call'** doctor wrongly categorises the death as **'expected'** and advises those in charge to contact the funeral director, the body might initially be removed to the funeral director's premises but have to be taken to the mortuary later, when it is found that the death has to be reported to the coroner.

4.35 In the light of this advice, it is obvious why there is often difficulty in arranging the attendance of an **'on-call'** or deputising doctor. In effect, they are advised not to attend. It is also easy to see how confusion and uncertainty can arise about the removal of the body. If the death is thought to be **'expected'**, the **'on-call'** doctor might tell the caller to instruct the funeral director to take the body away; however, the funeral director might refuse to do so if no one has confirmed the fact of death. Then, a police surgeon or paramedic might have to be called to confirm the fact of death before the body can be moved.

Practice in Different Areas

4.36 The Inquiry heard evidence as to the different practices that prevail in different areas. In some, those responsible for deputising services have issued guidance based on that issued by the BMA.

4.37 In South Manchester, the Inquiry was told that there is no difficulty in arranging attendance by a deputising doctor to confirm the fact of death. If it proves impossible to ascertain whether the deceased's general practitioner is able to certify the cause of death, and if the deceased's family is unwilling for the body to remain at the house until the next morning or such other time as the general practitioner can be contacted, the police become involved and, in effect, the death is reported to the Coroner. The body must be taken to the local mortuary, pending further enquiries of the general practitioner. This follows a ruling by Mr John Pollard, HM Coroner for Greater Manchester South, made in order to avoid uncertainty about what should happen to the body until the general practitioner has indicated whether or not s/he is able to certify the cause of death. On the day following the death (or on the following Monday morning, if the death occurs over a weekend), a coroner's officer will contact the deceased's general practitioner. If s/he is willing and able to issue an MCCD, the body is released to the funeral director of the family's choice. If the deceased's general practitioner is unwilling or unable to certify the cause of death, the Coroner will accept jurisdiction and 'take over' the case. This process has the advantage of certainty, although the result is that the police are involved in reporting to the Coroner deaths which, in the event, are certified by a general practitioner.

4.38 In Surrey, the practice is similar to that in South Manchester. Mr Michael Burgess, HM Coroner for Surrey, told the Inquiry that he expects the police to attend when the deputising doctor or ambulance personnel have confirmed death but no MCCD can be issued in the short term. The police have his authority to remove bodies to the local mortuary pending the decision of the general practitioner.

4.39 Dr Nigel Chapman, HM Coroner for Nottinghamshire, said that, following consultation with the Local Medical Committee and deputising doctor service in his area, an agreement has been reached which avoids what are seen as 'unnecessary' attendances by deputising doctors. In the case of an expected death occurring out of hours in a private home, nursing home or residential home, the body of the deceased may be removed directly to a funeral director's premises, even though it has not been possible to obtain confirmation from the treating general practitioner that s/he is in a position to certify the cause of death. When a call is made to the deputising service, the doctor will enquire of the caller whether the fact of death has been confirmed by a qualified nurse or paramedic. If not, the doctor will attend. If the fact of death has been confirmed, the doctor will then enquire as to whether the deceased had been seen by his/her general practitioner within 14 days before the death and whether that doctor is likely to be able to issue an MCCD. If the fact of death has been confirmed and it appears that the general practitioner will be able to issue an MCCD, the deputising doctor will give permission, over the telephone, for the body to be removed to the funeral director's premises. Presumably, if the doctor is not satisfied, s/he will direct that the police must be called, the death reported to the coroner and the body taken to the mortuary. The Nottinghamshire practice appears to be based on the BMA guidance but imposes a requirement on the on-call doctor to attend if the fact of death has not been otherwise confirmed. It effectively avoids unnecessary police involvement and reports to the coroner. However, there is a risk that the information on which the deputising doctor bases his/her decision may not be satisfactory. The doctor will usually know nothing of the background other than what s/he is told by the caller. There is a possibility

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that, when the general practitioner learns of the death, it might after all have to be reported to the coroner and the body transferred to the mortuary. Provided that the funeral director has not begun any embalming process, no harm will have been done by such an error.

4.40 Kernowdoc, a general practitioner co-operative in Truro, Cornwall, operates according to a protocol, in some respects similar to that operated in Nottinghamshire, again agreed after consultation between the various interested parties. The Kernowdoc policy, in relation to expected deaths in a nursing home, also includes a requirement that the deceased's general practitioner should have given advance written confirmation of the fact that death is expected, before the body can be removed directly to the premises of the funeral director. Where written confirmation is not available, either the body will remain at the nursing home until the general practitioner can be contacted, or the duty doctor has to attend before the body can be released. The policy does not relate to unexpected deaths or deaths in private homes, which require the attendance of the duty doctor.

4.41 Doctors working for North Essex Doctors On Call Limited (NORDOC) are issued with advice based on the BMA guidance, to which I referred above. They normally attend a death occurring in a private home and make a judgement about whether the body should be removed to the funeral director's premises. In deciding whether to attend a death that has occurred in a nursing or residential home, they rely on the judgement of the staff at the home where the death occurs. Sometimes, they will take a decision to allow the body to be moved to the funeral director's premises following a telephone discussion.

4.42 Mr Christopher Dorries, HM Coroner for South Yorkshire (West), told the Inquiry that, in his District, there is often a delay in securing the attendance of an 'out of hours' doctor, with all the understandable distress that results. There is no protocol governing what happens in the event of the expected 'out of hours' death. If the deputising doctor cannot be persuaded to attend, a police officer attends the home and a police surgeon will be called out to confirm the fact of death before the body can be transferred to the mortuary. If the death has occurred late on a Friday afternoon, the body could quite easily remain in the mortuary until the following Monday, when Mr Dorries' staff will telephone the general practitioner. If s/he is prepared to issue an MCCD, the body will then be transferred from the mortuary to the funeral director's premises. This system involves quite heavy use of police resources.

4.43 The Metropolitan Police Force also reported difficulties in ensuring the attendance of a deputising doctor and estimated that, in 10–15% of cases, there was a need to call out the police surgeon to confirm death. Pending the arrival of the police surgeon, the attending officer remains at the scene, which creates practical difficulties because the officer is unavailable for deployment elsewhere. At a time when demands on police resources are growing, this is obviously undesirable.

4.44 In West Yorkshire, where it appears that there must on occasions be delay or difficulty in arranging the attendance of a doctor to confirm the fact of death, there is now a protocol in existence by which a paramedic supervisor employed by the ambulance service can, if necessary, be called out with the sole object of confirming the fact of death. This was felt desirable in order to reduce the amount of police time that was being spent awaiting the

arrival of a doctor. This protocol avoids the use of police resources, but places an additional and inappropriate burden on the ambulance service.

4.45 In the West Midlands, it seems to have been acknowledged that there is no sound reason why the police should attend a death in which there is no suspicion of criminal involvement, simply because it has not been possible to contact a general practitioner to discover whether s/he is able to certify the cause of death. West Midlands Police Order 53/2002, issued in June 2002, provides that the police will no longer accept requests for attendance at **'routine presumed natural deaths in home circumstances from doctors, hospitals, families or responsible adults'**. The Inquiry has not received evidence as to what happens if and when the police refuse to attend.

The Need for Clarity

4.46 It is clear that, at present, the procedures which operate in the immediate aftermath of a death vary in different parts of the country. There is also some confusion about what is expected of the police, ambulance and medical services. Without wishing to suggest that uniformity must be achieved in all things, it does seem to me that both professionals and the bereaved would be better served by a system in which the roles and duties of the various services were clarified. The professionals and those responsible for the provision of services should know what is expected of them so that they can allocate the resources and provide the necessary training. The bereaved would also benefit. In the immediate aftermath of a death, uncertainty about what is going to happen only increases distress.

4.47 There is also some tension between the services, which is not surprising, as attending at a death is not the main function or purpose of the police, ambulance or medical services. All have what might properly be regarded as more pressing duties in relation to the living.

4.48 For those reasons, it appears to me that there should be a nationally agreed policy for dealing with the immediate aftermath of a death occurring in the community. There will, in my view, always be a role for the police, the ambulance service and doctors. There must always be some flexibility in the provision of these services, especially in respect of deaths that occur at night and at weekends. However, because responsibility for dealing with the aftermath of a death does not naturally fall within the remit of any of the existing services, I shall consider whether it would be appropriate to allocate primary responsibility to those whose function it is to deal with death, namely the coroners. I shall discuss this proposal in greater detail later in this Report.

Further Involvement of the Police

4.49 So far, I have dealt with the duties of the police when summoned to attend a death in the community. If it appears to the officer attending that there are circumstances suggestive of criminal involvement, a police investigation will be set in motion. If it appears to the police officer in attendance that there is no doctor willing and able to issue an MCCD, the officer will report the death to the coroner. In that capacity, when reporting a death to the coroner, the officer will, at the same time, carry out a limited investigation of the circumstances of the death and complete one or more standard report forms. In their

capacity as coroner's officers, the police are also sometimes involved in the investigation of a death that has been reported to the coroner by others, such as a doctor or registrar. In that situation in the GMP area, the same report forms are used whether the death is reported to the coroner by the police or by others.

Sudden Death Report Forms

4.50 The police describe all deaths that they report to the coroner or investigate on the coroner's behalf as 'sudden deaths'. The forms used for the report or investigation are commonly known as 'Sudden Death Report Forms' or 'Reports of Sudden Death'. The police national training documentation defines a sudden death as any death involving some form of police action. This does not mean that the death was 'sudden' in the usual sense of the word.

4.51 The layout and content of the report forms vary from force to force. The forms commonly require information as to the personal details, occupational history and known medical history of the deceased. Some require details of the circumstances of the death and sometimes also a description of the circumstances leading up to the discovery of the death and of the death scene. Many require the provision of certain extra administrative information. Some forms request the identification of the source of the information. Some incorporate a statement of identification of the deceased but many police forces have a separate form for that purpose. Some focus specifically on the possibility of suicide. Many require details relating to the deceased's property. None of the forms I have seen requires a specific statement by the person confirming the fact of death.

4.52 The form in use in Cheshire appeared to me to be more comprehensive than those from other areas. Also, a sample of completed forms from Cheshire suggested quite a high standard of awareness of the type of information required. I saw a number of samples of forms of this kind that are used in Scotland, where they are submitted to the procurator fiscal. The forms in use in the Grampian and Strathclyde areas also appear to be more comprehensive than some of the English ones I saw.

4.53 In the GMP area, in addition to providing the information for incorporation into the FWIN, reporting officers complete two separate but related report forms, known as Form 751 and Form 751A, which are left at the hospital mortuary for the attention of the coroner's liaison officer (CLO). Form 751A is designed specifically for the purpose of providing information to the pathologist. Form 751 is directed to the coroner. Recently, the practice has changed so that the coroner receives both forms, whereas previously s/he would not see Form 751A. According to Chief Constable's Order 98/47, the role of the police in these circumstances is to **'help the coroner to find the cause of death'**. However, the information provided on these forms is scanty and no information is included about the enquiries that led the police to conclude that the death did not give rise to suspicion of criminal involvement.

4.54 Form 751, entitled **'REPORT OF SUDDEN DEATH'**, is addressed to the coroner and requires the provision of personal and administrative information. The time, date and place of death must be stated. A request on a previous version of the form for details of the **'time, date and place found and by whom'** is no longer included, which is, perhaps,

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unfortunate. The current form provides a total of six lines in which to record a **'brief medical history'** and **'brief circumstances of death'** and an earlier, but quite recent, version of the form provided only three. The kind of information routinely provided under this heading is very limited. For example, on the Form 751 relating to Miss May Lowe, who I found was killed by Shipman, this section was completed thus: **'Suffers from heart + circulation problems. Has had a bad dose of flu for the last 4 weeks'**. This information had plainly been derived from the person present at the scene when the officer attended.

4.55 Form 751A, entitled **'MEDICAL HISTORY IN A CASE OF SUDDEN DEATH'**, is intended to assist the pathologist who is to perform the autopsy. It requires the attending officer to record the time, date and place of death and the time and date when the deceased was last seen alive and by whom. There is a separate section for the brief circumstances of death. This encouraged the officer in the case of Miss Lowe to state that Miss Lowe's niece had gone to the house, as she could not contact her aunt by telephone. She had entered by the rear door and found her aunt **'lying there'**. That information had not been provided on Form 751, although it would also be of use to the coroner. The section concerning the medical history simply asked: **'Was deceased receiving medical attention at time of, or before death? If 'Yes' give details.'** On Miss Lowe's form, the officer wrote: **'Yes. Heart + trouble with circulation'**, although she did not mention the bad dose of 'flu. The form also sought details of any **'permanent disability, long term illness or industrial disease'**. On Miss Lowe's form, this is answered: **'No'**. The form asked whether drugs have been prescribed and, if so, the details. It appears that the usual practice is to see what drugs are at the bedside or in the bathroom and kitchen cupboard and to list those. The form asked whether or not the deceased had access to drugs besides those listed above. How reliable a negative answer to that question could ever be is doubtful and the question is not on the most recent version of the form. Finally, Form 751A asks whether there is any other information that may assist the pathologist to determine the cause of death. This box is not completed very often. It is perhaps asking a lot to expect a patrol officer to proffer such further details when s/he is very unlikely to know what type of information would be helpful.

4.56 Forms 751 and 751A are unsatisfactory. First, they contain a number of questions which are common to both; yet the officer is required to complete two separate forms instead of making two copies of one form. This must increase the work the police officer has to do and the repetition must also cause irritation. There is no possible justification for having two forms, a fact that was acknowledged by many GMP witnesses who gave evidence. Because the quality of completion of the forms is poor, the content has to be checked and sometimes supplemented by the CLO who receives them. This leads to further duplication of effort.

4.57 The Inquiry examined Form 751 and/or Form 751A in 32 cases involving GMP officers. These revealed very variable standards of reporting. Some Forms 751 and 751A were good, containing an appropriate amount of information, clearly expressed. Very many contained little information and would be of scant value to the coroner or pathologist for whose benefit they were intended. Such was the variability of standard that it appeared to me that the problem was probably one of failure of training and supervision, rather than individual shortcoming. Accordingly, I directed that the Inquiry should not send letters

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warning of potential criticism ('Salmon letters') to individual police officers but only to the GMP, as their employers. On behalf of the GMP, DCS Stelfox, in his written and oral evidence, accepted the substance of those criticisms. I stress that none of the shortcomings or failings to which I have referred resulted in Shipman escaping detection for killings which might otherwise have been expected to be revealed. I should also say that I heard criticism of the standards of completion of such forms by the officers of other police forces besides the GMP.

4.58 Examination of the forms also revealed that the officer completing the form often had no idea why the death had to be, or had been, reported to the coroner and what the issues were that the coroner would have to decide. For example, in the case of Mrs Lily Shore, a patient of Shipman who I found died a natural death and whose death had been certified as due to bronchopneumonia, the coroner was investigating the question of whether a road traffic accident, which Mrs Shore had suffered two months before her death, had caused or contributed to her death. It could have done, if she had remained immobile for a substantial period after the accident; she would have been vulnerable to chest infection. The information needed was how Mrs Shore had been in the interval between the accident and her death. Had she made a full recovery and had she been mobile? It is clear from the answers given on the forms that the officer did not realise what the issues were. DCS Stelfox explained that he would not expect the officer to realise why there was a possible connection between the accident and the death, given the lapse of time of two months and the officer's lack of medical knowledge. Yet, that was the reason why the coroner had to consider the death. DCS Stelfox also confirmed that the medical enquiries made by police officers for the completion of the forms are extremely limited. If enquiry had been made by a person who understood why there was a possibility of a causal link between the accident and the bronchopneumonia which caused the death, it could have been discovered that Mrs Shore's accident had been a relatively minor one and she had made a full recovery. There would then have been no need for an inquest or even an autopsy.

4.59 I do not propose to burden this Report by further examples of this problem. Suffice it to say that this, and other cases examined in the course of the hearings, have satisfied me that the way in which deaths are reported to the coroner by the police, and investigated by the police on the coroner's behalf, is not satisfactory.

Is Police Involvement in the Investigation of Deaths for the Coroner Appropriate?

4.60 I have said earlier that, in my view, there will always be some role for the police in the aftermath of a death. They must attend if there is any possible suspicion of criminal activity. They must attend if there is a need to break into premises or to locate a next of kin. If, while carrying out any of these functions, they discover anything that ought to be reported to the coroner, plainly they should do so. However, it is necessary to consider whether or not the police should continue to fulfil their present roles as 'coroner's officers', undertaking responsibility for the admission of bodies to the mortuary and the completion of the forms reporting the death.

4.61 It appears to me that there are several reasons why the police should no longer be involved in the investigation of deaths that do not give rise to any suspicion of crime. First, they do not have the skills or expertise necessary for the job. Second, they do not consider it to be important to them as police officers and this contributes to the variable quality of the work they do. Third, the work places a heavy burden on limited police resources.

Skills and Expertise

4.62 DCS Stelfox agreed that the standard of police handling of deaths which appear to involve no suspicion of crime (non-suspicious deaths) is very variable. He explained that any individual officer might attend such a death only once or twice a year. Procedures that are not practised frequently are unlikely to be conducted to as consistently high a standard as those that are performed often.

4.63 DCS Stelfox said that the police role should be to eliminate suspicion. Once this has been done, others who could be better trained should undertake any further enquiries. He accepted that police officers, who might attend a non-suspicious death only relatively infrequently and who have no medical training, would not understand the purpose behind the questions that they were asking. He said that, when an officer does not understand the issues, s/he is likely merely to ask the question as it appears on the form and to record what the witness says. He agreed that what was needed in such circumstances was a person specially trained to investigate non-suspicious deaths. It would not be feasible to train the entire uniformed police force to make this kind of enquiry satisfactorily, not least because an individual officer might attend only a few non-suspicious deaths before being moved away from patrol duties.

4.64 DCS Stelfox said that the lack of guidance on the issue of sudden deaths is likely to have arisen from the tendency to separate non-suspicious deaths from **'murder and suspicious deaths'** within published policy and within the training environment. Hence, murder and suspicious deaths are likely to be investigated by the application of a focussed approach to investigation and crime scene management, whereas the investigation of non-suspicious deaths is more procedural and concentrates on issues surrounding the function of a coroner, identification of the deceased, the medical history of the deceased and dealing with the bereaved relatives of the deceased.

4.65 DCS Stelfox explained that the traditional involvement of police officers in this task has been based on an assumption within the police service that the basic investigative procedures that officers employ when attending deaths, such as scene examination and the interviewing of witnesses, are generic skills that they will have acquired during the course of other duties and which need little adaptation to the investigation and reporting of non-suspicious deaths. In his evidence to the Inquiry, he admitted that he was now of the view that this assumption was flawed.

4.66 In my view, DCS Stelfox is right to say that generic police skills are not fitted to the investigation of non-suspicious deaths. Moreover, the task does not utilise the skills in which they have been trained. As I have already observed, this probably explains why the police do not wish to be involved in this type of work and why they do not do it as well as they might. It appears to me that the reporting and investigation of such deaths require

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skills that most police officers do not possess. It is clear that many enquiries to be made on a coroner's behalf will entail medical issues and I am satisfied that a police officer with no medical knowledge is not an appropriate person to undertake them.

Police Resources

4.67 Police attendance at deaths in which there is no suspicion of crime has an impact on police manpower and resources. The GMP has recently analysed the time occupied by attendance at 60 non-suspicious deaths. The average time involved was two and a half hours. Other police forces contacted estimated varying periods of time, but the GMP figure does not seem unrepresentative. PS Walker told the Inquiry that, as a supervisor, he would effectively 'write off' for the duration of his shift any officer called to attend a sudden death. Other officers spoke in similar terms of the effect on their shift of being called out to attend sudden deaths.

Other Considerations

4.68 The interests of the family of the deceased may also make it inappropriate for the police to attend at deaths in which there is no suspicion of criminal involvement. The Brodrick Committee noted that some members of the public were aggrieved that a uniformed police officer would call on them to take particulars of a death to which no suspicion of crime attached. GMP officers reported that they had observed similar concerns. Police Constable (PC) Rachel Mitchell and PC David James described their experience of the discomfiture of bereaved families when the police attend a death in the middle of the night. PC Mitchell said that attendance by uniformed officers in a marked vehicle, often in the middle of the night, is quite daunting for the families. I find that wholly understandable.

Is There a Need for Police Involvement in All Deaths?

4.69 At present, the police do not attend most deaths in the community. They are certainly summoned if there is any ground to suspect criminality. Otherwise, it seems to be largely a matter of chance whether or not they become involved. In the light of the experience gained during the Inquiry, I have had to ask myself whether there ought to be a requirement for the police to attend every death, in order to rule out suspicion of foul play?

4.70 In my view, this should not be necessary and is not desirable from either the viewpoint of the police or that of the families of the deceased. Usually, if there is any obvious reason to suspect criminal involvement, a witness to the death, the person who discovers the body or someone connected with the deceased will summon the police. If an ambulance is called, the crew will be alert to observe anything out of the ordinary and will summon the police if their suspicions are aroused. If there are suspicious signs that are not obvious, they are unlikely to be detected by the attendance of a police officer. It will be very rare that a sudden death not reported as a suspicious death will be identified as suspicious by a patrol officer. I heard evidence to that effect from the individual officers who gave evidence. DCS Stelfox considered that trained ambulance personnel were as well placed as a police patrol officer to notice whether there were any suspicious signs. He would be content if, in any case to which paramedics were summoned, they were to determine

whether the circumstances of a death were or were not suspicious of criminal involvement. I note that the Brodrick Committee (at paragraph 21.10 of its Report) doubted **'whether a policeman acting as coroner's officer is any more likely than a properly trained civilian working for a coroner to discover an unsuspected factor in a death which has been reported to the coroner by a doctor or informant but was not reported to the police immediately'**.

4.71 In my view, it would not be satisfactory or sensible to require the police to attend every death in order to rule out the possibility of concealed homicide or neglect, which must be detected by other means. The involvement of the police in the investigation of deaths in the community should be limited to those cases in which there is a suspicion of criminal involvement. Insofar as they may be contacted to attend a death at which they are not needed, provision should be made for them to report the death to someone with professional responsibility for dealing with it.

Conclusions

4.72 The present arrangements for dealing with the aftermath of a death in the community are unsatisfactory, especially in relation to deaths that occur out of normal working hours. Their operation results in uncertainty for relatives of the deceased and the inappropriate use of resources of the police and, arguably, the ambulance service. There is tension between the providers of medical and emergency services. In my view, there should be a policy governing the responsibilities of the various services, so that each knows what is expected. However, although there will always be a role for the police, ambulance service and doctors in dealing with the aftermath of a death, I consider that their roles should be secondary to, and supportive of, a service with primary responsibility for dealing with deaths in the community, both in and out of hours. In my view, this service should be based in the coroner's office and should be one of the duties of a team of well-trained coroner's officers. I shall describe this proposal in greater detail later in this Report. For the moment, I say only that I base the proposal upon my belief that a task is performed better by those who have been specifically trained to carry it out and for whom the task is important and central to their work, rather than peripheral.

4.73 For the reasons I have explained, the present arrangements by which uniformed police patrol officers act as coroner's officers and are responsible for the initial investigation of deaths which are to be or have been reported to the coroner are unsatisfactory and must be replaced. The usual role of the police should be limited to the investigation of deaths where there is some reason to suspect crime. My proposal will be that the investigation of non-suspicious deaths should be carried out by a team of coroner's officers or 'coroner's investigators'.

CHAPTER FIVE

Medical Certification of the Cause of Death

The Existing System

The Duty of the Attending Doctor to Complete a Medical Certificate of Cause of Death

5.1 The systems of certification of the medical cause of death and the registration of deaths remain much the same now as they were in 1927. The law is now governed by the Births and Deaths Registration Act 1953.

5.2 Before a death can be registered, the cause of death must be certified by a registered medical practitioner who has **'attended'** the deceased during his/her **'last illness'**; alternatively, the death must have been reported to the coroner and the appropriate certificate provided by him/her. There is no statutory definition of the terms **'attended'** or **'last illness'**.

5.3 Once a death occurs, it becomes important to identify the cause of the death. Apart from cases in which an inquest has been opened and the coroner gives specific authorisation, it is only when the cause of death has been certified that burial or cremation of the body can take place. The individual most likely to be able accurately to identify the cause of death is the doctor with the best knowledge of the deceased's medical history, in particular the history during the days and weeks immediately preceding death. In the case of a death occurring in the community, this will usually be the deceased's general practitioner; where a death occurs in hospital, it will usually be a member of the medical team responsible for the deceased's care prior to death.

5.4 Section 22(1) of the Births and Deaths Registration Act 1953 requires that:

> **'In the case of the death of any person who has been attended during his last illness by a registered medical practitioner, that practitioner shall sign a certificate in the prescribed form stating to the best of his knowledge and belief the cause of death ...'**.

5.5 This section imposes on the doctor who has **'attended'** the deceased during the **'last illness'** a duty to issue an MCCD whether or not s/he can identify the cause of death. This is not sensible and, in practice, doctors issue an MCCD only if they can identify the cause of death with sufficient confidence. If they cannot, they report the death to the coroner. There is no statutory duty upon a doctor to make such a report, but there is a common law duty on every citizen to give information which may lead to the coroner having notice of circumstances requiring the holding of an inquest. Doctors now regard it as a professional duty to report a death to the coroner if they are insufficiently certain of the cause or are aware of other reasons why the death should be reported.

5.6 One of the most common reasons for a doctor to report a death to the coroner arises from the so-called 14-day rule, which I have called the 'either/or rule'. Regulation 41 of the Registration of Births and Deaths Regulations 1987, which in this respect is in the same terms as the Registration (Births, Stillbirths, Deaths and Marriages) Consolidated

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Regulations 1927, imposes on the registrar a duty to report to the coroner any death where it appears that the medical practitioner who has issued the MCCD had not either seen the deceased within 14 days before death or seen the body after death. It appears that the rule is widely misunderstood by medical practitioners, many of whom believe that they are obliged to report a death to the coroner if they have not seen the deceased within 14 days before death, regardless of whether or not they have seen the body after death.

Completion of the Medical Certificate of Cause of Death

5.7 The form of the MCCD is prescribed by the 1987 Regulations. Books of MCCDs are issued by local registrars of births and deaths to general practices, hospital wards or departments and, sometimes, to individual general practitioners. MCCDs are supplied in a book rather like a large cheque book. When a doctor has completed a certificate, s/he tears it out of the book. He or she is then left with a counterfoil in the book on which s/he records details of the certificate s/he has completed. Each book also contains notes, giving detailed guidance on completion of the certificates. Different forms of certificate are supplied for use in the case of a neonatal death or stillbirth; I shall confine my description to the certificate prescribed for use in the case of a death occurring after the first 28 days of life (Form 66). A blank MCCD can be seen at Appendix B of this Report.

5.8 The MCCD requires the doctor to state the name and place of death of the deceased, the date of the death and the deceased's age, as stated to the doctor, and the date on which the doctor last saw the deceased alive. The doctor is also required to circle the number preceding one of the statements from the following group:

> **'1. The certified cause of death takes account of information obtained from post-mortem.**
> **2. Information from post-mortem may be available later.**
> **3. Post-mortem not being held.**
> **4. I have reported this death to the Coroner for further action.'**

5.9 The first three statements refer to the possibility that a 'hospital' post-mortem examination (i.e. a post-mortem examination carried out for medical reasons with the consent of the next of kin and not pursuant to an order of a coroner) may have taken place or be planned for the future. In the majority of cases, the doctor will circle **'3'**, i.e. **'Post-mortem not being held'**.

5.10 Then, the certifying doctor must circle the letter preceding one of a further three statements, namely:

> **'a. Seen after death by me.**
> **b. Seen after death by another medical practitioner but not by me.**
> **c. Not seen after death by a medical practitioner.'**

5.11 In the majority of cases, the certifying doctor will circle **'a'** or **'b'**, i.e. **'Seen after death by me'** or **'Seen after death by another medical practitioner but not by me'**. In a relatively few cases, the answer will indicate that the deceased was not seen after death by any medical practitioner.

5.12 The doctor must then state the cause of death, listing the disease(s) or condition(s) that caused the death, in order of immediacy to the death itself. The chain of causation must be set out in accordance with World Health Organisation guidelines. Under Part I(a), the doctor should record the most immediate cause of death. At I(b), s/he should go on to identify the disease or condition that led to the immediate cause of death. If the doctor considers that there is a further link in the chain of causation, the relevant disease or condition providing that link should be recorded at I(c). By way of example, if the death had been precipitated by a brain haemorrhage, which resulted from cancer-related secondaries in the brain, caused in turn by a primary carcinoma of the lung, the cause of death should be set out as follows:

CAUSE OF DEATH

The condition thought to be the 'Underlying Cause of Death' should appear in the lowest completed line of Part I.

I	(a)	Disease or condition directly leading to death	Intracerebral haemorrhage .....
	(b)	Other condition, if any, leading to I(a)	Cerebral metastases .....
	(c)	Other disease or condition, if any, leading to I(b)	Squamous cell carcinoma of the left main bronchus
II		Other significant conditions CONTRIBUTING TO THE DEATH but not related to the disease or condition ..... causing it	Diabetes mellitus.....

5.13 The guidance contained in the book of MCCDs states that the statement of cause of death should be as specific as possible. Hence, in the example above, the site of the primary tumour (the left main bronchus) is specified, in addition to details of the histology (squamous cell). Diabetes mellitus is identified in Part II as a condition that has contributed to the death but was not part of the main causal sequence leading to death. The guidance notes contained in the book of MCCDs make the point that Part II should not be used to list all the medical conditions from which the deceased person suffered at the time of his/her death; only those which played a part in causing the death, perhaps by hastening it, should be included. If there is only one condition that led to the death, with no antecedents, it is acceptable to identify only one cause of death (e.g. 'I(a) subarachnoid haemorrhage').

5.14 The guidance notes remind doctors that it is not acceptable to state as the only cause of death a mode of dying (e.g. heart failure). This gives no indication as to why the patient died and, if it is stated on the MCCD, should result in the death being referred to the coroner by the registrar. An underlying cause of death (e.g. myocardial infarction) must

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be given. A list of terms that imply a mode of dying, rather than the cause of death, is set out in the guidance notes.

5.15 The MCCD also seeks information about the approximate interval that elapsed between the onset of each condition identified in the 'Cause of Death' section of the certificate. This information is not entered in the register of deaths (although it is valuable for statistical purposes) and provision of the information is not obligatory. As a consequence, this information is, the Inquiry was told, rarely provided.

5.16 Where the certifying doctor believes that the death was or might have been directly contributed to by the employment followed at some time by the deceased, s/he is required to tick the 'Spearing box'. Some employment-related causes of death are listed on the reverse side of the MCCD and a more detailed list appears in the guidance notes.

5.17 The certifying doctor is required to declare:

> **'I hereby certify that I was in medical attendance during the above named deceased's last illness, and that the particulars and cause of death above written are true to the best of my knowledge and belief.'**

5.18 He or she must then sign the form and state his/her qualifications, as registered with the General Medical Council. In the case of a hospital death, the name of the consultant responsible for the care of the patient must also be given.

Delivery of the Medical Certificate of Cause of Death to the Registrar

5.19 Having completed the MCCD, the doctor is then obliged to deliver to a **'qualified informant'** notice in writing that a certificate has been signed. Those persons qualified to give information for the registration of a death are specified in section 16 (where the death occurred in a house) and section 17 (other deaths) of the Births and Deaths Registration Act 1953. Usually, the informant will be the nearest surviving relative of the deceased or, if there are no relatives, the person who is making the funeral arrangements. The Act requires that the doctor completing the MCCD shall **'forthwith deliver that certificate to the registrar'**. In practice, this does not happen. Instead, the doctor hands over the MCCD (usually in a sealed envelope) to the informant or some other family member. The informant then delivers the MCCD, usually still in its envelope, to the registrar, at the same time as attending to fulfil his/her duty to report the death to the registrar for births and deaths for the sub-district in which the death occurred.

The Purposes of the System

5.20 There are three main purposes to be served by a modern system of certification and registration of deaths. One is to provide an accurate record of deaths for administrative purposes. Another is to identify, as accurately as is practicable, the cause of each death. This information is needed for the purposes of medical research and for the allocation of the resources of the National Health Service. A third is that the system should provide a safeguard against the concealment of homicide and neglect leading to death. This third purpose should be served in two related ways: first, by providing a deterrent against crime

or neglect before it takes place and, second, by providing a means of detecting crime or neglect that has already occurred.

5.21 The first of these purposes is satisfactorily achieved by the procedure of registering the death. The evidence received by the Inquiry shows that the second objective is achieved by the present system to a reasonable degree of satisfaction. Dr Cleone Rooney, a medical epidemiologist employed by the Office for National Statistics (ONS), the body responsible for the collation of data relating to causes of death, said that, although the information relating to causes of death is not entirely accurate, the present arrangements achieve enough accuracy and consistency for the purposes to which the ONS put the statistics. That is not to say that the ONS is not always anxious to improve the accuracy of information provided and to improve the speed at which the information becomes available. However, it is in respect of the third purpose that the present system is seen to have failed, in that it did not deter Shipman from killing patients over a period of 24 years; nor did it detect that he had killed any of his 215 victims.

The Strengths and Weaknesses of the System

5.22 In considering the strengths and weaknesses of the current system, I am dealing only with the system of certification, registration and reporting to the coroner that applies to all deaths, regardless of the method by which the family chooses to dispose of the body. As will already be apparent from Chapter Three, a separate system of certification applies to deaths to be followed by cremation; this imposes additional requirements. I shall consider that system further in Chapter Eleven.

The Advantages of the Present Arrangements

5.23 The present arrangements for death certification and registration have three very real advantages. They are speedy, cheap and convenient. Usually, the doctor who is going to issue the MCCD will do so within a very short time of the death. As the doctor has treated the patient during the last illness, s/he should be familiar with the medical history and the task of completing the MCCD should take only a few minutes. Most doctors will be able to complete the certificate and give it to a relative within about a day of the death. The doctor is not permitted to charge a fee for the issue of the MCCD, so there is no expense to the family. Registration is not usually inconvenient, at least for relatives who live in the same area as the deceased. The register office is open every weekday and the informant may, if s/he wishes, attend without appointment. Registration is free, although there is a charge for the certified copies of the entry in the register that will be needed to settle the deceased's financial affairs. As was apparent with many of the deaths examined by the Inquiry, it is often possible to register a death within a day or two of its occurrence. Sometimes, there is a delay if the certifying doctor is off duty or decides that s/he wishes to discuss the case with the coroner. If the death is reported to the coroner, an autopsy may result in some delay in registration. However, in the majority of cases where the doctor issues an MCCD, the formalities proceed quite smoothly. In some areas, registrars provide a special weekend service for members of minority religious groups who wish to bury their dead very shortly after death.

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The Main Weakness: Dependence on a Single Medical Practitioner

5.24 The very feature that gives rise to the advantages to which I have just referred also gives rise to the major weakness, namely dependence on a single medical practitioner. Only about 38% of deaths are reported to the coroner. All other deaths are registered on the basis of an MCCD issued by a single doctor, who certifies the cause of death, saying that s/he has attended the deceased in the last illness, and provides the cause of death **'to the best of** [*his/her*] **knowledge and belief'**. If the MCCD is in order, that is, if it appears to the registrar that the certificate has been properly completed by a doctor who appears to be qualified to issue it and that the cause of death is acceptable, the death will be registered.

5.25 A doctor's decision as to whether or not s/he should report a death to the coroner or can properly certify the cause of the death is a matter for the doctor. If s/he decides to issue an MCCD and not to report the death, the decision is subject to very little check or control. Despite the recommendations of the Brodrick Committee in 1971 that there should be, there is still no statutory duty upon a doctor to report any death to the coroner. Provided that the doctor completes the MCCD fully and in appropriate terms, there is no check on the truth or accuracy of what s/he states. The registrar is under a duty to report certain classes of case to the coroner. However, in practice, as I shall explain in Chapter Six, the registrar has very little opportunity to discover whether or not the death should be reported. Similarly, although it is open to any member of the public to report a death to the coroner, this only rarely happens in practice. Many people do not even know that it is open to them to make such a report, let alone that they have a common law duty to do so in certain circumstances. Even if they did, most people would not challenge the word of a doctor who said that it was not necessary to report a death.

5.26 It follows that the present system depends almost entirely on the good faith and judgement of the doctor who signs the MCCD or decides that the case should be reported to the coroner. It also depends on the courage and independence of doctors, for the system places upon them some responsibility to police their colleagues, for example by refusing to certify a death which may have been contributed to by some misconduct, lack of care or medical error on the part of a professional colleague. It may not be easy for a junior member of the clinical team responsible for the care of the deceased to withstand the expectation that s/he will certify the cause of death, rather than report the case to the coroner for investigation.

5.27 So long as doctors do their best, in good faith, to report those cases where they are insufficiently sure of the cause of death and are vigilant in respect of signs of criminality or neglect by others, including other members of the medical profession, the present system should work. I have no doubt that the great majority of doctors perform their duties of certification conscientiously.

5.28 However, because it depends so heavily on the good faith, judgement, courage and independence of the certifying doctor, the present system of certification and registration does not provide adequate protection against the concealment of homicide by the certifying doctor him/herself. That Shipman was able to kill so many times, without triggering any alarm bells within the system, is proof of that. It is often said that there will

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never be 'another Shipman' and that the system should not be changed radically just because of him. However, we have no means of knowing how many cases of homicide by doctors and other health professionals remain undiscovered. Nor do we know how many medical errors or incidents of misconduct or neglect leading to death go undetected. Ideally, the system of certification should reveal this sort of incident. In my view, that ideal is not achievable in every case. However, the system can and should be more robust than at present.

The Paucity of Information Contained in the Completed Medical Certificate of Cause of Death

5.29 In my opinion, one of the major shortcomings of the existing system of death certification is that the MCCD requires the provision of so little information. It does not call for a summary of the relevant medical history or even a brief account of the events leading to death. It requires only a bare statement of the cause of death. There is, to the right of the 'Cause of Death' box, an opportunity for the doctor to state, if s/he wishes, the period of time that has elapsed since the onset of the conditions advanced as causes of death. If that information is provided, it gives some limited insight into the deceased's medical history. However, it is often not provided. The MCCD calls for much less information than cremation Form B.

5.30 During Phase One of the Inquiry, I became aware that, in a case where the deceased had been buried and there was therefore no cremation Form B, there was no available record of any account by Shipman of the deceased's medical history or of the events leading to the death. The MCCD would provide the date on which Shipman claimed to have last seen the deceased before death but that was all the information available. Thus, even if the registrar possessed the knowledge necessary to evaluate the medical information contained on the MCCD, no history is provided. If a death is reported to the coroner, s/he has no written account of the history, only the note made over the telephone during the doctor's oral report to the coroner's officer. Although a clear medical history should be available in the medical records, this is not always the case. Often there is no account of the circumstances of the death. In any event, the medical records are not available either to the registrar or to the coroner when s/he is considering whether to take the case over or to invite the doctor to issue an MCCD.

5.31 In my view, any certificate of medical opinion concerning the cause of death should contain a short history, focussed on the condition which the doctor believes has caused the death. Such an account, including the main features of the chain of events leading to death, would serve several useful purposes. First, it would clarify the doctor's own thought processes about the underlying causes of death. Second, it would facilitate a professional evaluation of the opinion by another doctor or by a coroner. Third, if discussed with the next of kin or a family member who knew the deceased, it would prevent or deter the advancement of a false account. Indeed, I believe that, if Shipman had had to provide such an account, knowing that the family of the deceased would become aware of it, this would have been a real deterrent. Even if he had not been deterred, I think it likely that, sooner or later, discrepancies between the account he had given and what the relatives

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knew to be the case would have led to enquiries being made into the circumstances of some of the deaths.

The Uncertainty about the Meaning of 'Attendance During the Last Illness'

5.32 Another shortcoming of the MCCD is the uncertainty that arises in respect of the essential qualification before a doctor may issue. This is that s/he was **'in medical attendance'** on the deceased during the **'last illness'**. The **'last illness'** is not defined and its interpretation gives rise to uncertainty. In her witness statement, Dr Rooney told the Inquiry that the basic principle is that, in order to be qualified to sign, the doctor should have been directly involved in the medical care of the patient in connection with the illness which led to the death. He or she need not have been solely responsible. Care might have been shared with other members of the clinical team in hospital or with a partner in general practice. Even a locum general practitioner may be able to issue the certificate. Dr Rooney said that the doctor could not be said to have been attending the patient **'during his last illness'** unless s/he had diagnosed the illness leading to death before the death occurred and was giving treatment or advice in respect of that condition.

5.33 It may well be that the overwhelming majority of doctors abide by these principles. However, I note that they are not explained as part of the guidance given to doctors on completion of the MCCD. I think that many doctors do not regard it as necessary to have diagnosed the potentially fatal condition before death. Many elderly people die with a variety of conditions, any one of which could lead to death. Examples are ischaemic heart disease, congestive heart failure and hypertension. However, such conditions are often treatable and are controlled by medication. The patient might live for many years with such a condition and then might die after only a brief deterioration. In many such cases, there is no identifiable **'last illness'**. I have the impression that many doctors, wishing to issue an MCCD, feel entitled to say that they have attended the deceased during the last illness if they are the patient's usual doctor. It is undesirable that a doctor should certify that s/he has attended a patient in the **'last illness'** if there is no identifiable last illness.

The Uncertainty about the Degree of Confidence Needed before Certifying the Cause of Death

5.34 A further shortcoming of the MCCD is that it is not clear how confident a doctor must be of the cause of death before s/he should feel able to issue an MCCD and submit it to the registrar, without drawing attention to any uncertainty as to the cause. As I have said, the doctor who has attended the deceased during the last illness is under a statutory duty to issue an MCCD stating the cause of death to the best of his/her knowledge and belief. Most doctors who feel insufficiently confident of the cause of death decline to certify and instead refer the death to the coroner. The statutory requirement imposes on the doctor a duty of good faith, but does not provide any guidance as to the necessary degree of confidence. No guidance is provided for the doctor in the notes contained in the book of MCCDs. Dr Rooney told the Inquiry that the doctor should be **'reasonably sure'** of the cause of death, but the Inquiry has not been referred to any official documents in which that advice is promulgated. In any event, that expression is not clear.

5.35 Nor is the doctor explicitly required to exercise his/her own professional judgement. The MCCD does not require the doctor to state the sources of his/her knowledge and belief. A doctor might issue an MCCD after a very brief personal contact with the patient, believing that what another doctor has told him/her about the patient's condition is true, but not exercising his/her own judgement.

5.36 Evidence given to the Inquiry suggests that there is much uncertainty about the standard of confidence required before a doctor should issue an MCCD. Opinions and practices vary. Some doctors say that they feel able to sign if they think that they know the probable cause of death. Others are unwilling to sign unless they feel a much higher degree of confidence. It is worth mentioning that, according to the evidence of the registrars from whom I heard, if a doctor reveals that s/he is relying on a 'probable' cause of death, the registrar will reject the MCCD on the ground that the cause of death appears to be 'unknown'.

5.37 It was suggested in evidence that good practice requires that the standard of confidence appropriate for the diagnosis of a cause of death should be the same degree of confidence that the doctor would apply when diagnosing the condition of a live patient. That may be a variable standard, depending on the nature of the condition and the treatment contemplated. However, this suggests that the standard of confidence should be higher than the mere balance of probabilities.

5.38 In my view, the existing requirement (to state the cause of death **'to the best of** [*the doctor's*] **knowledge and belief'**) is unacceptably vague. I have already mentioned that the Brodrick Committee recommended that the doctor should be required to certify the cause of death **'with accuracy and precision'**. It appears to me that that suggested an unrealistically high standard. However, I agree with the Brodrick Committee that a standard of confidence for certification should be imposed. I shall discuss what that standard should be later in this Report. One of the difficulties about certification by doctors is that of training them to assess whether the appropriate standard has been reached in any particular case. Many doctors certify a cause of death only a few times each year. Any skill that is not practised regularly is likely to decline.

Inappropriate Attitudes to Certification of the Cause of Death

5.39 Uncertainty about the degree of confidence required before a doctor should issue the MCCD may be the reason why certain doctors appear to think that their duty of certification is to some extent discretionary. Mr Christopher Dorries, HM Coroner for South Yorkshire (West), drew attention to a study published in 1993[1], which reported that 18.5% of general practitioners admitted that they might **'modify'** what they considered to be the true cause of death in order not to distress relatives. Just over 17% of general practitioners might make a similar modification so as not to involve the coroner. In research[2] in which Mr Dorries himself was involved, two doctors admitted that they would record a natural cause of death rather than report a case of potential suicide to the coroner, so as to avoid

[1] Maudsley, G and Williams, EMI (1993) 'Death certification by House Officers and General Practitioners – practice and performance', Journal of Public Health Medicine, Vol 15, No 2, pp 192–201.
[2] Start, RD, Usherwood, TP, Carter, N, Dorries, CP, Cotton, DWK (1995) 'General practitioners' knowledge of when to refer deaths to a coroner', British Journal of General Practice, April 1995, pp 191–193.

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financial loss to the family. Mr Dorries and Mr Michael Burgess (HM Coroner for Surrey), both experienced coroners, suggested that some doctors certify the cause of death, even though they are doubtful about it, because they wish to save the family distress.

5.40 It appears that doctors may sometimes be put under pressure, either expressly or implicitly, by the relatives of the deceased to issue a certificate, even though they are in doubt about the cause of death. Families are often worried by the thought that the death may have to be reported to the coroner and may be distressed at the thought of an autopsy. On the other hand, the doctor should realise that, if s/he certifies a cause of death without a sufficient degree of confidence, the certificate is of little value and the rigour of the system of certification is undermined.

5.41 The Inquiry has not heard evidence from any doctor who admits that s/he is less than conscientious in the performance of his/her duty of certification. I would not expect to hear such an open admission. Nonetheless, I think it likely that such practices occur, although only with a minority of doctors. The research tends to confirm this view.

The Poor Quality of Certification and Lack of Training

5.42 Even though the requirements of the existing MCCD are very limited, it appears that some doctors have difficulty in completing it satisfactorily. Many doctors receive no advice on their duties of death certification during training although, for some, a lecture might be available. General practitioners usually receive some guidance during their vocational training. Hospital doctors, in their pre-registration year, are often expected to complete MCCDs with very little help from their senior colleagues. This is despite the guidance contained in the book of MCCDs which states:

> **'Death certification should preferably be carried out by a consultant or other senior clinician. Delegation of this duty to a junior doctor who was also in attendance should only occur if he/she is closely supervised.'**

5.43 Several witnesses told the Inquiry that, when the new twice-yearly intake of house officers arrives at the local hospital, there is a noticeable (albeit temporary) decline in the standard of certification. Mr Dorries said that he believes that hospital bereavement officers (who are not medically qualified) often have to advise doctors who are about to issue an MCCD that the death is one which ought to be reported to the coroner. He said that doctors who come to this country already qualified as medical practitioners, with no knowledge of our legal requirements, are not tested on their understanding of what is required in death certification.

5.44 The poor quality of death certification has been regularly illustrated by research conducted over the years. Research conducted recently[3] confirms that standards of death certification are still poor. Of 1000 completed MCCDs examined, only 55% were of an acceptable standard. Nearly 10% were very poor, being illogically or inappropriately completed. This research was conducted at a teaching hospital, where standards might be expected to be higher than elsewhere. In a useful review of death certification

[3] Swift, B and West, K (2002) 'Death Certification: an audit of practice entering the 21st century', Journal of Clinical Pathology, No 55, pp 275–279.

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practice[4], the authors point out that education is frequently suggested as a mechanism for improving the accuracy of death certification. However, the evidence for its efficacy is sparse and not encouraging[5,6], prompting Dr Ryk James, a forensic pathologist who participated in one of the Inquiry's seminars, to conclude[7] that **'there is no "quick fix" for the problem'** and that even postgraduate education programmes might not result in significant improvement, assuming there was a will to institute such programmes. This view is also expressed in the article by Swift and West (see above) who observed that death certification practice had not improved despite the introduction of formal education on certification into the medical student curriculum in one UK medical school.

5.45 In my view, the completion of an MCCD is an important duty, a fact which, in the past, has received insufficient recognition from the profession and from those responsible for medical training. Moreover, there is no system of audit or review of doctors' performance of their duties in connection with death certification.

Reporting a Death to the Coroner

Difficulty in Recognising Reportable Deaths

5.46 As I have said, doctors have voluntarily assumed the primary responsibility for reporting deaths to the coroner. Many such reports are made because the doctor is uncertain about the cause of death. However, even if the doctor is quite satisfied as to the cause of death, s/he should also consider whether the death is reportable for some other reason. Because there is no statutory duty on the doctor, there is no statutory list of reportable deaths for the doctor to consult. Guidance, in the form of a list of circumstances in which a death must be reported, is provided in the book of MCCDs issued to doctors. Some coroners issue a list of the types of case that they require to be reported. These lists are broadly based on regulation 41 of the Registration of Births and Deaths Regulations 1987, which governs the categories of death that the registrar is obliged to report to the coroner: see paragraph 6.12. However, some coroners extend the scope of their lists beyond the provisions of the regulation and seek to impose additional 'local rules'. Different lists are in circulation in different coroners' districts. Doctors usually seek to comply with the wishes of their local coroner, but do not always succeed as well as they should. Particular difficulties are experienced when a doctor moves from one coroner's jurisdiction to that of another.

5.47 Studies by Dr Roger Start, a consultant histopathologist who participated in one of the Inquiry's seminars, and others (including Mr Dorries), undertaken in 1993 and 1995,[8] showed that both general practitioners and hospital doctors had difficulty in recognising the circumstances in which a death should be reported to the coroner. In the 1993 study,

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[4] Maudsley, G, Williams, G, Williams, EMI (1996) 'Inaccuracy in death certification. Where are we now?', Journal of Public Health Medicine, Vol 18, No 1, pp 59–66.
[5] Weeramanthri, T, Beresford, W, Sathiananthran, V (1993) 'An evaluation of an education intervention to improve death certification practice', Australian Clinical Review, No 13, pp 185–189.
[6] Pain, CH, Aylia, P, Taub, NA *et al.* (1996) 'Death certification: production and evaluation of a training video', Medical Education, No 30, pp 434–439.
[7] James, DS, Bull, AD (1996) 'Information on death certificates: cause for concern?', Journal of Clinical Pathology, 1996, No 49, pp 213–216.
[8] Start, RD, Delargy-Aziz, Y, Dorries, CP, Silcocks, PB, Cotton, DWK (1993) 'Clinicians and the coronial system: ability of clinicians to recognise reportable deaths', British Medical Journal, Vol 306, 17th April 1993, pp 1038–1041; Start *et al.* 'General practitioners' knowledge of when to refer deaths to a coroner' (see footnote 2, p. 121).

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135 clinicians of various grades from the general medical and surgical firms of a large teaching hospital considered 16 fictitious case histories. Fourteen of the histories contained a clear indication for referral to the coroner. The clinicians were asked to decide whether the case should be referred and to give reasons. The case histories were also considered by two coroner's officers and two deputy coroners from Mr Dorries' office in Sheffield. The study found that the average percentage of correct answers for clinicians in each grade was between 56% and 69%. Consultants fared slightly worse than house officers. Senior registrars were the most successful. By way of example, 20 out of 34 consultants failed to recognise the need to report the death of a 49 year old paraplegic who had suffered spinal injuries in an accident at work 15 years earlier. He had been transferred from the spinal injuries unit suffering from septicaemia resulting from infected sacral sores. Despite treatment, he developed a chest infection and died. The death should have been reported, as the cause was plainly related to the spinal injuries sustained in an accident at work.

5.48 If this pattern of poor recognition were to be repeated in practice, it would suggest that many deaths that ought to be reported to the coroner are not. It was noted that clinicians appeared to have the greatest difficulty in recognising when to report a death associated with medical treatment. The coroner's officers and deputy coroners all identified correctly the reportable cases. Although Dr Start and his colleagues did not draw this express conclusion, it is apparent to me that the reason for this is that they are dealing with the relevant issues regularly day after day, whereas any clinician will apply his/her mind to the problem less frequently.

5.49 In the 1995 study, 196 general practitioners, two coroner's officers and two deputy coroners considered 12 fictitious case histories, ten of which contained an indication for referral to the coroner. On average, the general practitioners scored just over 70%, a rather better result than the hospital clinicians. Only six general practitioners achieved a maximum score. Fifteen and a half per cent recognised half, or fewer than half, of the reportable cases. Again, the coroner's officers and deputy coroners all achieved full marks. Mr Dorries told the Inquiry that there was no reason to suppose that doctors would perform any better today than they had done in 1993 and 1995.

5.50 The Inquiry has heard that some doctors never report a death to the coroner. It seems unlikely that this is because no death certified by them ever comes within the categories of reportable deaths. It is more likely that the doctor does not know which deaths should be reported or does know but is seeking to spare families the ordeal of a report to the coroner and a possible autopsy. It may be that the doctor has personal objections to the autopsy process.

5.51 On examination of a random selection of registrars' referrals to the South Manchester Coroner's office, the Inquiry came across an example of a doctor's failure to refer an obviously reportable case to the coroner. A young man attempted suicide by taking an overdose of insulin. The police investigated and found a note. The man was admitted to hospital, where he survived for some weeks in a coma. When he died, a hospital doctor certified that the death was caused by I(a) right basal pneumonia, (b) persistent vegetative state and II Type 1 diabetes mellitus with insulin overdose and hypoglycaemic

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brain injury. The registrar queried the MCCD because of the inclusion of the words **'overdose'** and **'injury'**. The informant, the deceased's sister, told the registrar about the attempt at suicide and the subsequent investigation. The registrar reported the death to the coroner. A member of the coroner's staff spoke to the doctor and asked him why he had certified the death and had not reported it to the coroner. His response was that he had done nothing wrong. The deceased had died of pneumonia, which was a natural cause. Plainly, that doctor had no understanding at all of the circumstances in which a death should be reported to the coroner. Another example was provided by Dr Richard Hardman, Medical Referee at Stockport crematorium since 1990. He received cremation forms which revealed that the deceased had been found dead in his car. The cause of death was said to be asphyxia. Suspecting that the deceased might have committed suicide, Dr Hardman reported the death to the coroner. After an autopsy and inquest, a verdict of suicide was entered. Yet a doctor had been prepared to certify the cause of death without referring the death to the coroner, which was obviously the proper course in the circumstances.

5.52 There is no system of audit or review of those cases where the doctor certifies the cause of death and does not report the death to the coroner. The cases that I have referred to above only came to light because words indicative of an unnatural death were used in the 'Cause of Death' section of the MCCD. There may be many cases where there is no such automatic trigger and where a death that should have been reported to the coroner goes undetected. If that happens, and the deceased is to be buried, there is no subsequent procedure that would bring to light a failure to report. If the death is to be followed by cremation, it is possible that the failure might be revealed by the cremation certification procedures. However, as I shall explain in Chapter Eleven, this may well not be the case.

5.53 I conclude that the present arrangements whereby, in practice, doctors decide whether or not to report a death to the coroner, are not satisfactory. From the research, it would appear that more reliable decisions would result if coroners or coroner's officers, who deal with the issue of reportability on a daily basis, were responsible for this process. However, I recognise that the coroner's officers from Sheffield, who took part in this research, are more experienced than many and have had the advantage of working under the supervision of Mr Dorries, who is very knowledgeable about coronial law and, I think, requires high standards from his officers. If coroner's officers are to make such decisions, they must be trained and their capability tested.

When the Doctor Believes that the Death Must Be Reported

5.54 If a doctor is insufficiently confident that s/he knows the cause of death or realises that, although the cause is known, there is some other reason to report the death to the coroner, s/he will usually telephone the coroner's office. Because there is no statutory duty on the doctor to report the death, there is no formal or official means of making the report. No prescribed form is supplied for the purpose. The report is usually made informally, by telephone. The doctor will speak to the coroner's officer and will explain the reason why s/he is making the report. The coroner's officer might decide to take over responsibility for the death and might consult the coroner before making the decision. The doctor might

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hear no more about it although, in some cases, s/he will be asked to provide a statement or report about the death and may have to attend to give evidence at an inquest.

5.55 The legal position is that, when the coroner is informed of a death, s/he must decide whether the death gives rise to a reasonable suspicion that the circumstances call for an inquest, i.e. that the death was violent or unnatural or occurred while the deceased was in prison or other specified forms of custody or that the death was sudden and the cause is unknown. If there is no such reasonable suspicion, the coroner has no jurisdiction to take on the case. Some doctors complain that, if they telephone to say that they are not sufficiently sure of the cause of death, the coroner (or more likely the coroner's officer) will indicate that s/he is not willing to accept the case (an oft-used phrase seems to be that 'the coroner won't be interested') and will seek to persuade the doctor to issue an MCCD. The doctor feels under pressure to do so because, if the coroner will not accept the case and the doctor refuses to issue an MCCD, the relatives are unable to register the death or dispose of the body.

5.56 Coroners deny that this kind of situation ever arises. They say that they are always willing, even anxious, to take on cases that require investigation. It may be that sometimes the problem is one of misunderstanding or of differing perceptions of the respective roles of the coroner's office and the certifying doctor. The coroner or coroner's officer might genuinely believe that the doctor is being over-cautious about certifying the cause of death. However, as I shall explain in Chapter Seven, there is evidence that doctors are sometimes put under pressure to issue an MCCD.

When the Doctor Is in Doubt about Whether to Report the Death

5.57 Many doctors make a practice of telephoning the coroner's office to discuss a death, if they are in doubt about whether they should report the death or whether it would be in order for them to issue an MCCD. Some will telephone to seek a dispensation in relation to some aspect of the rules with which they cannot comply. It is quite common for a doctor to seek and receive permission to issue an MCCD in respect of a death which the registrar would be bound to report to the coroner, for example, because the doctor has not seen the deceased within 14 days before death or seen the body after death. Although some telephone calls are made for the purpose of reporting a death, many are made for the purpose of seeking advice. Some coroners encourage such informal discussions. These discussions are, to a very large extent, controlled by the coroner. I shall discuss them in greater detail in Chapter Seven.

No Certificate of the Fact of Death

5.58 Another shortcoming of the present system is that there is no requirement that a doctor or any other health professional should certify the fact that the deceased has died. It is quite possible for a family member to conclude that death has occurred, to telephone the doctor to say so and for the doctor to issue an MCCD without seeing the body. In practice, as I have explained in Chapter Four, it is usual for a doctor or paramedic to check that the person has indeed died, but there is no legal requirement that this should be done. Nor

is there any requirement that any record should be made of the time or circumstances of the death.

5.59 As I discovered when investigating the deaths of Shipman's patients during Phase One of the Inquiry, any knowledge of the circumstances of the death is valuable. Information recorded at the time of the examination by the doctor or other suitably qualified health professional who confirms the fact of death would be particularly useful to anyone who might later be responsible for investigating the death. I have in mind information such as the time and place of death and the identity of any person present at the death or, if the deceased were alone, of the person who found the body. If someone were present at the death, a brief account of how the death occurred would be valuable. If the deceased had been found dead, a note of the position of the body and the way in which the deceased was clothed would also be helpful. When paramedics are called to a death, they record some information of this kind. In many cases, however, such information is never recorded.

5.60 The Brodrick Committee recognised the need for formal certification of the fact of death. They proposed a combined certificate of fact and cause of death. In my view, a separate document would be more appropriate. Nowadays, the doctor who knows most about the deceased's medical history might well not attend to confirm that death has occurred. As I have explained in Chapter Four, many doctors use deputising services outside normal working hours. Many deaths are also confirmed by paramedics.

5.61 In my view, there should be a requirement that the person confirming the fact that death has occurred should complete a short form providing the type of information I have suggested. In so saying, I do not suggest that it should be mandatory for a doctor to attend to certify the fact of death. In my view, a registered nurse or paramedic would be capable of examining the body, certifying that the deceased is dead and completing the form.

5.62 Not only would such a form assist in the professional scrutiny of the circumstances of death, it would also form a valuable safeguard against any attempt to provide false information about the death. Shipman often told lies about the circumstances of death. If he had had to complete a form such as I have described, and if the deceased's next of kin, family member or partner had learned of its contents, there would have been a very good chance that the falsehoods would have been noticed. Indeed, as I observed in respect of the requirement to complete a form containing the medical history, Shipman's knowledge that he would have to complete a form describing the circumstances of death would have acted as a significant deterrent.

Shipman's Manipulation of the System

5.63 Shipman's ability to certify the cause of death of the patients he had killed, without objection from anyone, enabled him to pass off the killings as natural deaths. To relatives or anyone with an interest in the deceased, who might have considered making a report to the coroner, Shipman would say that he knew the cause of death. Usually, he would give the relatives a brief explanation and tell them that there was no need to have an autopsy or report the death to the coroner. If a relative suggested to him that the death seemed

very sudden and unexpected, his usual reply was to tell the relatives that the death might have been unexpected to them but it was not unexpected to him. The relatives so trusted Shipman that they did not question his word.

5.64 There was nobody in authority with the power or knowledge to question the certificate that Shipman had issued. In the case of all but two of the killings (those of Mrs Renate Overton and Mr Charles Barlow), the Coroner for the Greater Manchester South District was not even aware of the death. In a few more (the death of Mrs Kathleen Grundy was one), it appears that Shipman probably spoke informally to a member of the Coroner's staff and was 'permitted' to issue the MCCD, stating the cause of death he had proposed. I have no doubt that, in those few cases, Shipman gave the member of staff a highly plausible account of the death.

5.65 The registrar would rarely have any basis on which to query the issue of an MCCD by Shipman. The registrar would query the certificate only if there was some fault in its completion. Shipman was usually very careful to complete MCCDs properly and only rarely gave a cause of death that was not acceptable to the registrar. A registrar might have felt it appropriate to report a death to the coroner if a relative had told him/her that, notwithstanding Shipman's certificate, the family was concerned that the death had been very sudden and unexpected. Shipman often took precautions to avoid that kind of occurrence by telling the victim's family that, if the case were reported to the coroner, it would mean that there would have to be an autopsy and that this procedure would probably delay the funeral. Relatives are often reluctant to submit the bodies of their loved ones to autopsy, if it can be avoided. Often they are anxious to make funeral arrangements and are worried that an autopsy will cause delay. So it was easy for Shipman to manipulate their feelings in this way.

Loss of Public Confidence due to Shipman

5.66 The discovery of Shipman's crimes has resulted in a substantial loss of public confidence in a system that depends so heavily on the integrity of a single doctor. I consider that, even if it were to be shown that the present system of death certification by a single practitioner was working well in most cases, the loss of confidence is such that the public will not be satisfied unless and until significant change is made. This loss of confidence is a measure of the damage that Shipman has caused to his former profession. I can well understand the sense of outrage that honest and conscientious doctors must feel.

Conclusions

5.67 In my view, the present system of death certification requires reform. My first reason for so saying is that the system is open to abuse by a dishonest doctor. An adequate system of death certification must provide some effective cross-check upon the account of events given by the doctor who has treated the deceased and who claims to be able to identify the cause of death. An account of the same events should be obtained from a family member or someone with knowledge of the circumstances of the death. Such a cross-check is needed, not only to deter a doctor such as Shipman, but also to deter any doctor

who might be tempted to conceal activity less serious than murder, such as an error or neglect by him/herself or a colleague.

5.68 I have also outlined other aspects of the system that are less than satisfactory. The Brodrick Committee advocated reform of the system of certification, even though its members believed that there was no appreciable risk of concealment of homicide or malpractice. Their perceptions of the shortcomings of the system were similar to mine. My reasons include the paucity of information gathered on the MCCD, the irrationality of the 'either/or rule', the elasticity with which doctors interpret the rules of qualification, the uncertainty about the standard of confidence required before the doctor should certify the cause of death and the unsatisfactory practice relating to the reporting of deaths to the coroner.

5.69 Some of the shortcomings I have outlined in this Chapter might be capable of resolution if doctors were to be educated in the purposes of death certification and trained how and when to complete an MCCD. However, in my view, and as the research suggests, education could not provide an answer to the more fundamental deficiencies.

5.70 I have already said that I have concluded that the present arrangements, whereby, in effect, doctors take the decision as to whether or not a case should be reported to the coroner, are not satisfactory. My conclusion is based partly upon the research by Dr Start and his colleagues, which suggests that, even when making a proper effort to reach the right decision, doctors fail to do so in an unacceptably high proportion of cases. A further reason for my view is that I am satisfied that some doctors are vulnerable to pressure not to report a death in circumstances in which they know that they should do so. Later in this Report, I shall consider whether it would be appropriate for all deaths to be reported to the coroner service, thereby removing from doctors the decision as to whether or not to report and also avoiding the need for the compilation and interpretation of a long list of circumstances in which a death should be reported.

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CHAPTER SIX

Registration of Deaths

The Registration Service

6.1 The registration service is organised within 172 local authority areas in England and Wales. Registrars of births and deaths ('registrars') are statutory office-holders who have no employer and no line manager. Their duties are prescribed by statute and regulations. They are appointed by the local authority, but may be removed from office only by the Registrar General, to whom they are accountable for the performance of their statutory duties. All registrars must appoint at least one deputy. In large urban areas, several full-time registrars may be based at one register office, together with deputies, some of whom work part-time. In sparsely populated rural areas, there may be a part-time registrar and one deputy, also part-time. In those circumstances, a deputy registrar may work very infrequently.

6.2 Registrars need no specific qualifications and those entering the service come from a variety of employment backgrounds. They have no medical expertise; indeed, medical practitioners are one of the classes of person at present disqualified from holding the office of registrar. In the past, the General Register Office (GRO), which is the office of the Registrar General and forms part of the Office for National Statistics (ONS), provided residential training courses for registrars (but not deputies), covering all aspects of their work, including death registration. In recent years, however, the policy has changed, probably for financial reasons. Now, the onus is on the appointing authorities to organise local training. The GRO will provide assistance with the content of that training. The GRO also holds seminars and distributes written information, explaining important changes in registration law and practice. It provides a distance-learning package and produces the Handbook for Registration Officers, which contains instructions to registrars in carrying out their functions; the Handbook is up-dated frequently.

6.3 In 1994, the GRO, in collaboration with local authorities, introduced an examination of registration law and practice, which tests candidates' knowledge of the law and practice relating to registration, and includes a practical examination. The examination is not compulsory. The GRO also carries out periodic inspections of the work of registrars and register offices.

6.4 Local authorities in some areas (Lincolnshire is one) have developed excellent training programmes for registrars and deputies. In other areas (for example, Manchester), there is little or no training provision and very limited opportunity for contact between registrars working in different register offices. As a consequence, practices within local register offices vary significantly and registrars can experience a degree of isolation.

6.5 The GRO provides an advice line, offering assistance to registrars who have queries about registration matters. So far as the registration of deaths is concerned, the majority of queries relate to the cause of death. A registrar might not understand the cause of death that appears on the MCCD or might be uncertain as to whether s/he should report the death to the coroner. Those employees of the General Section of the GRO who deal with

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such queries have no medical qualification or specific training for the task and are reliant upon medical reference books and notes of past advice that has been received or given. As I shall explain in due course, these notes are not always helpful. In the event of a particularly complex medical query, it is open to the staff to seek the advice of medical epidemiologists employed by the ONS. However, the evidence given to the Inquiry strongly suggested that most questions are resolved by members of the staff within the General Section, without recourse to medical advice.

The Registration of a Death

6.6 The Births and Deaths Registration Act 1953 governs the registration of deaths. In order to register a death, the informant must attend personally before the registrar to give information. The only exception to the requirement for personal attendance before the registrar arises where an inquest is held. In that event, the coroner provides the particulars necessary for registration after the inquest has been concluded and no signature in the register (other than that of the registrar) is required. In other cases, the informant must attend the register office before the expiration of five days from the date of death or finding of the body; however, if the informant sends to the registrar written notice of the death, together with notice from the doctor that the MCCD has been signed within the five-day period, that period is extended to 14 days.

6.7 The registrar must enter particulars of the death in a register, from which a certified copy of any entry identified in the index may thereafter be supplied on request, upon payment of a fee. The Registration of Births, Deaths and Marriages Regulations 1968 prescribe the particulars which must be recorded in the register of deaths: a blank entry can be seen at Appendix C to this Report. Information about the date and place of death, the name, occupation, sex and usual address of the deceased and details of the informant must be recorded. The cause of death must be recorded precisely as it appears on the MCCD or coroner's certificate. The name and qualification of the medical practitioner who completed the MCCD must be entered in the register. The registrar will also ask the informant a number of questions, the answers to which are not recorded in the register but are sent to the Registrar General, to be used for statistical purposes.

6.8 If the MCCD appears, on its face, to have been fully and correctly completed and contains an acceptable cause of death, and if the registrar is not aware of any circumstance requiring that the death be reported to the coroner, the registrar will proceed to register the death in reliance upon the MCCD. If the registrar proceeds to registration, the relevant particulars are entered in the register and signed by the informant. The registrar will then issue at least one certified copy of the entry in the register (often known as the 'death certificate', although that term is also used, incorrectly, to describe an MCCD) and will issue a disposal certificate, certifying that the death has been registered. A copy of a blank disposal certificate can be seen at Appendix C to this Report.

6.9 There are circumstances in which the registrar will have further documentation to consider, in addition to the MCCD. Before the death comes to the registrar, it may have been reported to the coroner, probably by the deceased's treating doctor. If the coroner has completed his/her enquiries into the death, no post-mortem examination has been

held and the coroner does not intend to take any further action in connection with the death, the coroner's office will usually send to the registrar a Form 100A, signed by the coroner, confirming that no post-mortem examination has been held and the coroner does not consider it necessary to hold an inquest. There is no legal requirement on the coroner to issue a Form 100A and the form is not prescribed by statute. Copies of the form are supplied by the Registrar General for use by coroners. A blank Form 100A can be seen at Appendix C of this Report. The cause of the deceased's death will usually (although not always) be recorded on Form 100A. However, the instructions on the reverse of the form direct the registrar to rely on the cause of death that appears on the MCCD when making the entry in the register of deaths. In practice, the coroner's staff will usually ensure that the cause of death on Form 100A is the same as that which appears on the MCCD. However, if there is inconsistency, it is the information on the MCCD upon which the registrar must rely.

6.10 If the death has been reported to the coroner and s/he has directed a post-mortem examination and is satisfied, as a result of that examination, that no inquest is necessary, the coroner's office will send to the registrar a Form 100B, signed by the coroner, confirming that the coroner does not consider it necessary to hold an inquest. Under the provisions of section 19(3) of the Coroners Act 1988, a coroner is required, when satisfied as a result of a post-mortem examination that an inquest is unnecessary, to send to the registrar a certificate stating the cause of death as disclosed by the report of the examination. The form of the certificate is not prescribed by statute and Form 100B is provided by the Registrar General for this purpose. A blank Form 100B can be seen at Appendix C of this Report. The instructions on the reverse of the form direct the registrar to enter the cause of death which appears on Form 100B in the register of deaths. In practice, it is highly unlikely that the registrar will have received an MCCD in a case where a post-mortem examination has been undertaken, so that there will be no alternative source from which the registrar could take the cause of death.

6.11 If the death has been reported to the coroner and an inquest is held, the death cannot be registered until the conclusion of the inquest. The coroner is then required by section 11(7) of the Coroners Act 1988 to send to the registrar a certificate giving various details about the death and the inquest. That certificate must specify the particulars to be registered, including the cause of death. The form of the certificate is not prescribed by statute and Form 99 is provided by the Registrar General for this purpose. A blank Form 99 can be seen at Appendix C of this Report.

The Duty of a Registrar to Report a Death to the Coroner

6.12 In certain circumstances, a registrar will not register the death, but will instead report it to the coroner. Regulation 41 of the Registration of Births and Deaths Regulations 1987 provides:

> **'(1) Where the relevant registrar is informed of the death of any person he shall ... report the death to the coroner on an approved form if the death is one:**
>
> **(a) in respect of which the deceased was not attended during his last illness by a registered medical practitioner; or**

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(b) in respect of which the registrar:
(i) has been unable to obtain a duly completed certificate of cause of death; or
(ii) has received such a certificate with respect to which it appears to him, from the particulars contained in the certificate or otherwise, that the deceased was not seen by the certifying medical practitioner either after death or within 14 days before death; or
(c) the cause of which appears to be unknown; or
(d) which the registrar has reason to believe to have been unnatural or to have been caused by violence or neglect or by abortion or to have been attended by suspicious circumstances; or
(e) which appears to the registrar to have occurred during an operation or before recovery from the effect of an anaesthetic; or
(f) which appears to the registrar from the contents of any medical certificate of cause of death to have been due to industrial disease or industrial poisoning.'

6.13 In practice, registrars report deaths to the coroner comparatively infrequently. Indeed, in 2001 (the last year for which ONS statistics are available), reports from registrars accounted for only about 4% of all deaths referred to the coroner. Usually, the attending doctor will have recognised that the death is one which should be reported and will have taken the step of reporting the death before the stage of registration has been reached. It is obviously preferable, where a death must be reported for one of the reasons set out above, that this is done as soon as possible. This enables the coroner to begin his/her enquiries earlier than would be the case if the death were reported at the registration stage, with less delay to the funeral arrangements. In 2001, 95.7% of coroners' referrals were made by doctors. There is, as I have said, in Chapter Five, no statutory duty upon a doctor to make such a referral. However, doctors are encouraged by their professional associations and by the GRO (in the guidance notes contained in books of MCCDs) to report to the coroner any death which they judge would need to be referred to the coroner by the registrar. The remaining referrals to the coroner (less than 1% in 2001) were made by the police and other agencies.

6.14 In general, if a registrar communicates with the coroner's office about a death, it is because one of the following circumstances has arisen:

(a) The doctor completing the MCCD has indicated that s/he has reported **'this death to the Coroner for further action'**. If that has been done, the registrar cannot register the death without ensuring that the coroner has completed his/her enquiries into the death. The coroner will usually give notice that s/he has completed his/her enquiries and intends to take no further action by issuing a Form 100A: see paragraph 6.9.

(b) The cause of death (or certain words used to describe the cause of death), as certified by the doctor, is one which the registrar has been instructed should be referred to the coroner. This might arise, for example, if the word 'dehydration' (which

might suggest an element of neglect) or 'fracture' (which might mean that the death was due to an accident and, therefore, violent or unnatural) appears within the causes of death stated. Another example would arise if the registrar took the view that the cause of death certified amounted to a 'mode of dying', rather than a cause of death.

(c) The informant or another member of the deceased's family gives the registrar information that suggests that the death might fall into one of the categories referred to in regulation 41. The Inquiry was told that this most commonly occurs in the case of industrial disease; for example, when the deceased dies of a respiratory condition and the family tells the registrar that s/he was in receipt of a pension relating to byssinosis contracted when working in the cotton industry. Such cases should result in an autopsy and inquest.

(d) There is disclosed on the face of the MCCD information that suggests that the death should have been reported to the coroner by reason of the statutory requirements or because of a 'local rule' operated by the coroner. Regulation 41(1)(b)(ii) requires that a death must be reported to the coroner, if the certifying doctor did not see the deceased either after death or within 14 days before the death (the 'either/or rule'). However, many coroners have a 'local rule' whereby all deaths where the certifying doctor did not see the deceased during the 14 days before death must be reported, irrespective of whether the doctor saw the deceased after death. Another common local rule requires deaths occurring within a certain period (usually 24 hours) after admission to hospital to be reported.

6.15 Regulation 41 provides for the registrar to report to the coroner deaths within the categories specified in the regulation on an approved form. The approved form is known as Form 52; it is not prescribed by statute, but is produced by the Registrar General for the use of registrars. A blank Form 52 can be seen at Appendix C to this Report.

6.16 In the case of a death which the registrar has reported to the coroner, or which s/he knows has been notified to the coroner, or which s/he knows it is the duty of some other person or authority to report to the coroner, the registrar must refrain from registering the death until s/he has received either a coroner's certificate after an inquest (Form 99) or a notification (usually on Form 100A or Form 100B, but sometimes oral) that the coroner does not intend to hold an inquest. Receipt of such notification enables the registrar to proceed to register the death.

The Process of Registration

Meeting the Informant

6.17 The registration service rightly lays considerable stress on the need for accurate information about the deceased. Hitherto, personal attendance by the person likely to have the best knowledge about the deceased has been seen as the only way to ensure the accuracy of information. However, changes have been proposed recently which would make personal attendance optional. I shall refer to those proposed changes later

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in this Chapter. Many registrars consider that a face to face meeting between the registrar and the informant is helpful to bereaved relatives. They believe that families welcome the opportunity to take a formal part in the process of registration. Under the present system, the visit to the register office often constitutes the only contact with 'the authorities' during the post-death procedures and may be welcomed by some as a practical task in which they can be involved in the aftermath of the death. For others, it must be an inconvenience, even an ordeal. In many other jurisdictions, personal attendance is not required in order to register a death. I have the impression that registrars are very considerate of the bereaved and make every effort to ensure that the process of registration causes as little distress as possible.

6.18 As I have said in Chapter Five, the doctor usually hands over the MCCD to the informant or another member of the deceased's family in a sealed envelope; some doctors do not tell that person the cause of death before handing over the certificate. Registrars report that it is quite common for the relatives of the deceased to be unaware of the cause of death when they present the certificate at the register office. Registrars say that relatives sometimes bring the MCCD without its envelope or they find that the envelope has been opened; it appears that the family has looked at the MCCD. The registrar does not challenge the family about this, unless it appears that the certificate has been tampered with. However, often, when the envelope has not been opened, the relatives ask to see the certificate when the registrar has opened it. The registrar allows them to do so and the relatives are sometimes puzzled, distressed or even angry when they find out the cause of death that the doctor has given. Registrars often have to try to explain the cause of death to the deceased's relatives and are ill equipped to do this. A relative might be distressed to see that a cause of death such as 'alcoholism' appears on the certificate. Sometimes, the relative will challenge what the doctor has put, asserting that the deceased certainly did not suffer from the condition to which the doctor has attributed the death. The registrars say that they try to do what they can to help the relatives in these difficult and distressing circumstances but feel that this is more than should be expected of them, as administrators of the system. They consider that the informant should be told of the cause of death by someone with medical knowledge before registration takes place. Obviously, it is highly desirable that this should be done by the doctor who completes the MCCD at the time the certificate is handed over.

Obtaining Information from the Informant

6.19 There is certain information that a registrar must seek from the informant in the course of their meeting. He or she must obtain the details to be recorded in the register of death and must seek other information required for statistical purposes. The registrar must also find out whether the deceased is to be buried or cremated. He or she must find out how many certified copies of the entry in the register of deaths are required by the informant. However, there is no requirement for the registrar formally to seek information relating to the circumstances surrounding the death. Nor is the registrar required to confirm information given by the doctor who has issued the MCCD. If it appears to the registrar that there are circumstances that suggest that the death is reportable to the coroner under the provisions of regulation 41, his/her duty is to make the report. However, the registrar

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is not required to make direct enquiries of the informant, with a view to ascertaining whether or not such a report is necessary.

6.20 Sometimes, the informant will volunteer information during the course of the meeting (e.g. about a recent fall suffered by the deceased which might have had a bearing on the death) that will alert the registrar to the need to report the death. Sometimes also, in the course of general conversation, it will become evident that there are differences between the facts as stated by the doctor on the MCCD and as given by the informant. In those cases, the registrar might make further enquiries or might report the death to the coroner.

6.21 There appears to be some confusion among registrars about the ambit of the questions that the registrar is required to ask the informant. One witness, a deputy registrar, stated in her Inquiry statement that it was a requirement of the registration process to ask the informant when the doctor last saw the deceased. It is clear from the evidence of Miss Ceinwen Lloyd, Branch Manager Births and Deaths Registration at the GRO, that this is not in fact the case. At a register office that I visited personally, for the purpose of seeing registrars at work, some registrars believed that it was obligatory for them to ask an informant whether the deceased had suffered any fall or other accident prior to death. They always did so. One of their colleagues, however, said that he never asked this question. He was unaware of any requirement that he should do so and Miss Lloyd's evidence makes it clear that no such requirement in fact exists. Within the Tameside register office, it is clear from the evidence that different registrars had differing practices in relation to the questions asked of informants.

The Registrar's Duty to Scrutinise the Medical Certificate of Cause of Death

Has the Correct Form Been Used?

6.22 The registrar must first check that the correct form has been used; there are separate forms for neonatal deaths and stillbirths. Then, s/he must scrutinise the MCCD to ascertain whether it appears to be 'valid' and 'acceptable'.

Is the Doctor Qualified?

6.23 The first stage is to ascertain that the form has been signed by a doctor who was qualified to sign it. If the form is not signed, or the doctor who has signed it was not qualified to do so, the MCCD is invalid. There are two necessary ingredients to qualification. First, the signatory must be a registered medical practitioner. Usually, this is easy to check. The registrar becomes familiar with the names and the writing of the doctors working in the district, although there will be a twice-yearly influx of new house officers at hospitals. The task of the registrar would be made easier if the doctor were required to print his/her name and to add his/her General Medical Council registration number.

6.24 Second, the doctor must have attended the deceased during the last illness. As I have said in Chapter Five, the meaning of this phrase is not defined. The certifying doctor states in the declaration contained on the MCCD that s/he was in medical attendance during the deceased's last illness. When considering whether the doctor is qualified in this respect,

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the registrar is wholly dependent on the doctor's assertion. The registrars who gave evidence to the Inquiry said that they did not understand it to be their task to ask the informant questions designed to check the truth of statements made by the certifying doctor. If, however, the informant, or anyone accompanying the informant, were to volunteer information that cast doubt on an assertion made by the doctor (as, for example, by remarking that the deceased had not seen a doctor for months), the registrar should heed that and should report the death to the coroner.

Application of the 'Either/Or Rule'

6.25 If the registrar is satisfied that the certificate is 'valid', s/he must then consider whether it is 'acceptable'. The registrar will check to see if the doctor has recorded that s/he saw the deceased within 14 days before death or has seen the body after death. The registrar is not required to check with the informant when the certifying doctor last saw the deceased. In this, as in other matters, the registrar is dependent on the word of the doctor. If the doctor has stated that s/he has seen the deceased's body after death but had not seen the deceased for, say, several months before death, the registrar may wonder whether the doctor is sufficiently certain of the cause of death. There is no official guidance available to a registrar on this issue.

The 'Spearing Box'

6.26 Next, the registrar will look at the 'Spearing box' where the doctor should state whether s/he has any reason to believe that the death was or might have been caused by the employment followed at some time by the deceased. When that box has been ticked, the death must be reported to the coroner, if that has not already been done. Several registrars told the Inquiry that doctors frequently fail to tick this box when it would obviously have been appropriate for them to do so. As the registrar has to ask the informant about the deceased's former occupation, there is an opportunity to discover whether the death might have resulted from exposure to an industrial hazard. Questions about pensions may also lead to relevant information being given. Mr Christopher Dorries and Mr John Pollard, HM Coroners for South Yorkshire (West) and Greater Manchester South respectively, said that, in their experience, the most common reason for a registrar to report a death to the coroner was the discovery of a possible connection between the deceased's former occupation and the cause of death. Some registrars, on seeing a death from lung disease (particularly lung cancer) make a practice of asking questions designed to discover whether the death might have been occupational in origin. However, it does not seem that the practice is universal.

Scrutiny of the Cause of Death

6.27 The registrar will then examine the cause of death. It is this process which gives rise to the registrar's main difficulty. Registrars have no medical training. Some registrars told the Inquiry that they felt ill equipped to undertake this task and thought that it should be undertaken by someone with a medical qualification.

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6.28 Various difficulties arise. Sometimes, the problem is only that the doctor's writing is difficult to read. Sometimes, the registrar is not familiar with, and does not understand, the medical terminology used in stating the cause of death. Not having any medical training, the registrar is seeking to 'recognise' the terms used by the doctor to describe the cause of death, but will frequently not understand them. Experienced registrars become familiar with the most common causes of death but, from time to time, the registrar is faced with a cause of death of which s/he has never heard. It has not been thought practicable to provide registrars with a list of acceptable causes of death. I can understand why. The list of possibilities would be almost endless. If in difficulty, the registrar might telephone the doctor to ask what the cause of death means. But s/he might hesitate to do so for a variety of reasons. In any event, s/he cannot assess the validity or reliability of the answer. Alternatively, the registrar might telephone the GRO advice line. Depending on the experience of the individuals concerned, a member of the GRO staff might have a wider knowledge of medical terminology than the registrar. However, like the registrars, the GRO staff are not medically qualified. The evidence strongly suggests that they do not often refer queries from registrars to one of the medical epidemiologists employed by the ONS. This situation is not satisfactory and it would be manifestly better for the scrutiny of the cause of death to be carried out by someone who understands the terminology employed and has immediate access to medical expertise, if required.

6.29 The GRO issues guidance to registrars about causes of death that, if they appear on the MCCD, should be reported to the coroner. For example, the Handbook for Registration Officers states that tetanus is almost always the result of an injury and, when it appears on the MCCD, should be reported. Registrars are also advised that blood poisoning and septicaemia should be reported if they appear alone on the MCCD and if they appear in association with an injury. The Handbook also advises that modes of dying do not, on their own, positively identify a cause of death. If all the information recorded in Part I of the cause of death takes the form of a mode of dying, rather than a cause of death, the death should be regarded as one where the cause is not known and should be reported to the coroner. Examples of statements implying a mode of dying include 'respiratory arrest', 'respiratory failure', 'cardiac arrest' and similar expressions. If, however, the mode of dying is supported by a cause of death that would not of itself be reportable, that is acceptable. For example, 'cardiac arrest' in Part I(a), without more, would not be acceptable. However, if the immediate cause were given as I(a) cardiac arrest due to I(b) myocardial infarction and I(c) ischaemic heart disease, the MCCD would be acceptable. Sometimes, a doctor will place the diseases or conditions causing death in the wrong order, for example with the immediate cause at I(c) instead of at I(a). An experienced registrar will learn to recognise this and will see that the certificate does not make 'medical sense'.

6.30 Since 1985, 'old age' has been acceptable to the registration service as the sole cause of death, provided that the deceased was aged 70 or over. The Inquiry was told that the decision to accept 'old age' was made because it was thought that conditions such as 'bronchopneumonia' were being used by certifying doctors in order to avoid referrals to the coroner in cases where frail and elderly persons died without having any specific

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disease diagnosed or treated. Until 1996, the guidance to certifying doctors about the use of 'old age' was as follows:

> **'In some elderly persons, there may be no specific condition identified as the patient gradually fails. If such circumstances gradually lead to deterioration and ultimate death, 'old age' or 'senility' is perfectly acceptable as the sole cause of death for persons aged 70 and over.'**

6.31 This guidance is closer to, although not as stringent as, the criteria which Dr John Grenville, a general practitioner, advised the Inquiry should be applied before a doctor could properly certify a death as being due to 'old age'. In his oral evidence, given during Phase One of the Inquiry, Dr Grenville said:

> **'It** [*old age*] **is an appropriate thing to put where an elderly patient has been suffering for some time with generalised degenerative disease involving several organs, the elderly patient has been ill for a significant period of time, usually weeks or months, with multiple organ failure and the death is fully expected. It may be difficult in those circumstances to determine exactly which organ it was that ultimately failed and brought about the death. So, in that situation, the diagnosis of old age or senility is acceptable.'**

6.32 The description given by Dr Grenville amounts, in effect, to a positive diagnosis of 'old age' as the cause of death, not merely a default cause to be used in the absence of any other possibility.

6.33 In 1996, the guidance to certifying doctors was amended under the supervision of the Deputy Chief Medical Statistician and the ONS Death Certification Supervisory Group to state:

> **'... do 'not' use 'old age' or 'senility' as the *only* cause of death in Part I unless a more specific cause of death cannot be given and the deceased was aged 70 or over'**.

6.34 The references to gradual failure and deterioration, which appeared in the earlier guidance, were not reproduced in the later version. In my view, the effect of the more recent guidance is this. If a doctor does not know the cause of a patient's death but is confident that the death was natural, s/he can certify that the death was due to 'old age', provided that the patient was 70 or over. The average life expectancy in England and Wales is now about 75 years for men and 80 for women. About two-thirds of male deaths and four-fifths of female deaths occur at age 70 or over. There is, therefore, a general feeling that 70 is very young to be certified as having died of 'old age'. The ONS shares this view. Its response to the Inquiry's Discussion Paper said that the reason the age limit was not changed when the guidance was last up-dated was that **'it was considered impractical to ensure that a revised age limit would be made widely known'**. Not surprisingly, some registrars are unhappy about the use of 'old age' as the sole cause of death, fearing that it may be a cover for the fact that the doctor does not really know the cause of death.

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6.35 In practice, however, if a doctor certifies the death as being due to 'old age' and if the deceased person is 70 or over, the registrar is virtually bound to accept the MCCD. The deceased's age is the only objective measure of the acceptability of 'old age' available to the registrar. He or she will in general have no information about any other medical condition(s) from which the deceased might have suffered and which might have caused the death. The registrar is left to rely on the doctor's integrity and judgement as to whether 'old age' is appropriate in the particular case. The registrar is not required to ask questions designed to check on the validity of a cause of death given by a doctor. In practice, it appears that some registrars do ask such questions and, if they discover anything that suggests to them that 'old age' is not appropriate (e.g. that the deceased person was suffering from other conditions which might have caused the death), they will refer the death to the coroner. However, it is clear from the evidence given to the Inquiry that many registrars feel that such enquiries fall beyond their remit. One registrar told the Inquiry that, if the family told her that the deceased person had been up and about the week before being certified as dying of 'old age', she would not report the death to the coroner. She would advise the relatives to speak to the doctor if they had concerns and would then proceed to register the death. So far as she was concerned, she would have a viable MCCD with no reason to delay registration.

6.36 It is clear that, where a doctor gives 'old age' as the only cause of death in a person of 70 or over, the death is likely to be registered, and a disposal certificate issued, without any enquiry as to whether the deceased suffered the kind of gradual deterioration and decline that would warrant a diagnosis that death was caused by 'old age'.

Reports to the Coroner

The Incidence of Reporting by Registrars

6.37 Although the registrar is under a duty to report to the coroner any death falling within the provisions of regulation 41, the number of cases in which a registrar makes a report is in fact limited. Most reportable cases have already been reported to the coroner by a doctor before they reach the registrar. Cases reported by a doctor will not usually come to the registrar until the coroner has considered the matter and issued a Form 100A, a Form 100B or a Form 99.

6.38 Another reason why the registrar makes very few reports to the coroner is that s/he has only a very limited opportunity to learn information that might result in the realisation that the death is reportable. As I have said, the registrars told me that they are not required to ask questions about the circumstances of the death. Both Mr Dorries and Mr Michael Burgess (HM Coroner for Surrey), believe that registrars do ask probing questions. Another coroner who provided evidence to the Inquiry spoke of families being questioned by the registrar, apparently with a view to eliciting any concerns they may have about the death. It may be that there is some misunderstanding of the extent of the registrars' role. It may be that practice varies from place to place. However, I have the impression that, in general, very few questions are asked by registrars, other than those directly required by the process of registration. It is a remarkable anomaly within the present system that the only person who is under a statutory duty to report a death to the coroner (except for those

with a responsibility for persons who die in custody, to whom special requirements apply) has so little opportunity to investigate its circumstances and no training to equip him/her to do so.

Formal Reports

6.39 As I have said, regulation 41 requires a registrar to report deaths to the coroner on an approved form. That form is Form 52. An example of the form appears at Appendix C. The form requires the registrar to record the date and place of death, some details about the deceased, the cause of death (as given on the MCCD), the name of the certifying medical practitioner and the reason for reporting the death. Having completed and despatched the form, the registrar retains the counterfoil, on which s/he should record the date and place of death, the deceased's details, the cause of death, the name of the coroner to whom the death was reported and the date when it was reported. There is also space to record the date when the registrar received one of the various forms (e.g. Forms 100A, 100B or 99), advising him/her of the result of the coroner's enquiries.

6.40 Mrs Jane West, registrar for the Boston district and Training Officer for the Lincolnshire registration service, explained that there were a number of advantages in using Form 52 when making a report to the coroner. First, the counterfoil provides a written record of the report which the registrar can retain. This would be valuable in the event that any question were raised in the future about the registration of the death, or the validity of the MCCD upon which the registration was based.

6.41 Second, Mrs West said that receipt of a Form 52 means that the coroner's office has to respond to the report in some way, even if it is only to inform the registrar that no further action is to be taken and no form (i.e. no Form 100A or Form 100B) will be issued. When a registrar reports a death to the coroner, s/he expects to receive one of those forms, indicating that, after considering the death (and in the case of Form 100B holding an autopsy), the coroner has decided that no inquest is necessary. Alternatively, s/he would expect to receive a Form 99, signifying that an inquest has been held. The forms provide confirmation that the coroner's investigation has been completed and that the registrar is at liberty to register. The coroner has a legal obligation to send to the registrar Form 100B and Form 99 in the appropriate circumstances. However, no such duty exists in relation to Form 100A. Most coroners recognise the uncertainty in which the registrar is placed if s/he receives no documentation relating to a reported death and no notification of what decision has been taken in relation to the death. Such coroners, if they do not intend to order an autopsy, will send a Form 100A. However, Miss Lloyd told the Inquiry that she was aware that there were coroners who would never issue a Form 100A on the basis that they have no statutory duty to do so. She reported that this was less of a problem than it had been in the past, since there appeared to be a growing awareness that this type of inflexibility was inappropriate.

6.42 The third potential advantage of the Form 52 is that, if there are several conditions specified in the cause of death at Part I(a), (b) and (c) and Part II, it can be easier to understand them if they are seen in writing, in the order they appear on the MCCD, rather than relayed over the telephone. Mrs West's personal practice is to photocopy the MCCD

and send it to the coroner with Form 52. She always uses Form 52 when reporting a death to the coroner. Some coroners insist that Form 52 be used whenever a registrar reports a death to them. Mr Dorries does not require a Form 52 in all cases, but requests registrars to send him a copy of the MCCD. If the MCCD has been poorly completed, that enables him to take up the matter with the doctor concerned or, if the certifier is a hospital doctor, with one of his/her seniors. Miss Lloyd told the Inquiry that there were districts where the coroner makes it clear to registrars that s/he prefers telephone referrals and does not welcome reports by way of Form 52. Mrs West observed that that had been the case in her district in the past. However, the registrars insisted on reporting deaths by means of the correct procedure and that has now been accepted by the coroner's office.

Informal Reports

6.43 In some areas, however, registrars do not habitually use Form 52 when making a report to the coroner. Mr John Pollard told the Inquiry that, during 2001, his office had received a total of only 14 reports of deaths referred by way of Form 52 by registrars at the three register offices in his district. He was not able to say what proportion of the total deaths reported to him was reported by registrars. He could only say that it was a very small proportion. However, the evidence available to the Inquiry would suggest that the total number of deaths reported in a year by registrars at the three register offices would be significantly more than 14. Mr Burgess said that he received very few Forms 52. He estimated that he receives less than one a week from four register offices. He assumed that registrars preferred to use the telephone. Before attending to give evidence to the Inquiry, Mrs West carried out a survey of the Forms 52 issued by her. For some years, they have averaged one a month. It may be that, as well as adopting the practice of making all reports by means of Form 52, Mrs West is also more ready to report deaths to the coroner than are the registrars in South Manchester. There was also evidence that the frequency with which registrars report by using Form 52 has increased recently. The Tameside registrars have now adopted the practice of making all their reports to the coroner by means of a Form 52.

6.44 The fact that some registrars have not in the past habitually used Form 52 when making a report to the coroner may be because of the preference of staff at the coroner's office. It may be because the registrars themselves prefer to adopt the less formal procedure of telephoning the coroner's office to report a death. The perceived justification for this informality is speed. If the need to report a case to the coroner arises during the registration process, the informant (and, possibly, other members of the deceased's family) is already at the register office. Registrars are naturally anxious to avoid any delay in the registration process. They do not wish to distress or inconvenience the bereaved family. This is understandable and commendable. However, the effects of this informality are often undesirable and result in further loss of rigour in a system that is not inherently very rigorous. In any event, no time (save the very few minutes required to complete Form 52) need be lost in sending a Form 52 to the coroner's office. Mrs West's practice is to fax a copy to the coroner's office immediately and follow it up with a paper copy afterwards. A Form 52 could also be sent electronically, provided the necessary technology is available.

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6.45 A registrar who telephones the coroner's office, saying that the MCCD which has been presented to him/her is or might not be acceptable, will sometimes be told by the coroner's officer that the coroner will not take over the case and will not issue a Form 100A. In that event, the registrar has little option but to proceed to register the death. Sometimes, registrars are made to feel that they are making a fuss about nothing. The outcome seems to depend on who is the stronger personality, the registrar or the coroner's officer. Such a conversation might well go unrecorded; it is likely to be treated as an informal request for 'advice'. If a more formal method of reporting were adopted, such informal conversations would not take place. Then if, as sometimes happens, the coroner (or the coroner's officer on his/her behalf) declines to accept jurisdiction, leaving the registrar no option but to accept the MCCD and register the death, at least there would have to be a record of the decision.

Conclusions

6.46 The registrar's role is essentially administrative. He or she is required to record details of births, marriages and deaths. The information recorded by registrars forms the basis of an important public record and is widely used for statistical and research purposes. It is vital that it is recorded meticulously and accurately. The main function of registrars is to ensure that that is done. Most of the information with which they are concerned is taken from members of the family affected by the registration concerned. Registrars also have the task of guiding members of the public through the formalities associated with the most important of all life events.

6.47 In the case of the registration of a death, registrars are also required to carry out a function of a completely different nature. They have to scrutinise a certificate written by a doctor and assess, insofar as they are able, whether it provides an acceptable medical explanation for the death. They have to be alert to circumstances that might be mentioned in, or evident from, the MCCD and which might make a report to the coroner appropriate. They have to do this with no background of medical knowledge, no training in the skills needed to question members of the public so as to elicit the correct information and no clear direction as to whether they should be doing this or not. All the while, they are conscious of their lack of medical knowledge and of the consequent difficulty of questioning the judgement of the certifying doctor.

6.48 My main concern is that registrars are not trained or equipped to provide the only form of scrutiny applied to MCCDs issued by medical practitioners. Unless they are encouraged to question the informant about the circumstances of the death, they cannot form any view as to whether the death ought to be reported to the coroner. Even if they do ask relevant questions (as, I believe, some do), they have not been trained in the enquiries which they should make. Nor are they in a position properly to evaluate the replies that they receive. Without medical expertise, they cannot effectively consider the cause of death given by the doctor. This is a not a criticism of the registrars, but of the system that imposes a statutory duty upon them, while not equipping them to fulfil it. In future, any information about cause of death provided by a doctor should be scrutinised by a person with a medical qualification, or at least someone with special training in medical matters and ready access to expert medical advice. That person should also have the opportunity to

cross-check the essential facts with a relative of the deceased or someone with knowledge of the circumstances of the death. In my view, the task of scrutinising the cause of death should no longer be that of the registrars. Theirs should be a purely administrative function.

6.49 One of the real problems created by the present arrangements is that the registrar is put in the position of having to make a 'snap' judgement. He or she sees the MCCD only when the informant arrives at the office. There is no opportunity to reflect on it. The informant expects to be able to register the death. The registrar is then under pressure, knowing that any delay will cause distress. The fact that the MCCD contains very little information means that the family may well give some additional, unexpected information in the course of a registration. That may cause a problem that the registrar will have to attempt to resolve there and then. If the person assessing the validity and acceptability of the certificate were able to consider its contents in advance of the face to face meeting, with the benefit of a great deal more information and medical advice on hand, there would be far greater opportunity to make a considered judgement. Moreover, the family could be prepared for any problems that might arise. Any such problems could then be resolved without the extreme pressure of time that characterises the present arrangements.

6.50 In the course of the Stage Two hearings, the Inquiry heard a considerable amount of evidence about practice at the Tameside register office. This was necessary, because it was there that the deaths of virtually all Shipman's patients were registered. The evidence showed that there were some practices in force at the Tameside register office that contrasted unfavourably with those operated, for example, in register offices in Lincolnshire, about which Mrs West gave evidence. I shall discuss those practices in Chapter Fourteen of this Report. Recent correspondence from the GRO has confirmed what I had believed to be the case, namely that the departures from best practice about which the Inquiry has heard are not confined to Tameside. Indeed, such is the concern of officials at the GRO about variations in practice throughout the country that, following a meeting with Home Office officials, they have written to all registrars and coroners, giving guidance about good practice in relation to a number of matters (including the need to use Form 52 whenever a report to the coroner is made) that have been explored in the course of evidence given to the Inquiry.

6.51 It is not surprising that variations in practice in different areas have grown up over the years. The uneven training provision and the relative isolation in which some registrars work make such variations virtually inevitable. Furthermore, as I shall discuss in due course, practice within coroners' offices is similarly variable, for similar reasons. The differing relationships between staff at local register offices and coroner's offices must also be a factor that has encouraged variations in practice to develop and flourish.

Future Changes to the Registration Process

6.52 In January 2002, following public consultation, the Government published a White Paper entitled 'Civil Registration: Vital Change. Birth Marriage and Death Registration in the 21st Century'. The document contains a number of important proposals for change.

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6.53 It is proposed that responsibility for registration should be transferred entirely to local authorities. Registration officers would become employees of local authorities. Local authorities would have responsibility for their training, although the Registrar General would continue to provide some technical training, mainly via computer assisted learning, as at present. Services would be tailored to meet local needs.

6.54 It is also proposed that individuals would be able, on production of the appropriate evidence of identity, to register deaths remotely via the Internet or by telephone. There is no proposal at present to remove the option of registering in person. The document suggests that:

> **'... the giving of information to the registrar about a death is much more than a legal duty. It forms an integral part of the grieving process. A registrar is perceived as the person who can provide advice, reassurance and information at a time of great sadness.'**

However, it seems inevitable that the number of face to face registrations will reduce over time with the introduction of the new arrangements.

6.55 The facility for remote registration of deaths will be dependent on the introduction of electronic data exchange between doctors, coroners and registrars. This will enable information about cause of death, coroner's certificates and other documents to be transmitted electronically. Although the development and installation of the information technology necessary to put the proposals into practice will take some time, it seems likely that, within a few years, the system of registration of deaths in England and Wales will be very different from that which it is now. It may well be that, in time, the practice of personal attendance by the deceased's family to register a death will disappear altogether.

6.56 In the long term, it is proposed that death information will be capable of being viewed electronically, thus removing the need for a paper death certificate. The record of death registration would form part of a 'through life' record, which would link records of births, marriages and deaths. Access to 'through life' records would be restricted.

6.57 Historic records, i.e. those more than a hundred years old, would be open and fully available to the public. In the case of records less than a hundred years old, information such as addresses, occupations and cause of death would be treated as confidential and would not be released into the public domain. Access to such information would be available only to the deceased's family, those who were granted permission by the family and those agencies having legally prescribed access. There would be an additional form of death certificate, which would be acceptable for most administrative purposes. Such a certificate would omit the cause of death.

6.58 The document does not explain how, when dealing with remote registration, registrars would comply with their duty to report certain categories of death to the coroner. If regulation 41 were to remain in force, they would presumably continue to make such reports if there appeared reason to do so from the contents of the MCCD and any other information provided by the informant. In reality, however, their opportunity to identify the circumstances making a death reportable would be limited. I have already described the difficulties that registrars have in identifying those deaths that should be reported to the

coroner under the current system. The proposals for change, with the consequent advent of on-line and telephone registration, would compound those difficulties. This confirms my view that registrars should be relieved of their duties under regulation 41. In the future, their function in relation to the registration of deaths, as with other aspects of their work, should be purely administrative.

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CHAPTER SEVEN

Coroners and Their Jurisdiction

Status, Appointment, Removal and Conditions of Service

7.1 Coroners are independent judicial officers, answerable only to the Crown. Responsibility for appointing a coroner lies with the local authority for the district over which the coroner has jurisdiction, subject to notification being given to (or, in some cases, approval being given by) the Home Office. The local authority also has responsibility for remunerating the coroner and for funding the running of his/her office and the conduct of his/her inquests. Each district has a deputy coroner and some have one or more assistant deputy coroners.

7.2 The Lord Chancellor has power to remove a coroner from office for inability or misbehaviour in the discharge of his/her duty. As I have already mentioned in Chapter Two, the Lord Chancellor also has power (with the concurrence of the Home Secretary) to make rules governing the practice and procedures relating to inquests and autopsies. However, the Lord Chancellor's Department (LCD), which has responsibility for the judicial system, plays no part in the appointment of coroners, in their training and continuing education, or in the running of coroners' offices or courts.

7.3 The Department which provides the point of contact between coroners and central government is the Home Office, through the Coroners Section of its Animal Procedures and Coroners Unit.

7.4 The minimum qualification for the offices of coroner, deputy and assistant deputy coroner is five years' qualification as a solicitor, barrister or medical practitioner. The Inquiry heard that coroners' appointments are now generally made after an open competition. However, there still appear to be some areas where the tradition is that the office passes from partner to partner within a single solicitors' practice. Mr Michael Burgess, Honorary Secretary of the Coroners' Society of England and Wales ('the Coroners' Society') and HM Coroner for Surrey, explained that many local authorities are reluctant to appoint anyone as a coroner who has not already had experience of coronial work. Under section 6 of the Coroners Act 1988, a coroner is required to appoint as his/her deputy a person approved by the chairman of the relevant local authority. He or she may appoint as assistant deputy a person who has been similarly approved. In practice, provided that the coroner proposes for appointment somebody suitably qualified, his/her choice is likely to be approved. In effect, therefore, the coroner can select his/her deputy and assistant deputies. As these are likely to be the only persons who will ever gain experience of coronial work, and are likely therefore to be the strongest candidates for appointment as coroner in the future, it would seem that, to a large extent, coroners are still a self-perpetuating group. I do not think that such a system is consistent with the principle of equal opportunity. Also, the effect of the system is that the position of coroner may not always be held by the most suitably qualified person.

7.5 Some coroners have reciprocal arrangements with neighbouring coroners by which each acts as the other's deputy or assistant deputy. By way of example, Mr John Pollard, HM Coroner for Greater Manchester South District, was formerly a partner in a solicitors'

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practice and was appointed Deputy Coroner for Cheshire by the senior partner of the practice, who was then Coroner for Cheshire. Mr Pollard's appointment took place as soon as he had attained the minimum period of five years' qualification as a solicitor. Thirteen years later, he was appointed Coroner for Greater Manchester South District. Mr Pollard's former partner (who still occupied the position of Coroner for Cheshire) then became Deputy Coroner for Greater Manchester South District. That arrangement continued until recently, when it was adjusted so that the present Coroner for Cheshire (appointed following the death of Mr Pollard's former partner) and Mr Pollard became Assistant Deputy Coroners for each other's districts and new Deputy Coroners were appointed.

7.6 As at February 2003, according to the Home Office, there were 129 coroner's districts in England and Wales and 115 coroners, of whom 23 were full-time. The Home Office has told the Inquiry that only nine or ten coroners (as opposed to deputy or assistant deputy coroners) are medically qualified. Two of those hold both a legal and medical qualification. Full-time coroners are paid an annual salary on a scale according to the population of their district.

7.7 Expenses in connection with the holding of inquests and the conduct of autopsies are met by the local authority. None of the coroners who gave oral evidence to the Inquiry reported any problems in persuading their local authorities to fund their activities. The Inquiry understands that financial constraints may be more of an issue in smaller districts served by part-time coroners.

7.8 The quality of facilities available to coroners varies widely. Mr Christopher Dorries, HM Coroner for South Yorkshire (West), has his main office at the Medico-Legal Centre in Sheffield. The lower floor houses the city's public mortuary. The office of Mr Dorries and his staff, together with a dedicated court room, is on the upper floor. Also situated on the upper floor is the University of Sheffield Department of Forensic Pathology, with a staff of four forensic pathologists (including two professors), a professor of toxicology and a forensic anthropologist. Thus, Mr Dorries has both ready access to medical advice and the benefit of having many of the autopsies which he orders carried out on the premises by specialist forensic pathologists. His staff of two coroner's officers (both serving police officers) and the equivalent of a full-time administrative assistant and a full-time secretary work from the main office in Sheffield; another coroner's officer is employed at a small office in a police station in Barnsley.

7.9 By contrast, the Inquiry has been told about another full-time coroner who works from home with, apparently, no secretarial assistance or access to fax machines or computer. Mr Burgess, also full-time, described how he works sometimes from his home, sometimes from the premises of the solicitors' practice in which he was previously a partner and, at other times, from a retiring room (equipped with a computer and telephone) at one of the courts at which he holds inquests. He has no clerical support; if an acute need arises, it is met by using clerical staff from his former practice.

7.10 The arrangements for the provision of staff to support the coroner in his/her work vary considerably from district to district. Traditionally, the coroner was supported by coroner's officers who were serving police officers. Today, most coroners have civilian coroner's

officers, but also rely to some extent on serving police officers and administrative staff. I shall describe these arrangements more fully in Chapter Eight.

Part-Time Coroners

7.11 As I have said already, according to the Home Office, there are 23 full-time coroners in England and Wales. The remainder are part-time and may continue to pursue their legal or medical practice when not engaged on coronial duties. Part-time coroners are paid according to the number of deaths they deal with over a given period. The terms vary. Some authorities pay on the basis of the number of cases which are formally reported to the coroner and in respect of which s/he accepts jurisdiction; others pay on the basis of the number of cases reported to the coroner, whether formally or informally. It is not uncommon for part-time coroners who practise as solicitors to discharge their coroner's duties from their practice premises, with secretarial and administrative assistance from practice staff. Others carry out their duties from home.

7.12 Most part-time coroners are solicitors in private practice. I am unsure to what extent there is recognition of the potential problems of conflict of interest and loss of independence inherent in these arrangements, but the potential undoubtedly exists. Take, for example, the position of a part-time coroner who is investigating the death of the driver of a motor vehicle involved in a road traffic accident. If the coroner's partner were instructed by the widow of the deceased to bring a claim for damages against the driver of the other vehicle involved, the coroner could face a conflict of interest. As a partner in the firm, s/he might well have an interest in the successful conclusion of the widow's action. Alternatively, one might consider the position of the part-time coroner who is also a partner in a solicitors' firm with a criminal practice. It would be quite possible for his/her firm to be dealing with a murder that is also being dealt with in the coroner's office.

7.13 The problem is exacerbated by the lack of facilities provided by local authorities. As I have said, it is not uncommon for a coroner to work from the premises of his/her legal practice. As I understand it, coroners use such premises, not from choice, but because the local authority has failed to provide an office from which to conduct the business of the coroner. In my opinion, the use of the premises of a private legal practice for the work of a part-time coroner is most undesirable. The coroner should be, and should be seen to be, independent of legal practitioners within the district.

Deputy Coroners

7.14 A coroner is required to hold him/herself ready at all times to undertake by him/herself or his/her deputy or assistant deputy any duties in connection with inquests and autopsies. Section 7 of the Coroners Act 1988 provides that deputy coroners may lawfully act for their coroners only in limited circumstances, namely when the coroner is ill, absent for some lawful or reasonable cause or disqualified for some reason from sitting on a particular inquest. Construed strictly, the limitations mean that, if a coroner is engaged, for example, on a substantial inquest within his/her district (so that s/he is not 'absent'), his/her deputy cannot be used to carry out other duties which require attention. Some coroners, however, consider that, if they are engaged on their duties in one part of their district, they are

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lawfully 'absent' from other areas and can therefore use their deputies to assist in carrying out necessary work in those areas. Assistant deputies can exercise the same functions as a deputy coroner, but only if the deputy coroner is ill or absent for some lawful or reasonable cause or disqualified from sitting on an inquest.

The Basis of the Coroner's Jurisdiction

7.15 A coroner can act only if and when a death is reported to him/her. In 2001, 37.8% of all registered deaths were reported to coroners. Doctors are responsible for reporting most deaths (95.7% in 2001), with the police and other agencies reporting less than 1%. Registrars account for about 4% of reported deaths. Coroners receive no information about (and cannot therefore take any steps in connection with) deaths that are not reported to them.

7.16 The jurisdiction of the coroner is based in statute. The current legislation governing the coronial system consists of the Coroners Act 1988 (which is largely a consolidation of previous Coroners Acts) and the Coroners Rules 1984.

Section 8 of the Coroners Act 1988

7.17 Section 8 of the Coroners Act 1988 provides that:

> **'(1) Where a coroner is informed that the body of a person ("the deceased") is lying within his district and there is reasonable cause to suspect that the deceased –**
>
> **(a) has died a violent or an unnatural death;**
>
> **(b) has died a sudden death of which the cause is unknown; or**
>
> **(c) has died in prison or in such a place or in such circumstances as to require an inquest under any other Act,**
>
> **then, whether the cause of death arose within his district or not, the coroner shall as soon as practicable hold an inquest into the death of the deceased ...'.**

7.18 There is no statutory definition of the words **'violent'**, **'unnatural'**, or **'sudden'**. I shall deal later in this Chapter with the problems that arise in understanding and applying these terms.

7.19 Section 8, therefore, requires the coroner to make a decision as to whether the reported death falls within the ambit of the section, i.e. whether there is reasonable cause to suspect that the death was violent or unnatural, or sudden and of cause unknown or that it occurred in prison. It follows that the coroner might decide that the circumstances of the death demand an inquest, even though the cause of death is clear. The death of a motorcyclist suffering fatal head injuries in a road traffic accident would be an obvious example. There would plainly be reasonable cause to suspect that the death was violent. There would also be reasonable cause to suspect that it had not been caused by a natural disease process and was therefore **'unnatural'**. On either of those two grounds, therefore, an inquest would have to be held. Alternatively, the coroner might consider that the reported circumstances of a death do not give rise to reasonable cause for him/her to suspect a

violent or unnatural death, but that the cause of death is not known or not known with a sufficient degree of confidence to permit certification of the cause of death by a doctor. In that event, the coroner would have to hold an inquest because of section 8(1)(b). Sometimes, of course, there will be reasonable cause to suspect that the deceased has died a sudden and unnatural death of which the cause is unknown (i.e. a death falling within section 8(1)(a) and (b)). This would arise, for example, where a decomposed body is found in circumstances suggestive of a fall or other form of violent death.

7.20 However, in relation to many cases reported to him/her, the coroner will conclude that the death does not come into any of the categories set out in section 8, and that, consequently, there is no power or requirement to hold an inquest.

7.21 In those circumstances, the coroner will often issue a Form 100A. I referred to the use of Form 100A in Chapter Six. On the form, the coroner states, **'The circumstances connected with the death of the above person have been reported to me and I do not consider it necessary to hold an inquest'**. The purpose of the form, which is supplied by the Registrar General, is to notify the registrar of the coroner's decision not to hold an inquest. The form also indicates that no post-mortem examination is to be held.

Section 15 of the Coroners Act 1988

7.22 Section 15 of the Act deals with the situation where the coroner has reason to believe that the circumstances of a death require an inquest but where the body has been destroyed or removed from his district. In such a situation s/he may report the death to the Home Secretary, who may then order him/her to open an inquest.

Sections 19 and 20 of the Coroners Act 1988

7.23 By section 20(1) of the 1988 Act, a coroner may, at any time after he has decided to hold an inquest:

> **'(a) request any legally qualified medical practitioner to make a post-mortem examination of the body or a special examination of the body or both such examinations; or**
> **(b) request any person whom he considers to possess special qualifications for conducting a special examination of the body to make such an examination'**.

7.24 Thus, section 20 authorises a post-mortem examination and/or a **'special examination'** to be ordered in cases in which the coroner has decided to hold an inquest.

7.25 The situation will often arise, however, where an immediate decision about whether to hold an inquest is not possible. This situation could arise, for example, where there is no reason to suspect that the death was violent, unnatural or occurred in prison, but where the cause of death is not sufficiently known to permit certification by a doctor and may be revealed by a post-mortem examination. In that event, the coroner may, under section 19, order a post-mortem examination to be carried out, if s/he is of the opinion that such an examination may prove an inquest to be unnecessary. If, as a result of the post-mortem

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examination findings, the coroner is satisfied that an inquest is unnecessary, s/he must send to the registrar a certificate, stating the cause of death as disclosed in the post-mortem examination report. That certificate is known as Form 100B. I referred to this form in Chapter Six. The informant then attends the registrar in the usual way. When the death is registered, the cause of death is taken by the registrar, not from an MCCD (there is unlikely to be one in existence), but from the coroner's Form 100B. If the post-mortem examination does not disclose an ascertained cause of death, the coroner must proceed to hold an inquest.

7.26 A **'special examination'** is defined in section 20 of the 1988 Act as an examination:

> **'... by way of analysis, test or otherwise of such parts or contents of the body or such other substances or things as ought in the opinion of the coroner to be submitted to analyses, tests or other examination with a view to ascertaining how the deceased came by his death'**.

7.27 Section 19 does not appear to confer on a coroner the power to order a special examination where no decision has been taken to hold an inquest. Moreover, the authority given by section 20 seems to authorise a coroner to request a special examination of the body only in those cases where s/he has already decided to hold an inquest. Yet coroners do order special examinations in cases where no decision to hold an inquest has been taken.

7.28 When ordering a special examination in a case where no decision has yet been taken to hold an inquest, some coroners rely on the provisions of section 19(2), which provides that, where a post-mortem examination is directed in a case in which the coroner believes that the examination may prove an inquest to be unnecessary, s/he shall have **'for the purposes of a post-mortem examination under this section ... the like powers, authorities and immunities as if the examination were a post-mortem examination directed by the coroner at an inquest into the death of the deceased'**. They contend that section 19(2) gives the coroner the power to order a special examination, even where the post-mortem examination has been ordered under section 19. Others view histological examination as 'part of' the post-mortem examination. This view is given some limited support by the fact that Form 100B contains the question **'Is a histological or bacteriological examination to be made?'** Since that form is only used when a decision has been made not to hold an inquest (i.e. when a post-mortem examination under section 19 has been carried out and has revealed a medical cause of death), and since section 19 appears to confer no power to order special examinations, it would make little sense if the examinations referred to on Form 100B were to be regarded as special examinations. So, the argument goes, they must be regarded, not as special examinations, but as part of the post-mortem examination.

7.29 Whatever the current legal position, it is obviously desirable that coroners should have the full range of investigative tools at their disposal in every case, not only where an inquest is inevitable from the start.

Concurrent Proceedings or Inquiries

7.30 In the event that criminal proceedings have been commenced in connection with a death, the coroner must adjourn the inquest unless the Director of Public Prosecutions (DPP)

informs him/her that an adjournment is unnecessary. The inquest may be resumed only at the conclusion of proceedings (unless the DPP notifies the coroner that it is open to him/her to do so earlier) and if, in the coroner's opinion, there is sufficient cause to resume. In most cases, the coroner will not resume the inquest, but will merely send the registrar a certificate stating the results of the relevant criminal proceedings. An inquest must also be adjourned, in the absence of exceptional reasons to the contrary, where the Lord Chancellor informs the coroner before the conclusion of the inquest that a public inquiry conducted or chaired by a judge is being or is to be held into the events surrounding the death. This provision was used to prevent simultaneous investigations into the deaths of Shipman's patients being conducted by the coroner and by this Inquiry: see Chapter Two of my First Report.

Some Weaknesses of the Current Coronial System

The Dual Nature of the Coroner's Duties

7.31 I have said that the professional qualification of the coroner may be either medical or legal. Some functions of the coroner (such as the conduct of inquests) require legal knowledge and experience and some (such as the determination of whether a death is or is not due to a natural disease process) require medical knowledge and experience. It seems to me that, in order to be able to fulfil all the present duties, a coroner should, ideally, have knowledge and experience of both medicine and the law. I have already said that a small number of coroners are, in fact, dually qualified.

7.32 Some legally qualified coroners now seek to appoint a medically qualified deputy. This may reflect their recognition of the need for medical expertise in the coroner's office. This solution is not ideal. The coroner and deputy cannot work in harness. As I have said, section 7 of the 1988 Act permits a deputy or assistant deputy coroner to act only when the coroner is ill or is absent for any lawful or reasonable cause. The deputy may also conduct an inquest which the coroner is disqualified from holding. Some coroners say that they seek advice from their deputies, which suggests that they are doing so when the deputy is not on duty. Others make it plain that they disregard the statutory rule; the deputies work even though the coroner is not 'absent'. Dr Nigel Chapman, HM Coroner for Nottinghamshire, told the Inquiry that he is so busy with and interested in the medical aspects of his work that he instructs one of his legally qualified deputies to conduct many inquests. This practice, which may seem sensible, breaches section 7 but no action has been taken to stop it.

7.33 As I shall go on to explain, it seems to me that the fact that both medical and legal expertise is not available in each coroner's office at all times is a serious weakness of the present system.

Competing Demands on the Coroner's Time

7.34 In cases that go to inquest, the coroner is involved in the process of enquiry from an early stage until the day of the inquest when s/he also assumes his/her judicial role. There is an obvious tension between, on the one hand, the demands on a coroner's time made by the

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requirement of preparation for and attendance at inquests, together with other duties necessitating his/her absence from the office, and, on the other hand, the need to deal with the constant daily stream of cases referred by doctors, registrars, the police or other agencies for advice and decisions. Mr Pollard's evidence was that he spends the equivalent of three full days a week in preparing for and conducting inquests. Mr Burgess said that he typically spends between two and two and a half days each week sitting on inquests and a further half to one day on preparation. Inquests are frequently held at some distance from a coroner's office, making communication between the coroner and his/her staff more difficult.

7.35 Whilst the conduct of inquests might at first sight appear more important, the other decisions for which the coroner is responsible are also of considerable potential importance, since they will determine whether or not an individual death is to be subjected to any official investigation. If, in relation to an individual death that has been reported to the coroner, the coroner decides that s/he has no power to hold an inquest and the cause of death is certified by a doctor, the overwhelming likelihood is that the death will pass through the remaining formal procedures without difficulty. If the deceased is to be buried, the death will be subjected to no further check. If s/he is to be cremated, the death is still unlikely to be subjected to any significant investigation. The fact that the death has been reported to the coroner and the coroner has 'cleared' the MCCD will confer on that certificate an authority which is likely to discourage further enquiry. Even if anyone has concerns or doubts about the death, those are likely to be quieted by the knowledge that the coroner has been informed of the death and permitted certification. It is not widely recognised that the involvement of the coroner often amounts only to a brief telephone conversation between a member of his/her staff and the certifying doctor, with no other investigation of the circumstances of the death.

7.36 Some decisions about the cause of death require urgent attention; delay can frequently mean disruption of the funeral arrangements. This is always a distressing prospect, but particularly so for members of certain religious groups. One of the important issues which I shall address later in this Report is whether it is practicable and appropriate for one person to combine the coroner's role of presiding over and preparing for inquests with the task of giving careful and proper consideration to the investigation and resolution of the issues of medical cause of death which are referred to the coroner's office on a daily basis.

Variability of Standards and Practice

7.37 One of the most frequent criticisms of the coronial system is that it operates very differently in various parts of the country. I have encountered many instances where there is lack of uniformity. In Chapter Four, I have mentioned geographical differences in practice concerning the removal of bodies to funeral directors' premises. In Chapter Six, I highlighted the differing practices of coroners concerning the issuing of Forms 100A and requiring reports by registrars on Form 52. I shall shortly deal with 'local rules' and the different lists that individual coroners issue, describing the categories of case that they expect to be reported to them. The Inquiry has heard about wide variations in the approach of different coroners towards autopsies, particularly relating to the use of histology and toxicology. There are also great differences in the way in which coroners run

their offices and in the way in which their staff work. In Chapter Eight, I will explain the great variation that exists in the tasks performed by coroner's officers working in different districts. The Coroner's Officers Association is concerned that the lack of uniformity is leading to a variation in the standard of service that is being provided to the public. I am sure there are other examples of differences in practice that I have not mentioned and it was not, of course, possible for the Inquiry to examine the practice in every district in the country.

7.38 That the system is variable can be demonstrated by consideration of the statistics produced by the Home Office. For example, in 2001, the proportion of cases reported to the coroner which resulted in an inquest varied very greatly. Although, typically, between 10% and 20% of all reported deaths were followed by inquests, the overall range was very wide. In North Tyneside, 53% of reported deaths were followed by inquest. In North Lancashire, the proportion was 2%. It is difficult to resist the inference that coroners are applying differing standards when reaching their decisions. Similarly, there was a wide variation between the proportion of reported deaths in which an autopsy was held. For example, in the District of North and East Cambridgeshire, an autopsy was held in 96% of all non-inquest deaths. In the adjacent District of South and West Cambridgeshire, the comparable figure was 45%. In the Scarsdale District of Derbyshire, the figure was 36%. There is also some variation in the proportion of inquest cases in which an autopsy is held. In most districts, there is an autopsy in virtually every inquest case but, in some, there is no autopsy in a significant proportion of cases. For example, in 2001, in Milton Keynes there was no autopsy in 26% of inquest cases. In Manchester West District, the figure was 29%. These disparities strongly suggest a wide variability of standards and practice.

7.39 Home Office Research Study 241 entitled 'Experiencing Inquests' was published in November 2002. The authors, members of Bristol University Law Department (including one professor), observed a total of 81 inquests in nine coroner's districts and interviewed 12 coroners and deputy coroners and 13 coroner's officers. Their Study confirmed the existence of a general variation in practice relating to inquests and highlighted considerable variation in the approach of coroners towards the calling of witnesses to give oral evidence and towards the airing of evidence relating to issues of culpability.

7.40 It seems to me that this variation of standards and practice is the result of two main features. The first is the lack of regulation, leadership, guidance and training provided for coroners. The second, which may flow from the first, is that coroners take different approaches to their statutory duties and to the ways in which they organise the work within their offices.

Lack of Regulation, Leadership, Guidance and Training

7.41 It has long been recognised that those taking judicial decisions must be – and must be seen to be – independent. Judges and coroners cannot be directed to take their decisions in a particular way. They cannot be 'managed' by an executive. However, there are many ways in which good practice can be fostered without any loss of judicial independence. That is exemplified by the training and guidance already given to other members of the judiciary. Unfortunately, no such advice or guidance has been given successfully and consistently to coroners. To a very large extent, coroners are left to their own devices.

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7.42 One method of promoting consistency is by the imposition of statutory rules of procedure. The existing Coroners Rules are mainly procedural rules relating to conduct of autopsies and inquests. They do not seek to regulate, by stipulating relevant criteria, the way in which the coroner approaches his/her decisions. Moreover, they have not changed with changing times. There is no committee charged with regular review of the Rules.

7.43 There is no senior coroner who can give guidance to other coroners. Nor is there an appellate court by which unsatisfactory decisions can be set aside. The only supervision exercised over the decisions of coroners is by the High Court under the procedure of judicial review and for the limited purpose of directing that an inquest be held, under section 13 of the Coroners Act 1988. The grounds on which judicial review can succeed are very limited; the applicant must show that the decision under review is either unlawful or unreasonable. A poor decision or poor practice cannot be corrected. Applications for judicial review are rare, although they have increased in recent years. The judges have been able to offer some guidance on difficult points of law, but this has necessarily been limited to the issues that have arisen in the few cases where judicial review has been entertained.

7.44 The only circumstances in which coroners meet to discuss their work is through the medium of the Coroners' Society. Although, at present, all coroners are members of the Coroners' Society, membership is voluntary. Not all members attend meetings. Many coroners have little contact with what their colleagues are doing and operate in virtual isolation without the kind of peer support available to those holding other types of judicial office. The fact that most coroners are employed only part-time exacerbates the position. They have to fit their coronial duties around their professional and other commitments.

7.45 Until recently, there was virtually no training available for coroners. Prior to 1983, the Coroners' Society assumed sole responsibility for training but, since that time, the Home Office has also been involved. The extent of training was at first very limited and was not compulsory. About three years ago, however, the Coroners' Society urged the Government to allocate increased resources for training and matters have improved, but only slightly. Training is still not compulsory and, according to Mr Burgess, there are some senior coroners who never undertake the voluntary training that is available because they believe they know all that there is to know.

Different Approaches to Statutory Duties and the Organisation of Work

7.46 The second reason why standards and practice are so variable is that coroners interpret the statutory provisions in different ways. Because there is no appeal structure and judicial review applications are relatively rare, coroners are effectively free to develop their own responses to the legislative provisions. In the remainder of this Chapter, I shall provide several examples of the way in which these factors result in variability of practice between different coroner's districts.

Decisions about Jurisdiction

The Initial Report of a Death

7.47 The coroner's jurisdiction is dependent upon a report made by some person, either as the result of a statutory duty to report or as a voluntary act. As I have already explained, apart

from where a death occurs in custody (when there are special obligations to report the death), the registrar is the only class of person with a statutory duty to report a death to the coroner. Although it is little known, there is a common law duty on everyone to report to the coroner or to the police circumstances requiring the holding of an inquest.

7.48 There is no standard way of recording a report to the coroner. Most reports are made by telephone and a member of staff, usually a coroner's officer, will deal with the call. Whether or not the officer makes a note will depend on the nature of the report and the practice within the relevant office. If a note is made, the amount of information recorded will vary from office to office; for example, far more information is recorded in the office of the Nottinghamshire Coroner than in that of the Coroner for Greater Manchester South District. Each office devises a method thought to be suitable to its own needs and the resources available. In some offices, a written or computerised record is made of every telephone call received by the office in connection with a death. In others, no record at all is made of calls from doctors seeking to 'discuss' a death when the discussion results in 'permission' being given to a doctor to issue an MCCD; a record is made only if the case gives rise to a need for the issue of a Form 100A.

7.49 Most reports to the coroner are made by doctors. They rely mainly on the guidance printed in the books of MCCDs issued to them by the General Register Office. This reproduces regulation 41 of the Registration of Births and Deaths Regulations 1987, which sets out a list of criteria identifying those categories of death where a duty is imposed on the registrar to report the death to the coroner. This regulation is set out in paragraph 6.12. The list of criteria in regulation 41 does not replicate the list of categories of deaths in which the coroner is required to hold an inquest contained in section 8 of the Coroners Act 1988; it is longer and more detailed. Although it incorporates all those types of death in respect of which the coroner is required to hold an inquest, it also specifically identifies a number of factual circumstances which would bring a case within the section 8 categories. For example, it refers to deaths occurring during an operation and deaths which appear to have been due to industrial disease or industrial poisoning. Both types of death might potentially fall within the 'unnatural' categorisation. I find it strange that the regulation 41 list and the section 8 list are not the same, but it is not perhaps surprising that it was felt necessary to specify some of the more common types of unnatural death for the assistance of registrars who are neither medically nor legally qualified.

7.50 Many coroners, however, consider that even the regulation 41 list is not sufficient and they issue (not only to registrars, but also to hospitals and doctors) their own lists of the types of case that they wish to have reported to them; such lists can, of course, have no legal status. Mr Dorries, who has written a well-respected textbook on coroners' law and practice[1], has circulated locally a list of the types and categories of deaths that he would like to be reported to him and a modified version of that list appears on page 46 of his textbook. As he says in introducing the list in the textbook:

> **'The present requirements for reporting deaths to the coroner are a muddle of legislation, common law and varying advice. This is most unsatisfactory and in an effort to provide doctors in his jurisdiction with**

[1] Dorries, CP (1999) 'Coroner's Courts – a guide to law and practice'. Chichester: John Wiley and Sons.

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> **some clear guidance the author prepared the list set out ... in Table 3.2. With one or two minor amendments this has found a general measure of favour among coroners in the Yorkshire region.**
>
> **It should be clearly explained that the list is merely the author's own interpretation of statute and (hopefully) common sense combined. It is, of course, possible to find exceptions or arguments in many of the categories.'**

7.51 Inevitably, as Mr Dorries acknowledges, the drawing up of an illustrative list will always be vulnerable to criticism on the grounds of unwarranted inclusion or exclusion of certain types of death. Some coroners regard the practice of circulating lists of criteria with local variations as undesirable. Those who issue them wish to extend the range of deaths reported to them, expecting that this will improve their chances of catching more of the deaths that warrant the holding of an inquest. This practice, adopted no doubt with the best of intentions, is bound to lead to some variability of practice. It explains, at least in part, the difficulties many doctors have in recognising reportable deaths. Indeed, local lists may actually exacerbate those difficulties. During the course of the Inquiry, as I considered the lists set out in section 8 and regulation 41 and the various lists of 'reportable deaths' issued by different coroners, I became gradually less surprised that doctors should have difficulty in making reliable decisions about whether an individual death ought to be reported, as the research I mentioned in Chapter Five shows that they do. Those doctors who move from one district to another during their early years will no doubt observe the variation in coroner's practice.

7.52 The evidence suggests that some doctors do not know which of the requirements imposed in their district are based on regulation 41 and which are imposed by the local coroner or are based on local custom and practice. Registrars are not always informed of local rules; for example, Mr Pollard did not tell the Tameside registrars that he had imposed a local rule requiring the reporting of deaths occurring within 24 hours of admission to hospital.

The Criteria for the Decision about Jurisdiction following the Report of a Death – Was the Death Violent or Unnatural?

7.53 As I have said, section 8 of the 1988 Act requires the coroner to accept jurisdiction in respect of any death reported to him/her if there is reasonable cause to suspect that the death was violent or unnatural or was sudden and of unknown cause or if it occurred in prison or in other circumstances in which an inquest is required by statute. If none of those criteria is satisfied, the coroner has no power to conduct an inquest or to order an autopsy and has therefore no jurisdiction. If any one or more of them is satisfied, s/he has jurisdiction and must hold an inquest, unless an autopsy has disclosed the cause of a sudden death not meeting any of the other criteria.

7.54 Decisions as to whether there is a reasonable suspicion that the death was violent are not usually difficult; in general, the circumstances in which the death or injury came to the attention of the reporting doctor will suggest a history of violence or the body will show

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signs of violence. However, determining whether or not there is reasonable cause to suspect that the death was unnatural may not be as straightforward.

7.55 There are two aspects to such decisions. First, there is the practical problem of receiving sufficient reliable information on which to base a decision. There can be no doubt that the coroner is entitled to undertake preliminary enquiries in order to reach a decision. The coroner has no power to call for documents, such as medical records, although I heard evidence that some coroners, or their officers, do so. Some also make enquiries of a member of the deceased's family. However, I have the clear impression that most initial decisions are based solely upon the information received from the person making the report, usually a doctor. That information might or might not be accurate and reliable; the person receiving the information might or might not make a full and accurate record of it.

7.56 Second, the question of whether a death is or is not 'natural' involves very difficult questions of law. Much light has been thrown on this issue by recent decisions of the Court of Appeal such as R v Inner London North Coroner, ex parte Touche[2] and R v Poplar Coroner, ex parte Thomas[3]. Even so, the issue is not always simple. It is now established that, where a death appears to have been due to natural causes, but contributed to by human failure or neglect, the failure or neglect must be of an obvious nature in order for there to be reasonable cause to suspect that the death was unnatural. There will also be cases which fall outside the category of 'neglect' and yet call for an inquest on the basis that the death, though in part resulting from 'natural causes', was wholly unexpected and would not have occurred but for some culpable human failure and was therefore in all the circumstances unnatural. However, the coroner is not expected to hold an inquest simply because there may be some question of negligence: see R v HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson[4] and the case of Touche referred to above.

7.57 An illustration of this second problem would be the common occurrence of the death of an elderly person following a fall. Some doctors regard a frail elderly person's propensity to fall as a natural consequence of the ageing process. So, if a fall results in an injury (often a hip fracture) which causes immobilisation leading to bronchopneumonia and death, they would say that the death is natural. A coroner might accept that view. Other doctors and coroners would say that any fall, even a spontaneous fall, is a traumatic and unnatural event and, if it is part of the chain of causation leading to death, the death is unnatural. Some coroners would say that, if the fall were spontaneous, the death is natural but if it were caused, say, by a defective carpet, then the death is unnatural. Finally, some coroners might regard such a death as violent and, therefore, as requiring an inquest. So, coroners will reach different conclusions about the need for an inquest in such a case.

7.58 Accepted learning about what amounts to a natural or unnatural death is not always logical or satisfactory. It appears to be generally accepted that a death due to smoking is a 'natural' death. It is also accepted that a death due to lung cancer caused by the inhalation of asbestos fibres is an 'unnatural' death. Both are due to the inhalation of a known

[2] [2001] QB 1206.
[3] [1993] QB 610.
[4] [1995] QB 1.

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carcinogen. If the death might be due to exposure during employment, it will be treated as unnatural. Regulation 41 requires registrars to report a death which appears to have been due to industrial disease or industrial poisoning. This is presumably because such a death is to be regarded as 'unnatural' and therefore falling within section 8 of the Coroners Act 1988. The distinction conventionally drawn between a cancer death due to asbestos and one due to cigarette smoking does not appear rational.

7.59 There was some evidence before the Inquiry that coroners' decisions on whether there is a reasonable suspicion that the death was unnatural are not always satisfactory. Dr Gordon Pledger, Medical Referee at the Newcastle-upon-Tyne crematorium, told the Inquiry of a case that had caused him concern. When reading a cremation Form B, he had noticed that the deceased was said to have died as a result of a head injury sustained in a road traffic accident two years before. There was no reference to the coroner on the Form B so Dr Pledger, being of the view that the death plainly called for an inquest, telephoned the coroner's office. He was told that the coroner was aware of the case and had decided not to hold an inquest. Yet, a death caused by injuries sustained in a road traffic accident would be regarded by most coroners as plainly 'unnatural'. It may be that the time which had elapsed since the accident explains the coroner's decision. However, the nature of the cause of the death is unaffected by time.

7.60 I heard evidence that, sometimes, a coroner's officer will reject a report on the basis that 'the coroner is not interested in that' and that no inquest will thus be held. For example, a Tameside registrar who attempted to report a death due to 'e-coli' was told that the coroner would not 'accept it', but would do so if any further deaths from that cause came to light. I do not see how the coroner could conclude that there was no reasonable cause to suspect that the death was due to neglect (e.g. by lack of proper hygiene precautions) without making some preliminary enquiries. The information given by the registrar, limited to the mere cause of death, could not be a sufficient basis for decision. Furthermore, the suggestion that a second death from the same cause would be treated differently by the coroner's office made no sense at all.

7.61 Similarly, there was evidence that one coroner would not accept a death due to tuberculosis. Such a death is to be regarded as 'unnatural' (and therefore requires an inquest) if it had resulted from occupational exposure to infection, for example, of a nurse in an isolation hospital. It is listed on the reverse side of the MCCD as an infectious disease which may be of industrial origin. Its causes are said to include **'contact at work'**. The Tameside registrar reporting it did not know how the disease had been contracted. The Coroner for Greater Manchester South District declined to hold an inquest, saying that tuberculosis was a naturally occurring disease. In evidence, it was apparent that he had not appreciated that, in some circumstances, such a death might be related to the deceased's occupation and therefore regarded as 'unnatural'.

7.62 On another occasion, a Tameside registrar telephoned the coroner's office to report a case in which the word **'dehydration'** appeared on the MCCD. Registrars are instructed that, if the word **'dehydration'** appears within the causes of death given on an MCCD, they must report the death to the coroner. The registrar completed Form 52 stating that dehydration was a reportable cause of death. The note made at the coroner's office was

that the registrar was **'Unable to accept dehydration without clearance'**. The reason why registrars are instructed to report cases of dehydration is that they may result from some form of neglect, so that the death may not have been natural. In the event, the registrar was given 'clearance' by the coroner's office by means of a Form 100A without any further enquiries being made. Thus, the coroner's office never discovered whether the dehydration resulted from neglect, or was the result of a natural disease process; instead, the report was treated merely as a procedural exercise. This defeated the whole purpose of the rule that such a death should be reported and of the intention that this should lead to an enquiry as to whether there had been any form of neglect.

7.63 Another case concerned two daughters of a deceased person who were concerned about his death. They expressed their concern to the registrar and said that they did not wish to register the death. The registrar telephoned the coroner's office to report the death. The deceased had, according to his daughters, appeared to be making good progress after a stroke and was about to be discharged from hospital, when he died suddenly. His daughters wanted an explanation as to why he had died so suddenly. The cause of death was certified by a doctor as bronchopneumonia resulting from a stroke. A member of the coroner's staff spoke to the certifying doctor, who said that he was **'quite happy with the cause of death'**. At that stage, neither the coroner nor any member of his staff spoke to a member of the deceased's family to ascertain the detailed reasons for their concern. On the basis of what the doctor had said, the coroner directed that a Form 100A should be issued, notifying the registrar that he did not consider it necessary to hold an inquest. One of the coroner's staff telephoned one of the deceased's daughters and informed her that the coroner was **'happy with'** the cause of death the doctor had given and would not order an autopsy. The daughter was not satisfied and wanted an autopsy. She was offered an opportunity to speak to the coroner personally but declined, saying that if he had made that decision, she did not want to speak to him but would take the matter further from there. In the event, she made a complaint through the hospital complaints procedure. In oral evidence, the coroner told this Inquiry that he had a report of a natural cause of death from the doctor and did not regard it as necessary to speak to the family, in order to ascertain the nature of their concerns, before taking a decision. He said that, where there was a conflict between the view of the doctor and the view of the family, he had to take the view of the professional. It may be that, in this instance, the professional's view was indeed correct. But until the coroner had informed himself of the family's concerns, he was not in a position to judge whether there was a reasonable cause to suspect that the death was unnatural.

7.64 These cases suggest that the bases upon which some coroners decide whether or not to accept jurisdiction in respect of a particular death are variable and of doubtful validity.

The Criteria for the Decision about Jurisdiction following the Report of a Death – Is the Cause of Death Known?

7.65 Under section 8(1)(b) of the 1988 Act, the coroner has to determine whether there is **'reasonable cause to suspect that the deceased ... has died a sudden death of which the cause is unknown'**. It should be noted that the requirement is for suddenness and an unknown cause. The words suggest that there is no need for the coroner's intervention if

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the death is slow and expected (i.e. not sudden) but of unknown cause. I do not think that that can have been the intention of Parliament. Assuming that the intention of Parliament was that there should be an enquiry into all deaths of which the cause is unknown, the wording of this sub-section seems to presuppose that all deaths that are not sudden are of known cause. I very much doubt that that is always the case.

7.66 It seems clear to me that what the provision is really driving at must be whether or not the cause of death is sufficiently known. The expression **'reasonable cause to suspect that the deceased ... has died a sudden death of which the cause is unknown'** is an unfortunate one. Whether or not something is sufficiently 'known' cannot be a matter of suspicion; the question should be whether the cause of death is known to a sufficient degree of confidence. It is to be hoped that coroners understand that that is the issue that governs this aspect of their jurisdiction.

7.67 If a deceased's doctor says that s/he does not know the cause of death and there is no other doctor qualified to issue an MCCD who has the necessary knowledge, the case falls within section 8(1)(b) and the coroner must either order an autopsy under section 19 or hold an inquest.

7.68 More difficult cases arise where the doctor is uncertain whether or not s/he is sufficiently confident of the cause of death to certify or is uncertain as to whether the condition s/he believes caused the death of itself gives rise to a duty to report the death. The doctor may then telephone the coroner's office for advice. Assuming that the proposed cause of death is not of itself such as to require the opening of an inquest, the issue for the coroner (or his/her officer) is whether it appears from the information available that the cause of death is known with a sufficient degree of confidence, such that there is no reason to suspect that the cause of death is unknown. Even if the doctor him/herself expresses confidence in the cause of death, that is not necessarily the end of the matter. The coroner (or his/her officer) may conclude that, in the circumstances (e.g. because the doctor has not seen the deceased recently and is not therefore in a position to diagnose the cause of death), there is still reason to suspect that the cause of death is unknown. It is for the coroner or the coroner's officer to judge whether the cause of death is known with sufficient confidence to avoid jurisdiction arising under section 8(1)(b).

7.69 Even where the deceased's doctor was in regular attendance on the deceased to the end of his/her life, is confident that s/he knows the cause of death and the coroner has no reason to doubt the doctor's word, difficulties can arise. As is made clear in the judgement of Simon Brown LJ in the Touche case cited above, it is quite likely that there will in many cases be several causes of death. In that case, the deceased had died shortly after giving birth by caesarean section. The medical causes of death, as recorded in the autopsy report and accepted by the coroner, were **'Ia. Brain swelling and tonsillar herniation b. Intra cerebral haemorrhage II. Recent pregnancy'**. These were undoubtedly accurate statements of the medical cause of death but provided an incomplete explanation for the death. Why had the deceased suffered an intra-cerebral haemorrhage? When the whole picture was later considered, it became clear that the underlying cause of Mrs Touche's death was that she must have developed very high blood pressure in the post-operative phase. This was a well-recognised complication; yet

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the hospital had failed to monitor her blood pressure and treat it if it rose. That failure was a contributory cause of the death. The current system by which coroners or their officers decide whether or not jurisdiction arises seems to me to require the person receiving the report of death to be very astute to the potential significance of underlying or contributory causes; yet these reports are very often received by untrained staff and, to the extent that they may be considered by coroners in person, there is wide variation in the approaches taken. That doctors and coroners may focus on the immediate medical cause without considering the relevant wider picture is evidenced by the case in which death took place some time after a road traffic accident (see paragraph 7.59) and also by the death of Mrs Renate Overton, whose case I shall deal with in Chapter Thirteen.

7.70 As I have intimated, many reports or 'requests for advice' from doctors to the coroner, relating to uncertainty over the cause of death, are taken by coroner's officers. In Greater Manchester South District, at least until recently, decisions about whether or not the Coroner would 'accept' the case were taken by coroner's officers. I had the clear impression that these officers did not realise that they were making decisions about jurisdiction on the Coroner's behalf. That is not intended as a personal criticism of them; they have had no formal training. Although they knew that, if the doctor did not know the cause of death, the case had to be 'accepted', I do not think they had any idea of where to draw the line in a case of doubt. They said that, if in doubt, they would consult the Coroner. I had the impression that they did so only occasionally. In any event, I think they would often have been unable to equip themselves with the information needed to enable the Coroner to reach a well informed decision. The coroner's officers frequently gave 'advice' to doctors to issue an MCCD, which advice, in effect, amounted to a decision, made on the Coroner's behalf, to decline jurisdiction. I do not think they ever realised that that is what they were doing. I think it is inappropriate that they were allowed to do so, although I am sure that the practice is not unique to that office.

7.71 Even in cases where it is the coroner personally who takes the decision, some further difficulty might well arise because it is not clear what level of confidence is required before s/he should decide that no inquest is needed and should encourage the treating doctor to certify the cause of death. Some coroners appear to apply a much higher standard of confidence than others. There is little guidance in the statute as to what standard is to be applied. The use in section 8(1) of the 1988 Act of the words **'reasonable cause to suspect'**, inappropriate though those words are, suggests a fairly low threshold before an inquest must be held and the need for a fairly high degree of confidence in the accuracy of the cause of death before the treating doctor should be encouraged to certify. It might be thought that good practice and the satisfactory operation of the death certification and coronial systems should require a high degree of confidence in the accuracy of the cause of death.

7.72 However, if a coroner imposes too high a standard of confidence, the result is neither sensible nor practicable. If the coroner, on receiving the report of the death, decides that the cause of death is unknown, s/he is virtually bound, under the present system, to order an autopsy, as that is necessary if s/he is to certify the cause of death without an inquest. Although the coroner could speak to the deceased's family and to witnesses with knowledge of the circumstances of the death and could examine any medical records

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made available voluntarily, in practice s/he moves straight to the autopsy as the first tool of investigation. Autopsies are expensive and a drain on resources. Moreover, they cause distress to many families who are upset to think that the body of a loved one is to be (as they see it) invaded. For some religious and ethnic minorities, there are very strong and deep-rooted objections. Coroners know this only too well. Mr Dorries, who, I think, requires a high degree of confidence about the cause of death before he will allow a treating doctor to issue an MCCD, told the Inquiry that, in cases where he is sure that the death was natural but the precise cause cannot be identified with confidence, he often wishes that he could certify that state of affairs, rather than being obliged to order an autopsy. However, not all coroners require so high a degree of confidence and I am sure there are many who, faced with that situation, take the view that they can and should tell the doctor that s/he may issue an MCCD.

7.73 It might be thought that a high standard of confidence would be desirable despite the fact that this might lead to a large number of autopsies. If the autopsy produced a high degree of certainty about the cause of death, the effect would be beneficial to the system, even though unpopular with the public. However, as I shall explain in Chapter Nine, that is not the case. The coroner's autopsy often does not provide the 'gold standard' cause of death which some believe it provides. It reveals the conditions with which the deceased has died, but not necessarily the condition which actually caused the death. It may also reveal one or more of several causes of death but it will not necessarily result in the identification of the true cause of death.

Concerns about the Soundness of Decisions on Jurisdiction

Decisions Taken for Inappropriate Reasons

7.74 On the basis of the evidence received by the Inquiry, it appears to me that there are grounds for concern about the soundness of the decisions of some coroners and coroner's staff on jurisdiction. Although I have no doubt that many coroners understand and apply the correct statutory tests when making decisions under section 8 of the 1988 Act, there is also evidence that some either do not understand the criteria or are influenced, deliberately or not, by extraneous matters. On occasions, it appears that decisions are taken for frankly improper reasons. I give below some examples of practices reported to the Inquiry by doctors. I acknowledge that the evidence is fragmented. The Inquiry has not conducted any research of the wider position but my overall impression from the evidence I have received is that the practices in question are likely to be general and widespread, rather than specific and local, features of the coroner service.

7.75 The experience of the doctors who gave evidence to the Inquiry was variable. Dr Alan Banks, a former general practitioner, later Assistant Director of Primary Care and Medical Adviser to the West Pennine Health Authority, gave evidence in Stage One of Phase Two. He said that, when working as a general practitioner in East Anglia, he used to talk to the coroner when he was unsure whether the available medical evidence was sufficient to enable him to certify the cause of death. Dr Banks plainly found the experience of discussing a death in this way to be helpful. Many doctors do. Dr Frances Cranfield, a general practitioner who gave evidence in Stage One, said that, on occasions, she would

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discuss a death with the Coroner so that she would be able to indicate that she had done so on the back of the MCCD. The Coroner would contribute little or nothing to her thinking on the cause of death but the process of registration would be facilitated. Dr Banks appears to have been luckier than many, in that he at least seems to have been able to speak directly to the coroner. The experience of Dr Ian Morgan, a general practitioner and medical referee from the West Midlands, was less satisfactory. He said that, in 15 years, he had never spoken directly to the coroner, save when he had attended an inquest.

7.76 Dr Rachel Pyburn, now a consultant geriatrician at Hope Hospital, Salford, said that, in the past, while working in the North East, she had had some very unsatisfactory experiences. She had been put under pressure to issue an MCCD when she had telephoned the coroner's office with the intention of reporting the death, because she did not feel confident that she knew the cause. One general practitioner from Yorkshire told the Inquiry that he and colleagues are sometimes asked by a coroner's officer whether they could not put 'bronchopneumonia' on the MCCD, because the coroner's office has a backlog of autopsies to deal with. Another general practitioner, again from Yorkshire, told the Inquiry that the coroner's officer, a police officer, usually advises the doctor to certify the cause of death if at all possible, even if there is uncertainty about it, so long as it is fairly clear that the death was due to natural causes. A clinical epidemiologist told the Inquiry that he had had conversations with a coroner about the certification of deaths following a fracture of the neck of the femur. This coroner wished doctors to avoid mentioning such fractures on MCCDs, even where the patient had died in the immediate period following a fracture as, if this were done, he would be obliged to intervene, presumably because it would appear that the death had resulted from a fall and was, therefore, unnatural. Quite apart from any other consideration, this sort of action has the effect, as the epidemiologist pointed out, of rendering completely unreliable statistics for excess mortality following a fractured femur.

7.77 I can see how such poor practices might arise. If a coroner is overworked or understaffed, s/he or the coroner's officer might be tempted to keep to a minimum the number of cases in which the coroner assumes jurisdiction for reasons which are, in fact, inappropriate. There will be less work to do and more deaths will be certified by the attending doctor. Fewer autopsies and fewer inquests will be held. Costs will be reduced. By and large, the population in the area will be content, as, in general, people do not want the bodies of their loved ones to be invasively examined. However, such a policy reduces the efficacy of the system to detect concealed homicide, malpractice or neglect and to provide information which might improve knowledge on health matters. It also produces a high level of distress and disappointment among those who are unsuccessful in securing the death investigation that they seek.

7.78 These are important concerns. The decision of a coroner to order an autopsy or hold an inquest is very important; yet it is not subject to any review. Indeed, the coroner does not even have to give reasons, unless (very occasionally) required to do so for the purpose of judicial review.

The Adequacy of the Information on which Decisions Are Taken

7.79 Even if the decision as to whether to order an autopsy or hold an inquest is taken in completely good faith, as I accept it usually is, there is reason to believe that the evidential

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basis is incomplete and unreliable. The decision is usually taken in an informal way and without any independent investigation of the death. The usual procedure is that the doctor wishing to report the death telephones the coroner's office and tells the coroner's officer about the death. The coroner's officer may take down some details and indicate what the decision is likely to be or else promises to put the facts before the coroner for decision. Some coroners will speak directly to the doctor but my impression is that that is very unusual.

7.80 The informality of the process, in which the doctor provides only a verbal account of the medical history and circumstances of death, is quite likely to result in the coroner's officer having an incomplete and imperfect understanding of the case. Not all doctors are good historians. Most coroner's officers do not have the medical expertise necessary to probe the doctor's account. The doctor might not tell the truth or the whole truth. The coroner's officer will know nothing about the doctor. He or she can check to ensure that the doctor is properly registered but that is all; s/he will not be privy to any other information and will not know, for example, whether or not the doctor has been the subject of disciplinary action or is under the supervision of the General Medical Council. He or she will often have no independent knowledge of the deceased's medical history or about the circumstances of the death, although in some areas, such as Cheshire, the coroner's officer might discuss these matters with the family before putting the information before the coroner.

7.81 In some cases, the doctor will have an underlying wish to issue an MCCD, possibly to save the relatives the distress of an autopsy or inquest. In that event, s/he might well present his/her view of the cause of death in a more confident light than the facts warrant. Alternatively, the coroner's officer might have a preconceived view. He or she might know that the office has a backlog of work or that the coroner is not particularly 'interested in' certain types of case. In such circumstances, the coroner's officer might well suggest to the doctor that it appears that s/he could issue an MCCD. The giving and recording of a complete and accurate account will not be helped by the existence of any preconceived attitudes on the part of either the doctor or the coroner's officer.

7.82 In my view, a single conversation with the reporting doctor is an inadequate basis for the important decision that is to be taken. The Coroners Act 1988 and the Coroners Rules 1984 do not deal with the way in which coroners should set about investigating deaths reported to them, nor the sources from which they should seek information. No power is given to coroners at that stage to enter and search premises, inspect documents or seize documents or other property relating to a death, although there is nothing to prevent a coroner from doing so, provided s/he has the consent of the person with control of the relevant premises, documents or property.

7.83 I consider that it would be far better if the coroner undertook some preliminary independent investigations before making his/her decision on jurisdiction. I accept that it would not be practicable for extensive investigations to be made at this stage. However, it seems to me highly desirable that someone from the coroner's office should obtain information from relatives of the deceased, those who had care of the deceased or those who had seen him/her recently before the death. Such a practice is usual in Nottinghamshire and Cheshire and is clearly quite practicable. Mr Dorries introduced this

practice shortly before he gave evidence to the Inquiry and it appeared that he had found it helpful. The cases referred to in oral evidence by Mrs Christine Hurst, senior coroner's officer for Cheshire, suggested that the arrangements in her District work well. When he gave evidence to the Inquiry in November and December 2002, Mr Pollard had not yet introduced the practice of speaking to relatives and others with knowledge of the deceased in the Greater Manchester South District, despite his acknowledgement that the present arrangements depend heavily on the integrity of the reporting doctor and his detailed knowledge of Shipman's dishonesty.

7.84 The form of any preliminary investigations might vary according to the circumstances of the death. Under the present provisions, the coroner might not only discuss the medical history and circumstances of death with the family or friends of the deceased or those who have cared for the deceased such as district nurses, s/he might also (with the consent of the next of kin) examine the deceased's hospital or general practitioner records. On some occasions, s/he might arrange to inspect the scene of the death. Any one or more of these steps might reveal evidence to show that there was or was not real cause to suspect that the death was violent or unnatural or might throw light on an uncertain cause of death. However, coroners do not generally undertake such preliminary investigations before reaching (or allowing an officer to reach) a decision on jurisdiction.

7.85 Whether this is because the coroner has no time for such enquiries or cannot fund them or does not undertake them because there is no statutory power to enforce the wish to undertake them, I do not know. No coroner told me that he wished to carry out such examinations but was thwarted, for example, by a lack of resources. All seemed prepared to accept the present system as it is, with all its limitations.

Decisions Taken by Coroner's Officers

7.86 Of particular concern was the evidence about the way in which coroner's officers – rather than coroners – take decisions on jurisdiction; these decisions should be taken only by coroners themselves. This practice is not universal, but, as I have already said, appears to be widespread. Dr Chapman claimed that he had some input into most of the decisions made or 'advice given' by his office. Mr Burgess permits his officers to give 'advice' to doctors. It was not clear to me which types of case call for 'advice' and which for a decision on jurisdiction. I suspect that the boundaries are blurred. Mr Burgess does not have any secretarial or administrative staff but sees no reason why, if he had, they should not 'give advice' to doctors. He says that all decisions taken by his officers are ultimately reported to him, although this might not occur until some time after the decision has been taken. His instructions about reporting decisions to him were recorded in writing for the first time in 2001.

7.87 In the Greater Manchester South District, until recently, any member of the coroner's staff (i.e. the first, second, or third coroner's officer or the clerk/typist) was authorised to deal with enquiries from doctors. They were authorised to take a decision about whether or not there should be an autopsy and about whether, if there was to be one, it should be conducted by a Home Office approved pathologist. Once the autopsy had been carried out, they were authorised to receive the results and decide whether to pass for certificates

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(Form 100B and cremation Form E) to be prepared or arrange an inquest. In other words, they took decisions on all aspects of the Coroner's jurisdiction. Their 'entitlement' to take these decisions, without reference to the Coroner, was set out in their job descriptions until very recently. The evidence was that the staff did sometimes refer decisions to the Coroner, but it is clear that they often did not. In any event, the Coroner would often not be available, as he would be away conducting an inquest. I formed the view that, only if the officer thought the case was difficult or unusual, would it be referred to the Coroner. The junior members of staff would seek advice from the first officer if in doubt about the decision to take. Mrs Mary Evans, first coroner's officer from 1986 until 1999, said that a new clerk/typist would not be able to handle a query for a considerable time after appointment. She might take the details down but would not make a decision. However, Miss Michelle Kennerley (now Mrs Michelle Greenwood), who began work as a clerk/typist in the coroner's office in May 1998, told the police in August 1998 that she was dealing with simple queries, including giving clearance to doctors to issue MCCDs, within a short time of beginning her employment. She claimed that by the time she left, after seven months in the office, she had become more experienced and confident and able to deal with straightforward cases alone and without reference to others. It may be that Miss Kennerley was an unusually apt pupil; she had worked as a medical secretary and was used to speaking to doctors.

7.88 The job description of the coroner's first officer at that time appeared to entitle the post-holder to take a wider range of decisions on the Coroner's behalf. Her role was said to be to 'deputise' for the Coroner. The extent of her delegated powers was not defined. Plainly, she could not conduct an inquest or sign the various forms which the Coroner would issue but it seems likely that she could do anything else.

7.89 The practice of permitting a coroner's officer or clerk/typist to make decisions on the coroner's jurisdiction is plainly unsatisfactory, at least where, as in Greater Manchester South, the officers have no medical knowledge, investigative experience or formal training. They could not have had the knowledge necessary to ask the right questions, let alone evaluate the answers. This practice, the Inquiry has been told, has now ceased.

The Effect of the Decision on Jurisdiction

No Jurisdiction

7.90 If, following a conversation with the reporting doctor, the coroner or one of his/her staff decides that the cause of death is sufficiently known and that the other circumstances are not such as to require an autopsy or inquest, the doctor will normally proceed to issue an MCCD. I have explained in Chapter Five that the MCCD and counterfoil provide the doctor with the opportunity to state whether s/he has reported the case to the coroner **'for further action'** but, for various reasons, the fact that the conversation has taken place is not always recorded on the MCCD. Assuming that the MCCD is otherwise apparently in order, the registrar will proceed to register the death on production of the MCCD and may not be aware that there has been any earlier contact with the coroner. If, however, the registrar becomes aware that there has been a report to the coroner, for example, because the doctor indicates on the MCCD that s/he has reported the death, the registrar will require

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a Form 100A (or, at least oral confirmation from the coroner that there is no intention to hold an inquest) before the death can be registered.

7.91 Form 100A is a notification that the coroner has been informed of the death and has decided not to hold an inquest. Its receipt provides official confirmation to the registrar that s/he can register the death. Some coroners issue a Form 100A in respect of any death of which they are informed, if they or an officer decide, for whatever reason but without an autopsy, not to hold an inquest. Others issue a Form 100A only in those cases that they regard as having been 'formally reported'. If the death has only been discussed with the coroner or 'informally reported', not only might the coroner not issue a Form 100A, but it is quite possible that no record at all will be kept of the referral. If a record is kept, it will probably be marked **'NFA'** (No Further Action). Here again, there is variability of practice. In some offices, the distinction between a formal report and 'discussions' and 'requests for advice' and 'informal referrals' is wholly unclear. Clearly, good practice requires that every contact with the coroner's office in respect of a death should be treated as a formal report, recorded as such and the outcome recognised as a decision on jurisdiction. Dr Chapman and Mr Dorries both operate such a system. In Mr Burgess' office, there is a distinction between formal and informal referrals, although a note is kept of all contacts. In Mr Pollard's office, the practice has recently changed so that every contact is treated as a referral and is considered by the Coroner. If jurisdiction is 'declined', a Form 100A is issued in every case. Previously, many conversations were dealt with by the staff on an informal basis and did not come to the attention of the Coroner. Many were not recorded; some were recorded and marked **'NFA'**. Forms 100A were frequently not issued. It was impossible to discern the criteria by which staff decided how to deal with any individual enquiry.

7.92 One of the effects of permitting a coroner's officer to take a decision without reference to the coroner is that the decision might have been acted upon before the coroner even knows of it. Mr Pollard agreed that, in the past, his staff made decisions on reports from doctors and, in a case in which jurisdiction was not accepted, and the doctor was told s/he could issue an MCCD, the doctor might well do so and give the certificate to the deceased's next of kin before he had seen the papers and issued a Form 100A. If the Coroner had disagreed with the officer's decision, that situation would have had to be set in reverse and it is likely that it would have caused considerable distress to the deceased's family. Mr Burgess said that 'he did not have a clue' whether doctors issued MCCDs before he had seen the papers and signed the Form 100A. It seems that the signing by coroners of Form 100A is, on occasions, no more than a 'rubber stamp' of previous decisions made by their officers.

7.93 It appears that, in some coroners' offices, Forms 100A pre-signed by the coroner are available to officers, who are then able to make a decision and put it fully into effect without reference to the coroner. In Mr Pollard's office, the staff used to keep a supply of such forms for use when Mr Pollard was away from the office. It was claimed that he gave permission before one was issued. Mrs Joan Collins, who was employed at the Coroner's office from 1985 until 2002 and was the first officer from 1999 until her retirement, said that only in exceptional circumstances would the staff use one without his prior knowledge. However, Mr Pollard agreed that he did not know whether staff used such forms without

his knowledge. There were no clear rules for their use and use was not audited. In my view, it is likely that, in the past, pre-signed forms were used without specific authorisation by the Coroner. That may well have been one of the respects in which Mrs Evans was permitted to 'deputise' for the Coroner. The practice of using pre-signed forms has now ceased.

Jurisdiction Accepted

7.94 If the decision is taken that the circumstances are such as to require an inquest to be held, the case will be 'taken over' by the coroner's office and the next stage will usually be to order an autopsy. I shall deal with what happens next in Chapter Nine.

Particular Examples of Decisions on Jurisdiction

'Old Age' as a Cause of Death

7.95 In Chapter Six, I explained that some registrars are unhappy about the use of 'old age' as a sole cause of death. However, if the deceased was aged 70 or over, and the MCCD is acceptable in other respects, the registrar is virtually bound to accept it and to register the death. Frequently, deaths where 'old age' is given as the cause of death will not be reported to the coroner. However, sometimes, doctors will contact the coroner to seek advice. Some coroners do not approve of 'old age' as a sole cause of death. Mr Dorries said that, if a doctor telephones his office to ask about certifying 'old age' as a cause of death, he will not approve it unless the deceased was over 80 and he is satisfied about the medical history. Deaths suggested as being due to 'old age' are not on Mr Dorries' list of reportable deaths and he admitted in oral evidence that he had no right to impose any conditions about use of the term. He is aware that at least some of the registrars in his district report cases of deaths due to 'old age' to him but he acknowledged in oral evidence that he did not get reports of all such cases. He said that, when doctors contacted his office to ask advice and he and his officers did not regard 'old age' as an appropriate cause of death, they would say so and the doctors would usually heed their advice. I have given detailed consideration to the use of 'old age' as a cause of death in Chapter Six.

7.96 According to Mr Pollard, the staff in the office of the Greater Manchester South District used themselves to make a judgement about the appropriateness of 'old age' as the cause of death in a case in which a doctor telephoned to ask advice. If in doubt, they would refer the decision to him. The staff who operated this system gave varying accounts of what happened in practice. Mrs Evans told the Inquiry that she would ask a series of questions, including how long the doctor had been treating the patient and whether the deceased had deteriorated gradually, as opposed to having died a sudden death. However, when making a statement for the police investigation of Mrs Kathleen Grundy's death in 1998, she said that **'... if a doctor had seen a patient within the required fourteen days and told us that they had died of old age having basically deteriorated over a period of time then we** [*i.e. the coroner's office*] **would not become involved'**. She said that such conversations lasted **'a couple of minutes'** only. Mrs Collins, who was employed in the office from 1985 until 2002, recalled that Mr Peter Revington, the Coroner

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until 1995, would be happy for 'old age' to be used, so long as the deceased was over 80 and had deteriorated over time. She said that Mr Pollard asked for more information than that. Mrs Margaret Blake, the current first officer, said that the only question asked prior to 1998 was the age of the deceased; if that was 75 or over, old age was acceptable. Mrs Blake said that she had been told that this was the policy in the office. It is doubtful whether, prior to the enquiries about Mrs Grundy's death in 1998, the procedure was ever as extensive as Mrs Evans and Mrs Collins described. Mrs Blake's account seems most likely to be right. An internal office form dated 1985, recording a discussion with a doctor about the appropriateness of 'old age' as the cause of death, contained no details at all of the deceased's state of health. It is clear that, in the past, many discussions were of a superficial nature and could not have led to a fully informed decision. Mrs Collins said that, recently, Mr Pollard has begun to speak to doctors personally in 'old age' cases.

7.97 The importance of a sound decision is obvious. Once the coroner has given his/her approval to 'old age' as a cause of death, the doctor can tell the deceased's family, the registrar and the medical referee of that approval. If insufficient care is taken when making the decision, the coroner's *imprimatur* is attached to a certification that may be quite unsatisfactory, even dishonest. 'Old age' has the very real potential to be used as a cause of death when, in fact, no cause is known.

7.98 On at least one occasion, Shipman manipulated the Coroner's staff in order to obtain the apparent approval of the Coroner when he certified a death as being due to old age. In the case of Mrs Grundy, who, until her death at his hand, was a very fit and active woman of 81, Shipman wished to certify that her death was due to 'old age'. It would have been difficult for him to think of any specific disease process to account for the death, as those who knew Mrs Grundy were aware that she was very well. After the death was discovered, Shipman telephoned the coroner's office, apparently to seek approval for his proposed MCCD. The call lasted only 2 minutes 11 seconds. There is no record in the coroner's office as to who dealt with his call or what was said. It is possible that Shipman was asked only to state Mrs Grundy's age. If he was asked more detailed questions, it would seem likely that he gave false details about Mrs Grundy's previous state of health and of a decline leading to death. No doubt, his account would have been plausible. It appears that the member of staff must have indicated that the coroner would have no objection to the death being certified as due to 'old age'. In so doing, she would be doing no more than was common practice in that office at that time. Armed with the coroner's 'approval', Shipman's certification of Mrs Grundy's death would not be questioned by anyone in authority.

The 'Either/Or Rule'

7.99 Perhaps the most common reason why a doctor will wish to speak to the coroner before issuing an MCCD arises from the so-called 'either/or rule'. As I have already explained, regulation 41 of the Registration of Births and Deaths Regulations 1987 imposes on a registrar a duty to report to the coroner any death in which it appears that the medical practitioner who has submitted an MCCD had not either seen the deceased within 14 days before death or seen the body after death. I have called this the 'either/or rule'. The unsatisfactory effect of the rule is that, provided the doctor has seen the body after death,

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it does not matter how long before death s/he last saw the patient alive. Some coroners, recognising that the 'either/or rule' is unsatisfactory, demand that, if a doctor has not seen the patient within 14 days before death, the death must be reported, regardless of whether the doctor has seen the body after death. As I observed in my First Report, it appears that Shipman believed that such a rule operated in the Greater Manchester South District. Indeed, I am satisfied that it did, although I have not been able to discover when it was introduced. It appears from the evidence of the coroner's officers (who were unaware of the existence of the 'either/or rule') that it must have been a rule of custom and practice dating back at least to the time of Mr Revington, the Coroner who preceded Mr Pollard, and possibly longer. It is clear that some coroners are uncertain about the 'either/or rule'.

7.100 Dr Morgan told the Inquiry that he did not regard himself as qualified to sign an MCCD unless he had seen the deceased within 14 days of death. He knows that that is not the law but regards the 'either/or rule' as illogical. It appears that many doctors believe that the law requires that a death should be reported to the coroner if they have not seen the deceased within 14 days before the death, regardless of whether or not they have seen the body after death. Mr Dorries said that, if this confusion did not exist, he would receive far fewer telephone calls from doctors concerned about their ability to certify. It is common practice for doctors who wish to certify the cause of a death, but who have not seen the deceased within 14 days before death, to telephone the coroner's office to seek 'permission' to do so. They believe that, if they state on an MCCD that they have not seen the deceased within 14 days before death, the registrar will refuse to accept the certificate, the death will be reported to the coroner and the relatives will be upset and inconvenienced. In fact, this fear may be misplaced as, if the doctor has seen the body after death, the registrar will accept the certificate, unless the doctor has not seen the deceased for a very long time before the death. There is no statutory provision and no other clear rule about how long this period of time is. However, many doctors do not realise this.

7.101 The response of the coroners to such a request for permission to certify varies. Some coroner's officers ask if the doctor has seen the body after death; if s/he has not, the coroner's officer advises the doctor to do so. Then, provided that the doctor says that s/he knows the cause of death and there is no other reason to report the death to the coroner, the doctor will be 'permitted' to issue an MCCD and the registrar will accept it. However, it appears that many coroners or coroner's officers do not enquire whether the doctor has seen the body but, on learning that the doctor has not seen the deceased within 14 days of death, engage in a discussion with the doctor about the medical history and circumstances of death and then either give or withhold 'permission' for the doctor to issue. Mr Dorries, who takes this approach, admits that, if the doctor has seen the body after death, he has no power to give or withhold permission to the doctor to issue. The doctor is qualified to issue and is under a duty to do so; it is a matter for his/her own judgement whether or not s/he feels sufficiently confident about the cause of death to state the cause in the unequivocal terms acceptable to the registrar. However, Mr Dorries takes the view that he should advise the doctor as to the appropriate course of action. If the advice is that the doctor should issue an MCCD, a Form 100A will be sent to the register office. In fact, provided the doctor does not record on the MCCD that s/he has reported

the death to the coroner **'for further action'**, there would be nothing on the face of the MCCD which would render it unacceptable to the registrar or prevent registration, so that a Form 100A would be unnecessary and not expected by the registrar.

7.102 I have already expressed my concerns about the fact that decisions of this nature are often taken by a coroner who is not medically qualified, based on information taken by a coroner's officer who may have little experience of medical matters. Where the coroner is not involved in the decision, it may be taken entirely by an officer with no formal training or qualification. The Inquiry has come across cases where such decisions are or were taken by coroner's officers on a plainly inadequate basis. For many years, the staff in the office of the Coroner for Greater Manchester South District operated a 'rule of thumb', whereby the officer would say that the coroner would give 'permission' for the doctor to issue an MCCD, provided that the doctor had seen the deceased within 28 days before the death. Plainly, the notion that an important decision as to jurisdiction was being made was far from anyone's mind. No proper consideration was apparently given to the cause or circumstances of death or to whether, if a doctor had not seen the deceased for 28 days, s/he was able to be sufficiently confident of the cause of death.

7.103 It appears to me that the whole procedure relating to the 'either/or rule' is in a muddle, mainly because the rule is not properly understood, even by coroners and those who work for them. Many doctors telephone the coroner to obtain formal 'permission' even though, having seen the body after death and being, therefore, qualified to issue the MCCD, they do not need 'permission'. Many Forms 100A are issued quite unnecessarily for the same reason.

7.104 The position of the doctor who falls foul of the 'either/or rule', i.e. who has neither seen the deceased within 14 days before death nor seen the body after death, is not regarded by coroners as entirely clear. Mr Burgess said that this is a 'grey area'. Yet, the coroners who gave evidence to the Inquiry assumed (rightly, in my view) that they were entitled, depending on the circumstances, to 'give permission' to the doctor to issue an MCCD.

7.105 The doctor in that position cannot issue an MCCD that will be acceptable to the registrar. However, s/he may be qualified to complete the MCCD because s/he attended the deceased during the last illness; in that case s/he will be under a duty to issue the MCCD, stating the cause of death to the best of his/her knowledge and belief. However, as the doctor knows that the registrar would reject the MCCD, s/he will report the death directly to the coroner. If the coroner is satisfied that the doctor knows the cause of death, s/he has no legal power to order an autopsy or hold an inquest, since the death will not fall within section 8 of the 1988 Act (unless, of course, one of the other section 8 criteria is met). The coroner's task is to assess whether the cause of death is 'known'. The likelihood of the doctor knowing the cause of death will to some extent depend on when s/he last saw the deceased. If the doctor says, 'I know it was a heart attack', but has not seen the deceased for a year, the coroner would surely be entitled to say that s/he had reasonable cause to suspect that the cause of death was unknown. But in the situation where the coroner is satisfied that the doctor's professed knowledge is soundly based, the doctor should be permitted to complete an MCCD, Form 100A should be issued and the coroner's role should be at an end. In other words, the registrar is prohibited by the strict requirements

of regulation 41 from registering the death because the doctor has seen neither the deceased within 14 days before the death nor the body after death. Registration can, however, take place once the registrar has the coroner's 'permission' to register; that 'permission' is granted on the basis of what is said by the doctor to the coroner and is formally confirmed by the issue of Form 100A. The registrar will register the death as usual, relying on the cause of death given in the MCCD.

7.106 Although some doubt was expressed about the legality of this process, I have come to the conclusion that it is lawful. In my view, the only statutory requirement (save for the fact that the doctor must be registered) governing the capacity of the doctor to issue the MCCD is that s/he attended the deceased during the last illness. He or she is not disqualified from so doing by an inability to satisfy either of the requirements of the 'either/or rule'. That rule only requires the death to be reported by the registrar to the coroner. But if the coroner comes to the conclusion that the doctor did attend the deceased during the last illness and knows the cause of death to a satisfactory degree of confidence, then the doctor's certificate is good and the death can properly be registered in reliance upon it.

When the General Practitioner Is Not Available

7.107 As I have just said, the essential qualification for the doctor who is to issue an MCCD is that s/he must have attended the deceased during the last illness. However, it not infrequently happens that the general practitioner who has attended the deceased during the last illness is, for some reason, unable to certify the cause of death, even though s/he may know it. For example, s/he might have been taken ill or might be away on holiday. General practitioners who are going away on holiday at the time when they are expecting the death of a particular patient often arrange for a colleague to visit the patient whilst still alive so that, if the death occurs during the holiday, the colleague will be able to issue an MCCD. But the plans sometimes go astray and there is no doctor qualified to issue an MCCD. In these circumstances, the death must be reported to the coroner. This is often done by the another member of the practice, who has been called out to confirm the fact that death has occurred or has otherwise been informed of the death.

7.108 The coroner's position is unclear. On the one hand, it might be said that the coroner must accept jurisdiction because, if there is no MCCD, there must be **'reasonable cause to suspect'** that the cause of death is not known. In practice, if there is no MCCD, the only person who can certify the cause of death is the coroner, either on the basis of an autopsy report or after an inquest. If the coroner refuses jurisdiction and will not put him/herself in a position to certify the cause of death, the deceased's family is in difficulty. How is the death to be registered? On the other hand, it might be said the coroner is not bound to accept jurisdiction, which arises only if s/he has reasonable cause to suspect that the deceased **'has died a sudden death of which the cause is unknown'**. It sometimes happens that the member of the practice who has reported the death to the coroner has access to the deceased's medical records and has spoken to the deceased's family about the circumstances of the death. That doctor might be able to tell the coroner, quite properly, that s/he is confident that the death was not sudden and that s/he knows its cause. In those circumstances, some coroners decline jurisdiction and instruct the doctor to issue an MCCD based on his/her knowledge of the history and circumstances. The

coroner sends a Form 100A to the register office. Yet the legal position is that the MCCD is invalid and the Form 100A cannot make it valid. As a matter of law, the registrar should reject the certificate and refuse to register the death. However, registrars recognise that, if the coroner refuses jurisdiction, the family is in difficulty. Their practice is to register the death, giving the cause either as stated on Form 100A or, failing that, taking it from the informant, using the invalid MCCD as 'guidance'. Dr Cleone Rooney, medical epidemiologist at the ONS, described such deaths as 'legally uncertified'. Mr Dorries' practice is a variant on this. He asks the member of the practice to write a letter explaining the situation and giving his/her opinion as to the cause of death. No MCCD is completed. Mr Dorries' office issues a Form 100A, giving the cause of death contained in the letter. The registrar then registers the death, taking the cause of death from the Form 100A.

7.109 If the coroner accepts jurisdiction, s/he might order an autopsy. However, where the death was expected and the cause known, that course of action would seem hard on the relatives and a waste of scarce resources. Some coroners have a way round this problem. Mr Pollard's practice is to open and adjourn an inquest and allow disposal of the body on the basis of the information given by the treating doctor's colleague. By the time the inquest is resumed, he will have obtained a letter or statement from the treating doctor, which is then accepted in evidence and allows him to reach a verdict. If the treating doctor is not available then (because, for example, he is ill), Mr Pollard will take the evidence from the doctor's colleague. An alternative course is to conduct an inquest immediately, taking evidence from a doctor who knows the cause of death from perusal of the medical records. Both these solutions comply with the law. Something less cumbersome would be desirable.

Shipman's Practice of Reporting Deaths to the Coroner

7.110 Very few of the deaths of Shipman's patients were ever reported to the Coroner. As I explained in Chapter Five, Shipman was able to issue an MCCD for the patients he had killed and give false reassurance to the families that it was not necessary for the death to be reported to the Coroner. I pointed to the essential defect in the present system that allowed Shipman to avoid the coronial system almost entirely.

7.111 In a few cases (we do not know how many since records would not necessarily have been kept), Shipman discussed the death of one of his patients with a member of the coroner's staff and obtained 'permission' to issue an MCCD. In this way, he forestalled any possible query from the registrar, the deceased's family, the doctor who would complete cremation Form C or the medical referee about whether it was appropriate for him to certify the death. The relevant member of the coroner's staff never apparently doubted that permission should be given. It is clear that, even if Shipman had made more such telephone calls, in effect giving the coroner the opportunity to take jurisdiction in those cases, it is unlikely that the outcome would have been different. If Shipman gave a false history and asserted that he knew the cause of death, neither the coroner's staff, nor even the coroner himself, would have been able to discover that the death was sudden, unexpected and of unknown cause, unless enquiry had been made of an independent person, such as a relative of the deceased or some other person with knowledge of the circumstances of the death.

7.112 Thus, although I have drawn attention to a number of aspects of poor practice in coroners' offices, the fact is that, even if those aspects were remedied, there would still be no effective safeguard for those deaths about which a doctor chose to tell lies. If there is to be any protection against another Shipman, or any doctor who seeks to conceal a crime or medical error by him/herself or a colleague, all deaths must be subject to scrutiny by someone who is independent of the certifying doctor. Furthermore, the history on which that doctor relies must be independently verified.

Conclusions

General

7.113 The present function of the coroner is to investigate, on behalf of the state, deaths which occur otherwise than as the result of a natural disease process. This function constitutes an important safeguard for the ordinary citizen. It is important that the circumstances surrounding deaths that have or might have resulted from some outside agency (such as an accident or exposure to a noxious substance at work) are properly investigated. Under the present system, the coroner becomes aware only of those deaths reported to him/her. He or she has no knowledge of other deaths and no means of knowing whether, in the case of any individual death which has not been reported, there was in fact a need for an investigation. All the coroner can do is act upon information which is given to him/her.

7.114 The present arrangements by which deaths are reported to coroners are unsatisfactory. They vary from place to place. Doctors find them difficult to apply. The system largely depends on the willingness of doctors to report deaths. The Inquiry has heard that some doctors never report a death to the coroner. It seems unlikely that this is because no death certified by them should have been reported. It may be that they do not know when a death should be reported. It may be that the doctor has personal objections to the autopsy process. It is likely that in many cases the doctor is seeking to spare families the ordeal of a report to the coroner and a possible autopsy. Registrars are not well equipped to make a decision on whether a death should be reported. Shipman was able to evade the coronial system almost completely. A way must be found to ensure that all deaths receive a degree of scrutiny and investigation, appropriate to their facts and circumstances. Even some deaths that might currently be treated as 'natural' deaths might warrant detailed investigation. One example might be where it appears that there is an increasing prevalence of a particular illness in a particular district. Another is where, for example, an otherwise healthy individual succumbs to an illness that is not normally fatal. It may well be of interest to the family and the wider public at large to know why that individual succumbed and what, if anything, can be done to prevent the same thing happening again.

7.115 Under the current arrangements, once a death is reported, the coroner must first take a decision as to whether s/he has jurisdiction, i.e. jurisdiction to order an autopsy and/or hold an inquest. I have several concerns about the way decisions on jurisdiction are taken by coroners or their officers. First, the decisions are taken far too informally. The information on which the decision is based is taken down over the telephone by a coroner's officer who usually has no medical training and very little medical knowledge. If

the death raises issues of any medical complexity, there is obviously a danger that the full picture will not be captured. The doctor is not required to put anything in writing or to produce any extract from the medical records. Instead of an informal account provided over the telephone, the coroner should, in my view, receive written information about the circumstances of the death from the health professional who has certified the fact of death. He or she should also receive written information about the deceased's medical history from a doctor with recent knowledge of it.

7.116 Second, the amount of information obtained depends largely on the extent and nature of the coroner's officer's questions. In some coroner's offices, I am sure that the questioning is careful and detailed. Regrettably, in others, only scanty information is obtained.

7.117 Third, the decision as to jurisdiction is, in general, taken on the basis only of what the reporting doctor says. If the doctor chooses to give a false or incomplete account, the coroner's officer, or indeed the coroner, is unlikely to realise. The coroner takes what the doctor says completely on trust. Usually, there will be no attempt to verify the accuracy of the information given by the doctor with any other source. As I have said, the doctor will not be required to produce any part of the medical records. Nor will the coroner's officer usually attempt to speak to a relative of the deceased. In my view, it would be far better if such decisions were based upon a broader knowledge of the death than is usually available at present. Instead of relying solely on the account of one doctor, information provided by the doctor or other health professional should be cross-checked with a member of the deceased's family or some other person with recent knowledge of the deceased.

7.118 Of particular concern is the practice followed in some offices of delegating the decision on jurisdiction to a coroner's officer. In my view, this practice is of very doubtful legality under the present Act. In any event, even if lawful, I do not think it is appropriate to allow a coroner's officer with no formal training to take such a decision. I have no doubt that many coroner's officers are very experienced and take such decisions very conscientiously. But I am also satisfied that some are inexperienced and take decisions based on scanty information and sometimes by applying rules of practice or other considerations which do not reflect the criteria by which the decision should be taken.

7.119 In the main, such decisions entail a decision based on medical judgement. Even when the decision is taken by the coroner, as opposed to the coroner's officer, the legally qualified coroner may be ill equipped to take the decision. Dr Chapman, the only medically qualified coroner to give oral evidence to the Inquiry, described the way in which medical knowledge enables a coroner to take an informed part in discussions with doctors about deaths that may or may not fall within his/her jurisdiction. Some of the legally qualified coroners agreed that medical experience was required. For example, Mr Pollard said that it was not appropriate for him, as a lawyer, to take the decision to allow a doctor to certify the cause of death if the doctor told him that s/he could not say whether the death had been caused by one of two natural causes. His only option was to order an autopsy. He felt that this was often not appropriate. His powers were limited. He said that, if the coroner had more flexible powers and if there were a medically qualified person in the coroner's office, it would be possible to avoid unnecessary autopsies. I accept that some legally

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qualified coroners do, after some years of experience, develop considerable expertise in medical matters. However, many do not. In my view, decisions of this kind should be taken by medically qualified coroners or, in the more straightforward cases, by coroner's officers with some medical background and ready access to expert medical advice.

7.120 There are substantial variations between the practices operated in different coroners' offices and much variability in the standard of service achieved. It would be desirable to achieve a measure of consistency of practice and of high standards. To achieve these ends, there is a need for leadership, organisation and structure in the work of coroners. Coroners must also receive continuing education and training.

Greater Manchester South District

7.121 Shipman's practice in Hyde fell within the coronial District of Greater Manchester South. Once his activities became known, there was some public disquiet that they had not earlier come to the knowledge of the Coroner for the District, Mr John Pollard. He had, in fact, first become aware of concern about Shipman in March 1998, when he was contacted by Dr Linda Reynolds, a local general practitioner. A police investigation followed, as described in my Second Report, and concluded that there was no substance in the concerns expressed by Dr Reynolds and others. No suspicions had previously been awakened within the coroner's office as a result of the deaths reported, or not reported, by Shipman. It was therefore necessary for the Inquiry to examine the practices within the coroner's office and to ascertain whether the absence of concern about Shipman's activities resulted from any fault on the part of the Coroner or his staff.

7.122 The procedures within Mr Pollard's office have been subjected to close scrutiny by the Inquiry. The Inquiry obtained a considerable amount of documentation relating to cases unconnected with Shipman, which had been dealt with by Mr Pollard and his staff. These cases, chosen at random, have thrown up concerns about decisions on jurisdiction made in Mr Pollard's office. I am not critical of individual members of staff, who had received no training and were no doubt doing their very best to discharge their duties in difficult circumstances. Nor am I very critical of Mr Pollard himself. He too had little training and suffered from the various problems which I have already described in this Chapter. Most significantly, I do not think that the practices within his office were any different from those in operation in many other coroner's offices up and down the country. It may be that, in some coroner's offices, the decision-making process is based on a sound understanding of the principles involved and the way in which those principles should be applied. However, the evidence available to the Inquiry suggests that this is certainly not always the case. I am confident that a close examination of the practices in operation in many other coroner's districts in England and Wales would reveal shortcomings similar to those which I have described in connection with Greater Manchester South District.

7.123 Most importantly, I doubt that the practices in operation in Mr Pollard's office had any effect on the outcome of those few deaths referred to him where Shipman had killed. In saying this, I exclude the case of Mrs Renate Overton, which I shall deal with in detail in Chapter Thirteen; in any event, Mrs Overton's death occurred during the time of

Mr Pollard's predecessor, Mr Revington. It is possible that, if the practices followed in Mr Pollard's office had been better, the outcome might have been different in those cases (we have no means of knowing how many, since no record would necessarily have been kept) where we know that Shipman spoke to the coroner's office to 'discuss' the death. For example, in the case of Mrs Grundy, a coroner's officer might have spoken to Mrs Grundy's daughter, Mrs Angela Woodruff, before giving 'permission' for Shipman to certify the death as due to 'old age'. However, the practice in the coroner's office can have had no effect on the vast majority of the killings, which never came to the Coroner's notice at all.

CHAPTER EIGHT

The Role of the Coroner's Officer

Introduction

8.1 In Chapter Seven, I dealt in detail with the position of coroners in England and Wales and mentioned the role performed by their officers. In this Chapter I shall expand upon the role played by coroner's officers. It will become apparent that there is an enormous degree of variation in the tasks performed by those who work on behalf of the coroners and that there is a lack of uniformity with regard to their employment terms, conditions and circumstances. There is also no consistency in the nomenclature of the posts that they hold. By way of illustration, the coroner's officers who work in the office of Mr John Pollard, HM Coroner for the Greater Manchester South District, are essentially secretarial or clerical staff. In some districts, the coroner's officer has an investigative role. Mr Pollard also has available to him the services of coroner's liaison officers (CLOs), who are employed by the Greater Machester Police (GMP), albeit in a civilianised post, and who perform some enquiries of an investigative nature on Mr Pollard's behalf. Other such enquiries are performed by GMP officers.

Historical Background

8.2 It has long been recognised that, in order to fulfil the many functions ancillary to his/her office, the coroner needs support and assistance. In 1893, the Select Committee on Death Certification explained the position at that time:

> **'The preliminary inquiries in a case referred to a coroner are usually made by his officer, who frequently is a parish beadle or police officer. In practice it is not unusual for it to be left to this official to decide after his own personal inquiries in the matter, whether an inquest is necessary. He also, in some cases, has the selection of the witnesses to be called, and it sometimes happens that a coroner does not know what witnesses are coming before him until they are called.**
>
> **It may be doubted whether this important part of the work connected with a coroner's inquiry should be entrusted to an official who cannot be expected to possess the requisite qualifications for its proper performance.'**

8.3 In 1971, the Brodrick Committee described the coroner's officer as occupying the position of **'general factotum'** in the coroner service. The Committee's view was that the coroner service had undergone a shift away from its concentration on crime towards a wider medical and social function, with the result that many of the tasks performed by the coroner's officer should not be performed by police officers. The Committee commissioned a survey, which was carried out by the Organisation and Methods Branch of the Home Office. The overwhelming majority of coroner's officers at that time were found to be serving police officers, seconded to serve the coroner. The paradox of the officer

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being employed by the police but controlled by the coroner was noted, as were the possible problems that might flow from this arrangement.

8.4 The Brodrick Committee recommended that police officers should no longer serve in the capacity of coroner's officers and that the involvement of police officers in that role should gradually be phased out. This fitted in with their view of the shift in function of the coroner service. It also fitted in with the Committee's intention that there should be greater reliance on doctors for the reporting of deaths and its expectation that there would be a corresponding reduction in the investigative function of the coroner and his officer. However, as with other recommendations of the Brodrick Committee, no substantive changes were made in the arrangements for coroner's officers.

8.5 In 1985, a further survey by the Organisation and Methods Branch of the Home Office on the work of coroner's officers was circulated by the Home Office to coroners, chief executives of county councils, chief officers of police and others concerned. This echoed the Brodrick Committee's recommendation that police coroner's officers should be replaced by civilian staff employed by local authorities. The Home Office Steering Committee was of the view that this step would enable police officers to be re-deployed on work more relevant to their police powers and training.

Recent Developments

8.6 In 1998, the Home Office published Research Study 181 on the Coroner Service, undertaken by Mr Roger Tarling. The Study recorded a gradual shift towards full civilianisation of the post of coroner's officer. However, it also recorded that, although many posts were civilianised, the majority of post-holders were former police officers. The Study noted that very little formal training was provided for coroner's officers, apparently on the grounds that little was needed because of the officers' previous employment. In all the police areas surveyed, training was provided **'on the job'** by **'shadowing'** a coroner's officer, usually the present incumbent of the post. Only ten of the 40 police forces who responded stated that they provided their officers with written guidance as to how to perform their duties. Although it was recorded that most police forces intended to continue to provide coroner's officers, this was not universal. There was noted to be a tension in some areas about who 'owned' the coroner's officers and who had the final say in directing their work. The Study identified a shift towards direct employment by the local authority or the coroner.

8.7 As a result of the publication of the Tarling Study, the Association of Chief Police Officers (ACPO) General Policing Committee set up a small working group to consider the issues raised in the Study. The conclusion of that group was that responsibility for the employment of coroner's officers should no longer rest with the police, but should be assumed by local authorities. It confirmed that the degree of responsibility conferred on coroner's officers, and the tasks required of them, varied significantly from one force to another and were very **'ad hoc'**. The group found it impossible to obtain a clear or consistent picture of what roles and functions had been handed over to local authorities and what residual tasks had been left with police forces. The training needs of coroner's officers, said the group, had to be addressed. Training at that time was still **'on the job'**.

8.8 The variation in provision throughout the country at this time is well illustrated by work done by Mrs Christine Hurst, the senior coroner's officer for Cheshire. In 1999, she produced a report entitled 'Survey of Standardisation of Duties and Practices of Coroner's Officers in England and Wales'. Upon assuming her post some time earlier, she had set about assessing how the practice of coroner's officers in Cheshire might be standardised. As part of that task, she circulated a questionnaire to coroner's officers all over the country. She received 200 replies which formed the basis of her survey.

8.9 The survey revealed that 184 coroner's officers were employed by police authorities and 15 by county councils. One did not know by whom s/he was employed. One hundred and fourteen coroner's officers were based at police stations, 36 in council offices and the rest in hospitals, the coroner's office or in solicitors' offices (presumably the offices of part-time coroners). The majority of coroner's officers received a salary of between £15,000 and £18,000 a year. One hundred were on a paid on-call rota, four were on unpaid on-call rota. Ninety six were not expected to work out of hours but almost half of these could be contacted at home out of hours and at weekends for advice and assistance in cases involving organ donation; some also attended the scene of road traffic accident deaths out of hours. Although the majority of coroner's officers have no formal medical training, 176 coroner's officers reported that they examined hospital medical notes during the investigation of deaths occurring in hospital. About 40 said that they attended all autopsies. Almost all had attended at least one autopsy. The most common tasks performed were the formal identification of the deceased, the completion of a report form for the coroner and/or pathologist, the taking of witness statements and some duties akin to those performed in a civil or criminal court by the court clerk or usher. A relatively high number, 152 in total, sometimes attended the scene of a death, whether at the time of the initial report or subsequently.

8.10 It is clear from this brief analysis of these various reports and surveys that the current arrangements in relation to the provision of coroner's officers are far from satisfactory. The shift in the coroner service from concentration on crime towards a wider medical and social function noted by the Brodrick Committee has, in my view, continued. Yet there is still, in some areas especially, a tendency to appoint, without providing further relevant training, retired police officers who have only a layman's understanding of medical issues and no real experience of investigation or file preparation.

8.11 In a letter to the Inquiry, Mr John Coopey, Chairman of the Coroner's Officers Association, explained that the reason for the setting up of the Association in 1997 was a perception on the part of coroner's officers that, following civilianisation of the role of coroner's officer, the lack of formal recognition by the Home Office of their role and the absence of structured training were operating to prevent coroner's officers from providing an adequate and uniform level of service. Although the Association has now been recognised by the Home Office and although it organises regular training days, Mr Coopey says that there is scope for considerable improvement. The Association advocates fundamental changes to the coroner service.

Inquiry Evidence: Training

8.12 Mrs Hurst is the Deputy Chairman of the Coroner's Officers Association. I was impressed during her oral evidence by Mrs Hurst's obvious enthusiasm for her work. In her capacity

as Deputy Chairman, she has been instrumental in setting up national continuing education and training programmes for coroner's officers. The Coroner's Officers Association, with a membership of only about 120, has, until recently, had to organise such training itself and has had to fund it from subscriptions. Mrs Hurst said that funds available for training are very limited, although lectures are given by speakers from outside the Coroner's Officers Association and some funding from the Home Office has been promised. Mrs Hurst recently collaborated in setting up a four-day course in Liverpool, adapted for the needs of coroner's officers from a Regional Health Authority course for medical coders. Medical coders are employed to interpret medical records and code diseases and medical procedures for epidemiological and other purposes. The object of the adapted course was to instruct coroner's officers in basic medical terminology. Mrs Hurst told me also of another course for coroner's officers, set up at the instigation of ACPO, at Teesside University. She has hopes and plans for the further development of more comprehensive courses.

8.13 Whilst it is commendable that Mrs Hurst and the Coroner's Officers Association have taken these initiatives, it is disappointing (and an undoubted product of the fragmented arrangements that currently exist) that such initiatives had first to come from the Association and not from, for example, the Home Office. I heard evidence, from various sources, of difficulties for many coroner's officers in securing funding to attend such courses. This problem results, in part at least, from the fact that coroner's officers work for the coroner but are very often employed by the police.

8.14 I heard evidence about a two-week training course provided by the GMP following the civilianisation of the coroner's officer post in 1998, which focussed on the relevant areas of law and issues such as grief counselling, interviewing witnesses, statement taking and file preparation. Those issues are, of course, very relevant to the work of the coroner's officer. However, the course did not offer any medical instruction, even though the majority of those attending had no medical background.

Inquiry Evidence: Variability of Support

8.15 The following description of the position in five areas illustrates the variability in the nature, extent and quality of support available to coroners from their coroner's officers.

Surrey

8.16 Mr Michael Burgess, HM Coroner for Surrey, has nine civilian coroner's officers, employed by the police. Three are ex-police officers and the others come from different employment backgrounds. These officers work out of four separate police stations and one hospital. Neither they nor the Coroner have any clerical or administrative support; all accounting work is done by the local authority.

8.17 The job description for the Surrey coroner's officer requires the officer to assist the Coroner and to enquire into specified categories of deaths, to arrange and manage inquests and to present witnesses, reports and statements to enable the Coroner to arrive at a verdict. All Mr Burgess' officers perform an investigative role. Although they are under no

obligation to attend deaths that occur or are reported outside normal office hours, Mr Burgess said that they tend to do so out of a sense of professional responsibility. Although it might have been expected that the former police officers would be most skilled in investigative work, his experience is that it is a former paramedic who stands out. The police officers who work for him had attained only a relatively junior rank in the police force and had acquired little experience of forensic investigative techniques.

8.18 Mr Burgess' officers do not normally attend the scene of a crime under investigation by the police. They do, however, attend the hospital or mortuary where the body is being held and liaise between the police and the coroner over the arrangements for the autopsy. Otherwise, they have no role during a criminal investigation and only a small role, if any, in the police investigation of a road traffic accident death.

8.19 In cases where there is no suspicion of criminal wrongdoing, the extent of the officers' involvement is variable. For example, in the case of the discovery of a body in circumstances suggestive of suicide, the police will attend, but their investigation ends if they exclude the possibility of third party involvement. The case is then taken over by the coroner's officers, who will make enquiries of witnesses and seize anything of evidential value.

8.20 The job description for Mr Burgess' coroner's officers states that it is desirable that the post-holder should understand, or have the ability to acquire an understanding of, medical procedures and terminology. In common with the practice in many other coroners' offices, however, many of Mr Burgess' officers have no medical background and the way in which they acquire an understanding of medicine is by 'learning on the job', by looking in medical dictionaries and by seeking help, when available, from Mr Burgess' assistant deputy coroners, who are medically qualified. Mr Burgess said that there is some cross-fertilisation of skills between his officers; no doubt the presence of a paramedic in his team is of some value. Mr Burgess said that he had perceived an increase in the number of deaths reported to his office that require some form of investigation into a medical mishap or an allegation of lack of medical or nursing care. It is clear that there is an increasing need for medical knowledge for coroner's officers, just as was observed by the Brodrick Committee in 1971.

South Yorkshire (West)

8.21 Mr Christopher Dorries, HM Coroner for South Yorkshire (West), has three coroner's officers, two based in Sheffield and one in Barnsley. Two are serving police officers and the third is a retired police officer. The office has the benefit of separate administrative and secretarial support. Mr Dorries' officers are paid by the police but their expenses are reimbursed by the relevant local authorities.

8.22 Unlike Mr Burgess' coroner's officers, Mr Dorries' officers are office-bound and the burden of their office duties is such that there is, according to Mr Dorries, no prospect of their being able to visit a scene of death or to take statements, save in the most exceptional case. The effect of this is that, although the officers are or have been serving police officers, they do no investigative work and the skills required for their job are not what would traditionally be regarded as police skills.

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8.23 All investigations are carried out for the Coroner by serving police officers of the South Yorkshire Police. Mr Dorries acknowledges that the investigations and the reports upon them are of variable quality and he has no direct control over how the work is done. It is, however, always open to him to revert to the reporting officer where necessary.

Nottinghamshire

8.24 Dr Nigel Chapman, HM Coroner for Nottinghamshire, has six coroner's officers under his jurisdiction, provided and employed by the City Council. They include two ex-police officers, but otherwise come from a variety of non-medical employment backgrounds, including school secretaries and the former manager of a cotton mill. As with Mr Dorries, Dr Chapman's officers perform no investigative role. This is undertaken by the police. The coroner's officers might discuss an investigation with the police and report back to the Coroner. As a result, the police might be asked to carry out further investigations. However, that is the limit of the coroner's officers' investigative role in Nottinghamshire.

8.25 Dr Chapman also reported that the quality of investigation by police officers attending the scene of the death was variable. He was of the view that it would be far preferable if investigating officers were answerable directly to him, rather than to their police employers.

Cheshire

8.26 The evidence relating to Cheshire came from Mrs Hurst. Mrs Hurst has been a coroner's officer since 1993. She had previously trained and worked as a nurse and medical secretary. When she first began working as a coroner's officer, she was given no specific training and felt particularly ill equipped for those areas in which she had no relevant experience, such as taking statements and the other investigative aspects of her job. On the other hand, she observed (accurately, I am sure) that she was at a considerable advantage over some police officers who were at that time in post and who did not have a good grasp of the medical issues with which they frequently had to grapple. Mrs Hurst expressed the view that a proper system of death investigation required a blend of skills that would be offered by a team with different backgrounds and experience. Mrs Hurst said that, in her capacity as Deputy Chairman of the Coroner's Officers Association, she had observed the growing trend towards recruitment of candidates from a non-police background.

8.27 The work of the coroner's officers, as carried out in Cheshire, is largely of an investigative nature. The coroner's officer receives reports of deaths from police officers. I have already observed in Chapter Four that the sudden death report form used by the Cheshire Constabulary is more comprehensive than that used by the GMP and many other police forces and I think that the actual system of reporting is correspondingly more robust. The coroner's officer checks the contents of the form and often speaks to a doctor about some aspect of the medical history. He or she also often speaks to a relative of the deceased to check or supplement some aspect of the information about the circumstances of the death. He or she takes that opportunity to discover whether the deceased's family has any concern about the death or about any medical treatment given. He or she liaises with

families over arrangements for autopsies and their results. He or she frequently has to examine medical records when investigating a death in hospital. Plainly, Mrs Hurst's medical background is invaluable when she undertakes these tasks. It was clear from Mrs Hurst's description of the way in which she works that, unlike many other coroner's officers, she undertakes investigations for the coroner both before and after he has made his decision whether to accept that he has jurisdiction over the death.

8.28 Mrs Hurst said that the Cheshire Coroner's office is somewhat understaffed and that such understaffing is a common problem, resulting possibly from the uncertainty as to who will in future take over the responsibility for coroner's officers. Because of this understaffing, Mrs Hurst performs a 'hands on' role, as well as the supervisory role required of her as senior coroner's officer.

Greater Manchester South

8.29 Procedures in the office of Mr John Pollard, HM Coroner for Greater Manchester South District, appear to differ significantly from those in place elsewhere in the country. As I briefly mentioned at the beginning of this Chapter, those whom he describes as his coroner's officers perform no investigative role. They deal with telephone reports of deaths and queries from doctors, registrars and members of the public. They generally started work in the office as clerk/typists and gained promotion to the position of coroner's officer when those previously so employed retired or left. The staff received no training but learned the job by following the example set by their seniors. None had any medical expertise, other than that picked up in post. No written advice or guidance was available until February 1999, when the then first coroner's officer, Mrs Joan Collins, assembled some information sheets for the newly appointed third coroner's officer. However, these have since become out of date and, when Mr Pollard gave evidence in November 2002, had not been up-dated or used for some time. On taking up his position in 1995, Mr Pollard made no formal enquiry into the procedures operated by his staff but said in oral evidence that, in order to ensure that his staff were on the right lines, he contented himself with listening to one side of telephone conversations, as he moved about the office.

8.30 Until 1998, Mr Pollard had available to him also the services of a small number of police coroner's officers, who were serving police officers, seconded to work for the Coroner. These posts were civilianised in 1998 and the job title became 'coroner's liaison officer'. Mr Pollard now has three such officers working for him, one for each of the three police divisions within his coronial district. All are former police officers. Two work from police stations and the third, the Tameside (G Division) CLO, is nominally based at Ashton police station but spends most of his time at the Tameside General Hospital mortuary.

8.31 There has been some confusion in the GMP area as to the extent to which CLOs should perform investigative work. Prior to civilianisation, the police coroner's officers' job description included the investigation and reporting of sudden death. Since 1998, however, the job description describes an essentially administrative function, with police officers carrying out the investigative role. It is not at all clear whether the CLO has or has not an investigative role. Mr Pollard said that the CLO's job 'has remained something of a mystery to many people' following civilianisation. In practice, the responsibilities attaching

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to the post do not seem to have changed significantly, if at all, since 1998. Mr Pollard said that, when opening an inquest, he tells the CLO what investigation he wants and the CLO attends to it. He told the Inquiry that some officers regard the post as involving administration, liaison and preparation for the coroner of information that has been gathered by others. Other officers take a far more proactive view and will undertake investigations largely upon their own initiative.

8.32 The current CLO for G Division is Mr Christopher Gaines. He was appointed in April 1998 and was the first divisional appointment to the newly civilianised post. He had previously retired from the police force in 1994 on the grounds of ill health. His police experience had been mainly in the performance of uniformed, non-investigative duties. He had had limited experience of preparing and submitting police investigation files. He has had no medical training; he told the Inquiry that he has purchased a medical dictionary and looks up the meaning of medical terms where he is unsure. For the investigation of deaths in G Division, therefore, Mr Pollard is dependent upon a retired police officer who undertook little investigative work before retirement and who has no medical background or training. There is no opportunity for any cross-fertilisation of skills, since Mr Gaines works largely alone. Mr Pollard acknowledged that Mr Gaines would find medical training of use in respect of much of the work he has to carry out.

8.33 Mr Gaines explained that, of 11 GMP appointees to CLO posts in 1998, all but three had formerly been police officers. He said that his workload has become so great that he requires assistance. He has now been provided with an assistant, who is a police officer with some 14–15 years' experience but no medical training or other training specific to his responsibilities as an assistant to the CLO. It is likely that this assistant will replace Mr Gaines' current deputy, Police Constable (PC) Peter Napier, in due course.

8.34 Mr Gaines spends most of his time at Tameside General Hospital mortuary but maintains frequent contact with Ashton police station. Although he carries out some investigative work, many of his duties are of a purely clerical nature. His working day normally begins with the collection and checking of the police reports of sudden death forms deposited in the mortuary overnight or over the weekend. He might expect to find between eight and twelve such forms on a Monday morning and between one and three such forms on other weekdays. Until July 2001, it was his practice to ascertain from the deceased's general practitioner whether s/he was in a position to certify the cause of death, but this task is now performed by the coroner's officers based in Mr Pollard's office. Mr Gaines faxes Forms 751 and 751A to the coroner's office and leaves the original Form 751A at the mortuary for the pathologist. During his working day, Mr Gaines will undertake interviews of the next of kin of a deceased and witness the identification of the body.

8.35 During the morning, Mr Gaines travels to Ashton police station, where he liaises with his former police colleagues and collects messages from his internal electronic mail system. He then goes to the coroner's office in Stockport to open inquests, transfer files and discuss cases with the Coroner. There is no fixed time for the opening of inquests and between one and six inquests might be opened at one time. Mr Gaines swears an oath, confirming the correctness of the information that he puts before the Coroner, which

includes Form 751 and any witness statements. He will receive instructions from the Coroner as to any enquiries he is to make or witness statements he is to take. Mr Gaines very rarely attends autopsies, although he might occasionally be called in by the pathologist, if the latter wishes something to be drawn to the attention of the Coroner. When he attends inquests, he does so as a facilitator or link between the witnesses, the family and the Coroner.

8.36 In respect of hospital deaths, Mr Gaines' duties are very limited. He receives reports of hospital deaths from the coroner's office. At the mortuary, he will ensure that the body has been properly identified and will complete Form 751, in effect repeating the information that he has been given by the staff in the coroner's office who will, in turn, have received that information from the hospital. Of course, although Form 751 is a GMP **'Report of Sudden Death'**, the police are not involved in the report of the death and Mr Gaines is not a police officer. Presumably, the GMP form is used because no alternative form has been devised and produced by the coroner's office. The extent of Mr Gaines' involvement, apart from repeating that which he has learnt from the coroner's office, is to fill in the details of the deceased's general practitioner and certain other information concerning the next of kin. His role is, therefore, almost entirely clerical and, given his lack of medical training, it could hardly be expected to be otherwise. Mr Gaines would not normally visit parts of the hospital other than the mortuary, except occasionally to take a witness statement from a member of staff when, for example, a deceased has previously suffered an injury on a ward.

8.37 PC Napier is Mr Gaines' deputy. He first deputised in 1990 for the erstwhile police coroner's officer, Police Constable (PC) Theresa King, who retired in 1997. He was the police coroner's officer himself, between 1997 and 1998, until civilianisation. He is still a serving police officer. During Mr Gaines' absence, PC Napier 'holds the fort' but he can do no more than that because he has other responsibilities as the police warrants officer. PC Napier has no medical training at all and the only instruction he has had with regard to the fulfilment of his duties was when working alongside PC King and thereafter 'on a casual basis'. PC King had no medical training. In a statement to the Inquiry, PC Napier expressed the view that access to medical advice is not necessary for his role, a comment which may well be accurate insofar as it relates to the role as he performs it. However, I am quite sure that a degree of medical knowledge and access to medical advice would be extremely valuable to coroner's officers performing the type of role that might be expected of them by many coroners. Mr Pollard readily accepted this.

Comment

8.38 Without intending any disrespect to the coroner's officers or CLOs whose work I have described, it is abundantly clear that there is an urgent need for change in the provision of suitable and properly trained support staff for coroners. Although the advantages of close contact with the police must be recognised and maintained, the time has come to accept that police officers or former police officers are often not well suited or equipped to carry out the wide range of functions which a coroner's officer ought to perform. To a large extent, the evidence gathered by the Inquiry has only served to confirm that which had already been recognised, as I shall shortly explain.

Inquiry Evidence: the Employment Position of Coroner's Officers

8.39 Problems flowing from the split responsibility for the employment of coroner's officers between local authorities and the police have been acknowledged in the past and were confirmed by numerous witnesses who gave evidence to the Inquiry.

8.40 Mr Burgess, who is also the Honorary Secretary of the Coroners' Society and has knowledge of practice in many parts of the country, confirmed that a number of police forces have sought to divest themselves of responsibility for coroner's officers. In his district, tensions arise because his officers are employed and paid by the police but work for him. Employment law and health and safety issues arise out of this hybrid status. He is not troubled by the fact that, although in charge of the investigation of a non-criminal death, he cannot ultimately direct those who are investigating it; however, I can easily envisage how problems could arise.

8.41 Mr Pollard said that tensions can arise because he cannot require his CLOs, who are employed by the GMP in a 'civilianised' post, always to act in accordance with his wishes. For example, he has recently been unable to insist that one of them attend a training course organised by the Coroner's Officers Association. Moreover, there are problems with deputising cover on G Division, in that PC Napier, the deputising officer for Mr Gaines, is still a serving police officer with other duties to perform when he is standing in as CLO.

8.42 Mrs Hurst said in terms that she finds it 'quite a difficult situation to be in', being employed by the police but working for the coroner.

Recognition of the Need for Change

8.43 I described in paragraph 8.7 above the findings of the small ACPO working group, set up following publication of the Tarling Study in 1998. The findings of the working group were brought to the attention of the Home Office Coroner Service Consultative Committee (CSCC) in 1999. This Committee is chaired by a representative of the Home Office and consists of representatives of the various Government Departments and agencies with a responsibility for, or an interest in, the coroner service. The Home Office invited views from the Association of Police Authorities and the Local Government Association. Although both bodies accepted that there was a case in principle for a transfer of responsibility for employment of coroner's officers from the police to local authorities, they could not agree on funding arrangements. In the meantime, the Home Office proposed to the CSCC that yet further work would be helpful in clarifying the duties of coroner's officers and a Working Party with wide Terms of Reference relative to the role of coroner's officers was established in early 2001. The Working Party consisted of representatives of the Home Office, the Coroners' Society, ACPO, the Metropolitan Police, the Local Government Association and the Coroner's Officers Association.

8.44 At about the same time, in the summer of 2001, the Coroners Review was established. The CSCC Working Party considered whether there was still a need for it to report and decided that there was. In April 2002 it provided its report entitled 'Report on the Provision of Coroners' Officers' to the CSCC. The Home Office accepted the report and, on 30th August 2002, issued it together with Home Office Circular 46/2002.

8.45 I do not propose to lengthen this Report by a detailed discussion of the findings and recommendations of the CSCC Working Party. Suffice it to say that they have undertaken the first ever detailed nationwide analysis of the work which is and should be done by a coroner's officer. Of course, their report is based upon the existing law relating to coroners and the deaths that they investigate and I shall make recommendations for changes in that law. However, there is a great deal in the Working Party's report that is valuable and will remain so, whatever changes are made to the coronial system. Any new system will depend heavily for its successful operation upon a well-trained and properly resourced cadre of coroner's officers.

8.46 The Working Party identified seven main functional areas of responsibility of the coroner's officer. These are administration, medical investigation, forensic investigation, the gathering of evidence and the taking of statements, family liaison, inquest duties and public relations. The report demonstrates that the members of the Working Party have a wealth of experience of what is entailed in the work and what is required to provide proper support for coroners and a suitable service to the public, especially the bereaved.

8.47 The report lays particular stress upon the need for training and adequate resources. I endorse the views expressed. I note also that the report envisages the provision of an 'out of hours' service. As I mentioned in Chapter Four, there is at present no service primarily responsible for dealing with deaths in the community, whether they occur in or out of normal working hours. In my view, there should be such a service and coroner's officers should provide it.

8.48 The report also advocates the recruitment of officers with a police or medical background (though not exclusively so) and suggests that a balance of such experience should be available within a coroner's district. I agree. Induction training and continuing education will be needed.

8.49 The report recognises the need for close co-operation between the police and the coroner service but also advocates a clear division between the tasks that are to be performed by coroner's officers and those to be performed by police officers. These tasks will vary according to the nature of the death under investigation. For example, the police will plainly be responsible for the investigation of crime. However, once suspicion of criminality has been ruled out, coroner's officers should take responsibility for investigating the death. The police should continue to play a major role in the handling of disasters and multiple fatalities. The police should have no role to play in the administrative duties connected with inquests or many of the other miscellaneous duties performed by coroner's officers under the direction of the coroner. Coroner's officers alone should perform the administrative duties involved in the case of deaths occurring abroad.

8.50 The authors of the report considered that it was not possible, on the basis of the information or research available, to assess the number of officers that an individual coroner might need. A list of key criteria, including numbers of deaths reported, numbers of inquests held, geography and topography and the availability of administrative and clerical support, was drawn up. I agree that it is not yet possible to estimate how many coroner's officers will be needed and would add that the uncertainty in this regard will be

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increased by any changes in the coronial system. However, it seems inevitable that there must be a substantial increase on the present provision.

8.51 The report recognised the need for adequate provision of transport and equipment and I endorse the relevant recommendations. I also endorse their suggestion that standard operating procedures or service level agreements should be negotiated to manage the interface between coroner's officers and the police.

8.52 In summary, this report will be an invaluable aid to those charged with the task of organising a service that will provide proper administrative and investigative support for coroners in the future.

Conclusions

8.53 The functions of coroner's officers vary from district to district. It is inevitable that the service they provide must also be of variable quality. It appears that, everywhere, the coroner would benefit from the support of a team of well-trained officers, preferably drawn from a wider variety of backgrounds than is presently the case. If the coroner were further able to direct and manage their work and working conditions, many of the current inadequacies would be avoided.

8.54 Fortunately, a great deal of preparatory work has already been done towards the standardisation of the role of the coroner's officer. The duties have been analysed and the need for training fully established. The need for close co-operation with, but clear demarcation from, the police has been recognised. Provided the resources can be made available, there is no reason why the performance of coroner's officers should not be greatly improved. For too long, coroner's officers have been expected to perform tasks requiring the application of skills which they do not possess and in which they have not been trained. It is likely that they will have to assume an enhanced role under a new coronial system to be recommended by the Coroners Review and by this Inquiry. Accordingly, the provision of such resources will become an urgent necessity.

8.55 I have in mind that each coroner should have a team of support staff, some of whom will be trained in investigative work. Others will supply administrative support. All will require appropriate training. I shall describe my proposals in greater detail later in this Report.

CHAPTER NINE

Coroners' Investigations and Inquests

Introduction

9.1 In Chapter Seven, I discussed the ways in which deaths are reported to the coroner. I also considered the ways in which (and the material upon which) the decision as to whether the coroner has jurisdiction over the death is taken. I shall now go on to consider the quality of the investigations carried out by and on behalf of the coroner once the decision has been taken that the death comes within the coroner's jurisdiction.

9.2 I have already mentioned that standards within coroners' offices in England and Wales appear to be very variable. I have no doubt that there are districts where investigations, both medical and circumstantial, are careful and thorough. However, even in those districts, the way in which investigations are undertaken is necessarily constrained by the legal framework within which coroners operate. I shall explain the reason for that constraint, and the respects in which it is undesirable, shortly.

9.3 I have already explained in Chapter One that, because Shipman's practice in Hyde fell within the coronial District of Greater Manchester South, it was necessary for the Inquiry to examine in detail the practices and procedures in operation within the office of Mr John Pollard, the Coroner for that District.

9.4 Disregarding the investigations and inquests which took place after Shipman's arrest, only a small number of deaths among those 508 cases for which I provided a decision in my First Report or for which Shipman was convicted, were reported to the Coroner. Even fewer were followed by an autopsy and/or inquest. Of those deaths where Shipman had killed the deceased, autopsies were performed only in the cases of Mrs Renate Overton and Mr Charles Barlow and, in both cases, the Coroner certified the cause of death on the basis of the autopsy findings, using the Form 100B procedure. Consideration by the Inquiry of the cases of Mrs Overton and Mr Barlow revealed cause for concern that the investigations in those cases had not been carried out with a sufficient degree of care or thoroughness.

9.5 Mrs Overton's death, in April 1995, was reported by Dr Rachel Pyburn, a doctor working at Tameside General Hospital, where Mrs Overton had been an in-patient for 14 months following an overdose of diamorphine (or possibly, morphine), administered by Shipman in February 1994. She had been in a persistent vegetative state throughout that period. Following an autopsy, the pathologist reported that the cause of death was hypoxic cerebral degeneration and expressed the view that the death was due to 'natural causes'. The then Coroner, Mr Peter Revington, decided not to hold an inquest and certified the cause of death (using the Form 100B procedure) on the basis of the autopsy report. Despite the fact that Dr Pyburn had alerted the coroner's officer to the possibility that the underlying cause of death was the administration of morphine in association with an asthma attack, there was no investigation or explanation as to how Mrs Overton came to be in a persistent vegetative state. Her death was wrongly attributed to 'natural causes'. I shall recount Mrs Overton's history in detail in Chapter Thirteen of this Report.

9.6 Shipman killed Mr Barlow in November 1995 and, most unusually, reported the death to the Coroner. When he telephoned the coroner's office, I suspect that he hoped to be given permission to certify the cause of death. He probably decided that it was prudent for him to seek the 'approval' of the coroner because Mr Barlow had had a hernia operation only 17 days before his death and had recently been discharged home. I suspect that Shipman told the coroner's officer when reporting the death that it had not been connected to the operation. Whatever Shipman said during the telephone call, the coroner's officer must have decided that Shipman could not issue an MCCD, so that an autopsy was necessary. A police officer attended the scene of the death on the Coroner's behalf. He completed the sudden death report Form 751. In it, he recorded little about the circumstances of the death. It may be that he did not understand that the purpose of his enquiry was to establish whether the recent operation had contributed to Mr Barlow's death.

9.7 Following the autopsy, the pathologist reported that the cause of death was bronchopneumonia due to tracheal compression due to a nodular thyroid goitre. Thereafter, Mr Pollard, the newly-appointed Coroner (he had then been in post for about four months), decided that an inquest was not necessary and certified the cause of death on the basis of the autopsy report. There was no investigation of the circumstances of the death and no detailed consideration of the autopsy findings, which were not confirmed by any histology. Investigation of the circumstances would have revealed that Mr Barlow had not been sufficiently ill when seen two hours before his death for him to have died of bronchopneumonia. Also, the goitre, said to be the underlying cause of death, had been present in an unchanged state for many years.

9.8 It was naturally a cause of some concern to the Inquiry that the Coroner's investigations in these significant cases had been to some extent defective and had missed evidence of unlawful killing. Unless these two cases were exceptional and the obvious shortcomings in their investigation attributable only to isolated individual failings, the possibility would exist that there might be deficiencies in the methods of investigation adopted by coroners elsewhere. As Stage Two of Phase Two of the Inquiry progressed, I began to realise that coroners' investigations are often superficial and I began to understand the reasons why that is so.

9.9 As I have explained, the Inquiry has concentrated upon the investigation of the procedures followed in the office of the Coroner for the Greater Manchester South District. The practices and procedures operated by Mr Pollard and his staff have come under close scrutiny. However, I have no reason to think that the practices and procedures followed in Mr Pollard's office are any different from those followed in many other coroner's offices throughout the country. Indeed, there is some evidence to suggest that they are typical. Accordingly, when I criticise these practices and procedures, I do not imply that the individuals who operated them should be singled out for personal criticism.

The Process of Investigation: the Autopsy

Deciding to Order an Autopsy

9.10 Some deaths are reported to the coroner because the circumstances are such that an inquest is required, even though the cause of death is clear. For example, there must be

an inquest into the death of a workman who suffers a crushing head injury in an industrial accident, because the factual circumstances in which the accident was sustained make the death unnatural. In such cases, an autopsy may not be necessary; in practice, one is almost always ordered.

9.11 However, a large number of deaths are reported to the coroner because the cause of death is not known with sufficient certainty. Until further enquiry as to the cause of death is made, it will not be clear whether or not an inquest will be necessary. If the medical causes of death are established by an autopsy and appear 'natural', there will not usually be an inquest.

9.12 In the Greater Manchester South District, until the year 2000, the decision to order an autopsy and the practical arrangements for its conduct were usually made by a coroner's officer, without any reference to the Coroner. The decision to order an autopsy was almost automatic. Although that practice has now stopped and the Coroner himself orders the autopsy, the result is the same; the decision is, in effect, automatic. There is no consideration as to whether an autopsy is necessary in a case where the cause of death is obvious from the appearance of the body and the reported circumstances of the death. Nor is there any consideration of whether the cause of death could be established without resorting to a full invasive autopsy.

9.13 This resort to autopsy comes about as a result of the legislation. Although a coroner could, in theory, undertake a wide range of investigations, including an examination of the scene of death, consideration of medical records and the taking of witness statements, there must seem to be little point in doing so. If the cause of death cannot be certified by a doctor issuing an MCCD, the only ways in which the coroner can certify the cause are, first (after ordering an autopsy under section 19 of the Coroners Act 1988), by relying on the cause of death provided by the pathologist (the Form 100B procedure) or, second, by holding an inquest. If an inquest is to be avoided, there must be an autopsy. It seems that most coroners consider that as, in virtually every case where there is to be an inquest, an autopsy will be necessary and, since the autopsy will almost always provide a medical cause of death, there is little point in undertaking any investigation other than the autopsy.

9.14 There are at least two reasons why I regard this practice as undesirable. First, an autopsy should really be conducted only when there is a positive reason to do so; the decision should not be taken 'by default'. Many people are deeply distressed by the thought that the body of a beloved relative is to be 'invaded'. They will accept it with reluctance if it is necessary, but not otherwise. Some religious and ethnic groups are strongly opposed to such procedures. Orthodox Jews are most anxious to avoid an autopsy, although they accept that, if and when the law so demands, it must be done. Muslims take a similar view. Second, an unnecessary autopsy is a waste of scarce resources. Although section 19 of the 1988 Act permits that the autopsy may be carried out by any legally qualified medical practitioner, in practice the examination is almost always performed by a consultant histopathologist. Almost all the histopathologists who perform autopsies for coroners are also employed on NHS contracts to carry out diagnostic work in connection with living patients at general or teaching hospitals. There is a shortage of suitably qualified histopathologists available to carry out NHS work. The demands of coroners place a strain on the available resources.

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9.15 It follows that it would be preferable, in my view, if coroners had the power to certify the cause of a death after some preliminary investigations but without necessarily resorting to autopsy. There must be many cases in which a coroner with medical knowledge could, following examination of medical records and consideration of evidence of the circumstances of the death, reach a sufficiently confident conclusion about the cause of death to give a certificate without autopsy. Autopsy would still be necessary in some cases, but in fewer cases than at present.

9.16 There are other adverse consequences that flow from this automatic resort to autopsy. Some pathologists devote far less time to coroners' autopsies than they do to a 'hospital' autopsy (that is one undertaken for clinical and/or research purposes with the consent of the next of kin or the consent of the deceased, given in life), knowing, no doubt, that so long as they can identify some pathology capable of explaining the death, the cause they provide will be accepted. Another adverse consequence of the automatic resort to autopsy is that the autopsy report is usually considered by the coroner in isolation rather than in the context of other evidence. As a result, its reliability is much impaired. I shall expand upon this problem below.

Investigations Pending Receipt of the Autopsy Report

9.17 If, having decided that the circumstances of the death may require him/her to hold an inquest but will not necessarily do so (e.g. because there is uncertainty as to the medical cause of death), the coroner may order an autopsy under section 19 of the 1988 Act. He or she will provide some background information for the pathologist. It might be thought that the coroner would also want to gather other evidence to inform the decision that s/he will have to take when the autopsy report is available. In the Greater Manchester South District at least, any other evidence which will have been gathered by the time the autopsy report is available is likely to be very limited indeed.

9.18 When the Coroner for the Greater Manchester South District orders an autopsy in cases reported by a doctor, the only information usually available to him is the oral account of the reporting doctor. As that account is given to a coroner's officer who has no medical training or expertise, the amount of information recorded is usually very limited and contains little detail. If the death has been reported, or a preliminary investigation has been undertaken, by a uniformed police officer completing Forms 751 and 751A, the police officer will have usually recorded only brief details of what any person who happened to be available for interview has said. The medical information recorded on the form will usually be scanty and couched in 'lay' terms. The account of the circumstances of the death will often fill no more than a line or two. The police officer completing the forms will have no understanding of the purpose of the questions or of the issues which the Coroner and pathologist will have to decide, as was the case following the death of Mr Barlow. The police officer will not know what information is relevant. Upon receipt of the forms, the coroner's liaison officer (CLO) will check the forms and complete any boxes left blank. The CLO will speak to the deceased's next of kin to ensure that the particulars of the deceased, such as date of birth, are correct but will not interview anyone to find out about the circumstances of the death.

9.19 I have said that a coroner could, in theory, carry out a wider range of investigations in the period before the autopsy report is available. Certainly, the coroner could obtain witness statements from any relevant witness. At present, as I have said in Chapter Seven, s/he has no power to order the production of any documents or records, nor is there any power to enter premises or to seize any property relevant to the investigation. That is not to say that coroners are unable ever to obtain such records and material prior to the inquest. They can do so with the consent of the person having control of the premises, records or other material. However, in practice, the Coroner for the Greater Manchester South District does not (and I think most other coroners do not) conduct or authorise any such investigations before deciding, in the light of the autopsy report, whether to hold an inquest.

The Autopsy and the Report on the Cause of Death

9.20 Evidence received by the Inquiry has suggested reasons why the autopsy is not the definitive source of information it is often thought to be. The pathologist who is to conduct the autopsy may have only very limited information about the deceased and the circumstances of death before conducting the autopsy. He or she will usually have Form 751A or its local equivalent. If the death has occurred in hospital, and if the autopsy is taking place in the mortuary of the same hospital, the pathologist will usually receive the deceased person's clinical notes and records. If the death occurred in the community, or at a hospital other than the one where the autopsy is held, the pathologist will not usually have any medical records. Even if the autopsy is taking place in the hospital where the deceased died, the medical records are not always examined. Some coroners and their officers provide high quality information for pathologists and are prepared to make any further enquiries requested. However, others are less efficient. Coroner's officers may be office-bound, may have no investigative role and may be unable to identify or discover further information which could be of assistance to the pathologist. Remoteness and lack of communication, as between the coroner and the pathologist, can also be a problem, particularly with part-time coroners.

9.21 It frequently happens that a pathologist conducting autopsies for a coroner will have a long list of such procedures to be carried out in one session. Coroners' autopsies are additional to the pathologist's duties for the hospital trust for which s/he works. The evidence suggests that coroners' autopsies are sometimes conducted rather quickly and that best practice is not always followed. For example, to save time, the mortuary technician may be permitted to open the body and remove the organs before the pathologist has carried out an external examination. Insufficient time may mean that the pathologist has no opportunity to inspect the medical records carefully or discuss the case with clinicians.

9.22 It is not uncommon for a pathologist to feel under pressure to reach a conclusion on the cause of death without conducting the ancillary tests that should properly form part of the autopsy procedure. The Royal College of Pathologists (RCPath) advises that diagnostic or confirmatory histopathology should be done in all cases, subject to the requirements of the Human Tissue Act 1961 and the instructions of the coroner. The attitude of coroners to the taking of samples for histology varies widely. Some will permit tissue samples to be

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taken for histology in only a few types of case. Such an attitude places the pathologist in considerable difficulty. Moreover, funding for histology can also be a problem. I shall discuss these issues further in Chapter Ten of this Report.

9.23 Some pathologists also report that they feel under pressure (whether self-imposed, imposed by the coroner or imposed by circumstances is not always clear) to find a natural cause of death, thereby avoiding the need for an inquest. I can understand how such pressures might arise. If there is to be an inquest, the pathologist will have to attend to give evidence. That will be time-consuming and possibly very inconvenient for him/her. The pathologist might think that the relatives of the deceased will feel relieved that a natural cause has been found and would rather not have to go through an inquest. The pathologist might also have the impression that the coroner would be pleased that a natural cause had been found. Inquests are very time-consuming for the coroner as well.

9.24 Professor Helen Whitwell, Head of the Forensic Pathology Department at the University of Sheffield, told the Inquiry that it is commonly recognised that, if a pathologist conducting a coroner's autopsy can find evidence of a condition which can account for the death, s/he is likely to attribute the death to that cause without undertaking histology to confirm that cause. Dr Martin Gillett, a consultant histopathologist who frequently carries out coroners' autopsies, agreed that further tests might not be ordered where there is pathology that could account for the death. Professor Whitwell explained that the reasons for this approach are partly financial and partly related to concerns about the retention of tissue. If this approach is prevalent, it is particularly likely to lead to mistaken diagnoses of the cause of death in the elderly, who will almost always have some condition that is capable of accounting for death. Mr Barlow's death is a case in point. The pathologist found macroscopic signs of bronchopneumonia and, without confirming them by histology, attributed the cause of death to that cause, citing, as an underlying cause, tracheal compression due to an enlarged goitre. As I have said, there was no reason to believe that Mr Barlow's goitre had changed in the weeks and months before his death. The pathologist did not know that. He found something that could account for the death and gave that cause as his opinion. Professor Whitwell said that the only reliable way to diagnose bronchopneumonia is by histological examination. Macroscopic examination is unreliable.

9.25 In addition to reaching a conclusion on the cause of death, the pathologist will, if s/he feels able to do so, express an opinion as to whether or not the cause of death is 'natural'; this is really a question for the coroner to determine. Some findings at autopsy are most likely to be consistent only with a natural cause; signs of an aortic aneurysm are a good example. Some findings, such as a stab wound to the heart, are consistent only with an unnatural death. However, there are many findings which could be consistent with either a natural or an unnatural underlying cause of death. Sometimes, if the pathologist has been provided with reliable background information about the circumstances of the death or has access to the medical records or can discuss the medical history and autopsy findings with a doctor who has treated the deceased, s/he may be able to reach a safe conclusion as to the underlying cause of death. If s/he can, so much the better.

9.26 Sometimes, a pathologist might express a conclusion about the underlying cause of death, or say that the cause of death was natural, without any proper basis for such a

conclusion. The death of Mrs Overton is a case in point. At the time of her death, Mrs Overton had been in a persistent vegetative state for 14 months. The findings at autopsy of cerebral hypoxic degeneration were wholly predictable. However, such findings could throw no light on what had happened to cause that condition. The degeneration could have been caused by a natural event, such as an acute attack of asthma leading to respiratory arrest, or it could have been due to an unnatural event, such as near drowning, near suffocation or – as in fact it was – drug overdose. In such circumstances, only by finding out what had happened to cause Mrs Overton's respiratory arrest could a safe conclusion be reached as to the underlying cause of death. No such information was available to the pathologist. Nonetheless, the pathologist expressed his opinion that her death was due to natural causes. As I shall explain in Chapter Thirteen, that conclusion was not well founded on evidence and went well beyond the limit of the pathologist's expertise. What the pathologist ought to do in those circumstances is to tell the coroner that s/he cannot tell what is the real or underlying cause of death from the autopsy findings and that other enquiries must be made.

9.27 The result of the practices and pressures I have described is that the coroner's autopsy is not the 'gold standard' means of ascertaining the cause of death that it is sometimes thought to be. In September 2002, the RCPath published a document, 'Guidelines on autopsy practice', to which I shall refer further in Chapter Ten. One of the recommendations made is that adequate background information about the death should be made available to the pathologist. I have no doubt that a thorough autopsy, conducted to the high standards recommended by the RCPath and viewed in the context of the background circumstances, provides the best basis for a decision as to the cause of death. However, the confident reliance presently placed on hurried and inadequate autopsies is ill founded especially when such reliance may result in the coroner's failing to apply his/her mind to the underlying cause of death; this is what may well have happened in the case of Mrs Overton.

9.28 The problem is compounded by the lack of any audit or quality assurance of coroners' autopsies. Concern has been expressed by organisations such as the National Confidential Enquiry into Perioperative Deaths about the quality, not only of autopsies, but also of autopsy reports. Some auditing of the reports of forensic pathologists has been introduced. However, there is no such system in place for coroners' autopsies performed by consultant histopathologists. Professor Whitwell reported that, where attempts at audit have been made in the past, some coroners would not consent to reports on their behalf being used for audit purposes. It would of course have been possible for the reports to be anonymised so as to protect the confidentiality of patients. It seems that the coroners concerned did not appreciate the value and importance of the audit process.

Certifying the Cause of Death on the Basis of the Autopsy Report

9.29 When the coroner receives the pathologist's report containing the medical cause of death, s/he is almost bound to accept it at face value. He or she will have no wider evidential background against which to consider it. Nor do most coroners have the medical expertise necessary to subject the report to any critical examination. If, in a case where the coroner has decided to order an autopsy under the provisions of section 19 of the

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Coroners Act 1988, the pathologist furnishes a medical cause of death (particularly if s/he expresses the view that the death was due to 'natural causes'), the coroner is likely to decide not to hold an inquest and will probably certify the cause of death in accordance with the pathologist's opinion.

9.30 The cases of Mrs Overton and Mr Barlow illustrate the effects of this practice. In Mrs Overton's case, the pathologist reported the immediate cause of death and, without any proper justification, ascribed the death to 'natural causes'. The Coroner had very little other evidence available to him and, on seeing the autopsy report in isolation, accepted it, apparently without realising that the autopsy had been unable to provide any explanation as to how Mrs Overton had come to be in a persistent vegetative state. If the Coroner had obtained evidence from the doctor who had reported the death, had examined the hospital medical records and had had the medical knowledge necessary to understand their significance, he would have realised that an inquest was necessary and that his investigation ought to focus on whether Mrs Overton had been given a single dose of 20mg morphine and, if so, in what circumstances. Reliance on the autopsy report and on a pathologist's opinion that went beyond what was justified by his findings resulted in the Coroner's failure to discover the true cause of death.

9.31 Similarly with Mr Barlow, the Coroner relied on the pathologist's view that death was due to bronchopneumonia. If he had had the advantage of a witness statement from Mr Norman Newton, a neighbour and friend of Mr Barlow who saw him daily, he would have learned that Mr Barlow was sitting in his chair drinking a cup of coffee only two hours before his death. Provided that the Coroner had sufficient medical knowledge, he would then have realised that Mr Barlow's condition two hours before death was not consistent with a death from bronchopneumonia. He would also have learned that Mr Barlow's enlarged goitre had not, so far as anyone knew, changed for a long time. The cause of death suggested by the pathologist would then have seemed an unlikely one. The Coroner would have realised that an inquest was necessary. Further investigations would have been required and might have revealed the truth.

9.32 These two cases suggest, first, that the results of an autopsy should be seen in the context of the surrounding evidence and not in isolation. The coroner's uncritical acceptance of a pathologist's opinion, given without knowledge or understanding of the background circumstances, is a recipe for an erroneous decision. Second, if the coroner is to scrutinise an autopsy report and test it in the light of the surrounding evidence, s/he needs some medical knowledge. If s/he cannot carry out such a scrutiny, s/he is wholly dependent on the pathologist. In effect, the decision is that of the pathologist, rather than the coroner.

9.33 My overall impression of the coroners and some of the pathologists about whose practices I heard is that there is in their minds an expectation that, if a death is not immediately identified as 'suspicious', it will be found to be due to natural causes; this is certainly the case in respect of many of the deaths referred to the coroner because the treating doctor does not know the cause of death. This expectation seems to lead to the attitude that it will be to everyone's satisfaction if a cause of death can be found that will enable the coroner to certify the cause of death without further delay, cost or inconvenience. It is easy to see how this attitude can become entrenched. The great majority of deaths will, in fact, be

natural. However, if a coroner's investigation is to be effective, there must be an ever-present readiness to keep in mind the possibility that the death might not have been natural. Quite apart from any question of homicide, the coroner should bear in mind the possibility that neglect, accident or medical error might have caused or contributed to the death. Dr James Young, Chief Coroner for the Province of Ontario, Canada, said that his coronial investigators are trained to 'think dirty', by which he meant that they are trained to approach each death not with the expectation that there will be 'something wrong' but keeping in mind the worst possibility. It seems to me that such an approach would be appropriate for coroners and pathologists, as well as investigators. Otherwise, the expectation that the death will be 'natural' may become a self-fulfilling prophecy.

The Process of Investigation: Preparation for the Inquest

9.34 As I have explained, in some cases it will be clear from the outset that there must be an inquest. In others, the coroner will decide, in the light of the results of the autopsy, that an inquest is necessary.

9.35 In a case in which there is an autopsy under the provisions of section 19, the inquest will be opened and adjourned soon after the receipt of the autopsy report. In many districts, it is then that the investigation begins. Sometimes, in an inquest case, the police or some other investigatory body such as the Health and Safety Executive, will have commenced an investigation immediately after the death. In this Chapter, I am concerned only with investigations carried out under the direction of the coroner.

9.36 As I have explained in Chapter Eight, the arrangements about who carries out the investigations on behalf of the coroner in preparation for an inquest vary from district to district. In some districts, the coroner's officers undertake no investigations at all; all investigatory work is carried out by the police. In other districts (and Greater Manchester South is one), some investigatory work is carried out by the CLOs and some by police officers, but the coroner's officers, who work only in the coroner's office, do none.

The Practice in Greater Manchester South District

9.37 Mr Christopher Gaines, one of the District CLOs, described the formal opening of an inquest in the Greater Manchester South District. He said that he attends Mr Pollard. Mr Pollard declares the inquest open and Mr Gaines then swears to his belief in the truth of the information then available (essentially, that contained in Forms 751 and 751A and a statement of identification). Mr Pollard then adjourns the inquest to some future time. Mr Pollard said that he regards the formal opening as a public occasion, although the public is not given notice of the event beforehand and it takes place in his room.

9.38 Upon adjourning the inquest, Mr Pollard issues instructions to Mr Gaines as to the investigations required. These might entail interviewing witnesses and possibly inspecting the scene of the death, albeit several days after the death has occurred. Typically, Mr Gaines would be asked to obtain an 'antecedents statement', meaning a statement of the life history of the deceased. This would usually be obtained from the next of kin or a close relative of the deceased. I have seen examples of such statements and

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they are often very detailed in the background history they provide. However, such statements as I have seen are not always well focussed on the issues likely to arise at the inquest.

9.39 In addition, Mr Gaines might be asked to take a statement from a nurse or carer from the nursing home or elderly persons' home in which the deceased had died. I have the impression that, although Mr Gaines conducts his enquiries conscientiously, he does not see his role as a proactive one; he simply records what the witness tells him about the death, rather than asking searching questions, for example probing why the carer had done what s/he had done or why the system in the home was as it was. I do not attribute this to any lack of interest on his behalf. Rather, I believe that it is explained by his lack of any medical or nursing background or training and by the fact that, even when in the police force, he was mainly engaged on uniformed patrol work, rather than investigative duties.

9.40 Mr Gaines was asked about the way in which he would investigate a death that might have resulted from industrial disease. He said that he would obtain the antecedent history from the next of kin. This would include an attempt to discover whether the deceased had been exposed to the substance thought to have caused the death. Mr Gaines might discover that, during his/her lifetime, the deceased had consulted a solicitor in connection with a claim for damages. In that event, the solicitor would probably hold a statement made by the deceased, dealing with his/her working life and exposure to the dangerous substance. However, if no such statement existed, Mr Gaines might obtain very little information. He would not attempt to contact a former employer to confirm the fact or circumstances of the deceased's employment. The only evidence of employment might be based on the recollections of, say, the middle-aged daughter of the deceased, trying to remember what her father had told her about his work when she was a child, 40 years earlier. Mr Gaines would not know anything about the medical evidence that might tend to confirm or refute the suggestion that the deceased had been exposed to a dangerous substance at work.

9.41 Mr Gaines also described what would happen when he investigated a case of suspected suicide. Usually, the police would be involved until they were satisfied that no third person had been involved. If a third person had been involved, there would be a suspicion of criminality. Once that had been excluded, Mr Gaines would take over and would obtain witness statements. In this, he would be left to his own devices although, if the Coroner wanted further statements when the file had been submitted to him, these would be obtained. Mr Gaines would not know what the medical evidence was and, in a drug-related case, might not have any knowledge of the effect of the drugs the deceased was suspected of taking.

9.42 As a rule, Mr Pollard would himself conduct any investigation of the medical aspect of a death. If evidence were needed from a doctor, whether a hospital clinician or a general practitioner, Mr Pollard would obtain it. Usually, if the death had occurred in hospital, he would write to the hospital administrator, asking for a report on the circumstances of the death from the appropriate consultant. In making such a request, he uses a *proforma* letter; he does not ask specific questions or refer to specific issues. Thus, the statement, when provided, would not be targeted at the issues to be decided at the inquest.

9.43 The overall impression that I gained was that investigations were unfocussed and lacked co-ordination by a person who understood the issues and had access to all the available information.

Deaths Possibly Caused or Contributed to by Medical Error or Neglect

9.44 As I mentioned in Chapter Eight, Mr Michael Burgess, HM Coroner for Surrey, said that the number of deaths reported to his office requiring some form of investigation into a medical mishap or nursing care was increasing. As with cases of other kinds, the practice relating to the investigation of this type of case varies from district to district.

Who Should Investigate Such Cases for the Coroner?

9.45 In some districts, possibly most, investigations involving a 'medical element' are carried out by the police, even though there is no suggestion that the medical error or neglect might amount to a criminal offence. There was general agreement among the witnesses at the Inquiry and the participants at the Inquiry's seminars that the police were not well placed to conduct such investigations. They did not have, and could not be expected to have, the necessary medical knowledge or expertise. Also, it seems to me that the involvement of the police in such a case would tend to raise to an unnecessary level the anxiety felt by any professional whose conduct or competence comes under scrutiny. In my view, such investigations should not be undertaken by the police unless there is a suspicion of criminality. If the investigation discovered facts suggesting that there had been neglect or error serious enough to warrant the consideration of criminal proceedings, the coroner could always refer the case to the police at that stage.

9.46 If such investigations are not to be conducted by the police, who should be responsible for them? In Greater Manchester South District, Mr Pollard does not usually involve the police in the investigation of allegations of medical error or neglect. As I have already said, he undertakes the investigation himself. The unsatisfactory nature of that process is illustrated by the following two cases, which were noticed by the Inquiry team on examining some of Mr Pollard's inquest files. In commenting upon the conduct of these two investigations, I do not wish it to be thought that I am being critical of Mr Pollard individually. I describe these investigations and their shortcomings to illustrate that the task of enquiring into a death which might have resulted from a medical error or neglect is very difficult to perform satisfactorily within the current legal framework and requires expertise which neither a police officer nor a legally qualified coroner with very limited medical knowledge is likely to have. They are further examples of the variability of practice and procedure noted by the Coroners Review and observed first-hand by the authors of Home Office Research Study 241, to which I have already referred in Chapter Seven.

The Case of Mr X

9.47 Mr X died at the age of 80. Two months before his death, he had undergone a right below-knee amputation; he suffered from severe peripheral vascular disease and had a history of problems with his right foot. Nine days after the operation, he was discharged to the nursing home where he had been living previously. While at the nursing home, he

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developed an infection of the stump. He was re-admitted to hospital two weeks before his death. Following the death, a doctor from the clinical team responsible for Mr X's hospital care contacted the coroner's office and indicated that he was prepared to certify the cause of death, if the coroner agreed. However, Mr Pollard decided to order an autopsy. Mr X's family was informed of the decision and expressed concern about the standard of care he had received at the nursing home. The autopsy result was faxed to the coroner's office four days after the death; the cause of death was said to be bilateral lobar pneumonia due to an infected right amputation stump. Mr Pollard opened and adjourned an inquest.

9.48 The autopsy report that followed recorded, as part of the history, that the deceased had been admitted to hospital two weeks before his death with general deterioration and dehydration. Mr X was said to have sacral pressure sores and an unhealthy gaping wound at the amputation site. The clinical impression was that he had a urinary tract infection. It was also recorded that Mr X had a past history of diabetes mellitus, dementia and peripheral vascular disease resulting in bilateral below-knee amputations.

9.49 The autopsy report did not mention whether or not the pathologist had found any sacral pressure sores. The principal finding was of bilateral lobar pneumonia. The flap over the right amputation stump was said to show an open wound. There was said to be no evidence of urinary tract infection at the time of death. The cause of death was given as stated above. The pathologist cited congestive cardiac failure, ischaemic heart disease and bilateral amputations for peripheral vascular disease as conditions that had contributed to the death, though not related to the disease or condition causing it.

9.50 Six days after the death, Mr Pollard wrote to the hospital asking for a report on their care of Mr X. The letter was in standard form and did not ask any specific questions. Neither Mr Pollard's CLOs nor his coroner's officers had any role in the enquiries that took place; nor did any police officer.

9.51 A month later, a member of the family wrote to the Coroner, enclosing a lengthy statement in which she set out in detail the concerns felt by the family about Mr X's medical treatment and care. These concerns can be summarised as follows:

(a) The family suggested that, in several respects, Mr X had not received proper care in the nursing home. It was suggested that, before the amputation, the staff had failed to keep his troublesome right foot dry, despite the fact that the hospital consultant had given instructions to that effect. They had failed to ensure that Mr X was taking his medication.

(b) Mr X had been discharged from hospital only nine days after his amputation. He had deteriorated quickly after discharge. The family was concerned that he had been discharged too soon.

(c) Staff in the nursing home had removed Mr X's catheter immediately on his return there, although the family had understood that it was to remain in situ for four weeks after the operation. They had also failed to ensure that Mr X was receiving adequate nourishment, particularly in the light of the fact that he had an impaired swallow reflex.

(d) The family had been told by the nursing home staff, three days before his re-admission to hospital, that a **'wound specialist'** had seen Mr X and had not been unduly worried by his condition. Nonetheless, only three days later, Mr X had developed pressure sores that were so badly infected as to warrant re-admission.

9.52 It is clear that, if these concerns were found to be true, they were capable of amounting to gross neglect, certainly so far as the nursing home was concerned. Mr Pollard responded to the family's expression of concern by saying that, at the inquest, he would permit such questioning as was needed to establish how, when and where the death had occurred. In oral evidence to the Inquiry, he explained that his perception was that the death could reasonably be regarded as being due to natural causes if the treatment was adequate. He did not undertake to investigate the family's concerns, but indicated only that the family could ask questions within the limits he had defined. It must have been extremely difficult for the family to understand the parameters Mr Pollard set on the inquest, how they would operate at the inquest, and the legal basis for setting those parameters.

9.53 Mr Pollard had not at that time received any evidence from the hospital. In due course, he received a report from Dr P of the Cardiology Department of the hospital, who said that he was the consultant responsible for Mr X's care during his last admission. This report described Mr X's poor condition on re-admission to hospital and explained the treatment provided – rehydration, intravenous antibiotics, debridement of the infected tissue of the stump and pain relief. Despite such treatment, Mr X's condition had deteriorated and he had died two weeks later. This report did not, and could not, have been expected to, address any of the concerns raised by the family; those concerns had not been communicated by Mr Pollard to the hospital. Yet, having by now received the family's detailed account of their concerns, Mr Pollard did not contact the hospital again, to ask questions specifically relating to the possible lack of care by the nursing home staff or to Mr X's post-operative discharge. Nor did Mr Pollard direct that any evidence should be obtained from the nursing home; in particular, he did not arrange for any nursing notes kept by the nursing home to be produced at the inquest. The management of the nursing home was not even notified that an inquest was to take place.

9.54 As a result, no evidence was obtained which would have allowed proper exploration of the issues raised by the family or the general adequacy of Mr X's medical treatment and nursing care.

9.55 At the adjourned inquest, which was not conducted by Mr Pollard, the only witness to give oral evidence was the pathologist. A verdict of natural causes was entered. That might have been correct; I cannot say. The papers contain no record of the evidence given orally, nor any note of the Coroner's reasons.

9.56 However, it is apparent that the family was not satisfied that there had been an adequate investigation of the death. After the inquest, the family wrote, asking for the notes of evidence of the inquest. Mr Pollard replied, enclosing copies of the 'depositions' which apparently comprised five sheets of paper. It appears that these were the autopsy report and the report of Dr P. The family then wrote again, asking why a verdict of natural causes had been entered. The Coroner who had conducted the inquest replied that, at the

inquest, the pathologist had been questioned very closely as to the cause of death. The pathologist had said that the cause was a natural cause, as she had said in the autopsy report. The Coroner suggested that if the writer wanted any further explanation, she should consult her general practitioner, taking with her a copy of the autopsy report. The family must have been deeply disappointed that their concerns had not been subjected to closer scrutiny. They had been given no answers by the inquest process.

9.57 In evidence to the Inquiry, Mr Pollard explained that he had not sought further evidence from the hospital or any evidence from the nursing home because the pathologist had given him 'a cause of death' and would be able to answer questions related to the issues of how, when and where Mr X had died. He considered that the pathologist would have been able, at the hearing, to answer any questions raised by the family. He said that in every inquest that he holds it is possible to consider that further evidence should be obtained; however, according to Mr Pollard, a line has to be drawn somewhere and there is too great a delay at present in the hearing of inquests in his district. I find that answer disturbing for several reasons.

9.58 First, it suggests undue reliance on the fact that the pathologist has found a cause of death, essentially the medical cause of death, without seeking to enquire, as the family understandably wished, about any contributory causes – in this case the treatment, or lack of it, provided by the nursing home. The role of a coroner in such circumstances should be to enquire, proactively. This is particularly so if concerns of a sensible nature are raised about the circumstances of the death. Of course, I accept that a coroner cannot be expected to investigate fully every minor expression of concern about possible contributory factors that he receives from a bereaved family, some of which might have played no part in causing the death. However, the concerns in the case of Mr X were expressed clearly and in detail. They appeared to be sensible and Mr Pollard did not suggest that they were not. If there had been neglect, as the family suggested, it might have been sufficiently serious to have contributed to the cause of death. Yet, Mr Pollard considered that he had fulfilled his investigative function by obtaining a narrative history from the hospital and saying that appropriate questions could be asked of the pathologist at the inquest. It appears that the family relied upon the Coroner to ask questions. That was not an unreasonable expectation, as they had explained their concerns in detail in advance. In my view, there had not been an adequate investigation of the circumstances of the death and, as a result, the inquest could not fulfil its proper purpose.

9.59 Second, it is apparent that it was expected that the pathologist would be able to deal with all the issues that the family wished to raise. However, the pathologist could not know important elements in the history, such as what steps the nursing home staff had taken to keep the foot dry and when the foot had begun to show signs of infection. Nor could she know what steps the nursing home had taken to ensure that Mr X took his medication and received adequate nourishment and fluids. Nor could she know what had happened when the 'wound specialist' had seen Mr X. She would not know when the pressure sores developed or how they were treated. These matters were questions of fact, which could be answered only by the nursing staff involved and by production of the nursing records. It appears that the pathologist would have been able to say that the premature removal of the catheter had not contributed to the cause of death; there was no evidence of urinary

tract infection at autopsy. However, she would not have been able to say whether any possible failure of the nursing home staff (in the respects I have mentioned above) could have had any effect on the course of Mr X's decline. To do so would have been outside her area of expertise. It appears that it is common practice for coroners to rely on the evidence of a pathologist on matters lying far outside his/her expertise. Other pathologists told the Inquiry that they are often asked, at inquests, to deal with issues outside their expertise. They find themselves doing their best, out of a desire to assist the family and the coroner by providing answers and allowing the proceedings to be brought to a conclusion. This practice is to be deprecated. No expert should ever be asked to answer questions outside his/her field of expertise and indeed should not agree to do so, and yet the practice adopted seems not to be uncommon.

9.60 Third, Mr Pollard said that he did not think it appropriate to ask the pathologist in advance about the issues likely to be raised by the family at the hearing; he thought there was a danger that the family might suggest that he had 'primed' the witness. I think that such a suggestion could be avoided if the communication between the coroner and pathologist is set out in correspondence that the family can be shown. Otherwise, if the risk of such a suggestion is to be avoided and no communication is to take place between coroner and pathologist, not only may the pathologist be ill equipped to provide an opinion, by virtue of his/her lack of expertise in the area, but s/he will also be deprived of an opportunity to consider the issues in advance. The effect of Mr Pollard's practice is that he would begin the inquest hearing with no idea whether or not the pathologist would be able to deal with the issues raised. Mr Pollard said that he would be quite prepared to adjourn the hearing if it emerged that the pathologist could not deal with the issues. That, in my view, is not a proper approach to a hearing which the bereaved family has attended with anxieties and raised expectations. In any event, in Mr X's case, there should have been no question of the pathologist dealing with the issues, because of her lack of knowledge of the factual background.

9.61 Mr Pollard said that he did not have the time or the staff to deal with cases such as this in an appropriate way. That may well be the case but, if so, it is not a satisfactory state of affairs. However, I think that the real problem is not too large a caseload, but the lack of appropriate expertise. In my view, a legally qualified coroner, without a medically qualified colleague, might well find it difficult and time-consuming to analyse what is required for the proper investigation of such a case as this. A medically qualified coroner would be in a better position to do so. Moreover, it is obvious that, if proper enquiries were to be made at the nursing home, they would have to be undertaken by a coroner's officer with some medical or nursing background or knowledge and an understanding of the issues likely to be addressed at any future inquest.

The Case of Mrs Y

9.62 The second inquest case examined by the Inquiry concerned Mrs Y. She had attended an accident and emergency department late one evening, complaining of severe abdominal pain. She was admitted and underwent an operation at about midnight. It appeared to her family that she was making a reasonable recovery from her operation, but she died suddenly two days later. The death was reported to the Coroner, who ordered an autopsy.

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9.63 The autopsy report described a perforated area 2cm in diameter in the lower third of the oesophagus. There was leakage of contents from the oesophagus into the right pleural space, where there was brown fluid and associated inflammation. The oesophagus appeared somewhat narrowed in the perforated area. The stomach was found to be unremarkable. In the duodenum, there was an area of oversewing of the anterior wall, which must have represented the site of the operation. The operative site appeared healthy. There was an ulcer 2cm in diameter on the wall of the duodenum but no evidence of leakage of the contents of the duodenum into the peritoneal cavity. All other findings were unremarkable.

9.64 The pathologist's conclusion was that the cause of death was a perforated oesophagus following surgery for a perforated duodenal ulcer. This conclusion was, to some extent, ambiguous. It rather sounded as though the pathologist was suggesting a causal connection between the perforated oesophagus, which was the immediate cause of death, and the previous surgery to repair the duodenal ulcer. However, from reading the body of the report, it appears that no such causal connection was believed to have existed, only a connection in time. The body of the report suggested that the perforation that had caused the death was in the oesophagus (from which leakage had been observed), and not in the duodenum, where there were signs of a successful operative repair. A further ulcer in the duodenum had not apparently perforated.

9.65 On receipt of the autopsy report, Mr Pollard wrote to the hospital, using his standard letter, asking for a report on the treatment of Mrs Y. In due course, this was supplied. The report was written by the consultant surgeon nominally in charge of the patient's case. She had discussed the case with the junior doctors involved but had no personal knowledge of it. She described the findings on admission and the steps taken to diagnose the perforation of the duodenal ulcer. The report named the surgeon who had carried out the repair operation. After repair, the peritoneal cavity was washed out and a drain inserted. The post-operative care was described. Progress was said to be satisfactory for two days until Mrs Y died suddenly at 5.30am. Attempts at resuscitation failed. The consultant drew attention to the autopsy findings and the conclusion that the cause of death was a perforation of the oesophagus. She described Mrs Y's past medical history of oesophagitis and expressed her doubt that Mrs Y always took the medication prescribed for that condition. The writer then expressed the opinion that the perforation of the oesophagus had occurred shortly before the death. She suggested that the nursing chart provided a clue as to the time at which the perforation had occurred. There had been a sudden rise in the pulse rate to 130 beats per minute at about 10pm on the evening before death. However, this had fallen back to 110 beats per minute by 2am the next morning. The writer observed that no change had been observed in Mrs Y's general condition during this period and she had not complained of chest pain, which was said to be a **'cardinal symptom'** of an oesophageal perforation.

9.66 Apart from a brief statement taken from a member of Mrs Y's family, the only evidence obtained in advance of the inquest was the autopsy report and the consultant's letter. The family had not expressed any concern about Mrs Y's treatment at hospital. However, it would be normal for them to wish to know whether she had died as the result of error made in the treatment given in hospital or whether the death had been 'natural', and there is also

a wider public interest in knowing that information. Only the pathologist and a member of the family were asked to attend the inquest. Neither the consultant who had written the report, nor the surgeon who had repaired the duodenal ulcer, was asked to attend.

9.67 There is no record of the conduct of the inquest. Mr Pollard returned a verdict of misadventure. In evidence to the Inquiry, he explained that that verdict implies that the death was due to an unexpected result of a deliberate action; in other words, it was not due to natural causes. Mr Pollard agreed that, on the basis of the written materials, he could not explain how it was that he had come to the conclusion (as he apparently had) that Mrs Y's death had been due to something that had gone wrong during the operation on the duodenum. He thought it was probably connected with the fact that the site of the operative repair to the duodenum was not far from the site of the fatal perforation of the oesophagus. He said that oral evidence had been received from the pathologist that had drawn him to his conclusion. He had made no written record of that evidence and could not now remember what it was. There was no record of his reasons for reaching a verdict of misadventure. I was concerned and puzzled that the pathologist could have expressed the view that the oesophageal perforation (which had clearly caused the death) had somehow been caused at the time of the operation. If there were any signs observed at autopsy which had enabled him to reach that conclusion, one might have expected to see them recorded in the autopsy report.

9.68 Of further concern is the fact that the Coroner reached a conclusion which implied some degree of responsibility upon the surgeon who had performed the repair of the duodenum without giving that surgeon any notice that his conduct might be called into question or any opportunity to give evidence. The hospital authority had been given notice of the inquest, but not of the possibility of any criticism. The surgeon who performed the operation would have been an important witness. He had not even been asked to provide a statement. Mr Pollard's verdict might or might not have been correct. Whichever it was, I am left with a feeling of unease about the adequacy of the investigation and the accuracy and fairness of the inquest verdict.

Conclusions about Investigations

9.69 There is, in my view, an urgent need for a more focussed, professional and consistent approach to coroners' investigations; this is needed from the time that the death is reported, right up to the verdict. There needs to be clarity as to the purpose and scope of the enquiries that are made. Coroners themselves, who are to direct the conduct of an investigation, require training. Legal experience, particularly as a solicitor, should provide a sound basis for the conduct of an investigation into non-medical matters, but it is apparent, from the cases that I have described, that medical knowledge and experience is vital for the proper conduct of many investigations, as well as for the proper evaluation of evidence and the taking of decisions. Coroner's officers, who are, at present, almost wholly untrained, will require training, management and direction if they are to assume an effective investigative role.

9.70 The quality of information which comes into the coroner's office at the time of a death must be greatly improved. Instead of an oral account from the reporting doctor, there should

be a short written account of the deceased's medical history and a written account of the circumstances of the death, each to be provided on a prescribed form. Coroner's officers should always seek to obtain information from relatives or those with knowledge of the deceased in order to verify or expand upon the information provided by the health professionals who have completed the forms.

9.71 The coroner should have the power to seize or compel the production of documents, records and other material relevant to the investigation of a death. I agree with the recommendation of the Brodrick Committee which, as long ago as 1971, suggested that the coroner should have power to take possession of a body, to enter and inspect premises where a body has been found or has been moved from or where the deceased was prior to death, to inspect, receive and copy information from documents relating to the deceased and to seize any property material to the investigation.

9.72 The coroner should have the discretion to certify the cause of a death following investigation, without the need in every case to order an autopsy or hold an inquest. Instead of proceeding automatically to order an autopsy, coroners should make use of a variety of investigative methods; for example examining medical records, ordering an external (i.e. non-invasive) examination of the body and obtaining witness statements. If the coroner considers that an autopsy is necessary, the family should be notified in advance and the reasons for the decision should be explained to them. They should be able to make representations and should have the right to appeal the decision. I will discuss later where such an appeal should lie.

9.73 Coroners should be required to provide improved information for pathologists instructed to perform an autopsy. No pathologist should ever be expected to manage without the medical records of the deceased. Nor should a pathologist be denied the opportunity to conduct whatever ancillary tests s/he thinks appropriate for the proper investigation of the cause of death provided that there is proper medical justification for the carrying out of those tests. I endorse the recommendations of the RCPath in their drive to improve the conduct of autopsies.

9.74 Death investigations in which any issue of medical error or neglect arises require particular expertise. I shall suggest that, if there is any degree of complexity, such investigations should be conducted by a specialist team of investigators.

Inquests

9.75 In the light of the very limited number of inquests that were conducted into the deaths of Shipman's patients, it might be wondered why there is any need or justification for me to consider the topic of inquests. I do so because, in the course of the Inquiry, I became aware of the widespread concern felt about the number of inquests currently held and the way in which many inquests were conducted. Such concerns were apparent from the reports of legal cases I had to consider, as well as from responses to the Coroners Review Consultation Paper. They were confirmed by Home Office Research Study 241, 'Experiencing Inquests', to which I have already referred. As I intend to make recommendations about the jurisdiction of the coroner and the way in which the coronial

service should be organised, it seems sensible to include such views as I have been able to form about inquests. I shall not embark on a detailed consideration of the way inquests are conducted but will confine myself to consideration of the purposes of the coroner's investigation and the circumstances in which a public inquest should be held.

9.76 On other issues, I shall say little or nothing. I have read the Report of the Coroners Review, which has examined the issues relating to inquests in detail. I concur with the views expressed in Chapter 8 of the Review's Report on inquest outcomes (paragraphs 25(a), (b), (c) and (d)), evidential standards (paragraphs 30 and 31), implications of liability (paragraphs 32 to 40) and the scope of the inquest (paragraphs 53 to 59). In Chapter 9 of the Review's Report, which deals with the handling of inquests, I agree with the views expressed as to jurisdiction and support (paragraphs 1 to 13), the need for a Rules Committee (paragraphs 14 to 19), the pre-inquest hearing (paragraphs 20 and 21), disclosure (paragraphs 22 to 28), addresses as to the facts (paragraphs 29 to 31) and publicity (paragraphs 55 to 58). I say nothing about the questions of self-incrimination and juries, which I regard as particularly difficult subjects requiring detailed consideration.

The Purpose of Coronial Inquests

9.77 The purpose of an inquest in England and Wales is not currently defined by statute. Instead, section 8 of the Coroners Act 1988, to which I have already referred at paragraph 7.17, states the circumstances in which a coroner is under a duty to hold an inquest. Rule 36 of the Coroners Rules 1984 sets out the matters to be ascertained at the inquest and provides:

> **'(1) The proceedings and evidence at an inquest shall be directed solely to ascertaining the following matters, namely –**
>
> **(a) who the deceased was;**
>
> **(b) how, when and where the deceased came by his death;**
>
> **(c) the particulars for the time being required by the Registration Act to be registered concerning the death**
>
> **(2) Neither the coroner nor the jury shall express any opinion on any other matters.'**

9.78 It is possible to infer from section 8 and from rule 36 that the function of an inquest is to discover, in the case of a violent or unnatural death, a sudden death of which the cause is unknown or a death in prison, who the deceased was and how, when and where s/he came by his/her death. The inquest will also seek to establish the particulars required for the registration of the death. However, these provisions throw little light on why it is thought desirable to discover these facts in the deaths caught by section 8.

9.79 Historically, the purpose of the coroner's inquest was to determine whether there was criminal involvement in the death. That was plainly a 'public interest' purpose. Nowadays, such investigation is the province of the police. Today, the purpose of the public investigation of the deaths caught by section 8 is unclear. The coroners who gave evidence stressed the need for the purposes of the coronial inquest to be clearly stated

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in future. I have the impression that they feel that the fact that the inquest has no defined purpose which the public can understand leads to difficulty and unrealistic expectations.

9.80 According to the author of the latest edition of Jervis on Coroners[1], the functions of an inquest are **'really to determine certain facts about the deceased, the cause of death, and the circumstances surrounding both death and that cause'**. In R v South London Coroner, ex parte Thompson[2], Lord Lane CJ observed that **'the function of an inquest is to seek out and record as many of the facts concerning the death as public interest requires'**. In R v HM Coroner for North Humberside and Scunthorpe, ex parte Jamieson[3] the Court of Appeal said that the main question to which evidence and inquiry are most often and most closely directed was how the deceased **'came by his death'**. That question was to be contrasted with the issue of **'how the deceased died'**, which might raise general and far-reaching issues. It has repeatedly been said that it is not the function of a coroner or his/her jury to determine, or appear to determine, any question of criminal or civil liability or to apportion guilt or attribute blame. The coroner is required to find out what happened, but not to attribute blame, even though the actions of someone involved might appear to warrant it. In short, the coroner has a difficult task with uncertain parameters.

9.81 These dicta, helpful though they are, only define the function of the inquest, not its purpose. For whose benefit is the inquest to be conducted? Lord Lane suggested that it is the public interest that is to be served. In 1971, the Brodrick Committee identified five grounds of public interest which they believed a coroner's inquiry should serve, namely:

> **'(i) to determine the medical cause of death;**
> **(ii) to allay rumours or suspicion;**
> **(iii) to draw attention to the existence of circumstances which, if unremedied, might lead to further deaths;**
> **(iv) to advance medical knowledge;**
> **(v) to preserve the legal interest of the deceased person's family, heirs, or other interested parties'**.

9.82 Parliament requires an inquest to be held in the cases covered by the provisions of section 8 of the 1988 Act, presumably because that section identifies deaths, such as violent or unnatural deaths, that might reasonably be expected to give rise to public concern if the circumstances remained unclear. I have already observed that it is not easy for coroners to decide whether a death falls within the provisions of section 8 and the results of their decisions often do not bear logical examination. Moreover, the general perception of those contributing to the Inquiry is that many deaths properly caught by section 8 do not give rise to any question of public interest or concern. Also, section 8 fails to catch some deaths that do give rise to public concern.

9.83 This issue was considered by Simon Brown LJ in the case of R v Inner London North Coroner, ex parte Touche[4]. In that case, the deceased had died as the result of a cerebral

[1] Matthews, P (2002) 'Jervis on Coroners', Twelfth edition. London: Thomson Sweet & Maxwell.
[2] [1982] 126 SJ 625.
[3] [1995] QB 1.
[4] [2001] QB 1206.

haemorrhage after developing high blood pressure following a caesarean section. This was a natural cause of death and the Coroner initially declined jurisdiction. On judicial review, the Coroner was ordered to hold an inquest. His appeal failed. In dismissing the appeal, Simon Brown LJ suggested that there was a powerful case for holding an inquest not only into 'unnatural' deaths but also **'whenever a wholly unexpected death, albeit from natural causes, results from some culpable human failure'**. He observed that such deaths caused understandable public concern which could be allayed by a coroner's investigation. The implied suggestion was that section 8 is not a satisfactory means of selecting deaths for public inquest. Simon Brown LJ also drew attention to the rather tortuous means which coroners sometimes have to adopt in order to bring a death within section 8. For example, some coroners who wished to conduct an inquest into deaths from legionnaire's disease (on the face of it a rare but natural cause of death) had been driven to reason that the mechanical spraying of infected water into the atmosphere (apparently a reference to the operation of an inadequately maintained air-conditioning system) made a death resulting from that spraying 'unnatural'.

9.84 In short, section 8 is not a satisfactory means of selecting those deaths where the public interest requires public investigation. In my view, in the modern era, the purposes of the public inquest should be:

- to conduct a public investigation into deaths which have or might have resulted from an unlawful act or unlawful acts
- to inform interested bodies and the public at large about deaths which give rise to issues relating to public safety, public health and the prevention of avoidable death and injury
- to provide public scrutiny of those deaths that occur in circumstances in which there exists the possibility of an abuse of power.

Do We Have Too Many Public Inquests?

9.85 In this country all inquests are conducted in public. Plainly that is appropriate if the inquest is to serve a public interest. If the public has no interest in a death, should there be a public inquest, merely because the death might be due to an unnatural cause such as suicide or an industrial disease? It might be more appropriate for the investigation of such deaths to take place in private.

9.86 The effect of section 8 of the Coroners Act 1988 is that a very large number of public inquests are held in England and Wales each year. In 2001 (the most recent year for which figures are available), inquests were held into nearly 25,800 deaths, which represents almost 13% of all deaths reported to coroners and nearly 5% of all registered deaths. Enquiries made by the Inquiry team suggest that inquests are held into a far greater proportion of deaths in England and Wales than in many other countries, where deaths are investigated (often more thoroughly than in England and Wales) and a written report is prepared.

9.87 Some jurisdictions have no provision at all for the conduct of an inquest. For example, in Maryland, USA, deaths are investigated by medical examiners and an expression of

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opinion about the cause of the death is added to the autopsy report. This opinion will also contain information about the circumstances of the death. The report is a public document. Any person with a sufficient interest in the report can seek a review of the report, first by the Chief Medical Examiner, then, if leave is granted, by an administrative judge, from whom there is a final right of appeal to a circuit court judge. Information from the death investigation is harnessed for the purposes of improving public health and safety and is passed to a number of relevant bodies responsible for injury prevention and community health. Thus, the interests of the family in finding out what happened and the interests of the community are served without holding an inquest.

9.88 In Finland, there is no inquest or comparable proceeding. Deaths reported to the medical examiner are investigated by pathologists and often by the police, even where there is no suspicion of criminal involvement. A report into the death is produced and seen by relatives but is not a public document. Information from the investigation is provided to the authorities with responsibility for public health and safety.

9.89 In the state of Victoria, Australia, and the province of Ontario, Canada, inquests are held, but in far fewer cases than in England and Wales. In Victoria, 0.8% of total deaths are followed by a public inquest. Apart from a few circumstances in which an inquest is mandatory (for example for cases of homicide, deaths in custody or care, or cases where the body is unidentified), the conduct of an inquest is a matter for the coroner's discretion. This is usually exercised where there is a matter of public interest at stake. Deaths reported to the coroner, in which no inquest is held, are investigated and a report is prepared which becomes a public document.

9.90 In Ontario, there is a similar provision for mandatory inquests; otherwise, inquests are held in the pursuance of the public interest. The number held is small (only 72 inquests were held in 2002 out of about 20,000 deaths reported to the coroner) but the issues are examined in depth and the purpose of such inquests is the production of recommendations directed to the avoidance of death or injury in similar circumstances. Indeed, the motto of the Ontario Chief Coroner's Office is **'We Speak for the Dead to Protect the Living'**. It is quite common for a single inquest to be held into several deaths, all of which have arisen in similar circumstances or share a common cause. In deaths which are reported to the coroner where no inquest is held, a report on the death is prepared and provided for a defined class of family and associates of the deceased. The report is not a public document.

9.91 In Scotland, some classes of death are reported to the procurator fiscal, who will cause the police to investigate the circumstances and will direct such medical investigations as s/he thinks necessary to determine the cause of death. At the end of the investigation, the procurator fiscal is obliged to report certain categories of case to the Crown Office, and to make recommendations. The Lord Advocate, assisted by Crown counsel, will then decide whether further action is necessary, either by way of prosecution or by the conduct of a fatal accident inquiry.

9.92 Fatal accident inquiries are conducted by sheriffs, the judicial equivalent of the circuit judge in England and Wales. A fatal accident inquiry is mandatory in deaths due to an accident in the course of employment and for deaths in custody. Otherwise, the decision

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to hold a fatal accident inquiry is a matter of discretion for the Lord Advocate. Before the decision is made and the procurator fiscal makes his/her recommendations about the future conduct of the case, the family of the deceased will be consulted. The usual criteria are related to public interest and concern. A fatal accident inquiry is designed to find the facts relating to the death and not to allocate blame. Recommendations for the future avoidance of a similar occurrence, or relating to any aspect of public health or safety, are sent by the sheriff to the procurator fiscal who promulgates them to the appropriate body. Very few fatal accident inquiries are held; in the year 2001/2, only 64 were held out of a total of 13,625 deaths reported to the procurator fiscal. That figure represents less than 0.5% of the deaths reported to the procurator fiscal.

9.93 It is clear that other jurisdictions manage without any or without a large number of public inquests. I think that the inquest is so well entrenched in our legal system that its complete abolition would not be acceptable. The real question is whether the criteria for holding a public inquest should be changed. I think there are positive reasons to have inquests, provided that they are thorough and are well conducted. There are public health and public safety advantages. Also, where issues of public concern arise, an inquest can expose failings or engender confidence. However, if no such issues arise, the public inquest may be an unnecessary invasion of privacy.

Views Expressed at the Inquiry

9.94 At the Inquiry, there was a large measure of agreement with the suggestion advanced in the Inquiry's Discussion Paper that too many inquests are held in England and Wales. Of the four coroners who gave evidence, only Mr Christopher Dorries, HM Coroner for South Yorkshire (West) was of the view that the present arrangements were satisfactory and that the criteria for the holding of inquests in public were appropriate. He said that an inquest was 'a voyage of discovery' and often found out previously unsuspected facts and circumstances. He did not believe that the facts could be adequately discovered by a thorough investigation without an oral hearing. Moreover, he said that the relatives of the deceased welcomed an oral hearing as it gave them the opportunity to question the pathologist in a formal setting where the pathologist was obliged to provide answers to their questions.

9.95 When he gave evidence, Mr Burgess expressed the view that the number of inquests conducted was appropriate, although he thought that some should take place in private. By the time of the seminars, he had modified his view and agreed that too many hearings took place. He thought that the categories of deaths to be investigated should remain the same, but that many deaths could be properly investigated without a hearing. The result of the investigation could instead be set out in a written report.

9.96 Mr Pollard stressed the need for families to receive a written decision, so that they could know what had happened and why, but he thought there was no need for all inquests to be conducted in public. He agreed with Mr Dorries that families welcome the opportunity to question the pathologist, but he also agreed that, provided that opportunity were given, this need not take place in the formal setting of the court room.

9.97 Dr Nigel Chapman, HM Coroner for Nottinghamshire, would be content to see the number of inquests reduced and felt that the criterion for holding an inquest should be whether the death raised issues of public interest. He said that far too many inquests are held in public and that this is often distressing, and even harmful, to the relatives. He described an occasion when he had encouraged a widow to give limited (and misleading) evidence about the background reasons for her husband's suicide in order to avoid distressing facts going into the public domain.

9.98 Mrs Aline Warner, who represented the Coroner's Officers Association at the Inquiry's seminars, expressed the view that bereaved families needed to know what had happened and welcomed the idea that some investigations should not take place in public. She suggested that the result of any investigation should be made public, because this would allay any rumour or gossip about the death.

9.99 Dr Peter Acland, a forensic pathologist who represented the RCPath at one of the seminars, said that, in his view, there were too many inquests; he doubted whether they were of much benefit to relatives. He thought that a less formal way of conveying the results of an investigation to relatives would be preferable. Dr Anne Thorpe, a consultant histopathologist representing the British Medical Association, agreed with that view.

9.100 Professor Richard Baker, Director, Clinical Governance Research and Development Unit at the University of Leicester, speaking at the seminars, also agreed that there was no need for so many public inquests but stressed the need for the community to learn from the investigation of deaths. He considered that, in England and Wales, this feature of the coroner's inquest or investigation was neglected. There was general agreement that the knowledge gained from an inquest or investigation should be harnessed for the general good.

Conclusions about Inquests

9.101 In summary, the general view at the seminars was that there must be an investigation of all deaths to an appropriate depth. The results of the investigation must be fully explained to the relatives of the deceased. However, provided that any lessons learned from the investigation can be harnessed for the public good, there is, in many cases, no need for, and little benefit to be derived from, a public hearing. I agree with that general view.

9.102 In my view, coronial investigation is important for three reasons. It ensures that relatives of the deceased, and those with a personal interest in the death of the deceased, understand how and why the death has occurred. That will entail an understanding of the medical cause of death and, if necessary, clarification of the factual circumstances in which it occurred. Such understanding is a natural human need. It assists in coming to terms with the death and may avoid suspicion and resentment about the circumstances in the future. Second, an investigation is needed in the public interest so as to ensure that neglect or misconduct resulting in a death does not go undiscovered. Only by learning how and why a death has occurred is it possible to learn from errors and avoid the recurrence of an avoidable death. Third, the public also has a legitimate interest in the accurate diagnosis of the cause of death. This is of benefit

to the advancement of medical science and the proper use of the resources of the state in the prevention and treatment of illness.

9.103 All those important interests could, in most cases, be served by an investigation of the death (to whatever depth is appropriate in the circumstances), followed by the communication of the results to those with a private interest or with a duty to safeguard some aspect of the public interest. In many such cases, nothing is gained by the public airing of the evidence. Indeed, in many cases, such exposure amounts to an unwarranted invasion of privacy and only causes increased distress to the bereaved.

9.104 In my opinion, the public inquest should be limited to those deaths about which there is a real public 'need to know', as opposed to the theoretical public interest that section 8 of the 1988 Act is designed to identify. I would favour the abolition of the section 8 criteria for the holding of an inquest and would confine inquests to deaths where the particular circumstances are such that the public interest requires a public hearing. I suggest that, apart from a few types of situation in which an inquest should be mandatory (such as cases of homicide not followed by conviction and deaths in custody), the coroner should have discretion to decide (after consultation with interested parties) whether a public inquest should be held in that individual case or group of cases. The decision should be subject to an appeal, not only by relatives of the deceased, but also by anyone with a legitimate interest in the case. Coroners should receive guidance on the types of issue that will require a public investigation at inquest.

9.105 I realise that it appears that I have recommended a more limited set of circumstances that would call for a public inquest than has the Coroners Review. In one respect, I certainly have. I do not think that a public inquest is necessary in any case in which it is necessary to resolve a conflict of evidence. In my view, that could quite well be done in private, by the coroner calling the witnesses to give evidence on oath. Interested parties could be allowed to attend and ask questions if they wished. In other respects, I think the difference between what I suggest and what the Coroners Review has proposed may be almost semantic. The Review seeks to identify the types of circumstance in which a public interest will arise. I agree that the list contains appropriate categories. However, in my view, there may be many other types of circumstance in which a public interest can arise. It would be well nigh impossible to compile a complete list. In my view, just because the death fits into a particular category should not mean that there must be a public inquest. The facts of the individual case should be examined to see whether they do raise public interest issues.

9.106 Some obvious examples of cases in which there must be a public interest spring readily to mind. The public needs to know how and why fatalities have occurred on the public transport system, at an accident blackspot or because of a failure of design of a vehicle or piece of equipment. They need to know about a death at the hands of the police. If it appears that a death has been caused by the failure to carry out a proper procedure in a hospital such that others might be affected by a repetition of the failure, the public interest may demand a public hearing.

9.107 I also consider that the procedure by which coroners may make recommendations for future change should be continued, but strengthened. I shall return to this issue in Chapter Nineteen.

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9.108 It is interesting to note that the Brodrick Committee recommended changes similar to those I have suggested. They suggested that the coroner should have complete discretion as to the type of investigation to be carried out. The existing categories of death in which an inquest had to be held should be swept away. Instead, the only circumstances in which an inquest should be mandatory would be deaths from suspected homicide, deaths of persons deprived of their liberty by society and deaths of persons whose bodies were unidentified. The Committee's view, expressed over 30 years ago, accords almost exactly with mine.

CHAPTER TEN

The Role of Pathology in the Coroner Service

Hospital and Coroners' Autopsies

10.1 I have already referred in Chapter Nine to the role of the autopsy as one of a number of investigative tools available to the coroner. The purpose of the coroner's autopsy is to identify the cause of death and, in particular, to determine, or assist in determining, whether the death was 'natural' or 'unnatural'. The coroner's autopsy takes place at the direction of the coroner; the consent of the deceased's family is not required. A hospital or 'consent' autopsy is conducted for clinical and/or research purposes. If consent was not given by the deceased in life, such an autopsy requires the consent of the family.

10.2 In the UK, the number of 'consent' autopsies on adults has declined markedly over the past 30 years, whereas the number of coroners' autopsies has remained relatively constant. In 2001, about 130,000 autopsies were conducted in England and Wales. Of these, 121,000 were coroners' autopsies. Coroners ordered autopsies in just over 60% of the 201,000 deaths reported to them. Over 20% of all registered deaths in England and Wales were followed by autopsy. That is more than twice the rate in both Northern Ireland and the Republic of Ireland, 10% more than in Scotland and more than many other jurisdictions.

The Practitioners Who Conduct Autopsies

10.3 The Coroners Rules 1984 provide that post-mortem examinations should be made, wherever possible, by a pathologist with suitable qualifications and experience.

Forensic Pathologists

10.4 Where there is a suspicion of homicide, the autopsy will be carried out by a pathologist listed on the Home Office Register of Forensic Pathologists. The police should be consulted about the choice of pathologist. There are very few (about 36 – reduced from 52 in 1992) forensic pathologists in England and Wales. Of these, almost 50% practise independently, often carrying out autopsies in public mortuaries that are not attached to any hospital or other institution. Such public mortuaries are owned and operated by local authorities. Other forensic pathologists have hospital and university appointments. In some districts (e.g. Sheffield), the coroner works alongside a university forensic pathology department and has the benefit of having forensic pathologists to carry out many of his/her 'routine' autopsies. Such arrangements are, however, the exception.

10.5 Forensic pathologists enter into individual service contracts with local police forces. They also provide services for coroners and others, including defendants in criminal cases. They have no management structure and the forensic pathologist service is fragmented. There are perceived problems of lack of training opportunities, uneven standards of practice, difficulties in managing heavy workloads and lack of opportunity for career development. These problems have recently been addressed by the Home Office Review of Forensic Pathology Services in England and Wales, which reported in March 2003.

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I shall refer to the recommendations of that Review later in this Chapter. These problems, together with many other issues, were also discussed at one of the Inquiry's seminars, held on 23rd January 2003, as well as during the course of oral evidence.

Consultant Histopathologists

10.6 In most districts, routine coroners' autopsies are carried out by histopathologists employed in local National Health Service (NHS) hospitals. Such histopathologists should be on the General Medical Council (GMC) specialist register. These practitioners spend most of their time performing histopathological work in connection with the care of living patients. Some histopathologists have a particular interest in conducting autopsies and acquire an expertise in the field. Others are unenthusiastic about the work and do it only because the hospital is a base for coronial autopsy and it is therefore expected of them. Pathologists receive a set fee (currently £78.60) for a routine coroner's autopsy; this is over and above the salary that they receive in connection with their NHS employment. The conduct of coroners' autopsies can be a significant source of additional income and this factor provides some incentive to do the work. GMC-registered trainees can perform coroners' autopsies under the supervision of a trained histopathologist, provided that the coroner agrees.

Specialist Pathologists

10.7 Certain autopsies are carried out by specialists such as neuropathologists or paediatric histopathologists. However, skill shortages in these areas can make such autopsies difficult to arrange. Furthermore, the Inquiry was told that coroners do not always recognise the need for an autopsy to be carried out by a specialist. The Royal College of Pathologists (RCPath) is currently considering the possibility of developing a list of approved specialist pathologists and making this list available to coroners.

Other Practitioners

10.8 Until relatively recently, coroners' autopsies were carried out on a reasonably frequent basis by doctors who were not accredited histopathologists. The Inquiry has been told that the number of medical practitioners without specific training in autopsy practice who perform autopsies has decreased. However, at the Inquiry's seminar on pathology, one participant mentioned that he was aware of general practitioners and a microbiologist who still carried out such examinations. Another participant said that he also was aware of general practitioners who currently carried out autopsies.

Problems with Coroners' Autopsies

The Number of Coroners' Autopsies Performed

10.9 The Inquiry has heard that there is a substantial body of opinion to the effect that too many coroners' autopsies are performed. At the pathology seminar, there was unanimous support for the suggestion that there should be fewer, better selected coroners' autopsies. Dr Anne Thorpe, who represented the British Medical Association (BMA) and is herself a

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consultant in histopathology and cytopathology, said that many autopsies were carried out by reason of automatic triggers, such as the fact that the deceased had not been seen by a doctor during the 14 days before death. Such autopsies frequently added nothing to the knowledge about the deceased or the cause of death. There was a general feeling that too little importance was attached to the results of in-life investigations, which might provide a clear diagnosis of cause of death without the need for an invasive autopsy. Dr Roger Start, another consultant histopathologist, gave examples of autopsies which he and his colleagues had been required to carry out in cases where robust diagnoses had been made during life. There was general agreement that a decision as to whether or not an autopsy should be carried out should be made on a case-by-case basis, rather than by the application of inflexible rules.

The Shortage of Pathologists

10.10 Considerable concern was expressed about the shortage of both forensic pathologists and histopathologists. There are few university departments teaching forensic pathology. Fragmentation of the forensic pathology services means that there are few consultant posts or training opportunities. As a consequence, there is a lack of training and experience in the conduct of autopsies among those who have entered the medical profession more recently. A dramatic reduction in the number of hospital autopsies being carried out has had the effect of making it difficult for a trainee to gain experience in carrying out and observing dissection techniques. Some coroners are unwilling to allow trainees to carry out autopsies on their behalf, even with supervision from a consultant.

10.11 There are other factors that tend to deter histopathologists from carrying out coroners' autopsies. Some prefer to work with the living, rather than the dead. The need to attend to give evidence at inquests on a regular basis can be extremely disruptive of the pathologist's other duties. NHS managers tend to view coroners' autopsies as a distraction for staff employed to meet the clinical needs of live patients. Histopathologists may therefore receive no encouragement to perform coroner's autopsy work. In addition, the recent, much publicised controversies relating to the retention of organs and tissues have discouraged some practitioners from becoming involved in coroners' autopsies.

10.12 Professor James Underwood, President of the RCPath said at the pathology seminar that, before doctors embark upon their training, the interest in forensic pathology tends to be high. However, the lack of pathology in the undergraduate curriculum leads to a dissipation of that initial interest. The challenge is to nurture and develop it. The RCPath is working on the development of a modular training programme, which would enable pathologists to elect whether or not to undergo training in autopsies. This would ensure that only those with a real interest in performing autopsies underwent the necessary training. Equally, it would enable a pathologist to specialise in autopsies, either as their sole activity or alongside some diagnostic work connected with living patients. Dr Start pointed out that, as a consultant histopathologist, the only way in which he could carry out autopsies on a full-time basis under the current system would be to become a forensic pathologist, which he does not wish to do. He would welcome the introduction of the opportunity to specialise in the field of autopsy. Plans are also afoot to facilitate the transition from histopathology to paediatric histopathology, in order to alleviate the acute

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shortage of practitioners within that specialist field. Both Professor Helen Whitwell, who heads the Forensic Pathology Department at the University of Sheffield, and Professor Underwood reported that the RCPath is currently considering how training in autopsy practice can be improved. The Inquiry has also heard about a national strategy to increase the number of trainees in pathology. Professor Whitwell believed that, if a unified autopsy service were created, medical professionals would be attracted to work in the field.

The Inadequacy of the Information Available to Pathologists

10.13 Concerns have been expressed by the RCPath and others about the adequacy and quality of information available to pathologists prior to a coroner's autopsy. Plainly, if the pathologist is to place his/her findings in context and properly interpret them, s/he must have full and accurate information about the deceased's medical history and the circumstances of the death.

10.14 At the pathology seminar, Dr Start observed that, while pathologists in his locality had no difficulty in obtaining the information they required, he was aware that the information received by some of his colleagues elsewhere was confined to that contained on police sudden death report forms and could be extremely limited. He was also aware that some coroners would not make medical records available to pathologists or allow communication between pathologists and clinicians involved in the deceased's care. He said that one of the fundamental problems of the current system was the variation in the practices of different coroners. Others also referred to the problems caused by lack of consistency in practice between coroners.

10.15 Professor Whitwell stressed the importance, particularly in a complex case, of discussion with the clinicians responsible for the deceased's care. The 2002 Report produced by the National Confidential Enquiry into Perioperative Deaths (NCEPOD) recorded how clinicians were frequently unaware of the date or time of an autopsy and were often unable to attend. One surgeon reported to the NCEPOD that the local coroner did not permit communication between a surgeon involved in the deceased's care and the pathologist carrying out the autopsy unless the surgeon had a specific question. Presumably, this policy is intended to ensure that the pathologist is in a position to provide a wholly independent opinion. At the seminars, however, Dr Start said that, if he were not permitted to contact those involved in the deceased's care in order to obtain the information he required, it would seriously diminish his ability to provide the best possible autopsy report. He is fortunate in that he can contact his clinical colleagues and access information about the patient on the hospital computer. Some coroners will not permit pathologists to do this when conducting autopsies on the coroner's behalf.

10.16 The RCPath has advised that a minimum amount of information should be presented to a pathologist who is instructed to carry out an autopsy following a death occurring in the community. This information should include the precise circumstances of the death, the medical history of the deceased and details of any prescribed medications and any recent hospital admissions. Such information is obviously critical to pathologists if they are to carry out their task properly.

The Standard of Coroners' Autopsies

10.17 I have referred in Chapter Nine to the fact that coroners' autopsies are not always performed to a high standard. There is general concern that the coroner's autopsy is often of lower quality and less thorough than the hospital autopsy. This difference in quality has been attributed to a number of factors. I have already mentioned the fact that pathologists carrying out coroners' autopsies frequently do not have the background information that is necessary in order to put their examination into context. Often, they do not have the same opportunity to consult the medical records or discuss the case with clinicians that they would have if they were conducting a hospital autopsy. The fact that they are carrying out coroner's autopsy work in NHS time (or attempting to fit it in before the start of the working day) may mean that they are under pressure of time. The same pressure of time can arise if the pathologist has a long list of coroners' autopsies to undertake on a single day. Limitations (e.g. as to the histological examination to be carried out) may be imposed by the coroner, and the pathologist may be under pressure to find a cause of death without having conducted all the investigations that s/he would wish to conduct before giving a final opinion. There is no audit or means of quality assurance to ensure that coroners' autopsies are carried out to a suitable standard. The NHS has no such audit procedures since the autopsies are not carried out within the pathologist's NHS employment.

10.18 The RCPath has sought to address these problems by producing a document, 'Guidelines on autopsy practice', which was published in September 2002. A copy of the document has been sent to every coroner in England and Wales. Thus, it is hoped, coroners will at least be able to compare the service that they are currently receiving against the standards set out in the Guidelines. Also, the RCPath is developing minimum standards for autopsies relating to specific types of death. The standards are intended to alert pathologists as to how they should be doing their work. If a coroner refuses to allow the pathologist to include within his/her examination an element (e.g. the taking of a tissue sample for histology) that the pathologist regards as necessary in order to give a full and reliable opinion, the pathologist will be able to rely on the Guidelines in support of his/her request that permission be granted. If it is not, the pathologist may decline to conduct the autopsy.

10.19 Both Professor Underwood, for the RCPath, and Professor Margaret Brazier, Chair of the Retained Organs Commission, agreed with Dr Peter Goldblatt of the Office for National Statistics that the content of a properly conducted autopsy should be given the endorsement of the law, possibly by means of a code of practice with statutory force.

10.20 The RCPath is anxious to ensure that the standards to which coroners' autopsies are carried out should be the same as those applicable to hospital autopsies and that the benefits derived from both types of autopsy should be the same.

The Future Delivery of Autopsy Services

10.21 The shortage of forensic pathologists, together with perceived problems with the organisation of the forensic pathology service, has led recently, as I have already explained, to a Home Office Review. From that Review emerged the suggestion that a

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central body should be created to manage the service and to tackle the various problems confronting it. The Review concluded that, given the close involvement of the forensic pathology service with the criminal justice and coronial systems, both of which are currently administered in part by the Home Office, the responsibility for the management of the forensic pathology service should also lie with the Home Office. The other option which had been considered was to place the service within the jurisdiction of the Department of Health (DoH) by, for example, creating a new Special Health Authority.

10.22 The Review took the view that direct control of the forensic pathology service by a Government Department would be undesirable. Instead, it suggested that the service should be at arm's length from the Home Office. The solution eventually recommended was that the forensic pathology service should be integrated into the existing Forensic Science Service, which is an Executive Agency of the Home Office.

10.23 It was further recommended that specialist regional service delivery centres (centres of excellence) should be established, providing a base for forensic pathologists and suitable mortuary facilities, as well as facilities for histology processing and other purposes.

10.24 It was suggested at the Inquiry's pathology seminar (which took place before the Review reported) that there should be a unified service which would deliver the whole range of pathology services, including those required for routine coroners' autopsies. The service would employ, not just the relatively few forensic pathologists doing mainly cases with a criminal involvement, but also histopathologists performing autopsy work. Although the RCPath is not directly concerned with the organisation and management of pathology services, Professor Underwood, representing the College, supported the idea of a free-standing, independent service, with functions to include a duty to provide autopsy and other related services to the coroner.

10.25 At present, responsibility for pathology services is split between the Home Office and the DoH. The College's view was that this arrangement did not benefit either the public or the profession. Professor Underwood observed that the logical place for all autopsy services was within the DoH, possibly by way of a Special Health Authority. It would then be possible for an NHS consultant to spend most of his/her professional time working in hospital, dealing with disease in living patients, but to be contracted to carry out autopsy work for the new service on a sessional basis.

10.26 Under the working model set out in the Inquiry's Discussion Paper, the Inquiry envisaged that there would be regional coroner's offices, preferably situated at or near to the forensic pathology centres of excellence. There would also be a larger number of district coroner's offices. The district offices would be served by local histopathologists with a particular interest and expertise in autopsy. External examinations and autopsies would be carried out in the mortuaries of local hospitals. At the pathology seminar, Dr William Lawler, representing the British Association in Forensic Medicine, was supportive of such an arrangement. He envisaged that the regional forensic pathology centres would deal with the more complex cases, including many of those involving criminality. The centres would also play a part in training and could provide a career structure, as well as the specialised facilities already mentioned.

10.27 Professor Underwood, representing the RCPath, spoke of the importance of pathologists having the appropriate skills for the particular examination to be undertaken. For example, in a case where a deceased person had been in intensive care for some time prior to death, a knowledge of intensive care procedures and the changes in the living body which can result from those procedures was required. It was to be hoped that the provision of a unified service would enable a variety of such skills to be developed and to be made available at a regional, if not a district, level. Professor Whitwell referred to the need for specialists in maternal deaths, a need not always recognised by coroners. The requirement for a specialist to conduct autopsies in perinatal deaths is more widely recognised. Professor Whitwell also mentioned the need for facilities to carry out radiology, which, in her view, is under-used at present in post-mortem investigations.

10.28 At present, coroners' autopsies are conducted outside the NHS, although they are usually conducted by an NHS employee, in the mortuary of an NHS hospital, with the assistance of other staff employed by the NHS and often within the hours of the pathologist's NHS employment. However, because the autopsies are commissioned by coroners, the NHS has no control over how they are performed. There is no audit of coronial autopsy reports and no quality assurance. The autopsy report will usually be received by a coroner who has no medical expertise and is therefore not in a position to judge the adequacy or acceptability of its contents. Professor Whitwell expressed the view that it would be appropriate for the NHS to assume responsibility for a patient up to the point of disposal of the body, rather than, as at present, merely up to the point of death. If the new service were based within the health sector, this could be done. Placement within the health sector would also enable there to be proper quality control of autopsies. It would mean that issues such as communication with relatives about autopsies, organ and tissue donation and other relevant matters could be dealt with in a consistent manner, whether the autopsy was being undertaken by consent or at the direction of the coroner. This view was supported by Dr Stephen Leadbeatter (Director of the Wales Institute of Forensic Medicine), Dr Start and Professor Brazier. Professor Brazier said that the Retained Organs Commission would endorse the idea of a Special Health Authority providing pathology services independent from the NHS. She felt that such an arrangement would help to provide quality, as well as consistency, of service.

10.29 For the BMA, Dr Thorpe stressed the need for pathologists to be independent of the NHS. At present, autopsies in cases where there is a suggestion of wrongdoing on the part of the clinical team responsible for caring for the deceased are carried out on the instructions of the coroner. He or she can instruct the pathologist of his/her choice, with the experience which s/he deems necessary. If, for any reason, the pathologist is unwilling to carry out the autopsy (e.g. because s/he knows the deceased's family has complained about the deceased's care or s/he does not feel s/he possesses the right skills), the coroner will instruct another pathologist. There are fears within the profession that, if a system were to be created whereby a hospital trust contracted to provide pathology services for the coroner, there would be pressure on pathologists to carry out autopsies in circumstances where it would be inappropriate for them to do so. That problem would not arise if pathology services were provided by a free-standing, independent pathology service.

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The Purpose of the Autopsy

10.30 The purpose of the hospital autopsy is to increase medical knowledge, either in relation to the particular case or more generally. The autopsy may also reveal genetic features relevant to other members of the deceased's family. It may add to the family's understanding of the death and may help them come to terms with their loss. It can be used for the purposes of audit and research.

10.31 Over recent years, the number of hospital autopsies has declined markedly. There are a number of reasons for this. Professor Underwood, representing the RCPath, said that one reason was a misplaced confidence by clinicians in ante-mortem diagnoses of causes of death. Clinicians no longer regard autopsies as important and do not request them. In addition, following the recent controversies about the retention of organs and tissues, there is heightened suspicion on the part of the public about the purpose of autopsies and a reluctance on the part of doctors to ask for consent for an autopsy to be conducted. The procedures which have to be undertaken in order to obtain consent are, the Inquiry was told, in themselves a deterrent. Furthermore, the general pressure on the pathology services has made the performance of hospital autopsies less attractive. Nevertheless, there was a general view among participants at the pathology seminar that hospital autopsies had an important role to play in the understanding of disease and the audit of clinical care.

10.32 Hospital autopsies are generally carried out in the hospital where the deceased died. The pathologist has access to the latest information about the deceased's medical history. He or she has contact with the clinicians who were responsible for the deceased's care. The autopsy is carried out within the pathologist's employment with the NHS and the results are made available to clinicians.

10.33 In its 2002 Report, the NCEPOD drew a distinction between hospital and coroners' autopsies. It suggested that the coroner's autopsy had lost its link with clinical medicine. As a consequence, it was failing to provide lessons which clinicians needed to learn in order to understand the patient's death. It observed that clinicians were feeling more and more disillusioned and frustrated with the information obtained from coroners' autopsies, which may not help in the understanding of a patient's death. The problem, the Report observed, appeared to be that the information required by a coroner from an autopsy was quite different from that required by clinicians. The Report said that the current system put limits on the quality of information that a pathologist can contribute to his/her clinical colleagues and upon his/her ability to function within a team. The RCPath has also expressed concern that the potential benefits that could accrue to society from the large number of coroners' autopsies undertaken in England and Wales are not being realised. This has become particularly important at a time when the number of hospital autopsies being undertaken is declining and is now such a small proportion (about 10%) of the total number of autopsies being conducted.

10.34 Quite apart from the frequent lack of communication between pathologists and clinicians before coroners' autopsies are conducted, there is often a lack of communication after the autopsy. Autopsy reports are not always made available to the clinicians who treated the deceased. Thus, the potential for harnessing valuable information gleaned on autopsy is

lost. Sometimes, the reports of coroners' autopsies are in any event superficial, dealing only with the immediate cause of death diagnosed and containing little information of interest to the clinician.

10.35 Professor Whitwell gave the example of the elderly person who dies with dementia. If the cause of death was bronchopneumonia, most coroners will be satisfied with 'pneumonia due to dementia' as the cause of death. The type of dementia cannot be ascertained without detailed neuropathological examination of the brain. If the relatives knew that such an examination were possible or that it might be of benefit to them and to others, they might well be happy for such an examination to go ahead. But, with the coroner's autopsy, the relatives will not usually be informed of the possibility of such an examination and the opportunity will therefore be missed.

10.36 At the seminars, there was discussion about the aims and purposes of a coroner's autopsy. There was a general view among the pathologists that, once a decision had been taken to perform an autopsy, whether by consent or for the coroner, the autopsy should be carried out as thoroughly as possible. Professor Underwood, for the RCPath, observed that it is only by reliably ascertaining the cause of the death that a picture of the health of the nation can be developed and that changing patterns of disease incidence can be observed which, in turn, might lead to the discovery of new causes of disease. He said that the autopsy made a very important contribution to public health.

10.37 Professor Brazier, for the Retained Organs Commission, said that, in her experience, once a decision has been taken to perform an autopsy, most families wish the maximum amount of useful information possible to come out of it, both for their own benefit and for the benefit of others. She felt that the crucial factor was that the family should be given a full explanation of what was going to be done and why. She acknowledged that there would be a small minority of families for whom any form of autopsy is a violation of their personal faith or personal convictions and who would want the autopsy to be as narrowly focussed as possible.

10.38 In general, however, there was a strong feeling that all autopsies, whether carried out by consent or at the direction of the coroner, should be carried out with the same thoroughness and to the same high standard.

External Examination

10.39 The RCPath Guidelines criticise the practice whereby a mortuary technician is permitted to remove and dissect organs before the pathologist has checked the identity of the deceased and carried out an examination of the external surfaces of the body. The effect of this practice may be to destroy signs that should be observed by the pathologist and thus to impair the value of the autopsy. In her evidence to the Inquiry, Professor Whitwell strongly supported the College's position on this issue.

10.40 At the seminars, the potential of an external examination of the body as a possible alternative to the full autopsy was discussed. Professor Whitwell was of the view that careful assessment of clinical records and death scene circumstances, coupled with a thorough external examination of the body, could potentially reduce the number of cases

in which an autopsy was required. These steps could be combined with random toxicology in some cases.

10.41 At the seminars, Dr Start referred to the difficulty, even for an experienced pathologist like himself, in distinguishing between external marks (e.g. bruising) which were, or might have been, caused by violence and those which were innocent in origin. The task was particularly difficult where a patient had been subjected to vigorous treatment by paramedics or staff in an accident and emergency department. Such treatment might give rise to marks on the body. Dr Start said that the tendency of pathologists at present is to overlook marks (e.g. bruising in an elderly patient living in a care home), because of ignorance of how properly to interpret the marks.

10.42 Dr Start observed that, if external examination were going to be performed by health professionals other than pathologists, or by persons other than health professionals, a significant amount of training would be needed. Professor Whitwell said that, for some time, there had been a lack of training among doctors in basic forensic medicine, such as bruise and wound interpretation. Professor Underwood, for the RCPath, agreed. He said that, if doctors were to be required to undertake detailed external examinations of bodies, the GMC would have to ensure that proper training was in place.

10.43 Dr Lawler, for the British Association in Forensic Medicine, envisaged a two-stage process whereby the initial screener, who need not be medically qualified but must be carefully trained, would carry out an external examination according to a protocol. If anything untoward was observed, that person would raise the alert and a further examination by a medically qualified person (probably a pathologist) would follow. That sort of arrangement exists informally at present. Dr Lawler said that he knew of homicide cases where enquiries into the death had been initiated as a result of information given by mortuary technicians who had identified suspicious features on bodies received at the mortuary.

10.44 Both Professor Underwood and Dr Lawler raised a note of caution as to the likely accuracy of diagnoses of causes of death based on external examination of the body. Dr Lawler observed that it would inevitably result in less accurate determinations of the cause of death than if a full autopsy had been carried out. Research into the efficacy of external examination by trained personnel as a way of diagnosing cause of death would have to be undertaken.

The Partial Autopsy

10.45 There was discussion at the pathology seminar about the value of partial autopsies, limited to only a part, or certain parts, of the body. This idea had been canvassed in evidence and had received little support from witnesses or from respondents to the Discussion Paper. Two possible circumstances in which a partial autopsy might be appropriate were suggested. First, where an unequivocal cause of death (e.g. a ruptured aortic aneurysm) was found at an early stage of the investigation and the deceased's family were known to be opposed to the principle of an autopsy. Second, where there was a risk of infection (e.g. from brain tissue) and a cause of death was found before the brain was examined. In

evidence, Dr Martin Gillett, a consultant histopathologist who frequently carries out coroners' autopsies, said that there were occasions when he received a message from the coroner to the effect that, if he found a cause of death that did not involve opening the skull, he was not to proceed to open the skull, as the relatives had asked that this should not be done.

10.46 For the RCPath, Professor Underwood said that he could see a role for the partial autopsy in the context of a hospital autopsy, where the purpose of the autopsy might be to answer a specific question about the nature of the disease. He did not think that a partial autopsy in a coroner's case would be appropriate. In its Guidelines, the College had stated its view that any autopsy carried out should be as full, and of as high a quality, as possible and should address all questions relating to the death. Professor Brazier, on behalf of the Retained Organs Commission, took the view that, in the majority of cases, it was the initial intrusion upon the body that gave rise to the distress felt by families. Once the process had begun, provided that the family were properly informed about what was to happen, they would usually accept a full examination, particularly since that might result in findings (e.g. about genetic disease) which would benefit other family members. Also, she felt that, if the family had been led to expect a limited examination only, and the expected cause of death was not found, there might have to be further discussions about extending the examination, which would be more distressing than if a full examination had taken place in the first instance. Other participants, all of them pathologists, were doubtful about the value of partial autopsies and were concerned about the potentially valuable information which would be lost by limiting the extent of the examination. Dr Start pointed out that the standards set by the RCPath were intended to be applicable to all autopsies. A suggestion that some autopsies might be partial would introduce a 'grey area' and might expose the pathologist to criticism if s/he did not comply in full with the standards.

10.47 During the course of discussion at the pathology seminar, I pointed out that, where an autopsy was being imposed upon a family against their wishes, or those previously voiced by the deceased, it was difficult to see how an examination going further than was necessary to establish the cause of the death could be justified. I suggested that, in such a case, it would be a matter for the coroner to agree with the family limitations on the extent of the autopsy and to give appropriate guidance to the pathologist. In response, Professor Brazier voiced her belief that, if families had clear explanations, only a few would seek restrictions. She agreed that there was a place for compromise but observed that it would be extremely difficult to negotiate such a compromise, bearing in mind that the position could change once the examination started. She also stressed the need for absolute clarity of the pathologist's position.

The Use of Non-Invasive Techniques

10.48 In recent years, there has been increased interest in various non-invasive or minimally invasive post-mortem investigations such as magnetic resonance (MR) scanning, thoracoscopy, laparoscopy, radiology and needle biopsy with histology, as alternatives to the full invasive autopsy. Such techniques have particular attractions for those minority groups who hold strong religious and cultural objections to the invasive autopsy. In Manchester, for example, the use of MR scanning has been pioneered by Dr Rob Bisset,

a consultant radiologist at the North Manchester General Hospital. The Jewish community has paid for scans to be carried out on its members where an invasive autopsy would otherwise have been necessary and, where Dr Bisset has been able to identify a cause of death from the scan, the coroner has certified that cause of death.

10.49 Dr Bisset told the Inquiry that MR scanning gives excellent results in some areas of the body. However, he acknowledged that it has limitations. It cannot detect metabolic disease, nor can it at present define the coronary arteries. With more powerful resolution in the future, the latter should be possible. Dr Bisset has carried out MR scanning in a relatively small number of cases. He observed that scanning had produced a cause of death in the majority of those cases without recourse to an invasive autopsy. Others have pointed out that there has been little research as yet as to the quality of the correlation between the causes of death reached as a result of MR scanning and those which would have been diagnosed on invasive autopsy.

10.50 Dr Bisset said that there is a shortage of MR scanners in the UK. The one which he uses is privately owned and is therefore available for use upon payment. Dr Bisset also pointed out that there is an even greater shortage of radiologists. He observed that, as things are at present, the pressure on the use of MR scanners for live patients is so great that use of scanning for post-mortem investigations on a large scale is unlikely to be acceptable to the public other than in relation to neonatal deaths. In a letter to the Inquiry, the Royal College of Radiologists referred to the need for further research to identify more clearly the limitations of MR scanning in ascertaining the cause of death. The College supports such research, but has serious concerns about the general introduction of MR scanning post-mortem. Its letter referred to the shortage of scanners, radiologists and radiographers and pointed out that waiting lists for living patients are very long.

10.51 Dr Ian Barnes, a pathology modernisation adviser to the DoH, referred to a study which had recently been commissioned by the Department. This had concluded that the research evidence as to the effectiveness of non-invasive techniques of post-mortem examination was at present limited. The Department was currently seeking funding to conduct more detailed research. There was considerable support at the seminars for further exploration of the potential of non-invasive techniques to provide an alternative to autopsy, at least in some cases. Professor Underwood said that the RCPath would welcome a well-funded research study. There was a need to research and audit the accuracy of the techniques. However, Professor Brazier emphasised that, even if other techniques came into regular use, it was important that families should be made aware of the limitations of those techniques and of the fact that invasive autopsy may ultimately be necessary in their particular case.

Histopathology

10.52 In its 2002 Guidelines, the RCPath stated that:

> **'Diagnostic or confirmatory histopathology should be done in all cases, subject to the requirements of the Human Tissue Act 1961 and the instructions of the Coroner.'**

10.53 As I have already mentioned, coroners' attitudes to the taking and retaining of samples for histology vary widely, particularly since the recent controversies about organ and tissue retention. Pathologists are sometimes prevented by coroners from taking tissue samples which the pathologist believes are necessary in order to establish or confirm the cause of death. The only course open to the pathologist in those circumstances is to decline to state a cause of death before histology has been done. Often, however, the pathologist might be able to state a provisional cause, in which case some coroners would not permit histology. Funding for histology can also be a problem. In the past, hospitals were prepared to carry out basic histology without charge. This is less common today. The Inquiry heard of one coroner who will pay for histology only in a case where an industrial disease is believed to have caused the death. If a pathologist in that area feels that histology is necessary in a non-industrial disease case, s/he takes it, but neither s/he nor the hospital receives any payment for it. If a great deal of histological investigation is required in a non-industrial disease case, the coroner will sometimes agree to pay on a 'one-off' basis.

10.54 At the pathology seminar, Professor Underwood, for the RCPath, emphasised the fact that an organ or tissue which looks normal to the naked eye at autopsy may well be found to be abnormal if examined microscopically. He also referred to the College's view (shared by the BMA) that tissue blocks and slides which have been subjected to histological examination should be retained as part of the deceased's medical records. Examples of cases in which this is of value are deaths stated to be caused by Sudden Infant Death Syndrome where the occurrence of a second similar death in the family, or the advance of medical science, might make it necessary for the death to be re-appraised. It is also sometimes desirable in criminal cases. In the case of a coroner's autopsy, organs and tissues may be retained only for such period as the coroner thinks fit. Sometimes, coroners refuse to allow material to be retained in circumstances where the pathologist believes it is necessary. Obviously, there is a need for consistency of practice in those cases where there is a real medical need for retention.

10.55 Professor Brazier explained that the Retained Organs Commission was recommending the creation of an authority to regulate collections of organs and tissues taken for non-coronial purposes. She agreed that, in the future, coroners might have to adjudicate on the retention of material taken during coroners' autopsies but stressed that they would have to be clear as to the purposes for which the material was being retained.

10.56 Dr Start referred to the uncertainty on the part of pathologists as to what they can and cannot do in terms of histology. He stressed the need to validate the observations made with the naked eye and to discover whether the pathologist's belief about the disease processes present was correct. He regarded this as vital to maintaining the quality of autopsies. On occasions, the finding on histology can produce surprises that wholly change the pathologist's view of the case. Moreover, the present system, whereby different coroners operate different rules about the taking of histology, would prevent the effective policing of the quality of all autopsies in accordance with the RCPath's new Guidelines.

10.57 Dr Start observed that the establishment of a unified autopsy service, especially with in-house histopathology, would mean that the histological element of the autopsy was

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accorded a greater priority than at present when, in a busy histopathology department, histology associated with coroners' autopsies comes at the bottom of the pile. Delay in informing relatives of the cause of death causes distress and diminishes the value of the examination. Sufficient support staff should be available to deliver a quality service.

Toxicology

10.58 Most forms of toxicological death will not show any specific features on autopsy, although there may be non-specific findings and a history suggestive of the cause. Sometimes, needle marks may be evident on an examination with the naked eye or tablet material may be seen among the gastric contents. However, toxicology is necessary to establish the cause of death. In a young person who dies with no evident macroscopic cause of death, toxicological analysis will generally (and, according to Professor Whitwell, should always) be undertaken. However, toxicology is much less frequently carried out among the elderly since, in an elderly person, there is usually some condition evident on autopsy which could constitute a plausible cause of death.

10.59 In the case of many, if not all, of Shipman's victims, if an autopsy had been carried out in the absence of toxicology, it is highly unlikely that the true cause of their deaths would have been revealed. Certainly, this was so in the case of Mr Charles Barlow, one of Shipman's victims, who was subjected to an autopsy. I have referred to Mr Barlow's case in Chapter Nine of this Report. In some jurisdictions, much greater use is made of toxicology. It is performed in conjunction with virtually every autopsy and is also carried out in some cases where there is no autopsy. The Inquiry was told about the experience in Maryland, USA, which is that 'random' toxicology of this type throws up some surprising results. Drugs have been found in babies, young children and the very elderly. Indeed, a response to the Inquiry's Discussion Paper from a consultant histopathologist in London related how, at the time of the Shipman trial, he undertook a coroner's autopsy on an elderly woman found dead at home. There was no history of suspicious circumstances and ample evidence of coronary heart disease. He gave the cause of death as ischaemic heart disease but, out of interest, sent a blood sample for toxicological examination. When the results were returned, he found that there had been a fatal overdose of anti-depressants. It seems likely that, if greater use were made of random toxicology, some deaths which would otherwise be characterised as 'natural' would be discovered to have resulted from the administration, or self-administration, of a drug.

10.60 In England and Wales, samples taken for toxicology usually consist of blood, urine and/or stomach contents; on occasions, tissues are also taken. Tests for alcohol (and, often, a drugs screen) are carried out in all deaths by road traffic accident. Dr Lawler explained that the first drugs screen is qualitative only, in that it reveals the presence of a drug. If further quantitative testing is necessary, this can take a considerable time and is expensive.

10.61 Professor Whitwell, who works alongside a medical professor of toxicology, pointed out that the interpretation of post-mortem toxicology can be extremely complex. In some laboratories, with no medical input, the interpretation of testing may be inaccurate. In the long term, she would like to see toxicology departments, with medical expertise, available

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at the regional centres of excellence previously referred to. In the shorter term, regional centres could deal with the more straightforward cases (e.g. many of those involving alcohol) and could refer the more complex cases to the specialist toxicological centres, such as the one at Sheffield.

10.62 Dr Start said that, at present, routine screening by the University of Sheffield Department in suicide and road traffic accident cases costs, on average, about £225 per case. Coroners were understandably reluctant to incur this level of cost in all but those cases where it was obviously necessary to do so. As a result, toxicology is not carried out in some cases where the pathologist might feel it to be justified.

10.63 Professor Whitwell pointed out that the cost of £225 would include both quantitative and qualitative screening. Her understanding is that urine, which is available in the majority of cases, can be screened for the presence (as opposed to the quantity) of alcohol and drugs much more cheaply than this figure, and within a short time. Her view was that the aim should be to use screening toxicology in virtually every autopsy. Professor Kevin Park, Professor of Pharmacology at the University of Liverpool, said that, with greater throughput and the technological advances that are likely to be made, he would expect the cost of toxicology to reduce in the future. For the DoH, Dr Barnes pointed out that, as well as improved technology, there was a need to train and recruit skilled technical and scientific staff to produce analytical data and to interpret that data.

10.64 Dr Lawler drew attention to the fact that, in some cases, a urine screen may be negative, but sampling of the blood may show the presence of a lethal substance. He gave the example of a case in which he had been involved recently, where there was a fatal level of morphine present in the blood which, because the individual had died rapidly after administration of the drug, was not present in the urine. He pointed out that this had particular significance in the context of Shipman's mode of killing.

10.65 Professor Underwood, for the RCPath, agreed with a suggestion that there should be a protocol governing toxicological investigations which should deal with matters such as identifying the drugs to be tested for, the samples which should be taken, how long after death the samples should be taken and from where in the body.

Challenge to the Decision to Hold or Not to Hold an Autopsy

10.66 If homicide is suspected, it is plain that the public interest in holding an autopsy would outweigh any individual view as to whether the autopsy should be held. In all other cases however, there was general support for a right to challenge the decision to be given to properly interested parties, provided that the challenge could be mounted and resolved speedily. For the Retained Organs Commission, Professor Brazier supported the right to challenge a decision to hold an autopsy. She emphasised the need for the challenge to be dealt with swiftly. She also observed that the right should be real, in that the family should fully understand the processes involved and be able to make their challenge effectively and with appropriate support. She herself was concerned that a right to legal representation might draw out the appeal process and would create funding issues. However, some members of the Commission are, she reported, concerned that, without

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legal representation, the right of challenge for many people could not be exercised effectively. Professor Brazier also considered that there should be a right for families to request an autopsy in a case where the coroner did not regard one as necessary. However, the family would have to advance a valid argument in order to justify the use of resources in their particular case.

10.67 For the RCPath, Professor Underwood observed that an American colleague of his refers to autopsies as 'information therapy', meaning that the family can derive benefit, comfort and satisfaction from knowing the reason for their loss. He suggested that it should be a part of the NHS bereavement service that relatives should have the opportunity of a publicly funded autopsy. This would be another facet of the principle previously discussed that the NHS should assume responsibility for a patient until the time of disposal of his/her body.

Conclusions

10.68 It is clear that, at present, there are serious deficiencies with some coroners' autopsies. Autopsies are conducted in circumstances where they are unnecessary. Insufficient thought is given to whether the result of medical investigations carried out in life provide an adequate diagnosis of the cause of the death. Often, pathologists are supplied with information that is wholly insufficient to enable them to place their findings in context. Sometimes, they are prevented from seeing the medical records or from conferring with their clinical colleagues. As in other respects, the approach of coroners varies widely from district to district, making it difficult for a pathologist to know what s/he can and cannot do.

10.69 Coroners' autopsies are focussed on a specific purpose. The results are often not disseminated to clinicians. Even if they are, they may not be very helpful for clinical purposes. The potential benefit of the coroner's autopsy to increase medical knowledge is frequently lost. Moreover, families do not derive the benefit from, for example, genetic features ascertainable on autopsy and are often unaware that the opportunity to derive such benefit exists.

10.70 All these problems plainly need addressing. I wholeheartedly support the efforts of the RCPath to do so by way of the Guidelines, which I have mentioned and the minimum standards which they are currently developing.

10.71 Any future coroner service will be dependent on an efficient, high quality autopsy service to support and assist its investigations into deaths. Given the current problems with pathology provision, the recommendation of a unified pathology service seems to me an excellent one. I agree with the RCPath that it should include, not only Home Office registered forensic pathologists, but also those histopathologists who wish to conduct an autopsy practice, whether full-time or part-time. It should also include facilities for histology, toxicology, radiology and other necessary support services. In Chapter Nineteen, I shall set out my recommendations for the future of the service and for the place that it should occupy within the structure of Government.

CHAPTER ELEVEN

Cremation Certification

Introduction

11.1 Despite the many attempts to introduce change, current procedures for obtaining authorisation to cremate a body remain little altered since their introduction in 1903. The procedures are still governed by the 1930 Regulations (as amended).

11.2 The cremation procedures require the use of a number of forms prescribed in the 1930 Regulations. However, no single 'standard' set of forms is produced and distributed by the Home Office or any other central body. Instead, each cremation authority provides its own 'personalised' set of forms. Over the years, some authorities have modified the forms, by adding explanatory notes, changing the layout slightly and, in some cases, adding supplementary questions. There is no requirement that crematoria should submit their forms to the Home Office for approval and, in general, they do not do so.

11.3 Evidence given to the Inquiry suggests that most crematoria have no formal procedure for regular review of their cremation forms. Instead, the staff tend to wait until a new supply of forms is required before introducing any changes. Supplies of forms are held by funeral directors, hospitals and by some general practices. After a new version of the forms is issued by a crematorium, it takes some time for supplies of the old forms to be exhausted. For a time (sometimes years), completed forms of both the old and the new style will continue to be submitted. When a death occurs outside the area usually covered by the crematorium where a deceased is to be cremated, it is not uncommon for the forms submitted to be issued by a different crematorium. In general, that causes no problems. However, difficulties can arise where the requirements imposed by the forms issued by the two crematoria differ. An example of this is when the crematorium where the cremation is to be held has a requirement that one of questions 5–8 of cremation Form C should be answered in the affirmative, whereas the crematorium from which the forms originate does not.

11.4 Specimen cremation forms can be seen at Appendix D to this Report. Those included in the Appendix are the forms used at the Dukinfield crematorium, where most of Shipman's patients were cremated.

The Application for Cremation: Form A

11.5 The Application for Cremation (Form A) is usually completed by the deceased's closest relative or his/her executor. Included on the form are questions about the date, time and place of the deceased's death. The applicant is required to state whether s/he knows of any reason to suspect that the death of the deceased was due, directly or indirectly, to violence, poison, privation or neglect. The applicant is also asked whether s/he knows of any reason whatever for supposing that an examination of the remains of the deceased may be desirable. Those two questions are invariably answered in the negative; if the facts were such as to lead to either question being answered in the affirmative, the death is likely to have been reported to the coroner. The applicant is asked to state the name and

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address of the ordinary medical attendant of the deceased and the names and addresses of the medical practitioners who attended the deceased during his/her last illness.

11.6 The form must be countersigned by a person who knows the applicant and is prepared to certify that s/he has no reason to doubt the truth of any of the information furnished by the applicant. In practice, Form A is frequently completed by the funeral director making the cremation arrangements (after obtaining the necessary information from the applicant) and the applicant merely signs the form. It is usual for a representative of the funeral director to countersign the form.

The Certificate of Medical Attendant: Form B

11.7 The Certificate of Medical Attendant (Form B) must be completed by a medical practitioner who has attended the deceased before death and has seen and identified the deceased's body after death. This form asks a number of questions about the circumstances and cause of the death and about the certifying doctor's involvement with the deceased before death. Form B is usually completed by the same doctor who has issued the MCCD. If an early decision has been made by the relatives to have a cremation, Form B may be completed at the same time as the MCCD. More often, however, it is completed slightly later, sometimes after registration of the death has taken place. The doctor completing Form B receives a fee, currently recommended at £45.50. This fee is recommended by the British Medical Association (BMA) and is usually increased annually.

11.8 Included on Form B are questions about the date, time and place of the deceased's death. The certifying doctor is asked if s/he is a relative of the deceased and, if so, to state the relationship. The doctor is also asked whether s/he has any pecuniary interest in the death of the deceased. Neither the form nor the Regulations make clear what the effect of such relationship or pecuniary interest may be; in particular, there is no indication that the existence of either disqualifies a doctor from certifying. In practice, however, rarely – if ever – is either of these two questions answered in the affirmative.

11.9 The certifying doctor is asked (at question 5) if s/he was the ordinary medical attendant of the deceased and, if so, for how long. The term **'ordinary medical attendant'** can cause some difficulty when the deceased has been in hospital for only a short time prior to death. The question then arises as to whether a doctor who treated the deceased in hospital can properly be described as his/her **'ordinary medical attendant'** or whether the deceased's general practitioner (who may know little of his/her last days) is the appropriate person to certify. There appears to be no consistency of approach. However, the next question (question 6) is more important. That asks whether the certifying doctor attended the deceased during the last illness and, if so, for how long. The words **'attended'** and **'last illness'** are not defined within the cremation legislation. Nor, as I have pointed out in Chapter Five, are those terms defined in the legislation governing certification of the medical cause of death.

11.10 Question 7 requires the certifying doctor to say when (by reference to hours and days before death) s/he last saw the deceased alive. Question 8(a) asks how soon after death

the doctor saw the body and, on the Dukinfield crematorium Form B, there is a reminder that the certifying doctor must see the body after death. This is in contrast to the MCCD, where there is no legal requirement that the certifying doctor should have seen the body after death.

11.11 The Form B doctor is then asked (by question 8(b)) what examination of the body s/he has made. In Shipman's case, the reply was almost always that he had made a 'complete external examination'; other doctors use similar descriptions, some indicating that they have examined for signs of life. Form B does not require the doctor completing it to state what findings were made on examination (or, indeed, precisely what examination was carried out) and this is virtually never stated.

11.12 As I have said in Chapter Three, question 8A was introduced by the Cremation (Amendment) Regulations 1985 and asks:

> **'If the deceased died in a hospital at which he was an in-patient, has a post-mortem examination been made by a registered medical practitioner of not less than five years' standing who is neither a relative of the deceased nor a relative or partner of yours and are the results of that examination known to you?'**

11.13 The purpose of this question was to dispense with the need for Form C to be completed if the Form B doctor was aware of the results of an autopsy and had used that knowledge to inform his/her diagnosis of the cause of death. The post-mortem examination referred to is a 'consent' or 'hospital' examination, rather than an autopsy directed by a coroner.

11.14 In practice, Form B doctors rarely answer question 8A in the affirmative. Even when they do, it is not unusual for Form C also to be completed, despite the fact that it is not required. As has frequently been pointed out since its introduction, question 8A is unsatisfactory in a number of respects. The Form B doctor is not required to identify the practitioner who performed the autopsy; thus, it is not possible for the medical referee to check that the practitioner has the necessary five years' registration. It is not uncommon for trainees to carry out hospital autopsies, in which case a Form C (usually completed by the supervising pathologist) is still required. Also, question 8A contains a number of constituent parts and a negative answer can be ambiguous. For example, it is not possible to determine, if the question is answered in the negative, whether there has been no post-mortem or whether there has been a post-mortem, but the results of it are not known to the Form B doctor. Some crematoria (e.g. Newcastle-upon-Tyne) have sought to solve this difficulty by splitting question 8A into two separate questions.

11.15 Question 9 requires the certifying doctor to state the cause of death in essentially the same way as on the MCCD. Question 10 asks about the mode and duration of death. Examples of possible modes (syncope, coma, exhaustion and convulsions) are given on the form. This question has been much criticised. The medical referees who gave evidence to the Inquiry were uncertain as to the value of the question. It may originally have been intended to seek information about the surrounding circumstances of the death. Instead, it tends to provoke a one-word response, chosen from the terms listed in the question. If such a response is inserted by a doctor who was not present at the death and is merely

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speculating as to how the death occurred, it can provide no assistance at all. Different doctors apply different terms to describe similar modes of death. If the question required a brief description of how the death occurred, it would be of real value.

11.16 Question 11 asks the certifying doctor to state how far the answers to the last two (in the Dukinfield crematorium version, the word **'two'** is emphasised by underlining) questions are the result of his/her own observations or are based on statements made by others. The reference to **'the last two questions'** is ambiguous. It could refer either to parts (a) and (b) of question 10 (i.e. (a) the mode and (b) the duration of death) or it could apply to questions 9 (cause of death) and 10 (mode and duration of death). Some crematoria have tried to remove the ambiguity by including an explanatory note, or additional words, on their forms. The Form B issued by Newcastle-upon-Tyne crematorium specifies that question 11 refers to the answers given in question 10. The Form B issued by Stockport crematorium contains a note which begins: **'State how far the answers to the last two questions 9 and 10 are the result ...'**. The difference can be significant. One medical referee who gave evidence to the Inquiry understood question 11 to refer to both questions 9 and 10. (This was despite the fact that a marginal note on the Form B issued by the crematorium at which he officiated stated that the Home Office had advised that question 11 referred to question 10(a) and (b).) In response to question 9, the Form B doctor states his/her views about the cause of death. Therefore, the medical referee took the view that it was essential, if the Form B was to be accepted, that the doctor should record in response to question 11 that s/he had made the relevant observation. That would indicate that s/he was relying on his/her own observations in order to assess the cause of death. If the certifying doctor inserted in response to question 11 the name of a relative of the deceased, or a nurse or carer, the form would not, in his view, be acceptable. The same witness acknowledged that, if question 11 referred only to the two parts of question 10 (relating to mode and duration of death), it would be perfectly permissible for the certifying doctor to record only the names of those people who had observed the deceased during the process of death. In summary, it is clear that there is no consistency of approach to this question.

11.17 Question 12 asks if the deceased underwent any operation during his/her final illness or within the year before death and, if so, seeks information about the nature of the operation and the identity of the person who performed it. The purpose behind this question is to ascertain whether the deceased has undergone any surgical procedure that might have caused or contributed to his/her death.

11.18 Question 13 asks for information about those who nursed the deceased during his/her last illness. Some doctors take this to mean only professional nursing care; others understand it to include care provided by relatives. One purpose of this question is to provide the Form C doctor with the names of persons whom s/he may wish to question in connection with the completion of Form C. However, no address, telephone number or other contact details are sought. Question 14 was designed for the same purpose and asks who were the persons (if any) present at the moment of death. Here also, there is no requirement to give the contact details of such persons. Presence **'at the moment of death'** might seem unequivocally to suggest that the person(s) identified should have been in the presence of the deceased when s/he drew his/her last breath. However, some doctors interpret the

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phrase differently. Dr Ian Morgan, a general practitioner and crematorium medical referee, told the Inquiry that he would regard a wife as having been present at the moment of her husband's death if she had left him alive at night, gone to sleep in the next door room and found him dead the next morning.

11.19 In questions 15, 16 and 17, the certifying doctor is asked whether s/he feels any doubt whatever as to the character of the disease or the cause of death, or has any reason to suspect that the death was due, directly or indirectly, to violence, poison, privation or neglect. The doctor is also asked whether s/he has any reason whatever to suppose a further examination of the body to be desirable. As on Form A, those questions are invariably answered in the negative. If the certifying doctor had any concerns, the death would no doubt have been reported to the coroner. At the Dukinfield crematorium, a note has been added opposite question 16. The note reads, **'Death due directly or indirectly to alcohol has now to be reported to the Coroner'**. This is a 'local rule', presumably indicating that the Coroner classifies such deaths as 'unnatural'.

11.20 Question 18 asks if the Form B doctor has also issued the MCCD and, if not, who has. In most cases, this question will be answered in the affirmative. However, one might have a situation where the attending doctor is away at the time of death, a colleague is qualified to issue the MCCD and the attending doctor arrives back in time to complete the Form B; this would be perfectly permissible. There are other circumstances when such a situation might legitimately arise.

11.21 The Form B issued by the Dukinfield crematorium has an additional question, question 19, which is not on the form prescribed by the Regulations. This asks if the coroner has been notified of the death and, if s/he has, requests full details. Some of the forms issued by other crematoria contain an instruction to the certifying doctor to provide this information but do not ask a specific question. An example will serve to illustrate the purpose of the question. If a deceased person has undergone a recent operation, that fact may raise a question as to whether the operation played any part in the death. The attending doctor will contact the coroner's office and may be given 'permission' to certify the death. He or she should then record the fact of his/her contact with the coroner's office and the outcome in response to question 19 of Form B. The effect of that will usually be that the medical referee will not investigate further the possibility that the operation had a bearing on the death. Were it not for the information given in response to question 19, s/he might feel constrained to do so. A belief that the coroner (in fact, in most cases, the coroner's officer) has been informed will usually be sufficient to satisfy the medical referee, who will accept the doctor's word.

11.22 At the conclusion of Form B, the doctor is required to certify:

> **'... that the answers given above are true and accurate to the best of my knowledge and belief, and that I know of no reasonable cause to suspect that the deceased died either a violent or an unnatural death or a sudden death of which the cause is unknown or died in such place or circumstances as to require an inquest in pursuance of any Act'**.

11.23 The versions of Forms B, C and F produced by certain crematoria (of which Dukinfield is one) state that the forms are regarded as strictly confidential, the right to inspect them

being confined to **'the Secretary of State, the Ministry** [*sic*] **of Health and the Chief Officer of a Police Force'**. This reference to confidentiality does not appear on the forms issued by all crematoria. However, the forms are generally treated as confidential. Form B is never shown to the deceased's relatives, who thus have no opportunity of confirming the accuracy or otherwise of the details contained in it. Many relatives of Shipman's former patients saw the cremation forms (apart from Form A) for the first time when they were shown them by a member of the Inquiry legal team.

11.24 It is not unusual for Form B to be delivered to the crematorium with some questions unanswered. In areas where the cremation forms contain a warning about confidentiality, many funeral directors take the view that they are precluded from checking the forms before delivery to ensure that they are complete. Consequently, it is left to staff at the crematorium – sometimes the medical referee – to chase up missing information. As with MCCDs, Forms B are frequently completed by inexperienced junior hospital doctors and this can give rise to particular problems with defective forms. However, evidence received by the Inquiry suggests that most doctors complete the forms carefully and accurately.

11.25 Although a completed Form B provides much more information than a completed MCCD, it is still of limited usefulness for the purpose of the investigation of the cause and circumstances of the death by another doctor or by the medical referee. It would also be of limited usefulness if seen by the coroner (which it is not). It does not require what I regard as the two essentials for the investigation of any death, namely a brief medical history and an account of the circumstances of the death.

The Confirmatory Medical Certificate: Form C

The Choice of Doctor to Complete Form C

11.26 Despite conflicting views about its value, completion of the Confirmatory Medical Certificate (Form C) remains a requirement for all cremations where the coroner has not issued Form E following a post-mortem examination and/or the opening of an inquest. The doctor completing Form C receives a fee set at the same level (currently £45.50) as for Form B.

11.27 In order to be able to give a Form C, the certifying doctor must have been registered in this country for not less than five years. There has been ongoing controversy over the precise meaning of this requirement. The Regulations drafted in 1989 would have included within the five-year period any period of provisional or limited registration, provided that full registration had been achieved at the time the Form C was completed.

11.28 The Form C doctor must also be independent, to the extent that s/he must not be a relative of the deceased or a relative or partner of the Form B doctor. The word 'partner' is inappropriate to the completion of Form C in a hospital setting. Indeed, it may be inappropriate in some general practices, where no partnership exists. In the early 1980s, an official from the Home Office wrote to medical referees, explaining the Department's view that the Form C doctor should be **'demonstrably independent'** of the Form B doctor. The Home Secretary was said to take the view that, in the case of a death occurring in

hospital, the Form C doctor should not have been in charge of the patient or directly concerned in his/her treatment. The letter indicated that the **'spirit of the Regulations'** would usually prohibit two doctors from the same firm (i.e. the hospital team responsible for the care of the patient) from completing Forms B and C in the same case. The Forms C issued by some crematoria contain notes at the head of the form, reflecting this view. No such note appears on the version of the Form C issued by the Dukinfield crematorium.

11.29 In practice, following a death in hospital, Form C is frequently completed by a pathologist, even where there has been no autopsy. Examination of the Dukinfield cremation register revealed that the same doctors employed at the Tameside General Hospital appeared time and time again as signatories of Forms C for deaths at the hospital. It appears that many hospitals have a small pool of doctors who complete Forms C on a rota system. The fees consequent upon membership of the pool can, it would appear, be quite significant. The Form C doctor must state the office (on the Dukinfield crematorium form, the word 'appointment' is used) that s/he holds.

11.30 When a death occurs in the community, it is usually the attending (Form B) doctor who chooses which of his/her colleagues should complete the Form C. Occasionally, the choice will lie with the funeral director. This might happen if the body is lying at a funeral director's premises some distance from the attending doctor's surgery and from his/her local colleagues. In those circumstances, it may be more convenient for the funeral director to select a Form C doctor who practises nearby and can attend to view the body without inconvenience.

11.31 Where the Form B doctor is responsible for the choice, it is often one of convenience. It is often the case that two doctors, or two general practices, operate a reciprocal arrangement whereby each signs the other's Forms C. Sometimes, the arrangement is more complex. Shipman, for example, used members of the Brooke Practice to sign virtually all his Forms C, save where it would have been geographically inconvenient for them to do so. Three members of the Brooke Practice reciprocated by asking Shipman to sign their Forms C; the other two members went elsewhere. The relationship between the Form B and Form C doctors is often a close one, sometimes social as well as professional. Such a relationship does not encourage the Form C doctor to approach the task of assessing the evidence about cause of death with a critical eye. Instead, s/he is likely to embark upon his/her assessment with a degree of confidence that all will be well. Indeed, even if s/he were tempted to probe (e.g. by inspecting the medical records), s/he is likely to be discouraged from doing so for fear of appearing to question the judgement (or even the honesty) of a friend and/or colleague. Furthermore, the doctor who undertakes a minute examination of the medical history before completing Form C may well find that, in the future, the task of completing Form C goes to one of his/her less conscientious colleagues.

11.32 Evidence heard by the Inquiry suggests that, although doctors are aware of and comply with the requirement that the Form C doctor should be independent of the Form B doctor, most doctors have not thought about the reasons for it and have not appreciated the need for true independence of mind. It appears that the requirement for independence is regarded by most as a technical matter.

11.33 As I have already explained in Chapter Three, the original concept of the Form C doctor was of a practitioner holding a prestigious public appointment that would have set him/her apart from the doctor who had completed Form B. Such a practitioner would – or should – have had the necessary detachment, authority and confidence to express disagreement with the Form B doctor, had s/he thought it right to do so. The position of such a practitioner would have been very different from that of a doctor in the community performing the same function today.

The Personal Inquiry

11.34 Before completing Form C, the doctor should examine Form B and make a **'personal inquiry'** into the death. The nature of that **'personal inquiry'** is identified in the series of questions posed in Form C. I have already set out (at paragraph 3.25) the eight questions that appear in Form C, as prescribed in the 1930 Regulations. I shall now consider these questions, and the way in which doctors answer them, in greater detail.

Questions 1–4

11.35 The first question asks whether the doctor completing Form C has seen the body of the deceased. The evidence received by the Inquiry suggests that, in the community setting, the Form C doctor always attends at the premises of the funeral director to view the body and complete Form C. Payment of the fee for completing the form is often made at the time of this visit.

11.36 The second question asks whether the Form C doctor has **'carefully examined the body externally'**. Although that question is invariably answered in the affirmative, it is evident that the nature and extent of the examination undertaken varies widely. Often, conditions at the funeral director's premises are not conducive to a full and careful examination. At one of the Inquiry's seminars, Dr John Grenville, a general practitioner, gave a graphic account of the conditions that had prevailed at the premises of a busy funeral director when he had attended there the previous day. Those conditions would have made a thorough examination of the naked body difficult, if not impossible. Sometimes, the body to be examined is already dressed and in a coffin and there is a reluctance on the part of the funeral director to remove and strip it. According to the funeral directors who provided evidence to the Inquiry, the extent of the examination varies from doctor to doctor. Some carry out a thorough examination of the front and back of the body. At the other extreme, some confine their examination merely to checking the identifying tag or bracelet and viewing the face. The rest fall somewhere in between. The variations in practice described by the funeral directors were confirmed by the evidence of doctors accustomed to completing Forms C.

11.37 Even if carried out conscientiously, a physical examination will not, in the majority of cases, assist in diagnosing the cause of death. Signs of emaciation may tend to confirm a diagnosis of death caused by terminal cancer. Yellowing of the skin may indicate liver disease. Surgical scars may confirm a history of recent illness requiring operative treatment. But an examination will not shed any light on whether a person died of a coronary thrombosis, a cerebrovascular accident or as a result of any one of a number of

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other natural causes. It would not have led to a correct diagnosis of the cause of death of one of Shipman's victims. It may well be that it is because they realise that an examination is unlikely to yield any useful information that many doctors regard it as a mere formality which can safely be dispensed with.

11.38 A thorough physical examination, made in appropriate conditions, could be expected to reveal signs of violence such as wounds, bruising and (possibly) petechiae (the tiny haemorrhages which are often observed after a death from suffocation or strangulation) or signs of possible neglect, such as pressure sores and malnutrition. There is no way of knowing how frequently such signs have gone unnoticed in the past because no proper physical examination has taken place. However, the examination by the Form C doctor is not the only opportunity to observe signs of violence or neglect. In many (if not most) cases, the funeral director will see the body unclothed in the course of preparation for burial or cremation. He or she is in a good position to notice any abnormal signs and the Inquiry was told that it is not unusual for a funeral director to refer a death to the coroner if abnormal signs are observed. Some of the doctors who gave evidence suggested that a representative of the funeral director would usually be present when they attended to view the body and they would expect that person to mention any unusual signs that had been noticed.

11.39 The third question on Form C asks whether the certifying doctor has made a post-mortem examination. Unless the doctor is a pathologist who has undertaken a hospital post-mortem, this will rarely be answered in the affirmative. The Inquiry is aware of one general practitioner in Hyde who regularly gave an affirmative answer to this question, on the basis that an external examination made after death was, strictly speaking, 'a post-mortem examination'. He was, however, the exception. Where a hospital post-mortem has been carried out and the result is known to the Form B doctor, this should of course be indicated in response to question 8A of Form B and no Form C is then necessary. Fewer hospital post-mortems have been carried out in recent years and they are, in any event, rare where a patient dies in the community.

11.40 Question 4 of Form C asks whether the certifying doctor has seen and questioned the Form B doctor. For practical reasons, such conversations frequently take place on the telephone and doctors answer the question in the affirmative even when they have not met the Form B doctor face to face. Forms B and C are delivered to, or collected by, the Form C doctor, who takes them (in fact, they are often joined in a single document in booklet form) to the funeral director's premises. Alternatively, the forms may be left with the funeral director for the Form C doctor to view when s/he attends.

11.41 The evidence received by the Inquiry suggests that some discussion between the certifying doctors invariably takes place. Most Form B doctors know the type of explanation of the clinical history which is expected of them and provide the necessary information.

11.42 It is clear from the evidence available to the Inquiry that it is not usual practice for a doctor completing Form C to inspect the deceased's medical records before giving the certificate. Dr Ian Morgan, Medical Referee at the Robin Hood crematorium, Solihull, told the Inquiry that to request to see another practitioner's medical records in a general

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practice setting would imply a degree of suspicion. It would not be seen as a neutral enquiry. He contrasted that with the position at the hospice where he is Medical Director. There, the records are left out, as a matter of course, for the Form C doctor to examine. In my view, this is good practice.

11.43 There is no statutory requirement that any of the questions contained in Form C must be answered in the affirmative if a cremation is to be authorised. The Regulations drafted in 1989 would have introduced such a provision in relation to questions 1, 2 and 4; those Regulations never became law. However, as I have already said, the version of Form C issued by every crematorium in the country (so far as the Inquiry is aware) contains a note to that effect.

11.44 Affirmative answers to questions 1, 2 and 4 usually indicate that the doctor has seen the deceased's body and examined it to a greater or lesser extent. That examination may have provided confirmatory evidence of the diagnosis of cause of death (e.g. in the terminal cancer case). More likely, the examination will have been too superficial to reveal anything of significance, or the cause of death will be one that would not give rise to evidence, even on a thorough physical examination. Thus, the examination will have provided no independent evidence upon which the Form C doctor can rely. The Form C doctor will also have heard the account of the clinical history and the reasons for the diagnosis of cause of death, as propounded by the Form B doctor. That account will not have been confirmed by inspection of the medical records.

11.45 The pathologist who has given an affirmative answer to question 3 will, of course, be in a completely different position. He or she will have undertaken an autopsy and will have had the opportunity of comparing the findings of that examination with the clinical history given by the Form B doctor.

Questions 5–8

11.46 Questions 5–8 of Form C ask whether the certifying doctor has seen and questioned:

- any other medical practitioner who attended the deceased
- any person who nursed the deceased during his/her last illness
- any person who was present at the death
- any of the deceased's relatives
- any other person.

The doctor is also asked to give names and addresses and is asked whether s/he has seen the person(s) alone.

11.47 The obtaining of evidence from a source separate and independent from the Form B doctor was an important element of the system described in the 1903 Departmental Committee Report. It constituted the only effective check on the Form B doctor. It seems, however, that the significance of this evidence, and therefore the importance of questions 5–8, was rapidly forgotten, certainly after the relaxation of the rules (as a result of the 1930 Regulations) governing those qualified to complete Form C. Even in 1935 (see

paragraphs 3.24 to 3.29), it was reported that some Form C doctors invariably failed to question anyone except the Form B doctor; indeed, it was claimed that some did not even do that. The Home Secretary's letter of that year, which emphasised the need for affirmative answers to questions 1, 2 and 4, made no mention of questions 5–8.

11.48 From time to time over subsequent years, as I have explained in Chapter Three, various individuals and organisations drew attention to the fact that the investigations referred to in questions 5–8 afforded the Form C doctor an important opportunity to obtain evidence from an independent source and therefore provided an essential safeguard. In 1960, Dr John Havard, then Assistant Secretary of the BMA, claimed on behalf of the Association that potential criminals were deterred by the knowledge that an independent doctor questioned relatives, nurses and other persons in every case. In reality, even at the time Dr Havard made that claim, it is evident that many members of the BMA were carrying out no such questioning.

11.49 Despite these references, attention was more generally directed at the reported failure of doctors to carry out even the investigations required in order to answer questions 1, 2 and 4 affirmatively and at ways (e.g. by means of the draft Regulations circulated in 1962) in which they might be compelled to carry out their duties (i.e. to see and carefully examine the body and to question the Form B doctor) properly.

11.50 The Brodrick Committee, which reported in 1971, also recognised the potential importance of the questioning of persons other than the Form B doctor. The Committee found that many Form C doctors were not taking the opportunity to carry out their own investigations. This fact, coupled with evidence that the physical examination carried out was frequently inadequate or non-existent, led the Committee to the conclusion that Form C was valueless and should be abolished as soon as possible. The Committee does not appear to have considered the imposition of a requirement that independent investigations should be made in every case. It may be that members of the Committee did not believe that, even with such a requirement, effective investigations would be made. In any event, their view must have been coloured by the fact that they did not accept that there was a real risk of cremation being used to conceal evidence of homicide.

11.51 In July 2002, the Inquiry received a letter from Dr Derek North, a general practitioner from Gosport, Hampshire. He enclosed a copy of the Form C used at the Portchester crematorium, which serves his local area. He pointed out the note on that form which reads as follows:

> **'The Medical Referee requires that at least one of the questions No. 5–8 should be answered in the affirmative.'**

11.52 Dr North had visited the Inquiry website and noticed that the cremation forms from the Dukinfield crematorium that appeared there did not bear a similar note. In his letter, he commented as follows:

> **'This simple requirement on the crem**[*ation*] **form I am sure would have made it much harder for Harold Shipman to commit his murders. I and my partners have never signed a form C without having answered at least one of those questions in the affirmative. I have been a GP for 20**

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> **years and I have always ensured that I could answer one of the questions in the affirmative. I was quite amazed to see that as recently as 1997 that** [*sic*] **Doctors filling in form C were answering No to all of those questions**'.

11.53 The Inquiry had previously been aware that some of the doctors practising in Todmorden in the 1970s had, before completing Form C, questioned relatives of the deceased in most cases. This had become evident when examining the cremation forms completed by Shipman during his time at Todmorden. Cremation forms dating from his time in Hyde revealed very few instances of a Form C doctor questioning anyone other than Shipman. The Inquiry team assumed that the practice of questioning persons other than the Form B doctor had lapsed with time.

11.54 Once Dr North's communication had been received, further enquiries were made. They revealed a number of other crematoria with a similar requirement to that imposed by the Portchester crematorium. Enquiries of those crematoria have shown that, in some cases, a marginal note setting out the requirement has appeared on their Forms C for as long as anyone can remember. However, the Halton Medical Referee, Dr David Robertson, was responsible for its introduction at the Warrington crematorium, and (with a colleague) at the Widnes crematorium, in the 1990s. He gave his reasons for the change as:

> **'... dissatisfaction on my part with the standard of information being provided and the level to which many forms failed in my view to accurately confirm the facts on Form B. There was no third party corroboration and the only dialogue reported was that between the two doctors. Potentially scope was present for abuse and collusion.'**

11.55 The Darlington Medical Referee, Dr Louis Rosin, introduced a similar requirement in about 1970, for similar reasons. Conversely, the Medical Referee at the Carlisle crematorium, Dr Peter Tiplady, removed the requirement recently, after objections from doctors from neighbouring areas who were not accustomed to it.

11.56 Enquiries have been made of those employed at the crematoria concerned, as well as of the Home Office and the Cremation Society of Great Britain, in order to discover whether any advice or guidance was issued which may have prompted the decision by some crematoria to impose the requirement of an affirmative answer to one of questions 5–8. No evidence of any such advice or guidance has been found although the similarity of the wording on the forms issued by different crematoria strongly suggests a common source. It seems that officials currently employed in the relevant section of the Home Office were unaware that any crematoria imposed this requirement until informed by the Inquiry.

11.57 Investigations by the Inquiry suggest that, where a local requirement to answer one of questions 5–8 in the alternative is imposed, it is complied with in all but a few cases; those few cases may well relate to deaths occurring in neighbouring areas where no such requirement exists. Often, a medical referee will not enforce the requirement where a doctor has completed a Form C issued by a different crematorium in good faith. Such a doctor may not realise that there is a local requirement at the crematorium where the cremation is to take place. Where no local requirement is in force, questions 5–8 are

answered in the negative in most cases. Crematoria in one area have had a requirement since about 1996 that one of the questions 6–8 should wherever possible **'contain details of an enquiry sufficient to help satisfy the Medical Referee that sufficient enquiry has been made'**. The Medical Referee has told the Inquiry that general practitioners usually provide satisfactory information, but hospital doctors invariably fail to comply.

11.58 Where the crematorium requires the Form C doctor to question someone other than the Form B doctor, a significant proportion of Form C doctors question relatives, as opposed to the other categories of person named on the form. This is no doubt because, if a deceased person has not been in hospital and has not received nursing care from persons other than family, there will be no one else available with knowledge of the death. If the death occurs in a nursing home or similar setting, questions may be asked of the staff.

11.59 The Inquiry obtained evidence from a number of doctors who practise in areas where the local crematorium requires an affirmative answer to one of questions 5–8. They were asked about their experience of speaking to relatives. It had previously been suggested to the Inquiry that it was impracticable to question relatives because it would cause undue distress. In general, the experience of the doctors who provided evidence was that, so long as relatives are informed in advance that another doctor would be contacting them, and so long as they fully understand the purpose of the contact, they are happy to assist. In practice, the Form B doctor usually informs relatives that another doctor will be in touch with them. The doctors did not report any difficulty with speaking to relatives, nor any signs of hostility, resentment or distress at the approach. Many of them saw the contact as offering a valuable opportunity for relatives to voice any concerns or doubts that they might have about the death.

11.60 In Scotland, the Form C prescribed by the Cremation (Scotland) Regulations 1935 requires the form to be completed by a doctor who has seen and examined the deceased's body and spoken to the Form B doctor. In other words, the equivalent of an affirmative answer to questions 1, 2 and 4 of the Form C prescribed for England and Wales is a prerequisite to completing the Scottish form. The questions which the Form C doctor has to answer relate only to whether s/he has performed a post-mortem examination (question 1) and whether s/he has questioned a third person, other than the Form B doctor (questions 2–5). There is no statutory requirement that any of the questions on the form should be answered in the affirmative. However, marginal notes indicating a requirement for one (sometimes two) affirmative answer(s) appear on the Forms C used by many Scottish crematoria. The importance of the requirement for at least one of the questions to be answered in the affirmative was emphasised in a letter sent by the Scottish Office Home and Health Department to all medical referees and deputy medical referees in Scotland in September 1995.

11.61 The Dukinfield crematorium imposes no local requirement for affirmative answers to any of questions 5–8 and it is the local practice for questions 1, 2 and 4 only to be answered in the affirmative. It is clear from the Inquiry's investigations that the practice at Dukinfield is typical of that prevailing in the majority of crematoria throughout England and Wales.

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Prevalent Attitudes to Form C

11.62 Evidence heard by the Inquiry suggests that many doctors regard the completion of Form C as a technical requirement only. Just as they have never thought about why it is necessary for the Form C doctor to be independent of the Form B doctor, they have never thought about what Form C is designed to achieve. They do not see themselves as carrying out an independent investigation of the cause and circumstances of the death. A common perception, among doctors who I am sure are in other respects entirely conscientious, is that they must listen to the history and decide whether the Form B doctor's conclusion as to the cause of death is a reasonable one. If they know the doctor to be inexperienced, they might approach the task with some expectation that s/he might be wrong. However, if they know the doctor and believe him/her to be competent, the strong expectation will be that the Form B doctor will be right. The doctors who gave oral evidence to the Inquiry admitted, when pressed about the matter, that they had never previously thought that they were in any way 'policing' their colleagues. Most had never thought that they were supposed to consider whether their colleagues might have concealed wrongdoing of any kind, whether deliberate or through lack of care. This lack of understanding of the purpose of Form C and the doctors' function in completing it is not altogether surprising since it appears that doctors do not receive any formal education or guidance about the purpose or completion of Form C. However, it is disappointing that they do not have a greater understanding. The BMA has been stressing the importance of Form C in representations made on behalf of its members to Government Departments and independent committees of enquiry for over 50 years.

11.63 The Inquiry heard evidence about the degree of care and attention that Form C doctors apply to their task. It appears that it is quite common for the Form C doctor to rely almost completely on the oral account given by the Form B doctor and not to scrutinise what has been written on Form B in any detail. This seems to come about in part because, quite often, the Form C doctor does not see either Form B or Form C until s/he reaches the premises of the funeral director where s/he is to view the body. By that time, s/he will have heard the oral account and will have made up his/her mind that the death was natural and that the cause of death was as explained by the Form B doctor. What the doctor has put on Form B does not, by then, appear important. When Shipman's forms were examined, it was found that the Form C doctor had often failed to notice that Form B contained internal inconsistencies that would have been obvious on careful examination.

11.64 It appeared from the evidence that many, although not all, Form C doctors regard the physical examination of the body as a mere formality, no more than a hoop to be jumped through before signing the form. As I have explained, this attitude is to some extent understandable, as examination of the body is unlikely to provide much information relevant to the cause of death. However, it might provide evidence of injury, ill treatment or lack of care. Once again, it is disappointing that doctors appear to have so little understanding of what they should be looking for or why, particularly given that their representative body has in the past laid such stress on the importance of the Form C procedure.

Attitudes to Questions 5–8

11.65 As I have said, some crematoria require that one of questions 5–8 should be answered in the affirmative. Where this is so, the Form C doctor must question someone with knowledge of the death who is independent of the Form B doctor. In areas where the provision of an affirmative answer to one of questions 5–8 is not compulsory, it is unusual (although not unheard of) for a Form C doctor to make any enquiry of a person independent of the Form B doctor. Some doctors say that they would question a relative or carer if they had any doubts about the cause of death but that this rarely, if ever, occurs. Others say that they never do it, as questioning would be intrusive and would cause additional distress to relatives. However, the evidence of those who practise in areas where such enquiries are made suggests, as I have already said, that relatives do not find such questions intrusive or distressing. Of course, much will depend on the sensitivity of the questioner. However, it appears that, if the bereaved family knows that a doctor will contact them to ask questions about the death and that this is normal procedure, no offence is caused.

Could Questions 5–8 Provide a Useful Safeguard?

11.66 As I have said, the Dukinfield crematorium was not one of those where a positive answer was required to one of questions 5–8. In the vast majority of cases, the doctors who completed Forms C for Shipman did not question anybody independent of Shipman. They trusted him as a respected colleague. He lied to them; they believed his account of the death and they confirmed his dishonest opinion of the cause of death. The Form C procedure, as operated, served no useful purpose as a deterrent or as a means of detecting Shipman's activities. The question is whether it would have been useful in either respect if there had been a requirement that one of questions 5–8 should be answered in the affirmative.

11.67 During Phase One of the Inquiry, it became apparent that Shipman frequently explained a death to the deceased's family in one way and described the circumstances on Form B in quite a different way. He would often pretend that the death was expected by the family, who had been in attendance. On Form B, he would name or describe a particular person, a relative, carer or warden, who, he said, had been present at the death. If the Form C doctor had been obliged to ask questions of a person independent of Shipman, it is highly likely that s/he would have spoken to that person. In many cases, there would have been a real prospect that the Form C doctor would have discovered that Shipman had not told the truth about a purely factual matter.

11.68 By way of example, in the case of Miss Maureen Ward, whom Shipman was convicted of killing and who lived in sheltered accommodation, Shipman claimed that the warden was present at the death. Had the warden been asked, she would have told the Form C doctor that she most certainly was not present at the death and that Shipman had come to find her to tell her that he had found Miss Ward dead in her flat. She would also have added that she was most surprised about the death because she had seen Miss Ward earlier that day, out and about and apparently quite well. This would have been quite inconsistent with Shipman's claim that Miss Ward had died as the result of carcinomatosis resulting from a secondary tumour in the brain.

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11.69 In the case of Mrs Joyce Woodhead, whom I found that Shipman killed, Shipman stated on Form B that Mrs Woodhead had died as the result of a coronary thrombosis and that her sister had been present at the moment of death. In fact, her sister, Mrs Freda Hibbs, was not present and, had the Form C doctor questioned her, she would have said so and would have added that she had been very surprised to find her sister dead in bed. She might also have added that her sister looked very peaceful. If questioned, she would have said that, so far as she knew, her sister had no previous history of heart disease. The Form C doctor should then have realised that Shipman had not only told a lie on Form B, but also appeared to have certified the cause of death on inadequate grounds.

11.70 Another example is the case of Mrs Eileen Crompton. Shipman killed her by giving her a lethal injection in the presence of Mrs Patricia Heyl, the Deputy Manager of Charnley House, a residential home for the elderly. Shipman stated on Form B that **'the Matron'** was present at the death. Had the Form C doctor spoken to Mrs Heyl, she might have learned the surprising information that, before administering the injection, Shipman had said that he was giving a 'kill or cure' injection. That information should have puzzled and alarmed the Form C doctor.

11.71 Quite apart from the cases in which Shipman told demonstrable lies on Form B, there are a very great number of cases in which a relative, when questioned sympathetically by a Form C doctor, would have confided that s/he was extremely surprised by the suddenness of the death. I think it likely that many would have given an account of the deceased's previous state of health which would have caused the Form C doctor to question Shipman's ability to certify the death. I do not suggest that all the relatives would have expressed their concerns; some were so completely taken in by Shipman's explanation for the death that they would have done no more than repeat it to the Form C doctor. However, I believe there were many who would have confided their surprise and concern if questioned directly. There is a world of difference between giving a relative a direct opportunity to express a concern and merely leaving it to the relative to contact the coroner or the police. Most people would not approach the coroner or the police unless they had strong suspicions or concerns based on specific factors. On the other hand, if given the opportunity, a relative might well express surprise or puzzlement about a death, even in the absence of actual suspicion of wrongdoing.

11.72 I do not suggest that, merely because a Form C doctor discovered that some aspect of Shipman's account was factually inaccurate, or heard an expression of concern from a relative, s/he would immediately suspect wrongdoing. However, if conscientious, s/he could not merely complete Form C. He or she would at least have to speak to Shipman again and ask further questions. He or she might well feel it necessary to refuse to sign Form C and to advise Shipman to report the death to the coroner. If a Form C doctor had had to query cases with Shipman on a regular basis, this should have attracted notice. What would have happened if a Form C doctor had refused to sign the certificate is not clear. Shipman would not have wished to approach another doctor to sign Form C as, when s/he consulted the family member or carer, s/he would be likely to hear the same information as the first Form C doctor, together with the fact that another doctor had been asking questions. Shipman might have promised to speak to

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the coroner and have returned with the claim (which might or might not have been true) that the coroner had approved the cause of death. He might have had to report the death to the coroner and risk the possibility that an autopsy might not provide a plausible cause of death and that toxicology would follow.

11.73 I cannot say precisely how the Form C doctors would have responded to the discovery that Shipman's Forms B contained serious inaccuracies or that he appeared willing to certify deaths in a number of cases where relatives and carers were concerned, surprised or puzzled. However, I do think that it would have been much more difficult for Shipman to deceive. I think it likely that he would have appreciated the difficulties he would face if he told lies on Form B or gave a different account to the relatives from that given to the Form C doctor. I think he would have recognised the risk he would run that either the Form C doctor or a relative or carer might realise that he had lied and that he had been present alone with the deceased at the moment of death. I think this recognition would have acted as a real deterrent. As I explained in my First Report, Shipman was able to control his urge to kill when he perceived himself to be at risk of discovery. If there had been a requirement at Dukinfield crematorium that the Form C doctor should answer at least one of questions 5–8 in the affirmative, I think it likely that Shipman would have killed fewer patients.

11.74 Further, if Shipman had taken the risk of killing despite the knowledge that the Form C doctor would be likely to question relatives and carers, I believe that the chances of his being detected would have been increased. I cannot say that, on the first occasion on which a doctor declined to complete a Form C for Shipman, the death would have been reported to the coroner, an autopsy and toxicology would have followed and that morphine would have been found and he would have been discovered. But, if he had taken the risk often enough, the chances of detection would have been greatly increased. Quite apart from the actual process of a report to the coroner, autopsy and toxicology, the Form C doctors should have noticed that relatives often had concerns about a death involving Shipman. I cannot say that they would have done but, if they had heard a similar story, often repeated, their suspicions might well have been aroused. The kind of report that Dr Linda Reynolds made to the Coroner in March 1998 might have been made earlier and with much greater attendant detail. I cannot say when this would have happened but I think it likely that questioning relatives and carers would have led to Shipman's detection at some stage, whereas the system as operated never did.

The Authority to Cremate: Form F

The Medical Referee

11.75 Authority to cremate a body is given by a medical referee or (in his/her absence or if s/he has been the deceased's medical attendant) a deputy medical referee. The post of medical referee is a part-time one. The medical referee (or deputy) attends the crematorium office for a short time on weekdays as necessary. If s/he is still in other employment, s/he will fit in his/her visits to the office with the demands of his/her employment. If the medical referee is retired, s/he will attend the office when and for as

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long as is necessary. A medical referee is remunerated for each cremation authorised. The current recommended rate is £5.50 per cremation. Rates at privately owned crematoria may be higher. There are currently about 550 medical referees and deputy medical referees, covering over 240 crematoria.

The Appointment of Medical Referees

11.76 Medical referees and deputy medical referees must be registered medical practitioners of not less than five years' standing and, in the words of Regulation 10 of the 1930 Regulations:

> **'... must possess such experience and qualifications as will fit them for the duties required of them ...'.**

11.77 If appropriately qualified, a medical referee or deputy medical referee may also be a coroner. The Inquiry is not aware of any medical referee who currently holds both positions. The 1930 Regulations also provide that the medical referee or deputy medical referee may be a medical officer of health. It is a common arrangement for a director of public health to act as medical referee to a local crematorium. In some areas, the posts of medical referee and deputy medical referee, when vacant, have traditionally been filled by doctors from the public health department at the local health authority. In other areas, medical referees and their deputies have always been appointed from among doctors working in general practice.

11.78 Provided that s/he fulfils the other qualifications, a medical referee or deputy medical referee can complete Forms C and F in respect of the same death. The Inquiry was told by Dr Morgan that this happens at the crematorium where he officiates. The 1930 Regulations specifically provide for this eventuality. As I explained in Chapter Three, at the time when the rules for cremation were first devised, an arrangement whereby the medical referee carried out a personal investigation into a death was considered ideal, although not possible to achieve in every case. It was because of the practical difficulties (in particular, difficulties of geography) that it was decided to place responsibility for personal investigation on the Form C doctor, rather than the medical referee.

11.79 The Regulations provide that:

> **'The Secretary of State** [*i.e. the Home Secretary*] **shall appoint as Medical Referee and Deputy Medical Referee such fit persons as may be nominated by the Cremation Authority.'**

11.80 The system is that, when a vacancy occurs, the cremation authority notifies the Home Office of the name of the doctor who the authority proposes should fill that vacancy. Sometimes, a curriculum vitae accompanies the notification. The Home Office checks that the doctor fulfils the registration requirement but makes no further check on the suitability of the proposed appointee. In effect, the part played by the Home Office in the appointment process is merely a 'rubber-stamping' exercise. At paragraph 3.22, I explained how the Home Office had become concerned, prior to 1930, at the manner in which the cremation authorities were exercising their power to appoint. It was because of that concern that the power to appoint was transferred to the Home Office by the 1930

Regulations. It is not clear to what extent, if at all, the Home Office ever sought to use that power in order to regulate the quality of appointees to the post of medical referee.

11.81 The failure by the Home Office to carry out any enquiry into applicants' suitability for the role of medical referee has been the subject of complaint and comment from time to time over the years. The Home Office has openly admitted that it has no machinery to 'vet' nominations for the post. The stance of Departmental officials has been that the Department is not in a position to make meaningful enquiries into the qualifications and experience of medical practitioners. Instead, the Home Office has relied on the cremation authorities to carry out all necessary checks.

11.82 The draft Regulations circulated in 1962 (which, as I have explained, were largely overtaken by the work of the Brodrick Committee and were, therefore, not implemented in their original form) would have removed from the Home Office the responsibility for appointing medical referees. This responsibility would then have passed entirely to the cremation authorities, thus bringing England and Wales into line with the position in Scotland. The BMA opposed the proposed change strongly, questioning the extent to which cremation authorities (in particular private authorities) could be relied upon to make appropriate appointments and emphasising the importance of the role of the medical referee. The BMA argued that the effect of placing the power of appointment entirely in the hands of the cremation authority would be to compromise the independence of medical referees. The BMA urged the Home Office to retain the power of appointment itself and to introduce proper machinery for selection. The 1965 Regulations, when implemented, did not introduce any change to the system of appointment, which has remained the same ever since. The Brodrick Committee recognised the reality of the Home Office's role in the appointment process and observed that **'... the approval of the Home Secretary amounts to little more than a "rubber stamp"'**.

11.83 In 1997, an 'efficiency scrutiny' of government procedures was undertaken, in order to examine the statutory arrangements whereby certain local authority powers were subject to approval by central government. At the conclusion of that process, it was recommended that the power of the Home Office to appoint medical referees should be removed. This was because it was recognised that, in reality, the Home Office exercised no independent judgement in relation to such appointments. The Home Office declined to comply with the recommendation, relying on the point previously made by the BMA, namely that the lack of accountability of private cremation authorities made it inappropriate for the power of appointment to be entirely vested in them. There was, however, no change in the way appointments to the post of medical referee were made.

11.84 The Inquiry has not undertaken any detailed survey of cremation authorities, in order to discover whether any authorities appoint medical referees by means of open competition and/or after a detailed enquiry into the experience and suitability of the various candidates for the post. It may be that there are some authorities that do have proper selection procedures. However, the evidence received by the Inquiry suggests that, at most crematoria, the post of deputy medical referee is virtually in the gift of the existing medical referee. He or she usually seeks candidates for the post from the health authority by which s/he is, or was formerly, employed or from the general practice of which s/he is or was a

member. Since the deputy medical referee usually succeeds to the post of medical referee, in effect, the medical referee chooses his/her successor. It does not appear that much consideration is given to the issue of whether the experience and professional background of the potential applicant fits him/her for the position. A striking example of this was the appointment of Dr Betty Hinchliffe as Deputy Medical Referee, then Medical Referee, of the Dukinfield crematorium. She had spent her entire career (save for two years working in hospital immediately post-qualification and two years as a locum general practitioner) in the field of child health, where she had a special interest in paediatric audiology. When appointed as Deputy Medical Referee in the late 1970s, she had had no experience of general practice or of the care and treatment of elderly people, for over 20 years. She had not completed a Form B for even longer and had completed perhaps two Forms C during her entire professional career. Her deputy, Dr Jane Holme, had no experience whatsoever of general practice or of the care or treatment of elderly people. She also had spent her professional life working in the field of child health.

11.85 Home Office officials have said that they saw no reason not to rely on cremation authorities to make proper enquiries before appointing medical referees. However, there is no evidence that the Department made any enquiry about the selection procedures being used or offered any advice as to how the process of appointment should be carried out. Nor does the Department appear to have taken any steps to ensure that cremation authorities fully understood the functions of the medical referee and his/her role within the cremation certification system as a whole.

11.86 The lack of any proper selection procedure prior to the appointment of a medical referee creates the impression that the position is an unimportant one, which can satisfactorily be filled by any doctor with the requisite registration. That impression is confirmed by the lack of training and support provided once a medical referee has been appointed.

Training and Support for Medical Referees

11.87 The Home Office provides no formal training for new appointees and little ongoing support. There is no handbook or other reference material; new recruits are usually given a copy of the Cremation Act and Regulations by their cremation authority but, except insofar as it is produced locally, no explanatory material is available. Those appointed learn by observing and talking to their colleagues at the crematorium. The Home Office has always taken the view that, given their medical expertise, medical referees should be able to carry out their task without the need for instruction. So far as the medical aspects of the job are concerned, that is of course so. However, in order to do the job effectively, it is important that a medical referee understands the role which s/he is required to perform and the roles of others (in particular, the Form C doctor) who also play a part in the system of cremation certification. As I shall explain later in this Chapter, it is evident that some (perhaps many) do not. One reason for this may be that their predecessors also had no understanding of their role and so were not in a position to pass on that knowledge to those who followed them.

11.88 Medical referees are subject to no monitoring or audit procedures. It is true that they attract few complaints. However, the public is largely unaware of their role and existence,

as the Shipman case has demonstrated. The only time when a medical referee is likely to attract criticism is when s/he requests an autopsy or takes any other action which disrupts, or threatens to disrupt, arrangements for a cremation. This rarely occurs.

Contact between Medical Referees and Others

11.89 In the past, medical referees around the country were in contact with each other through the Association of Crematorium Medical Referees. I have referred to the Association in Chapter Three, in connection with representations made by its members to the Home Office over the years. The Association became defunct in 1974 and thereafter, for a period of 28 years or so, medical referees had no forum for the exchange of ideas or the discussion of common issues and problems. Certain enthusiastic medical referees attempted, through the Home Office, to initiate moves to encourage contact but the Home Office took the view that it was for the referees themselves to undertake any necessary organisation and therefore took no active steps to assist. Recently, and in the face of the obvious threat to their existence posed by the aftermath of Shipman's criminal activities, there have been moves, under the auspices of the BMA, to re-launch the Association.

11.90 The lack of any contact between medical referees has led to them becoming isolated and unaware of different practices in operation elsewhere in the country. This is no doubt one reason why the contents of the cremation forms issued by different crematoria have become so divergent. Similarly, medical referees have little or no contact with other professionals involved in operating the post-death procedures. The evidence given to the Inquiry suggests that they rarely, if ever, speak to their local coroner. The coroner may have no understanding of the role and functions of the medical referee. The medical referee is unlikely to have occasion to speak directly to the registrars in his/her district. The cremation system operates in virtual isolation (save for the exchange of forms and contact of a purely administrative nature) from the death certification, death registration and coronial systems.

Advice and Guidance for Medical Referees

11.91 Over the years, the Home Office has issued some advice and guidance. Examples are the advice about the need for affirmative answers to questions 1, 2 and 4 of Form C and the requirement for the Form B and Form C doctors to be **'demonstrably independent'**. However, such guidance has been minimal and, where not concerned with a forthcoming change in the law, has usually been issued only in response to a direct request for advice. In his oral evidence, Mr Robert Clifford, Head of the Coroners Section of the Animals Procedures and Coroners Unit, which deals with cremation-related matters, emphasised that the Home Office was concerned not to encroach upon the independence of medical referees in relation to individual decisions that they might make. That is of course understandable and proper. However, such a consideration would not have precluded the issuing of general guidance and advice as to the approach to be adopted by medical referees. In particular, it would not have precluded advice and guidance as to the role that the medical referee was required to play within the cremation certification system as a whole.

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11.92 A few medical referees have produced their own guidance notes for use locally. Dr Gordon Pledger told the Inquiry about guidance that he had prepared, setting out what was required of the referee and deputy referees at the crematorium at Newcastle-upon-Tyne, where he is Medical Referee. He also issues guidance for doctors completing cremation forms; a copy of his guidance notes accompanies every blank set of forms sent out by the crematorium. In 1997, the Medical Referee at the Central Durham crematorium, Dr Clive Buxton, issued his own guidance notes for doctors completing Forms B and C. Those notes were subsequently reproduced in Resurgam, the journal of the Federation of British Cremation Authorities. They sought to clarify some of the common uncertainties about the meaning of questions appearing on Form B.

Duties of Medical Referees

11.93 The duties of the medical referee are set out in the 1930 Cremation Regulations (as amended). Regulation 12 provides that:

> **'(3) He shall, before allowing the cremation, examine the application and certificates and ascertain that they are such as are required by these Regulations and that the inquiry made by the persons giving these certificates has been adequate. He may make any inquiry with regard to the application and certificates that he may think necessary ...**
>
> **(5) He shall not allow the cremation unless he is satisfied that the fact and cause of death have been definitely ascertained; and in particular, if the cause of death assigned in the medical certificates be such as, regard being had to all the circumstances, might be due to poison, to violence, to any illegal operation, or to privation or neglect, he shall require a post-mortem examination to be held, and if that fails to reveal the cause of death, shall decline to allow the cremation unless an inquest be opened and a certificate given by the Coroner in Form "E" ...**
>
> **(8) He may in any case decline to allow the cremation without stating any reason.'**

These duties have remained virtually unchanged since 1903.

11.94 Having satisfied him/herself as required by regulation 12(5), the medical referee completes the Authority to Cremate (Form F). In doing so, s/he certifies:

> **'... I have satisfied myself that all the requirements of the Cremation Acts 1902 and 1952, and of the Regulations made in pursuance of these Acts, have been complied with, that the cause of death has been definitely ascertained and that there exists no reason for any further inquiry or examination ...'.**

11.95 Except where the coroner has certified the cause of death after autopsy or where an inquest has been opened, the medical referee will have inspected the completed Forms A, B and C. The only exception is that, where the Form B doctor is aware, when completing

Form B, of the result of a hospital post-mortem examination (so that no Form C is required), only Forms A and B should be submitted to the medical referee.

11.96 The time limit for delivery of the forms varies from crematorium to crematorium. At Dukinfield crematorium, forms must be delivered not later than 11am on the working day (Monday–Friday) before the cremation. (The note on Form B suggests that forms can be delivered on a Saturday but the Inquiry was told that this was not in fact the case.) Sometimes, perhaps because of delay on the part of doctors in signing the forms or for other reasons, the forms are delivered late. Occasionally, they are delivered on the very day of the cremation. Late delivery can cause great practical difficulties in contacting doctors and others in connection with queries arising from the forms. In those circumstances, it is, of course, open to the medical referee or superintendent registrar of the crematorium to insist that the cremation be postponed because there is insufficient time to complete the formalities. In practice, however, they will do everything possible to avoid this, because of the distress that such postponement would cause to the deceased's relatives. One solution, resorted to occasionally, is to allow the funeral service to go ahead, but postpone the actual cremation until all the formalities have been complied with. Even this, however, is avoided if at all possible.

11.97 The result is that a medical referee is under considerable pressure to approve the forms speedily and to ensure that any enquiries that s/he makes are limited to those that can be accomplished within the restricted time available. This does not tend to encourage the making of detailed enquiries. Under the Regulations, the medical referee has wide-ranging powers. He or she can make any enquiry that s/he thinks necessary. He or she can require a post-mortem examination, refer the death to a coroner or simply decline to authorise a cremation without giving any reason. In reality, however, the evidence received by the Inquiry suggests that the last power is never used (it is hard to imagine the circumstances in which it could properly be) and medical referees rarely exercise their powers to order a post-mortem examination or even to report a death to the coroner. As I have already indicated at paragraphs 3.76 and 3.77, the Brodrick Committee reported similar findings in 1971 and the Committee's view was that medical referees were being asked to perform an impossible task for which they were given neither the time nor the facilities.

11.98 In addition, the medical referee's examination of the forms takes place at a time when registration of the death has occurred (so that the registrar has, implicitly, 'approved' the cause of death) and when one doctor has certified, and a second doctor has confirmed, the cause of death. The applicant has signed a form, stating that s/he has no reason to believe that the death was suspicious. In some cases also, the medical referee will be aware that the death has been 'discussed with the coroner' (in fact, more likely, a coroner's officer) who has also, it might be inferred, 'approved' the cause of death. The medical referee's place, at the end of this chain of persons scrutinising the death, must inevitably affect the way s/he approaches his/her task.

11.99 There are three other aspects of the medical referee's task that I should mention. First, it is unrealistic that s/he should have to certify, on the basis of assertions contained in the cremation forms, that s/he is satisfied that the cause of death has been **'definitely**

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ascertained'. In the vast majority of cases, the cause of death cannot be **'definitely ascertained'** without an autopsy and sometimes not even then. The fact that the level of confidence required on the part of the medical referee is unrealistically high affords no encouragement to a medical referee to exercise a great degree of care when scrutinising the forms and making enquiries.

11.100 Second, in the event that a medical referee orders a post-mortem examination, there can be difficulty over who should pay for it. Some cremation authorities are willing to meet the cost; others require the family to pay, which is obviously extremely unpopular. The cost of the examination is, of course, in addition to the distress and inconvenience caused by the requirement for a post-mortem examination so near to the funeral. The alternative course is for the medical referee to refer the death to the coroner. However, if the coroner declines to act in circumstances where the medical referee feels that the death should be investigated further, the medical referee can be left with little choice but to order the examination at the family's expense. In one case of which the Inquiry is aware, a medical referee who found himself in that position (not an isolated case, he said) discovered that the body had already been embalmed, rendering a post-mortem examination of little or no value. In these circumstances, the power to order a post-mortem examination can be somewhat illusory.

11.101 Third, if a medical referee indicates his/her intention to order a post-mortem examination or refer the death to the coroner, it is open to the applicant to dispose of the body by burial (for which only the registrar's disposal certificate is necessary) or to make an application to another crematorium where the medical referee may be prepared to permit the cremation. The Inquiry is aware of cases where this has happened. The ability of an applicant to 'shop around' in this manner is obviously highly damaging to the authority and effectiveness of the medical referee.

Certificate after Post-Mortem Examination: Form D

11.102 If a medical referee does exercise his/her power to order a post-mortem examination and the pathologist can identify a cause of death, the pathologist will complete a Certificate after Post-Mortem Examination (Form D), stating that s/he is satisfied that the cause of death is as stated on Form D and that there is no reason for making any toxicological analysis or for an inquest. The medical referee will then give authority to cremate on the basis of the information contained in Forms A and D.

Coroner's Certificate: Form E

11.103 If a death is referred to the coroner and the coroner has ordered an autopsy, after which s/he is satisfied that no inquest is necessary, or if the coroner has opened an inquest into the death, the coroner may issue the Coroner's Certificate (Form E). On the certificate, the coroner states which of the two circumstances referred to above applies and certifies that s/he is satisfied that there are no circumstances likely to call for a further examination of the body. The certificate does not state the cause of death; in the case of a death where an inquest has been opened, no cause of death will yet have been determined. The provision whereby a Form E can be issued (and a cremation allowed to proceed) before the

conclusion of an inquest was, as I have explained in Chapter Three, introduced by the Cremation Regulations 1965 in order to avoid the distress caused to families as a result of having to wait many months for an inquest to be concluded before being permitted to cremate their dead.

11.104 A sizeable proportion of the cremations dealt with by medical referees are authorised by a coroner's Form E. The medical referee gives authority to cremate on the basis of Forms A and E. Neither contains information relating to the cause of death. Yet the medical referee must complete Form F, in which s/he states that s/he is satisfied that the cause of death has been **'definitely ascertained'**. The medical referee also has the disposal certificate issued by the registrar. However, this does not give information about the cause of death either. The authority to cremate given in these circumstances amounts to no more than a 'rubber-stamping' of the decision made by the coroner. This anomaly was identified in the Brodrick Report. The draft Regulations of 1989 would have made it unnecessary for a medical referee to authorise cremation where a coroner had issued a Form E. However, those Regulations never became law and, thus, the anomaly remains. Again, the fact that a medical referee has no choice but to ignore the requirements of Form F when dealing with this large group of cases does little to encourage a more careful approach when dealing with others.

Variability of Practice among Medical Referees

11.105 The lack of Home Office guidance and contact between medical referees in different parts of the country has had important effects on the efficacy of the system. I have already described one important difference in relation to the completion of questions 5–8 on Forms C.

11.106 The Inquiry also found that medical referees approached their task in different ways. In effect, there are two schools of thought about what the task should entail. All medical referees who gave evidence to the Inquiry agree that the forms must be carefully checked to ensure that all the questions have been answered and that the factual information (such as names, address and dates of birth and death) is consistently stated throughout. In some crematoria, such clerical checks are carried out by administrative staff. It is also generally agreed that, in satisfying him/herself before completing the declaration on Form F, the medical referee must rely principally on reading the cremation forms submitted. He or she will not usually embark on any independent enquiries. The differences of view arise over what, if any, mental process the medical referee must go through in order to satisfy him/herself **'that the cause of death has been definitely ascertained and that there exists no reason for any further inquiry or examination'**.

11.107 Some medical referees take the view that their statutory duty requires them to scrutinise the forms (mainly Form B) with a view to seeing whether the 'picture' created or the 'story' told by the forms hangs together and makes medical sense. Dr Pledger and Dr Morgan described their functions in this way, although they did not, even so, see their role as an investigative one. Plainly, such an operation requires medical expertise. On the other hand, some medical referees take the view that theirs is essentially a clerical function. They say that their task is to check that the forms have been properly completed, that all

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questions on Forms A and B are answered, that there are affirmative answers to questions 1, 2 and 4 on Form C and that the causes of death on Forms B and C are the same. They are not required, they say, to consider the content of the forms and do not seek to discover whether the picture presented makes medical sense. They consider that the cause of death has been **'definitely ascertained'** by the two doctors who have completed Forms B and C. The medical referee, they say, is entitled to assume that those two doctors have done their job conscientiously.

11.108 Dr Holme, formerly Deputy Medical Referee at the Dukinfield crematorium, described her duties in this way. So did the medical referee of a crematorium that I visited personally, for the purpose of seeing a medical referee at work. He told me that his function was to ensure that all the boxes on the forms had been completed. He did not examine the content of the forms. That, he said, was not his function. He had only to ensure that the information was there and would be preserved in case it should be required for any future investigation. When asked why, if the duties were purely administrative, it was necessary for the medical referee to be a medical practitioner, this medical referee said that, when, as became necessary from time to time, a medical referee had to telephone a doctor who had failed to complete part of a form, it was necessary for such a conversation to be conducted by a medically qualified referee as, otherwise, the certifying doctor might refuse to co-operate.

11.109 In my view, it is clear that the clerical approach cannot be what is envisaged. First, the requirement that the medical referee should be a practitioner of at least five years' standing makes it clear that there is an expectation that some medical expertise is to be exercised by a doctor with some experience and authority. I cannot accept as reasonable the suggestion that a doctor is required so that an uncooperative certifying doctor can be brought into line. Second, the medical referee is given the power to order a post-mortem examination. It seems clear that a medical referee who performs only a clerical check would never have occasion to order a post-mortem examination or, for that matter, to refer a case to the coroner. I leave out of account the fact that the wording of Form F requires the medical referee to be personally satisfied that the cause of death has been definitely ascertained. As I have said, that seems to be an unrealistic goal.

11.110 I am satisfied that these differing views about the functions of the medical referee are genuinely held. It appears that the Home Office was for many years unaware of these differing views and practices. This dichotomy of view (and misunderstanding by some) could not, I think, have survived if medical referees had undergone any training or appraisal, had received written guidance or had met regularly for discussion of their professional duties and problems. There are documents in existence, such as the Report of the Departmental Committee responsible for drafting the Cremation Regulations 1903, which explain the function and purpose of the medical referees' task. Those documents, or a summary of their contents, could easily be disseminated to all medical referees.

Does the Medical Referee Perform a Useful Function?

11.111 I have described the two schools of thought as to how the medical referees' work should be performed. It is obvious that, if the task is essentially a clerical check, it can provide no effective scrutiny of the accuracy and validity of the cause of death; nor can it do anything to detect cases of concealed homicide or neglect.

11.112 If the task is carried out as Dr Pledger and Dr Morgan described it, the operation should have some value. However, it appears that medical referees very rarely exercise their powers to stop a cremation and order a post-mortem examination. Research published in 1995 showed that, although 10% of 250 Forms B from a single cremation authority showed errors in the cause of death, none had resulted in a referral to the coroner, a post-mortem examination or an approach to the Form B doctor for clarification.[1]

11.113 Only rarely will the medical referee even speak to the coroner's office. In the overwhelming majority of cases, the forms are approved and the cremation proceeds. This may well be because the papers are in order and there is no cause for concern. The task of looking for one case with 'something wrong' out of thousands that are in order is a thankless one and it cannot be easy to maintain an appropriate standard of vigilance. It seems to me that, even where the medical referee approaches his/her task in the right way, the sheer monotony of the task is likely to result in some faults being overlooked.

11.114 There are other reasons why even a conscientious medical referee might miss a case in which cremation should not be allowed. As I have observed, the scrutiny takes place at the end of the cremation certification process. The effect of what has gone before is to engender a degree of confidence in the validity of the application to cremate. Dr Pledger spoke of the feeling that his position was that of a longstop, who was looking only to see if something had gone 'hideously wrong'. Far from expecting to find anything, he would have an expectation that all would be in order. For him to question an application would be, in effect, to question the judgement of a range of other people who had dealt with the death previously.

11.115 Another factor that may well affect the medical referee's approach to his/her task is the pressure of time, to which I have already referred. The fact that, if detailed enquiries are to be made or an autopsy undertaken, the cremation would have to be postponed, with consequent disruption and distress to the family, must inevitably have the effect of discouraging a medical referee from taking such steps. There is a tension between the requirement that the statutory procedure should be properly satisfied and the need to avoid disruption.

11.116 The scope of the medical referee's task is very limited. It is a paper exercise and does not involve any independent investigation. Even if the documentation is completed conscientiously, the forms frequently contain inadequate information to enable the medical referee to gain a clear picture of the events leading up to the death. Form B does not require the doctor to provide even a brief account of the deceased's medical history, nor of the circumstances of the death. Such an account would be most useful to the medical referee. As I have previously explained, the Inquiry has become aware of inconsistencies in the way in which different doctors complete the forms. The only enquiries which most medical referees make are of the Form B doctor, if some aspect of the form is unclear. Often, it is not easy to contact the doctor and there is a temptation for the medical referee to make assumptions, sometimes unwarranted, to 'fill the gaps'. The system is based upon trust in

[1] James, DS (1995) 'An examination of the medical aspects of cremation certification: are the medical certificates required under the Cremation Act effective or necessary?', Medical Law International, Vol 2, pp 51–70.

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the truthfulness and integrity of those taking part in the procedure. In particular, the medical referee is dependent on the integrity of the Form B doctor.

11.117 In summary, it seems to me that the role of the medical referee is of limited value, even when the duties are carried out, as they often are, most conscientiously. When the role is limited to that of a clerical check, it is completely without value.

The Role of the Home Office

The Actions of the Home Office prior to Shipman's Conviction

11.118 It has been known for over 50 years that the system of cremation certification was not working as was intended. The Home Office has certain responsibilities in relation to cremation procedures. In particular, it has responsibility for keeping under consideration the need for changes to cremation legislation. I have had to consider whether, in permitting the cremation system to remain virtually unchanged for a century, the Home Office properly discharged its responsibilities.

11.119 It seems likely to me that the high standards expected in the early days of the last century gradually fell out of use. I suspect, for example, that it was usual practice in the early days for one or more of questions 5–8 to be answered in the affirmative. By 1950, it was known that standards of completion of Forms C were poor and the Interdepartmental Committee recommended that the Form C procedure should be strengthened. Nothing was done and, in 1971, the Brodrick Committee recommended that the entire system of cremation certification should be abolished as soon as the system of medical certification of the cause of death had been strengthened. The Committee also recommended that Form C should be abolished forthwith, even if their main recommendations could not be immediately implemented. The Form C doctor simply relied on the Form B doctor's opinion, so that the second certificate was, in effect, worthless. In any event, it was, in the Committee's opinion, unnecessary as the risk of concealed homicide was minimal.

11.120 As I have explained in Chapter Three, in 1975, the Government of the day accepted the Brodrick proposals (albeit with some modification to satisfy the Director of Public Prosecutions) as its policy. Following the change of Government in 1979 and throughout successive administrations, implementation of the Brodrick recommendations remained the aim. The requirements for medical certification of the cause of death were to be strengthened and the separate system of cremation certification was to be abolished. As I have said, there were a number of stumbling blocks in the way to legislation but the main reason why the policy was not implemented was that the Government Law Officers and the BMA objected to the abolition of the Form C procedure. Many attempts were made to reach a consensus on the way forward. None succeeded. However, as I have already said, the implementation of the Brodrick proposals, which relied completely upon the integrity of the single certifying doctor, would not have deterred Shipman from killing; nor would it have led to his earlier detection.

11.121 I can well understand why little attention was paid to the operation of the cremation system during the many years in which it was hoped and intended that it would be abolished. The focus of attention was on its replacement. Although the Law Officers and the BMA wished

to see a system that retained some form of second certification, as a safeguard against concealed homicide, only the BMA positively wished to preserve the Form C procedure. It is apparent that there were those in Government who were sceptical of the BMA's motives. They thought that the BMA wanted to keep Form C because the income from it was attractive to doctors. It is not for me to say what lay behind the BMA's stance. They certainly advanced their arguments on the basis that the completion by a doctor of a second certificate provided a safeguard against a risk of concealed homicide. However, I can understand why some were sceptical of the doctors' position.

11.122 Many of the doctors who have given evidence about the Form C procedure stress that they do not regard the fee they receive as a 'perk'. They say that, although the form is simple to complete, they often have to travel some distance to view the body. The money, they say, is not an attraction at all. It is simply reasonable remuneration for their effort. I find that hard to accept, for several reasons. First, the nickname for the Form C fee is 'ash cash'. The expression is redolent of the notion that the fee is a 'perk'. Second, doctors often ask their friends to complete Forms C for them. I have not been told that doctors have to ask their friends because no other doctor will accept the burden. I have heard that doctors in multi-handed practices take turns to share out the Forms C that come to the surgery. I have not been told that they are sharing out the burden so that no one doctor has to shoulder more than his/her fair share; far from it, I have the impression that doctors guard their right to Forms C. Furthermore, in hospitals, where the majority of deaths occur, there is less inconvenience and potentially greater income from this source.

11.123 Form C was never abolished, as the Brodrick Committee had advised. Although there are few overt references to it within the Home Office documents, and although Mr Clifford was anxious not to be indiscreet on the subject, it is apparent to me that there was in Government a reluctance to 'take on' the medical profession. It seems that successive Governments regarded cremation certification as a matter for the doctors. For example, although, since 1952, the Home Secretary has had the power to fix the fees payable for issuing cremation certificates, he has never exercised this power, but has always left it to the BMA to recommend the appropriate rates.

11.124 Twenty seven years elapsed between the publication of the Brodrick Report and the discovery of Shipman's crimes. Had the Brodrick proposals been implemented, and had Shipman still committed serial murder undetected over a period of 24 years, it would have been impossible to criticise the Government for operating a system that had failed to detect him. It would have been entirely reasonable for them to implement a Report of such authority and standing. However, they did not; they tried but, in the end, their efforts came to nothing. All the while, they knew that the existing Cremation Regulations were not working as they were intended to work. Ought they to have done something to improve the operation of the cremation system, given that it must at some stage have become apparent that the Brodrick recommendations were unlikely to be implemented? The only reform which, in my view, would have provided any effective safeguard against concealed homicide would have been a mandatory requirement in respect of questions 5–8 of Form C.

11.125 It seems to me that there were two stages at which the Home Office might have considered reform of the cremation certification process. The first arose in late 1988

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and early 1989, following the decision to postpone attempts to abolish the Form C procedure until after legislation strengthening the death certification system had been brought onto the statute book. That process would not be speedy; consultation was necessary and it was obvious that the Cremation Regulations, including the Form C procedure, would remain in force for some time. At that stage, the Home Office intended to consolidate the various sets of Cremation Regulations and to bring in some amendments. There was an opportunity to improve the Form C procedure. One of the proposed amendments related to Form C. An affirmative answer was to be required to questions 1, 2 and 4. In fact, this would have only formalised what was already existing practice. It appears that no consideration was given to the 'strengthening' of the Form C procedure. The thinking in the Home Office at this time was that the recommendations of the Brodrick Committee were sensible and appropriate, the risk of concealed homicide was negligible and the Form C procedure was unnecessary. So there would be no point in improving it. The Government Law Officers were reluctant to see its abolition, without some compensating improvement in death certification. They still considered that Form C provided a useful safeguard against concealed homicide. However, they did not suggest that there was any need to strengthen the procedure, only to keep it. It appears that the Home Office was unaware that, at some crematoria, an affirmative answer was required to one of questions 5–8. The Home Office papers of this period reveal no discussion about the purpose to be served by questions 5–8. It does not appear that anyone suggested to the Home Office at that time that there was any need for an independent check on the account of events given by the Form B doctor, such as would be provided by consideration of questions 5–8. So, although the opportunity for strengthening the Form C procedure through amendment of the Regulations plainly presented itself, I do not think that the Home Office should be criticised for not taking that opportunity. In the event, the attempt to amend and consolidate the Regulations met with opposition and was eventually abandoned.

11.126 Given Home Office officials' actual state of knowledge and belief about the Form C procedure, I do not think they should be criticised for their failure to make any attempt to strengthen the Form C procedure. They believed it to be unnecessary and a waste of time. Their knowledge of how the system worked on the ground appears to have been gained mainly from the Brodrick Report; they did not visit crematoria to inspect them and did not have meetings with medical referees. They knew from the Brodrick Report that the Form C procedure was often carried out in a perfunctory way. They did not know that, at some crematoria, an affirmative answer to one of questions 5–8 was required. Although the Brodrick Report had drawn attention to the fact that questions 5–8 were very frequently answered in the negative, it had not been discovered that this was due to differing practices at particular crematoria.

11.127 However, in my view, the Home Office is to be criticised for its lack of awareness of how the cremation certification system was operating throughout the country. It ought not to have delegated responsibility for operation to the cremation authorities, as it did. The Home Office should have had a policy for the selection of medical referees; it should have provided training and support for them once appointed. It should have maintained contact with them and ensured that they had contact with each other. Had the Home

Office operated the system 'hands on', officials should have been aware that different practices were followed at different crematoria; they should have known that, at some crematoria, an affirmative answer was required to one of questions 5–8 and they should have found out why this was so. Had they known these things, they might have realised that a requirement for an affirmative answer to one of those questions would have strengthened the protective effect of the procedure. Although no one had suggested to them the need to strengthen the Form C procedure, they might have thought of it and might have proposed that improvement. I say only that they might have done these things because, as they believed the whole process was pointless, they might have thought of and rejected the idea of strengthening the procedure. Even had they proposed such an improvement, I very much doubt that it would have been successfully incorporated into the amended Regulations. The amendments, as drafted in 1989, failed to meet with the approval of interested parties. A significant strengthening of Form C would certainly have aroused strong objections. As the Home Office did not regard the Form C procedure as a whole to be important, I do not think they could have been criticised had they failed to pursue such changes with the vigour and determination that would have been necessary to overcome those objections.

11.128 The second occasion on which a particular opportunity arose, which should possibly have triggered a move towards reform of the Form C procedure, occurred in the late 1990s. It arose from a survey, conducted in Scotland and completed in September 1995, which was drawn to the attention of the Home Office in November 1997. The survey had discovered defects in the standard of completion of cremation forms. Advice was issued by the Scottish Office Home and Health Department to doctors and medical referees. One of the requirements was that at least one of questions 2–5 on Form C should be completed in the affirmative, unless the Form C doctor had carried out a post-mortem examination. As I have explained earlier, questions 2–5 on the Scottish Form C are the equivalent of questions 5–8 on the forms in use in England and Wales. Unfortunately, Mr Clifford, the official responsible for cremation issues at the time, did not understand the nature or significance of the difference between the Scottish forms and those used in England and Wales. He did not, therefore, fully appreciate the nature of the advice being given. However, even had he done so, it seems unlikely that he would have been able to bring about a change in the practice in England and Wales before 1998, when Shipman was arrested. His reaction to the Scottish research was to decide that it would be useful to conduct something similar in England. He took some steps towards this end but these progressed slowly. There had never been any reason to perceive a need for urgency. I do not think that the realisation that the Scottish system was different would have caused him to act with any greater degree of urgency.

11.129 In short, the history of Home Office supervision of cremation procedures is not impressive. The approach was to leave matters to the cremation authorities to an extent that I regard as inappropriate. Officials were concerned almost entirely with attempts to abolish the procedures – or Form C at least. That was understandable in the light of the Brodrick Report and its underlying philosophy. In any event, I do not consider that there is any ground on which the Home Office can be held responsible for the failure of the cremation certification system to detect Shipman's course of criminal conduct.

Home Office Reactions since the Discovery of Shipman's Crimes

11.130 After the discovery of Shipman's crimes, steps were taken to set in motion reviews of the whole system of death and cremation certification and coroner services. There was bound to be delay before any reforms suggested by these reviews could be implemented. However, even then, no urgent attempts were made to address the inadequacies of the cremation certification system.

11.131 The only step taken was the despatch of a letter to medical referees, at the time of Shipman's conviction, reminding them of their power to refuse to authorise a cremation and their right to refer a death to the coroner if not satisfied with the application to cremate. The letter also reminded medical referees to be **'vigilant at all times'** and that they should not feel constrained from making further enquiries about a death by the wish of the family to adhere to proposed funeral arrangements.

11.132 Until very recently, it appears that the Home Office had not given any consideration to the introduction of a requirement that one of questions 5–8 on Form C should be answered in the affirmative. The Inquiry has now been informed that, on 6th February 2003, a meeting was convened, at which Home Office officials met with representatives of the cremation organisations and medical referees to discuss various proposals for the introduction of interim improvements in the operation of the cremation certification procedures. As a result, the Home Office is **'to explore the experience of those crematoria which currently require at least one mandatory affirmative answer to questions 5–8 of cremation Form C and, if necessary, to set up a controlled pilot scheme in one or more areas'**. It is said that **'these steps should provide useful information about the practicality and effectiveness of introducing such a requirement generally'**. I welcome this move, belated though it is. However, I doubt the need for a pilot scheme, given that this procedure is already operated by several crematoria in different parts of England and Wales, together with most crematoria in Scotland. It is difficult to see why a **'controlled pilot scheme'** should yield more information than an examination of current practice in those areas where an affirmative answer to questions 5–8 (2–5 in Scotland) is already required. I am also concerned to think that it is expected that a pilot scheme would prove or disprove the effectiveness of such a change of practice. At least, I would hope that the change would not be deemed ineffective simply because a pilot scheme failed to uncover a murderer.

The Future of Cremation Certification

11.133 In my view, the cremation certification procedure, as presently carried out in most places, is of very little value. As I shall be recommending a new system of certification for all deaths, not only those to be followed by cremation, it is not appropriate to consider in detail how it might be improved. However, like the Brodrick Committee, I too realise that my main recommendations might not be implemented as rapidly or as completely as I would wish. In that event, my strong recommendation is that the cremation certification system should be preserved and that the forms should be standardised throughout the country and modernised. Above all, it should be mandatory for the Form C doctor to question at least

one person who is independent of the Form B doctor and who has some knowledge of the circumstances of the death.

11.134 If it should appear that the post of medical referee is likely to remain in existence for more than a few months from the publication of this Report, I recommend that any new appointments should be scrutinised by the Home Office and should be approved only if the applicant has suitable medical experience, as well as five years' standing. The Home Office should provide training and guidance material, explaining the medical referees' role and the way in which it should be performed, and should fund periodic meetings of an Association of Crematorium Medical Referees. Issues of this kind were discussed at the meeting in February 2003, to which I have already referred. In the event that the existing cremation certification procedure is to be retained for a significant period, I would hope that these discussions will result in the speedy introduction of the interim measures that I have suggested.

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CHAPTER TWELVE

The Bereaved Relatives

Introduction

12.1 At the outset of the Stage Two hearings, the Inquiry invited a number of the relatives of Shipman's victims to describe their experience of the death and cremation registration and certification procedures in operation at the time of their loss. They were also asked to make suggestions for change and improvement. Information and opinions about the way in which the present procedures fail to meet the needs of the bereaved were also received from a variety of other witnesses, including registrars and coroner's staff. At the consultation stage, the Inquiry received responses from persons and organisations with a particular interest in the needs of the bereaved. These included bereavement officers, Cruse Bereavement Care (Cruse) and Victim Support. A representative from Cruse and a bereavement co-ordinator participated in the Inquiry's seminars.

12.2 The evidence as to present practice showed, first, that families of deceased persons are little involved in the processes of certification and investigation of a death and that the needs and feelings of the bereaved are sometimes not given the consideration they deserve. Second, it demonstrated that this results in the loss of the opportunity to tap a valuable source of information about the deceased and the circumstances of his/her death. In my view, any changes contemplated for the future must take account of the desirability of ensuring that families and those close to the deceased are kept informed and are consulted and involved. However, their involvement must be handled sensitively and not intrusively.

12.3 Although none of Shipman's victims came from a minority ethnic or religious group, the Inquiry became aware of the beliefs held, and special practices followed, by various such groups whose members wish, where possible, to avoid post-mortem interference with the body of the deceased and to arrange disposal of the body as soon as possible after the death. Representations were received from members of the communities of Muslims, Hindus and orthodox and liberal and progressive Jews. The needs of these communities must be borne in mind when the Inquiry considers proposals for change.

Death and Cremation Registration and Certification

Understanding the Cause of Death

12.4 The Tameside registrars told the Inquiry that families of the deceased often did not know what the certified cause of death was when they attended at the register office, bringing with them the MCCD. The legal position is that the family of the deceased has no right to see the MCCD. In practice, the informant is often used as a means of conveying the certificate from the doctor to the registrar and it is usually in a sealed envelope. Good practice would require most doctors who have had responsibility for the treatment of the deceased to explain to the family the import of what they have put on the MCCD or, if it be the case, why they have decided to report the death to the coroner. However, it is clear

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that good practice in this respect is not always followed. The registrars said that families often ask to see the MCCD and are sometimes shocked and upset to find what has been stated as the cause of death. Sometimes they do not 'agree' with the stated cause. Perhaps more often they are unaware that their relative has been suffering from the condition to which the doctor has attributed the death.

12.5 To discover an unexpected cause of death during the registration process, when it is not possible to discuss matters with the doctor, can only increase the relatives' distress. The relatives must make an immediate decision whether to postpone registration and return to speak to the doctor or to accept that the cause will be registered as the doctor has certified. As the death register is, in effect, a public document and as any copy of the entry (commonly known as the 'death certificate') obtained by either the family or anyone else will include the cause of death, the attribution of the death to a cause with which the family is not content may give rise to a real and lasting sense of grievance. It appears to me that any future system must ensure that the family of the deceased has the opportunity to discuss the cause of death with the person who is to certify the cause before the certification takes place. That is not to say that families should have the right to dictate what cause of death is put on the certificate. That would be quite wrong. But they should have the right to have the rationale underlying the cause of death explained to them. It is highly likely that, if this is done carefully and sensitively, the concerns held by the family will, in many cases, disappear.

12.6 The registrars also reported that families are sometimes upset when a cause of death is given which they feel causes embarrassment, such as, for example, a cause that states or implies that the deceased died as the result of drinking excess alcohol or of a sexually transmitted disease. In my view, a death certificate must tell the truth, even if this causes embarrassment, although care should always be taken by the certifier to express the cause in proper professional terms.

12.7 I note that the Office for National Statistics (ONS) has proposed that a short version of the death certificate should be provided in future, not including the cause of death. Such a certificate could be used for many of the purposes for which a certificate is required for the settling of the deceased's estate. I think many families would welcome this as it would provide greater privacy. However, it would still be important to ensure that the relatives understood what had been recorded in the register of deaths, which would, of course, contain the cause of death.

Personal Involvement in the Registration

12.8 The registrars expressed the view that many informants and members of the deceased's family regard their involvement in the registration process as important. Like the funeral, it is one of the 'rites of passage' and part of the grieving process. From a visit I made to a register office, and from the evidence I heard, I have the clear impression that the registrars do all they can both to ensure that the experience of attending the register office causes the least distress possible and to provide answers to any queries the relatives may have relating to the practical steps that they should take following the death. As I have already mentioned in Chapter Six, it appears from the White Paper, 'Civil Registration: Vital

Change. Birth, Marriage and Death Registration in the 21st Century', that it is intended that, in future, it will be possible for registration to be effected without personal attendance. That might be more convenient for many families. However, if and when such a change is made, it will be important to ensure that the family of the deceased is provided with a replacement means of contact with authority. I recognise that families often receive much support and advice from the funeral director, but I consider that there should be open, easy and expected contact with the authorities responsible for the post-death procedures. I shall recommend that this contact should be with the coroner's office.

The Views of the Relatives of Shipman's Victims

Present Practice

12.9 The evidence of the relatives of Shipman's victims showed that, although they were aware that Shipman had signed the MCCD and although they themselves had attended to the registration of the death, they were largely unaware of the process of cremation certification. Members of the families signed the cremation application, Form A, after it had been completed by the funeral director, but they never saw Form B and never met the Form C doctor. It was clear that, had they seen the information that Shipman had given on Form B, or had they been questioned about the circumstances of the death by someone independent of Shipman, many would have given information which would have shown that Shipman had lied. Such a practice might well have led to Shipman's earlier detection, or would at least have deterred him from killing so frequently.

12.10 As I have explained in Chapter Eleven, in some parts of the country it is usual for the Form C doctor to speak to a member of the family, if the death has occurred in the community, so as to obtain some independent verification of the circumstances outlined by the Form B doctor. However, this is rare. Some doctors seem to think that this practice would be intrusive and would upset the bereaved relatives. However, the evidence of the families of Shipman's victims was that they would not find such enquiries intrusive. In those areas where it does happen and where they are warned that it will occur, the families accept it and do not regard it as intrusive. Most family members who gave evidence stressed that they would have welcomed the opportunity to speak to someone about the concerns they had at the back of their minds.

12.11 Many of the relatives were naturally distressed that the present system of certification had failed so completely to deter or detect Shipman. Their perception was that the system was fragmented and that the various agencies were not in contact with each other.

Hopes for the Future

12.12 There was a common thread running through the evidence of the family witnesses. Most wanted to see a thorough system of death investigation applied to all deaths and not just, for example, to those to be followed by cremation. Some thought this would be necessary only for sudden or unexpected deaths. Most wanted the family of the deceased to be involved in the process and to contribute to it.

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12.13 Witnesses advanced two possible suggestions for 'a thorough investigation'. Some suggested that there should be two doctors involved in the certification process. The second doctor should be independent of the first and should do 'a thorough job', including examination of the medical records and speaking to the family about the circumstances of the death and any concerns family members might have. Others suggested that the death should be referred to some independent person or body with medical expertise, who would investigate the death, examine the medical records and speak to the family. There was a general view that families should be consulted at an early stage and that, if they were to be asked to examine any documents, they should be given plenty of time in which to do so. Some family witnesses would be content if it were made easier for relatives to express their concerns to someone who is independent. Some thought that there should be an audit of death certification.

12.14 There was a strongly expressed preference for a system which ensured that the family would be consulted automatically and did not depend upon the family member taking the initiative. For example, Mrs Angela Woodruff, a solicitor and the daughter of Mrs Kathleen Grundy, Shipman's last victim, spoke of the sense of shock she had suffered on learning of the death of her mother. At that time, she had no reason to suspect that her mother had been murdered; nevertheless, the death was extremely sudden and unexpected. Her state of shock was such that she had difficulty in pulling her thoughts together. In that state, she (and she believes other bereaved relatives) would be unable to make the first move to contact the authorities to express any worries. She expressed the view that any system for consulting the family about their concerns should be proactive; it would not be sufficient merely to provide a facility for concerns to be expressed. She said that she would not have found it intrusive if a doctor or someone from the coroner's office had telephoned her to make enquiries about her mother's death.

12.15 Mrs Jane Ashton-Hibbert, the granddaughter of Mrs Hilda Hibbert, agreed that enquiries made by a second doctor or coroner's officer would not be intrusive. She felt it was essential that there should be someone wholly independent of the certifying doctor to whom a family member could express a concern without apparently making an allegation of impropriety and 'putting someone's reputation on the line'. She did not think it appropriate that the family member should have to take the initiative to express a concern; she thought that the initiative should come from the investigator, be it the second doctor or the coroner's officer. She would like the consultation, or the opportunity to express concern, to take place at an early stage, so that the family did not feel that anything they said would have the inevitable effect of disrupting the funeral arrangements.

12.16 Mrs Kathleen Wood, the daughter of Mrs Elizabeth Baddeley, said that there was a need for someone independent to be involved in investigating the death before registration. She thought that someone should speak to the family to find out about the deceased's state of health.

12.17 Mr David Jackson, the son of Mrs Nancy Jackson, said that even if he had realised that there were inaccuracies on the Form B Shipman had completed in respect of his mother, he would not have concluded that these were lies. He thought there was a need for someone independent to speak to family members before certification was complete to

see if they had any reservations. His preference was for a second doctor to carry out these enquiries, which would not be intrusive. He thought that a 'bureaucrat' would just ask 'yes and no' questions. It appears to me that he recognised the need for the questions to be asked in an appropriately professional way by someone with a degree of medical knowledge or training.

The 'One-Stop Shop'

12.18 Several of the relatives of Shipman's victims expressed the opinion that, in future, there should be one readily identifiable agency with whom the bereaved family could be in contact in relation to a death. It appeared to them that, at present, there were several authorities that had little or no contact with each other. They suggested that what was required was a 'one-stop shop', through which all the formalities relating to the death could be effected. This would be more convenient and less demanding for relatives at a difficult time, rather than expecting them to be in contact with one or two doctors, a registrar, and, possibly, the coroner's office. Some witnesses went so far as to suggest that this agency should also provide bereavement counselling. In my view that would not be appropriate, as a bereavement counsellor might well need to remain involved with a family member long after all other formalities had been concluded. Instead, such an agency should put bereaved relatives in touch with an organisation which can provide bereavement counselling and other support and advice. However, I recognise the merit in the suggestion that bereaved relatives should have as few as possible points of contact at such a difficult time. Also, I think it would be feasible and desirable for the functions of investigation, certification, permission to dispose of the body and, possibly, even registration of the death, to be brought under the umbrella of the coroner's office. I shall recommend that the coroner's office should be the agency at the centre of the post-death procedures.

12.19 Several witnesses expressed the view that there was a need for improved education of the public about what to expect when a death occurs and for improved sources of information. The leaflet produced by the Benefits Agency was thought to be useful but something of more general application was required.

Coronial Investigation, Autopsies and Inquests

12.20 In Chapter Nine, I explained why, in my view, all coronial investigations should include consultation with the deceased's family and, usually, the gathering of evidence from them and any person who has cared for the deceased during the last illness.

12.21 At present, the rights of the family to know and understand the results of an investigation which does not proceed to inquest are very limited. The family has no right to see what the person (usually a doctor) has said to the coroner's office when reporting the death. Nor does the family see the content of any form completed by a police officer or coroner's officer (such as the Form 751 or 751A used by the Greater Manchester Police and described in Chapter Four). Nor, in the unlikely event that any other evidence is obtained besides the autopsy report, is the family entitled to see it. Under rule 57 of the Coroners Rules 1984, a person who, in the opinion of the coroner, **'is properly interested'** is

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entitled, on payment of a fee (which the coroner can waive at his/her discretion) to receive a copy of the autopsy report.

12.22 It is apparent that, at present, many coroners and coroner's officers do not contact a member of the deceased's family before deciding whether or not to 'take over' a death, even though, whatever decision is made, it will be important for the family. If the coroner is minded to decide that s/he does not have jurisdiction to hold an inquest and does not intend therefore to 'take over' the death, it would be helpful to him/her to speak or to get one of the officers to speak to a family member. The coroner or coroner's officer might discover that the death was possibly 'unnatural' or discover some concern about the death or the last illness, which might affect the decision whether or not there was jurisdiction. In the cases where the coroner is minded to 'take over' the death, it would be courteous, humane and sensible to speak to a member of the family to explain the reasons for that decision.

12.23 If the coroner intends to order an autopsy, as will generally be the case under the present legislation if s/he decides s/he has jurisdiction, s/he should explain to the family why this is necessary and could take the opportunity to explain why it might be necessary for tissue samples to be taken for histological or toxicological investigation. This would give the family an opportunity to express any reservations or objections they may have about an autopsy. It appears to me that trouble is caused when the decision is taken without consultation or explanation. Mrs Lesley Creasey, the niece of Miss Ada Warburton, one of Shipman's last victims, expressed the belief that few people would object to an autopsy, provided that they knew that there was a good reason for it. Professor Margaret Brazier, Chair of the Retained Organs Commission, who has extensive experience of the attitudes of the bereaved towards autopsies and the taking and retention of organs and tissues, told an Inquiry seminar that little objection is encountered provided that the intentions and reasons are explained to the family openly and honestly.

12.24 The expression **'properly interested person'** in the Coroners Rules allows the coroner to exercise a discretion as to whom s/he regards as being sufficiently close to the deceased to have a right of access to the autopsy report. This highlights a difficulty that arises when considering the rights and reasonable expectations of the bereaved. In this Report, I have used the expressions 'family' and 'relatives' to indicate anyone who is sufficiently close to the deceased to have a proper interest in the cause of death and any investigation into it. I recognise that defining the class of person with such an interest is not easy. Many close and enduring ties of affection are formed outside the framework of the conventional family. Those with responsibility for determining who in a particular case should be consulted, or should have access to information about a death, should be given guidance on how to make a decision. In my view, such guidance should give full recognition to ties of affection alone, as well as those also recognised by law. I say nothing more about this, as I understand that the Department of Health (DoH) is currently undertaking work on such guidance. I shall continue to use the words 'family' and 'relative', with the intention that they should include any person with a sufficient interest.

12.25 One difficulty for relatives of a deceased person whose body has been subject to autopsy is that the autopsy report may not be readily understandable to the lay person; explanation

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is needed. It is the practice at the Greater Manchester South District coroner's office to suggest to the family that they should take the report to a general practitioner. A better solution, possible under the present legislation, would be for the family to have, on request, an explanation from someone in the coroner's office with the necessary medical expertise. If there is no such person, the family could meet the pathologist concerned. However, the inability of many legally qualified coroners or members of their staff to provide an explanation which can be understood by a lay person, demonstrates, yet again, the need for medical expertise in the coroner's office.

12.26 Apart from the autopsy report, there is no right under the Coroners Rules for a **'properly interested person'** to receive any other form of evidence in advance of an inquest. Many coroners do permit advance disclosure of witness statements and other reports, but this is a discretionary matter. At the inquest, the family will eventually hear the evidence of the pathologist and will have the opportunity to ask questions. Pathologists are often willing to speak informally to family members after the inquest to clarify any aspects of their evidence that the family has not understood or has felt unable to ask questions about during the hearing.

12.27 In my view, there is a need to ensure that, whether or not there is to be an inquest, the family receives an adequate account of any investigation into the death, couched in non-technical language. Preferably, this should be in writing, so that it can be referred to again, but sometimes an oral explanation will be desirable as well.

12.28 In September 2002, the DoH produced a consultation paper entitled 'Families and Post Mortems: a Code of Practice'. This document sets out draft recommended practice for all those involved in communicating with relatives of individuals (both children and adults) who may undergo or have undergone an autopsy. It seeks to ensure, among other things, that those close to the deceased person understand the reasons for hospital and coroners' autopsies, the processes involved and their rights in the decision-making process. It deals with issues of consent for the retention of organs and tissues. It includes guidance on good practice in the provision of bereavement services. The formulation of guidelines for good practice in this difficult and sensitive area is plainly an important step. I hope that, in due time, an approved code will be issued and will assist bereaved families in coming to terms with the need for an autopsy in certain cases.

12.29 I note also that Home Office Research Study 241, entitled 'Experiencing Inquests', described concern about the variable degrees to which families were involved in, and kept informed about, preparations for inquests.

Two Related Issues

12.30 Two specific matters of concern were raised by the families of Shipman's victims. There is a common thread; it is that those in authority (in these two cases, the Coroner) did not show proper consideration for the feelings of the bereaved. Instead, they followed normal or convenient procedures, apparently without thought for the consequence for the individuals affected.

12.31 Some distress was caused to the families of many of Shipman's patients in May 2001, when the Coroner for Greater Manchester South District, Mr John Pollard, opened – and

then immediately adjourned – inquests into 232 deaths, without giving any notice to the families of his intention to do so. As I explained in Chapter Two of the First Report, this procedure was adopted in order to avoid duplication of the Inquiry's investigative work and of my findings in relation to the deaths. The opening of the inquests was, therefore, to be a pure formality; no evidence was to be called and no decision taken. However, although rule 19 of the Coroners Rules requires a coroner to notify the date, time and place of an inquest to the spouse, near relative or personal representative of the deceased whose name and address are known to him/her, Mr Pollard took the view that it would be too great an administrative burden to expect him to find the names and addresses of the families of Shipman's patients, in respect of whom inquests were to be opened. I fully accept that Mr Pollard did not intend to be insensitive to the feelings of the families concerned; indeed, when he realised that he had caused distress, he apologised. However, the incident demonstrates the need for those in authority to have at the forefront of their minds the fact that they are dealing with people whose emotions may be in a fragile state and to make allowance accordingly.

12.32 Mrs Woodruff was much distressed when she learned that the cause of her mother's death, as it appeared in the register of deaths, had been altered without her knowledge and in terms that she found offensive and deeply distressing. It will be recalled that Shipman certified that Mrs Grundy had died of 'old age'. In fact, Shipman had killed her by administering an overdose of morphine or diamorphine. In January 2000, he was convicted of her murder. Mrs Grundy's body had been exhumed on 1st August 1998. It was then subjected to autopsy and toxicological tests which revealed the true cause of her death. That information was sent to the Coroner. On 11th January 1999, Mr Pollard opened an inquest into Mrs Grundy's death. He then immediately adjourned it, pending the outcome of the criminal trial. He sent to the registrar, as he was required to do, a certificate setting out the particulars required for registration, including the cause of death. Usually, when an inquest is adjourned pending a criminal trial, the death will not have been registered and the certificate will be necessary to enable the death to be registered and the deceased person's affairs to be settled. The family of the deceased person will need the certificate and will be aware that it is to be or has been issued. Mrs Grundy's case was unusual because her death had been registered some time previously and her family were in no immediate need of the certificate. On 12th January 1999, a new entry was made in the register of death, recording particulars of Mrs Grundy's death in accordance with the certificate forwarded by the Coroner.

12.33 Mr Pollard did not inform Mrs Woodruff of his actions. Following Shipman's conviction, Mrs Woodruff wished to ensure that the death register was corrected. She contacted Mr Pollard to enquire whether this was possible. She found, to her surprise, that it had already been done. This would not have mattered so much of itself (although I think she felt that it had been a discourtesy to effect the change without telling her), but she was greatly distressed to find that her mother's death was now attributed to **'overdose of morphine'**. There was nothing to show that this was not self-administered; future generations in the family might wonder if their ancestor had been a heroin addict. Mr Pollard explained that he had merely followed the usual procedure. Usually, when he sent a Form 100B to the registrar with the result of an autopsy, the family would be aware of his actions as they

would attend at the register office to register the death; if there had been an inquest, the family would be aware of the outcome and would know how the cause of death was to be registered. In the case of an inquest adjourned pending the outcome of criminal proceedings, the deceased's relatives would usually, as I have said, need the coroner's certificate to effect registration of the death and would see the certified copy of the death entry, including the cause of death stated therein. Mr Pollard also made the point that he was required to provide a cause of death to the registrar in accordance with the autopsy report. He had merely copied the cause of death given by the pathologist.

12.34 Once again, I am sure that Mr Pollard did not intend to be discourteous to Mrs Woodruff; nor did he wish to cause her and her family distress. But the following of 'procedures', without thought for the consequence, in what was plainly a very unusual case, resulted in understandable distress. Consultation with Mrs Woodruff would, I am sure, have led to a satisfactory resolution of these problems. At the very least, it would have enabled her to understand what was being done and the reasons for it.

The Special Needs of Minority Groups

12.35 Religious beliefs have always played an important role in the practice relating to the disposal of the dead. Although cremation is now the most common method of disposal in England and Wales, some communities do not practise it. Many Roman Catholics prefer interment. Orthodox Jews and Muslims always inter their dead. Hindus always cremate theirs.

12.36 For some religious groups, it is of great importance that the disposal takes place very shortly after the death. Orthodox Jews prefer that the burial should take place before sundown on the day of the death; otherwise, they wish it to take place as early as possible on the following day. For Muslims and Hindus, it is also important to avoid any delay between death and disposal.

12.37 For Muslims and orthodox Jews, it is also important, if at all possible, to avoid the need for any post-mortem interference with the body. There are also, of course, some people who are strongly opposed to invasive post-mortem examination, not on the ground of religious belief, but simply as a matter of conviction.

12.38 In the course of the consultation process, the Inquiry received responses from representatives of several minority groups, who were anxious to ensure that any changes the Inquiry might recommend in the procedures for death investigation and certification should not have an adverse effect on them. I am grateful to those who contributed in this way. I am particularly grateful to Mr Laurence Brass, who attended one of the seminars as the representative of the Board of Deputies of British Jews, for his illuminating explanation of the philosophy behind the practices of orthodox Jews and of the practical effects upon the family of a deceased person of delay before the funeral. I was grateful too for his unequivocal statement that, although orthodox Jews will always wish to avoid an autopsy, they recognise that there are times when the law demands that one be carried out. The Muslim community adopts the same attitude.

12.39 Because of the need to avoid delay before disposal, and in particular because there may be a wish to inter a body during a weekend, the orthodox Jews and Muslims have sought

to make special arrangements with the registrars and coroners in their districts. The evidence suggests that these arrangements are more successful in some areas than others. For example, I was told, during a visit to a register office, that the registrars provide an out of hours service. An on-duty registrar attends at a local synagogue and mosque at specified times and will issue a disposal certificate on production of a valid and acceptable MCCD. The registrar will have with him/her the office mobile telephone, on which s/he can be contacted if a problem arises. The on-duty registrar will be able to contact a member of the coroner's staff if necessary (and, if necessary, the coroner himself). I understand that similar arrangements are made in some, but by no means in all, areas.

12.40 In some areas, the coroner will arrange for an autopsy to take place at the weekend in order to facilitate early burial. Dr Nigel Chapman, HM Coroner for Nottinghamshire, is able to do so. Mr Christopher Dorries, HM Coroner for South Yorkshire (West) cannot, although it is always possible to arrange an urgent autopsy in the case of a suspicious death. Mr Leonard Gorodkin, HM Coroner for Greater Manchester City District, permits an alternative to invasive autopsy in some cases where the cause of death is uncertain. Members of the orthodox Jewish community fund an arrangement whereby the body is examined using a magnetic resonance scanner. If the consultant radiologist is satisfied (as he sometimes is) that the cause of death can be adequately determined, the Coroner will accept the result and will certify the cause of death according to the scan. The issue of whether or not this practice complies with the provisions of the Coroners Act 1988 has not been raised in the courts.

12.41 It appears to me that, although the community leaders of the minority groups are not entirely content with the present arrangements, their main concern is that their position should not be worsened as the result of any future changes. I can well understand their concern as, in the light of the Shipman case, there is a general expectation that death investigations will be made more thorough and are, therefore, likely to take longer.

12.42 In my view, the reasonable expectations of all sections of the community must be met. We live in a multicultural society and, if the needs of minority groups require the provision of additional resources, so be it. I do not think that such arrangements should be left entirely to local negotiation, as at present. There should be recognised protocols for dealing with those needs, applicable throughout England and Wales. I am not suggesting that especially favourable arrangements should be made just for those who can demonstrate that they hold a particular set of beliefs. The reasonable expectations of all should be met, whether they are Muslim, Jew, Christian, atheist or of any other faith or persuasion. Nor must it be thought that I am advocating any relaxation of the legal requirements that are now in force, or will come into effect in the future. I suggest that the system should be sufficiently well resourced so that, if anyone expresses a need for speed in completing the post-death formalities, it will be possible to meet that need. Insofar as autopsies are concerned, my view is that all members of society (regardless of religious persuasion) should be entitled to have their objections heard and taken into account; in the face of an objection, an autopsy should be ordered only if it is really necessary.

12.43 As I have already indicated, I shall recommend that the coroner's office should be at the centre of all post-death procedures. In my view, that office should provide a 24-hour service for advice and urgent death certifications. If my recommendations are brought into effect, I believe that the position of those with particular expectations will be improved, rather than worsened. That is certainly my intention.

CHAPTER THIRTEEN

The Death of Mrs Renate Overton

Introduction

13.1 In Phase One, the Inquiry investigated the death of Mrs Renate Overton, who died on 21st April 1995, at the age of 47. For 14 months before her death, she had lain unconscious and brain damaged in Tameside General Hospital. She had been admitted in the late evening of Friday, 18th February 1994. During that evening, Shipman had attended her home to treat her for an asthma attack. She had collapsed in his presence, in cardiac and respiratory arrest. Mrs Overton's daughter was in the house and an ambulance was called. By the time the ambulance arrived, Mrs Overton was deeply and irreversibly unconscious. The paramedics re-started her heart and took her to hospital. Shipman himself recorded in Mrs Overton's medical records that he had given her a quantity of diamorphine. My conclusion was that Shipman had deliberately given Mrs Overton an overdose of diamorphine (or possibly morphine), intending to kill her, and that this had caused her collapse, her unconsciousness and, ultimately, her death. My decision in this case is at page 283 of Volume Five of my First Report.

13.2 Consideration of this death in Phase One caused me to realise that it had many disturbing features, quite apart from Shipman's own actions. First, it became apparent to me from examination of the hospital records that the doctors at the Tameside General Hospital realised that Shipman had given Mrs Overton an intravenous bolus dose (i.e. a dose given quickly and 'in one go') of an opiate (they thought it was 20mg morphine), which had probably caused her collapse. It also appeared that they knew that such a dose, given in that way, was excessive and dangerous, especially when given to a patient suffering from asthma. Yet, it appeared that no report had been made of Shipman's conduct and no investigation into Mrs Overton's collapse was initiated. It seemed possible that an opportunity to uncover Shipman's criminality had been missed. Second, Mrs Overton's death was reported to the Coroner. The report of the death drew attention to the possibility that morphine administration with asthma had been an underlying cause of death. An autopsy had taken place but had recorded that the death was due to hypoxic cerebral degeneration and was due to 'natural causes'. No inquest was held. It appeared possible that a second opportunity to uncover Shipman's criminality had been missed.

13.3 In Phase Two of the Inquiry, I was to examine the actions of those with responsibility for the procedures and investigations following the deaths of Shipman's victims. I was also to examine the conduct of those with responsibility for the monitoring of primary care provision and the use of controlled drugs. I resolved that the circumstances of Mrs Overton's death, and the conduct of all those involved in her treatment and in reporting and enquiring into the circumstances of her death, should be fully investigated. This Chapter contains the results of that investigation.

Background

13.4 Mrs Overton was a cigarette smoker and probably drank quite heavily. She suffered from asthma, hypothyroidism, epilepsy, anxiety and depression. She was, nevertheless, active and independent. She had previously worked as a nurse.

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13.5 Mrs Overton's medical records show that, until 10th February 1994, she had never complained of any symptoms suggestive of ischaemic heart disease. On that date, according to the handwritten records, Mrs Overton attended Shipman's surgery for a routine asthma check, almost certainly carried out by the practice nurse. The notes suggest that, whilst there, Mrs Overton complained of a heavy feeling in her chest, numbness in her left arm and shortness of breath. It appears that Shipman was told of this, possibly saw Mrs Overton and prescribed Tildiem, an anti-anginal and anti-hypertensive drug. There is a corresponding entry in the computerised records describing chest pain and the prescription of Tildiem. Shipman added no further details to the history, recorded no examination and arranged no investigation.

13.6 In my First Report, I found that it was not possible to determine whether or not these symptoms were in fact cardiac in origin. However, I doubt that they were. Although Mrs Overton's smoking habit put her at risk of cardiac disease, a battery of tests following her admission to hospital suggested that she did not have heart disease. The autopsy carried out in April 1995 revealed no ischaemic heart disease. I find it suspicious that, having apparently diagnosed angina, Shipman instigated no further investigations.

The Events of Friday, 18th February 1994

Mrs Overton's Collapse

13.7 In February 1994, Mrs Overton was living at 56A Green Street, Hyde, with her 22 year old daughter, Mrs Sharon Carrington.

13.8 At about 8pm on 18th February 1994, Mrs Overton returned home after having been out drinking in Hyde. Mrs Carrington thought that her mother had had too much to drink; also she was wheezing quite badly. After a short while, Mrs Overton telephoned Shipman because of her breathing problems. Mrs Carrington was not particularly concerned because the breathing difficulties did not appear to be unduly serious.

13.9 Shipman arrived within about half an hour. Mrs Carrington showed him into the front room where her mother was waiting. He had brought a nebuliser with him. A nebuliser is a portable air compressor; it delivers a drug to the patient in the form of a fine mist, which the patient inhales through a mask. This is a very effective way of giving a drug to a patient suffering an asthma attack, when co-ordination and respiratory effort are often poor. Mrs Carrington decided to go up to her room, leaving her mother, as she thought, in safe hands. She told Shipman where he could find her if he needed her. She went to her room and closed the door behind her.

13.10 Between ten and 15 minutes later, Mrs Carrington heard Shipman banging on the bannister rail and shouting for her to come downstairs quickly. She came on to the landing and saw Shipman at the foot of the stairs. She went downstairs and followed him into the front room where she saw her mother lying on her back on the floor, apparently unconscious. She sounded as though she was gasping for air.

13.11 At Shipman's request, Mrs Carrington commenced mouth-to-mouth resuscitation and, as she did so, Shipman gave external cardiac massage. They continued in this way for a

short while until Shipman reached into his bag and took out a needle and syringe. Mrs Carrington asked Shipman what he was intending to inject. She cannot recall Shipman's exact response but he said either that it was morphine or that it was adrenaline. He said that the injection was to ease Mrs Overton's breathing and he proceeded to inject the contents of the syringe into the crook of Mrs Overton's left arm. Within moments of the injection Mrs Overton seemed to stop breathing altogether.

13.12 Shipman instructed Mrs Carrington to telephone for an ambulance. She left the room to make the telephone call. She recalls that Shipman shouted to her, 'Tell them she's gone into respiratory arrest.' When she returned to the front room, Mrs Carrington continued with mouth-to-mouth resuscitation and Shipman continued with cardiac massage. According to Mrs Carrington, the ambulance arrived within a few minutes.

The Arrival of the Ambulance

13.13 The Greater Manchester Emergency and Paramedic Service Patient Report Form (PRF) reveals that the ambulance crew received the call to attend Mrs Overton's house at 9.33pm and arrived at 9.40pm. The crew members were Mr Neil Harrop, a paramedic and himself a patient of Shipman, and Mr Michael Smith, an ambulance technician. Both gave oral evidence to the Inquiry. They said that they saw Mrs Overton lying on her back on the floor and that cardiopulmonary resuscitation was in progress.

13.14 Mr Smith took over the resuscitation from Shipman while Shipman gave the history to Mr Harrop. He explained that he had been called out to see Mrs Overton because she was suffering an asthma attack. He said that, whilst he was with her, she had begun to complain of chest pain and he had suspected she was suffering a heart attack. He said that he had given morphine because of her pain. Mr Harrop recorded on the PRF that the mechanism of injury or medical history was cardiac arrest.

13.15 Mr Harrop assessed Mrs Overton's condition. He detected neither pulse nor respiration. The heart was in ventricular fibrillation. He attempted defibrillation. A first attempt met with no success, and a second, though partially successful, was not effective in restoring a proper heartbeat or sinus rhythm. It resulted in a period of electromechanical disassociation (EMD), a hybrid state of affairs in which there is discernible electrical activity within the heart but no pulse.

13.16 At about 9.50pm, Mr Harrop administered intravenous adrenaline (which was appropriate treatment) and succeeded in establishing a sinus rhythm. However, Mrs Overton remained in respiratory arrest. Mr Harrop then gave lignocaine so as to reduce the risk of refractory ventricular fibrillation. Mrs Overton was then transferred to the ambulance and taken to hospital.

13.17 Mr Harrop recorded his treatment of Mrs Overton on the PRF. When he first completed the form, he omitted to mention that the second attempt at defibrillation had resulted in EMD. The top copy of the PRF was left at the hospital with Mrs Overton. When he left the hospital, Mr Harrop realised that he had made an error and, on the carbon copy, he noted that the second attempt had resulted in EMD and that the intravenous adrenaline had then produced a sinus rhythm. The carbon copy was recovered from the file retained by the ambulance service.

13.18 Mr Harrop also recorded on the PRF that a spontaneous pulse was achieved at the scene. He explained in evidence that, by this expression, he meant that the heart was 'beating on its own with no longer having to do cardiac compressions'. Although his use of this term has been questioned, I think that his use of the word 'spontaneous' was entirely reasonable.

13.19 According to Mr Harrop, either he or Mr Smith would have contacted the hospital by radio to tell the staff that they were bringing in a patient who was 'post-VF arrest', to describe the treatment they had given and to advise of their estimated time of arrival. He said that they would not necessarily have informed the hospital of the circumstances giving rise to the collapse, prior to arrival at the hospital. Such information would usually be communicated on arrival and, as I will explain shortly, I am sure that this is what happened on this occasion.

13.20 Even at the time, it struck Mr Harrop as very unusual that Shipman should have administered morphine to a patient who was experiencing breathing difficulties. He knew that morphine depresses the central nervous system, acts as a respiratory depressant and would normally be contra-indicated for a patient suffering from asthma. Mr Harrop did not raise the issue with Shipman, partly because he would always defer to the judgement of a doctor and partly because he was too busy.

Shipman's Note of His Treatment and First Contact with the Hospital

13.21 Shipman's handwritten note for 18th February 1994 is uncharacteristically detailed. It reads as follows:

> **'V**[*visit*] **Called at 8.50.**
> **arrived 9.15 – Acute Asthma**
> **given nebuliser**
> **Pulmicort nebul. × 1**
> **Ventolin nebul × 5ml.**
> **BP 150/100. HR 120/m**
> **Resp > 30.**
> **After nebuliser A/E = BS good**
> **not cyanosed**
> **Approx 9.30 collapsed C/O chest**
> **pain sweating + pulse thready**
> **given IV diamorphine 10mg stat (only**
> **dose in bag)**
> **Settled then ?arrested**
> **Laid down ECM × 5**
> **Daughter called**
> **MTM/established patient**
> **ECM/not cyanosed**
> **pupils dilated fixed**
> **Ambulance called. pupils dilated**
> **ECM/ maintained**

MTM/
15 mins Ambulance crew IV Adrenaline
IV Lignocaine. Intubated pink
pupils fixed dilated'

Then, continued on a separate sheet:

'H/R. established output OK
[*illegible*] **No respiration established**
→TGH
CAS S/N informed of arrival
+ diagnosis + Rx'

13.22 This note suggests that, when Shipman arrived at 9.15pm, he found Mrs Overton suffering an acute asthma attack. He gave Pulmicort and Ventolin through a nebuliser. He recorded Mrs Overton's blood pressure as 150/100 and her heart rate at 120 beats per minute. The respiratory rate was said to be greater than 30 breaths per minute. The note states that, after the nebuliser, Mrs Overton's air entry was equal on both sides and the breath sounds were good. She was not cyanosed. If this were so, it would represent a good response to the nebuliser.

13.23 The note also suggests that, at about 9.30pm, Mrs Overton collapsed, complaining of chest pain. She was sweating profusely and her pulse was thready. Shipman's response was apparently to give Mrs Overton 10mg diamorphine intravenously, which, he noted, was the only dose available in his bag. If that were intended to be an excuse for giving a larger than appropriate dose, it would not be a satisfactory one. Even though the doctor might load a large dose into the syringe, he need not inject it all. When giving an opiate for the relief of cardiac pain, the injection should be given slowly, and should be stopped as soon as the desired effect has been achieved. This method of administration is known as titration against response and it should be contrasted with the administration of a 'stat' or 'bolus' dose. It appears from the handwritten record that Shipman had originally written not **'diamorphine'**, but **'morphine'**. Diamorphine is twice as potent as morphine. The note says that Mrs Overton **'settled'** but then **'?arrested'**, which would suggest that her heartbeat and respiration probably stopped. The rest of the note describes Shipman's attempts to resuscitate Mrs Overton, his calling of her daughter and the arrival of the ambulance crew. There are three references in the note to Mrs Overton's pupils being dilated or fixed and dilated.

13.24 The last two lines of the note suggest that Shipman himself contacted the casualty department of the hospital and told a staff nurse there of Mrs Overton's imminent arrival, the diagnosis he had made and the treatment he had given. It is not clear who took that message but it is likely that it contributed to the history as recorded in the hospital records.

13.25 Mrs Carrington contacted her mother's parents to tell them of Mrs Overton's collapse. They came to the house and arrived just as the ambulance was leaving. Mrs Carrington travelled in the ambulance; her grandparents followed. Mrs Carrington has no recollection of the journey, no doubt due to the extremely distressing nature of the situation in which she found herself.

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Arrival at the Hospital and Triage

13.26 Mr Harrop recalled that, when the ambulance arrived at the casualty department, at about 10.10pm, Mrs Karen Taylor, the triage nurse, and other emergency staff were waiting at the entrance and Mrs Overton was taken to the resuscitation area. Mr Harrop gave the history to the casualty staff and someone told him that Shipman either was or had been on the telephone.

13.27 Mrs Taylor made the first entry in the clinical notes. It reads as follows:

> **'H/O** [*history of*] **asthma attack**
> **SB** [*seen by*] **GP at home**
> **given nebuliser**
> **Pulmicort + Ventolin**
> **after neb Pt** [*patient*]
> **went into cardiac**
> **arrest.**
> **O/A** [*on arrival*] **Intubated i/c** [*with cardiac*]
> **output**
> **Given morphine by**
> **GP'**

13.28 In evidence, Mrs Taylor said that she believes that she must have obtained this history from the ambulance personnel. She would have made the note after her involvement with the patient ceased, which would have been immediately after she had seen Mrs Overton safely into the resuscitation room. She was with Mrs Overton for only about 'a couple of minutes'.

13.29 Mrs Taylor said that she was struck, as Mr Harrop and Mr Smith had been, by the information that a respiratory depressant, such as morphine, had been given to someone suffering an asthma attack. This was most unusual and her immediate thought was that the doctor had made a mistake. Her evidence was similar to that of many of her medical and nursing colleagues. She knew that morphine should not normally be given to an asthmatic. If it is to be given, perhaps because of the presence of severe chest pain suggestive of a heart attack, she knew that it should be titrated against response and, had she been told that 20mg had been given, she would have known that that would be an excessive dose.

13.30 Mrs Taylor's note makes no mention of the dosage of morphine given. This suggests that she was not told the dosage. If she had been told, I think she would have noted it in the records. Also, the ambulance crew have no recollection that they were told the dosage. It appears that the information about the dosage had not yet been communicated to those in charge of Mrs Overton's care.

Assessment by the Casualty Doctor

13.31 The first hospital doctor to see Mrs Overton that night was Dr Simon Siong Sih Lee, the casualty senior house officer (SHO). He does not remember having any contact with the

family. Dr Lee's responsibility was to maintain Mrs Overton in a stable condition and, once he had done so, to pass her care on to his specialist colleagues. He was directly involved with her treatment for about ten minutes. He probably referred Mrs Overton first to the medical SHO on call, Dr Li Cher Loh. There is the possibility that he simultaneously referred Mrs Overton to the SHO in anaesthetics, Dr Ratna Mukhopadhyay, who certainly became involved in Mrs Overton's treatment within a short time. The precise sequence is of no great importance.

13.32 Dr Lee made an entry in the records at 10.30pm, which reads as follows:

'asthmatic + H/O IHD (?MI previously)
Asthmatic attack (SOB and wheezy)→
Respiratory arrest → cardiac arrest
VF → D/C Shocked into SR + Adrenaline ×
Lignocaine × 1 } **by Paramedic**
No chest pain before collapsing
given morphine 20mg IV by GP
On arrival o/e Intubated correct position
o pneumothorax AE [*illegible*]
O_2 Sat 99% on 12 l/m
P 107 BP 108/73
Rx – Naloxone
– Blood (FBC, U + E [*illegible*]**)**
– CXR, ECG – SR
Admit ITU'

13.33 This note suggests that Mrs Overton was a known asthmatic with a history of ischaemic heart disease who had possibly suffered a myocardial infarction in the past; she had suffered an asthma attack, with symptoms of shortness of breath and wheeze, which had been followed by respiratory arrest and then cardiac arrest. She had gone into ventricular fibrillation and the paramedics had then 'shocked' her into sinus rhythm. She had also been given adrenaline and lignocaine. Dr Lee noted that she had suffered no chest pain before collapsing and that she had been given 20mg morphine intravenously by her GP. This is the first reference to the dose of morphine given. The note states that the dose was given intravenously but does not say whether it had been titrated against response or given as a bolus or stat dose. On examination, Dr Lee found that Mrs Overton had been correctly intubated. There was no pneumothorax and it appears from the note that air entry was equal on both sides. Dr Lee administered naloxone, the antidote to morphine. It is clear that he thought that morphine was the cause or one of the causes of Mrs Overton's collapse and he told the police that the dosage of naloxone was 400mg. Blood samples were sent for examination. An electrocardiogram (ECG) was ordered and showed that the heart was in sinus rhythm. A chest x-ray was ordered. Mrs Overton was to be admitted to the Intensive Treatment Unit (ITU).

13.34 I cannot be sure who was the source of the information that Mrs Overton had suffered no chest pain prior to her collapse. Mrs Carrington did not believe that her mother had

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suffered any chest pain and it is possible that she gave this information directly to Dr Lee. It is most unlikely that it came from Mr Harrop, who seems to have told Mrs Taylor that Mrs Overton had collapsed complaining of chest pain. It is clear that Dr Lee had not seen Mrs Taylor's note when he made his own record.

13.35 As to the dosage and mode of administration, Dr Lee told the police in February 1999 that he had some recollection that Shipman had telephoned the casualty department and told a member of staff that he had given Mrs Overton 20mg morphine. In the statement he made to the Inquiry in November 2002, which he essentially confirmed in his oral evidence, Dr Lee said that he believed that, after he had been told that morphine had been administered, he asked one of the nurses to telephone Shipman to find out exactly how much morphine Mrs Overton had been given. His recollection was that Shipman could not at first be contacted but that he later telephoned the hospital to give the information. Dr Lee explained that he would have wanted to know how much morphine had been given so that he would be able to administer an appropriate dosage of the antidote.

13.36 A second entry in Mrs Overton's general practitioner records about the events of that night also strongly suggests that Shipman was the source of the information concerning the dose. It reads as follows:

> **'18/2/94 T 10.45 CAS Rang - S/N**
> **? dose of diamorphine at time**
> **No established respiration yet.'**

13.37 This entry seems to record that the staff nurse from the casualty department of the hospital had telephoned Shipman at about 10.45pm, querying the dosage of diamorphine (or morphine) he had given. It is most likely that it was Shipman, therefore, who provided the information that he had given 20mg of morphine. He had at an earlier point in the general practitioner records written that it was 10mg diamorphine. Insofar as there is an obvious discrepancy between the two sets of notes, with the general practitioner notes implying he told the staff nurse that it was diamorphine that was given, and the nursing notes suggesting that he said that morphine was given, I prefer the latter. In other words, I believe that Shipman said in this telephone call that he had given 20mg morphine. In fact, he had given a substantial overdose of diamorphine.

Assessment by Dr Loh

13.38 Dr Loh was probably the next doctor after Dr Lee to see Mrs Overton. He probably saw her shortly before 10.40pm. He now lives in Malaysia and provided a witness statement to the Inquiry, in which he elaborated on the clinical notes that he made at the time. He did not attend to give oral evidence.

13.39 Dr Loh assessed Mrs Overton in the casualty department and decided that she should be transferred to the ITU. He contacted the SHO in anaesthetics, Dr Mukhopadhyay, through whom the necessary transfer arrangements were to be made. Dr Loh recollects that someone mentioned at some stage that Shipman had telephoned the hospital.

13.40 After seeing Mrs Overton, Dr Loh made an extensive entry in the records, beginning at about 11pm. The first part of that note is self-explanatory and concerns Mrs Overton's collapse and resuscitation:

> **'Well**
> **Went out @ 3pm today**
> **Came home ≃ 9pm.**
> **"Wheeze" + "SOB"**
> **Knocked on daughter's door**
> **(lives č her).**
> **Called GP →**
> **Gave Nebuliser. Partially**
> **relieved. dev. ?chest pain**
> **Given IV "Morphine" 20mg stat.**
> **→ became unresponsive – started CPR.**
> **Called Paramedics.**
> **Noted VF.**
> **Cardio** [*illegible*] **200J**
> **then 200J → S.R. then**
> **also Adrenalin 1mg IV**
> **Lignocaine 100mg IV** **Given**
> **Intubated + Ventilated'**

13.41 I note that Dr Loh queried whether Mrs Overton had complained of chest pain. He recorded that 20mg morphine had been given as a stat dose (i.e. it had not been titrated against response).

13.42 Dr Loh then made further notes in which he recorded that Mrs Overton was not breathing spontaneously and was on a ventilator. Her heartbeat was 90, regular and in sinus rhythm and heart sounds were normal. There was no raised jugular venous pressure and her chest was found to be clear on both sides. Other findings on examination were that she had no rash or meningism. Her pupils were pinpoint and poorly reactive. She was flaccid in all four limbs.

13.43 Dr Loh went on to make detailed notes concerning Mrs Overton's previous medical and social history. He noted the history of hypothyroidism, **'asthma/bronchitis x years'** and epilepsy that was said to be well controlled. He mentioned that there was a possible history of angina but no family history of ischaemic heart disease. He believes that he obtained this history from the family, whom he described as being supportive. He also obtained information from them as to the type of regular medication that Mrs Overton was taking for these complaints, but he did not obtain any information as to the dosage.

13.44 Dr Loh then went on to record the results of a number of clinical tests that had been performed by himself or his colleagues. In particular, he noted that an ECG had excluded any acute cardiac changes, that the heart was in sinus rhythm (confirming the observation of his colleague Dr Lee) and that a chest x-ray revealed nothing abnormal. In brief, according to his witness statement, the evidence available at that time suggested to him that Mrs Overton had not suffered a heart attack.

13.45 Dr Loh recorded the following provisional assessment:

> **'47 yo lady**
> **Acute Onset SOB č Wheeze**
> **followed with respiratory arrest?**
> **?ppt by morphine IV**
> **Hypoxia to cardiomyocardium**
> **č VF'**

13.46 In effect, his assessment was that Mrs Overton had suffered an acute attack of shortness of breath with wheeze. An intravenous injection of morphine had then been given which Dr Loh suspected had precipitated respiratory arrest. This had resulted in the reduction or cessation of oxygenation to the heart muscle, leading in turn to ventricular fibrillation. This assessment was entirely reasonable on the basis of the information available and was, in the event, proved to be correct.

13.47 Dr Loh then went on to deal with Mrs Overton's future management. He recommended that Mrs Overton should remain ventilated. He suggested that enquiries as to her regular dosage of medication be made of her general practitioner the following day.

Transfer to the Intensive Treatment Unit

13.48 Dr Mukhopadhyay attended the casualty department at 10.40pm. She made a detailed note as follows:

> **'Attended casualty for fast bleep at 10-40P.M.**
> **47 yrs old lady asthmatic, epileptic,**
> **hypothyroid had an attack of asthma at**
> **home. GP was called in. She had**
> **ventolin nebuliser. After that (reason**
> **unknown) 20mg of Morphine (IM or IV)**
> **given by G.P. Patient had respiratory**
> **arrest. When ambulance man reached**
> **She was on** [*sic*] **ventricular fibrillation (VF)**
> **She had D.C. Shock 200J twice.**
> **She had adrenaline, lignocaine.**
> **VF turned into Sinus rhythm. Endotracheal**
> **tube was put in as she was not**
> **breathing.**
> **In casualty ventilation with**
> **100% O2 done. Naloxone 400mg given I.V.**
> **Patient is completely sedated. NO response**
> **(Dr. Wright was informed. Advised**
> **to keep on ventilator for to-night.)**
> **O/E: P-100/min (R)**
> **B.P. – 96/60**
> **Pupil – constricted (both), no reaction**
> **to light.**

Lungs – No adventitious sound.
Heart – I, II, regular heart
CNS – no reflex could be elicited.
Plantar – no response'

13.49 It would appear from this extract from Dr Mukhopadhyay's note that she saw Mrs Overton at 10.40pm. Having briefly noted the circumstances in which Mrs Overton had been attended and nebulised by her general practitioner, Dr Mukhopadhyay recorded that Mrs Overton had been given 20mg morphine either intramuscularly or intravenously by the general practitioner. She stated that the reason for his doing so was unknown. She made no mention of chest pain. She then described the circumstances of Mrs Overton's resuscitation.

13.50 Dr Mukhopadhyay knew that Mrs Overton would have to be admitted to the ITU. Before this could be done, however, she had to obtain permission from the ITU consultant anaesthetist on call, Dr John Wright. His name appears in this note. Dr Mukhopadhyay duly telephoned Dr Wright at home. There is an issue between them as to what was said. I will address this issue shortly.

13.51 Having described her findings on examination of Mrs Overton, Dr Mukhopadhyay recorded the results of the biochemical investigations that had also been noted by Dr Loh together with certain blood gas results. Having done so, she wrote that her diagnosis was:

'Asthmatic attack č Hypoxia
(potentiated č Morphine) leading to
VF.'

13.52 Dr Mukhopadhyay's diagnosis was thus that Mrs Overton had suffered an asthmatic attack with hypoxia, potentiated by morphine, and this had led to ventricular fibrillation. Dr Mukhopadhyay did not sign her note and it is likely that she was called away before she had time to do so. I am sure that this was a typically busy Friday evening in the casualty department. Dr Mukhopadhyay then gave certain advice as to how Mrs Overton was to be managed overnight, based on what she was told by Dr Wright.

13.53 According to Dr Mukhopadhyay, she not only told Dr Wright that she wanted Mrs Overton to be admitted to the ITU but also conveyed the relevant and important parts of the history which she had noted in Mrs Overton's medical records, including the fact that 20mg morphine had been given. She said that she would have done this, as it was her normal practice. I accept that the giving of morphine would be a relevant part of the history, particularly as the dose was very large and Dr Mukhopadhyay believed that the collapse had been potentiated by the morphine.

13.54 Dr Wright has no recollection of the events of that evening. His belief is that he was simply asked to authorise admission to the ITU. If the staff were busy, he would be provided only with the essential information. I find that hard to accept. I would expect that the consultant anaesthetist, who was in effect the 'gatekeeper' of the ITU, would wish to know something of the patient's history and any provisional diagnosis before giving permission for her to be admitted to the ITU, which had a very limited number of beds.

13.55 In one of the witness statements he made to the Inquiry, Dr Wright stated:

> **'Whether Dr Mukhopadhyay did or did not advise me of all the matters recorded on the history sheet as she says, my only concern would have been as to whether the patient needed to be ventilated or not.'**

13.56 Dr Wright said in oral evidence, however, that he would have had more than one concern. If made aware of the full circumstances, his first concern would have been to arrange treatment and his second concern would have been to investigate the circumstances of the overdose. He said that to give 20mg morphine would have been 'ludicrous', 'a gross overdose' and he would have followed up the suggestion that such a dose had been given by asking further questions of Dr Mukhopadhyay. If the information had been confirmed by her, he would have considered trying to contact Shipman and would have made it his 'business' to raise it with Dr Husaini or Dr Brown. He recollects no such discussion with either colleague. I am sure that none in fact took place. I am unconvinced by Dr Wright's claim. He had very limited responsibility for Mrs Overton. By the following morning, Dr Murtaza Husain Husaini, a consultant cardiologist and a joint director of the ITU, would be on duty and would become responsible for Mrs Overton's care. Dr Geraint Ceri Stewart Brown, a consultant anaesthetist and also joint director of the ITU, was to come on duty and assume joint care of Mrs Overton with Dr Husaini on the following Monday. There was no urgency that night to investigate the circumstances of Mrs Overton's collapse. I find it hard to believe that Dr Wright would have been so extremely conscientious that he would have made enquiries that could quite easily and more appropriately be carried out by others over the following days.

13.57 On balance, I think it likely that Dr Mukhopadhyay did mention the relevant and important parts of the history, including the fact that 20mg morphine had been given and that she thought this had caused or contributed to the collapse. However, I also think it likely that the significance of what he was told did not register with Dr Wright. This may well have been because his main concern was with the immediate future management of a patient who was admitted, not under his care, but under the care of consultant colleagues who were very shortly to be directly involved in the management of the patient. I am not critical of Dr Wright for failing to act upon the information he received about Mrs Overton. He was never directly responsible for her care and he knew that other consultants would soon be fully aware of what had happened.

13.58 At about 11pm, Mrs Overton was admitted to the ITU. A nursing note made by Nurse Susan Millward records as follows:

> **'Emergency admission via A + E.**
> **Called emergency GP this evening**
> **Extremely breathless. Had nebs × 2.**
> **daughter says felt easier. GP says Renate**
> **c/o chest pain Morphine 20 mg given**
> **IV. Paramedics arrived...**
> **... On arrival to A + E Unconscious**
> **pupils fixed and pin point ...**
> **... Sinus rhythm 68 bpm. Temp 33C axilla ...'**

13.59 These notes support the inference I have drawn that Shipman had been in contact with the hospital and had said that he had given 20mg morphine. They also mention, amongst other things, the appearance of Mrs Overton's pupils and her body temperature, matters to which I will refer again shortly.

The Involvement of Mrs Overton's Family

13.60 Having been contacted by their granddaughter, Mrs Overton's parents contacted their son, Mrs Overton's younger brother, Dr Michael Overton, who was a general practitioner. Dr Overton lived quite close to Hyde, although his practice was in Gorton, near to the centre of Manchester. In 1994, he had been fully qualified as a doctor for about 13 years and had started in general practice in August 1984. He came to Tameside General Hospital on the evening of 18th February. The family was told of the seriousness of Mrs Overton's condition. Mrs Carrington and Dr Overton recalled that there was some discussion that night about turning off Mrs Overton's life support system and the fact that her collapse appeared to have been caused by the inappropriate administration of morphine. I am satisfied that no such discussions took place that night, although they undoubtedly took place later.

Saturday, 19th February 1994

Mrs Overton Is Assessed by Dr Premraj

13.61 On the morning of Saturday, 19th February 1994, Mrs Overton suffered a number of grand mal seizures, which were brought under control by epileptic medication. Mrs Overton was seen at about 10.30am by Dr Kamudini Premraj, a registrar in anaesthetics working under Dr Brown. She made several entries in the notes and records over the weekend and on the following Monday, 21st February. The relevant parts of her clinical note read as follows:

> **'47 year old lady. Admitted last night. Known Asthmatic.**
> **Severe asthmatic attack. –Recieved** [*sic*] **ventolin**
> **nebuliser and morphine 20mg ?IM or IV given by GP**
> **Resp. arrest thereafter. Resuscitated by GP**
> **until arrival of ambulance crew.**
> **Seems to have had a cardiac arrest too**
> **as there was no output without cardiac**
> **massage ...**
> **... As this lady seems to have been hypoxic**
> **prior to arrest and for ? how long after'**
> **She needs to be ventilated for 24-48 hours'**

13.62 Dr Premraj told the Inquiry that she has no recollection of her involvement. However, she accepted that it was obvious that the 20mg morphine had caused the respiratory arrest and that it must also have been obvious that to give 20mg morphine was excessive and a mistake by whoever had given it. Her note makes no reference to chest pain. She would have discussed the sequence of events with Dr Husaini when he came on duty.

Mrs Overton Is Seen by Dr Husaini

13.63 Mrs Overton was seen, later that day, for the first time by the consultant cardiologist under whom she was to remain until her death, Dr Husaini. As I have already said, during Mrs Overton's stay in the unit (until 1st March 1994, when she was transferred to ward 17), he and his consultant anaesthetist colleague and fellow ITU director, Dr Brown, were jointly responsible for her care.

13.64 Dr Simon Rushton was Dr Husaini's SHO, a position he had held since his transfer to ward 17 from the casualty department earlier that month. He accompanied Dr Husaini on his ward round that day and was thereafter intermittently involved in Mrs Overton's treatment on ward 17. Dr Rushton told the Inquiry that he had no recollection of his initial reaction to the circumstances of Mrs Overton's collapse, although he explained that he would have read the notes and would have been aware that the giving of 20mg morphine in the circumstances noted would be wholly wrong. Had he thought that his consultant was unaware of the problem, he would have reported the circumstances to him. Dr Rushton knew, however, that Dr Husaini knew of the circumstances of Mrs Overton's collapse and so the need to report did not arise, so far as he was concerned.

13.65 In evidence, Dr Husaini said that he realised from the hospital notes made by the junior staff that Mrs Overton had suffered a respiratory arrest resulting from the administration of morphine by her general practitioner. Basing his opinion on the facts as then known to him, this mechanism of injury was logical. On his 'post-take' ward round, when he saw the recently admitted patients, Dr Husaini made the following brief entry in the clinical notes:

> **'- Respiratory arrest**
> **-known epileptic**
> **-known asthmatic?**
> **-known alcoholism.'**

13.66 Dr Husaini explained that he did not mention ischaemic heart disease because he did not think that there was anything wrong with Mrs Overton's heart. He based this opinion on the clinical findings that the ECG results were normal, heart sounds were normal, there was no evidence of cardiac failure and the lungs were clear. He considered that the administration of morphine to an asthmatic patient was wrong; he would not do it under any circumstances. He knew that 20mg morphine would be a grossly excessive dose and that, in whatever dosage it was given, it should always be titrated against the patient's response. Dr Husaini said that he was distressed to realise that a fellow doctor had caused Mrs Overton to be in this terrible condition. At an early stage, according to his evidence, he resolved to ensure that his concerns were conveyed to the authorities. However, I note that Dr Husaini did not anywhere record his opinion that 20mg morphine administered intravenously in a bolus dose was grossly excessive and nor did he record his intention to convey his concerns to the authorities.

The Involvement of Dr Brown

Dr Brown Sees Mrs Overton

13.67 Dr Brown was on holiday at the time of Mrs Overton's admission to hospital and returned to work on Monday, 21st February. From that day until her transfer to ward 17 on 1st March

1994, Dr Brown shared responsibility for Mrs Overton's care with Dr Husaini. During her stay in the ITU, it became increasingly clear that Mrs Overton's prognosis was extremely poor.

13.68 Dr Chithambaram Veerappan was in a staff or 'middle' grade position, responsible to Dr Brown. He saw Mrs Overton with Dr Brown on 21st February and on several occasions thereafter until her transfer to ward 17. He realised that an excessive dose of morphine given in an inappropriate way had caused Mrs Overton's collapse and he told the Inquiry that he would probably have discussed this with Dr Brown and some of the nursing staff.

13.69 Dr Brown told the Inquiry that, although the clinical notes suggested that Mrs Overton's collapse had been caused by the administration of morphine, he was not by any means convinced that morphine was the cause of her collapse or that the dosage given was as high as had been recorded. Dr Brown said that he thought the history recorded in the notes was confusing; there were a number of inconsistencies in the accounts given. These led him to consider that Mrs Overton's condition had not been properly understood. Dr Brown relied on a number of factors.

The Ambulance Patient Report Form

13.70 According to Dr Brown, the PRF (as well as Dr Lee's notes) left it unclear why adrenaline was given by the paramedics if there was a sinus rhythm. In fact, it was given, as it often is, to treat EMD. I accept that this was not apparent from the top copy of the form left at the hospital but I cannot accept that Dr Brown regarded it as important at the time, if indeed he considered it at all. Certainly, he did not suggest that the mention of adrenaline implied, for example, that morphine had not been given in the dosage suggested.

13.71 Dr Brown also said that he could not understand why the pulse was said to be spontaneous. As I have said, Mr Harrop explained that he meant that the heart was 'beating on its own with no longer having to do cardiac compressions', a meaning which I accept as reflecting a normal and natural meaning of those words and a meaning accepted as legitimate by Dr Brown. Dr Brown pointed out that the PRF does not indicate what was the cause of the cardiac arrest. This is so, but I would not necessarily expect paramedics to be able to provide such information unless they were told by a doctor. In any event, I do not accept that Dr Brown regarded this as important and I reject the suggestion that these matters had any effect on his thinking.

Dr Lee's Note

13.72 In evidence, Dr Brown said that the notes made by Dr Lee suggested that the cause of the collapse was Mrs Overton's asthma with 'possibly a significant contribution from a pre-existing heart problem ... sufficient to have possibly given the patient an MI in the past'. Dr Brown knew the results of all the tests carried out on Mrs Overton's heart and should have known that his consultant cardiologist colleague thought there was nothing wrong with Mrs Overton's heart. However, I accept that a cardiac event could not be excluded.

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13.73 The same notes recorded the giving of 20mg morphine, which Dr Brown accepted was a grossly excessive dose. He said in evidence: '20mg morphine is a grossly excessive dose of morphine to give to somebody who has an asthmatic attack. In fact, one should probably not give it in an asthmatic attack. But if you have chest pain, 20mg is certainly far too much. It should be given in small doses incrementally.'

Dr Loh's Note

13.74 Dr Brown knew of Dr Loh's note and provisional assessment of Mrs Overton's condition. His reaction was to dismiss the content of this note as revealing only that Mrs Overton: '... had had a degree of pathology which was associated with the respiratory arrest with a possibility of it having been precipitated by morphine intravenously but no indication of when the morphine was given in relation to the respiratory arrest'.

13.75 In support of the contention that Mrs Overton had had a heart problem, Dr Brown noted that, in addition to Dr Loh's note, **'? chest pain'**, a high blood sugar level had been found and this might suggest that Mrs Overton was suffering from diabetes mellitus, which is often associated with ischaemic heart disease. Dr Brown contended that the absence of signs of a heart attack on the ECG did not exclude the possibility of chest pain resulting from ischaemic heart disease. I have said that I accept that the possibility of a cardiac problem could not be completely excluded.

13.76 Dr Brown also mentioned that Dr Loh had recorded that Mrs Overton's chest was clear; this suggested that there was no ongoing asthma and cast doubt on the cause of the initial complaint. In fact, if Mrs Overton had not had an asthma attack at all but had complained of chest pain, morphine would have been appropriate treatment, but there would still be concern about the giving of 20mg morphine as a bolus dose.

Nurse Millward's Note

13.77 Nurse Millward's note recorded that Mrs Overton's general practitioner said she had had chest pain and had been given 20mg morphine. It also recorded that on arrival at the hospital, Mrs Overton had been unconscious and her pupils fixed and pinpoint. Dr Brown said that this last observation suggested to him that morphine had been given, although the fact that she had obviously also suffered some hypoxic brain injury made it more difficult to say that the morphine was the cause of the pinpoint pupils.

13.78 Dr Brown postulated that the mechanism of the hypoxic brain injury might have been the slowing of her metabolic rate. He suggested that the low body temperature recorded (33 degrees C) might indicate the possible presence of some other pathological process and, if this was not asthma or ischaemic heart disease, 'the probability was a hypothyroidism leading to a decreased basal metabolic rate'. By 5.30am next day, Mrs Overton's body temperature was restored nearly to normal by giving her extra blankets. In the presence of the other more obvious explanation for the collapse suggested by Dr Loh and Dr Mukhopadhyay, I do not believe that Dr Brown ever seriously considered that a decrease in metabolic rate had caused Mrs Overton's collapse.

Dr Mukhopadhyay's Note

13.79 Dr Mukhopadhyay had noted that there were no adventitious sounds in the lungs when she examined Mrs Overton at about 10.40pm. To Dr Brown, this suggested that Mrs Overton might not have had an asthma attack. However, I do not think anyone could attach much weight to this argument, as, if the asthma had been stabilised by the use of a nebuliser, one would not expect to hear sounds two hours later.

Dr Brown Accepts that the Likely Cause of the Arrest Was a Combination of Asthma, Chest Pain and the Giving of Morphine

13.80 Despite the inconsistencies referred to, Dr Brown accepted in evidence that the view of Dr Loh and Dr Mukhopadhyay, that Mrs Overton had suffered a respiratory arrest precipitated by the administration of morphine, was sensible and was justifiable on the basis of the evidence available. He also accepted that the administration of morphine had played a part in Mrs Overton's collapse; in oral evidence, he said the most likely cause of the arrest was a combination of asthma, chest pain and the giving of morphine.

Dr Brown's Understanding as to the Dose of Morphine Given

13.81 Dr Brown said in evidence that he doubted the accuracy of the entries recording that 20mg morphine had been given. The dose was so large that he could not accept that it had been given. He said that he thought 20mg must have been a mistake, and that possibly 2mg, 5mg or 10 mg had been given. At the Inquiry, he was asked what steps he had taken to verify the information that the dose had been 20mg. He agreed that he had taken no steps. He said that he had in mind, at the time, that there was no good evidence as to the dose but that enquiry of, for example, Dr Lee would have produced only hearsay evidence, which would not have been good enough. I cannot accept that Dr Brown did go through this thought process, weighing up the potential value of such evidence, without taking any steps to establish how reliable the evidence was as to dosage. Enquiry of staff in the casualty department would have allowed him to ascertain where the information had come from. He might well have been able to speak to the person who had spoken to Shipman and to assess how confident that person was that Shipman had said that the dose was 20mg.

13.82 Dr Brown claimed that he had thought of telephoning Shipman to ask him what dose of morphine had been given but had decided against it. He said that he had it in mind that, even if Shipman were to admit having given 20mg morphine, and even if Dr Brown were to make a written note of this, Shipman could always later deny what he had said. I am afraid that I wholly reject Dr Brown's suggestion that these factors operated on his mind at all at that time.

13.83 I observe finally on this issue that the evidence suggesting that 20mg morphine had been given is consistently recorded throughout the notes, which mention no other dosage (except that Dr John Peters, who was Dr Husaini's registrar, once referred to diamorphine rather than morphine having been given).

13.84 If Dr Brown had been in doubt about the accuracy of the information within the notes, I would have expected him to discuss his doubts with Dr Husaini, who did not apparently share them. He did not do so. If his doubts persisted, I would have expected Dr Brown to try to find out who in the casualty department had supposedly received information from Shipman about the dosage. He did not make this attempt. If he were still unsatisfied, I would have expected him to speak to Shipman. If he were in genuine doubt about the dose given, it would be important to find out the true dose and to give Shipman the opportunity to correct the misapprehension that was current in the hospital.

13.85 I can accept that Dr Brown might have hesitated to do that because he might have thought that Shipman would have a motive to understate the dose. I also accept that, with the benefit of hindsight, we know that Shipman would almost certainly have lied to Dr Brown. But the fact that Dr Brown did not voice his doubts or make any of the enquiries I have mentioned suggests to me that he was not then in the state of doubt that he now claims he was in. It appeared to me that, at this stage of his evidence, Dr Brown was 'clutching at straws' in his attempts to justify his supposed doubts about the history and the cause of Mrs Overton's collapse. However, the evidence which satisfied me completely that Dr Brown never thought that the dose had been mistakenly recorded and had never doubted that morphine was the cause of that collapse was the content of his police statement.

Dr Brown's Police Statement

13.86 After Shipman's arrest but before his conviction, the police were investigating Mrs Overton's death. Dr Brown was asked to provide a statement. Before doing so, on 9th March 1999, Dr Brown telephoned the Medical Defence Union (MDU) for advice. Dr Brown explained that Mrs Overton was thought to have collapsed following a possible asthma attack or myocardial infarction. She had then been nebulised and given morphine by her general practitioner, following which she had gone into cardiac arrest. She had been taken to hospital where she had survived in a persistent vegetative state. Dr Brown went on to explain that he would be critical of the dose of morphine given and wanted to know whether he needed to instruct his own solicitor. He was told that he did not.

13.87 On 15th March, Dr Brown wrote to the MDU, enclosing the statement that he proposed to send to the Greater Manchester Police (GMP). He said that he would particularly welcome advice from the MDU on his concluding comments in which he stated his opinion as to the actions of another doctor. That statement was approved by the MDU. The advice given to Dr Brown was that, so long as his concluding comments amounted to **'fair comment'**, they could reasonably remain in the statement.

13.88 The statement contains a clear and concise narrative of the circumstances surrounding Mrs Overton's collapse and admission to hospital. It also contains logical and unequivocal criticism of the treatment given by Shipman, unqualified by any of the reservations Dr Brown was later to say he had felt about the accuracy of the information contained in the hospital records. Dr Brown wrote:

> **'If the initial diagnosis of an asthmatic attack was correct, it was treated appropriately with the nebulisers. Intravenous Morphine plays no part in**

the management of patients with asthma outside the hospital. There is a statement in the notes by the admitting physician that she may have had chest pain, although this contradicts the clear statement of the casualty officer that she had no chest pain prior to her collapse. While intravenous Morphine has a place in the management of acute myocardial infarction (heart attack) I have always understood that it should be given intravenously, in small amounts, with time between doses to assess the affect [*sic*] **of the drug. In addition, it would be essential to monitor the heart rate and blood pressure of the patient in order to detect any signs of a cardiovascular collapse. In my experience of managing patients who have developed wheeze following a heart attack, I have never seen a dose of 20mg of Morphine used. I should add that I am familiar with the administration and effects of Morphine because in my work as an anaesthetist I regularly administer Morphine intravenously to patients undergoing surgery. I am also familiar with the use of Morphine post-operatively in patient controlled analgesia pumps and it is common for these pumps only to allow 1mg of Morphine to be given at a time with five minutes elapsing between doses of Morphine.'**

His considered opinion was expressed as follows:

'It was my opinion at the time that the patient's initial management by the general practitioner was highly unusual even dangerous.'

13.89 I cannot believe that Dr Brown would have made such a statement to the police if he had harboured any doubts about the dose of morphine Shipman had given or the cause of Mrs Overton's collapse. It is quite clear that he is describing there what had been his opinion at the time when he was treating Mrs Overton, and not any opinion informed by later events, such as Shipman's arrest. I am satisfied that, in common with many other hospital staff, Dr Brown believed in 1994 that Mrs Overton's collapse had been caused by the highly unusual and dangerous administration of a bolus dose of 20mg morphine.

Dr Brown Speaks to Mrs Overton's Family

13.90 Dr Brown recalled that his first conversation with Mrs Overton's family took place on 21st February and I am sure this is correct. He said that he thought it important for him to speak to the family to see what they knew about the prognosis. He told them that it was grim. An entry in the nursing notes for that day confirms that such a discussion took place:

'Parents and daughter interviewed
by Dr Brown and given poorest possible
prognosis. No further visitors since.'

13.91 Dr Brown had learned earlier that day that Mrs Overton's brother was a general practitioner. That evening, he spoke to Dr Overton alone. Again, an entry in the nursing notes confirms that such a discussion took place. Dr Brown told the Inquiry that he spoke to Dr Overton as he wanted to raise his concerns about the fact that Mrs Overton had been given morphine, which would not normally be given to an asthmatic. When asked by his

own counsel what had been his purpose in speaking to Dr Overton, he replied: 'To tell Dr Overton that as well as the bleak prognosis that his sister had, that a dose of morphine had been administered by the general practitioner and for him to consider whether he felt the matter should be taken further.' Dr Brown said that, had Dr Overton not been medically qualified, he would have told the family that the matter had to be taken further but that – out of respect for his professional colleague – he could not, in Dr Overton's case, be so 'directive'.

13.92 Dr Overton recalled that his conversation with Dr Brown took place on the evening of 18th February. I am sure he is mistaken, as he accepted may well be the case. Dr Overton agreed that Dr Brown told him that his sister had been given morphine and that she was known to be an asthmatic. Dr Overton's recollection was that Dr Brown asked him whether he understood the significance of what he was being told. Dr Overton said that he did. He realised that morphine should not usually be given to an asthmatic patient. He also realised that Dr Brown was giving him this information so that he and the rest of the family could consider whether or not to take any further steps. Dr Brown and Dr Overton agreed that Dr Brown did not tell Dr Overton either that the dosage given was 20mg or that it had been given as a bolus dose. Dr Overton learned this important further information only when supplied with the relevant papers by this Inquiry. This is a very surprising and disturbing omission on the part of Dr Brown.

13.93 There are two reasons why I find this omission disturbing. First, there is a world of difference between the information given to Dr Overton and the picture as Dr Brown knew it to be. It might well be understandable for a doctor, in the heat of the moment, to give a small titrated dose of morphine to an asthmatic who began to complain of chest pain. But the administration of a 20mg bolus dose could not be so readily understood. If Dr Brown had been in genuine doubt about the dose given and had genuinely had in mind that further enquiry of Shipman or the person at the hospital who had spoken to him would be fruitless, he should at least have given Dr Overton the option of having the information clarified. Second, although Dr Brown said that his intention was to alert Dr Overton to the possibility of making a complaint, I am not convinced that is correct or, at least, that it tells the whole story. Dr Brown must have expected that Mrs Overton's brother, being a doctor, would be bound to ask what had caused the collapse. In speaking to Dr Overton, Dr Brown was supplying some of the information that Dr Overton would be expected to seek. However, Dr Brown must have recognised that, by giving only part of the picture, and presenting it in a relatively innocuous way, there was a very real danger that Dr Overton might be put off further enquiry.

13.94 Dr Overton was about nine years younger than his sister. They were not close. They saw one another every month or two, at Christmas and on family occasions. I formed the impression that Dr Overton probably thought that his sister would have been a very demanding patient for Shipman to have on his list. In a statement he made to the Inquiry, he described her as a **'heartsink'** patient, meaning that she was the kind of patient who would cause her doctor's heart to sink when she attended for an appointment. He confirmed to me, however, that Mrs Overton shared the widely held view that Shipman was an excellent doctor. She had nothing but praise for him. Dr Overton told me that he knew that Shipman also enjoyed a good professional reputation locally.

13.95 Dr Overton explained to his family that there was the possibility of bringing a claim against Shipman. He had, as I have said, only incomplete information. His understanding was that his sister had developed chest pains after being successfully treated for an asthma attack. He believed that Shipman had thought these pains were cardiac in origin. He felt that Shipman had made an honest mistake in stressful, chaotic circumstances. He did not believe that the mistake had arisen from lack of knowledge. In oral evidence, he said: 'Morphine can certainly be used for cardiac pain. So in that way it would not have been a surprise that he may have felt it necessary to give it her but unfortunately with the asthma it is not appropriate ... I realise that it is not considered normal practice. In the heat of the moment in an emergency situation, I felt he would have made a clinical judgement – not a judgement I would have made but that is how it seemed at the time, that he made that clinical judgement.'

13.96 The family decided that they did not wish to pursue any complaint or claim. They trusted Shipman and believed that he had made a genuine mistake. Mrs Carrington was also a patient of Shipman and she held him in very high regard because of the way in which he had cared for her. Mrs Overton's parents were strongly opposed to the idea of making any complaint or claim. This was obviously an extremely distressing time for the family. I entirely understand the decision not to take things further, especially as it was founded on the incomplete information provided by Dr Brown.

13.97 Dr Overton can have had no reason to doubt the accuracy of the information he had been given. Dr Brown had ostensibly made a special effort to ensure that the family was informed of his concern over the administration of morphine and Dr Overton could not have suspected that important information was being withheld. Unless told otherwise, his expectation would be that the morphine had been administered in the usual way and in the usual dose. When asked at the Inquiry what the decision of the family would have been if he had been told that Shipman had given 20mg morphine as a bolus dose, Dr Overton thought that this might have altered the course that the family decided to take. He emphasised, however, that his father was vehemently opposed to any complaint being made. It seems to me that, if all the relevant information had been furnished by Dr Brown and if Dr Brown had expressed his view that the declared dosage, if given, was **'highly unusual even dangerous'**, Dr Overton would have been very shocked and would probably have advised the family to make a complaint. I can understand that he would wish to protect his parents and niece from further distress but I think he would have felt it right to take some action.

13.98 On the afternoon of Friday, 25th February, Dr Overton and Dr Brown spoke again. The nursing notes record a conversation in which Dr Brown is said to have informed Dr Overton of the lack of progress and the bleak prognosis. Dr Brown recalls that it was on this occasion that he was told that the family did not want to take the matter further and Dr Overton accepted that this might have been the case. There is no doubt that Dr Overton told Dr Brown of the family's decision. The timing is not important. I am satisfied that, by about 25th February, Dr Brown knew that, if any concerns about Shipman's treatment of Mrs Overton were to be pursued at all, the initiative would have to come from the senior staff at the hospital, in effect, himself, Dr Husaini or both.

Dr Brown Decides to Take No Further Action

13.99 Dr Brown told the Inquiry that he was informed that the family did not want to take the matter further because Shipman was a good doctor, a judgement which Dr Brown had no reason to doubt. He said that he felt that, without the support of the family, he could not initiate the enquiries necessary to gain more evidence of the quantity of morphine given. He said that the first step he would have taken would have been to obtain a letter of referral from Shipman, something which, if Shipman refused, he could not have insisted upon without the authority of the family. I am wholly unpersuaded by this piece of evidence. In my view, if Dr Brown had wished to put Dr Overton in the picture so that he could consider what, if any, steps the family should take, the first thing he would have wished to tell Dr Overton was that it appeared that Shipman had given a bolus dose of 20mg morphine. If Dr Brown had felt that this required verification, he would have explained that to Dr Overton. That Dr Brown did not do so persuades me that he did not intend to enable the family to make an informed choice as to how to proceed.

13.100 Dr Brown said that he decided that it would not be appropriate for him to initiate any complaint against Shipman or precipitate any investigation of Shipman's treatment of Mrs Overton. He advanced several reasons for this decision. It is only fair that, before giving my final view about these reasons, I should know more about what, in terms of reporting concerns, was generally regarded as appropriate at that time. The Inquiry will hear evidence about these matters in late 2003 and I shall address them in my final Report.

13.101 Dr Brown's first reason was that he felt he ought to honour the family's wish that no complaint should be made about Shipman. He said that, in such circumstances, as with situations where important decisions about treatment are made, the wishes of the family must be paramount. I accept that in decisions about whether a complaint is to be made, the patient or the patient's family have an important voice. However, my provisional view is that, where there is a possible danger that the apparent error made by a doctor might be repeated and harm other patients, the safety of other patients must override the wish of the family to do nothing.

13.102 Second, Dr Brown said that he was unaware of any local procedure or mechanism that would have enabled him to pursue a complaint against a general practitioner. He believed, correctly, that it would not be appropriate to do this through the 'Three Wise Men' procedure, which was available only to investigate concerns about hospital doctors. In fact, there was a procedure available by which a complaint against Shipman could have been pursued. If a report had been made to the local Family Health Services Authority, it could have referred the report to the local Medical Services Committee, which could investigate and hold a hearing. The simplest way for a doctor in Dr Brown's position to initiate this procedure would have been to inform either the Chief Executive designate or the Medical Director designate of the Trust which was to be responsible for running Tameside General Hospital, and which was due to come into being on 1st April 1994.

13.103 Third, Dr Brown said that he believed that the only route to follow was to make an individual complaint to the General Medical Council (GMC). He did not think that he had sufficient information to found such a complaint. He was concerned to strike the correct balance between the need to report a colleague's misconduct or mistake and the need to avoid

making false accusations against a colleague, and was worried that he might, by pursuing the complaint, be considered by the GMC to be acting improperly. In a supplemental statement made by Dr Brown, he said:

> **'In general I would not consider making an allegation of malpractice against another doctor unless the evidence was based on direct observation of behaviour or supported by clinical measurements.'**

13.104 Dr Brown told the Inquiry that professional etiquette had a bearing on his decision not to pursue the matter further. He said that, as part of doctors' training, they are told to be very reluctant to criticise other doctors or to pass opinions on them. In fact, when doctors not involved in the treatment of a patient are asked about that treatment by patients or others who are concerned, it is usual for them to say, 'I am sorry, I cannot say anything. I was not there to judge.' I accept that Dr Brown was genuinely influenced by this consideration. His decision to telephone the MDU for advice before giving the police a statement about Mrs Overton confirms that, as recently as 1999, he was hesitant about criticising a fellow practitioner, even one who had been arrested for murder.

13.105 Fourth, as to raising his concerns with the Chief Executive or any other individual or body, Dr Brown claimed that he knew that, before making any allegations, he had to have firm evidence and he considered that the clinical notes were insufficient for this purpose. I shall consider Dr Brown's position further, later in this Chapter and will now continue my account of Mrs Overton's history.

Mrs Overton's Transfer to Ward 17

13.106 Mrs Overton's condition did not alter significantly during her stay in the ITU but it was possible to wean her from the ventilator on 27th February. She was transferred to ward 17 on 1st March. The prognosis remained very poor. I am satisfied that, by this time, it was common knowledge in the ITU, and was soon to become common knowledge on ward 17, that the reason for Mrs Overton's collapse was that she had been given an overdose of morphine by her general practitioner.

The Issue of Withdrawal of Treatment

13.107 Some time before her collapse, Mrs Overton had told her daughter that, if ever she were to be in a vegetative state, she would not wish her life to be prolonged by artificial means. The two women had been discussing the case of Mr Anthony Bland, the Hillsborough victim. Mr Bland's parents had sought the permission of the High Court to withdraw life-sustaining treatment from their son, who was in a persistent vegetative state and the case was much in the news in the early 1990s. The case was heard in the Family Division of the High Court in November 1992 and in the Court of Appeal and the House of Lords in December 1992. Their Lordships' opinions were delivered on 4th February 1993.

13.108 In the light of this expressed wish, and provided they were satisfied that Mrs Overton's prognosis was hopeless, her close relations had no desire for her life in a vegetative state to be prolonged by medical intervention.

13.109 On 3rd March, Dr Peters, Dr Husaini's registrar, was involved in a discussion with the family, in the course of which they communicated their views to him. Dr Peters made a note of their wishes in the hospital records and decided that he should discuss the matter with Dr Husaini.

13.110 That discussion with Dr Husaini apparently took place at 3.30pm on Friday, 4th March. Dr Husaini agreed that Mrs Overton should not be resuscitated in the event that she stopped breathing. She was to continue with full nursing and medical care, at least until Dr Husaini had reviewed the latest electroencephalograph (EEG), which was not at that time available. Dr Peters made a note of this discussion.

Dr Husaini Contacts the Coroner

13.111 Three days later, on Monday, 7th March, Dr Husaini contacted the Coroner for Greater Manchester South, then Mr Peter Revington. According to Dr Husaini, he was seeking advice on two issues. First, he was concerned that Shipman had given morphine, which had caused a respiratory arrest and brain death, and that its administration had been a mistake. He wanted advice from Mr Revington about how he should pursue his concerns. Second, he wanted to know whether the withdrawal of treatment was legally possible.

13.112 I am unable to accept that Dr Husaini sought advice from the Coroner about his concerns over the administration of morphine. The evidence suggests irresistibly that his only purpose was to seek advice about Mrs Overton's future management. There are a number of reasons for this conclusion.

13.113 First, in Dr Husaini's clinical note of 7th March, there is no reference to his concerns about Shipman's treatment. On the contrary, the note deals explicitly and exclusively with future treatment issues noted by Dr Peters on 3rd and 4th March. The note reads:

> **'Mr Rivington** [*sic*] **Coroner consulted.**
> **He says that the patient is not legally dead** ∴
> **do not** [*illegible*] **withhold food**
> **or antibiotics or any**
> **other medical or nursing treatment required**
> **SEEK COURT ORDER IF**
> **WE WISH.'**

The advice from Mr Revington in connection with the seeking of a court order can have referred only to an application to withdraw life-sustaining treatment.

13.114 Second, the nursing note for 7th March records that the EEG report had been received and revealed no cerebral activity. It continued to the effect that, after review of the EEG, Dr Husaini had contacted the Coroner **'re: further management'** and made no mention of any expression of concern.

13.115 Third, the timing of the contact with the Coroner points towards its having been prompted by the recent discussion about the withdrawal of treatment.

13.116 Fourth, the Coroner would have been an improbable person to contact for advice about how to pursue concerns about treatment. As I have already suggested, one obvious first

port of call would have been someone within the hospital administration, such as the Chief Executive designate, Mr Roger Butterworth.

13.117 Finally, when Dr Husaini wrote to his defence body following Shipman's arrest, asking how he should respond to a request by the police for a statement, he did not suggest that he spoke to the Coroner about the concerns he had but wrote:

'I did speak to the Coroner regarding ... withholding treatment.'

13.118 After speaking with the Coroner, Dr Husaini spoke to Mr Butterworth later that same day.

Dr Husaini's Contact with Mr Butterworth, Mrs Nuttall and Mr Howorth

13.119 Dr Husaini told the Inquiry that, when speaking with Mr Butterworth that day, he informed him of the two issues he had raised with the Coroner. His evidence as to the concern he expressed about the treatment given was inconsistent. At one stage in his evidence, he said that he told Mr Butterworth that the treatment given had been incorrect but, at other times, he explained that he had not said that he thought the general practitioner was to blame because he did not want to pass judgement on his conduct in that way. He said that he contemplated that there would be a meeting about the issue of treatment by the general practitioner, attended by those members of the hospital staff who had understood that morphine had been given. According to Dr Husaini, Mr Butterworth said he would ask Mrs Lynn Nuttall, the Hospital's Business Manager, to contact Dr Husaini.

13.120 In evidence, Mr Butterworth denied that Dr Husaini had mentioned the circumstances in which the collapse had occurred. I accept his evidence. Again, I rely on a note made by Dr Husaini at the time, the emphasis of which is the same as the emphasis of the note of his contact with the Coroner. It makes no mention of concerns about past treatment but focusses on withdrawal of treatment issues. It reads as follows:

'Mr Butterworth chief executive informed
Father and Mother informed
re E.E.G. flat
& will be repeated
day after tomorrow
after withdrawal of
Epilim
We need a court order
to stop treatment.'

13.121 At some stage during the following fortnight, Mrs Nuttall also contacted Dr Husaini. According to Dr Husaini's oral evidence to the Inquiry, he told Mrs Nuttall also of his concerns about the treatment given. He said: '... I spoke to her about what I spoke to Mr Revington and to Mr Butterworth and that is although the patient was under my care, I was not satisfied with all the aspects of her illness and what led to her illness as well as for her future care.' For her part, Mrs Nuttall says that Dr Husaini raised only one matter with her, that of the possibility of withdrawing Mrs Overton's treatment.

13.122 In a memorandum dated 21st March, Mrs Nuttall asked Dr Husaini to write to Mr Charles Howorth, legal adviser to the then North West Regional Health Authority, with

Mrs Overton's full medical history and other relevant details. She did not ask him to articulate any concerns he had about the treatment Mrs Overton had received, as I would have expected her to do, if Dr Husaini had mentioned them to her. She informed Dr Husaini that Mr Howorth would advise him of the steps to take and that she was available to give further help if this was required.

13.123 The contents of this memorandum suggest strongly that Mrs Nuttall had in mind only the future treatment of the patient and not an investigation of concerns about past treatment. Her oral evidence was that, had Dr Husaini told her that he was concerned about Mrs Overton's treatment at the hands of her general practitioner, she would have remembered it. She said that she would have returned to Mr Butterworth to convey those concerns to him and that, as she did not do so, she cannot have been told of such concerns. I accept her evidence and reject that of Dr Husaini.

13.124 Dr Husaini wrote to Mr Howorth on 24th March. The letter is very clear. It explicitly seeks advice about Mrs Overton's future management but does not even obliquely seek advice about how Dr Husaini might pursue his concerns about past treatment. The only reference to the administration of morphine is couched in rather reassuring terms. The suggestion is that it might have been given for **'restlessness'**, but it does not say (as is the case) that it would be wholly inappropriate for it to be given for that condition. There is no suggestion in the clinical notes that morphine had been given for that reason. The letter mentions that Mrs Overton had a history of asthma but does not say that morphine should not be given to an asthmatic. Nor does the letter say that the dosage of morphine was dangerously high or that it was the administration of morphine that led to the collapse. It only implies that morphine might have been the cause by referring to the reversal of the respiratory arrest by the giving of naloxone, the antidote to morphine. Nor did Dr Husaini state who had given the morphine. If he intended to raise concerns, it is surprising that he did not identify the object of his concerns.

13.125 In oral evidence, Dr Husaini said that, when writing this letter, he thought that the circumstances of Mrs Overton's collapse would be investigated. He wanted to know what he should do next and believed that Mr Howorth would take into account not only the contents of the letter, but also the contents of the conversations that he had had with Mr Butterworth and Mrs Nuttall.

13.126 I regret to say that I am firmly of the view that, when writing this letter, Dr Husaini did not intend to communicate his concerns about past treatment to Mr Howorth. In evidence, he acknowledged that his letter, looked at carefully, did not communicate his concerns. It appears to me that Dr Husaini probably deliberately avoided mentioning his concerns. His reference to the giving of morphine for restlessness seems designed to explain away its administration rather than to raise any concern about it.

13.127 By 14th April, Mrs Nuttall had spoken to Mr Howorth. In a memorandum to Dr Husaini of that date, she mentioned the case of Mr Bland and another case concerning the withdrawal of treatment from a patient in a persistent vegetative state. Judgement in the Bland case had been delivered in February 1993 and the other case had been heard by the Court of Appeal in January 1994. She told Dr Husaini that she was awaiting copies of the judgements in those cases. She would then arrange for them to meet to discuss **'what**

the next steps will be'. Mrs Nuttall believes that, a short time later, she passed copies of the court transcripts to Dr Husaini and then left matters in his hands.

13.128 The memorandum of 14th April represents yet further contemporaneous evidence that Dr Husaini and the hospital administrators were concerned only with the issue of withdrawal of treatment. I am satisfied that neither Mr Butterworth nor Mrs Nuttall were ever aware of the concern that had been felt about the circumstances of Mrs Overton's collapse. I am also quite satisfied that Mr Howorth, who is a lawyer and not a doctor, believed that his opinion was being sought only in connection with the question of Mrs Overton's future management.

13.129 On 15th April, Mr Howorth wrote a letter, responding to Dr Husaini, saying that he had discussed the situation with Mrs Nuttall, that he had written to her with information **'relating to the legal position'** and suggesting that Dr Husaini liaise further with her.

13.130 Dr Husaini remembers being told that, before any application could be made to the court for permission to withdraw treatment, the patient had to be in a persistent vegetative state for 12 months from the time of the collapse. This is consistent with the medical evidence in the Bland case, which was to the effect that, if a patient in such a state shows no signs of recovery after six months, or at most a year, there is no prospect of recovery. It may be that Dr Husaini read this in the transcripts with which he was provided. Alternatively, he may have become aware of it following the involvement of Dr David Shepherd.

The Involvement of Dr Shepherd

13.131 Dr Shepherd was a visiting consultant neurologist to Tameside General Hospital, based at North Manchester General Hospital. He retired on health grounds in December 1998 and was unfit to attend the Inquiry to give oral evidence. In April 1994, he was asked to see Mrs Overton, with a view to advising on her future treatment, and he saw her on 25th May. It is unlikely that he spoke directly to Dr Husaini about Mrs Overton. After examining her, Dr Shepherd recorded his opinion that, three months post-collapse, the likelihood of recovery was remote but that her persistent vegetative state or coma vigil state could not be said to be unequivocal and, therefore, permanent until 12 months had elapsed. According to him, Mrs Overton was not **'brain stem dead'** because she was breathing spontaneously.

13.132 I accept Dr Shepherd's written evidence that he had no concerns about the circumstances of Mrs Overton's admission to hospital. His knowledge of morphine was very limited; he had not prescribed it for about 30 years. The effect of a 20mg dose of morphine would have been outside his area of expertise. His concern and the sole purpose of his visit was to advise on Mrs Overton's current condition and prognosis.

Mrs Overton Remains on Ward 17

13.133 Mrs Overton remained on ward 17. She received a very high standard of nursing and medical care, although an acute medical ward, such as ward 17, was not an ideal environment for a long-term patient. The staff became attached to her. She was a fixture on the ward, an unconscious human presence, who nonetheless inspired affection. Her

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family appreciated the treatment that Mrs Overton received at the hospital and were very keen for her to remain there.

13.134 For much of the duration of her stay, however, there loomed on the horizon the prospect that she would be removed to an alternative placement, in a nursing home or similar establishment. In early May 1994, even before Dr Shepherd visited her, it was mooted that she might be transferred to a local long-stay facility in Chadderton. Later in the year, the possibility was raised that she might be transferred to the Royal Hospital and Home, Putney, London. This was a specialist unit with experience of managing persistent vegetative state patients. The family were unhappy at the prospect of a move but the possibility remained open into the New Year.

13.135 Quite apart from the fact that the family wanted Mrs Overton to stay on ward 17 because of the high quality of care she was receiving, there was another good reason for opposition to a move. Such a move could well have had severe financial and social consequences for Mrs Carrington, who had paid many of her mother's debts and had maintained the mortgage repayments on their home. If Mrs Overton were to be transferred to a nursing home, it appeared that charges would be payable and these would have to be defrayed from Mrs Overton's capital. The equity in her home represented her only capital and, if that had to be realised, her daughter would be rendered homeless. Such a possibility was to be avoided at all costs. Dr Overton represented the family in correspondence and meetings with the hospital staff and sought to ensure that his sister was not transferred from the hospital.

13.136 In early 1995, there were further discussions between the hospital and the family about Mrs Overton's future. An entry in the clinical records at this time recorded improved cerebral activity; a transfer to Putney was to be reconsidered. At a meeting on 20th January, it was decided that Dr Shepherd should be instructed again, with a view to his advising on future management and also as to whether there were any suitable specialist units in the North West. On 25th January, Dr Shepherd advised that Mrs Overton's clinical condition had not changed, although the signs on her EEG had improved. He advised that the hospital should contact Dr Krystyna Walton, who ran a local rehabilitation unit in Rochdale. He also mentioned the possibility of an assessment at the Royal Hospital and Home and said that Dr Keith Andrews, who was based there, was **'the main expert'** on persistent vegetative state in the United Kingdom and might be able to offer some help with regard to withdrawal of treatment.

13.137 Dr Walton is a consultant physician in rehabilitation medicine and the Head of the Floyd Unit for Neurological Rehabilitation at Birch Hill Hospital, Rochdale. She was asked to assess Mrs Overton's suitability for admission to her unit and examined her on 30th January 1995. Dr Walton's recollection of her conversation with the nursing staff on ward 17 was that consideration was being given to withdrawal of treatment and that, since this could not be done on the ward, the Floyd Unit was seen as a possible alternative place for this to be done. I am satisfied this was not the intention of the medical staff and that there was a misunderstanding between the nursing staff and Dr Walton. In any event, Dr Walton quickly realised that Mrs Overton was not suitable for rehabilitation in her unit. She made an entry in the notes, recommending a nursing home placement at Chadderton Total Care

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(which had been discussed nine months earlier). However, Mrs Overton remained on ward 17 and no further steps of any significance were taken with a view to her transfer.

The Weeks Leading up to Mrs Overton's Death

13.138 I am slightly disadvantaged in describing Mrs Overton's clinical course during the weeks leading up to her death because no clinical records are available for the period beginning on 7th March and ending on 20th April. I am quite satisfied that some such records must have been made and I was for some time worried about the possible circumstances in which they had gone astray. However, having seen and heard the evidence of those treating Mrs Overton, having seen the nursing notes (which are available) and having read an account of the attempts that have been made to locate the missing notes, I am satisfied that there is no sinister explanation for their disappearance.

13.139 The evidence from the nursing notes, supported in many respects by the evidence of the witnesses, reveals that, at the beginning of March 1995, Mrs Overton developed an infection around the site of her gastrostomy feeding tube. This was treated with antibiotics. She was also suffering from symptoms of acid reflux and related gastric problems. She seemed to recover from these ailments in about the middle of March.

13.140 On 22nd March, just over 13 months after Mrs Overton's original admission, Dr Husaini again sought Dr Shepherd's advice. He wanted to know whether the presence of cortical activity in the brain excluded a diagnosis of persistent vegetative state. Dr Shepherd advised that it did not but that an EEG suggesting that there was a response to external stimuli would exclude such diagnosis. On 11th April, almost certainly as a result of this advice, a further EEG was ordered, but there was some uncertainty about precisely what was required and the EEG was cancelled on 20th April.

Mrs Overton's Death

13.141 Early in the morning of Friday, 21st April, a nurse, Mr Michael Berrisford, was on duty on ward 17. He remembers checking on Mrs Overton at about 5.15am and finding that she was not breathing. He listened to her chest and heard no heartbeat. He made the following note:

> **'0515 hrs Checked to see if alright, found Renata not to be breathing with no pulse. Sr on block phoned. Dr Davies contacted. No warnings, noises prior to this routine check.'**

13.142 Mr Berrisford called the nursing sister on duty, Sister Mariko Tazaki (now Sharples), and the on-call doctor, Dr Jacqueline Davies (now Shaw). According to Sister Tazaki's note, Dr Davies attended at 6.20am and confirmed that Mrs Overton was dead. Dr Davies' note records that she was asked to see Mrs Overton and confirmed that she was dead, finding

neither breath sounds nor heart sounds. An entry written in the margin of the notes, recording the time as 5.30am, was probably made by Dr Rachel Pyburn, to whose involvement I shall turn shortly. It is unclear to what precise event this time is intended to refer.

13.143 It is clear that Mrs Overton's death came as a shock to those who were involved in her care. It came as an emotional shock because they were fond of her. It also came somewhat unexpectedly, as Mrs Overton had not been suffering any acute illness that led those about her to believe that her death was imminent. Everyone recognised, however, that the nature of her chronic condition was such that she might die at any time.

The Report of the Death to the Coroner

The Evidence of Dr Pyburn

13.144 Dr Pyburn graduated from Newcastle University in 1989. She is now a consultant geriatrician at Hope Hospital, Salford. She arrived at Tameside General Hospital in July 1994 and was initially assigned to work as a medical registrar on ward 17. She left ward 17 during the same month, but returned there in February 1995.

13.145 In late July 1994, just before they both left ward 17, Dr Rushton told Dr Pyburn about the circumstances of Mrs Overton's collapse and admission. Dr Pyburn told the Inquiry that she shared Dr Rushton's concern that the collapse had been caused by morphine being given following an asthma attack. She was told, probably by both Dr Rushton and Dr Husaini on her first ward round on ward 17, that the circumstances had been 'gone into' following Mrs Overton's admission to hospital. She was made aware that the matter had been discussed by Dr Brown with Mrs Overton's family following her admission and that one member of the family was a doctor. She could not remember being told that the matter had been referred to the Coroner or the GMC. Nor could she remember the detail of what Dr Husaini had said about any enquiry or investigation that had taken place. Dr Pyburn then had no involvement with Mrs Overton until her return to ward 17 the following February.

13.146 Dr Pyburn has no recollection of Mrs Overton's condition in the days and weeks leading up to her death. Whilst she was not expecting Mrs Overton to die, the death was not, in Dr Pyburn's words, 'a total surprise'. She told me that she was saddened by it. Dr Pyburn probably learned of the death at some time before 9am on 21st April. She immediately felt that she had a responsibility to report the death to the coroner. That sense of responsibility was also tinged by concern that the general practitioner in question (whom she did not at that stage know by name) was bound to be affected and possibly upset by the investigation into the death that she expected would follow. She told the Inquiry that she believed that Mrs Overton's case was 'a complete tragedy' that had resulted from 'medical error'. It was the circumstances of the original collapse that caused her to report the death and not the fact that she could not confidently state what specific condition had caused Mrs Overton to die when she did.

13.147 Dr Pyburn described personal circumstances that strengthened her resolve to ensure that the case was properly reported. Her grandmother had died following an asthma attack

and her grandfather had believed that more might have been done at the time to save her life. Dr Pyburn had only learned of this some years later when she became medically qualified. Moreover, her personal experience that coroner's officers were sometimes keen to persuade junior doctors to suggest a natural cause of death meant that she decided not to delegate the task of telephoning the coroner's office.

13.148 Dr Pyburn said that she telephoned Dr Husaini to ask whether he wished to report the death to the coroner or whether she should do so. He agreed that it should be done and said that she should do it. She telephoned the coroner's office in the mid-morning. There is a sharp conflict of evidence between Dr Pyburn and Mrs Mary Evans, the coroner's first officer at that time, as to what was said by Dr Pyburn.

13.149 Dr Pyburn's evidence was that her conversation with Mrs Evans lasted about ten minutes. She told the Inquiry that she sought to explain that Mrs Overton's respiratory arrest and death had been caused by the giving of morphine in circumstances in which morphine would not normally be expected to be given. However, because she had not been present at the time of the collapse, she said that she wanted to avoid giving the impression that she was judging the issue and she avoided using the word 'negligence'. She said: 'I would have quite a clear recollection of my intentions in ringing the Coroner's office and also in struggling with words at various times to try and convey what had happened without using the word '*negligence*'. I would not have wished to use the word '*negligence*' because I had not been present at the time and that would seem to be a judgement that somebody ought to make after an appropriate investigation.'

13.150 Dr Pyburn said that she believed that she was quite clear in saying that there had been a 'medical mishap' and that she told Mrs Evans so. However, in the light of what she said in the above extract, I doubt that Dr Pyburn used any expression as clear as that. This was unfortunate because, as Dr Pyburn realised, Mrs Evans was not medically qualified and could not be expected to understand the significance of the giving of morphine unless it were spelled out to her.

13.151 Dr Pyburn said that she was sure that she had said enough to satisfy Mrs Evans that the death ought to be investigated. She said that she did not seek to put forward any provisional causes of death and that she never contemplated that the coroner might 'accept' any cause of death that she proposed. She always believed that there would have to be an inquest.

13.152 I am puzzled by Dr Pyburn's reluctance to mention the word 'negligence' or otherwise to spell out her concerns in clear terms. She acknowledged that she felt a degree of concern for the doctor, who was unknown to her, upon whose head she would bring trouble by making the report. I cannot understand why, if she had decided to make a report because of her concern about the circumstances of Mrs Overton's collapse, she felt unable to say that, although she had not directly observed the circumstances of Mrs Overton's collapse, the clinical notes made at the time suggested that the general practitioner had made a serious mistake and had given a gross overdose of morphine with terrible consequences. It may be that Dr Pyburn's unwillingness to use clear words reflects an attitude that is widespread among doctors, namely a reluctance to comment, even hypothetically, on the conduct of colleagues.

13.153 Following her conversation with Mrs Evans, Dr Pyburn made a note in Mrs Overton's clinical records, as follows:

> **'D/W Dr Husaini, to D/W Coroner's Officer.**
> **HM Coroner's officer feels post mortem is required.**
> **No DC** [*death certificate*] **to be issued.'**

The second line of this entry suggests that Dr Pyburn might have been less determined that the case should be fully investigated than she claimed. The words suggest either that Dr Pyburn was enquiring of the officer whether or not an autopsy was required or that she was actively suggesting to the officer that an autopsy was not necessary but that the officer felt that it was. Dr Pyburn strongly denied that this was the case when it was put to her by Senior Counsel to the Inquiry. She said that she was recording that Mrs Evans had agreed that an autopsy was required and that a death certificate was not to be issued. I find that assertion hard to accept, as it is not really consistent with the words used. I think that expressions such as 'HM Coroner's officer agrees' or 'HM Coroner's officer also feels' would have been far more appropriate to convey what Dr Pyburn told the Inquiry was said and would quite readily have come to her mind.

The Evidence of Dr Husaini

13.154 In his witness statement, Dr Husaini said that he agreed that Mrs Overton's death must be reported. This was partly because the death was sudden and of unknown cause. In oral evidence, he said that the only reason for making the report was on account of the concern over the administration of morphine. I am uncertain as to what was in Dr Husaini's mind, or even that he applied his mind to the point at the time. It is possible that he simply agreed with Dr Pyburn's proposal that the death should be reported and believed her to be a suitable person to make the report. That Dr Husaini did not speak to the Coroner himself tends to confirm my view that he had not mentioned his concerns about the circumstances of Mrs Overton's original collapse when he had spoken to the Coroner in March 1994. Had he done so, I would have expected him to wish to remind the Coroner that the person to whom he had earlier referred had now died and he remained concerned about the circumstances of her collapse which were directly related to her death. At the very least, I would have expected him to tell Dr Pyburn that he had explained his concerns about Mrs Overton to the Coroner. Dr Husaini said that he told Dr Pyburn but Dr Pyburn had no recollection of being told this.

13.155 The fact that Dr Husaini delegated to Dr Pyburn the task of reporting the death to the Coroner casts doubt on his determination that the matter be fully investigated, as does his subsequent inactivity when there was no inquest. Moreover, it is unlikely that he told Dr Pyburn about the earlier referral to the Coroner. Had he done so, I think Dr Pyburn would have mentioned it to Mrs Evans and it appears that she did not.

The Evidence of Mrs Evans

13.156 In 1995, Mrs Evans was the first coroner's officer. She had begun working in a clerical/typing/secretarial role in 1974. In about 1984, she had become the coroner's second

officer and in 1985 she became first officer. In giving evidence, she had no independent recollection of her involvement in the reporting of Mrs Overton's death but recognised her writing on the report of the death, which must have been completed during her conversation with Dr Pyburn. She said that the extent of her involvement was to receive the report and then (after consultation with Mr Revington) to arrange an autopsy.

13.157 Mrs Evans' account is necessarily a reconstruction of events based on what she recorded at the time. She completed the heading of the form and recorded Mrs Overton's name, age, address and date and place of death. She then recorded, in the section described as **'Brief Report'**:

> **'Admitted 18.2.94 after a respiratory arrest.**
> **Had been in a coma for over a year.'**

This information is written in black ballpoint pen, but certain additional information, concerning details of Mrs Overton's next of kin (her brother) and the causes of death I(a)–(c), are written in pencil. Mrs Evans explained that she would use the ballpoint pen to record the account taken from Dr Pyburn. She said that she would then have changed to pencil to record Dr Pyburn's suggested causes of death, as these could only be provisional, until 'accepted' by Mr Revington. After recording the provisional causes of death, she would have continued to use a pencil to record the details of the next of kin. In the **'Cause of Death'** section, she wrote:

> **'I(a) Persistent vegetative state**
> **(b) Respiratory arrest**
> **(c) Asthma + morphine administration.'**

13.158 According to Mrs Evans, the conversation with Dr Pyburn cannot have been as Dr Pyburn claimed. First, it must have lasted less than ten minutes. Second, Dr Pyburn can only have given a brief account of the death and cannot have mentioned morphine until she provided the provisional causes of death. Third, Mrs Evans maintained that Dr Pyburn was seeking to provide provisional causes of death, which, if Mr Revington had been prepared to accept them, would have become the registered causes.

13.159 Mrs Evans' evidence as to whether she had or had not been told that the morphine had been given in inappropriate circumstances was inconsistent. In her written statement, she seemed to suggest that she had not been told this. However, when questioned by counsel for Dr Pyburn, she at times seemed to agree that she had. As she had no direct recollection of this event, I infer that this evidence shows that Mrs Evans does not know whether or not Dr Pyburn said that. Mrs Evans denied that she had been told that there was any causal connection between any medical treatment given to Mrs Overton and her death, even though, of course, she wrote that the underlying causes of death were **'Asthma + morphine administration'**. Mrs Evans said that she recognised that morphine administration was being put forward as a cause of the death and was not just mentioned incidentally as being the treatment for the primary pathological cause.

13.160 According to Mrs Evans, after she had taken down the report of the death, she would have discussed it with Mr Revington, who must have said that there should be an autopsy. She would then have spoken again to Dr Pyburn to inform her of this decision. Dr Pyburn did

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not accept this; she said that she spoke only once to the coroner's officer and that there was never any doubt or discussion as to whether an autopsy was needed.

13.161 When questioned, Mrs Evans accepted that she herself sometimes authorised an autopsy in cases in which it was plain to her that the doctor was not in a position to certify the cause of death. She said that she would not have done so in this case because the mention of morphine 'rang warning bells'. I do not accept the reasoning behind this remark. If morphine rang warning bells in Mrs Evans' mind, it would surely be to convince her that the Coroner must accept jurisdiction and it would follow that there would have to be an autopsy. If she was in no doubt about the Coroner 'taking a case on', she was accustomed to order an autopsy without consulting the Coroner. I am unable to decide whether Mr Revington was or was not involved in the decision to order an autopsy. However, the point is not of great importance.

13.162 I have to resolve the conflict of evidence between Dr Pyburn and Mrs Evans. Before attempting to do so, I must examine the evidence of what happened after the report of the death was received at the coroner's office. The way in which the report was handled in the coroner's office throws some light on the conflict of evidence.

The Involvement of Mrs Collins

13.163 In 1995, Mrs Joan Collins worked as Mr Revington's second coroner's officer, placing her one rung below Mrs Evans. She was involved in dealing with Mrs Overton's death at some time after Mrs Evans had taken the initial report. She had no independent recollection of her involvement but recognised marks and writing she had made on the form. She said that she had made the red ticks on the first few lines and had written the following entries, in the order in which they appear on the form:

> **'Ask Terry to check'** [*in pencil*]
> **Robinson + Jordan, Hyde.** [*in red ink*] **Funeral fixed for**
> **Friday 28.4.95'** [*in pencil*]
> **'Dr D L Bee**
> **Ia Hypoxic cerebral degeneration'** [*in red ink*]

13.164 The last two lines of that record were plainly made after the autopsy had been carried out on 26th April. Dr Bee was the pathologist responsible. Of more immediate interest is the entry **'Ask Terry to check'**. **'Terry'** must be a reference to Police Constable (PC) Theresa King, then Tameside Division police coroner's officer. She was based at Ashton-under-Lyne police station and the mortuary at Tameside General Hospital. She was accustomed to undertake enquiries for the Coroner. Mrs Collins could not remember when or in what circumstances she came to make this entry; nor could she remember speaking to PC King or even what it was that PC King had to check. She postulated that Mr Revington had been in court when the report of the death was initially taken and that, on his return, he saw it and asked Mrs Collins to pass a message to PC King. Mrs Collins now believes that Mr Revington must have wanted to know whether morphine had been given 14 months earlier, and by whom and in what circumstances. I think she is probably correct.

The Involvement of Police Constable King

13.165 PC King came to the Inquiry voluntarily from the Republic of Ireland, where she has lived since her retirement from the police force. Although Mrs King is no longer a police officer, I shall refer to her as PC King throughout this Chapter. In 1995, she was experienced in police work and had been the police coroner's officer since 1985. However, she had no medical training or knowledge, save what she had picked up in the course of her work.

13.166 The usual procedure, in the case of a hospital death that had been reported to the coroner, was for one of the coroner's officers to ask PC King to complete Forms 751 and 751A, the functions of which I have explained in Chapter Four. PC King would receive information from the report of the death to the coroner's office and would then ask the next of kin or a member of the deceased's family to attend the mortuary to identify the body. PC King would check the information given to the coroner's office with the next of kin and would complete the forms. The information on the forms is duplicated to a large extent. Both contain some limited information about the medical history and circumstances of the death. Form 751 is returned to the coroner's office; Form 751A is left at the mortuary for the pathologist. This form contains a specific request for **'Any other information which may assist the Pathologist to determine cause of death'**.

13.167 PC King arranged for Dr Overton to attend her office, situated in the Tameside General Hospital mortuary complex, probably on 24th April. She completed Form 751 on the basis of information supplied by Dr Overton, the Coroner's staff and, in relation to the time of death, information probably obtained from the ward. The important evidence as to the medical history and the circumstances of the collapse and of the death was, I am sure, provided by the Coroner's staff and not by Dr Pyburn. It was not usual for PC King to speak to the doctor who had made the report. PC King did not seek from Dr Overton, and nor did Dr Overton offer, any elucidation as to the circumstances of Mrs Overton's original collapse. PC King said that she would not normally do so, even when the next of kin was a doctor. Dr Overton and the rest of the family had, of course, long since decided to 'let sleeping dogs lie'.

13.168 On Form 751, PC King stated that Mrs Overton had suffered from asthma and was hypothyroid. She recorded that Mrs Overton had been admitted on 18th February 1994, after a respiratory arrest. She had been in a coma for over a year.

13.169 Form 751A contains essentially the same information. Responding to the specific request for any other information which might assist the pathologist to determine the cause of death, PC King wrote:

> **'Dr. states possible cause of death as:**
> **Persistant** [*sic*] **vegetative state, due to**
> **resp. arrest, due to asthma, Also**
> **morphine administration.'**

It is likely that the **'possible cause of death'** was based on what Dr Pyburn had told Mrs Evans. PC King wrote Dr Pyburn's name at the top of Form 751A. When Forms 751 and 751A were complete, PC King followed her usual practice and sent Form 751 back to the coroner's office and left Form 751A for the attention of the pathologist.

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13.170 I observe in passing that the process of completion of Form 751A involved two medically unqualified people (a coroner's officer and a police coroner's officer) being used as conduits for information passing between a doctor who had treated the deceased and reported the death and a pathologist who was to decide (when the doctor could not) what was the cause of death. This is not a satisfactory way of communicating information which might be of a technical nature.

13.171 The autopsy was to take place on Wednesday, 26th April. PC King was not usually expected to carry out any further investigations until after the autopsy, when the coroner would decide whether or not to hold an inquest. If there were to be an inquest, PC King might then undertake some further investigations. However, it is clear that, on this occasion, PC King was asked to undertake an enquiry before the autopsy. Unfortunately, there is no record of the nature of the enquiry, and this is consistent with the poor quality of record keeping in the coroner's office at that time. It is only possible to work out what the request must have been from a note made on 25th April by Mrs Margaret Blake, the third coroner's officer (and the third person in the office to have been involved with Mrs Overton's death). It is plainly a note of PC King's report to the office of what she had found out in response to the request for her **'to check'**.

13.172 This note clearly shows that PC King must have been asked to find out from Shipman what had happened when he had attended upon Mrs Overton on 18th February 1994. PC King was at pains to point out that, had she been told that there was a suggestion that poor practice by Shipman had caused or contributed to Mrs Overton's death, she would not have spoken to him. I accept her evidence on this point. It would have been quite inappropriate for a police officer of her rank to undertake any investigation of an allegation of potential negligence or misconduct by a doctor. Moreover, I do not think the Coroner would have asked her to make such an enquiry if he had realised that there was any suggestion that Shipman might have been at fault in the treatment he had given Mrs Overton. I am satisfied that PC King had been given no warning that Shipman might be at fault. Indeed, in view of the fact that the request that she should speak to Shipman probably came from Mrs Collins, who had not taken the original report and would have had before her only the written report form, there does not seem to have been any opportunity for PC King to be told of Dr Pyburn's concerns, assuming that she had expressed them. However, PC King knew that the administration of morphine was said to be an underlying cause of death and that it was a potentially dangerous drug. Had she thought the matter through, she might have realised that malpractice by Shipman was a possible explanation for what had occurred. However, she did not.

13.173 Mrs Blake's note confirms that Shipman accepted that he had been called out to see Mrs Overton; she was suffering an asthma attack and he had stabilised her. He had then gone upstairs to tell Mrs Carrington that her mother would need some hydrocortisone. When he returned, he had found Mrs Overton flat on the floor. There is no record that he mentioned chest pain. Nor did he apparently tell PC King why Mrs Overton had collapsed. The note records that Shipman then commenced resuscitation. The ambulance crew arrived. Although they had **'managed to get a beat'**, Shipman took the view that Mrs Overton was **'brain dead'**. She had been in a coma ever since. The penultimate sentence of Mrs Blake's note of PC King's report reads:

'Dr Shipman does not feel there was anything perculiar [*sic*]**. She had some emotional problems in the past but everything seemed to be ok at the time.'**

13.174 When PC King was asked how she could have failed to ask Shipman what part, if any, morphine had played in Mrs Overton's death, she replied, with commendable frankness, that she had 'absolutely no idea.' She conceded that it really had been up to her to ask him that question. PC King agreed also that it appears that she had not asked Shipman what had caused Mrs Overton's sudden collapse. She explained that, because she used to work across two sites, at the mortuary and at the police station, she may have had neither her notes nor Forms 751 or 751A in front of her, when speaking to Shipman. This would be quite unsatisfactory but may explain, though it could not excuse, her failure to raise those matters with him.

13.175 It is clear that PC King did not appreciate that this death was in any way problematical and did not have any clear idea of what she was trying to find out. She cannot have been told that there was any suspicion that a medical error had been made. I think she approached Shipman asking for a purely factual account of what had happened. I think she would then have accepted his account without question and without considering whether he had provided the answers she needed. I think it likely that, in common with many people in Hyde at the time, she was taken in by Shipman's confident manner and possibly cowed by his condescending attitude. I think that, having only an imperfect understanding of what she was supposed to be finding out, she did not stop to think for long about what she had (and had not) been told. I bear in mind that PC King had no medical background or training, and was ill equipped to question Shipman or to go behind his assertion that there was nothing peculiar about the death.

13.176 Mrs Blake said that she took the message without knowing what PC King had been asked to find out or why she had been asked. She said that, even if she had seen the original report at the time of taking the message, she would not have realised that the issue of the administration of morphine had not been addressed because her role was simply to take down the message. There is no evidence as to whether the Coroner ever saw the note of PC King's enquiry of Shipman. He should have done and it should have been clear to him that Shipman had not confirmed or denied the administration of morphine. Nor had he explained why Mrs Overton had collapsed so suddenly in his absence. Even if Mr Revington had not previously been alerted to the possibility that Shipman had given an overdose, he should have recognised the need to find out if, when and why morphine had been given and what reason Shipman was giving for the collapse. As Mr Revington is not able to answer questions from the Inquiry owing to ill health, it will never be known what was in his mind at this stage of the investigation into Mrs Overton's death.

13.177 I conclude that Mrs King did fail properly to investigate and report upon the circumstances of Mrs Overton's collapse. In particular, she failed to ask Shipman whether he had given any morphine and why he thought Mrs Overton had collapsed in his absence. I am quite sure that Shipman was very persuasive and authoritative when they spoke and I accept that she had no prior suspicion that his treatment of Mrs Overton might have been incorrect. It is to her considerable credit that she acknowledged her fault when she gave

her oral evidence. It is also to her credit, and for this I am very grateful, that she attended the oral hearings from the Republic of Ireland, when she could not have been compelled to attend.

Resolving the Conflict of Evidence between Dr Pyburn and Mrs Evans

13.178 I found Dr Pyburn a most persuasive witness. She is intelligent, quietly articulate and obviously sincere. Whether or not her evidence is true and accurate is a different question. Listening to her, I felt convinced by her claim that she was determined to ensure that the circumstances of Mrs Overton's respiratory arrest in February 1994 were fully investigated. I went so far as to express that view during oral submissions. Yet, careful analysis of the whole of the relevant evidence has made me aware that there are several factors that point against this conclusion.

13.179 First, the fact that Dr Pyburn said that she was reluctant to use plain language critical of Shipman when making the report suggests to me that she was also ambivalent about conveying the message that Mrs Overton was the victim of a 'medical mishap'. It may well be that Dr Pyburn mentioned the administration of morphine in its natural position in a narrative explanation of the course of events. It may well be that she also said that morphine had been given by a doctor in circumstances in which it would not normally be given. If she did, I do not think that those expressions would necessarily have made Mrs Evans realise that Dr Pyburn was concerned about the treatment. I am quite satisfied that Dr Pyburn did not criticise the treatment directly. As I have already said, I find it hard to understand why, if she were anxious to report her concerns about the treatment, she could not bring herself to do so in clear language, without prejudging any issue.

13.180 Second, the extremely scanty details of the death recorded by Mrs Evans suggest that Dr Pyburn may not have given as full an account of the circumstances as she claims. I am satisfied that neither Mrs Evans nor anyone in the coroner's office realised that it was being suggested that Shipman had done anything wrong. PC King would not have been sent to make enquiry of Shipman if it had been realised that there was a possibility that his treatment of Mrs Overton might be called into question at an inquest. I observe, in passing, that the report of death, as recorded by Mrs Evans, was not adequate, either to allow the Coroner to decide whether or not an inquest into the circumstances of the respiratory arrest was necessary or for him to consider whether or not to approve the provisional causes of death. Whatever she believed the purpose of the report to be, Mrs Evans should have asked far more questions about the circumstances than she did. I do not criticise her personally for this, as I am satisfied that, at any rate at this period, decisions were often made in the coroner's office on inadequate material.

13.181 Third, there is the fact that the proposed causes of death were written down in pencil, which was, I accept, the usual practice in the office where a doctor was seeking the Coroner's approval to issue an MCCD. Dr Pyburn said that she had no recollection of providing any causes of death and, indeed, on the first day of her evidence, asserted that she had not done so. However, on reflection, she accepted that she must have done. There was no one else who could have formulated them. Mrs Evans did not have the medical knowledge to do so. Dr Pyburn was unable to suggest how this might have come

about. I think it is not impossible to imagine circumstances in which Mrs Evans might have encouraged Dr Pyburn to provide provisional causes of death, even though she was reporting her concerns about the circumstances of the death. However, a far more simple and obvious explanation for the proffering of the provisional causes is that Dr Pyburn was seeking approval for the causes of death but, when Mrs Evans heard and wrote the words 'morphine administration', they rang warning bells and she (or the Coroner) decided that there would have to be an autopsy.

13.182 Fourth, Dr Pyburn's own note in the clinical records of her conversation with Mrs Evans suggests either that Dr Pyburn had telephoned the office to seek approval for the proposed causes of death and permission to issue an MCCD (which had been refused) or that her report had been 'neutral' in that she was just putting the case before the Coroner in case he wanted to investigate it.

13.183 I have found this a difficult issue to resolve. In the end I have been driven to doubt my own reaction to Dr Pyburn's evidence. I have concluded that it is more likely that Dr Pyburn telephoned the coroner's office to seek approval for her proposed causes of death than that she reported the death because she wished her concerns to be investigated. I think it likely that, since Shipman's exposure, Dr Pyburn has come to believe that she reported this death for investigation, when the truth is that she did not. I think it likely that, following her realisation that Shipman was a mass murderer, she became far more concerned about Mrs Overton's death than she had been at the time of the death. With the passage of time, she has, I think, come to believe that she was deeply concerned. As she knows that it was she who reported the death to the Coroner, I think she has become convinced that she did so only because she was determined that the circumstances of Mrs Overton's original collapse should be investigated. I think she had been concerned about the reasons for Mrs Overton's collapse but that she had put her concerns to the back of her mind because Dr Husaini and Dr Rushton had told her that the case had been 'looked into' around the time of her first admission to hospital. In those circumstances, being still somewhat concerned, Dr Pyburn decided that the death should be reported to the Coroner so that he would have the opportunity to look into the death if he thought it appropriate. I think that she was willing to certify the causes of death, if the Coroner gave his approval. Although I reject her evidence as inaccurate, I do not think Dr Pyburn deliberately misled the Inquiry. Nor do I criticise her conduct. Considering her state of mind, as I have found it to have been, I consider that her decision to report the death in a neutral way was not unreasonable.

The Autopsy

Dr Bee

13.184 Dr David Lyle Bee was a consultant pathologist for 26 years from 1969 until his retirement in October 1995. He used to perform about 20 autopsies a week. On some days he might carry out as many as eight. The most usual number was three or four. Eighty per cent of those autopsies were for the Coroner. He said that the performance of an autopsy could last anything between 15 minutes and 2 hours, depending on its complexity. He told the Inquiry that coroners' autopsies were usually less complex than hospital autopsies. He

thought that the autopsy performed in Mrs Overton's case was straightforward and would have lasted about 20 minutes. Not surprisingly, he had no recollection of the case and relied on his limited contemporaneous records, combined with his recollection as to what was then his usual practice.

13.185 According to Dr Bee, he felt under some kind of self-imposed pressure to find a natural cause of death in order to avoid an inquest. If he was satisfied that the cause was natural, but the evidence revealed only a possible cause, he would nevertheless record that that was the actual cause of death if there was no other obvious competing cause. I understand that this is not an uncommon practice. Dr Bee said that there were very few cases in which he reported that no definite cause of death could be found; in evidence, he said that this would happen in about one case in 40 or perhaps once a month (which would amount to about one case in 85).

13.186 I find it disappointing that a consultant pathologist should have so lax an approach to a scientific examination. Dr Bee did not explain why he felt under such self-imposed pressure. It seems likely that he felt that he would be doing the Coroner, the deceased's relatives and himself a favour if he were able to avoid an inquest.

Professor Whitwell

13.187 Professor Helen Whitwell gave evidence to the Inquiry on several occasions. She is Professor of Forensic Pathology and Head of the Department of Forensic Pathology at the University of Sheffield. I have dealt with some of her evidence in Chapters Nine and Ten. She provided written and oral evidence dealing with Dr Bee's involvement in Mrs Overton's case. I found her evidence very helpful. I remind myself that I should not expect the same level of forensic skill in a consultant pathologist in a general hospital (as Dr Bee was) as that of a forensic pathologist, particularly one of Professor Whitwell's experience and ability.

Dr Bee's Report

13.188 Dr Bee said that, when conducting the autopsy on Mrs Overton, he had available the medical notes and records and Form 751A. The information on Form 751A was, as I have said, very limited. In particular, Dr Bee had not been alerted to any concerns felt by the hospital staff as to the propriety of the morphine administered. However, if he had read the medical notes, he should have seen the dosage of morphine and the opinions of the junior doctors that the morphine given by the general practitioner had caused or contributed to Mrs Overton's initial collapse and precipitated her persistent vegetative state. It is worth noting, however, that neither Dr Brown nor Dr Husaini had recorded in the clinical notes any opinion as to the conduct of the general practitioner. Had they done so, the post-death investigations might well have followed a very different course.

13.189 The autopsy was performed at 10am on Wednesday, 26th April. The signed typewritten autopsy report (or **'POST MORTEM EXAMINATION REPORT'**) itself is extremely brief. It records that the brain was small with dilated ventricles. It was generally soft, especially in the parietal regions. There was a little atheroma of the cerebral circulation. The bronchi

were clear although there was a little congestion and oedema of the lungs. The heart weighed 254g and there was mild atheroma of the coronary circulation. The liver and kidneys were said to be congested.

13.190 The report form invites the pathologist to provide an opinion as to the causes of death. It explains that the pathologist should list, first, the disease or condition directly leading to death, next, any morbid conditions giving rise to the direct cause, and, last, any other significant conditions contributing to the death but not related to the disease or condition causing it. An explanatory note states that what is sought is the disease, injury or complication which caused the death and not the mode of dying.

13.191 Dr Bee gave the opinion that the cause of Mrs Overton's death was hypoxic cerebral degeneration. Whilst this may accurately explain that shortage of oxygen had caused degeneration of Mrs Overton's brain and that this had caused her death, it does not explain what had caused the oxygen deprivation. It may seem trite to say so but the human brain is normally well perfused with oxygen. It is obvious, and must at the time have been obvious to Dr Bee, that there must have been some mechanism to cause that position to alter and yet he seems not to have realised this. Without apparently determining what had caused Mrs Overton's brain to be deprived of oxygen, Dr Bee went on to state:

'In my opinion death was due to natural causes.'

13.192 It must have been clear to Dr Bee that, since 14 months had passed since Mrs Overton's original collapse, pathological examination was unlikely to reveal a great deal about the circumstances of the collapse. In fact, as Dr Bee accepted, it revealed absolutely nothing about them. It might have been expected to reveal (as it did) something about Mrs Overton's cardiac condition and it would have been expected (as it did) to reveal severe cerebral atrophy. So, all that the autopsy could tell Dr Bee was that the immediate cause of Mrs Overton's death was hypoxic cerebral degeneration. If he accepted that the degeneration had followed a cardiac arrest (which was mentioned as a possibility in the notes), he would be able to say, from the autopsy, that it was unlikely that the cardiac arrest had been caused by ischaemic heart disease. But, from the autopsy, he could not form any view whatever as to what had caused the cardiac arrest. As Professor Whitwell explained, the appearance of the brain some months after a severe hypoxic episode would be the same however the hypoxic episode had occurred. For example, there would be no way of telling from the brain whether the hypoxia had been caused by near drowning, by near suffocation, by a naturally occurring cardiac arrest or by a cardiac arrest induced by the administration of an overdose of a respiratory depressant such as morphine. Dr Bee did not disagree with that proposition. It is clear that his conclusion that the death was due to natural causes could not properly have been based upon his autopsy findings.

13.193 Dr Bee claimed that he had reached his conclusion that the death was due to natural causes after perusing the hospital notes. He could not remember exactly what he had read but said that he would have looked only at the casualty notes and the other notes at the beginning of the file, as the whole file was **'rather substantial'**.

13.194 Dr Bee said that his examination of the notes drew him to the conclusion that ventricular fibrillation had led to cardiac arrest and was the principal cause of death. This ventricular

fibrillation could have resulted from 'spasm of the coronary artery or something like that rather than the morphia'. Dr Bee was 'inclined to think that ventricular fibrillation came before the respiratory arrest'. For many reasons, I find it impossible to accept that Dr Bee reached any such conclusions.

13.195 First, I observe that he did not enter ventricular fibrillation as the underlying cause of death on the autopsy report, as he should have done, had that been his opinion. Second, Dr Bee did not mention this conclusion in his written statements to the Inquiry. He revealed it for the first time in his oral evidence. By that time, Dr Bee was aware that he was open to criticism for having certified that the death was due to natural causes without having any proper basis to do so. In oral evidence, Dr Bee sought to reconstruct what had been in his mind at the time of reporting on the autopsy examination. I cannot accept that the reasons and explanations he gave were in fact operating on his mind at the time. I am afraid that by the end of his evidence, I was quite satisfied that Dr Bee's endeavours were directed far more towards creating a picture that would result in his being absolved from blame than towards genuinely working out what had been in his mind at the time.

13.196 Third, Dr Bee's conclusion that the cause of Mrs Overton's death was ventricular fibrillation was not soundly based. There was no pathological evidence to explain why the patient might have gone into ventricular fibrillation and Dr Bee was forced to speculate that this might have happened as the result of some coronary artery spasm. Dr Bee drew attention to the entries in the early clinical notes suggesting the possibility of ischaemic heart disease but apparently chose to ignore the fact that Mrs Overton's heart was revealed to be normal, both in the clinical assessments following her admission to hospital and as part of his own autopsy examination. Ventricular fibrillation was one possible cause of the death but there was nothing to suggest that it was a more likely cause than any other.

13.197 Fourth, if Dr Bee did think that the death was due to ventricular fibrillation and was prepared to certify the death as being due to natural causes for that reason, he must have known that, in so concluding, he was in disagreement with the views expressed by the treating doctors in the clinical notes. Those notes make it clear that those treating doctors who expressed an opinion had reached the view that the administration of morphine had played a part in Mrs Overton's respiratory arrest. Although the notes contain conflicting information as to whether Mrs Overton had or had not suffered chest pain before her collapse, there was abundant material to suggest that the collapse had been caused by the administration of 20mg of morphine, given intravenously in a bolus dose. In addition, Form 751A flagged up the belief of the reporting doctor that morphine had been an underlying cause of death. Professor Whitwell said that the mention of morphine as a potential contributory cause of death should have sounded warning bells in the mind of any pathologist.

13.198 Dr Bee had little knowledge (and certainly far less experience than the treating doctors) of the circumstances in which it might or might not be appropriate to give morphine to a patient. This is not surprising and he should not be blamed for it, because it is likely that many pathologists would be similarly unaware. Further, he did not know what dosages of morphine would be appropriate. Yet, he did not speak to any member of the clinical team from ward 17, such as Dr Pyburn, whose name was mentioned on Form 751A. The reason

Dr Bee gave for this omission was that Dr Pyburn would have been able to say no more than the notes said. That explanation is not acceptable. What Dr Bee needed was advice about whether it would have been reasonable for the general practitioner treating Mrs Overton to give 20mg morphine as a bolus dose, and whether such a dose given in that way might be expected to cause respiratory depression or arrest. There can be no doubt what advice he would have received had he made such an enquiry. I agree with Professor Whitwell that, before he reached any conclusion about whether the death was natural, Dr Bee should have discussed the case with the treating clinicians. In evidence, Dr Bee said that he considered that, if a patient suffering from an asthma attack was suffering from the 'psychological overlay' that sometimes increases pain, it might be legitimate to give morphine. The notion that any doctor who knew anything about the effects of morphine would think it reasonable to give a 20mg bolus dose for 'psychological overlay' enters the realm of fantasy. Dr Bee said that it did not appear to him that the administration of morphine had been inappropriate. He said he would on that issue rely on the judgement of the clinician who administered it. He did not think of checking the British National Formulary to ascertain what was said about dosage and mode of administration.

13.199 In short, I cannot believe that Dr Bee actually went through so deeply flawed a process of reasoning as could have resulted in an honest conclusion that the death had been caused by ventricular fibrillation leading to cardiac arrest and had not been caused or contributed to by the inappropriate administration of morphine. He admitted in evidence that his conclusion involved a significant degree of speculation. In my view, his opinion that the death had been due to natural causes can be explained only by his misplaced desire to avoid the need for an inquest. It is possible that he concluded, after brief and superficial thought, that the collapse might have been due to an asthma attack. Whatever he thought, his reported conclusion that this death was due to natural causes was untenable and his performance inadequate. I recognise that he had not been alerted, as explicitly as he might have been, to the possibility that Shipman had made a serious error in treatment. However, knowing, as he did, that there was a possibility that morphine had caused or contributed to the death, it was quite wrong of him to discount that possibility and certify that the death was due to natural causes, without even making the enquiries I have mentioned.

13.200 When Dr Bee came to communicate his findings to the coroner's office he should have made it plain that, although he had found an immediate cause of death, cerebral hypoxic degeneration, and believed that the underlying cause of that was a cardiac arrest some 14 months earlier, he was unable to establish the underlying cause of the cardiac arrest. It would then follow that he was unable to say whether the death had been due to natural causes. That should have been the gist of the oral report that Dr Bee gave to the coroner's office as soon as he had completed the autopsy. If he had said that or something like that, the Coroner would have ordered an inquest. The same message should also have been reflected in Dr Bee's written report which was to follow. In the event, as I shall shortly explain, it seems likely that, when reporting orally, Dr Bee mentioned only the immediate cause of death, cerebral hypoxic degeneration, and said nothing more.

13.201 A particularly unattractive feature of Dr Bee's evidence was his attempt to justify his opinion that the death had been the result of natural causes by saying that there had been

no way of proving otherwise, and that, at any inquest that might have taken place, Shipman would have given an account to justify the administration of morphine, and that that account would have been believed at the time. That may be so; much would have depended upon the thoroughness of the investigation carried out by the Coroner before the inquest and the willingness of doctors such as Dr Husaini, Dr Brown and Dr Pyburn (any of whom might have been called to give evidence) openly to criticise Shipman's treatment. Whatever difficulties there might have been at inquest, there is no excuse for the serious deficiencies of Dr Bee's work.

Mr Revington Decides that No Inquest Is Necessary

13.202 Mr Revington was 74 years old when Mrs Overton died. He was to retire at the age of 75. Although he did not enjoy the best of physical health, having suffered from polio as a child, he still retained all his mental faculties.

13.203 As I have already explained, I am unable to decide whether Mr Revington was personally involved in the decision to order an autopsy, although I suspect that he may not have been. I am satisfied, however, that he was behind the decision to **'Ask Terry to check'**. By the time that instruction was given, he was clearly aware in general terms that it had been suggested that one of the underlying causes of Mrs Overton's death was the administration of morphine. I infer, from the terms of Mrs Blake's report of PC King's conversation with Shipman, that Mr Revington had asked for clarification of the circumstances of Mrs Overton's collapse, including the possible involvement of morphine.

13.204 When Mr Revington received the report of PC King's enquiry, probably on 25th April, he should have realised that it did not provide answers to two obviously important questions. Had Shipman given Mrs Overton any morphine? Why had she collapsed? It appears that Mr Revington did not ask for any further enquiry to be made. It seems likely that he was generally reassured by the final sentence of the report, that there was nothing peculiar about the death.

13.205 The result of the autopsy was almost certainly telephoned through to the coroner's office by Dr Bee or someone acting on his behalf, at some time during the late morning or afternoon of Wednesday, 26th April. Mrs Collins wrote on the report of death form that the cause of death was hypoxic cerebral degeneration. She did not write **'natural causes'**. I think that she would have done, if she had been told that that was Dr Bee's opinion.

13.206 Mr Revington's task was then to decide whether or not to hold an inquest. He made that decision on Wednesday, 26th April. If he was satisfied that the death was due to natural causes and that the cause of death was known, he would decide that an inquest was not necessary and he would send a Form 100B to the register office, confirming that he did not consider it necessary to hold an inquest and stating the cause(s) of death found at autopsy. The bundle of papers on which Mr Revington was to base his decision included Mrs Evans' initial report of the death, Form 751, and Mrs Blake's file note of PC King's report. It is not clear whether or not the written autopsy report was by then available. Usually, there would be a little delay between the completion of the autopsy and delivery

of the written report; that is why the result was usually communicated informally by telephone. As Mr Revington made his decision on the same day as the autopsy took place, I think it likely that he considered his decision before receiving the written report.

13.207 On examination of the papers, it should have been apparent to Mr Revington that the autopsy had confirmed the immediate cause of death proposed by the reporting doctor from the hospital but had not confirmed the proposed underlying causes. He should have realised that he did not know the underlying causes of the cerebral degeneration or whether the death was due to natural causes. He must have known that cerebral hypoxic degeneration can result from a great number of different causes, some natural and some unnatural. He must, for example, have been aware of the case of Mr Bland, to which I referred earlier. The decision of the House of Lords in that case was a landmark of which all coroners should have been aware. The mention in Mrs Evans' note of Mrs Overton's persistent vegetative state, combined with the reference to her having been in a coma for over a year, probably would, in my view, have struck Mr Revington as resonant of Mr Bland's case. Mr Bland had suffered his injuries in the Hillsborough disaster, as I have already stated.

13.208 In my view, Mr Revington could not properly have reached a decision not to hold an inquest on the basis of the information in the papers before him, unless those papers included Dr Bee's written report, which seems very unlikely. It is possible that Mr Revington spoke to Dr Bee on the telephone and asked him if he thought the death was due to natural causes. Dr Bee has no recollection of such a conversation but that does not mean it did not happen. However, Mr Revington did not make a note on the file to say that he had spoken to Dr Bee. As it was his usual practice to make a note of any such conversations, I infer that it is unlikely that he did so in this case. In any event, Mr Revington decided that no inquest was necessary and he issued Form 100B, giving the cause of death as cerebral hypoxic degeneration. He also issued Coroner's Certificate 'E' for Cremation (Form E) in which he said that he was satisfied that there were no circumstances likely to call for further examination of Mrs Overton's body. That would permit the medical referee to authorise cremation of her body. With the signing of these forms, Mr Revington effectively closed the enquiry into the circumstances of Mrs Overton's death. Yet the question as to the role played by morphine in the death remained unanswered.

13.209 Mrs Collins said that she was surprised that no inquest took place because the autopsy report did not say what had caused the coma. She agreed that the circumstances would cry out for an inquest. She was also surprised that hypoxic cerebral degeneration was given as the cause of death with no underlying cause stated.

13.210 Why did Mr Revington decide not to hold an inquest? I think that the answer is that Mr Revington did not think through the issues in the case with sufficient thoroughness or clarity. I have said that the mention of morphine in the written report of the death undoubtedly prompted the involvement of PC King. However, I am satisfied that Mr Revington did not realise, when he suggested that PC King make that further enquiry, that it was being suggested that Shipman had made a gross error of judgement in his administration of morphine and that this had led to Mrs Overton's original collapse. Had

he done so, he would not have suggested so informal an enquiry. Had he known of that suggestion, he would have been less willing to close the investigation without an inquest. I think that Mr Revington understood no more than that it was being suggested that one of the underlying causes of death was the administration of morphine and that he wanted to know more.

13.211 I think that Mr Revington also fell prey to two pieces of misinformation with which he was provided. First, he relied uncritically on the passage in the note of PC King's report that Shipman had not felt that there was anything peculiar about the death. He plainly should not have done so and he should have made further enquiries as to the administration of morphine. Second, he accepted the cause of death stated by Dr Bee, although, as I have already said, that did not explain what had caused the cardiac arrest and coma; nor did it suggest that Dr Bee had considered and discounted the role played by morphine in the death. Again, Mr Revington should not have done so. He could, had he been reluctant to order an inquest, have spoken to one of the doctors on ward 17 (Dr Pyburn's name was available to him) and enquired what information was available about the use of morphine. I am sure Dr Pyburn would have told him that the notes suggested a 20mg bolus dose, which was extremely large.

The Registration of the Death

13.212 On the basis of Mr Revington's Form 100B, Miss Marilyn Partoon, registrar at the Tameside register office, recorded that the cause of death was hypoxic cerebral degeneration and the death was duly registered.

The Reaction of Dr Husaini and Dr Pyburn

13.213 Dr Husaini says he was worried when he realised that there was to be no inquest, but did nothing. He had expected that the Coroner would have looked into the death and would have spoken to Shipman. He said that he cried when time passed and he had not been asked to provide a report and realised that there had been no inquest and that the death must have been registered.

13.214 If Dr Husaini really was so concerned, it is very surprising that he did not then pursue the matter with the Coroner, Chief Executive or any other person or body, especially when he knew that there had been no investigation immediately following the initial collapse. I do not accept that Dr Husaini was at all concerned about the fact that there had been no inquest.

13.215 Dr Pyburn said that she believed that her report of the death would lead to a discussion with the family, followed by an autopsy and inquest. In her previous experience of coroners' cases, there had been no communication back from the coroner following the initial report. On one occasion, Dr Pyburn had been told that she was not even entitled to the result of the autopsy. She told me that she would not have expected to be contacted about any information that she could give because she had not been present at the time of Mrs Overton's admission to hospital.

The Actions of the Doctors following Shipman's Arrest

13.216 In the course of the police enquiries following Shipman's arrest, investigating officers sought witness statements from Dr Husaini and Dr Brown, in relation to Mrs Overton's case. As I have already said, both sought advice from the MDU. For the purposes of the Inquiry, both waived any privilege that might have attached to relevant communications. I have already dealt with Dr Brown's communications and his police statement in paragraphs 13.86 to 13.89.

13.217 Dr Husaini telephoned the MDU on 24th November 1998. Having explained the background to the MDU adviser, Mr Kuncewicz, Dr Husaini apparently said that he felt vulnerable because he had been aware that Mrs Overton had been treated with morphine. He was unsure whether this was substantiated in the notes but he thought it might have contributed to the death. He was advised to obtain a copy of the medical notes and records and to send a draft statement to the MDU for approval. He was advised that the statement was to be factual and had not to contain assumptions.

13.218 There then followed some correspondence and, on 11th December, Dr Husaini wrote to the MDU advisers, giving an account of the relevant history and enclosing Mrs Overton's hospital notes. The letter refers to the circumstances surrounding the original admission to hospital. Dr Husaini expressed no reservations about the accuracy of the history that he described which was, in summary, that Shipman had first nebulised Mrs Overton for an asthma attack and had then given 20mg morphine, which had caused respiratory arrest. The letter goes on to describe the contact that he had had with the Coroner and Mr Charles Howorth, the Health Authority's legal adviser. His previous contact with Mr Revington was said to have been **'regarding ... withholding treatment'**. This was, as I have explained, inconsistent with the account he gave to the Inquiry, in which he said that he also voiced his concerns about the treatment initially given.

13.219 Further, Dr Husaini told the MDU that he had reported his concerns to Mr Howorth and had:

> **'... clearly mentioned that the patient had received I.V. morphine following which she became unresponsive'**.

He continued by saying that, after the patient's death, the case was reported to the coroner. He did not say why or with what effect. He then added:

> **'There is no doubt that ventolin nebulisers can induce ventricular fibrillation. There is also no doubt that morphine, by suppressing respiration in a patient who is already anoxic can induce ventricular fibrillation.'**

13.220 Dr Husaini went on to explain that he had at no stage spoken to Shipman and asked whether he should have done. He added:

> **'Family Practitioners do sometimes use morphine to sedate patients who are restless.'**

13.221 Finally he said:

> **'I do not think I am in any way responsible for her death.'**

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It seems to me that, at this time, Dr Husaini was feeling vulnerable. He was concerned that he had not investigated what Shipman had done by speaking to him. Also, he was seeking to imply, without actually saying so, that he had reported his concerns to Mr Howorth. I have already found that Dr Husaini did not report his concerns to Mr Howorth. He was also seeking to suggest that Mrs Overton's respiratory arrest might have been caused by ventricular fibrillation, due to the use of a ventolin nebuliser, a suggestion that he did not advance before the Inquiry. He also suggested that the general practitioner might have been justified in giving morphine if he believed the patient was restless and in need of sedation. He did not make it plain that the dosage given could never be justified for such a purpose.

13.222 On 18th December 1998, he wrote to the coroner's office for the first time on the subject of Mrs Overton's case. He asked Mr John Pollard (Mr Revington's successor) what had been Mr Revington's conclusion as to the **'mechanism of this patient's death'**. I observe again that it would be most surprising, if Dr Husaini was as upset as he said he was when he realised there would be no inquest, that he did not contact the Coroner until December 1998. He did so only when he was feeling vulnerable to criticism for not having done more to bring about an investigation of the circumstances of Mrs Overton's collapse.

13.223 The MDU replied to Dr Husaini on 22nd December, offering to review any statement made and explaining that it was not possible to give a specific answer as to what Dr Husaini ought to have done. He was told that, where he thought that another doctor was causing harm to patients by inappropriate treatment, he had an ethical duty to point this out to the doctor. In the event, Dr Husaini was not required to furnish the police with an account of his involvement in Mrs Overton's treatment.

Responsibility

13.224 It follows from what I have said that, despite the fact that it was widely known at Tameside General Hospital, within a short time after Mrs Overton's admission, that her collapse had been caused by the inappropriate administration of a large bolus dose of morphine, no steps were taken during her lifetime to ensure that the cause of her collapse (which had devastating consequences) was properly investigated. Moreover, after Mrs Overton died, and when the opportunity arose for a coroner's investigation into her death, there was never any proper enquiry into the circumstances.

13.225 I do not blame any of the junior doctors for their failure to act. In my view, the responsibility, if any, for ensuring that the circumstances were reported fell squarely on the shoulders of Dr Brown and Dr Husaini. I should deal briefly, however, with the state of knowledge of the doctors and nurses who treated Mrs Overton.

The State of Knowledge of the Nurses and Junior Doctors Treating Mrs Overton

13.226 Dr Husaini said that the doctors who treated Mrs Overton knew the reason for her collapse. He said:

> **'Whenever I would come to the ward I would have mentioned the fact that this is not right what has been done to her. I freely admit it. I admit**

because you might ask me some further questions as to what I do but I think it would be unusual or unthinkable of me not to have mentioned that morphine administered has resulted in unnecessary suffering to a patient.'

13.227 I accept that Dr Husaini probably did speak openly with his junior colleagues about his view of the circumstances of Mrs Overton's collapse. I also think that many of those treating Mrs Overton independently reached the view that the reason for her collapse was the inappropriate intravenous injection of a 20mg bolus dose of morphine.

13.228 Dr Lee admitted that both he and Dr Loh thought it unconventional that morphine had been given to someone who was suffering an asthma attack and they discussed the issue together. Dr Loh readily admitted that it was clear to him at the time that the dose of morphine given was excessive. Even in the situation of a concurrent heart attack and asthma attack, he acknowledged that the maximum dose given would be about 5mg diamorphine and that this would have to be titrated against response. To his credit, Dr Loh said, **'It is right to say that with hindsight I feel upset about the matter and wish that more had been done.'** I have no reason to doubt the truth of that comment. I think that Dr Mukhopadhyay must have realised the serious mistake that had been made and its consequences. Dr Premraj accepted that it was obvious that to have given 20mg morphine was excessive, represented a mistake by whoever had given it and had caused the respiratory arrest. Dr Rushton acknowledged as much and agreed that all the junior staff would have felt that what had happened was not right and would have talked about it. Dr Veerappan realised that an excessive dose of morphine given in an inappropriate way had caused Mrs Overton's collapse. He said he would have discussed this with Dr Brown and the nursing staff. Dr Peters took the view that 20mg was a huge dose to give. He had no recollection of discussions at the time. I have explained the reaction of Dr Pyburn when Dr Rushton informed her, in the summer of 1994, of the circumstances leading up to the collapse.

13.229 Statements were taken from 16 nurses who were responsible for Mrs Overton at various times. Some worked in the ITU and others on ward 17. Five nurses gave oral evidence. According to almost all of the nurses, it was common knowledge in the ITU and on ward 17 that the reason for Mrs Overton's condition was that she had been the victim of a serious mistake by her general practitioner, who had given her an excessive dose of morphine. After the individual nurses first became aware of the circumstances, which would normally have been on handover, I am sure that that knowledge slowly receded to the back of their minds as they concentrated on treating Mrs Overton, although I am sure they did not forget about it. I am sure that it was the subject of discussion between the nurses, although again this will have been more the case in February and March 1994 than later. I am quite satisfied from the evidence I heard that the nursing staff were fully aware that their consultants knew of the circumstances. I am also satisfied that they believed that some steps at least had been taken to enquire into the circumstances.

The Absence of Criticism in the Medical Records

13.230 I note that, despite what was known on the ITU and on ward 17, no expression of anxiety about or criticism of the general practitioner's treatment of Mrs Overton was entered in

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the notes and records. Dr Brown said in his written statement that there is a reluctance to put in writing any adverse comments about the conduct of colleagues for fear that they could be used in legal cases brought by patients. If this were correct, I would deprecate such an attitude, which seems to be motivated by a desire to protect doctors rather than to support patients. I will consider this issue in detail in Stage Four.

The Responsibility of Individuals

13.231 I have made it plain that I am quite satisfied that many among the nursing and medical staff at Tameside General Hospital were aware of the circumstances that had led up to Mrs Overton's collapse. I have also said that I think that the responsibility, if any, for ensuring that those circumstances were reported and investigated lay on the shoulders of the two consultants who treated her, Dr Brown and Dr Husaini. I shall postpone my consideration of whether they should be criticised for their failure to report the circumstances until I have heard further evidence during Stage Four of Phase Two of the Inquiry, dealing with the climate or culture surrounding the making of an adverse report by one doctor about another.

13.232 I can say at this stage, however, that I am left in no doubt that Dr Husaini did not at any stage report to Mr Revington, Mr Butterworth, Mrs Nuttall or Mr Howorth any concerns that he may have harboured about the role of Mrs Overton's general practitioner in her collapse. It is, I am afraid, to his great discredit that he sought to persuade me otherwise. I believe that Dr Husaini realised, when preparing his evidence for the Inquiry, that his initial contact with the Coroner in March 1994 afforded him the opportunity to claim that what was being discussed around that time was not only Mrs Overton's future management but also his concerns over her past treatment. I have rejected that claim.

13.233 So far as Dr Brown is concerned, he did not claim to have reported his concerns to anyone in authority. Whilst I shall defer consideration of whether he should be criticised in that respect until after the Stage Four evidence has been heard, I should say at this stage that I have had no hesitation in rejecting as untrue Dr Brown's assertion that his state of mind in 1994 was that the circumstances of Mrs Overton's collapse were so uncertain that he could not reasonably act upon them. I think that his state of mind was neatly encapsulated in the witness statement that he made to the police at the beginning of 1999 when he said that he had been of the view in 1994 that Shipman's treatment of Mrs Overton had been **'highly unusual even dangerous'**.

The Handling of the Report of Death by the Coroner's Office

13.234 I have explained in detail why I have concluded that neither Dr Pyburn nor Mrs Evans should be the subject of individual criticism in relation to their respective duties to report and record the circumstances of Mrs Overton's death.

13.235 However, this case has illustrated the shortcomings of the systems in operation in the office of the Greater Manchester South Coroner at the material time. First, the report of the death was taken over the telephone by a coroner's officer who had no training whatsoever, other than what she had picked up from colleagues over the years of her

employment. Mrs Evans followed procedures that I think had probably been in operation for years. As I have explained in Chapter Seven, coroner's officers working in the office of the Greater Manchester South Coroner were permitted to make decisions about whether or not the Coroner would accept jurisdiction in respect of a death without reference to the Coroner and on the basis of scanty information. I have said that Mrs Evans should have obtained far more information from Dr Pyburn before bringing the conversation to an end. I think that, as soon as she heard of a factor which told her that jurisdiction must be accepted and that there would therefore have to be an autopsy, she was content to end the conversation. I think that would be standard procedure.

13.236 Second, no record was kept of the important instruction that Mr Revington must have given in connection with PC King's enquiry of Shipman. Record keeping was poor in the office at that time and at all times until relatively recently.

13.237 Third, a system in which no fewer than three coroner's officers took and passed messages about the same case, without any understanding of why the death had been reported, is not satisfactory. Mrs Evans spoke to Dr Pyburn and she came away from that conversation with an imperfect understanding of why Dr Pyburn had reported the death. She either spoke to the Coroner or put her report before him. Thereafter, she had no further dealings with the case. Mrs Collins seems to have spoken to the Coroner and conveyed a message to PC King that she was to check with Shipman. But she did not know the background to the death and would have been unable to explain in detail what was wanted and why. When PC King had seen Shipman, her report was passed to yet another coroner's officer, Mrs Blake, who had no knowledge of the case and who was, like Mrs Collins, no more than a carrier of messages.

13.238 I have explained why I must also criticise PC King, although there exists substantial mitigation for her failure to enquire fully of Shipman about the circumstances of Mrs Overton's collapse and the possible role of morphine.

13.239 I have explained in detail why I am critical of the work of Dr Bee. He failed to provide an adequate report (oral or written) stating the extent of the findings he had been able to make as a result of the autopsy and his examination of the clinical records. Instead, he provided an incomplete oral report and a written report containing a conclusion that went far beyond that which he could properly have advised. Neither his oral nor his written reports addressed the issue of the administration of morphine.

13.240 I bear in mind when criticising Mr Revington that he has been unable to attend the Inquiry due to ill health and has not been able to provide a detailed account of events in writing. Even bearing that in mind, I feel compelled to criticise him for his failure to realise that PC King's report did not say whether Shipman had given any morphine and provided no explanation for Mrs Overton's collapse.

13.241 I must also criticise Mr Revington for his decision, on the manifestly inadequate information available to him, not to hold an inquest. He had to consider whether there were reasonable grounds to suspect that the death might not have been due to natural causes. He could not rationally have reached the conclusion that there was no such suspicion and that an inquest was not necessary.

General Conclusions

13.242 I shall say nothing at this stage about the lessons that may be learned from this case about the duty of doctors and other health professionals to report concerns or allegations of misconduct or incompetence by a fellow professional.

13.243 The investigation undertaken by and on behalf of the Coroner in this case vividly illustrates many of the shortcomings I have previously identified and lends support to the conclusions I expressed in Chapters Seven, Eight and Nine.

13.244 The initial gathering of information was inadequate. The coroner's officer who took the report did not fully understand what had happened and why the death had to be investigated. She had long experience in the job but no formal training and no medical knowledge. She passed a very brief report to the Coroner, so his understanding was also limited. Unusually, he gave an instruction for a further enquiry to be made but the instruction was transmitted by a different coroner's officer with no knowledge of the facts. It is small wonder that PC King did not understand what she was enquiring about and failed to ask vital questions of Shipman. No one obtained the medical records or returned to Dr Pyburn for a better understanding of the background. No one in the coroner's office had the medical knowledge to appreciate the significance of the information which could have been obtained. In short, the investigation from within the coroner's office was fragmented, uninformed and superficial.

13.245 The provision of the pathologist's opinion illustrates the shortcomings I have mentioned in Chapter Nine. I have no reason to think that Dr Bee's conduct of the autopsy itself was in any material respect inadequate. However, his report was manifestly inadequate. He provided no underlying cause of death and should have said that he was unable to do so. Instead, he gave an unfounded opinion that the death was due to natural causes, thereby giving the Coroner a way of avoiding an inquest. In Chapter Nine, I observed that there appeared to be an expectation on the part of some pathologists and coroners that a death would be 'natural' and that an inquest would be avoided. This is an example of a case where such an expectation was clearly present.

13.246 The Coroner's decision not to hold an inquest appears to have been based on the pathologist's oral report and the manifestly inadequate report of PC King's enquiry. The Coroner's understanding of the background circumstances cannot have been other than superficial. Nor can he have had any understanding of the medical issues involved. A more thorough investigation was required but, even on the basis of the limited information available, an inquest was plainly necessary.

CHAPTER FOURTEEN

The Tameside Registrars and the General Register Office

Introduction

14.1 One of the principal aims of the Inquiry has been to discover whether the various agencies responsible for post-death procedures in Tameside were in any way to blame for not detecting signs of Shipman's criminal activities. Most of the deaths of Shipman's patients, including those whom he killed, were registered at the Tameside register office. It has been necessary therefore to examine procedures and practices at the Tameside register office, both generally and in relation to deaths certified by Shipman.

14.2 The first matter examined related to the number of Shipman-certified deaths registered at the office. After his criminal activities were revealed, there were suggestions that the registrars who registered those deaths should have noticed that they were registering an excessive number of deaths which had been certified by Shipman. The Inquiry has therefore examined the deaths registered by each registrar in order to ascertain whether any pattern should have been evident.

14.3 Second, suggestions were also made that the registrars had in fact noticed an excess of deaths among Shipman's patients and had talked about this between themselves but had failed to take any action or to draw their concerns to the attention of the appropriate authorities. I have examined the evidence relating to these discussions and made findings in relation to it.

14.4 Third, during the course of the evidence, there was criticism of certain procedures in operation at the Tameside register office. It was necessary for me to consider those procedures and, in particular, to decide whether they had had any effect upon the registration of deaths certified by Shipman.

14.5 Finally there was criticism of the registration procedures adopted in a number of individual cases. The Inquiry has examined those cases in order to ascertain how they were handled and whether, if they had been handled better, Shipman's activities might have been noticed earlier. In two of those cases, the registrars acted on the advice of staff at the General Register Office (GRO). It has therefore been necessary for me to consider whether that advice was correct and, if not, how it came to be given.

Should the Frequency of Registration of Deaths Certified by Shipman Have Been Noticed?

The Background

14.6 There are four registrars at the Tameside register office. Each is responsible for her own register of deaths. In the absence of a full-time registrar, some registration work is carried out by deputy registrars who usually do other administrative work. Registrars have other duties besides the registration of deaths. No registrar sees the complete picture of death registrations effected in the office as a whole. Nor is there any system in place (or indeed any duty to operate such a system) for the gathering of statistics relating to deaths, let

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alone for the monitoring of the deaths of a particular doctor. Although the identity of the doctor who has certified the cause of death is recorded by the registrar, the name would not be important unless a difficulty arose because, for example, the doctor had not completed the MCCD properly. Unless the doctor frequently failed to complete MCCDs to the registrar's satisfaction, the name would be unlikely to stand out in her mind. Shipman usually (although not always) completed MCCDs quite satisfactorily.

14.7 The Inquiry team collated the numbers of Shipman-certified deaths registered by two current registrars and one former registrar from the commencement of their employment until 1998. These three registrars had been responsible for registering the greatest number of deaths certified by Shipman. The numbers were compared with the total numbers of deaths registered by the registrars during the same period. Also, the Inquiry team identified a number of short periods when the concentration of Shipman-certified deaths registered by each registrar was at its highest. The object was to see whether, during those short periods, the frequency of Shipman-certified deaths should have been noticeable.

Miss Marilyn Partoon

14.8 Miss Marilyn Partoon registered 69 deaths certified by Shipman between 1988 and 1998. During that period, she registered a total of 6734 deaths. Two three-month periods from 1996 and 1997 were analysed. These showed six Shipman-certified deaths out of a total of 199 in the first period and seven Shipman-certified deaths out of 239 in the second.

Mrs Carol McCann

14.9 Mrs Carol McCann registered 71 deaths certified by Shipman between 1985 and 1998. During that period, she registered a total of 8258 deaths. Three short periods were analysed. The highest concentration was found to be four Shipman-certified deaths out of a total of 95 during two months in 1996.

Mrs Dorothy Craven

14.10 Mrs Dorothy Craven registered 120 deaths certified by Shipman between 1978 and 1998. During that period, she registered a total of 11,711 deaths. Four short periods were analysed. I refer only to two. The two highest concentrations of Shipman-certified deaths occurred during two months in April/May 1997, when she registered seven Shipman-certified deaths out of a total of 113, and in a period of three and a half months in late 1997/early 1998, when she registered ten Shipman-certified deaths out of a total of 200.

Conclusion

14.11 I am quite satisfied that the frequency with which Shipman-certified deaths occurred would not have been noticeable to any registrar. Nor, in my view, were the clusters of greatest intensity particularly remarkable. Such research as the Inquiry team was able to carry out showed that clusters of deaths certified by an individual doctor occur with reasonable frequency.

Had Any Registrar Noticed an Excess of Deaths Certified by Shipman?

14.12 All the registrars denied that they had in fact noticed an excess of deaths certified by Shipman. There was some evidence that one or more registrars had made comments to others from which it appeared that they had in fact done so. Three such incidents were investigated.

Mrs Dorothy Craven and Miss Marilyn Partoon

14.13 In her Inquiry statement, dated 25th March 2002, Miss Partoon suggested that, prior to August or September 1998, she had a recollection that Mrs Craven might have remarked that 'a lot of Shipman's MCCDs were for old ladies'. Miss Partoon did not recall any speculation arising from that remark. Mrs Craven has always said that she has no recollection of the comment.

14.14 In evidence, Miss Partoon was adamant that the remark was made once the police investigation into the death of Mrs Kathleen Grundy was under way, at a time when a list of relevant entries in the registers of death was posted on the wall of the storeroom at the register office. That would have been no earlier than September 1998, possibly later.

14.15 The version of the incident given by Miss Partoon in oral evidence makes little sense in that, once it was known that deaths certified by Shipman were under investigation (as they were when the list of names was on the wall), any remark about the gender of Shipman's patients would have been wholly unmemorable. Moreover, it would have been a mere observation, rather than an item of information, such as Miss Partoon originally suggested she had been given. In my view, Mrs Craven probably did make a remark about the predominant gender of Shipman's deceased patients during one of the periods in which she registered a cluster of deaths certified by him. However, the remark does not suggest that Mrs Craven thought there was anything sinister about the gender distribution of the deaths of Shipman's patients.

Mrs Carol McCann and Mrs Margaret Burns

14.16 Mrs Margaret Burns worked at the register office as a clerk/receptionist. She sometimes acted as a deputy registrar. She recalled an occasion when Mrs McCann commented to her that a death was 'another one of Shipman's'. This, she said, occurred soon after both of them had been off work with 'flu and is likely therefore to have taken place in January/February 1997. Mrs McCann apparently remarked that there had been two or three deaths certified by Shipman in the past few days (two such deaths were registered on 5th February 1997 and one had been registered on 29th January 1997). The conversation then turned to the 'flu virus which was going around at the time. Mrs McCann did not seem concerned. For some reason, Mrs Burns remembered Shipman's name, although she has told the Inquiry that she had not heard of him at the time. However, she was acquainted with Mrs Margaret Walker, who was employed as a computer operator at Shipman's surgery.

14.17 Mrs McCann said that she has no recollection of the conversation. She suggested that she might have made such a remark if she had opened an envelope containing an MCCD when she had received other certificates from the same doctor very recently.

14.18 I think it likely that Mrs McCann made a comment along the lines suggested by Mrs Burns. This may very well have occurred on 5th February, when she opened the second MCCD from Shipman. I do not think that any significance can be attached to Mrs McCann's remark; it certainly does not suggest that she had noticed an abnormal number of deaths certified by Shipman or that she was concerned about them.

Mrs Margaret Burns and Mrs Margaret Walker

14.19 In her Inquiry statement, Mrs Walker said that she used to chat to Mrs Burns on the bus. She knew Mrs Burns worked at the register office and said that Mrs Burns knew that she worked at Shipman's surgery. She recalled that, one day, Mrs Burns asked her if there had been a lot of deaths at the surgery. Mrs Walker replied that there had. She believes the conversation took place prior to October 1996, during the winter; she says she attributed the high level of deaths at the time to the 'flu vaccine. Mrs Burns denies that this conversation took place. She says the most that could have happened is that she might have said that they had had a lot of deaths at the registry.

14.20 The Inquiry has not heard oral evidence from Mrs Walker. However, the conversation was related in the context of an account of her fluctuating awareness of the fact that there was a high number of deaths at the surgery. She recounted how this conversation was the first time that it occurred to her that there was a high number of deaths.

14.21 I think it likely that a conversation did take place between these two women about the number of deaths occurring at that time. I think it most unlikely that Mrs Burns asked Mrs Walker specifically about deaths among Shipman's patients. I think it likely that she was aware, probably from casual talk in the register office, that a lot of deaths had recently been registered. I think it likely that her question was a general one and was not founded upon any suspicion that there were more deaths among Shipman's patients than among those of any other doctor. I think it likely that Mrs Walker has remembered the conversation because it was the first time she realised that there were a lot of deaths among Shipman's patients and this was something she was to notice from time to time over the next few years.

Conclusion

14.22 There is no evidence from which I could reasonably infer that any of the registrars had noticed an excess of deaths certified by Shipman or that they had any other concern about him.

Procedures at the Register Office

14.23 I shall now consider three procedures which the Inquiry has heard occurred from time to time at the Tameside register office and about which some concerns have been expressed.

'Mode of Dying' Cases

14.24 I have already said in Chapter Six that the Handbook for Registration Officers advises that modes of dying do not, on their own, positively identify a cause of death. If all information

recorded in Part I of the cause of death takes the form of a mode of dying, rather than a cause of death, the death should be regarded as one where the cause of death is not known and should be reported to the coroner. Examples of statements implying a mode of dying include 'respiratory arrest', 'respiratory failure', 'cardiac arrest' and similar expressions. If, however, the mode of dying is supported by a cause of death that would not of itself be reportable, then the cause of death is acceptable. Mrs Jane West, registrar for the Boston district and Training Officer for the Lincolnshire registration service, told the Inquiry that, in her county, registrars were trained that, if a doctor had given a mode of dying unsupported by an acceptable cause of death, the death should be reported to the coroner, in accordance with the guidance contained in the Handbook.

14.25 The practice at the Tameside register office was, until recently, different. If the registrar was not prepared to accept an MCCD because the supposed cause of death was, in truth, a mode of dying, the registrar would telephone the certifying doctor to ask whether s/he was able to amend the certificate by adding an underlying cause of death or to issue a new certificate with an acceptable cause of death. As Mrs West pointed out, this is not good practice, as it puts the registrar in the position where s/he might be tempted to suggest (or be understood to be suggesting) to the doctor what to put on the MCCD. If that were to happen, the MCCD, which is supposed to contain the doctor's professional opinion, would be without value. The basis of the system of certification would be undermined.

14.26 The Tameside registrars explained to me how this practice began. If a registrar telephoned the coroner's office to report a death in which the cause of death was not acceptable, instead of taking on the death for investigation, the coroner's officer would ask the registrar to contact the doctor in an attempt to resolve the problem. The registrars, who would in some ways have preferred not to do this, agreed to do so because they felt they were helping the deceased's family, who might well become anxious if there appeared to be a problem over the registration of the death. As the reaction of the coroner's officer was always the same, eventually the registrars took to telephoning the doctor themselves, after checking with the coroner's officer that a Form 100A had not already been issued. This might have occurred if the certifying doctor had spoken informally to the coroner's office and had been given 'permission' to certify the death in the terms appearing on the MCCD.

14.27 It was common ground among other witnesses that the procedures operated at the Tameside register office did not constitute good practice. Mr Christopher Dorries, HM Coroner for South Yorkshire (West), said that he and his officers would not ask a registrar to speak to a doctor about a 'mode of dying' problem. It is a matter for the coroner's office to deal with. One of his officers would contact the doctor, tell him/her that the MCCD was not acceptable and ask the doctor to tell him about the death. If the doctor could explain and justify an acceptable cause of death, the officer would say that it was up to the doctor to write another MCCD and that the office would back that up with a Form 100A. Mr Dorries would prefer that a second MCCD were issued so as to spare the family the trouble of taking the original certificate back to the doctor for amendment. On occasions, he has known a hospital to pay for a taxi to take a replacement MCCD to the register office.

14.28 Mr John Pollard, HM Coroner for Greater Manchester South District, said that, in his District, the practice was rather different. On his instructions, the coroner's officer would

suggest to the registrar that she should telephone the doctor and ask him/her to telephone the coroner's office. The purpose of that suggestion was not, he said, that the registrar should seek to solve the problem, merely that she should put the doctor in touch with the coroner's office. That explanation does not make sense. If the registrar is speaking to the coroner's officer about an unacceptable MCCD, she is trying to report the death to the coroner. It would be quite pointless for the coroner's officer to ask the registrar to ask the doctor to report the case. I reject that explanation. In any event, the evidence of Mrs Mary Evans, who was employed in the coroner's office from 1974 until 1999, latterly as first coroner's officer, confirmed the evidence of the Tameside registrars. I am quite satisfied that this poor practice was followed for many years, until it was recently stopped.

14.29 Mrs West condemned this practice and observed that it rather looked as though the coroner's office was seeking to avoid taking responsibility for such cases. However, another possibility is that the staff in the coroner's office thought that the difficulty that arose when a doctor gave a mode of dying, rather than a cause of death, was primarily the registrar's problem. It was the GRO who would not accept a mode of dying as a cause of death; therefore, the registrar should speak to the doctor to sort out the problem. Mrs Evans agreed that she regarded a 'mode of dying' as mainly the registrar's problem, although she added, rather less certainly in my view, that the coroner should not accept a mode of dying as a cause of death either. Mrs Joan Collins, who was employed at the coroner's office from 1985 until 2002 and was first coroner's officer from 1999 until her retirement, said that such an attitude did not prevail in her day. She did say, however, that the source of the information that the coroner's office should no longer allow doctors to issue MCCDs stating a mode of death only had been the register office. I think it likely that Mrs Evans, at least, was of the view that it was up to the registrar to sort out the problem if a doctor gave a mode of dying as a cause of death.

14.30 Whatever the reason within the coroner's office, I am quite satisfied that the Tameside registrars adopted this poor practice because the coroner's office pushed responsibility onto the registrars to sort out the problem of the defective MCCD. I accept that the Tameside registrars agreed to take responsibility for obtaining a corrected or new MCCD from the doctor in order not to cause distress for relatives, who would otherwise have been left without an acceptable MCCD. In that case, the death would have had to be reported to the coroner and an autopsy might have followed.

Conclusion

14.31 Although I do not regard this practice as acceptable, I do not think that, in Tameside, the outcome of any individual case examined by the Inquiry would have been any different if the correct procedure had been followed. If that had been done, the coroner's officer, rather than the registrar, would have spoken to the doctor, but the coroner himself would never have done so. The coroner's officer would have had no more expertise in medical matters than the registrar and would have been no more equipped to handle such a conversation satisfactorily. Both the registrar and the coroner's officer would have been quite unable to probe, question or challenge what the doctor said.

14.32 I mentioned in Chapter Six that the GRO had recently written to all registrars, giving guidance about good practice in relation to a number of matters that have been explored in the course of evidence given to the Inquiry. One of those matters related to the procedures which I have just described. The circular, sent to all registrars, contained the following instruction:

> **'Registrars should refer to certifying doctors only apparent clerical errors about the medical certificate of cause of death, such as the omission of dates or signatures, possible misspellings or where clarification of abbreviations is needed. Where it appears that a death must be reported to the coroner, for example where the only cause given is a mode of dying, it is for the coroner to discuss the cause with the certifying doctor. Registrars should not address such matters directly with the certifying doctor.'**

14.33 A letter to all coroners, sent out at the same time, has made it clear that any discussion with, or enquiries of, doctors should be conducted direct with the doctor, not through the registrar.

Keeping of Written Records of Discussions

14.34 There is no written advice or guidance in the Handbook for Registration Officers about the notes which registrars should keep of discussions with doctors, the coroner's office or the GRO. Miss Ceinwen Lloyd, Branch Manager Births and Deaths Registration at the Office for National Statistics (ONS), said that GRO advice was that notes should be made of all such discussions. However, it is not certain to what extent, if at all, that advice was promulgated. The evidence suggests that it was the Tameside registrars' practice to record on the reverse of the MCCD any advice received from the GRO.

14.35 If there is a formal referral to the coroner, a record will exist on the counterfoil of Form 52. However, as I have said, it appears that informal referrals have, in the past, been preferred, not only in Tameside, but generally. If the referral is by telephone, there are no clear rules as to whether and, if so, how a record should be made. If, as a result of the referral, the coroner issues a Form 100A, this form will be retained in the register office and, in due course, forwarded to the GRO as a record of the referral. However, if no Form 100A is issued, there may be no record of the referral in the register office. Mrs West said that she would always use the formal Form 52 procedure to refer a case to the coroner. However, if that were not done, she would expect to see a record made of any informal referral. Mrs Craven, now retired, said that she would have made a record in such circumstances. However, I am by no means convinced that there is any standard practice.

14.36 The practice relating to cases resulting in the issue of an amended MCCD or a second MCCD was not uniform. A Tameside registrar, Miss Partoon, said that, if in the end she obtained an acceptable MCCD, she would not make any note of the procedures she had gone through to get it. Another Tameside registrar, Mrs McCann, said that she would usually write a note on an unacceptable MCCD if it were superseded by a second, acceptable one. However, she would not do so if the first certificate were amended and

initialled by the doctor. Mrs West said that it was good practice to make a note of what had occurred in both types of situation.

Conclusion

14.37 It is plain that there was uncertainty and lack of uniformity in the approach to the making of notes within the Tameside register office. However, in the absence of any authoritative guidance or advice on the topic, I am not critical of the individual registrars.

14.38 The recent circular sent to registrars, to which I have already referred, contains detailed guidance on the written records that should be kept by registrars. In particular, registrars are now advised that a note should be kept of any discussion with the coroner's office about a particular death and that, where an amended or fresh MCCD is issued, a note of the circumstances should be made and clipped to the certificates when returned to the GRO.

The Removal of Valid Medical Certificates of Cause of Death from the Register Office

14.39 The evidence showed that, on occasions, the Tameside registrars allowed an informant to take an MCCD back to the certifying doctor for amendment. This happened, for example, in the cases of Mrs Dorothy Andrew and Mrs Bertha Parr, to which I shall refer later in this Chapter.

14.40 The Handbook for Registration Officers provides (at Section D2):

> **'16. Except as provided in paragraphs 7 and 15, the registrar must not part with a duly completed medical certificate without the Registrar General's sanction. He/She may, however, submit it on request to a coroner on the understanding that it will be returned.'**

14.41 The phrase **'duly completed'** is ambiguous; it could mean 'valid' or 'valid and acceptable'. Mrs West took the view that a valid MCCD (even if not 'acceptable') should not be released by the register office except to the coroner; even then, the practice of her office is to send only a copy. Miss Lloyd observed that releasing an MCCD to an informant was not advisable, although she could appreciate the registrars' motives for doing so.

14.42 Miss Partoon said that she used to think that it would be acceptable to release an MCCD if it was 'not viable' (i.e. not acceptable) and the death had not been registered. However, she is now more careful and releases an MCCD only if a coroner's officer has specifically asked for the doctor to provide an underlying cause of death. In that event, she takes the view that she is releasing an MCCD with the approval of the coroner. Mrs McCann also believed that, in releasing an MCCD in those circumstances, she was doing so with the implicit agreement of the coroner's office. Mrs Craven had had no concerns about releasing an MCCD during her time at the register office.

Conclusion

14.43 The guidance contained in the Handbook for Registration Officers is ambiguous. While the reasons for the practice of not releasing an MCCD can readily be appreciated, the

registrars cannot be criticised for releasing valid, but unacceptable, certificates in the circumstances in which this occurred. The practice appears to have arisen by reason of the procedures operated between the register office and the coroner's office for contact with doctors.

Additional Duties for a Nominated Officer

14.44 In a register office where several registrars work, it is usual and approved practice for a nominated officer to be appointed to carry out a range of administrative duties. This occurs at Tameside, where the registrars take turns to be nominated officer for two weeks at a time. At Tameside, the nominated officer carries out a duty that is not standard practice, namely to screen all the MCCDs as they are brought in by informants. The nominated officer will spot any potential problems and will try to resolve them before the actual process of registration begins. The registration will be carried out, not by the nominated officer, but by another registrar.

14.45 The Tameside registrars like this screening procedure because they say that it can be very distressing for an informant to discover, part way through the process, that the MCCD is not acceptable, so that the death cannot be registered on that day. If the problem is spotted at an early stage, it might be possible to resolve it; if not, at least the informant will be told before the process begins.

14.46 Miss Lloyd was concerned about this procedure because, she said, the registrar who is to carry out the registration should be personally responsible for scrutinising the MCCD. If a nominated officer has 'passed' it as acceptable, the registrar might not examine it as carefully as s/he should and might not take full responsibility for the registration. Mrs West expressed concerns of a similar nature.

14.47 The Tameside registrars said that they do examine the MCCD carefully even though the nominated officer has seen it. However, I had the clear impression from the evidence of one of the deputy registrars that she would rely primarily on the scrutiny of the nominated officer. This is perhaps understandable in view of the fact that she would be significantly less experienced than the nominated officer.

Conclusion

14.48 Miss Lloyd and Mrs West had concerns about this practice. However, provided that each registrar understood that she bore ultimate responsibility for the registration and provided that each exercised her own judgement in respect of the MCCD on which the registration was based, it does not seem to me to be particularly objectionable. Having said that, in paragraphs 14.65 and 14.69, I shall describe two occasions on which the knowledge that the nominated officer had checked the MCCD caused the registrar who registered the death to do something different from that which she might otherwise have done.

Individual Deaths

Registrars Liaising with Doctors

14.49 The Inquiry examined two deaths certified by Shipman which illustrate the procedure then current in the Tameside register office, whereby the registrars, rather than staff at the

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coroner's office, liaised with doctors who had identified unacceptable causes of death. The first death was that of Mrs Dorothy Andrew, which was a 'mode of dying' case. The second, that of Mrs Bertha Parr, had been certified by Shipman as due to 'natural causes'.

Mrs Dorothy Andrew

14.50 Shipman killed Mrs Dorothy Andrew on 12th September 1996. When he first issued an MCCD, he certified the cause of death as renal failure. When Mrs Andrew's family presented this MCCD at the register office, the registrar would not accept it. She spoke to Shipman and told him that it was not acceptable. The certificate was taken back to Shipman's surgery and he amended it, adding uraemia as the underlying cause of the renal failure and stating that 'old age' was a significant condition contributing to the death but not related to the disease or condition causing it. Mrs Andrew was 85. She had been in quite good health until her death and was active up to the end. The registrar was not certain whether to accept the amended certificate and telephoned the coroner's office. She then told Mrs Andrew's family that the coroner was not satisfied and thought that there might have to be an autopsy. This upset Mrs Andrew's daughter. The registrar advised that the family return to Shipman again. This time, Shipman issued a second MCCD, giving the cause of death as renal failure due to uraemia and old age. This was accepted and the death was registered.

14.51 This procedure was unsatisfactory in two respects. I have already said that the practice whereby a registrar speaks directly to a doctor in an attempt to obtain an improved and acceptable MCCD is undesirable. The first MCCD in this case was unacceptable and the death should have been reported to the coroner. If anyone is to discuss an amended or second MCCD with the doctor, it should be the coroner, not the registrar. However, for reasons I have explained, I do not consider that the registrars who followed this practice should be personally criticised.

14.52 The second unsatisfactory feature of this MCCD is that the causes of death Shipman gave did not make medical sense. Uraemia is a condition in which there is too much urea in the blood. It is caused by renal failure. So, uraemia is a consequence of renal failure, not a cause of it. Anyone with medical training would have realised that. Registrars do not have any medical training; they pick up some medical knowledge from their work. The registrar who failed to realise that, even in its final form, this MCCD did not make sense is not to be criticised. She did not have the training and expertise to know that. However, it is, as I have already observed, a matter of concern that registrars are expected to scrutinise MCCDs without the expertise necessary for the job.

14.53 What is even more a matter of concern is that the person in the coroner's office who advised the registrar does not appear to have realised that the causes of death advanced by Shipman did not make medical sense. This does not surprise me, in that there was no one in Mr Pollard's office with any medical expertise or training. This case underlines the need for MCCDs or their replacements to be scrutinised by someone with appropriate training or expertise and with ready access to medical advice. Only if the person in the coroner's office had realised that this certificate was nonsense, could it have become evident that this death should be investigated by means of an autopsy.

Mrs Bertha Parr

14.54 Shipman killed Mrs Bertha Parr on 11th November 1997. She was 77. When Shipman first completed the MCCD, he certified that the cause of death was 'natural causes'. In the view of Mrs West and Miss Lloyd, both of whose evidence I agree with and accept, 'natural causes' should never be acceptable to the registration service as a cause of death. The expression does not explain what has caused the death; it asserts only that the death was due to a natural disease process. In Mrs Parr's case, it appears that the nominated officer or registrar telephoned Shipman and told him that the MCCD was not acceptable. It seems that Mrs Parr's son took the MCCD back to Shipman's surgery and Shipman amended it (and the counterfoil) adding 'old age' as the underlying cause of death. The MCCD was then acceptable to the registrar and the death was registered.

14.55 I have said earlier that the practice which should have been followed was for the death to be reported to the coroner on Form 52. However, it was common practice in the Tameside register office for the registrars to seek to resolve problems of this kind without involving the coroner. As I have said, I am satisfied that they did so out of a desire to assist the family of the deceased and also because, if they contacted the coroner's office, it is more than likely that they would have been asked to contact the certifying doctor to see if s/he was prepared to amend the certificate to make it acceptable. In any event, if the death had been reported to the coroner, the coroner's officer would have asked Shipman if he were able to provide an acceptable certificate. He would have done so. The death would not have been investigated and there would have been no autopsy. The outcome would have been the same.

An Occupationally-Related Death

14.56 Concern was expressed about another death, where a registrar had failed to discover that a death was or might have been occupationally-related and should, under the provisions of regulation 41 of the Registration of Births and Deaths Regulations 1987, have been reported to the coroner.

Mr John Livesey

14.57 Shipman killed Mr John Livesey on 25th July 1997. On the MCCD, Shipman stated that the death had been caused by renal failure. However, he gave hypertension as an underlying cause of death and, with that underlying cause, renal failure is acceptable. Therefore, no 'mode of dying' problem arose. Shipman also stated that chronic obstructive airways disease had contributed to Mr Livesey's death. In the box below that (the 'Spearing box'), which allows the doctor to state that the death might have been due to or contributed to by the employment followed by the deceased, Shipman had put no tick. It happens that Mr Livesey had worked for many years in the ventilation industry and had been exposed to asbestos. Mrs Joanne Livesey-Carter, Mr Livesey's daughter, told the Inquiry that, when she attended at the register office to register her father's death, she was not asked any questions about exposure to an industrial hazard.

14.58 I have already said in Chapter Six that some registrars, on seeing a death from lung disease, make a practice of asking questions designed to discover whether the death

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might have been occupational in origin. However, it does not seem that the practice is universal. It may be that it is not always followed with a common disease such as chronic obstructive airways disease. As I have explained earlier, the task of the registrar is primarily to obtain factual information about the deceased from the informant and to scrutinise the MCCD. I can well understand why, if the 'Spearing box' is not ticked, the registrar assumes that there is no history of exposure to an industrial hazard. I have the impression that if, when the registrar enquires as to the nature of the deceased's employment, s/he realises that it might have entailed exposure to an industrial hazard, s/he will ask the informant whether or not it did and might then refer the death to the coroner for investigation of whether the industrial hazard caused or contributed to the death. However, I do not think registrars are trained that they must always investigate the question of whether the deceased was exposed to a hazard.

14.59 In the present case, Mrs Livesey-Carter described her father's occupation as 'managing director', which indeed he was. Unfortunately, that would not have put the registrar on enquiry as to the possibility that his employment had involved exposure to an industrial hazard. Had the registrar asked questions and discovered that Mr Livesey had been exposed to asbestos, it might be that the death would have been referred to the coroner and that there would have been an autopsy. Whether that would have revealed that the true cause of his death was morphine poisoning, I cannot say with confidence. For reasons I have outlined in Chapter Nine, it is quite possible that the pathologist would have found some other condition capable of explaining Mr Livesey's death, in which case it is unlikely that toxicology would have been carried out.

14.60 I do not think I could criticise the registrar for failing to ask Mrs Livesey-Carter more about the nature of her father's employment. I have little doubt that Shipman knew that Mr Livesey had worked with asbestos and deliberately omitted to tick the 'Spearing box'. To do so would have been to invite the registrar to refer the death to the coroner, something Shipman would certainly have wished to avoid.

Advice from the General Register Office

14.61 The Inquiry found two deaths where registrars at the Tameside register office had sought advice from the GRO before registering the deaths. I have already explained in Chapter Six that the GRO runs an advice line, manned by members of staff from the General Section. Those members of staff have no medical background or expertise. They are recruited from other sections of the GRO and externally. They are trained on the job. They deal with written and telephone queries, ranging from simple enquiries from members of the public to more complex medical issues raised by registrars. Queries from registrars often relate to uncertainties over whether or not a death can properly be registered.

14.62 In order to assist them in answering queries, staff in the General Section have access to an annotated medical reference book, the Handbook for Registration Officers, various leaflets and internal files (known as 'P' Books) containing documents relevant to various issues, including referral to the coroner. They also have access to ONS epidemiologists in the event of complex medical enquiries; however, the evidence strongly suggests that most queries, including those from registrars, are resolved by the clerical staff. The registrar witnesses agreed that staff at the GRO are very approachable nowadays.

14.63 It does not appear that, within the documentation available to staff in the General Section in 1996, there was any unequivocal written statement to the effect that 'natural causes' was not an acceptable cause of death. Certainly, there was no such statement in the Handbook for Registration Officers. However, the Inquiry was told that the 'P' Books contained a letter, written by an ONS (then OPCS) epidemiologist in 1994 in response to a query from a coroner. The letter indicated that doctors within the OPCS did not agree as to the acceptability of 'natural causes' as a cause of death. The author of the letter said that his own reaction would be to accept an MCCD with 'natural causes' as the cause of death. He considered it to be **'self-evidently within the 'rules''**. Furthermore, he did not regard it as any less clear a cause of death than 'old age'. Anyone reading that letter might well have understood that 'natural causes' was, or at least might be, acceptable as a cause of death.

Mrs Erla Copeland

14.64 Shipman killed Mrs Erla Copeland on 11th January 1996. He certified that the cause of death was 'natural causes'. When the MCCD was presented at the Tameside register office, it appears that Miss Partoon, as the nominated officer, telephoned the GRO to seek advice about the acceptability of the cause of death. She recorded on the back of the MCCD, **'Checked with the GRO - Acceptable because of age'**. Mrs Copeland was 79. It is not known who at the GRO gave the advice. It appears that the adviser at the GRO had taken the view that 'natural causes' could be equated with 'old age'. Mr David Trembath, the manager of the General Section since October 1996, was unable to shed any light on how this advice could have been given. He suggested that, possibly, the registrar had tried to report the death to the coroner but that the coroner or his officer had been unwilling to accept it. In that event, the registrar might have sought advice from a member of staff at the GRO, who might have advised that, in those circumstances, 'natural causes' should be accepted. There is no evidence at all to suggest that that happened in this case.

14.65 The death was registered by Mrs Craven. She said that, if she had not known of the advice received from the GRO, she would have telephoned the coroner's office. She would not have made a formal report using Form 52. However, in view of the advice received from the GRO, she registered the death. She said that it would not have occurred to her to question advice from that source. I can well understand why. The giving of poor advice by the GRO in this case is worrying, as such advice disseminates poor practice. Any registrar hearing of such advice in one case would be likely to act upon that advice in other cases, without further reference to the GRO. If the GRO gave this poor advice to Miss Partoon, it is likely that it will have been given to other registrars all over the country.

14.66 I am not critical of Miss Partoon or Mrs Craven. I can well understand why they would prefer to telephone the GRO, rather than to refer the death to the coroner.

14.67 If this case had been reported directly to the coroner, I do not think that the outcome would have been significantly different from what in fact occurred. The likely outcome would have been that the coroner's officer would have requested the registrar to speak to Shipman and ask whether he was able to provide a more specific cause of death.

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Alternatively, the coroner's officer would have spoken to Shipman. I am quite sure that Shipman would have obliged and would have thought of something to put on the MCCD. Indeed, it is surprising that he had been so careless as to certify the death as due to 'natural causes'; usually, he was careful to provide an acceptable (albeit untrue) cause. As Mrs Copeland's history did not reveal any obvious potential reason for her to die, I think it likely that Shipman would have certified the death as due to 'old age'. I think it most unlikely that the coroner's officer would have suggested to the coroner that he should take jurisdiction over the case and direct an autopsy. Only by speaking to those who had seen or spoken to Mrs Copeland shortly before her death could the coroner's officer have come to suspect that Mrs Copeland's death was sudden and unexplained.

Mrs Marion Higham

14.68 Mrs Marion Higham died on 19th July 1996, at the age of 84. After reviewing all the evidence relating to her death, I concluded that Shipman had probably killed her. He certified that the cause of her death was 'natural causes'. When the MCCD was presented, Mrs Craven, as the nominated officer, telephoned the GRO to ask advice about the acceptability of the cause of death. This is contrary to what she had said she would have done in the case of Mrs Copeland, six months earlier. It may well be that she felt it necessary to check with the GRO that the advice given then still held good. She recorded the outcome of her conversation with the GRO on the back of the MCCD as follows: **'SHEILA SIDES. GRO - ACCEPTABLE'**.

14.69 Mrs McCann then registered the death. Her evidence was that she would not have registered the death on her own initiative but did so in reliance on the advice of the GRO. She said that, although she does not always accept the advice of the GRO as authoritative, she did so on this occasion, probably because the advice had already been accepted by the nominated officer.

14.70 Mrs Sheila Sides had worked at the GRO for several years but, in July 1996, had worked on the advice line in the General Section for only a few weeks. It cannot have been she who advised Miss Partoon in January 1996 in respect of Mrs Copeland. Mrs Sides said that, in 1996, the policy in respect of 'natural causes' was clear; it was not acceptable. She suggested that her advice in this case could have been given as a result of a mistake or misunderstanding by her.

14.71 It was suggested by Counsel for the GRO, and accepted by Mrs McCann, that Mrs Craven might have spoken to the certifying doctor and the coroner's office before approaching the GRO. Mrs Sides suggested that one explanation for the advice that she gave might be that the registrar told her that she had already spoken to the coroner, had been told that the coroner was 'not particularly interested' (meaning that he did not want to take the case on) but that Mrs Craven was still 'unhappy' with the cause of death. In that event, Mrs Sides said, she would not have 'overruled' the coroner but would have told the registrar that she could go ahead and register the death. Mr Trembath appeared to think that was a possibility.

14.72 In my view, that suggestion does not make good sense for several reasons. First, if Mrs Craven had spoken to the certifying doctor, the doctor either would have offered to

provide a more specific cause of death on a new or amended MCCD (in which case, the death could then have been registered) or would have said that he could not identify a specific cause of death, in which case, the death would have had to be reported to the coroner. In practice, Shipman would have provided a more specific cause of death.

14.73 Second, it is highly improbable that Mrs Craven would have spoken to the coroner's office before seeking the advice of the GRO. It would not be logical to do so, unless the registrar regarded the death as clearly reportable and the coroner would not accept jurisdiction. In that event, there would almost certainly have been a note to that effect on the MCCD. There was not. In any event, the evidence of Mrs Evans, Mrs Collins and Mrs Margaret Blake, the coroner's officers at the time, was that, if a registrar had reported a death said to be due to 'natural causes', the coroner would have accepted jurisdiction. Finally, Mrs Sides' suggested explanation would be wholly inconsistent with the note written on the reverse of the MCCD that the cause of death was **'ACCEPTABLE'**.

14.74 Initially, Mrs Sides was adamant that the GRO policy towards 'natural causes' was so clear and unequivocal that there would have been little room for mistake or misunderstanding. She thought she could not have been confused by the letter in the 'P' file into thinking that 'natural causes' might be acceptable in some cases. However, she later conceded that she might have been confused by the letter.

14.75 The fact that similar (wrong) advice was given on two occasions during 1996 makes it unlikely that the GRO had a policy which was clearly understood by all staff in the General Section on the acceptability or otherwise of 'natural causes'. If such a policy did exist, it would have been easy to understand and put into practice. The fact that no such policy did exist (or was known only to some within the Section) may well be because the situation did not arise frequently. No policy was written down and, indeed, the written material which was available tended to suggest that 'natural causes' might constitute an acceptable cause of death; at the very least, it would have confused the issue.

14.76 In the absence of a clearly understood policy, no criticism can be levelled at Mrs Sides personally for her conduct in 1996. She may have given the advice on her own initiative, misunderstanding the position. Alternatively, she may have sought guidance from others who did not properly understand the position. Either way, she should not be blamed.

14.77 The suggested explanation put forward by Mrs Sides and Mr Trembath for the giving of the advice causes some concern. Both Mrs Sides and Mr Trembath suggested that, if a registrar was unhappy with the fact that the coroner was 'not interested' in taking up a case and sought the advice of the GRO, the advice would be to register the death, even if (as in the case of 'natural causes') the GRO believed the cause of death to be unacceptable. This seems to defeat the purpose of a registrar seeking independent professional advice from the GRO. Whilst, in the final analysis, it may be the case that there is little a registrar can do if the coroner refuses to act on a referral, it would at least be open to the registrar to take some further action, for example, by approaching the coroner personally or by submitting a Form 52. It would have also been possible for the GRO to make representations to the coroner on the registrar's behalf. The evidence also suggests that the GRO believes that coroners sometimes refuse to accept jurisdiction in deaths which have not been properly certificated and yet the GRO does nothing about it. The priority

appears to be to ensure that registration takes place, rather than to ensure that a satisfactory cause of death is established.

14.78 In respect of both the deaths examined, the Inquiry has been reliant on notes made by the registrars concerned. No record was or is maintained by the GRO of advice given on the acceptability of causes of death. In the light of the potential importance of the advice, this appears poor practice.

Conclusions

The General Register Office

14.79 It appears that the problems which have arisen in relation to the advice given by the GRO are caused in large part by a system whereby clerical staff without medical expertise are seeking to advise other clerical staff on matters which are essentially medical in nature. If the present system is to continue, it is apparent that improved training and guidance is required for the staff who answer queries from registrars. Also, if the advice line were to continue to operate in its present form, I would recommend that consideration be given to ensuring that one person with medical expertise is available to answer queries relating to the meaning or acceptability of a cause of death. However, if my recommendations for reform are accepted, registrars will no longer be required to decide on the acceptability of causes of death. For reasons I have already given, they are not properly equipped to carry out this function.

14.80 The recent circular to registrars advised that, where a death is reported as being due to 'natural causes', either without any other underlying cause of death or with an underlying cause of death which is also reportable, the death should be reported to the coroner. The Handbook for Registration Officers has been amended accordingly.

The Tameside Registrars

14.81 The Tameside registrars cannot be criticised for following the wrong advice given by the GRO.

14.82 As I have said, several of the procedures in operation at the Tameside register office were less than ideal. I am not critical of the individual registrars, who had not received clear training or guidance on the points of practice that arose. Nor had they any opportunity to meet registrars from other areas to discuss variations in practice. Accordingly, they had little opportunity to discover and correct any shortcomings in their own practice or to gain the necessary confidence to insist upon the correct statutory procedures. Their position was very different from that of Mrs West, who has had the advantage of exposure to contact with other registrars and the benefit of an excellent training programme. The only real opportunity afforded to the Tameside registrars to seek guidance on practice would arise when an inspector visited. However, such occurrences are not frequent and the main function of such a visit is for the inspector to satisfy him/herself that the registrar is conducting him/herself in accordance with the rules. The inspector might or might not discover an unorthodox practice during an inspection.

14.83 In any event, none of the unorthodox procedures followed at Tameside had a serious effect on the registration process. Nor would the outcome have been different in any of the cases I have considered had the procedures been correctly followed by staff at the register office.

14.84 Because of the fact that so many deaths certified by Shipman were registered at the Tameside register office, procedures at the office have been subjected to close scrutiny by the Inquiry. However, it is plain from the recent correspondence received from the GRO, to which I have already referred, that the departures from best practice about which the Inquiry has heard are not confined to Tameside. I welcome the advice and guidance which has recently been issued to registrars and hope that, in the future, it will also be possible to improve training facilities and opportunities for professional meetings for registrars and deputy registrars employed throughout the registration service.

CHAPTER FIFTEEN

The Doctors Who Signed Cremation Forms C for Shipman's Patients

Introduction

15.1 Many of the patients whom Shipman killed were cremated. Two hundred and ninety two cremation forms for deceased patients of his were obtained by the Inquiry, some dating back to the period when he was in practice in Todmorden. I have explained the role and duties of the Form C doctor in Chapter Eleven. In this Chapter, I shall consider the role of the doctors who signed Forms C for Shipman's patients.

Todmorden

15.2 While working in Todmorden, Shipman mainly used one doctor, Dr Stella Brown, to sign his Forms C. Dr Brown was a former partner in the practice that Shipman had joined. She signed nine of the ten certificates that survive from his time there. It is perhaps noteworthy that she usually, but not always, made some enquiry of one or more of the persons mentioned in questions 5–8 on Form C. The doctor who signed the remaining Form C made a similar enquiry. This would tend to suggest that it was custom and practice in Todmorden to make such enquiries. The form itself, unlike Forms C issued by some crematoria, contained no requirement that such enquiries be made.

Hyde

The Clarendon House Doctors

15.3 Shipman worked at the Donneybrook Practice between October 1977 and August 1992. During that period, he used the doctors from the two neighbouring Clarendon House practices to complete his Forms C. There were about 12 doctors involved and the numbers of forms completed by each doctor during this period were relatively few. During this time (with the exception of Dr Peter Bennett in one case, which I will mention), none of the doctors noticed anything unusual about Shipman's Forms B.

The Brooke Practice Doctors

15.4 After moving to the Market Street Surgery in August 1992, Shipman continued briefly to use the doctors from both Clarendon House practices. When the doctors from one of those practices moved, in August 1993, and set up the Brooke Practice, Shipman asked those doctors to complete his Forms C. The doctors who remained at the other Clarendon House practice ceased to complete forms for him.

15.5 It was during this later period, and particularly from 1995 onwards, that the number of deaths among Shipman's patients increased significantly, as did the number of his requests for Form C to be completed. The five Brooke Practice doctors, Dr Peter Bennett (who left in 1996 and was replaced by Dr Linda Reynolds), Dr Alastair MacGillivray, Dr Susan Booth, Dr Jeremy Dirckze and Dr Rajesh Patel, operated an informal rota, with

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the Forms C being shared between them on a roughly equal basis. Each doctor would, therefore, know that s/he was completing only about one in five of Shipman's Forms C.

15.6 The Brooke Practice doctors did not seem to notice that Shipman appeared willing to certify deaths that had occurred quite suddenly, in circumstances in which most doctors would have thought it necessary to report the death to the coroner. Nor did they notice that deaths often appeared to occur very shortly after Shipman had visited or that a large number of his patients seemed to die alone. Only Dr Patel seems to have noticed that Shipman had been present at more deaths than might have been expected. He mentioned his observation to Shipman, who rebuked him, as I shall describe later.

15.7 A few months after Dr Linda Reynolds joined the Brooke Practice, on 1st September 1996, she began to notice that she was being asked to sign cremation Forms C rather more often than had been the case at her former practice. She also noticed that Shipman had on several occasions been present at the death of the patient in question. She thought that this was odd because, in her experience, the presence of a general practitioner at the death of a patient was very unusual. She mentioned this to her partners towards the end of 1997, but they advised her that Shipman had a lot of elderly patients and was well known as a doctor who would visit his patients unannounced when he was concerned about their condition. His presence at the deaths of his patients would not be surprising to them, for these reasons.

15.8 In February 1998, Mrs Deborah Bambroffe, a funeral director, mentioned to Dr Booth that she was concerned about the deaths of Shipman's patients. Mrs Bambroffe said that she had noticed the high number of deaths among Shipman's patients, and that a lot of those patients were elderly women who had died at home, often apparently alone; they were found sitting up in a chair, dressed in day clothes and showing no sign of previous illness. She had also noticed that Shipman seemed to have been present either at or shortly after the deaths of many of them.

15.9 By late March 1998, the Brooke Practice doctors had decided to act. Some of them, but especially Dr Reynolds, were very concerned by the number of deaths among Shipman's patients and the unusual features reported by Mrs Bambroffe. On 24th March, acting on behalf of the Brooke Practice, Dr Reynolds reported their concerns to Mr John Pollard, HM Coroner for Greater Manchester South. A police investigation ensued and that investigation is the subject of my Second Report. Unfortunately, it failed to detect Shipman's criminal activities and it was closed on 17th April. Shipman continued to practise and killed three more patients before his arrest in September that year, on suspicion of the murder of Mrs Kathleen Grundy. As is now well known, he was later convicted of the murder of 15 patients and the Inquiry has found that he killed at least 200 more over a period of 24 years.

Assessing the Performance of the Hyde Doctors

15.10 It has been and remains a matter of public concern that the systems of death and cremation certification failed to deter Shipman or to detect his crimes. In the earlier Chapters of this Report I have described some of the shortcomings of the systems, as

operated throughout the country over many years. In my First Report, I explained that Shipman frequently gave dishonest and sometimes implausible accounts in cremation Forms B which he completed for patients he had killed. In this Chapter, I shall consider whether those doctors who undertook the duty of completing most of Shipman's Forms C ought to have noticed that something was amiss and done something about it. They might have done so for a number of reasons: because of the numbers of forms they were being asked to sign, because of the presence of unusual, possibly recurring, features of the deaths or because, in any given case or cases, Shipman's assertions on Form B were internally inconsistent, inherently implausible or suggested that the death should have been reported to the coroner.

15.11 There is no doubt that, with one or two exceptions to which I will refer, the doctors who signed Shipman's Forms C did not over many years notice any of these features. I shall consider whether, if they had undertaken their duties more carefully, they would have noticed them. I shall also consider whether they should be criticised for their failure to notice them.

15.12 During Stage Two, oral evidence was given by the ten doctors who signed most of the Forms C for Shipman. In this Chapter, I shall call them 'the Hyde doctors'.

Forms B

15.13 In the case of each of the Hyde doctors, the Inquiry examined the frequency with which and the usual circumstances in which s/he completed a Form B for one of his/her own patients and the standard to which s/he completed the forms. I formed the view that the Hyde doctors were all conscientious when completing Forms B. Typical cases in which they certified the cause of death and completed Forms B were very similar. The death was expected, the patient had been ill in bed and died either in a nursing or elderly persons' home or at home with family or carers in attendance. Those are just the circumstances in which one would expect a doctor to be in a position to certify the cause of death and complete and sign a Form B. He or she would be able to combine his/her direct knowledge of the medical condition of the patient with the carers' or family's account of the circumstances of death, in order to furnish the information required.

15.14 Such circumstances are very different from those of many deaths for which Shipman completed Forms B. Although he would often falsely suggest that the death was expected or that a relation or friend was present at the moment of death, Shipman would also frequently complete a Form B for the death of a patient who had died suddenly and apparently alone. Shipman would often admit that he had been present at the death; the other doctors were present at the deaths of their patients only on very rare occasions. He would often admit a visit on the day of the death, sometimes just an hour or so before the death. This might be understandable if it happened, from time to time, in the case of a chronically ill patient whom he was visiting frequently and for whom hospital admission would be of no value. It would not be readily understandable otherwise, especially if no one was available to care for the patient at home. In other cases, Shipman apparently had to estimate the time of death of the deceased, no one having been present around the time of death to provide him with that information.

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Training and General Attitude towards Forms C

15.15 The Inquiry sought to discover from each Hyde doctor the extent of any education or training s/he had received in the completion of cremation forms and his/her perception of the role of the Form C doctor. Most said that they had received no training or guidance of any kind and it was apparent that most of them had not, until recently at least, ever properly applied their minds to the purpose of the Form C procedure. Most did not perceive that part of the purpose was to provide an independent check on the Form B doctor. To the extent that they did appreciate this, they did not regard the chance of wrongdoing by the doctor as anything other than theoretical. To the extent that they were checking on the Form B doctor, it was, they believed, only to ensure that s/he had not made a *bona fide* error of judgement in diagnosing the cause of death. Enquiries made by the Inquiry have revealed that this attitude amongst the Hyde doctors was also prevalent among doctors from other areas. Some of the Hyde doctors said that they regarded the Form C procedure as a pure formality with no real purpose. It was just 'form-filling'. This attitude goes a long way to explain why those doctors did not feel it necessary to approach the task in a more critical and analytical way. As I have already explained in Chapter Eleven, I am sure that this attitude was far from unique to Hyde.

The Practice when Signing Forms C for Shipman's Patients

15.16 Although the Hyde doctors signed Forms C for doctors other than Shipman in the early years, those who moved to the Brooke Practice rarely, if ever, did so after the move. The opportunities for comparison with the practice of other doctors was, therefore, limited. This set Dr Reynolds' experience of completing Forms C apart from that of her colleagues at the Brooke Practice.

15.17 All described a similar process, which they followed when completing Forms C for Shipman. Usually, Shipman would visit the Form C doctor in his/her surgery and would give a very full oral account of the deceased person's medical history and the events leading up to the death. Sometimes, Shipman would have the medical records with him but not as a rule. In any event, even if he had them, he never offered to show them to the Form C doctor and the Form C doctor did not ask to see them. Sometimes, Shipman would take the completed Form B with him and hand it to the Form C doctor. Quite often, Shipman left the completed Form B and the blank Form C at the premises of the funeral director. In that situation, the Form C doctor would not be in a position to read what Shipman had put on Form B until s/he went to see the body, some time after his/her conversation with Shipman. Even if Shipman handed the Form B directly to the Form C doctor, the latter would not usually read it before or during the conversation. Shipman would give far more detail orally than he had written on the Form B. Some time after this meeting, not necessarily on the same day, the Form C doctor would attend the premises of the funeral director, examine the deceased's body, look at the Form B (if s/he had not already done so) and complete and sign Form C. In the overwhelming majority of cases, no enquiries would be made of the deceased's family, carers or other persons.

15.18 The Form C doctor would regard the oral account, rather than the written account on Form B, as the definitive account. Shipman was well respected by his professional colleagues

in Hyde, who trusted his word. Shipman appears to have been a plausible historian who always gave a very full and persuasive account of events. He would rely upon his reputation as a caring, old-fashioned doctor, who knew what was best for his patients and who believed firmly in their right to choose to remain at home rather than be admitted to hospital. He might allude to conversations that he had had with the coroner or coroner's office about how his preparedness to certify the cause of some deaths had been approved. I have no doubt that, on every occasion when Shipman had killed a patient who was cremated, he delivered his account of the patient's medical history and the circumstances of death in a forceful and convincing way.

15.19 Moreover, I believe that, because the Hyde doctors themselves would not certify the cause of any death or sign a Form B unless satisfied that they knew the cause of death, they always proceeded on the assumption that Shipman operated in the same way; because he was prepared to sign a Form B, the death in question was a 'natural' death of which he knew the cause. In this respect, the approach of the Hyde doctors is not unusual; indeed, I think it is probably almost universal. I have already said that the system of death certification has always relied on the integrity of a single doctor. Although, for cremations, the existence of the Form C doctor is supposed to introduce an additional and independent check (for which the Form C doctor should not merely accept the Form B doctor's word), it is clear that, for decades, Form C doctors have done little more than endorse the Form B doctor's view. That is one of the reasons why the Brodrick Committee recommended the abolition of the Form C procedure.

15.20 In these circumstances, it is easy to understand how, when Shipman gave them a false, but reasonably plausible, oral account of the death, the Hyde doctors readily accepted it and were prepared to complete Form C. However, in my view, they were nevertheless under a duty to read Form B carefully and to ensure that it was consistent with the account they had been given orally. It appears to me that some of the Hyde doctors cannot have undertaken this task as carefully as they ought. Some of them admitted that they had not done so. Others thought that they had read Form B carefully but could not explain how it was that they had failed in some cases to observe some strikingly unusual feature or inconsistency.

15.21 Form C requires that the doctor should state that s/he has seen and carefully examined the body. It follows that that should be done. In good conditions, a thorough examination of the body can be very useful in detecting signs of violence or neglect. As part of the independent investigation of the death and a check on the Form B doctor, it may have a useful role to play. Some of the Hyde doctors regarded the examination of the body as a mere formality. I think most of them carried this out in a cursory way. They considered, perhaps not unreasonably, that a thorough examination was unlikely to reveal very much to confirm or refute the cause of death. Provided that they saw nothing inconsistent with the cause of death, as stated on Form B, they were content. However, I do not criticise them personally for that. I consider that, in this respect, the Hyde doctors were no worse than countless of their colleagues elsewhere in the country. Moreover, even the most thorough examination of the body of a patient whom Shipman had killed would have revealed no cause for suspicion. The doctor might have noticed an injection mark on the hand or at the elbow, but that would not be unusual and would almost always be capable

of innocent explanation. If asked about it, Shipman would have been able to give a plausible explanation; indeed, on occasions when he knew that the lethal injection had left a mark he would pre-empt any questions by proffering an explanation to the family. For example, he did this just after he had killed Mrs Vera Whittingslow on 24th June 1997. I have little doubt that he would have given a similar explanation to the Form C doctor, had the issue arisen. He might well also have made a record to support it, had it been the practice for the Form C doctor to examine the medical notes.

15.22 The Form C issued by the Dukinfield crematorium (in contrast to that issued by some other crematoria) does not require that the doctor should answer any of questions 5–8 in the affirmative. The form contains a marginal note requiring affirmative answers to questions 1, 2 and 4. In effect, it was sufficient for the Form C doctor to discuss the death with the Form B doctor and examine the body. As a result, with just three exceptions that I will mention in due course where the doctors spoke to nurses or carers, none of the Hyde doctors ever made any enquiry of family, carers or others who might have been in a position to confirm or refute the account of Shipman, as a Form B doctor. Given that they did not perceive that their role was to check on the Form B doctor, this is perhaps not surprising. On the occasions when they did, it seems quite possible that they did so as a result of a chance or unrelated meeting with those carers or nurses to whom they spoke. Moreover, as I have already explained, it happens only very rarely elsewhere in the country that a doctor makes any such enquiry unless Form C expressly requires him/her to do so.

15.23 In my judgement, the general approach of the Hyde doctors to their Form C role, like the approach of a large proportion of doctors practising elsewhere in the country, was not appropriate. The *raison d'etre* of the Form C doctor is that s/he should seek to reach an independent opinion as to the cause of death. Doctors should not merely accept and endorse the view of the Form B doctor. They should carry out a careful examination of the body and they should not adopt the practice of never making enquiries of third parties. It might be argued with some force that this is apparent from the statements and questions in Form C and, in particular, questions 5–8. It might also be argued that a doctor who finds him/herself repeatedly in the position of giving the same negative responses to questions 5–8 should question whether his/her approach to the task in hand is correct. That such an approach was commonplace had long been recognised by the Home Office and others. Nevertheless, I observe that the profession as a whole was never instructed to change the approach that was commonly taken. It would not be fair to single the Hyde doctors out for criticism on account of their approach.

Form C Certification by the Individual Doctors

15.24 Having said that I will not criticise the Hyde doctors for their general approach to their Form C duties, I now turn to consider whether they should be criticised for their performance in connection with Forms C for Shipman's patients. I have to consider, in relation to each Hyde doctor, whether there were numbers or patterns of deaths or unusual, possibly recurrent, features of the deaths that should have been noticed and acted upon by him/her. I shall also consider whether, by checking carefully what Shipman had written on Form B, the Hyde doctors should have noticed unusual features or inconsistencies

between what Shipman had written and what he had told them. I shall also consider whether they should have noticed other circumstances that would or should have concerned them.

15.25 I remind myself that, in considering the way in which a Hyde doctor carried out his/her duties, it is only fair to bear in mind the dynamics of the relationship between that doctor and Shipman. I have said that Shipman was well respected by his colleagues. He was not well liked. Some of his colleagues found him prickly and arrogant; some, particularly the younger ones, found him intimidating. Some of the Hyde doctors said that they would have found it impossible to express any doubt about Shipman's opinion. I can understand that. It is asking a great deal of a young general practitioner to adopt a critical and analytical approach to the opinion of an older, respected and dominant colleague.

15.26 In deciding where criticism should fall, I apply the standard of the reasonably competent and conscientious general practitioner. In setting and applying that standard, I take into account all the relevant background considerations already described. This is not a straightforward exercise, not least because the position of the Hyde doctors, who had portrayed to them as natural such a large number of unexpected deaths, is clearly very unusual.

15.27 Finally, I will consider whether, if the Hyde doctors had performed their duties more carefully, Shipman might have been detected earlier.

15.28 In considering this last issue, I must bear in mind that, if a Form C doctor feels any concern about the opinion of the Form B doctor as to the cause of death or considers that the circumstances require a report to the coroner, his/her available courses of action are limited. He or she can decline to complete Form C and can suggest to the Form B doctor that it would be appropriate to report the death to the coroner. He or she would assume that the Form B doctor would accept that suggestion but would not check to ensure that s/he had done so. If a Hyde doctor had refused to sign one of Shipman's Forms C, there would have been nothing to prevent Shipman from taking the Form C to another doctor who might have less exacting standards. Alternatively, Shipman might well have gone away and returned later, saying that he had spoken to the coroner, who had approved the cause of death. It would then be very difficult for the Form C doctor to do anything other than to complete and sign the form. Only if the Form C doctor became positively suspicious of the Form B doctor (as opposed to thinking that s/he ought not to certify in the individual case) would s/he think of taking matters into his/her own hands by making a personal report to the coroner or the police.

15.29 Throughout my analysis of the work of the individual doctors, it should be assumed (unless I say to the contrary) that each doctor had had no training in the purpose or completion of cremation forms and that his/her experience of completing Forms B for his/her own patients was as I have described above. It should also be assumed that his/her experience of completing a Form C for Shipman was as I have described at paragraphs 15.17 and 15.18.

15.30 I shall consider the Hyde doctors in alphabetical order.

Dr Norman Beenstock

15.31 Dr Norman Beenstock was registered as a medical practitioner in 1956. He commenced work in general practice in about 1961 and in 1968 was appointed a principal at one of the Clarendon House practices, where he remained until his retirement in 1993.

15.32 Between 1980 and 1993, Dr Beenstock signed 18 Forms C for Shipman; that is one or two per year. There were no clusters of deaths. He could not have been expected to notice an excess of deaths and, in fact, only six of the deaths were unlawful killings. These occurred between 1983 and 1989. Shipman admitted that he was present at two. On both occasions, Shipman claimed that another person had also been present. Although Shipman's presence should have been regarded as unusual, I have no doubt that Shipman would have given a plausible explanation and, since the two deaths in question were about three years apart, I would not expect Dr Beenstock to notice or be concerned by this feature. I also note that Dr Beenstock's own practice was to do some 'chronic visiting' of patients who were unwell or infirm, but not to such a degree as to require them to live in a nursing or elderly persons' home.

15.33 In relation to the other unlawful killings, Shipman said that he had visited each patient within a few hours before the death. I observe that no such deaths followed immediately upon a similar one and the time periods between each were considerable. There is no reason why Dr Beenstock should have noticed any unusual pattern of conduct.

15.34 Mr Percy Ward was 90 years old, very ill and receiving nursing care from the district nurse in the period leading up to his death in 1983. Shipman was called out to see him because of a worsening in his condition. The mode of death was said to be coma and death was said to have occurred in the presence of his wife and daughter. These features would have been typical of the normal case in which a doctor might be expected to call often in the period leading up to death and in which it would be quite natural for him to have left the patient at home, because hospital admission would serve no useful purpose.

15.35 On the Form B for Mrs Deborah Middleton, whom Shipman killed in January 1986, Shipman gave various timings, which are internally inconsistent and confusing. Dr Beenstock said that he must have noticed these and probably believed that Shipman had made a mistake or was himself confused about the times. He had not thought that there was any cause for suspicion and noted that Mrs Middleton's granddaughter was present at the death. He had had the impression that the death was expected. I am not sure that Dr Beenstock did notice the inconsistent timings. If he did, he should, strictly speaking, have had them corrected. But, if he noticed them at a time when he was not with Shipman, I can understand why he did not trouble to do so. They would not of themselves have seemed suspicious. I do not criticise Dr Beenstock for failing to ensure that they were corrected.

15.36 Dr Beenstock also failed to notice a mistake in a date on the Form B for Mrs May Hurd, whose death was not an unlawful killing. The error, if noticed, would not have aroused suspicion.

15.37 Except for a brief period at the beginning of his career, Dr Beenstock never made any enquiries of persons other than the Form B doctor. On the occasions when he had done so,

he told the Inquiry that he had found the process 'unrewarding in every way'. I note that, if Dr Beenstock had spoken to Mrs Middleton's granddaughter, he would have found out that she had not been present at the death and was most surprised by the death. If Shipman had told that lie and been discovered, Dr Beenstock would have been most disturbed. If Shipman had not been able to tell that lie (because he knew that the Form C doctor was likely to question the granddaughter) and had said that Mrs Middleton died alone, Dr Beenstock would have been more likely to suggest a referral to the coroner. I say this, not as a criticism of Dr Beenstock, but to demonstrate the importance of cross-checking the certifying doctor's story with someone independent of him/her, such as a relative.

15.38 There is no other case on which I need to pass comment. Although Dr Beenstock's practice as a Form C doctor did not fulfil the intention of the legislation, he performed his duties in much the same way as many other doctors did and still do. I do not criticise him.

Dr Graham Bennett

15.39 Dr Graham Bennett was registered as a medical practitioner in 1954. In 1965, he and two partners set up practice in Clarendon House, Hyde, where he remained until his retirement in 1989.

15.40 Between 1981 and 1989, Dr Bennett completed 14 Forms C for Shipman, of which four were unlawful killings. Five of the 14 deaths occurred in 1985, but three of them were natural deaths and the Forms B for the other two give no cause for concern or suspicion, even with the benefit of hindsight. Otherwise the deaths were well spread in time. I do not think Dr Bennett could have been expected to notice any excess of deaths.

15.41 Of the four unlawful killings, Shipman admitted that he was present at only one death, which occurred in 1986. He suggested that others were also present and the account on Form B was not such as to arouse concern. In relation to the other three unlawful killings, Shipman said he had visited each patient on the day of death. In the cases of Mrs Selina Mackenzie, Mr Albert Cheetham and Mrs Elsie Harrop, the facts suggested by Form B, which Shipman would no doubt have elaborated upon, are consistent with the picture of an ailing patient who was either being supported at home or receiving follow-up visits from Shipman. Some Forms B had omissions or internal inconsistencies. However, none of these was of any great significance and Dr Bennett should not be criticised in respect of his failure to ensure that they were corrected. In two cases, Shipman had purported to estimate the time of death by reference to the temperature of the body. As I have said in my First Report, he was unable to do this but I accept that he created the impression that he knew how to do it and that some of his colleagues believed that he had had some forensic training. In any event, even if a fellow general practitioner doubted Shipman's ability to make such an estimate, I do not think s/he would have regarded it as more than a harmless boast.

15.42 Dr Graham Bennett is not to be criticised.

Dr Peter Bennett

15.43 Dr Peter Bennett was registered as a medical practitioner in 1966. In 1972, he was appointed a principal at one of the Clarendon House practices. In 1993, he moved with his partners to the Brooke Practice, where he remained until his retirement in 1996.

15.44 Between 1981 and 1996, Dr Bennett signed 33 Forms C for Shipman. Fifteen of those were unlawful killings. Although the annual rate increased slightly during the 1990s, the increase was not such that I would expect Dr Bennett to have noticed it.

15.45 Shipman admitted his presence at six deaths, although at only one did he admit to being alone with the patient. Two of these deaths occurred within a year of each other. Mr Fred Kellett died in December 1985 and Mrs Mary Tomlin in October 1986. Both were said to have died as the result of a heart attack. In fact, Shipman killed them both. Shipman claimed that neighbours were present at Mr Kellett's death and a home help at Mrs Tomlin's. With the benefit of hindsight, it may appear that Dr Bennett should have noticed that Shipman had been present at two rather similar deaths within a fairly short time. However, he did not do so and I am not critical of him. The suggested presence of other persons at the deaths would have mitigated any potential concern that might have arisen, and, in each case, I am sure that Shipman would have explained how he had been called out in an emergency to treat a dying patient. However, I draw attention to these two cases as examples of the potential usefulness of an enquiry of an independent person. If Dr Bennett had tried to contact the neighbour who had supposedly been present at the death of Mr Kellett, he would have failed, as there was almost certainly no one else there besides Shipman. Similarly, if Dr Bennett had contacted either of Mrs Tomlin's home helps, he would have found that neither of them had been present at the death and that both were extremely surprised at the suddenness of the death. One of them, Mrs Dorothy Foley, would also probably have mentioned Shipman's bizarre behaviour around the time of the death, which has been described fully in my First Report.

15.46 Dr Bennett completed a Form C for Mr James Wood, who died in December 1986. Shipman certified the death as due to old age. Careful examination of Form B suggests circumstances not consistent with the gradual decline of a frail elderly person. Dr Bennett agreed that these features should have struck him as strange. However, as he said, Shipman would have emphasised the patient's frailty. He agreed that it appears that, after hearing Shipman's account, he did not read the Form B with great care. I do not single him out for criticism in this respect because, as I have already explained, I am quite sure that very many doctors rely almost exclusively on the oral account given by the Form B doctor.

15.47 On the Form B for Mr Walter Tingle, whom Shipman killed in November 1988, Shipman said that he and a warden were present at the death. Dr Bennett must have read this form carefully as he noticed that Shipman had misstated the date of death and Dr Bennett corrected it. He also said in evidence that he noticed that the death appeared to be very sudden. Shipman had written on Form B that Mr Tingle had died of a coronary thrombosis following a collapse shortly after Shipman's arrival. Dr Bennett said that he told Shipman that he could not sign Form C and that the case should be reported to the coroner, as it was a sudden death. Shipman was not pleased. However, he told Dr Bennett that he had already spoken to the coroner who had said that he could certify. Dr Bennett was then prepared to accept the situation and completed Form C. He said that he found Shipman's claim credible, as the coroner had sometimes allowed Dr Bennett himself to certify the cause of a sudden death. It is not possible to discover whether Shipman ever did speak to the coroner, or even to the coroner's officer, as no records were made at the coroner's office of that kind of discussion. However, this case illustrates the false sense of certainty

that a 'discussion with the coroner' can give to what is in fact a wholly unreliable cause of death. Dr Bennett said that he would have regarded acceptance of the cause of death by the coroner as 'the gold standard'. I am not critical of Dr Bennett for his conduct in respect of this death. Indeed, I note that Dr Bennett was the only Form C doctor who reported having ever suggested to Shipman that he would not sign a Form C. At this time, Dr Bennett was a senior general practitioner and was certainly not intimidated by Shipman.

15.48 I must consider the case of Miss Ethel Bennett, who died only a month after Mr Tingle. The Form B in her case should have rung alarm bells for Dr Bennett. On the first page, Shipman said that Miss Bennett had died of bronchopneumonia at about 4pm. He had last seen her alive about six hours before her death. Yet, on the next page, he also said that he had seen Miss Bennett himself at 1pm, that a neighbour had heard her moving about at 3pm and that her son had found her dead, seated in a chair, at 6.30pm. He said that she had been in a coma for **'hour only'**. She had not been nursed before death and no one had been present at the death. This account is riddled with inconsistency and implausibility. It is unusual to die of bronchopneumonia after less than about two days' serious illness. Death can be more sudden but such an event is rare and the diagnosis of bronchopneumonia after so sudden a deterioration would not be an obvious one; it would require confirmation by autopsy and histology. Dr Bennett said that he thought Shipman must have said something quite convincing and that he, Dr Bennett, cannot have read the form carefully enough. I have no doubt that Shipman did say something that sounded plausible. But, in my view, the information given in Form B was such that Dr Bennett should have refused to sign Form C, however persuasive Shipman might have been. I think that Dr Bennett failed in his duty as the Form C doctor in this case. This death should have gone to the coroner for autopsy. It may be that, having challenged Shipman only a month earlier, Dr Bennett was reluctant to take him on again.

15.49 There are three other cases worthy of mention, although I shall not criticise Dr Bennett in respect of them. On the Forms B for Mrs Eileen Robinson and Mrs Edith Scott, Shipman had entered coronary thrombosis as the sole cause of death. He did not suggest that either had been suffering from any underlying heart disease. Each had died alone and had been found some time later. On the face of each Form B, there was insufficient information for Shipman to have diagnosed the cause of death. However, I am quite sure that he would have provided a detailed history of heart disease, which I have no doubt Dr Bennett would have believed. I do not criticise him for failing to ensure that the supposed underlying disease was entered on Form B. In fact, Mrs Scott's medical records showed no sign of heart disease. Nor did Mrs Robinson's, although she did suffer from hypertension. In relation to the death of Mrs Elsie Lewis, who died in Charnley House elderly persons' home, Dr Bennett stated on Form C that he spoke to the staff at the home. Mrs Lewis was not killed by Shipman, who certified that the cause of her death was 'senility' and that her mode of death was coma lasting 24 hours. Although it is possible that Dr Bennett telephoned or called at the home with Mrs Lewis' case specifically in mind, it is equally possible that he had, by the time he signed Form C, already discussed her death with the staff when attending another patient at the home, enabling him to make the relevant entry on Form C that he later made. In any event, it was not his practice in his capacity as Form C doctor to discuss the circumstances of the patient with family, nurses, carers or others.

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Dr Susan Booth (formerly Maclure)

15.50 Dr Susan Booth was registered as a medical practitioner in 1982. In 1985, she became a principal at one of the Clarendon House practices. In 1993, she and her partners moved to the Brooke Practice, where she remained until her retirement in 2000.

15.51 Between December 1987 and April 1998, Dr Booth signed 41 Forms C in relation to deaths of patients of Shipman. After four deaths in the period 1987–1989, Dr Booth then signed no forms until 1993. She signed seven in that year, three in 1994, seven in 1995, eight in 1996 and 1997 and four in the first four months of 1998. As she knew that the Forms C for Shipman were being shared equally among the Brooke Practice partners, she must have realised that Shipman had a large number of deaths in his practice. However, I think that she and her partners were not alarmed by this but thought that the explanation was that he had a lot of elderly patients on his list. It is now known that no fewer than 29 of the 41 patients for whom Dr Booth signed Forms C had been killed by Shipman.

15.52 In 12 of these 29 cases, Shipman stated on Form B that he had been present at the death. Three of those deaths occurred within four months of each other in 1993 and all three occurred at about the same time of the early afternoon. Shipman said he was alone with Mrs Amy Whitehead when she died of a myocardial infarction on 22nd March 1993. He said that he and a mobile warden were present when Mrs Nellie Mullen died from the same cause on 2nd May 1993. He said he was alone with Mrs Jose Richards when she died of left ventricular failure on 22nd July 1993. Dr Booth had not completed any other Forms C for Shipman during this period. Dr Booth had never been present at the death of any of her patients. Yet she says that she did not notice anything unusual about these deaths. In my view, she should have done. Even taking into account that she, like other doctors, would start from the assumption that all was in order, I consider that this cluster of deaths was such that, at any rate by the third one, she should have noticed their unusual features. I am not suggesting that she would immediately have thought that Shipman was doing anything wrong. However, I do think that these cases should have caused her to be more alert if similar cases or clusters of cases arose in the future. Dr Booth herself completed 20 Forms B in relation to her own patients between 1989 and 1994. She was present at none of those deaths.

15.53 Had Dr Booth noticed the cluster in the spring/summer of 1993, it would not have been long before she should have noticed that Shipman was present, apparently with members of the family, at another death, that of Mr Charles Brocklehurst, on 31st December 1993. Then, on two occasions within three months, in March and June 1995, Shipman was again present at deaths, again apparently in company with others. Given that, by that time, Dr Booth had never been present at the death of a patient in 13 years of practice, the fact that Shipman had been present at six in just over two years should, I think, have been noticed and mentioned to Dr Booth's partners, as an unusual feature. Dr Booth said that she did not notice these features. Of course, it is possible that she did not read the Forms B and that Shipman did not mention that he had been present at the deaths.

15.54 In June 1996, Dr Booth signed Form C for another death at which Shipman was present, that of Mrs Margaret Vickers. On Form B, Shipman stated that Mrs Vickers died of a stroke, after being in a coma for **'minutes'**. He said that he had attended upon her for 30 minutes

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before her death. He and **'a neighbour'** were present at the death. When asked about this death at the Inquiry, Dr Booth agreed that it was most unusual for a patient to die so suddenly from a stroke. She agreed that, standing alone, Form B did not make sense. She could not imagine what Shipman could have told her in his oral account but agreed that, if he had given a convincing story (which I think he probably did), she cannot have correlated it to the entries on Form B and cannot have read Form B as carefully as she should. She maintained that, at the time, this death had not struck her as strange. She agreed that she had accepted the clinical history without having exercised any independent clinical judgement about the death. If Dr Booth had scrutinised Form B carefully, and if she had borne in mind that this was yet another death at which Shipman was present, I think she would not have felt able to sign Form C. Alternatively, she might have decided that she had to seek some independent corroboration of the circumstances. Had she done so, she would have learned that there had in fact been no neighbour present at the death.

15.55 There was another cluster of unusual deaths in 1997. In January, February and June, Dr Booth signed Forms C in respect of three further deaths at which Shipman admitted having been present. In relation to a fourth death, that of Mrs Eileen Crompton, he admitted presence **'immediately before death'** and seeing the body **'about two minutes after death'**, admissions which, taken together, are tantamount to an admission of presence at death. On 6th January 1997, Dr Booth signed Forms C in relation to the deaths of Mrs Crompton and Mr David Harrison, who had died on 2nd and 3rd January 1997, respectively. The circumstances of Mrs Crompton's death were most out of the ordinary. Enquiries of the staff at Charnley House residential home for the elderly, who were said to have been present at Mrs Crompton's death, would have revealed that Mrs Crompton had died immediately after having been given an injection by Shipman and that before giving the injection he had said that it was intended to 'kick-start' her heart and would either 'kill or cure' her. Dr Booth should have been alarmed to hear that and should have insisted on finding out what the drug was. Examination of the medical records would have shown that Shipman claimed to have given benzylpenicillin, which was not a drug which could be said to 'kill or cure' or to be capable of 'kick-starting' the heart. The fact that Mrs Crompton had died so quickly after its administration would have been remarkable and most worrying. Dr Booth could not then have signed Form C. There would have had to be an inquest.

15.56 Mrs Lizzie Adams died on the afternoon of 28th February 1997. Shipman certified that the cause of Mrs Adams' death was bronchopneumonia with no underlying cause. He said that he had attended her during her last illness for just half an hour. Form B says nothing about calling an ambulance to take her to hospital. Shipman said that the mode of death was syncope lasting **'minutes only'**. Mrs Adams had not been nursed during her last illness. Shipman and a **'neighbour'** were said to have been present at the death. This Form B does not make sense. It is hard to imagine what Shipman could have told Dr Booth to make her think the death was due to bronchopneumonia. She should have refused to sign the Form C in this case. Of course, Shipman might have said that he had already spoken to the coroner. Whilst I do not criticise Dr Booth for not speaking to **'the neighbour'**, who was supposed to have been present at the death, that was certainly one

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of the options that was open to her if she had been in any way concerned about the frequency with which Shipman was present at the deaths in question. Had she done so, she would have heard a most astonishing account from Mr William Catlow, which would have been quite inconsistent with the notion that Mrs Adams had bronchopneumonia or that her death was in any way expected. Mrs Adams had done active housework on the day of her death.

15.57 Four months later, Mrs Whittingslow was to die, according to Form B, of a stroke which apparently came on during Shipman's presence at her home and killed her within 15 minutes. Although her husband was also said to have been present, the fact that this was effectively the fourth death in Shipman's presence in such a short time ought to have struck Dr Booth. I do consider that Dr Booth should have felt increasingly puzzled about the frequency with which Shipman was present at deaths. I do not think that she did feel any such puzzlement until concerns were raised by others in early 1998.

15.58 There are also other individual Forms C about which, in my view, Dr Booth might have felt concern. Mrs Marion Higham died in July 1996. On the Form B, Shipman certified the cause of death as **'natural causes'**. That is not an acceptable cause of death; it is not a cause of death at all, only an assertion that the death was natural. The registrar should not have accepted it, although she did so on the advice of the General Register Office (see Chapter Fourteen). Nor should Dr Booth have 'confirmed' natural causes as a cause of death on Form C. She should have asked Shipman to provide a proper cause of death and, if he could not do so, to report the case to the coroner. Dr Booth suggested that Shipman might have said that he had reported it to the coroner and that is possible. If he did, I can understand why Dr Booth would be prepared to sign Form C. However, Shipman did not record the fact that he had done so on cremation Form B.

15.59 In the case of Mrs Dorothy Andrew, who died in September 1996, the causes of death, renal failure, uraemia and old age, did not make good medical sense. Shipman stated on Form B that the coroner had approved the cause of death and Dr Booth said in oral evidence that Shipman would sometimes say that he had spoken to the coroner about a death. I can understand why Dr Booth let it pass, although she should have noticed the cause of death. Shipman might well have spoken to the coroner or at least to the coroner's officer. The death was reported to the coroner by the registrar and it seems highly likely – if not certain – that Shipman was contacted by the coroner's office (see, again, Chapter Fourteen). If he did speak to the coroner's officer, he must have pulled the wool over her eyes. Shipman had certainly killed Mrs Andrew.

15.60 In the other cases examined by the Inquiry, I am satisfied that Shipman gave a plausible explanation of the deaths and that Dr Booth should not be criticised for not noticing internal inconsistencies in the Forms B.

15.61 That Dr Booth signed the Forms C in respect of Mrs Vickers and Mrs Adams and that she failed to observe the frequency with which Shipman was present at the deaths in the three clusters to which I have referred, reflects that which she admitted in oral evidence, namely, that she invariably accepted the clinical history from Shipman without having exercised any independent clinical judgement about the death. Whilst it may be that many Form C doctors do accept without hesitation what they are told by their Form B colleagues, I am

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afraid that I must criticise Dr Booth individually for her failure to observe the clusters of deaths from 1993 and for signing Forms C in respect of Mrs Vickers and Mrs Adams.

Dr Jeremy Dirckze

15.62 Dr Jeremy Dirckze was registered as a medical practitioner in 1983. In 1989, he became a partner in one of the Clarendon House practices, succeeding Dr Graham Bennett. He moved with his colleagues to form the Brooke Practice in 1993.

15.63 Between 1990 and 1998, Dr Dirckze signed 44 Forms C for Shipman. Of these 44 deaths, 25 were unlawful killings. In the years 1990 to 1994, Dr Dirckze signed only between one and three Forms C each year. However, in 1995, 1996 and 1997, he signed ten forms in each year and he signed five in the first half of 1998. Dr Dirckze said that he did not notice the increase. He said that, if he had perceived it subconsciously, he would have ascribed it to the fact that, since the Brooke Practice had been set up, the Forms C were being spread between fewer doctors than previously. That was so, but rationally considered, it could not account for the increase. First, the move to the Brooke Practice had occurred in 1993 and had not been followed by any increase in 1994. Second, the increase in 1995 was larger than could be explained by a halving of the number of doctors signing the forms.

15.64 Given that he knew that Shipman's Forms C were spread between the five Brooke Practice doctors, I think Dr Dirckze could reasonably have been expected to notice that Shipman had a large number of patient deaths. Dr Dirckze maintained that he did not notice the large number either in 1995 or in the ensuing years. He thought that he might have had a vague feeling that there was a discrepancy between the numbers of deaths in the respective practices but nothing more. He said that when the numbers were drawn to his attention by Dr Reynolds, he saw what he thought was the explanation. He thought Shipman had a lot of elderly patients and preferred to keep them at home rather than admit them to hospital. Also, he believed that Shipman was a 'hands on' doctor who, if called out, would take over the function of the ambulance service, for example by undertaking resuscitation procedures himself. It follows that, although I think Dr Dirckze should have noticed the increase in the number of Forms C he was signing for Shipman, I do not think, if he had, he would have realised that there was anything sinister about the numbers. I accept that he would have found what seemed to be a rational explanation.

15.65 Of the deaths for which Dr Dirckze signed Forms C, Shipman admitted his presence at only four deaths, spanning six years, and said that he was alone with the deceased at only one. That feature, although unusual, would not arouse suspicion when spread over a long period. The one case in which Shipman said that he had been alone with the deceased was that of Mrs Dora Ashton, who died in Shipman's surgery. Although Dr Dirckze recognised that a surgery death was unusual, one such death had occurred at the Brooke Practice, so a single surgery death would not have struck him as strange. Nor do I think that Dr Dirckze should have been expected to take particular note of the other deaths at which Shipman admitted he had been present; there were not many such deaths and Shipman claimed that other people had also been present.

15.66 The particular recurrent feature of the deaths for which Dr Dirckze signed Forms C was that Shipman frequently stated on the Forms B that he had been present shortly before the death had been discovered. In 1995, Shipman admitted that he visited, on the day of their deaths, no fewer than nine patients for whom Dr Dirckze signed Form C. Three of those deaths were natural; each patient was suffering from a terminal illness and visits on the day of death would not be unusual. During the following two and a half years, there were fewer cases in which Shipman admitted having attended on the day of death and again there was a proportion in which the death was natural and the recent attendance explained because of prolonged illness. In such cases the mode of death was most commonly said to have been coma of some hours' duration.

15.67 There were, however, also cases in which Shipman had apparently recently departed the home of a patient who had not suffered prolonged illness and who was to die a sudden death, apparently soon after his departure. In such cases, it appeared that Shipman had left the patient alone at home, in circumstances where most doctors would have made arrangements for admission to hospital. I would expect a doctor to regard that kind of situation as unusual and somewhat worrying. It is not the picture that appears from Dr Dirckze's Forms B; of 25 of his Forms B considered by the Inquiry, he had been present on the day of death of only three patients and all three died either in a nursing home or in the presence of a district nurse. It would appear from Shipman's Forms B that he had not provided appropriate treatment or made suitable arrangements for the patient. I accept that, in such cases, Shipman might have been able to tell a plausible tale. Perhaps the patient was being cared for, but not strictly speaking nursed, by a relative or neighbour. Perhaps the patient wanted to remain at home. Perhaps the patient, whom other doctors might have persuaded to go into a nursing home, could remain living at home because of the high level of care that Shipman was prepared to give. In particular, in the Forms B for Mrs Erla Copeland and Mrs Valerie Cuthbert, one can discern what might have formed the basis of such a tale. However, I must look to see whether clusters or patterns of such cases exist in order to assess whether Dr Dirckze should be criticised for having failed to observe them as unusual.

15.68 There were three unlawful killings where Form B recorded circumstances of this type in January and March 1995. I note that Shipman suggested (falsely) that Mrs Alice Kennedy was being nursed by her daughter and, since she lived in sheltered accommodation and had an alarm with which she could summon the warden, Dr Dirckze might reasonably have understood that, although she had died alone, Mrs Kennedy had not been 'abandoned' by Shipman. Similarly, although they were not said to have been present at the death, ambulance personnel were said to have provided information to inform Shipman's views as to the mode and duration of death of Mrs Vera Brocklehurst. Such extenuating circumstances were not suggested by the Form B relating to the death of Mr Joseph Shaw. However, I would accept that Dr Dirckze might reasonably not have been concerned by this cluster.

15.69 More such cases occurred in 1996. Between January and May, there were three cases in which the death apparently occurred shortly after a visit by Shipman. In each case, Shipman claimed on Form B that the patient was alone at the moment of death. In the case of Mrs Copeland, who died in January, Shipman certified on Form B that the cause of

death was **'natural causes'**. That is not an adequate cause of death. Dr Dirckze agreed that he ought not to have confirmed that as the cause of death on Form C, as he did. Shipman stated that he had seen Mrs Copeland about two hours before her death and had seen her body about ten minutes after death. He claimed that the mode of death had been **'syncope'** lasting **'seconds'**, that this was based in part on statements made by Mrs Copeland's neighbour and sister-in-law, that no one had nursed Mrs Copeland during her last illness and no one had been present at the moment of death. It is not possible to guess what Shipman had in mind as the 'last illness'. Form B gives no clue as to the cause of death. Dr Dirckze said that he must have equated 'natural causes' with 'old age'. That is possible, as Shipman stated on the MCCD and initially wrote on Form B that Mrs Copeland was 89 when she died; in fact she was 79. Dr Dirckze admitted that he would have been 'guided by Dr Shipman'. This demonstrates clearly that Dr Dirckze did not carry out an independent check, as he should have done. Dr Dirckze should not have signed Form C in this case. Mrs Jane Shelmerdine died in February and Mrs Cuthbert, whom I have already briefly mentioned, died in May. In Mrs Shelmerdine's case, Form B suggested that she suddenly collapsed two to three hours after Shipman's departure.

15.70 In December 1996 and February 1997, there were two further cases in which Shipman stated on Form B that the death had occurred soon after he had visited. In both cases, the deceased was alone at the death. In my view, by this time, Dr Dirckze should have observed the pattern of these unusual cases. Then, between May and September 1997, there were three more such cases. The first was that of Mrs Doris Earls, who was found dead on the sofa in the afternoon of 21st May. Shipman, who certified that the death was caused by a cerebrovascular accident due to hypertension, claimed on Form B that Mrs Earls had been suffering from hypertension for over two years. He claimed that he had seen her about three hours before her death. He did not explain on Form B what he then discovered which enabled him to certify that Mrs Earls had had a fatal stroke after his departure. If Mrs Earls was displaying symptoms of a stroke when he saw her, it would appear from Form B that Shipman must have left her without care; if she was not displaying any symptoms, it is hard to see how Shipman could have been sufficiently confident of the cause of death to enable him to certify it. It is possible that Shipman told Dr Dirckze that he had left Mrs Earls in the care of her husband. Dr Dirckze might well have accepted that. However, sudden death from a stroke is fairly rare and I would expect Dr Dirckze to have noticed that. Had he tried to speak to Mr Earls, he would have found that Mr Earls suffered from Alzheimer's disease and was usually cared for by his wife. Further enquiries would have revealed that Mrs Earls was fit and well only about two hours before her death was discovered.

15.71 The second of these three deaths, that of Mrs Nancy Jackson, occurred on 1st September 1997. Although Shipman said on Form B that Mrs Jackson was being nursed by her daughter, he also suggested that she had been seen by a neighbour in a coma one hour before her death and that no one had thereafter seen her. I can see that Shipman probably gave a plausible explanation for the fact that Mrs Jackson was alone at the moment of death. However, the third death in this group, that of Mrs Mavis Pickup, which occurred only three weeks later on 22nd September, should have caused Dr Dirckze real concern. According to Form B, Mrs Pickup died of a stroke at about 4pm and was found by a

neighbour some time later. Shipman claimed that he had treated Mrs Pickup for **'4–6 hours'** before her death but he did not say what underlying illness had caused her stroke. He stated that he had last seen her alive about four hours before her death. On Form B, he said nothing about what signs he had then observed which would have enabled him to diagnose a stroke as the cause of death. As with Mrs Earls, it is not clear whether Mrs Pickup was then showing signs of a stroke (in which case it is strange that Shipman left her alone without care) or whether she was not (in which case it is hard to see how Shipman could have diagnosed the cause of death with sufficient confidence). Even if Shipman told Dr Dirckze a plausible tale, as I accept he probably did, Dr Dirckze should have realised that this apparently sudden death from a stroke was remarkably similar to that of Mrs Earls.

15.72 Dr Dirckze said that it did not strike him that in these cases Shipman was not giving his patients appropriate care. He said that he felt slightly intimidated by Shipman, who was very dominant when he came across to the Brooke Practice Surgery with a Form C. Shipman was quite firm that his was the correct way of treating patients and I can easily understand why Dr Dirckze said that he would have found it very difficult to question his opinion. I think Dr Dirckze was in awe of Shipman. He told the Inquiry that he accorded 'ultimate credibility' to the account given by the Form B doctor. As I observed in Chapter Eleven, if the Form C procedure is to be effective, the doctor completing it must be independent of the Form B doctor. But s/he must also have sufficient confidence to criticise the actions and opinion of the Form B doctor where appropriate. It is clear that Dr Dirckze was unable to do this because he was in awe of Shipman.

15.73 The death of Miss Ada Warburton warrants special mention. Miss Warburton was killed by Shipman on 20th March 1998 and Dr Dirckze signed her Form C on Monday, 23rd March. The partners in the Brooke Practice had met to discuss their concerns just three or four days earlier. Form B, which is internally inconsistent in many respects, suggests that Shipman and a neighbour were present around the time of Miss Warburton's death. Miss Warburton was said to have died of a stroke for which Shipman had first treated her at about 12.30pm that day. When asked about the circumstances in which he came to sign this Form C, Dr Dirckze said that he would have been persuaded by Shipman of the truthfulness of the account given. He said that he also knew that the partners had agreed that steps be taken to ensure that enquiries would be made into Shipman's practice. As I have explained in the Second Report, I think that, in the late afternoon or early evening of that day, Dr Dirckze decided to extract from the practice records the comparative figures showing how many Forms C the partners had signed for Shipman in the previous months and how many MCCDs they had signed in the same period. I also think that Dr Dirckze specifically mentioned Miss Warburton's death to Dr Reynolds. Miss Warburton's name found its way into Dr Reynolds' *aide memoire* that was recovered after her death by her husband. In these circumstances, Dr Dirckze should not be criticised for signing Miss Warburton's Form C.

15.74 Dr Dirckze said that he never found it necessary to speak to anyone independent of the Form B doctor. However, I note that he did in fact speak to District Nurse Dorothy Clegg about the death of Mrs Annie Webb in 1991. Mrs Webb died as the result of pancreatic cancer and I decided that Shipman played no part in her death and authorised the Inquiry

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team to close the case. District Nurse Clegg was not said to have been present at the death of Mrs Webb, although she had apparently seen her shortly before her death, when Mrs Webb was in a coma. Dr Dirckze seems to have spoken to District Nurse Clegg and Shipman together and it is likely that there was some discussion as to Mrs Webb's decline in the period leading up to her death. I think it unlikely that this meeting took place specifically with Mrs Webb's Form C in mind. It is far more likely that it was a chance meeting at which Mrs Webb's death was discussed.

15.75 Had Dr Dirckze made it his usual practice to speak to a relative or to the person that Shipman said had been present at the death, he would sometimes have found that Shipman's account was inaccurate or untrue. I do not criticise him individually for failing to adopt this practice, however, because it is a failure he shares in common with a very large number of doctors.

15.76 In summary, I am critical of Dr Dirckze in connection with the Form C that he signed relating to Mrs Copeland. I am also critical of his failure to observe the number of deaths for which he signed Forms C where the patient had died alone soon after a visit by Shipman. In my opinion, he should have observed this by about early 1997 and should have been more seriously concerned after the death of Mrs Pickup in September 1997. Had he been, he might well have reacted more positively when Dr Reynolds mentioned her concerns to her partners in the autumn of 1997 and when Dr Booth communicated Mrs Bambroffe's concerns in February 1998.

Dr Stephen Farrar

15.77 Dr Stephen Farrar was registered as a medical practitioner in 1971. In 1973, he became a principal in one of the Clarendon House practices, where he remained until 1991. Since 1993, he has worked as a local general practitioner, as a partner in a practice in Openshaw, Manchester and as the director of a deputising service.

15.78 Between 1981 and 1991, Dr Farrar signed 23 Forms C for Shipman. These were equally spread over the years and there was no time when Dr Farrar should have noticed that the number of deaths among Shipman's patients was high or increasing. Nine were unlawful killings. According to the information on Forms B, from 1984, Shipman was present at no fewer than seven deaths. In four cases, Shipman said he was alone with the patient at the time of death. As I have said, the presence of a general practitioner at a death is unusual; for the doctor to be alone with the patient is very unusual indeed.

15.79 Dr Farrar signed Form C in six cases between July 1981 and November 1983. Shipman did not say that he was present at any of these; nor was any an unlawful killing. There were two cases in which he stated on Form B that he had visited on the day of death but both patients were receiving nursing care for chronic or terminal illness and the mode of death was prolonged, lasting 12 or 24 hours. Thus, in each case, the profile of the patient was such as to make it readily understandable that the general practitioner should visit and yet not arrange hospital admission, despite the fact that the patient was to die a few hours later.

15.80 Mrs Gladys Roberts died on 8th February 1984. She was the first patient in relation to whose death Shipman admitted, on Form B, that he had been present at the death.

Shipman said that Mrs Roberts had died of a pulmonary embolus due to a deep vein thrombosis (DVT). He claimed that he had seen her 12 hours before death, but that would seem unlikely as the death occurred at 4pm; Shipman is unlikely to have seen the patient at 4am. Shipman went on to state that, in the afternoon when she died, he had also seen her 10 to 15 minutes before her death, had diagnosed her condition and had gone away to call an ambulance and arrange hospital admission. When he returned within ten minutes, she had died. He said he was present at the death. There are internal inconsistencies in Form B but not such as would, of themselves, give rise to suspicion or concern. However, the story as recounted on Form B is implausible. Had Shipman attended Mrs Roberts for a DVT in the middle of the night, Dr Farrar would have expected Shipman to admit her to hospital or, at the very least, make arrangements to ensure that she was appropriately cared for. Dr Farrar said that he could not imagine what story Shipman could have given to satisfy him that it was appropriate to certify the death as Shipman had. He said that he would have trusted Shipman's word as to his clinical findings and the circumstances of death. My view is that, if Shipman did tell a plausible and acceptable tale, Dr Farrar cannot have checked it against Form B. I would not go so far as to say that Dr Farrar should have refused to sign Form C in this case but I think the circumstances should have concerned him and should have made him more alert to any unusual circumstances in the deaths for which he was later asked to sign Form C.

15.81 Mrs Mary Winterbottom died about seven months later, on 21st September 1984. Shipman stated on Form B that he had last seen her alive two days before her death. She was known to suffer from heart disease. He attributed the death to a coronary thrombosis. He said that he had found her collapsed on the bed and had attempted resuscitation but this had failed. Shipman was present at the death. Mrs Winterbottom had, Shipman claimed, been seen by her niece two hours earlier, when all had been well. The effect of this account is that Shipman had just happened to arrive at the house soon after Mrs Winterbottom had collapsed. Dr Farrar said that he would have relied on Shipman's oral account of the death and did not notice anything unusual about the circumstances. It may be that Shipman told Dr Farrar that he had been summoned in an emergency. However, Dr Farrar agreed that he cannot have looked carefully at Form B. Had he done so, he could not have been satisfied that Mrs Winterbottom had died as a result of a coronary thrombosis. He also stated in oral evidence that it would be very, very rare for a general practitioner to be present at two deaths in a year. I observe that, in neither Mrs Roberts' case nor Mrs Winterbottom's case was anyone else said to be present at the death. Again, I would not go so far as to say that Dr Farrar should not have signed Form C in Mrs Winterbottom's case but I think the circumstances should have made him more alert to any unusual circumstances in the deaths for which he was later asked to sign Form C.

15.82 Shipman admitted that he was present at another death, that of Mrs Ellen Higson, in February 1985, only five months later. This was one of three deaths occurring in 1985 for which Dr Farrar signed Form C; neither of the other two was the result of unlawful killing. Shipman certified that the death of Mrs Higson was due to renal failure. He claimed that he had been attending her in her last illness for two weeks, that she was not being nursed and that she died after being in a coma for **'hours only'**. He and the home help were present at the death. Dr John Grenville, a general practitioner who gave evidence in Phase

One, advised the Inquiry that it would be most unusual for a patient with renal failure not to need nursing care and Mrs Higson was, of course, said to have been in a coma. Dr Farrar did not think that the circumstances of this death would have aroused his concern. I think that must be because he just did not think carefully about the circumstances but accepted Shipman's account uncritically. He should not have signed Form C. Had he spoken to the 'home help' (who was in fact an elderly lady who visited Mrs Higson to do errands and help in the house) or to Mrs Higson's daughter, he would have learned that Mrs Higson had not been diagnosed as suffering from renal failure and had not been expected to die.

15.83 In January 1986, Dr Farrar signed one Form C in respect of a patient at whose death Shipman said he was not present. Between September 1986 and January 1988, Dr Farrar signed Forms C for five more deaths, at three of which Shipman admitted on Form B that he had been present. Dr Farrar agreed that he should have felt some concern about the death of Miss Mona White, who died on 15th September 1986. She was only 63; she died in Shipman's presence, supposedly of a coronary thrombosis. Shipman stated that he was with her for 30 minutes before her death but made no reference on Form B to any attempt to resuscitate her or admit her to hospital. Dr Farrar said in evidence that he is now surprised that Shipman had not admitted Miss White to hospital. Once again, it does not appear that Dr Farrar gave sufficiently careful consideration to the circumstances of the death.

15.84 Dr Farrar said he was now also surprised that Shipman did not appear to have attempted to admit Mrs Alice Thomas to hospital before her death. On Form B, Shipman said that Mrs Thomas died of a right-sided stroke, on 16th April 1987. Shipman said that he had been with her for 40 minutes before she died but it appears that he had made no attempt to call an ambulance. He stated that he was present at her death. Dr Grenville advised the Inquiry that a right-sided stroke, which would be of an occlusive nature, would not usually result in a sudden death. In my view, if Dr Farrar had applied his mind carefully to the circumstances of this death, he would have been so concerned that he could not have signed Form C.

15.85 The death of Mrs Elizabeth Fletcher on 5th January 1988 was rather sudden and also said to have occurred in Shipman's presence. Shipman said that the death was due to a stroke, that he had been with Mrs Fletcher for an hour before her death and that she had died after being in a coma for 20–30 minutes. He did not refer to any attempt to admit her to hospital. He said that Mrs Fletcher's sister-in-law was also present at the death. I accept that Shipman might have been able to give a plausible account of this death and, looking at the death in isolation, I can understand why Dr Farrar signed Form C. However, this was yet a further death occurring in Shipman's presence in which he failed to call an ambulance. If Dr Farrar had given thought to the circumstances of these recent deaths, I think he would have noticed a pattern. I note also that, if Dr Farrar had tried to locate the **'sister-in-law'**, he would have found that there was no such person. If he had located Mrs Elizabeth Mellor (who is now deceased, having been killed by Shipman), a neighbour, who had called on Mrs Fletcher to find Shipman in the house with Mrs Fletcher's dead body sitting in a chair, he would have felt very concerned indeed about Shipman's certification of this death.

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15.86 The seventh death at which Shipman admitted he was present was that of Mrs Mary Hamer. She died in Shipman's surgery. Although, at that time, Shipman was a principal at the Donneybrook Practice, no one else was present at the death. Dr Farrar agreed that a death in the surgery is most unusual. When it had happened in his practice, the death had been reported to the coroner. Yet he did not demur when Shipman certified this one. It is possible that Shipman told Dr Farrar that the coroner had given permission for him to certify the death and, if he did so, I could understand how Dr Farrar might have agreed to sign Form C and, in the circumstances, I would not criticise him. It appears that at least one other patient died in the Donneybrook Surgery and the death was not referred to the coroner. If, however, Dr Farrar had spoken to a member of Mrs Hamer's family, he would have learned that she had been well and that her death was most unexpected. The surgery receptionist would have told him that Mrs Hamer looked well as she walked into the surgery.

15.87 I am critical of Dr Farrar's failure to notice the unusual features of the deaths of Mrs Roberts and Mrs Winterbottom and consider that he should have refused to sign Form C in respect of Mrs Higson's death. These three deaths occurred quite close together in time. I am also critical in respect of the deaths of Miss White, Mrs Thomas and Mrs Fletcher in that he did not notice that Shipman was present at the deaths of his patients and yet took no steps to call an ambulance or organise admission to hospital.

Dr Alastair MacGillivray

15.88 Dr Alastair MacGillivray was registered as a medical practitioner in 1973. In 1975 he joined one of the Clarendon House practices. In 1993, he moved with his partners to the Brooke Practice, where he remains.

15.89 Between 1980 and 1998, Dr MacGillivray completed 44 Forms C for patients of Shipman. Twenty five of the patients in question were unlawfully killed by Shipman. The number of Forms C Dr MacGillivray completed in each year rose markedly, beginning in 1995. Whereas the most he had completed in any year until then was three (in 1985, 1993 and 1994), in 1995, the number rose to six, then to seven in 1996 and nine in 1997. Given that Dr MacGillivray knew that Shipman's Forms C were spread between the five Brooke Practice doctors, I think that he could reasonably have been expected to realise, during this three-year period, that Shipman had an unusually large number of patient deaths followed by cremation. I think it likely that he was vaguely aware of the increase in Forms C but did not appreciate its significance. Dr MacGillivray shared the view of his partners that Shipman had a lot of elderly patients whom he preferred to keep at home rather than admitting them to hospital and that he was a 'hands on' doctor who, if called out, would take over the function of the ambulance service. Logically considered, these factors could not provide an explanation for the apparent increase in patient deaths. They might, however, on a superficial analysis, be thought capable of explaining the high numbers of deaths. Also, the role of the Form C doctor was to consider individual Forms B rather than to look out for any pattern. As I have already mentioned, Dr MacGillivray and his Brooke Practice colleagues were not signing Forms C for any other Form B doctor and so the opportunity for comparison was limited. For those reasons, I do not think that

Dr MacGillivray should be criticised for his failure to appreciate the significance of the increase in numbers.

15.90 Although Shipman admitted on Form B that he had been present at the deaths of four patients for whom Dr MacGillivray signed Form C, he never claimed to have been alone with the patient at the time of death. These cases were not clustered together in time and I do not think that Dr MacGillivray could have been expected to notice this feature or to regard those deaths as unusual, simply by reason of Shipman's presence at the death.

15.91 A more significant feature of the deaths considered by Dr MacGillivray was that, in no fewer than 23 cases, Shipman recorded that the patient was alone at the moment of death. In 14 of those cases, Shipman admitted a visit on the day of death. This reflected a pattern quite different from Dr MacGillivray's own professional experience, judging from his Forms B. Most of his patients died with family or carers present. All but four of the 63 patients for whom he signed a Form B between 1986 and 1998 died in the presence of a relative, friend or carer. That is a normal pattern. Usually, when a patient dies alone, the death is to some extent unexpected, the moment of death will not have been observed and it is appropriate to refer the death to the coroner.

15.92 There are several groups of Shipman's cases, covering quite short periods, where the patient ostensibly died alone, yet for which Dr MacGillivray signed Form C. For example, between October 1992 and May 1993, he signed three Forms C, relating to the deaths of Mrs Monica Sparkes, Mrs Hilda Couzens and Mrs Emily Morgan. All three deaths were attributed to stroke or heart attack. If the deceased were alone at the time of death, it is hard to see how Shipman could have known the cause of death with sufficient confidence to certify it. I can understand why Dr MacGillivray might have agreed to sign each of these individual Forms C in isolation but I think it should have occurred to him that Shipman made a habit of certifying deaths in circumstances where other doctors would not do so.

15.93 I accept that, in some cases, Shipman might have told Dr MacGillivray that he had spoken to the coroner, who had authorised him to certify the cause of death. Such a conversation and authorisation should normally be recorded on Form B, although there was no question specifically covering this point until about 1995; moreover, the old forms continued in use well into 1997. While giving evidence during Stage Two of the Inquiry, Dr MacGillivray claimed to remember that Shipman had once boasted to him that he often 'discussed' cases with the coroner and the coroner accepted them, even though they were sudden. It is strange that Dr MacGillivray recalled this incident so late in the day. He had provided written statements for the Inquiry and had given evidence during Stage One. His recollection was, he said, 'vague'. He had never mentioned this incident before. For that reason alone, I am doubtful as to its accuracy. I accept that it would have been typical of Shipman to make such a boast. However, I note that, when the new Forms B came into use, containing an additional question (number 19) which asked whether the coroner had been informed of the death, Shipman did not claim that he had done so in any of the cases handled by Dr MacGillivray. It is possible that Shipman made this boast but I think it more likely that Dr MacGillivray has persuaded himself that it was made.

15.94 Had Dr MacGillivray been more alert, I think it would also have occurred to him that the pattern of a visit followed by a sudden unattended death was completely at variance with

his own experience. I have already said, in connection with Dr Dirckze's position, that a recent visit followed by a sudden death would be surprising because one might expect an ambulance to be called out or other care arrangements to be made. The forms tell only a part of the tale, of course. I do not know what Shipman said to Dr MacGillivray in the three cases mentioned above but I do observe that Shipman made an entry in Mrs Sparkes' medical records, suggesting that he had called an ambulance and it is more than likely he spun a similar yarn to Dr MacGillivray. I note that Mrs Couzens was said in Form B to have had a history of ischaemic heart disease and to have had an alarm button fitted to her dress. The observations of a neighbour were said to have informed Shipman's view as to the mode and duration of death, in Mrs Morgan's case. I can see how these little pieces of information would be embroidered and embellished as necessary for the Form C doctor. When allied with the general perception of Shipman's ethos of visiting his patients at home and not admitting them to hospital, I can see how the picture painted by Shipman might have been very convincing.

15.95 Between July and November 1995, however, there were three more deaths at which the patient died alone. These were respectively said to be due to cardiac arrest, old age and coronary thrombosis. In each case, Shipman had apparently seen the patient an hour or two before death. Yet the patient was alone at the moment of death. If Dr MacGillivray had thought analytically about these deaths and other deaths that were to follow, and had he examined the Forms B carefully, I think he would have noticed a recurring pattern that patients whom one would normally expect to be receiving care were dying alone. However, he did neither. He freely admitted that he did not examine Forms B at all carefully and that he placed complete trust in the oral account given by Shipman.

15.96 There was a further cluster of three deaths in June and July 1996, where the deceased supposedly died alone. There was yet another cluster of four such deaths between January and April 1997. In all four of this last cluster, Shipman said on Form B that he had seen the patient within, at most, 12 hours before the death. Two of these patients were said to have died as the result of coronary thrombosis. It is very surprising that a patient should die alone of a sudden cause such as coronary thrombosis within 45 minutes and two and half hours after a visit from the doctor, as Shipman claimed had happened. It is also very hard to see how Shipman could have been thought able to certify the cause of death.

15.97 In the other two cases, Shipman certified the cause of death as bronchopneumonia. On the Form B relating to Mrs Elsie Dean, Shipman said that she had died of bronchopneumonia at about 3am on 8th January 1997. He had last seen her about 12 hours earlier. She had died alone, had had no nursing care and had been in a coma for six to nine hours before death. If true, these circumstances would be most surprising. They suggest that Shipman left this patient alone with no nursing care, at a time when she must have been suffering from a chest infection severe enough to cause her to fall into a coma and die within hours. I cannot think what Shipman could have said to explain this death. Even more surprising are the supposed circumstances of the death of Mrs Mary Coutts. She was said to have died of bronchopneumonia at 2.15pm on 21st April 1997. Shipman said he had last seen her alive at about 1pm. She had had no nursing care and was alone at the moment of death. She was found by a neighbour, dead in her chair. If true, that account would suggest that Shipman had left Mrs Coutts alone, without care, just over an

hour before her death. Dr MacGillivray did not notice anything unusual about this death. He should have done and he should have refused to sign Form C. I do not think Dr MacGillivray should have signed Form C in either of these two cases.

15.98 In my view, Dr MacGillivray did not take sufficient care when completing a Form C. I do not think he thought carefully about the circumstances as outlined by Shipman. If he listened to the oral account, he cannot have cross-checked it with the content of Form B. Dr MacGillivray ought to have refused to sign the forms relating to Mrs Dean and Mrs Coutts. He ought also to have noticed the unusual features of the deaths of Shipman's patients so that, when these matters were discussed between the partners of the Brooke Practice, he could have contributed his observations. I am critical of him in these respects. I think he failed in his duties as a Form C doctor. I think that he should, by about the beginning of 1997 at the latest, have realised that something was amiss and raised his concerns with his partners.

Dr Rajesh Patel

15.99 Dr Rajesh Patel was registered as a medical practitioner in 1986. He undertook general practitioner training under Dr Vikram Tanna at one of the Clarendon House practices in 1992. For a short period, he worked as an occasional locum for Shipman, to whom he was, of course, quite junior. In December 1993, he joined the Brooke Practice.

15.100 Between December 1993 and March 1998, Dr Patel completed 29 Forms C for Shipman. Shipman had killed 22 of the patients in question. He admitted on the Forms B that he had been present at a total of nine deaths. He claimed that no one had been present at 12 deaths. Both these features are unusual for deaths occurring in the community where it is far more common for the death to occur in the presence of family or carers. Examination of the 11 deaths for which Dr Patel himself signed a Form B between September 1993 and April 1998 reveals that all the patients had been suffering prolonged illness or were in a nursing home or died in the presence of a relative or carer.

15.101 I am satisfied that Dr Patel did at some stage notice that Shipman seemed to have a large number of patient deaths and was often present at the deaths. I am not sure when Dr Patel began to notice these features but I believe it was very probably prior to 1998. He signed one Form C in 1993, three in 1994, six in 1995, nine in 1996, seven in 1997 and three in the first three months of 1998. However, I do not believe it occurred to him that Shipman might have been guilty of wrongdoing.

15.102 In January 1994, Dr Patel signed a Form C for Miss Joan Harding, who had died in Shipman's surgery. I accept Dr Patel's evidence that Shipman gave a wholly convincing account of this death and observe there was nothing inconsistent within the account given in Form B. The fact that Shipman wrote that Sister Gillian Morgan, the practice nurse at the Market Street Surgery, had been present at the moment of death would, I am sure, have been very reassuring for Dr Patel. Had Dr Patel sought corroboration from Sister Morgan, she would have given him an account that was entirely consistent with a sudden natural death on the premises. She too was, in that respect, taken in by Shipman.

15.103 However, in July 1994, Dr Patel signed a Form C for Miss Maria Thornton. On Form B, Shipman said that she had died following a stroke. He had seen her about six hours before

death. She was alone at the moment of death. Shipman claimed that Miss Thornton had been found dead by a neighbour; she had apparently collapsed at the table when eating her tea. Dr Patel told the Inquiry that he did not know how he could have been satisfied at the time that Miss Thornton had died from a stroke. However, I note that Shipman wrote that Miss Thornton had underlying arteriosclerosis and I accept that he may well also have provided a detailed oral history of hypertension and arteriosclerosis. I do not criticise Dr Patel for signing the Form C in this case.

15.104 On 9th March 1995, Dr Patel signed Forms C for two patients who had died on 7th March. On Form B, Shipman said that Mrs Netta Ashcroft had died of a coronary thrombosis; she had underlying ischaemic heart disease. He had seen her at about midday, two hours before her death, when she was suffering from a chest infection. She had been alone at the moment of death and had been found by her niece, dead in a chair. Dr Patel was unable to suggest how Shipman had explained this death. Eventually, he said that he thought Shipman had probably told him that Mrs Ashcroft had had some angina that morning but that he had forgotten to put it on Form B. That is possible, although it seems unlikely, bearing in mind that Shipman had specifically mentioned that Mrs Ashcroft had a chest infection that morning. I am concerned that Dr Patel signed this Form C but, with a convincing history from Shipman, who might have mentioned that the niece was providing some kind of support, many doctors might have accepted that there was sufficient material for Shipman to certify the cause of death. There are also grounds for suspecting that Shipman might have suggested that he had spoken to the coroner about the death, something that he was to suggest on at least two occasions the following year. In the circumstances, I do not think that Dr Patel can legitimately be criticised for signing the Form C in this case.

15.105 On the very same day, Dr Patel also signed a Form C for Mrs Lily Bardsley. On Form B, Shipman said that Mrs Bardsley had died following a stroke. She had arteriosclerosis. Shipman had arrived half an hour before the death, which occurred at 2.20pm, and had been alone with her at the moment of death. He said that Mrs Bardsley had collapsed about 10–15 minutes before her death. So, the picture portrayed on Form B was that Shipman had arrived at the house, for an unspecified reason; about 15–20 minutes later, Mrs Bardsley had collapsed and after a further 10–15 minutes, she had died. Dr Patel cannot now say what Shipman told him but suggested that he might have said that Mrs Bardsley did not want to go into hospital. Dr Patel said that Shipman often spoke about his belief that patients had the right to choose whether or not they were to go into hospital. It would not have occurred to him to doubt Shipman if he said that a patient had refused to be admitted. I accept that Shipman probably gave a plausible account of this death and do not criticise Dr Patel for signing Form C. Dr Patel said that, at this time, it had not occurred to him that it was unusual for a doctor to be present at a death. It is very important to observe that Dr Patel's own patient list at the time comprised mainly young children and their mothers and that he had very few deaths among his own patients. At this time, he had signed only two Forms B for patients of his own. He was also still quite junior.

15.106 During the remaining months of 1995, Dr Patel signed four more Forms C for Shipman. I am satisfied that it was not unreasonable for him to do so in any of the four cases. I note that, in two of the cases, Shipman stated on Form B that he had spoken to the coroner,

who was agreeable to him certifying the cause of death. In the other two cases, Shipman said that he had not visited on the day of death. It may well be that the six Forms C that Dr Patel signed for Shipman in 1995, at a time when he was himself relatively inexperienced, set a norm for what Dr Patel expected of Shipman in terms of the latter's patient deaths.

15.107 In 1996, Dr Patel signed nine Forms C for Shipman. In respect of Mrs Marjorie Waller, Dr Patel accepted in oral evidence that he cannot have paid close attention to what Shipman had written on Form B. I think that must be so. Shipman said that Mrs Waller died of bronchopneumonia two hours after he had seen her. Her death had been preceded by a collapse of only a few minutes' duration. She was found dead on the bed by neighbours who had been to fetch her a prescription. Dr Patel accepted that this account did not make sense and I cannot see how the account Shipman gave orally can have been even remotely consistent with the account on Form B, if it was to be reasonably plausible. Dr Patel said that he must have heard and accepted Shipman's story and failed carefully to consider or compare the contents of Form B. I think that is so and I think that the circumstances are such that they must result in individual criticism of Dr Patel in respect of this death.

15.108 Dr Patel then accepted without question the account that Shipman gave him of the death of Mrs Edith Brady who died in his surgery, in circumstances very similar to those of the death of Miss Harding two years earlier. Dr Patel said in evidence that he had a recollection of being asked to complete Form C in Mrs Brady's case and that he had regarded it as factually similar to the death of Miss Harding. He had also become aware by this time of at least one other death in a doctor's surgery. Given that, in 1995, he had reasonably believed the death of Miss Harding to have been the result of natural causes, I do not think he should be criticised for accepting that a similar episode had occurred again, particularly as Shipman again said that Sister Morgan had been present at the moment of death. The remaining seven deaths for which Dr Patel signed Form C during 1996 do not give rise to any cause for individual criticism of Dr Patel. I accept that Shipman in each case gave a plausible account and that there was no reason for Dr Patel to question it.

15.109 The death of Mrs Fanny Clarke on the afternoon of Saturday, 18th May 1996 warrants special mention because it seems, not only that Shipman was called out to the death, but that the deputising service had also been called a short time previously. Mrs Clarke had complained to the deputising service of chest pains and had been advised that she should go to hospital immediately and that an ambulance would be arranged. She had refused an ambulance and so it came about that Shipman was informed. The case is significant because it goes some way to support the perception that patients of Shipman were likely to call him out in an emergency and would occasionally refuse hospital admission.

15.110 Dr Patel said that it might have been around this time that he noticed that Shipman had a high number of patient deaths and that he was present at many. When, on one occasion, he mentioned this, half jokingly, Shipman admonished him, saying that younger doctors were far too quick to send their elderly patients to hospital and that they did so because

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they were not prepared to look after them properly at home. Shipman himself, by implication, did not practise in that way and was accordingly far more likely to be present at the death of a patient at home. Although I am unsure when this conversation took place (it might have been rather later, in 1997 or even 1998), it must have made Dr Patel more ready to accept as explicable Shipman's frequent presence at the deaths of his patients.

15.111 In 1997, Dr Patel signed seven Forms C. Although in five of those cases Shipman had killed the patient, there was nothing on the Forms B to cause Dr Patel to refuse to sign Form C, particularly when I take into account Dr Patel's experience of Shipman by this time. I accept that Shipman would have given a plausible explanation in each case. Shipman admitted his presence at only one death and only one patient was said to have died alone. Dr Patel said that, during 1997, he had no suspicion about Shipman.

15.112 In 1998, Dr Patel signed three Forms C for patients of Shipman. In the first two, there was no obvious reason on the face of Form B why Dr Patel should refuse to sign Form C. I am prepared to accept that Shipman would have told a plausible tale. In the last case, that of Mrs Martha Marley, who died on 24th March, Dr Patel signed Form C on 26th March, even though he and all his colleagues had by then become concerned about Shipman's activities. It was on 24th March that Dr Linda Reynolds telephoned the Coroner and was visited at the Brooke Practice Surgery by Detective Inspector David Smith. Dr Patel knew that the police were to investigate Shipman and he signed this last form in the mistaken belief that the police would be aware of and would enquire into the circumstances of Mrs Marley's death. He thought that he was supposed to carry on as usual so that Shipman would not suspect that he was under investigation. There was nothing on the face of Form B to which Dr Patel could have taken exception; the form did not suggest that Shipman was present at or had discovered the death and I have no doubt that Shipman gave a plausible account of the death. I am not critical of Dr Patel for signing this form, although it is unfortunate that he did so.

15.113 I observe, in conclusion, that there are several cases in which, if Dr Patel had made an enquiry of a person independent of Shipman, he would have discovered facts at variance with Shipman's account and would no doubt have refused to sign Form C. In not adopting the practice of contacting such persons, Dr Patel was acting in the same way as the vast majority of doctors. It would be wrong to criticise him or any of his colleagues for that failure, although I find it regrettable that such a general failing exists. I criticise Dr Patel only in connection with the cremation Form C relating to Mrs Marjorie Waller.

Dr Stephen Proctor

15.114 Dr Stephen Proctor was registered as a medical practitioner in 1980. He was appointed as a principal at one of the Clarendon House practices in 1983, when he joined Dr Beenstock, Dr Farrar and Dr Tanna. He believes that, while a house officer, he may have had some cursory instruction in the completion of cremation forms. He described the procedure he adopted when examining a body before completing a Form C. I accept that he performed a thorough and careful examination.

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15.115 Between 1985 and 1993, Dr Proctor completed 17 Forms C for Shipman. It is now known that, in six of those cases, Shipman had killed the patient. Five of the 17 deaths occurred in 1985, but three of those were natural. Otherwise the deaths and unlawful killings were spread fairly evenly over the years. Shipman admitted his presence at three deaths; two of these were close in time. Miss Frances Turner and Miss Vera Bramwell died in August and December 1985, respectively. I do not think that Shipman's presence, in itself, should have made Dr Proctor suspicious; Shipman suggested that a warden was also present at the death of Miss Bramwell. From 1986 until May 1993, when Dr Proctor signed his last Form C for Shipman, Shipman did not suggest in relation to any patient for whom Dr Proctor completed Form C that he had been present at the death. In summary, I would not expect Dr Proctor to have been concerned about the deaths of Shipman's patients solely on account of Shipman's presence at those three deaths.

15.116 There were five deaths at which Shipman stated that no one was present. These were not close to each other in time. In two of the cases, those of Mrs Beatrice Toft and Mrs Alice Jones, Shipman had seen the deceased within a short time before death. However, these two deaths were over a year apart. I would not have expected Dr Proctor to notice from his involvement in these five cases that Shipman often seemed prepared to certify the cause of death in circumstances where many doctors would think it appropriate to refer the death to the coroner.

15.117 There are, however, two deaths about which Dr Proctor might have been concerned if he had thought more carefully about their individual circumstances. I do not, however, think that, in either case, Dr Proctor's performance was such as to attract individual criticism. I mention the cases for illustrative purposes.

15.118 Miss Frances Turner died on 23rd August 1985, at the age of 85. On Form B, Shipman stated that the cause of death was old age and that there was underlying arteriosclerosis. He said that he had seen Miss Turner two days before her death. She was not in receipt of nursing care. Shipman alone was present with the deceased at the moment of death. Dr Proctor said that Shipman would have given him a detailed, sensible and plausible account of the state of health of a patient whom he knew well, leading up to a death that it would be reasonable to ascribe to 'old age'. I accept that that is so. However, it is hard to imagine how Shipman might have explained his arrival just in time to witness the death, even though Shipman might have said that he was calling on the patient almost every day. Yet Dr Proctor did not apparently notice this. I think Dr Proctor was focussing only on the reasonableness of the cause of death. Given that Dr Proctor had no reason to doubt the truth of what he was being told by Shipman, I do not think I should criticise him solely on the basis that what was being described was a very unusual circumstance.

15.119 Mrs Alice Jones died in January 1988. On Form B, Shipman stated that she had died following a stroke. He did not say that she had any underlying condition. That does not mean that he did not include such a claim in his oral account to Dr Proctor. He might well have told him that Mrs Jones had arteriosclerosis, which would have been wholly credible at her age. On Form B, Shipman said that he had seen Mrs Jones one and a half hours before her death. No one had been present at the death. In evidence, Dr Proctor agreed that the cause of death could not have been sufficiently clear to allow Shipman to certify.

He agreed that if the death was due to a stroke, it must, by its suddenness, have been a brain stem stroke and these are rare. He said that, if Mrs Jones had been a patient of his, he would have wished to discuss the death with the coroner before certifying. It is my view that this death ought to have been reported to the coroner as a sudden death of which the cause was not known. However, I again refrain from criticising Dr Proctor for signing Form C in this case, as it is quite possible that Shipman told him that he had discussed the case with the coroner and had been given permission to issue the MCCD. I accept that, at times, he claimed to have discussed a case with the coroner and it is not clear whether he always noted the fact on Form B.

15.120 Dr Proctor agreed that there were many deaths among those he had considered where, if he had questioned a relative or carer or someone with knowledge of the death, he would have discovered facts which would have given rise to great concern and which would have caused him to refuse to sign Form C. In not adopting the practice of questioning such persons, Dr Proctor was acting in the same way as the overwhelming majority of doctors. It would be wrong to criticise him for that failure, although, as I have already said, I find it regrettable that such a general failing exists. I do not therefore find any grounds upon which to single out Dr Proctor for individual criticism.

Dr Vikram Tanna

15.121 Dr Vikram Tanna was registered as a medical practitioner in 1979 and was appointed a principal at one of the Clarendon House practices in 1982. He joined Dr Beenstock, Dr Farrar and Dr David Livingstone.

15.122 Dr Tanna claimed in oral evidence that he was aware that the Form C procedure was intended to provide a check on any possible wrongdoing by the doctor. I do not accept that he was. That would be inconsistent with his other evidence which was that he regarded the process as confirmatory, rather than investigatory, and that it had never occurred to him not to trust the Form B doctor. It would also be inconsistent with the approach that he manifestly adopted towards his duties as a Form C doctor.

15.123 Between 1987 and 1993, Dr Tanna completed nine Forms C for Shipman. Of those, it is now known that eight were unlawful killings. There were no clusters of deaths until early 1993, when Dr Tanna completed three Forms C within two months, two of which were completed on the same day, in respect of deaths on consecutive days. Shipman admitted having been present at four of the nine deaths, but in only one case did he say that he was alone with the patient at the moment of death. Three of those four deaths occurred between October 1988 and August 1989.

15.124 Mrs Alice Prestwich died on 20th October 1988. Shipman suggested on Form B that she had a history of ischaemic heart disease and died of a coronary thrombosis. He was with her during the last hour of her life and was present at the moment of death. The mode of death was collapse lasting minutes only. No one had nursed her and no one other than Shipman had been present at her death. Dr Tanna said that he had probably understood from Shipman that he had been called out urgently by the patient, who was suffering a coronary thrombosis and whom he unsuccessfully attempted to resuscitate. It did not appear that Shipman had made any attempt to admit the patient to hospital.

15.125 Mr Harry Stafford died on 17th December 1988. The circumstances were very similar to those of Mrs Prestwich's death. In the case of Mr Stafford, however, the cause of death was said to be left ventricular failure and a neighbour was said by Shipman to have been present at the moment of death, in addition to himself. Dr Tanna explained that the suggested presence of a neighbour would have provided strong support for the belief that this was an emergency. Again there is no reference to any attempt to admit the patient to hospital.

15.126 In relation to both cases, Dr Tanna said that Shipman would have given far more detail in his oral account than he provided on Form B. He might well have claimed, with some authority, that he had administered diuretic treatment for Mr Stafford's condition. Dr Tanna also explained that, in the late 1980s, elderly coronary patients were admitted, not to the Coronary Care Unit, but to the medical ward, and some did not want to be admitted to that ward if it was possible for them to be managed at home. That might explain Shipman's apparent failure to admit either patient.

15.127 The third death to occur during that ten-month period and for which Dr Tanna signed Form C was that of Mrs Marion Carradice. The factual circumstances were again similar, with the suggestion that only Shipman and a neighbour had been present at the death. In Mrs Carradice's case, however, the cause of death was said to be left-sided stroke, with hypertension as the underlying cause. Dr Tanna said that he would not have been struck by any inconsistency in the picture portrayed by the Form B, namely that a unilateral thrombotic stroke, which (according to the expert evidence given to the Inquiry by Dr John Grenville) normally leads only slowly to death, had led to Shipman being called out and had been followed by a fatal occlusive brain stem stroke, occurring after his arrival. Dr Tanna said that it was debatable whether the picture was inconsistent.

15.128 My view of these three deaths is that Dr Tanna should not be criticised for signing the relevant Forms C. The suggested presence of a neighbour, combined with what was then perceived by Dr Tanna to be Shipman's reasonable approach towards admitting his patients, are factors which carry significant weight.

15.129 There were four deaths in which Shipman recorded that no one was present at the moment of death. This is very unusual in a death that is to be certified by the general practitioner. These cases were well spread out in time save for two, which were only two months apart. I do not think this feature occurred with such frequency that Dr Tanna should be criticised for failing to notice that Shipman seemed to certify deaths that other doctors would have reported to the coroner.

15.130 I must deal with the last three deaths for which Dr Tanna signed Form C, which occurred in February and April 1993. The first in time was that of Mrs Olive Heginbotham who was killed by Shipman on 24th February, although he stated on Form B that she had died, by his estimate, between 1am and 2am on the following day. Whilst I think this would ordinarily have been regarded as a death that had to be reported to the coroner, Dr Tanna said that Shipman might well have explained that, since she was a patient whom he had been treating for 16 years and who had been suffering congestive heart failure for four weeks, it was reasonable for him to surmise that the cause of death was congestive heart failure.

15.131 Dr Tanna signed Forms C relating to the deaths of Mrs Fanny Nichols and Mrs Marjorie Parker on the same day, 28th April 1993. According to Form B, Mrs Nichols collapsed and died alone in her home two hours after a visit by Shipman. She was discovered by her daughter and Shipman was at the house within 30 minutes of the death. The cause of death was said to be congestive heart failure due to underlying ischaemic heart disease. A similar explanation of the death might well have been given by Shipman to that which he gave in the case of Mrs Heginbotham. Mrs Parker died on 27th April 1993. According to Form B, she died in the presence of Shipman, her husband and her son. Again, the presence of family members would have been very reassuring.

15.132 In summary, there are no deaths for which, in my view, Dr Tanna should be criticised for signing a Form C. There are several that, on the face of Form B, are unusual. However, in each case, I consider that it is likely that Shipman was able to tell a plausible tale which was not frankly inconsistent with what he had put on Form B.

15.133 In many of the cases considered by Dr Tanna, questioning of relatives or carers would have revealed a story completely inconsistent with the oral account that Shipman must have given. As Dr Tanna told me, he would have been extremely concerned to hear a relation or carer give a different account from that given by Shipman. It is most unfortunate that the practice in most areas was not to question the relatives. Dr Tanna should not, in this respect, be singled out for criticism and nor, as I have said, should he be individually criticised in any other way for his performance as a Form C doctor.

The Forms C Signed by Dr Linda Reynolds

15.134 I shall conclude by considering those deaths for which the late Dr Linda Reynolds completed Forms C. Her position is unusual for two reasons. First, she was unable to give evidence to the Inquiry. I have only a very general account of how she reacted to the experience of considering Shipman's Forms C. Second, she was the driving force behind the decision of the Brooke Practice doctors to raise their concerns about Shipman. She might not have been the first to notice anything strange but she was the first to feel strongly that something must be done. She was plainly conscientious. It would be unthinkable to criticise her for not having noticed the features that caused her to be concerned or for not having made her report sooner than she did.

15.135 Dr Reynolds was registered as a medical practitioner in 1975. Before joining the Brooke Practice, she had been a principal in a general practice in Reddish, Stockport, for 19 years.

15.136 I have no reason to believe that Dr Reynolds adopted a different general approach to the completion of Form C from that of her colleagues. I note, for example, that she did not make enquiries of any person independent of the Form B doctor and always answered questions 5–8 in the negative. I am satisfied that Dr Reynolds would have undertaken her Form C duties carefully and intelligently. Yet she never refused to sign one of Shipman's Forms C; nor, until soon after the death of Mrs Lily Higgins in March 1998, did she contact anyone in authority.

15.137 Between September 1996 and March 1998, Dr Reynolds completed 11 Forms C for Shipman. As it happens, Shipman had killed every one of those patients. Two of the patients died in late 1996, six in 1997 and three in early 1998.

15.138 I have already said that, at an early stage, Dr Reynolds noticed that she was completing Forms C more frequently than she had ever done at her practice in Reddish. That was her first concern. The Forms B also showed that Shipman said that he was present at no fewer than six out of the 11 deaths, although he said he was present alone at only one. It is known that Dr Reynolds noticed this feature and thought it odd. When she raised it with her partners around the end of 1997, they advised her that Shipman had a lot of elderly patients and was well known as a doctor who would visit his patients unannounced when he was concerned about their condition. She was somewhat reassured.

15.139 In four cases, Shipman had said on Form B that no one was present at the death. It is not known what Dr Reynolds thought about that. It would probably have been unusual for her to complete and sign a Form B in a case where no one had been present at the death, at least without discussing the circumstances with the coroner. It would be unusual because there would be no one available to describe to her the circumstances of the death and because, if the death had been expected, family or carers would be likely to have been present.

15.140 In short, the picture presented by the deaths of Shipman's patients was wholly abnormal. It must have been very different from her experience in Reddish. Yet, her concern about these features was not such that she felt compelled to take positive steps until she learned that Mrs Bambroffe was also concerned about the deaths of Shipman's patients.

15.141 I do not propose to lengthen this Chapter by detailed consideration of every death considered by Dr Reynolds. It suffices to say two things. First, there is no Form B among those that she considered that contained manifest inaccuracy, internal inconsistency or medical implausibility. Second, I can well believe that, in each case, Shipman would have been able to tell a convincing tale of what had occurred so that Dr Reynolds would have had no reason to doubt the truthfulness of what he said. Individually, the deaths considered by Dr Reynolds did not give rise to any cause for concern, sufficient to warrant a refusal to sign Form C. Viewed collectively, however, they revealed the disturbing pattern which Dr Reynolds noticed and which spurred her to act. I repeat, it would be unthinkable to suggest that Dr Reynolds ought to have felt concern at an earlier date than that at which she did.

Conclusions

15.142 In a few instances, I have been critical of individual doctors in connection with the performance of their duties as a Form C doctor. Their poor performance is mitigated, although not entirely excused, by the generally low standard of Form C completion prevailing throughout the profession. The low prevalent standards had been condoned by the profession generally and by the Home Office, the Government Department supervising the operation of the scheme, at least since they had been highlighted in the Brodrick Report, published in 1971.

15.143 In the great majority of individual cases, I accept that Shipman was able to tell a plausible tale, which was not frankly inconsistent with the account given on Form B. Even if, in the cases in which I have criticised a doctor for signing a particular Form C, the doctor had

queried the propriety of Shipman's decision to certify the cause of death, I do not think it would have led to his detection. I think it likely that Shipman would have claimed that, in the light of the objection raised, he had spoken to the coroner, who had approved the cause of death. Distrust of Shipman would not have been such as to cause the Form C doctor to verify the truth of that statement. However, if this had happened regularly, it would or should have attracted notice.

15.144 It is clear that the Form C procedure, as operated in this country for many decades, has been wholly inadequate as a safeguard against concealed wrongdoing by a Form B doctor. By wrongdoing, I mean, not only homicide, but also negligence and neglect. It is clear that any system which depends on the integrity of one doctor is open to abuse by that doctor, if s/he is dishonest.

15.145 I have said that some of the Brooke Practice doctors might have noticed, not only the number of deaths among Shipman's patients and the increase in numbers which occurred in 1995, but also some features of deaths which were unusual and out of line with their experience of deaths among their own patients. It is apparent that, eventually, some of them did notice the number or frequency of the deaths and also noticed that Shipman was often present. Eventually, they came to realise that these factors indicated that all was not as it should be but they did not reach that state of mind until Mrs Bambroffe had voiced her concerns. Ought they to have suspected Shipman sooner?

15.146 The problem was that, although Dr Booth, Dr MacGillivray, Dr Patel and Dr Dirckze all had reason to notice some unusual feature or features, the features were not the same for all of them. Dr Booth had a lot of cases at which Shipman was present at the death. For Dr Dirckze and Dr MacGillivray, the unusual feature was that the patient so often died alone, in many cases soon after Shipman had visited. Dr Patel had a significant number of cases at which Shipman was present and at which no one else was apparently present. When Dr Reynolds arrived, she too had a mixture of deaths at which Shipman was present and at which no one else was present. Given the different experiences of the five doctors, and given the prevailing attitude of complete trust in fellow professionals, it does not surprise me that the Brooke Practice doctors convinced themselves that the high number and apparently unusual features of Shipman's patient deaths were attributable to the prevalence of elderly patients on his list and the way in which he conducted his practice. Although, with the benefit of hindsight, it can clearly be seen that all these unusual features were in fact present because he was killing his patients, I do not think it would be fair to suggest that the Brooke Practice doctors should have appreciated the significance of the different factors before they did.

15.147 All the Hyde doctors now accept that, if they had questioned a relative or person with knowledge of the death, they would in many cases have discovered facts which would have caused them to refuse to sign Form C. As I have said in Chapter Eleven, I believe that, if it had been a requirement that the Form C doctors should complete at least one of questions 5–8 of Form C in the affirmative, Shipman would either have been deterred from killing so many patients or have been detected sooner than he was. The effect would have been the saving of a significant number of lives.

15.148 It is a matter of regret that the Hyde doctors, who have, I accept, found it distressing to realise that they have played a part, albeit an innocent part, in the Shipman story, have still not changed their practice in relation to completion of Forms C. Not one of those doctors told the Inquiry that s/he now speaks to a relative or carer before signing Form C. Their attitude seems to be that they will do so only if they are told that they must do so.

CHAPTER SIXTEEN

The Dukinfield Crematorium Medical Referees

Introduction

16.1 In this Chapter, I shall examine the work of the two doctors who were employed as medical referees at the Dukinfield crematorium during the years in which Shipman killed so many of his patients. Dr Betty Hinchliffe was appointed as the Deputy Medical Referee in the late 1970s and became Medical Referee on the death of her predecessor, Dr Thomas Holme, in 1989. Soon after Dr Hinchliffe's appointment, Dr Jane Holme, the daughter of Dr Thomas Holme, was appointed as her deputy. Dr Hinchliffe continued as Medical Referee until 1999, when she retired. Dr Jane Holme retired at the same time.

16.2 Dr Hinchliffe authorised the cremation of the bodies of 176 of Shipman's patients. Of those patients, Shipman had killed 107. Dr Holme authorised the cremation of the bodies of 31 of Shipman's patients, of whom 23 had been killed. I shall consider whether the frequency with which these medical referees considered cremation forms completed by Shipman, or the unusual content of those forms, should have caused the medical referees to be in any way concerned about Shipman's practice. I shall also consider whether the contents of any particular forms were so strange or unsatisfactory that the medical referee who saw them should have refused to authorise cremation of the body and have ordered an autopsy or referred the death to the coroner.

Professional Experience

16.3 I have already referred briefly to the careers of the two medical referees in Chapter Eleven. Dr Hinchliffe graduated in medicine from Manchester University in 1951. She then spent two years working in hospital, followed by two years as a locum general practitioner. Thereafter, she was employed in the field of child health, eventually specialising in paediatric audiology. She had no further experience of general practice or of the care and treatment of elderly people. Before her appointment as Deputy Medical Referee, she had very little experience of cremation certification. She had occasionally completed Forms B during her two years as a house officer. She said she had completed a Form C 'perhaps on two occasions'. She was appointed at the suggestion of the previous Medical Referee, Dr Thomas Holme, with whom she had previously worked in public health.

16.4 Dr Jane Holme, Dr Hinchliffe's deputy, graduated in medicine, also from Manchester University, in 1966. She spent her pre-registration year working in hospital and then moved to local authority work in the field of child health. She never worked in general practice and had no experience of the care and treatment of elderly people. She had completed some Forms B when working as a junior doctor in hospital, but had never completed a Form C. She was appointed Deputy Medical Referee by reason of her family relationship with Dr Thomas Holme and her professional relationship with Dr Hinchliffe.

16.5 In my view, a medical referee should have some experience of patients who die. This could most easily be gained by experience in the care and treatment of the elderly, as most people die in old age. Such experience might be gained in a number of ways, for

example in general practice. It cannot be gained by experience in the field of child health.

16.6 I also think it highly desirable that a medical referee should, at least for a time, have had experience of completing Forms B and C and working with others who also have such experience. He or she would then be aware of how the system works from the doctors' point of view, what the problems are with the completion of Form B and the extent of the investigation usually carried out by the Form C doctor. In my view, neither Dr Hinchliffe nor Dr Holme was adequately equipped by her professional experience for the work of a medical referee, who has to assess the information provided on cremation Forms B and C.

The Task to Be Undertaken

16.7 In Chapter Eleven, I set out the duties of the medical referee, as provided by the Cremation Regulations. I can summarise those duties briefly. The medical referee should seek to satisfy him/herself that the forms have been duly completed, that the enquiry made by the persons completing the forms has been adequate, that the fact and cause of death have been definitely ascertained and that there is no reason why the body should be examined further. In Chapter Eleven, I pointed out that the requirement that the medical referee should be satisfied the cause of death has been definitely ascertained is unrealistic and unachievable.

16.8 In Chapter Eleven, I also explained that there appeared to be two schools of thought about how the duties of the medical referee were to be carried out, some believing that the task was of an essentially clerical nature and others believing that they were under a duty to review, and form an independent judgement upon, the information in the forms. I concluded that the powers given to the medical referee, and the requirement that s/he be a medical practitioner of five years' standing, make it clear that s/he must undertake more than a clerical check. It is not clear from the Regulations how much more should be done or how the medical referee is to satisfy him/herself that the cremation should be authorised. As it appeared that it was the intention of Parliament that the medical referee should not usually undertake independent enquiries of his/her own, I expressed the view that the process of review described by Dr Gordon Pledger and Dr Ian Morgan, two medical referees who gave oral evidence to the Inquiry, seemed a reasonable one. Their approach entails a review of all the information given in the documents (especially Form B) and consideration of the 'whole picture', in order to assess whether the cause of death is consistent with that picture. I have already pointed out (see paragraph 11.116) that, even if completed conscientiously, the documents frequently contain inadequate information to enable the medical referee to gain a clear picture of the events leading up to death. Form B does not require the doctor to provide even a brief account of the deceased's medical history, nor of the circumstances of the death. Nevertheless, it is evident from the forms examined by the Inquiry that some impression of the circumstances (e.g. whether the death followed a terminal illness or occurred suddenly) can usually be gained. If the information is so sparse that this is not possible, it is open to the medical referee to make enquiries of the certifying doctor.

16.9 Form B provides most of the information upon which the medical referee will base his/ her judgement. In respect of Form C, the medical referees at most crematoria (including

Dukinfield) would expect to see only that the second doctor had carefully examined the body externally, questioned the Form B doctor and confirmed the latter's opinion as to the cause of death. It appears that most medical referees would deem that to be an adequate enquiry, although, as I have explained in Chapters Three and Eleven, there are some crematoria where an enquiry of a person other than the Form B doctor is required before authority to cremate will be given. I would expect that the medical referee would appreciate that the Form C doctor would probably not have examined the medical records and would have accepted the Form B doctor's account as honest. In other words, I would expect the medical referee to appreciate that the decision of the Form C doctor to confirm the Form B doctor's opinion as to cause of death would have entailed only a consideration of whether the opinion was a reasonable one, bearing in mind the history as given by the Form B doctor. At Dukinfield, as at most crematoria, there was no requirement for the Form C doctor to make an enquiry of a person independent of the Form B doctor, to check on the accuracy of the history provided by the Form B doctor.

Dr Hinchliffe's Perception of Her Task

16.10 Dr Hinchliffe's evidence was that, as well as a clerical check, she carried out the exercise of assessing the 'whole picture' as described by Dr Pledger and Dr Morgan. She described herself as 'trying to fill in a little jigsaw puzzle'. She also sought to make sure that every question had been answered, that there was consistency between the details (name, cause of death, date of death, etc.) contained in the various forms and that there was nothing on the face of the forms which would render the case reportable to the coroner. She told the Inquiry that she had never had occasion to order an autopsy, refer a death to the coroner or decline to allow a cremation to take place.

16.11 I regret to say that I am unable to accept Dr Hinchliffe's evidence that she carried out such an exercise. I reach that conclusion for several reasons. The first is that it was not until she came to give oral evidence that Dr Hinchliffe suggested that she had ever carried out a review of the 'whole picture'. In her first Inquiry witness statement, she described the procedure she would follow in some detail. At only one stage did she suggest that the task was anything other than administrative. She spoke of the need to check that the death was not due to trauma or a medical procedure, such as would make it reportable to the coroner. I accept that she did that. However, she did not suggest that she reviewed the information to see whether the cause of death was reasonable and consistent with the surrounding circumstances and with the picture as a whole. Twice in her Inquiry witness statements, Dr Hinchliffe described the task of a medical referee as **'clerical'** in nature. She observed that the task did not involve **'a review of the medical opinions expressed on the forms'**.

16.12 My second reason is that Dr Holme received her informal training from Dr Hinchliffe and her evidence was that Dr Hinchliffe had not taught her that the task was anything more than a clerical job.

16.13 Third, if Dr Hinchliffe had carried out the exercise of looking at the 'whole picture' or completing 'a little jigsaw puzzle', she would have been bound to observe that, in respect of a number of cases which she considered, the information contained in Form B was

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either inconsistent with the stated cause of death or was not adequate for the purpose of forming any view as to the consistency between the cause of death and the surrounding circumstances. Faced with a Form B which contained either inconsistent or inadequate information, she would have had to make further enquiries of the Form B doctor before she was able to decide whether or not to authorise cremation. She made no such enquiries in those cases.

16.14 Dr Hinchliffe said that she did not make such enquiries because she assumed that, if she had enquired, a satisfactory explanation would have been provided. She also said that it was acceptable for her to rely on such an assumption, rather than making further enquiries herself, because she believed that the Form C doctor would have made any necessary enquiries and would have satisfied him/herself that there was an acceptable explanation for any apparent inconsistencies or omissions. If this were indeed her approach, then any attempt by her to assess the 'whole picture' was completely without purpose. Even if that assessment revealed a glaring omission in the 'jigsaw', on her account, she would take no action, confident in the belief that the Form C doctor would have done so. There is a fundamental inconsistency between her claim that she was trying to see the 'whole picture' and her claim that it was reasonable for her not to make any enquiry of the doctor if she noticed inadequate or inconsistent information on Form B.

16.15 Fourth, it was Dr Hinchliffe's practice to make a note on the form if, for any reason, she had to speak to the Form B doctor to obtain additional information before she could take a decision whether or not to authorise cremation. Examination of a large number of forms reveals that they bear a number of endorsements in her hand, relating to such matters as the date on which the Form B doctor had last seen the deceased alive or, in a case where, for example, the doctor had not seen the deceased for more than 14 days before death, whether the death had been discussed with the coroner. However, no form bears any annotation relating to enquiries about the cause of death.

16.16 Finally, Dr Hinchliffe said that she dealt with each form individually. Yet she never gained any impression of the overall proportion of deaths that occurred in hospital and in the community. Nor had she formed any impression of the proportion of deaths referred to the coroner. She said she had never thought about these issues. If Dr Hinchliffe had indeed seen the 'whole picture' of every death, I would have expected that she would have gained at least a general impression of the profile of the deaths dealt with at the crematorium.

16.17 My conclusion that Dr Hinchliffe did not carry out a review of the information contained in the cremation forms is consistent with her general approach to her task. She had a very uncritical view of the whole process of cremation certification. She placed her trust in the Form C doctor as an 'independent source' but did not know that the Form B doctors selected the Form C doctor; it had not occurred to her therefore that the Form C doctor might not be independent of the Form B doctor. She did not know whether a Form C doctor ever examined the deceased's medical records, although she assumed (mistakenly in most cases) that the Form C doctor would have had access to them. She was unaware that the physical examination of the body by the Form C doctor was sometimes cursory. She did not consider the difficulties which might be experienced by a Form C doctor in disagreeing with a forceful, possibly more senior, colleague. It had never occurred to her

that a Form C doctor who gained a reputation as being a 'stickler' might not be invited to complete a Form C again in the future.

16.18 It appeared to me that Dr Hinchliffe's main concern and preoccupation was that the families of the deceased should not be distressed or inconvenienced by any delay in the funeral arrangements. Her objective was to ensure that the cremation forms could be approved in time. Whilst this is, of course, important, the medical referee also has a duty not to authorise a cremation until properly satisfied as to the cause of death. I am sure that Dr Hinchliffe thought it appropriate to authorise a cremation in every case where the forms had been properly completed. Her consideration of the cause of death was, I am confident, confined to checking that the cause given on Form C tallied with that stated on Form B.

16.19 I conclude that Dr Hinchliffe has persuaded herself that she used to carry out more than a clerical check of the forms whereas, in fact, she did not do so. In persuading herself of this, she might have been influenced by the evidence of Dr Pledger and Dr Morgan. Also, when she came to examine the forms for cremations she had authorised, and to reflect on the declaration which she had made on Form F in those cases, she might have come to realise that the medical referee's duties must consist of more than a clerical check. She has persuaded herself that she used to undertake the task of scrutinising the cremation forms in the way described by Dr Pledger and Dr Morgan. I am sure that she did not. Dr Hinchliffe believes that she carried out her duties conscientiously. In my view, she did indeed carry out her duties, as she then saw them, with a proper degree of care. However, she did not perform them as she should have done, because she did not realise, until shortly before she came to give evidence, that more than a clerical check was required of her. It is unfortunate that Dr Hinchliffe so persistently and unrealistically claimed in evidence that she had done more than she ever had.

16.20 I am reluctant to criticise any medical referee who, until recently, believed the task to be of an essentially clerical nature, because this mistaken belief was not uncommon and because there was no training or guidance by which mistakes could be corrected. However, I would have thought that the application of common sense to the words of the Regulations (particularly the power to order a post-mortem examination) should have suggested to Dr Hinchliffe that the task required the exercise of some degree of medical judgement and was intended to be more than clerical. I can only conclude that, like many of her colleagues, Dr Hinchliffe never paused to consider the underlying purpose of the work of the medical referee, nor why, if that purpose were essentially clerical in nature, the work had to be undertaken by an experienced medical practitioner.

Dr Holme's Perception of Her Task

16.21 Dr Holme's evidence was that her task was essentially to carry out a clerical check. She did not consider that she should review the medical opinions expressed by the Form B and Form C doctors. The only context in which she looked at the cause of death was to ensure that the same cause of death was given on both Forms B and C. She also looked out for indications that the death might be reportable to the coroner, for example because it had been caused by an accident. Although she sometimes spoke to the Form B doctor,

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to fill in a space on a form which had been left blank or occasionally to clarify a point, she never on any occasion queried the cause of death. Nor did she ever order an autopsy, refer a case to the coroner or decline to allow a cremation to take place.

16.22 Dr Holme thought that it was the duty of the Form C doctor to satisfy him/herself that the cause of death was appropriate and consistent with the medical history and circumstances. She seemed uncertain as to the way in which this might have been done. This is not surprising, given her own lack of experience as a Form C doctor.

16.23 Examination of the forms she considered shows that, within the limits she set herself, Dr Holme carried out the clerical check conscientiously. However, had Dr Holme undertaken a full assessment of the cremation forms, rather than a clerical check, such an assessment of many of Shipman's forms would have revealed inconsistencies and inaccuracies which would have required enquiries to be made before the cremations could properly be authorised.

16.24 Like Dr Hinchliffe and many of her colleagues, Dr Holme does not appear to have given any thought to the underlying purpose of the work done by the medical referee. Had she done so, she should surely have realised that the role involved the exercise of a degree of medical judgement, rather than just a clerical check.

Should the Medical Referees Have Noticed Shipman's Activities?

The Number and Distribution of Deaths

16.25 The number of Shipman-certified deaths dealt with by Dr Hinchliffe must be placed in the context of the total number (about 2000 per annum) of deaths that she processed. Moreover, whilst Shipman certified clusters of deaths at various times, it is apparent from the research carried out by the Inquiry that he was not alone in this.

16.26 The most remarkable cluster of deaths certified by Shipman occurred on 13th March 1995, when three of the 12 sets of forms examined by Dr Hinchliffe were for patients of Shipman. Because she was authorising so many cremations, and because other doctors also certified clusters, I accept that it was not unreasonable for Dr Hinchliffe to attribute to coincidence the fact that she was called upon to authorise the cremations of three of Shipman's deceased patients on the same day. I shall consider later whether Dr Hinchliffe should have noticed anything unusual about the circumstances of those three deaths.

16.27 I conclude that neither the number nor the distribution of Shipman's patient deaths scrutinised by Dr Hinchliffe were so unusual that she should have found them noteworthy.

16.28 Dr Holme saw only 31 of Shipman's Forms B and these were spread over eight years. There were no clusters. There was nothing about the numbers to draw Shipman to her attention.

The Failure to Recognise Inadequately Completed and Internally Inconsistent Forms

16.29 I have said that Dr Hinchliffe authorised cremations following 107 deaths where Shipman had killed. In some of those cases, even the most careful scrutiny of the forms would have

failed to reveal any inadequacy or inconsistency or, indeed, anything unusual about their contents. However, such features would have been apparent in the contents of a significant number of the forms examined.

16.30 I have already explained that I am sure that, before giving authority to cremate, Dr Hinchliffe carried out what was essentially a clerical check only on the cremation forms. In oral evidence, however, she contended that she had reviewed the forms in order to 'fill in a little jigsaw puzzle' and assess whether the picture as a whole was consistent with the cause of death. At the Inquiry hearings, she was referred by Leading Counsel to the Inquiry to the forms relating to a number of cases in which she had authorised cremations. Dr Hinchliffe was asked, in respect of each case, to explain the picture which had emerged from her review of the forms and the basis upon which she had felt able to authorise the cremation without further enquiry.

16.31 Dr Hinchliffe was asked in some detail about a number of such cases. However, I do not propose to lengthen this Report by a detailed exposition of the facts of each case in which Form B was unsatisfactory, the problems raised and Dr Hinchliffe's explanation for her decision to allow cremation. There were many such cases, including those of Mrs Marjorie Parker, Mr John Molesdale, Mr Joseph Shaw, Mrs Netta Ashcroft, Mrs Lily Bardsley and Miss Brenda Ashworth. In all these cases, Dr Hinchliffe authorised cremation without making any enquiry of Shipman. In the case of Mrs Erla Copeland, whose death Shipman had attributed to 'natural causes' (an unacceptable cause of death), Dr Hinchliffe claimed that she had spoken to Shipman before authorising cremation. However, I do not think she can have done, as there is no note on Form B of any conversation or additional information. I shall refer in detail to only two cases about which Dr Hinchliffe was asked in evidence, those of Miss Ethel Bennett and Mrs Eileen Robinson, by way of illustration.

Miss Ethel Bennett

16.32 According to the first page of the Form B completed by Shipman, Miss Bennett died at her home at about 4pm on 19th December 1988. The cause of death was said to be bronchopneumonia. Shipman said that he had been her doctor for 12 years. He said he had attended her for six hours during her last illness and had last seen her alive about six hours before her death. Dr Hinchliffe agreed that that implied he had visited her on one occasion during her pneumonia and that that visit had taken place six hours before death, i.e. at about 10am. Shipman also stated that he had seen the body about one and a half hours after death, which would have been at about 5.30pm.

16.33 On the second page of Form B, Shipman said that Miss Bennett had been in a coma for **'hour only'** before death. He wrote: **'Seen by self at 1300 hrs, found by son at 1830. Neighbour heard her at 1500 hrs moving about, then found sat in chair'**. He also stated that Miss Bennett had not been receiving nursing care and that no one had been present at the moment of her death.

16.34 It is immediately apparent that the timing of events given on the first page is inconsistent with that on the second. Dr Hinchliffe said that, when she reviewed the form, she had not noticed this inconsistency. There were also two inconsistencies between Form B and the information in Form A. Form A had been completed by Mr Alan Roy Bennett,

Miss Bennett's nephew, who stated that he was her nearest surviving relative. If that were right, Miss Bennett did not have a son who could have found her dead at 6.30pm. Second, on Form A, the time of death was said to be 6pm, whereas in Form B it was said to be 4pm. Dr Hinchliffe said that she had not noticed either of those inconsistencies.

16.35 Perhaps more serious was Dr Hinchliffe's failure to notice the inherent implausibility of Shipman's account of this death. The picture that Dr Hinchliffe should have pieced together was of an elderly woman whom Shipman visited at about 10am, but apparently left alone without any nursing care. From that, one would infer that she was not seriously ill at that stage. Shipman might or might not have seen Miss Bennett again at 1pm; the information is contradictory. Miss Bennett was apparently still **'moving about'** at 3pm, when she was heard by a neighbour. Yet, at about that time, she appears to have been lapsing into a coma that lasted for an hour before her death at about 4pm. Given that bronchopneumonia is not an extremely acute condition and that death is usually preceded by at least several hours of grave illness, this picture simply does not make sense. Yet, Dr Hinchliffe failed to realise this and could give no explanation for her failure. I can only conclude that, when reviewing the forms, she did not attempt to look at the 'whole picture' of this death, as she claimed. Nor, I am bound to observe, does she appear to have performed a particularly careful clerical check.

Mrs Eileen Robinson

16.36 Mrs Robinson died in December 1993, at the age of only 54. According to the Form B completed by Shipman, she died at home at about midnight on 22nd December. Shipman said he had been her doctor for 17 years and had attended her for four months during her last illness. He said that he had last seen her alive about 12 hours before her death, which would have been at about noon on the 22nd December. He stated that the cause of death was coronary thrombosis due to hypertension and that the death had been preceded by a collapse lasting **'seconds only'**. That information was said to be the result of his own observations. He said that nobody had nursed Mrs Robinson in her last illness and no one had been present at the death. He explained the circumstances in which Mrs Robinson had been found as follows: **'Broke in with police found on floor dead'**.

16.37 When asked what she thought must have been the 'last illness' for which Shipman had been attending Mrs Robinson for four months, Dr Hinchliffe replied that it must have been for some cardiac reason and then added that it might have been for hypertension. However, she seemed to agree that hypertension is a risk factor for coronary thrombosis, but could not properly be described as a 'last illness'. Dr Hinchliffe then suggested that the last illness might have been angina. However, this was pure speculation.

16.38 Dr Hinchliffe was then asked how, if Shipman had been treating Mrs Robinson for hypertension and she had been found dead on the floor, having apparently died alone, it would have been possible for him rationally to conclude that her death was due to coronary thrombosis, as opposed to some other cause such as a cerebrovascular accident. Dr Hinchliffe was driven to suggest that Mrs Robinson might have had a previous coronary thrombosis and that the Form C doctor would have discussed all these problems with Shipman and resolved them.

16.39 This case clearly demonstrates that Dr Hinchliffe did not look at the 'whole picture' when reviewing the cremation forms and thus did not notice the inadequacy of the information upon which Shipman had apparently based his diagnosis of the cause of death. In seeking to provide explanations for what Shipman had written, she was driven, when giving evidence, into speculation and unwarranted assumption.

16.40 I shall also consider two sets of cremation forms completed by Shipman, which related to cases in which Dr Holme had authorised cremations. These are the cases of Mrs Elsie Godfrey and Mrs Mary Coutts.

Mrs Elsie Godfrey

16.41 Mrs Godfrey was found dead at her home on 8th May 1996, at the age of 85. According to the Form B completed by Shipman, she died at home at 6.30pm on 7th May. Shipman said that he had been her doctor for 19 years and had attended her for over six weeks during her last illness. He said that he had last seen her alive on 3rd May and had seen her body about 18 hours after death, which would have been at about 12.30pm on 8th May. Shipman stated that the cause of death was old age, with hypertension and diabetes mellitus being other conditions contributing to the death but not related to the immediate cause. Shipman said that the mode of death was **'syncope'** lasting **'seconds only'**. He said that Mrs Godfrey had been **'Found by warden dead in chair by body temp died 1830 7.5.96.'** He said that no one had nursed Mrs Godfrey in her last illness and no one had been present at the death.

16.42 According to the form, Mrs Godfrey had died of old age. That would imply a gradual decline and deterioration, leading to death. Yet, she had received no nursing care (although she was in warden-controlled accommodation) and had died alone. Moreover, Shipman claimed to have attended her for only six weeks during her 'last illness'. He had last seen her four days before her death, yet was able to say she had died of a **'syncope'** lasting **'seconds only'**. He was also apparently able, 18 hours after her death, to estimate the time of the death with accuracy.

16.43 When asked about the death, Dr Holme said that she would not have formed a picture of the circumstances of the death and would not have considered whether the diagnosis was correct. Nor did she think she would have noticed the attempt to estimate the time of death. Had she done so, she might have ascribed it to a 'rather old-fashioned doctor'.

Mrs Mary Coutts

16.44 Mrs Coutts died in April 1997, at the age of 80. According to the Form B completed by Shipman, she died at home at 2.15pm on 21st April. Shipman said that he had been her doctor for 15 years and had attended her for two hours during her last illness. He said that he had last seen her alive at about 1pm on the day of her death. He said that he had seen the body about an hour after death, which would have been at about 3.15pm. He stated that the cause of death was bronchopneumonia, with chronic lymphocytic leukaemia being a condition contributing to death but not related to the immediate cause.

16.45 Shipman went on to say that the mode of death had been **'syncope'** lasting **'minutes only'**. He recorded that the observations about the mode of death were his own and those

of neighbours. He also recorded that Mrs Coutts had been **'found by neighbour dead in chair'**. No one had nursed her during her last illness and no one had been present at her death.

16.46 According to the form, Shipman left Mrs Coutts about one and a quarter hours before her death from bronchopneumonia. She was not being nursed and she died alone. Given the short time which was to elapse before her death, and the nature of the condition from which she died, Mrs Coutts must have been very ill indeed when Shipman left her. Upon reading the form, one is left wondering how a doctor came to leave her in that state and what arrangements he had made for the support and care she must obviously have needed.

16.47 Again, Dr Holme said that she would not have marshalled the facts so as to provide the sort of picture which I have set out above. Therefore, it would not have occurred to her that there was anything abnormal about the contents of the form.

Examination by Other Medical Referees

16.48 The Inquiry invited two experienced medical referees, Dr Pledger and Dr Morgan, to examine a number of cremation forms relating to Shipman's patients. They were requested to do so as if they were viewing the forms in the course of their normal duties at their crematoria. They were asked, as far as possible, to put from their minds the knowledge that Shipman is a known murderer. I bear in mind that that is a difficult condition with which to comply. Nonetheless, I am satisfied that both made a genuine effort to examine the forms objectively. Both medical referees found many forms that contained inadequate information upon which to form a judgement about the basis on which the cause of death had been diagnosed. In some, there were internal inconsistencies. Of the 33 sets of Dr Hinchliffe's forms examined by Dr Pledger, he would have accepted six without further enquiry. He would have wished to speak to Shipman in the other 27 cases. He recognised that, if Shipman had given a satisfactory and plausible account of the medical background, he might well have authorised cremation. However, he thought that, in four of those 27 cases, his level of concern would have led him to consider ordering an autopsy. Of the 60 sets of forms examined by Dr Morgan, he would have wished to speak to Shipman for clarification of some point in 17 cases. He too recognised that Shipman might have reassured him about most of those cases. However, in two cases, he thought that his level of concern would have been such that he would have referred the death to the coroner.

Conclusions

16.49 Had Dr Hinchliffe undertaken a review of the forms so as to see the 'whole picture' and had she not always been prepared to assume (as she was when giving evidence to the Inquiry) that the Form C doctor had considered and been satisfied by Shipman's explanation for any *lacuna* or inconsistency in the information he had provided on Form B, she would have found it necessary to contact Shipman to discuss the content of Form B on many occasions. Although I have little doubt that Shipman would, on each occasion, have provided a plausible explanation for the cause of death he had given, I do not think that

Dr Hinchliffe could have failed to notice the frequency with which she had to contact him. I believe that, had it been her practice to scrutinise the 'whole picture', she would from time to time have had to contact other doctors besides Shipman. The Inquiry examined a large number of Forms B completed by other doctors practising in the Hyde area. From that examination, it appears to me most unlikely that Dr Hinchliffe would have had to contact any other doctor anything like as frequently as would have been necessary with Shipman.

The Failure to Recognise Unusual Features Apparent from the Forms

16.50 Shipman's Forms B showed that he was present at 42 deaths for which Dr Hinchliffe authorised the cremations. Her evidence about whether she had noticed that Shipman was often present at the deaths of his patients was somewhat confused. Initially, she said that she had not noticed this feature but that, if she had, she would have attributed it to her belief that he was an attentive doctor who was willing to visit his patients. Later, she said that she had noticed this feature and had attributed it to this belief. I think it unlikely that she had in fact noticed this feature at all.

16.51 Dr Hinchliffe also believes that she noticed the cluster of three deaths, which I have already mentioned, for which she authorised cremation on 13th March 1995. These were the deaths of Mrs Netta Ashcroft, Mrs Lily Bardsley and Mrs Maria West. Dr Hinchliffe does not appear to have noticed the common features of these deaths. They were all deaths at home, occurring in the presence of or very shortly after a visit from Shipman and all were sudden in nature; as a group, they were therefore very unusual. This was in stark contrast to the nine other cremations that Dr Hinchliffe authorised that day. Those deaths all occurred in a hospital or other institution. All nine had a cause of death that suggested a prior illness of some duration. By contrast, Shipman's three patients appeared to have died suddenly of coronary thrombosis or cardiovascular accident of short duration. Yet Dr Hinchliffe attributed this cluster of deaths to coincidence. I accept that coincidences do occur and I have already accepted that it might be a coincidence that three out of 12 deaths in one day had been certified by one doctor. However, if Dr Hinchliffe had considered the 'whole picture' of each death, she would surely have noticed that all three of Shipman's deaths were different from the other nine. If she had had any personal experience of dying patients, she would surely have realised that the circumstances of Shipman's three cases were most unusual.

16.52 In all the circumstances, it is not surprising that Dr Hinchliffe did not notice these features. As she was performing little more than a clerical check, her knowledge of each death would have been of a piecemeal nature, so that she would not readily have noticed the common features of the death. Had she been looking at the 'whole picture', it is possible that, in particular when clusters of deaths occurred, Dr Hinchliffe would have become aware that the deaths of Shipman's patients had unusual characteristics. However, having regard to her lack of experience of general practice or of patients who had died, it is also possible that she might not have appreciated that the characteristics were indeed unusual. She might have continued, for example, to attribute one of the most striking of such characteristics, presence at or shortly before death, to Shipman's habit of visiting his patients on demand.

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16.53 As Deputy Medical Referee, Dr Holme did not deal with the same number or similar clusters of deaths. Shipman was present at or shortly before the deaths of 13 of the patients whose cremations she authorised. It is unlikely that she would have noticed the fact of Shipman's presence, or any other unusual characteristics of the deaths, for the same reasons as Dr Hinchliffe. In any event, she saw far fewer Shipman deaths and had a correspondingly smaller opportunity of observing their characteristics.

Other Medical Referees

16.54 The Inquiry also examined the forms relating to cremations of Shipman's patients that were authorised by other medical referees and deputy medical referees who officiated at the Dukinfield and Stockport crematoria. They dealt with few such deaths and even fewer cases where Shipman had killed. On the basis of their evidence, and the comments of Dr Pledger and Dr Morgan, who had looked at the forms, I did not regard it as appropriate to level any criticism against those referees in respect of the cremations which they authorised. I did note that one of them described in his Inquiry statement how he had reported deaths to the coroner on a number of occasions, usually because the deceased had undergone an operation shortly before death. On one occasion, he reported a death because he suspected (correctly, as it turned out) that the deceased had committed suicide.

16.55 The Inquiry conducted some very small-scale research into the performance of medical referees at other crematoria. Cremation forms covering two periods of three months were obtained from four crematoria. Analysis of those forms showed that, at three of the four crematoria, no notes made by medical referees on Forms B related to queries about the cause of death. Whilst the Forms B were generally completed to a reasonably good standard, the fact that no questions about the cause of death were raised, even in those cases where the picture was not completely clear or consistent, suggests that the medical referee concerned may not have adopted a very critical or enquiring approach.

Conclusions

16.56 I have already referred to the limited amount of information contained on completed cremation forms. However, it is usually possible to gain some impression of the circumstances of the death, based on the information provided by the Form B doctor. Neither Dr Hinchliffe nor Dr Holme undertook any assessment of the 'whole picture' presented by the cremation forms. Dr Hinchliffe claimed that she did but I have rejected her evidence. Dr Holme never claimed to have done so.

16.57 Had either of them done so, they would have found many Forms B in which the information provided by Shipman was inadequate or inconsistent. For Dr Hinchliffe, in particular, this would have meant that it was quite often necessary for her to speak to him to clarify the picture. Dr Hinchliffe would have found it necessary to speak to him considerably more often than she had to speak to other general practitioners.

16.58 Had Dr Hinchliffe carried out such an assessment and had she had the benefit of a more appropriate medical background, including greater experience of general practice, she

would have realised that there were unusual features among the deaths of Shipman's patients. In particular, I think she would have probably noticed the common features of the three sets of forms that she examined on 13th March 1995.

16.59 I have already said that I am reluctant to criticise either of these medical referees for the way in which they approached their duties. Nor can I criticise them personally for their lack of relevant medical experience. It was the fault of the system that they were appointed, despite such lack of experience. They were not given any formal training or even provided with a handbook of advice. The only instruction available was from the previous Medical Referee. It may well be that Dr Thomas Holme was under the same misapprehension about his role and passed this on to Dr Hinchliffe, who in turn passed it to Dr Jane Holme. There was no contact with other medical referees, with consequent absence of the means of learning that others might be carrying out the job differently and more effectively elsewhere. Further, the circumstances in which the job was performed, especially the pressure created by timing, encouraged the feeling that the job was a straightforward clerical exercise with the minimum of enquiry needed.

16.60 The evidence available to the Inquiry suggests that there are medical referees who perform their duties as they ought and who use their powers to institute appropriate enquiries and even to order autopsies on occasions. However, it appears that there are many (possibly the majority) who are not so active. This was certainly the view of the Brodrick Committee. The results of the survey conducted by the Home and Health Department of the Scottish Office in 1994/5, to which I have referred in Chapter Three, suggested that medical referees in Scotland were not performing to a high standard. There is no reason to suppose that practice has been any better south of the border. This is not surprising, given the lack of training or guidance and the isolation in which medical referees operate.

16.61 I conclude that, whilst the performance of Dr Hinchliffe, and (to a lesser extent) Dr Holme, fell short of that which might have been expected from the best of their colleagues, it is unlikely to have been significantly different from that of many other medical referees in England and Wales.

16.62 Had Dr Hinchliffe and Dr Holme had the benefit of relevant medical experience and had they realised that they were expected to undertake a careful assessment of the forms, they would have found inadequacies and inconsistencies in many of them. This should have led them to question Shipman. It is highly likely that, in any given case, he would have been able to proffer an explanation which would have satisfied them, just as it had already satisfied the Form C doctor. However, had there been a repeated need to contact Shipman and to ask similar questions in relation to cases with similar characteristics, this might well have led to concerns about his competence to complete the forms, possibly about his competence as a doctor and possibly even as to his honesty. Repeated questions directed at him might have acted to deter him from pursuing his criminal activities. However, the real possibility exists that he would merely have become more careful, would have modified his form-filling techniques to meet the requirements of the medical referees and would have thus ensured that his deaths passed through the system without question. He would have known that he could enter false information on the forms

at little risk of any cross-check being made as to the accuracy or truth of that information. Even had the medical referees exercised their power to order an autopsy, or referred a death to the coroner for him to do so, it would not have revealed evidence of criminal activity in the absence of toxicological tests.

16.63 I doubt very much that, even if the medical referees had performed their duties in a more critical manner, the course of Shipman's killing would have been changed.

CHAPTER SEVENTEEN

The Inquiry's Consultation Process: Responses to the Discussion Paper, the Seminars and the Feasibility Study

Introduction

17.1 In October 2002, the Inquiry issued a Discussion Paper, 'Developing a New System for Death Certification', which presented a 'working model' for a revised death investigation and certification system. The working model, which represented the Inquiry's preliminary ideas, was based on a redesigned coroner service, with medically and legally qualified coroners working side by side, but fulfilling different functions. Under the working model, the medical coroner would be responsible for investigating and determining all issues relating to the medical cause of death. The judicial coroner would determine the more complex factual issues and disputes and, where appropriate, would conduct an inquest. Both coroners would be supported by a team of trained investigators. The system would have a defined leadership, providing training, continuing education, advice and audit. Within the Discussion Paper was a set of forms designed by the Inquiry for use during the process of death investigation and certification. Those forms would replace the current MCCD and the cremation forms.

17.2 The purpose of publishing the Discussion Paper was to provide a focus, both for written responses and for discussion at a series of seminars held by the Inquiry in January 2003. The Inquiry received written responses to the Discussion Paper from 154 individuals and organisations. A list of those who submitted responses ('respondents') appears at Appendix E of this Report.

17.3 The seminars were spread over a period of nine days and covered the following topics:

(1) Preliminary observations at the scene of death and certification of the fact of death.

(2) Certification of the cause of death and identification of those deaths which require investigation.

(3) Systems for the investigation and certification of death in other jurisdictions (held over two days).

(4) How a medical coroner system might work: interface with the judicial coroner, the police and other investigative agencies (held over three days).

(5) The role of post-mortem investigations and possible alternatives and/or adjuncts to the full invasive investigation.

(6) The new-style forms.

17.4 The Inquiry invited a number of organisations with a particular interest or involvement in post-death procedures to nominate representatives to take part in the seminars. Those organisations included the British Medical Association (BMA), the Royal College of General Practitioners (RCGP), the Royal College of Physicians (RCP), the Faculty of Public Health Medicine, Cruse Bereavement Care (Cruse), the Royal College of Pathologists

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(RCPath), the British Association in Forensic Medicine, the Department of Health (DoH), the Office for National Statistics (ONS), the Coroners' Society of England and Wales (the Coroners' Society), the Coroner's Officers Association, the National Confidential Enquiry into Perioperative Deaths (NCEPOD), the Retained Organs Commission, the Board of Deputies of British Jews, the Association of Chief Police Officers (ACPO) and the ambulance services. In addition, the Inquiry extended invitations to a number of individuals with a particular knowledge of post-death procedures.

17.5 Participants in the seminars submitted written responses to the Discussion Paper in advance and expanded on those responses during the course of discussion at the seminars. The discussions were led by Leading Counsel to the Inquiry and covered a wide range of topics, including many of the issues which had been raised by respondents to the Discussion Paper. Persons attending the seminars as observers were able to raise points through Counsel for the consideration of seminar participants. I found the seminars of real value. Hearing the Stage Two evidence had already changed some of my preliminary views and, before the seminars began, my ideas were in a state of flux. In bringing together a range of opinions on each contentious issue, the seminars helped me to reach conclusions about the system I should recommend.

17.6 A list of the participants who attended the seminars appears at Appendix F of this Report. Further written responses have been received since the seminars and these too have been taken into account. Mr Tom Luce, Chair of the Coroners Review, attended for two days of the seminars and made a short statement, setting out the Review's provisional conclusions as at January 2003. It was extremely helpful to me to be made aware of those provisional conclusions at that stage.

17.7 In the course of this Chapter, I shall refer to some of the most significant points raised in the written responses received by the Inquiry and in the discussions that took place during the course of the seminars. I shall deal with the seminars relating to the systems in other jurisdictions in Chapter Eighteen. I have already referred in Chapter Ten to discussions which took place at the seminar on post-mortem investigations.

The Objectives of a Revised System for Death Investigation and Certification

17.8 The Discussion Paper suggested a number of objectives for a revised death certification system. Such a system must be effective in minimising any risk of the concealment of the fact that a death has been caused unlawfully. Given the background to the Inquiry and the findings contained in my First Report, that must be a primary objective. However, it cannot be the only one. The system should also, insofar as possible, provide reliable and accurate data about the cause of death. This is important because such data provides the statistical and epidemiological information necessary to plan health services and public health strategies, to evaluate their effectiveness and to identify and deal with threats to the health of the population or public safety. The Discussion Paper laid particular emphasis on the need to obtain full and accurate information about the circumstances in which the death occurred and about the deceased person's state of health before death. The better the quality of this information, the more accurate the diagnosis of cause of death is likely to be. Such information is also necessary in order to determine which deaths require

investigation. One objective of the system must be to ensure that information of the best possible quality is available for these purposes.

17.9 The Discussion Paper also suggested that there was a need for the system to be understood by those people (usually bereaved relatives) most closely affected by it. It was envisaged that relatives could and should be involved in the investigation and certification process to a much greater degree than under the existing system. The system must also be capable of meeting, wherever possible, the needs and expectations of the bereaved, including those who, for religious or cultural reasons, wish to bury or cremate their dead within a very short period after death.

17.10 In consultation, the suggested objectives met with broad approval. Some respondents drew attention to the obvious tension that exists between the objectives of collecting as full and accurate information as possible about the death and of meeting the needs and expectations of the bereaved. It was suggested that any revised system should not be so unwieldy as to cause distress to the bereaved relatives or undue delay in disposing of the dead. The need for independence on the part of those charged with the task of investigating deaths was also emphasised. A number of respondents stressed the need for the system to ensure that lessons were learned from deaths found to have been preventable. This is an aspect that is central to the systems operated in some of the other jurisdictions about which the Inquiry heard during the seminars. Professor Stephen Cordner, Professor of Forensic Medicine and Director of the Victorian Institute of Forensic Medicine, who attended the third seminar, suggested that the appropriate objectives in an effective system of death investigation and certification would be:

> **'... to accurately identify the deceased and to elicit the proper cause and circumstances of the death so that justice is advanced, that duties to the bereaved (and the deceased) ... are discharged and so that the community interest is served by learning for the purposes of death and injury prevention'**.

17.11 I shall refer to Professor Cordner's views, and those of the other international contributors, in Chapter Eighteen.

The Bereaved – Should They Be Involved in the Death Certification Process?

17.12 The Inquiry's Discussion Paper envisaged that, in any future system of death investigation and certification, there should be much closer involvement of the deceased's family in the post-death procedures, particularly in providing and receiving information about the circumstances of the death and in verifying information given by the treating doctor and others. This proposal received widespread support although some respondents suggested that relatives might be distressed by, and resent as intrusive, questions about the circumstances of the deceased's death. At the seminars, Mrs Anne Viney, representing Cruse, referred to the need of bereaved people for accurate information and honest explanation. She believed that most relatives would welcome an increased role in the post-death procedures and the opportunity of contributing any knowledge that they might have about the cause and circumstances of the death. She said that an impression

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that information is being concealed could impair the grieving process. She believed that those working in the coroner system could be trained to deal sensitively with families. She stressed the need to treat bereaved families 'like grown-ups' and to be aware that people's imaginings, or lack of knowledge, are often more distressing than being informed of the true facts.

17.13 Some respondents to the Discussion Paper expressed concern that greater involvement of families could result in delay in the conclusion of post-death procedures. Mrs Viney suggested that 'delay' meant a period of time that is greater than some expectation on the part of the public. In the context of a new system, the public would have to be clearly informed of how long the certification process (with and without an autopsy) could be expected to take and the system would have to be carefully costed and appropriately staffed so as to meet the expectations produced by that information. Targets and time limits should be set, performance should be monitored and the results published. A response submitted by Cruse after the seminars expanded upon this topic. It suggested that, once the public understood that the main aim of the system proposed for the future was to prevent untimely deaths and improve public health and safety, people were likely to accept that the timescale between a death and the funeral might, in some cases, be longer than at present. The important thing was for relatives to know what to expect, so as to be able to make plans and feel in control of their situation to a greater extent than at present. Cruse suggested that there should be a maximum period of no more than ten days between death and release of the body for burial or cremation, with the expectation that, in most cases, bodies would be released within a shorter period. Within such a timescale, arrangements would have to be made, wherever possible, to meet the needs and expectations of those minority groups whose religion or culture demanded an early funeral. Cruse also drew attention to the change in attitude, which I referred to in Chapter Four, whereby families now wish to have the body of a deceased relative removed from the house as soon as possible. This is in contrast to the tradition in the past, which was to keep the body at home, where relatives and friends would visit to pay their respects. Cruse suggested that a return to such a tradition would have a number of advantages; in particular, it was said that it would assist the bereaved in the grieving process. It might also, it was suggested, reduce pressure on the death investigation and certification system. Whether the public would be amenable to this sort of change, however, must be open to doubt.

17.14 Although respondents broadly welcomed the proposal for greater involvement of the family in the post-death procedures, they were not entirely unanimous in their support. In its written response to the Coroners Review, the Coroners' Society referred to the risk that bereaved relatives might try to influence the certification process. The Society observed that:

> **'... it is difficult to see how the majority of the bereaved can play a meaningful part in the process of certification, other than to try and influence its outcome, possibly for dubious reasons'**.

Comment

17.15 In my view this attitude towards bereaved families is mistaken. It may be that a few families might seek to influence the outcome of the certification process. However, if that risk

exists, it must be taken. There are two powerful reasons why that is so. First, common humanity demands that bereaved relatives should be treated with due consideration. I accept the views expressed, which accord with my own experience, that the bereaved generally prefer to be involved than to be excluded and usually welcome open and honest explanations. Second, the relatives and friends of the deceased constitute a valuable source of information, which may be vital to the proper investigation of the death. That source must be used. I accept that there is a risk that consultation with families might delay the certification process. That risk can be minimised by the provision of adequate resources.

The Desirability and Feasibility of Creating a New Role of Medical Coroner

17.16 In general, as I have explained, no medical expertise is currently available within the office of a coroner who has only legal qualifications. Advice may be obtained from time to time from the pathologists regularly instructed by the coroner. However, most of the decisions made by the coroner and his/her staff are taken without the benefit of independent medical advice. There was almost universal agreement among respondents that the introduction of some medical expertise into the coroner's office would be desirable in a revised system. There was, however, a division of opinion as to how this should be achieved.

17.17 There was a considerable amount of support for the principle of creating a post of medical coroner. For the ONS, Dr Peter Goldblatt, Chief Medical Statistician, welcomed the idea of a locally operated service, independent of health care providers, that would supervise the certification and investigation of deaths. He enumerated the benefits of such a service, including the potential for the medical coroner to monitor, and thus to improve, the quality of death certification, to educate the public and the medical profession in the working of the system, to monitor local mortality trends and to provide good quality mortality data and other information for use by the ONS and other agencies. Dr Goldblatt pointed out that, if the role of medical coroner were to command the respect of the medical profession, it would have to be equal in status to that of a consultant or principal in general practice and to have recognised standards of postgraduate training and specialist accreditation. Many other respondents echoed the points made by Dr Goldblatt. Mrs Marcia Fry, representing the DoH, expressed the Department's view that the suggested system would promote public health, public safety and public confidence.

17.18 The BMA also expressed the view that the introduction of a medical coroner had much to commend it. The main concern of the Association was whether, given current workforce shortages, the medical profession could provide enough suitably qualified candidates to fulfil the role. This was a concern that was shared by many respondents from within the medical profession and it was a theme that recurred throughout the seminars. The response of Dr John Grenville, a general practitioner who attended one of the seminars, was typical of many others. He pointed to the shortage of doctors within the UK and doubted whether many doctors would be attracted to work as medical coroners. Plainly, recruitment is a real problem at present, particularly in the field of pathology and, to a lesser but significant extent, in general practice. However, Dr Anne Thorpe, representing the BMA, believed that there might be little difficulty in recruiting candidates who were 20 years or so into their careers and looking for a change. She observed that, in order for that

to be so, there would have to be a proper career structure, with appropriate professional support and terms and conditions (in particular, remuneration), commensurate with the importance of the position. For the DoH, Mrs Fry agreed with Dr Thorpe that there would be a pool of doctors wishing to leave clinical practice and seeking an alternative. Medical coroners could be recruited from that pool. The Department's view was that such people would leave clinical practice in any event. They would not, therefore, be 'lost' to front line clinical practice solely because of the creation of the new position of medical coroner.

17.19 Professor Richard Baker, Director, Clinical Governance Research and Development Unit at the University of Leicester and himself a general practitioner, understood and shared the concerns of his colleagues about manpower shortages. However, he believed the solution was to approach the introduction of the revised system slowly and carefully. Doctors would need to be identified and trained to operate the system. It was important that they fully understood exactly what the system was intended to achieve. Professor Baker suggested that they might benefit from having some exposure to the systems in other jurisdictions about which the Inquiry had heard. He felt that it was only by proceeding with caution that the opportunities for creating a really first class system would be realised.

17.20 A number of coroners who responded to the Discussion Paper were completely opposed to the idea of a medical coroner and expressed the strong view that the objectives identified by the Inquiry could be achieved under the existing coronial system. In general, however, coroners accepted the need for the introduction of medical expertise into the coronial service. They took the view that the role of the person providing the medical expertise should be very limited and should be of an advisory and audit nature only. The Law Society agreed with this view. It contended that the separate but parallel jurisdictions of the medical and judicial coroners suggested by the Inquiry would give rise to potential conflict between the two, as well as to confusion in the mind of the public. Mr Christopher Dorries, HM Coroner for South Yorkshire (West), observed in his written response that the proposals would be **'a breeding ground for professional rivalries'**. There was obvious concern about the impact of the introduction of medical coroners upon the existing legally qualified (or 'judicial') coroners. Mr Michael Rose, HM Coroner for the Western District of Somersetshire, expressed the fear that the medical coroner would **'usurp the functions'** of the existing coroner and **'consequently sever the close connection between him and the area he serves'**. He was afraid that the work of the judicial coroner would decline and thus what he termed **'one of the many counterbalances to the excesses of Government'** would be removed. A number of respondents expressed the hope that, if the Inquiry's suggestions were implemented, both medical and judicial coroners would be placed within the same agency.

Comment

17.21 In my view, there is an urgent need for coroners with medical qualification. Many of the decisions now taken by legally qualified coroners depend upon medical judgement. In my view, it will not be sufficient (nor would it be appropriate) for the medical 'person' in the coroner's office to be of a lower status to that of the legally qualified coroner. I do not share Mr Dorries' concern that a lawyer and a doctor could not work together without damaging professional rivalry. There might in some cases be a clash of personalities; that can

happen in any organisation. I see no reason why it should arise particularly in a coroner's office. If a judicial and medical coroner were to work as part of the same team, each would have his/her own functions to perform and, where any decision called for both medical and legal knowledge or judgement, each would benefit from the other's contribution.

17.22 Insofar as the proposals might result in a reduction in the amount of work done by judicial coroners, I can only see that as a benefit. I do not accept that a local population would be less well served by a medically qualified coroner than one with legal qualifications. Nor do I accept that the changes proposed would in any way diminish whatever effect, if any, coroners presently have on Government. The evidence I have heard suggests that some coroners are overworked and give insufficient time (and possibly attention) to those duties for which they are not well qualified personally.

17.23 I recognise that the creation of a number of medical coroner posts would place a strain on the resources of the medical profession. However, it seems to be generally accepted that some medical expertise must be employed on coronial work. I am encouraged by the view expressed by the representatives of the DoH and BMA that, provided that the terms and conditions provide a proper career structure, there will be a pool of suitable candidates for the post of medical coroner. Moreover, these doctors would be seeking a change of direction in their careers and would be likely to leave clinical practice in any event.

The Position of the Medical Coroner within the System

17.24 The Discussion Paper sought views as to the way in which the system should be structured. Views were also invited about how best to assure the independence of medical coroners from those parts of the NHS responsible for delivering patient care, whilst not causing them to become professionally isolated. The need for independence (certainly from local NHS Trusts with whom their duties might bring them into a conflict of interest) was widely understood and accepted and the tension between independence from the NHS and professional isolation well recognised among respondents. A range of solutions was offered.

Should the Medical Coroner Be Integrated within Existing National Health Service Structures?

17.25 Some respondents believed that it would be possible for medical coroners to be employed by the new Strategic Health Authorities (SHAs) and still retain their independence. In its written response to the Discussion Paper, the RCPath expressed that view. The College regarded that as appropriate in view of the responsibility that the medical coroner would have for the accuracy of epidemiological data and also because medical coroners were likely to be recruited from NHS personnel. However, during the seminars, Dr Peter Acland, representing the RCPath, acknowledged his personal view that problems might be caused, for example, when a medical coroner was investigating a death that might have been caused by clinical malpractice at a local hospital. The public might well not perceive an individual employed by an SHA as truly independent of the Trust responsible for operating the hospital. Dr Thorpe, for the BMA, could see arguments for and against medical coroners being placed within NHS structures. The position of the

medical coroner would be a new one and the career path as yet uncharted. There was an obvious danger of professional isolation. There were links with public health that made it attractive to locate medical coroners within the SHAs. On the other hand, that would give rise to a division of accountability between medical and judicial coroners (who plainly could not be placed within the NHS), which would be undesirable. Placing the medical coroner within a unified coronial system might be more appropriate. Dr Thorpe also stressed the need for the medical coroner to be seen as independent of all medical structures. This issue of public confidence in the independence of the system was emphasised in a number of responses to the Inquiry's Discussion Paper.

17.26 The DoH favoured the location of the medical coroner service within the Government Offices of the Regions. Medical coroners would be independent officers, accountable to regional directors of public health and, through them, to the Chief Medical Officer (CMO). The Department's view was that this would solve the potential problem of professional isolation and would provide leadership, stability and continuity. Mrs Fry, speaking on behalf of the Department, felt that the fact that the accountability of medical and judicial coroners would lie in different directions would not present an insurmountable problem. She made the point that regional directors of public health are not involved in the day-to-day management and performance management of the Health Service and are directly accountable to the CMO, whom the public sees as independent of individual doctors at local level.

Is There Any Alternative to Integration within Existing NHS Structures?

17.27 In its response to the Discussion Paper, the Retained Organs Commission suggested that a new 'arm's length' body should be established, along the lines of the Special Health Authorities. Examples of such Authorities are the National Clinical Assessment Authority (NCAA) and the Retained Organs Commission itself. The Commission's response suggested that the service could have a dual relationship with the DoH and the Lord Chancellor's Department (now part of the Department for Constitutional Affairs), thus balancing the need for quasi-judicial independence and a degree of integration into the public health system. The Commission recognised that practical problems might flow from responsibility resting with two Government Departments, but felt that the benefits of the scheme would outweigh the problems. Another consultee suggested that a new body should be set up under the joint auspices of the DoH and the Home Office, in order to provide national leadership and accountability. Others felt that the coroner service as a whole should be accountable to the Home Office.

17.28 In its written response to the Discussion Paper, the Coroners' Society said that, in order to achieve independence from clinicians, medical coroners should be employed by the ONS. However, by the time of the seminars, Mr Michael Burgess, Honorary Secretary of the Society, no longer favoured that solution. He supported the idea of a single integrated service, comprising both medical and judicial coroners and wholly independent from the NHS. He could see no reason why medical coroners, like existing coroners, should not be office-holders under the Crown. The Coroner's Officers Association strongly favoured independence from local authorities, health authorities, the police service and any other

organisation that might have an interest in the death. The Association regarded the Lord Chancellor's Department (now part of the Department for Constitutional Affairs) as one possible location for the service.

17.29 The Society of Registration Officers suggested that the office of medical coroner should be a statutory post, independent from the NHS, with accountability passing up to a Chief Medical Coroner (the Society favoured the term 'Medical Examiner') at the head of a free-standing national agency. The Tameside Families Support Group suggested the creation of a similar agency with the difference that, under the Group's model, the medical coroner would be accountable to the judicial coroner and, at the head of the agency, to the Chief Coroner. The Greater Manchester Police supported the creation of a statutory medical and judicial coroner service, accountable to an independent body which would be responsible for establishing and maintaining consistent procedures and standards nationwide. The police are particularly anxious to see uniformity of practice throughout the service. They, more than any other organisation, experience the problems caused by inconsistent practices and procedures operated by coroners in different districts.

17.30 Professor Baker emphasised the need for those employed in the medical coroner service not only to be seen to be independent, but also to be independent in their attitudes, behaviour and understanding. However, that independence must, he said, be coupled with membership of a wider network ensuring professional development, regulation and continuing education. On the evidence of what was being done in other countries, he felt that all this was possible with proper leadership and management, even within a free-standing service. There would, he thought, be a sufficient number and hierarchy of medical coroners to achieve a degree of professional vitality, if the service could be formally associated with one of the Royal Colleges, which would assume the leadership and educational roles. Professor Baker also saw a role for some sort of administrative link with an NHS organisation, possibly the Commission for Health Improvement (shortly to be subsumed into the new Commission for Healthcare Audit and Inspection). Many of the other respondents to the Discussion Paper and participants in the seminars spoke of the need for continuing professional links so that medical coroners would be able to avoid professional isolation and maintain an up-to-date knowledge of current clinical practice and procedures.

Comment

17.31 The focus of these discussions was what the position of the medical coroner should be within the system. However, on reflection, it seems to me that the real question is what the position of the new coroner service should be. A structure or 'home' must be found for the whole service, not just the medical coroners. The discussion was most useful nonetheless. It highlighted the need for independence from Government and from existing NHS structures, which I fully accept. It drew attention to the need for both medical and judicial coroners to be independent office-holders under the Crown. It brought home to me how difficult a question the 'placement' of the coroner service will be. As will become apparent, I find the suggestion made by the Retained Organs

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Commission to be the most appropriate. I shall propose the creation of a special 'arm's length' body.

The Medical Coroner

What Qualifications Will Be Required?

17.32 In its Discussion Paper, the Inquiry suggested that the position of medical coroner might be suitable for clinicians from a range of different medical backgrounds, including forensic pathologists, public health doctors and police surgeons, as well as doctors with a background in general practice. Further categories were suggested by respondents to the Discussion Paper. These included senior hospital doctors, medically qualified coroners, doctors with medico-legal experience, general histopathologists with an interest in autopsy, epidemiologists, crematorium medical referees and forensic medical examiners.

17.33 There was general agreement that doctors from a variety of medical backgrounds would be suitable for the post. Dr Thorpe, representing the BMA, suggested that the ideal candidate for the post of medical coroner would be someone with a broad medical background and therefore with experience and understanding of many aspects of medicine, rather than an expert in a specialised area. However, there would be a necessity for specialist advice to be available when required.

17.34 Professor Baker originally suggested that the most suitably qualified doctors for the post would be public health doctors; they would be best placed to carry out a monitoring role and to use mortality data in determining the provision of local health services. At the seminars, however, Professor Baker agreed that the net could be cast wider. A number of respondents to the Discussion Paper suggested that public health doctors were unsuitable for the role because of their detachment from clinical practice. It was argued by some, including the NCEPOD, that public health doctors would not be appropriate candidates for the post unless they had substantial recent clinical experience. Professor Baker disagreed with that view. He acknowledged that some public health doctors were so distant from clinical practice that they would find it difficult to take on the role. However, many would be able to do so. He pointed out that public health physicians have a degree of detachment, together with the positive advantage of experience in evaluating the care given to patients. This view received some support, notably from Dr Gary Cook, of the Faculty of Public Health Medicine.

17.35 Some respondents thought that doctors currently working as crematorium medical referees would be ideal candidates for the job of medical coroner. A response from Dr W D S McLay, on behalf of the newly re-formed Association of Crematorium Medical Referees and the Association of Police Surgeons, suggested that, with appropriate resources and statutory authority, the existing role of the medical referee could be extended to cover many of the functions that the Discussion Paper envisaged being undertaken by the medical coroner.

17.36 It was generally acknowledged that, in order to function effectively, the medical coroner system would need to command the respect of the medical profession and that only

doctors of high standing and an appropriate level of experience should be eligible for the job.

Comment

17.37 In my view, doctors from a wide range of medical backgrounds should be capable, after appropriate training, of undertaking the work of a medical coroner. One aspect that was not mentioned by the contributors, which I regard as important, is that some administrative ability would be an asset.

What Sort of Training Would Be Required?

17.38 There was general agreement that, from whatever background a medical coroner came, an appropriate training programme would be essential. Ideas were put forward for a specific training course, leading to formal accreditation. Such a course would clearly need to cover a wide variety of the aspects of the work of the medical coroner. A number of key needs were identified, including training in forensic medicine, in the management of bereaved relatives and in the understanding of the needs of ethnic minority groups and, in particular, their religious and cultural requirements. The Royal College of Paediatrics and Child Health suggested that an understanding of child health and sudden unexpected death in infancy would be required. At the seminars, the possibility of having that kind of expertise available at a regional level was discussed. It was suggested a medical coroner would require some statistical and epidemiological knowledge. However, this would need to be at a basic level only. Every medical coroner would obviously have to possess an understanding of the legal and ethical issues surrounding death.

Comment

17.39 The contributors have identified the core requirements. It seems to me that the basic training of medical coroners should not present any great difficulty. In the longer term, a specific course leading to accreditation might be feasible and would, I think, promote the maintenance of high standards.

Would It Be Possible to Provide a Career Structure for Medical Coroners?

17.40 Under the current coronial system, there is no career structure beyond local level. Once a deputy coroner has been appointed to the post of coroner within a district, there is no further potential for promotion within the coronial system, save (for a part-timer) the possibility of moving to one of the few full-time positions.

17.41 There was broad support for the introduction of a regional and national structure within the coroner system. One of the advantages of such a structure is that it would provide a career structure for medical coroners, which would make the post more attractive to potential applicants. At the seminars, Dr Stephen Leadbeatter, Director of the Wales Institute of Forensic Medicine, suggested that doctors might occupy the post of medical coroner for a given period, as part of a wider career structure. The DoH also envisaged that some

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medical coroners might spend only a few years in the service before moving on elsewhere.

17.42 A further perceived advantage of a regional and national structure is the ability to provide support for medical coroners acting at local level, offering expertise and guidance where required. It was suggested by a number of respondents that, insofar as possible, medical coroners should work in teams to encourage professional inclusion. It was thought desirable that such teams should incorporate, where possible, a range of different skills and backgrounds of expertise. Specialist skills should also be available for use as and when required.

Comment

17.43 I am unsure whether there will be a real need for a career structure for medical coroners, other than by the progression from work at a district level to work at regional level. However, I do recognise that, if a doctor becomes a medical coroner, s/he should not be trapped in the post and unable to return to mainstream medicine if, for example s/he did not enjoy the work. There are two aspects to this. First, the financial arrangements must be such that the medical coroner could return to the NHS without loss of pension rights. Second, medical coroners must not be isolated to the extent that they lose touch with developments in clinical practice and with the ethos of the profession. However, they will have to be quite independent of colleagues at a local level.

The Investigation of Individual Deaths

Should There Be a List of Reportable Deaths?

17.44 Under the current system, a number of categories of death are reportable to the coroner. There is no definitive list of reportable deaths, although the circumstances in which a registrar must report a death and a coroner must hold an inquest are set out in the Registration of Births and Deaths Regulations 1987 and the Coroners Act 1988 respectively.

17.45 The Discussion Paper set out a list of circumstances in which it was suggested that a death should be reportable to the medical coroner. Respondents to the Discussion Paper put forward a large number of suggested amendments and additions to the list. Many of the suggested additions were very sensible. If incorporated, they would result in a list containing more than 30 individual categories of death. There were differences of opinion about the merit of including some of the circumstances suggested by the Inquiry. In particular, there was a good deal of disquiet among members of the medical profession at the suggestion that a death should be reportable where there was reason to suspect that the death was or might have been caused by medical error or lack of treatment.

17.46 The responses illustrated the difficulties of compiling a complete and comprehensible list of every circumstance that should give rise to a report to the coroner. It also illustrated the impracticability of requiring every doctor to remember and apply such a list. There was general agreement that any such list should be reviewed and updated regularly, so as to keep pace with changing circumstances. Changes in the list would inevitably cause

further difficulties for the medical profession. In addition, the production of a list of reportable deaths would merely serve to perpetuate the existing system whereby, in general, the decision whether or not to report a death to the coroner lies with the treating doctor.

17.47 At the seminars, two alternative solutions to the list of reportable deaths were considered. The first was that all deaths should be reported to the medical coroner, except those within a narrowly defined category (e.g. where the death was expected). This would represent a complete reversal of the current system, under which a death is not reportable unless it falls within certain categories. The second solution was that every death should be referred to the medical coroner.

One Possible Solution – Should All Deaths Be Reportable Except for the Expected Death?

17.48 The Inquiry suggested that a death might not be reported to the medical coroner if it was expected and had occurred as a result of a natural disease process. The cause of such deaths would continue to be certified by the treating doctor, although there would be additional safeguards. In particular, the deceased's family would see the documentation and have an opportunity to voice any concerns they might have.

17.49 If there were no requirement to examine expected deaths, the workload of the medical coroner would obviously be significantly less than if all deaths were reported. Dr Christopher Evans, representing the RCP, thought that over half of all deaths that occurred on the general wards in hospital (as opposed to in the accident and emergency department) were expected. Dr David Pickersgill, for the BMA, estimated that well over half of all deaths occurring outside hospital (including deaths in community hospitals, care homes, etc.) fell into that category. Dr Pickersgill did not, however, support the proposal that only unexpected deaths should be referred to the medical coroner. He contended that all deaths should be referred and argued that, if this were done, the expected deaths could be dealt with very quickly.

17.50 A suggested definition of an **'expected death'** was set out in the Discussion Paper. This was:

> **'... a death where there was, prior to death, an expectation among those around the deceased and his/her health care team that the death was imminent'.**

17.51 A number of respondents expressed the view that a death might be **'expected'**, even if not **'imminent'**, and argued that the use of the word **'imminent'** severely restricted the range of deaths that would fall within the definition. Others were happy with the requirement for imminence. The Tameside Family Support Group, for example, suggested that a time limit should be set within which a death could properly be regarded as **'imminent'**. A period of three months was proposed. Others suggested that there should be a requirement that the fact that a death was imminent should have been formally recorded in the medical records prior to the death occurring.

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17.52 The Royal College of Nursing (RCN) suggested that the definition contained in the Discussion Paper be qualified in the following way:

> **'... where a diagnosis of the illness leading to the death being expected has been confirmed and there has been no untoward incident in the period immediately prior to the death'.**

17.53 That form of words recognises the fact that, although a death may be 'expected' at the time it occurs, the condition that caused the death might have been precipitated by an event (e.g. an accident or adverse medical event) which makes an investigation into the death necessary. Dr Leadbeatter proposed the following definition, which encompasses both the element of 'expectedness' and the requirement that the death should be examined in the public interest:

> **'An 'expected death' is 'a death where there was, prior to death, an expectation among those about the deceased and his/her healthcare team that the death was imminent, and the underlying cause was known, and the cause was not violent or unnatural, and the person had not been 'deprived of liberty''.'**

17.54 The phrases 'natural death' and (to a lesser extent) 'violent death' cause considerable difficulty and are interpreted in different ways by different people. One example, which was the subject of discussion at the seminars, was the distinction to be drawn between the 'unnatural' death caused by lung cancer resulting from exposure to asbestos at work and the death (regarded under the existing system as 'natural') caused by lung cancer resulting from smoking cigarettes. It was agreed that the distinction is essentially one of social mores and is susceptible to change over time. Dr Ryk James, Senior Lecturer in Forensic Pathology at the University of Wales, suggested at the seminars that a 'natural' death was one that raised no issue of criminality, of civil liability or of public interest and was not attended by any complaint that might lead to any of those circumstances. There was, however, a general feeling that the concepts of the 'natural' and 'unnatural' death should be abandoned.

17.55 At the seminars, Dr Maureen Baker, representing the RCGP, suggested that, rather than having a positive requirement that death had been 'expected' before a death could be certified by a doctor, it might be easier to have a negative requirement that death was 'not unexpected'. This would cover, for example, a sudden death, apparently caused by a heart attack, in a patient with known ischaemic heart disease. This point had been raised by a number of respondents. During the course of discussion at the seminars, Dr Baker accepted that, in the example of the patient with ischaemic heart disease, the treating doctor would be able to offer only informed speculation as to the cause of death, particularly if the death was not witnessed by anyone and there was no report of the patient having exhibited the 'classic' signs of a heart attack. It is, after all, perfectly possible for a patient suffering from heart disease to die from some other, wholly unrelated, cause.

17.56 Both Dr Pickersgill and Dr Baker anticipated difficulties in determining whether or not a death had been 'expected' by the deceased's family. Family members may have been informed of the prognosis but may not have accepted it. Some may have been told but not

others. Mrs Viney was concerned that, if the fact that a death was 'expected' were to be a significant factor, this may have the effect of forcing discussions about topics that families might prefer to avoid.

17.57 Disquiet was expressed by some at the idea of treating expected deaths differently from other deaths. In a response sent to the Inquiry after the seminars, Cruse expressed concerns about the vulnerability of the terminally ill. The response pointed out that such people can be subject to inadequate care and treatment, even to criminal acts. Other respondents made similar points.

Comment

17.58 For several reasons, I have concluded that the idea of seeking to identify 'expected deaths' for separate treatment at certification is unworkable. First, it has proved almost impossible to define an 'expected death' in a simple but comprehensible way. Second, I share the concern expressed by Cruse and others that such a system would increase the vulnerability of the terminally ill to neglect or worse. I also reject as unacceptable (in the light of the Shipman experience) the suggestion that all deaths save the 'not unexpected' should be referred to the coroner.

An Alternative Solution – Should All Deaths Be Reportable?

17.59 It was argued by a number of respondents that any system that relies upon the reporting of deaths to the coroner is flawed and that the medical coroner system could be effective only if it scrutinised every death. This argument was advanced with particular force by Dr James. He said that the proposal to retain a system of reportable deaths:

> **'... retains one of the major weaknesses of the current system creating potential loopholes for the future Shipman; will undermine the provision of quality mortality data and will create unnecessary complexity'.**

17.60 In Dr James' experience, doctors frequently make wrong decisions about whether to report a death, owing to a lack of understanding of the reporting requirements and the relevant issues to be considered, or out of a desire to avoid further investigation. If the present system of relying on third parties (mainly doctors) to report deaths to the coroner were retained, a future Shipman might be able to exploit the system. He or she could decide not to report a death and thereby to exclude the medical coroner's involvement. Dr James felt that the system would not enjoy public confidence. He pointed to the poor quality of death certification at present. I have referred previously (see paragraph 5.44) to research that he has conducted on this topic. His view was that the medical coroner should certify the cause of death (or approve the cause of death, where a doctor has given a provisional cause) in every case. Dr James' view was shared by a large number of respondents to the Discussion Paper, in particular coroners and pathologists. The suggestion that every death should be reported to the medical coroner also received a considerable amount of support from participants at the seminars.

17.61 On the other hand, there was a general recognition that a requirement that all deaths should be reported to the coroner service would have very significant workload and

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resource implications. Doubts were expressed as to whether the service would be able to cope with the volume of work. The point was also made that, if all deaths were to be reported to the medical coroner, investigative resources might not be focussed on those cases where they were most needed. Concern was expressed about delays that might be caused by the coroner service becoming overloaded with work.

17.62 The issue of whether or not the service was able to cope with the reporting of all deaths would, of course, depend largely on the resources placed at its disposal. Plainly, the present infrastructure would not be equal to the task. Much would also depend on the extent to which the medical coroner and his/her staff undertook an investigation of the deaths reported to them and the way in which that investigation was organised.

17.63 Mr Thomas Hennell, senior analyst at Government Office for the North West, who participated in several of the seminars in his private capacity, said that the reporting of all deaths to the medical coroner would have a number of advantages. It would enable the medical coroner to co-ordinate all the post-death procedures. Such a system would also ensure that a public record of the death was made at the earliest possible time and that other agencies were informed promptly that the death had occurred. The medical coroner would also be a valuable source of advice to the relatives as to how they should proceed. Mr Hennell suggested that the medical coroner should not undertake a formal investigation in every case. He proposed that the doctor who certified the fact of death should send written notification of the death to the medical coroner (on the Inquiry's Form 1). The medical coroner would then discuss with the doctor whether or not the doctor was able to certify the cause of death. If it were concluded that the doctor was able to certify the cause of death and there was no reason for the death to be investigated, the doctor would be authorised to certify and the medical coroner would not conduct any investigation into the death. In those circumstances, copies of the Inquiry's Forms 1 and 2 (i.e. the forms used respectively to certify the fact and cause of death) would be delivered to the registrar and the medical coroner's office. With them would be the Inquiry's Form 3, which would contain a written account of events compiled by the deceased's family or carers. If any inconsistencies were noted, or if concern were expressed at the point of registration, the medical coroner could take matters further. Otherwise the death would be registered and disposal would follow.

Comment

17.64 I accept and agree with the concerns expressed by Dr James about the quality of decisions made by doctors when asked to recognise which deaths should be reported to the coroner. The alternative is that all deaths should be reported to the coroner. As Mr Hennell pointed out, there would be a number of consequential advantages. The resource implications would be considerable but, as Mr Hennell and Dr Pickersgill observed, not all deaths would require an in-depth investigation by the medical coroner. Much would depend upon how the deaths were handled in the coroner's office. Mr Hennell's suggestion (or something very like it) might be workable.

Is There a Need for a Second Doctor?

17.65 Under the Inquiry's working model, if a death were expected, the cause of death would be certified by the treating doctor alone. There would be no examination or enquiry by a

second doctor. The responses to the Inquiry's Discussion Paper revealed a strong feeling in many quarters that reliance on certification by one doctor was inadequate and did not afford sufficient protection, even within the limited category of expected deaths. Dr Grenville proposed an alternative model, by which a panel of doctors, practising in various fields of medicine, would be recruited to act as second certifiers on a part-time or sessional basis. Members of the panel would be specially trained and would need to demonstrate continuing competence in the field. They would have time to spend on the task of certification and would not have to fit it in between their other duties. Their work would be audited. The model would operate along broadly the same lines as the existing cremation certification procedure. The treating doctor would certify the cause of death, subject to confirmation by a member of the panel. The process of confirmation would include an examination of the medical records. The panel member would be wholly independent of the first doctor and would operate on a rota system, rather than, as now, being selected by the treating doctor to carry out the task. A limited number of medical coroners would be appointed and certain reportable categories of deaths would be referred to them. Medical coroners would also deal with deaths where the treating doctor and the second certifier were unable to agree about the cause of death. In other words, the system would remain the same as at present to the extent that the coroner would be dependent on others reporting deaths for investigation. However, death certification would be a two-tier process in every case.

17.66 The proposal for the creation of a panel of doctors approved to act as second certifiers was supported by the BMA and the DoH. Dr Pickersgill, representing the BMA, explained that he envisaged the panel operating under the auspices of the medical coroner. Every death would be reported to the medical coroner and members of the panel would carry out an investigation on his/her behalf. The view of the DoH was that there should never be certification of death by a single doctor. The DoH suggested that the second certifying doctor would speak to relatives, examine the forms completed as part of the certification process and, where considered necessary, would carry out a full examination of the body and consult the deceased's medical records. The Department would like to see the panel of second certifying doctors contracted to, and accredited by, the medical coroner. Dr Cook, on behalf of the Faculty of Public Health Medicine, supported the proposal in principle, but questioned the extent to which the panel would be perceived as independent of the local health service. Other participants emphasised the need for the second doctor to be of appropriate standing within the medical profession, so as to be able to question the judgement of the treating doctor, should that become necessary. As I have explained previously, Dr Grenville favoured retention of the existing system whereby certain categories of deaths only (rather than all deaths) are reported to the coroner. However, he observed that the two doctor system that he had described would work equally well if all deaths were reportable and the panel of doctors operated under the auspices of the medical coroner.

17.67 It will be appreciated that, if there were to be an examination and enquiry conducted by a second doctor in every case, this would go considerably further than Mr Hennell's suggestion of a discussion between the medical coroner and the treating doctor and would involve significantly greater medical resources. For the DoH, Mr Mann was

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optimistic that the human resource implications were acceptable. Dr Baker, of the RCGP, was less confident that the necessary manpower would be available.

17.68 Mr Hennell's suggestion was supported by Professor Baker. He was concerned at the retention of a category of deaths that could be certified by only one doctor. On the other hand, he was worried that the medical coroner might be 'swamped' if s/he had the task of investigating all deaths.

Comment

17.69 In my view, the proposal that a panel of doctors should provide a second tier of certification is far from ideal. First, the system would depend on the doctors' identification of reportable deaths and the need for a published list. However, I accept that a panel doctor could be trained to identify reportable deaths satisfactorily. Second, I consider that it would be difficult to ensure that the panel doctor was truly independent of the first doctor. The panel doctor would be a member of the same local professional community as the first doctor. In rural areas particularly, there could be no true independence. Third, if the second certification were to be carried out thoroughly and were to include consultation with the deceased's family, it would be very heavy on medical resources. The proposal bears an uncomfortable resemblance to cremation certification. I have little confidence in the assurances that the second certification would be thorough. As I recorded in Chapter Three, the BMA used to give repeated assurances that the Form C procedure was thorough and effective and I am quite sure it was neither.

17.70 The proposal that all deaths should be reported to the medical coroner, who would use a panel of doctors for certification, would be more acceptable but I fear that the medical resource implications would be immense if the panel doctor considered each death thoroughly. I think that some other way must be found of handling deaths within the coroner's office.

Additional Safeguards

17.71 Professor Baker observed that one advantage of the process proposed by Mr Hennell was that it would enable a medical coroner to undertake prospective checks on certain deaths. This was in contrast to the Inquiry's original suggestion that retrospective checks could be made on the documentation relating to certain deaths. Such retrospective checks would take place after disposal of the body so that, if suspicion were aroused, it would (at least where the body had been cremated) be too late to conduct an autopsy or other examination of the body. Professor Baker suggested that, if a medical coroner were concerned at the pattern of deaths occurring at a care home, or among the patients of a particular doctor, s/he could elect to investigate a death falling within that pattern at the time it was reported. Then, there would still be the opportunity for all necessary examinations to be carried out and matters would still be fresh in the minds of the available witnesses.

17.72 Professor Baker supported general, as well as specifically targeted, checks. He believed that it would be helpful to ensure that the general checks covered deaths occurring under

the care of all general practitioners and clinical teams in hospital, and those occurring in a variety of institutions such as hospitals and care homes. He estimated, for example, that it might be feasible for the service to audit at least one death among the patients of every general practitioner, every two to three years, and up to 10% of deaths occurring in each institution. If a concern was identified, a greater number of deaths would be examined and Professor Baker said that there would then be a useful part to be played by retrospective audit.

Comment

17.73 I agree with Professor Baker's views on the need for audit. I accept that, if all deaths are reported to the medical coroner, prospective checks on a proportion of deaths would provide a useful form of audit of whatever handling system were to be adopted. If, for example, the medical coroner were to undertake a full investigation only into those cases which would now be regarded as 'reportable' and the remaining straightforward cases were to be certified by the medical coroner's staff, some form of audit of those cases would be required. Targeted checks into certain categories of deaths (e.g. deaths occurring in a particular nursing home) would also be of value.

The Imposition of a Statutory Duty to Report to the Coroner

17.74 Under the current system, a registrar has a statutory duty, in certain defined circumstances, to report to the coroner a death which falls within the definition of a 'reportable' death. A statutory duty also falls upon those responsible for certain types of institution (e.g. prisons) in respect of the deaths of persons in their custody. In its Discussion Paper, the Inquiry sought views about drawing up a list of other categories of persons who would have a statutory duty to report a reportable death to the coroner. If a system were adopted whereby all deaths were referred to the coroner, a duty might still exist to report concerns about a death. It was suggested that it might be a criminal offence knowingly to fail to report a reportable death and, for professionals, a disciplinary offence negligently to fail to report.

Doctors and Nurses in Hospital

17.75 Representing the RCP, Dr Evans said that, in the context of a death in hospital, doctors should be under a statutory duty to report concerns if, for example, they had reason to suspect that the death might have been caused by inappropriate treatment. He thought the duty could reasonably be extended to a doctor who had not treated the patient personally, but who was told about inappropriate treatment by another doctor. He believed that the duty to report concerns should extend to nurses. The example was used of a nurse who had concerns about the care a patient had received prior to death and who was not reassured by the explanation given to him/her by the treating consultant. If the consultant refused to take the nurse's concerns further, Dr Evans believed that the nurse should have a statutory duty to report those concerns to the coroner.

Hospital Managers

17.76 Both Dr Evans and Professor Baker took the view that any statutory duty to report to the coroner should be extended to hospital managers. Dr Baker, representing the RCGP, made the point that the various professional codes of conduct for nurses, doctors and other health professionals state that their primary duty is to protect patients. That means that there is a professional duty to raise concerns about care. She also observed that there were imminent plans to implement a professional code of conduct for NHS managers, which would have the effect of bringing them into line with their professional colleagues. Mrs Viney, representing Cruse, thought it appropriate to impose a duty on the manager of a nursing or residential home in relation to the deaths of residents at their premises.

Unqualified Hospital Staff

17.77 Dr Evans said that, if the duty were to be extended to non-qualified staff within a hospital, it should be limited to reporting the event to a qualified member of staff. Professor Baker agreed that a statutory duty to report to the coroner should not be extended to non-qualified staff, except those in a management role. It was agreed that the most important step, both inside and outside hospital, was to create easy and recognised routes through which unqualified staff could channel any concerns that they might have.

Paramedics

17.78 Professor Keith Mackway-Jones, representing the Greater Manchester Ambulance Service NHS Trust, suggested that any duty to report should attach to the ambulance service, rather than to individual paramedics. The duty on an individual paramedic should extend only to reporting any concerns to a superior or to ambulance control.

Doctors and Staff in General Practice

17.79 Dr Pickersgill, representing the BMA, did not see any difficulty in a member of a general practice being placed under a statutory duty to report concerns, even though this might result in him/her having to report concerns about the treatment provided by another member of the practice. He did not think that it would be reasonable to impose a statutory duty on the administrative and secretarial staff. Instead, he suggested that efforts should be made to ensure that staff were aware of the routes via which they could raise concerns, such as to another partner in a group practice or to the primary care trust. Dr William Holmes, the Group Medical Director of Nestor Healthcare Group plc, a commercial organisation which provides out of hours cover for general practitioners, thought that it would be reasonable to impose a duty to report concerns about a death on deputising doctors. The requirement to do so could be incorporated into the protocols produced by his own company (and no doubt those of other organisations) for guidance when dealing with unexpected deaths.

Members of the Public

17.80 A small number of respondents, including Cruse, supported the extension of the duty to members of the public. At the seminars, Mrs Viney, representing Cruse, said that it would

be reasonable to impose such a duty. Indeed, she felt the creation of a duty might make it easier for family members to report concerns. It would prevent them from having to make what would otherwise be a difficult decision. However, a further response, received from Cruse after the seminars, indicated a change of mind. Having learned that the imposition of a statutory duty would involve the imposition of legal sanctions for non-compliance, Cruse now believes that the imposition of a duty on members of the public would not be appropriate. Instead, a culture should be developed in which it is perceived as a citizen's duty to report a death about which s/he has concerns. The majority of respondents agreed that members of the public should be encouraged to report deaths to the coroner, but felt that the creation of a statutory duty would be neither desirable nor readily enforceable. The DoH and others said that, if such a duty were to be created, a considerable amount of public education would be required to make the system effective.

Funeral Directors, Embalmers and Mortuary Technicians

17.81 The British Institute of Funeral Directors thought that funeral directors and embalmers should have an obligation to report deaths to the coroner. The National Association of Funeral Directors suggested that both funeral directors and mortuary technicians should have a specific right to report any concerns to the coroner. Both regularly see bodies stripped and are in an excellent position to observe any signs of violence or neglect. They also have close contact with families.

Police Officers

17.82 Commander Andre Baker, representing ACPO, saw no problem in imposing a duty on police officers but thought that a duty should not necessarily be imposed on all civilian staff.

Comment

17.83 In my view, it would be reasonable to impose on a qualified or responsible person a duty to report to the coroner a concern about a death that arose in the course of that person's professional duties. I include, in the categories of the qualified and responsible, doctors, nurses, hospital managers, nursing and care home managers and owners, paramedics, police officers, funeral directors, embalmers and mortuary technicians. I can see no objection in principle to the suggestion that the duty should be imposed by statute and should carry criminal sanctions. I think it would be in only a very rare case that the police would prosecute. In any event, in my view, each professional body should impose an ethical duty to report concerns about a death to the coroner.

17.84 I do not think it appropriate that unqualified staff should be under any such duty. For them, there should be the opportunity to express their concerns, without fear of any form of reprisal.

Certifying the Fact of Death and Ascertaining the Circumstances of Death: Form 1

17.85 There is currently no statutory requirement for certification of the fact of death and procedures for diagnosing or confirming death vary from area to area. The fact of death

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is often confirmed by a doctor. Increasingly, however, it is done by other professionals, including paramedics and nurses. In most areas of England and Wales, funeral directors will not move a body without death having been confirmed by a health professional. In some areas, however, funeral directors will take a body from the scene of death to their own premises without formal confirmation of the death having taken place. There is no statutory requirement for any record to be made of the fact that death has been confirmed or of the circumstances surrounding a death.

17.86 The Inquiry's Discussion Paper suggested that, in every case, there should be formal confirmation and certification of the fact of death. A form (Form 1) should be completed by the person who confirms the fact of death. Form 1 would require personal details of the deceased, together with details of the physical examination made in order to confirm the death and accounts of the circumstances of the death and of the medical condition of the deceased prior to death. A completed Form 1 would provide a snapshot of the information available very shortly after the death or the discovery of the death. There was unanimous agreement amongst the participants at the seminars that it was important to capture factual information about the circumstances of death at the earliest possible opportunity and to record it in a document such as Form 1.

Who Should Be Authorised to Certify the Fact of a Death Occurring in the Community?

17.87 Some respondents to the Inquiry's Discussion Paper had gained the mistaken impression that the Inquiry was suggesting that every death should be confirmed by a doctor and that other categories of health professional should be debarred from carrying out this function. Not surprisingly, this misunderstanding produced considerable concern about the potential burden that would be placed on doctors. In fact, the Inquiry was anxious to explore whether the categories of professionals trained to diagnose death might be extended, in order to relieve some of the pressure on doctors. Most respondents accepted that health professionals other than doctors should be authorised to confirm that death had occurred. However, in its written response to the Discussion Paper, Cruse argued that, in order for the system to have public confidence, every death should be confirmed by a doctor. At the seminars, Mrs Viney, Cruse's Chief Executive, recognised that such a requirement would present practical difficulties. In a further written response, submitted after the seminars, Cruse accepted that other qualified medical professionals, such as nurses and paramedics with relevant training, could properly be authorised to carry out the task of confirming death.

Doctors

17.88 Under the current system, if a patient dies in the community during surgery hours, the general practitioner or some other suitably qualified member of the practice team (such as a partner or the practice nurse) will usually attend and confirm the fact of death. If the person attending to confirm death is the deceased's usual doctor, s/he will certify the cause of death or, in an appropriate case, refer the death to the coroner.

17.89 Different procedures operate outside surgery hours. I have described these in Chapter Four. Given the increasing tendency of general practitioners to delegate out of hours care

to deputising services, general practitioner co-operatives and the like, it is likely that a doctor attending outside surgery hours will not be the deceased's own doctor and therefore will not be in a position to certify the cause (as opposed to the fact) of death. If the death occurs at a nursing or residential home and is expected, the BMA advises that there is little purpose to be served by the attendance of a doctor out of hours, unless there is some genuine concern as to whether the patient is dead. The obligation of the duty doctor or deputising service is merely to inform the deceased's general practitioner of the death early on the next working day. If a death occurs at the deceased's home, there may be distressed relatives who require the attention of a doctor. Mrs Viney observed that many people want the reassurance of having the death confirmed by a health professional. However, if the relatives are happy to arrange for funeral directors to remove the body without the attendance of a doctor, the BMA advises that there is no need for the duty doctor to attend.

17.90 Dr Holmes said that, in his experience, deputising doctors do generally attend to confirm the fact of death, despite the absence of a statutory requirement or professional obligation to do so. He stressed that this represents a considerable burden on the out of hours service. Dr Holmes estimated that attendance to confirm death accounted for approximately 4% of the home visits operated by his organisation and up to 10% of visits made after midnight. He said that there were already problems in recruiting suitable doctors to cover overnight shifts and that any additional workload would increase the burden on the out of hours service providers. He was concerned that the demands of gathering the information needed to complete the Inquiry's Form 1 would significantly increase the workload of the deputising services. Dr Pickersgill raised the same point and said that the resources of general practitioner co-operatives were already stretched. On an overnight shift, there might be one or two doctors covering the patients of up to 100 doctors.

17.91 The Inquiry had asked for views on whether a doctor should be permitted to certify the fact of death if s/he had a financial interest in the private hospital, clinic and/or care home in which the deceased resided at the time of his/her death. In their written responses to the Discussion Paper, the General Medical Council (GMC) and a number of other respondents suggested that a doctor should be permitted to certify the fact of death in those circumstances but that, as an additional safeguard, the death should then automatically be referred to the medical coroner. Others, including the DoH, took the view that no health professional with a financial interest should be able to certify the fact of death. Others expressed a similar view with regard to the certification of the cause of death. One respondent suggested that doctors should be required to declare such financial interests and that a register of interests should be maintained by the medical coroner.

17.92 The Royal College of Paediatrics and Child Health said in its written response to the Discussion Paper that, whilst other categories of person may be able to diagnose death in adults, only fully registered doctors should be permitted to certify the fact of death in children.

Nurses

17.93 The RCN told the Inquiry that it is current practice for registered nurses to confirm death in all NHS and independent sector settings, in accordance with locally established and

agreed protocols. It seems that different arrangements exist in different areas and hospitals. No problem arises with a suitably qualified nurse confirming the fact of death in a hospital setting. There was, however, some difference of opinion among respondents to the Discussion Paper as to whether a nurse employed in a nursing or other care home should be permitted to certify the fact that a resident in that home had died. Completion of Form 1 would involve the gathering and recording of information about the circumstances of the death and the deceased's medical history. If the death had occurred as a result of lack of care or some accident or ill-treatment in the home, there might be a temptation for a nurse employed there to seek to cover up the true facts surrounding the death, when completing Form 1.

17.94 Dr Pickersgill, representing the BMA, said that, in most areas of the country, agreements had been reached between doctors' practices and care homes as to who should confirm the fact of death. In the case of an expected death, this is done by a member of the nursing staff at the home concerned. Dr Holmes referred to the differences in the levels of experience of nursing staff (particularly agency staff) employed in care homes. Some were just not confident enough to confirm the fact of death. A number of participants at the seminars recognised the possibility of a conflict of interest for a nurse employed at the home. Professor Baker suggested that the solution to the potential conflict might be to permit nurses to certify the fact of death only in cases where the death was expected and the patient's general practitioner had indicated in advance that s/he was happy for a nurse to do so. He had experience of this being done in a nursing home or community hospital setting. Other respondents to the Discussion Paper also took the view that nurses should be permitted to certify the fact of death only where the death was truly 'expected'.

17.95 Not all respondents agreed that nurses should be authorised to confirm the fact of death. For example, the British Association in Forensic Medicine expressed the view that a nurse should not be able to certify the fact of death under any circumstances, without referral to a registered medical practitioner. The Nursing Midwifery Council (NMC) said that nurses should be able to confirm the fact of death, as they do under the current system, but that the decision whether or not to report the death to the medical coroner and the signing of a 'statement of professional opinion', as envisaged on the Inquiry's original Form 1, were outside the current remit of nursing practice. The NMC thought that it might be possible to extend the role of nurses with appropriate training and the use of agreed protocols, but that this would require careful consideration. In their written response to the Coroners Review, the Patients Association suggested that a solution might lie in limiting the function of certifying the fact of death to certain categories of nurse who could be provided with appropriate training.

Paramedics

17.96 In most parts of the country, paramedics are specifically trained to diagnose death, in accordance with protocols created by individual ambulance trusts. Those protocols are modelled on a protocol agreed by the Joint Royal Colleges Ambulance Liaison Committee. The circumstances in which paramedics are permitted to diagnose death vary from area to area. In general, they are restricted to cases in which an adult has

collapsed at least 15 minutes prior to the arrival of the paramedics, there has been no attempt at cardiopulmonary resuscitation and death has not occurred in a public place.

17.97 Professor Mackway-Jones said that paramedics undoubtedly had the requisite skills to certify the fact of death. However, in the case of an expected death, where there was no prospect of resuscitation, it was an inappropriate use of resources for a paramedic to attend. Professor Mackway-Jones was aware of instances of paramedics being called to deaths in the community because no doctor was prepared to attend. The family, or staff at a care home, had therefore turned to the ambulance service as the only agency available to confirm the fact of death. Professor Mackway-Jones accepted that, in a case where there was some prospect of resuscitation, attendance was clearly appropriate. However, the creation of a system that ensured that paramedics attended those cases, but not cases that simply involved confirming the fact of death, represented a real challenge to the ambulance service.

17.98 In cases where paramedics attend, but are not authorised to diagnose death (e.g. where the death occurs in a public place), they sometimes transport the body to the accident and emergency department of a local hospital so that a doctor can confirm the fact of death. Professor Mackway-Jones, who is the Medical Director of a busy accident and emergency department, said that this practice does not present a major problem at his hospital. He questioned whether paramedics should be permitted to certify the fact of death where that death had occurred after failed attempts by them at resuscitation. He pointed out that the situation gave rise to an obvious conflict of interests.

17.99 Professor Mackway-Jones said that, in principle, the ambulance service would be able to provide the sort of information required by Form 1, although he did have some specific observations about some of the questions contained on the version of the form which appeared in the Discussion Paper. Paramedics already complete their own forms after diagnosing death and Professor Mackway-Jones said that the completion of Form 1 would not increase the period of time that the paramedic spent at the scene of a death.

Police

17.100 There was support among some participants for police officers to be permitted to certify the fact of death in circumstances of obvious death, such as where the body has decomposed or decapitation has occurred. However, Commander Baker, representing ACPO, said at the seminars that he did not think that it was appropriate for police officers to certify death even in those circumstances, because of the other responsibilities they have at the scene. He was strongly opposed to officers certifying the fact of death in wider circumstances. He foresaw problems training officers to perform the diagnosis. He also recognised the potential for serious damage to public relations in the event that an officer mistakenly diagnosed death in a living person. Commander Baker also made the point that, although it is possible to certify the fact of death without any medical equipment, police officers would not have available to them the type of equipment available to a paramedic; therefore, the margin for error would be greater. Professor Mackway-Jones made the point that individual police officers would be called upon to exercise their skills in diagnosing death so infrequently that they would not develop the necessary confidence in performing the task.

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Coroner's Investigators

17.101 Mrs Aline Warner, on behalf of the Coroner's Officers Association, suggested that coroner's investigators (who, in the Inquiry's working model, would replace coroner's officers) should be authorised to certify the fact of death. This would reduce the number of people having to attend the scene of the death and would thus limit the potential for contamination. That would be an important factor if the death turned out to be suspicious and the scene had to be subjected to forensic examination. The ability of a coroner's investigator to certify the fact of death would be particularly convenient in certain circumstances. She cited the example of deaths caused by falling from cliffs in the area where she operates. At present, the coastguard recovers the body and brings it to the top of the cliff where the coroner's officer is in attendance. Under the present arrangements, it is then necessary to bring a paramedic, doctor or police officer to the scene to confirm the fact of death. Obviously, if a coroner's investigator were able to perform this task, that would be far more convenient.

Comment

17.102 In my view, nurses, paramedics and coroner's investigators should be authorised to certify the fact of death, provided they have undergone a suitable training course. Doctors should do so, of course; police officers should not. I do not think that a doctor or nurse should be prevented from certifying the fact of death and completing Form 1 on account of a financial interest in the institution in which the death occurs. Such a person may well be the only suitably qualified person on duty at the time of the death. There would be little point in calling another qualified person as, if the person with the financial interest wished to lie about the circumstances of the death, s/he could give false information to the person who was to complete Form 1.

Certifying the Fact of a Death Occurring in Hospital

17.103 When a death occurs in hospital, the problem of obtaining the services of a doctor or other health professional to confirm the fact of death does not arise as it does when a death occurs in the community. Death is confirmed by a doctor working in the hospital, or by a nurse authorised to perform this task. Discussion at the seminars therefore centred on the issue of who should complete Form 1 and whether the obligation to complete such a form would place unreasonable demands on hospital staff.

17.104 In his written response to the Discussion Paper, Dr James suggested that the most effective way of certifying the fact of death in hospitals would be to set up a designated team with responsibility for certifying the fact of death in every case. He suggested that this role could become part of the responsibilities of a nurse practitioner. Dr James saw several advantages arising out of the scheme. The fact that fewer people were certifying death more frequently would encourage consistency and high standards, and would allow for audit. It was anticipated that a professional relationship would develop between the team and the medical coroner's staff, which would also facilitate the process. Dr James proposed that, as part of the process of certifying the fact of death, members of the team should consider a number of specific points that, if present, might indicate that

the death should be referred to the medical coroner. For example, he suggested that the team should consider whether there were any issues that might implicate the hospital in the death and whether the death fell outside the usual pattern of deaths.

17.105 Dr James suggested that the same arrangement would also work in hospices and larger nursing homes. At the seminars, Dr Pickersgill observed that he did not believe it would be possible for the arrangement to operate in community and cottage hospitals. He thought that deaths in those institutions should be treated as deaths in the community, rather than as deaths in hospital. There are around 400 community and cottage hospitals in England and Wales. They account for about 10% (or 20,000) of NHS hospital beds.

17.106 Professor Mackway-Jones thought that special considerations applied to deaths that occurred in hospital accident and emergency departments. He suggested that responsibility for confirming the fact of death should remain with the clinical team who had treated the patient but that the process of completing Form 1 could thereafter be carried out by the team envisaged by Dr James or another member of staff. He gave the example of a cardiac arrest, where death is confirmed at the point that a decision is taken to stop attempts at resuscitation. It was important that certification of the fact of death was not delayed so that the body had to remain for a long period in the department, where there is frequently considerable pressure on space. Professor Mackway-Jones welcomed the suggestion that someone from outside the department should attend at a later stage to carry out any necessary investigations relating to the circumstances of the death.

17.107 Ms Pamela Dawson, who is currently the Bereavement Co-ordinator for the Borough of Bromley as well as a former Chair of the National Association of Bereavement Services, attended one of the seminars. She welcomed Dr James' proposal in theory but thought that, in certain hospitals, the scheme would be very difficult to implement. By way of example, she said that the Bromley Hospital is split over three sites in three separate boroughs. She said that each site would require a separate team available 24 hours a day. On average, the hospital has 40 to 45 deaths a week and there would be obvious advantages in releasing other hospital staff from the task of certifying the fact of death. However, the resource implications were considerable. Ms Dawson did not think that it would be possible for a member of the nursing staff to be available to certify the fact of death whilst at the same time working on a ward because, each time that person had to go and deal with a death, the ward would be left understaffed. For a one-site hospital, the practical difficulties would not be as great.

17.108 On behalf of the RCP, Dr Evans welcomed the proposal and the standardisation that it would bring to post-death procedures. He agreed that the fact that the service would have to be available 24 hours a day would give rise to issues of manpower. Dr Evans and Ms Dawson both thought that, as an alternative to a dedicated team, it might be possible to have a member of staff who had been trained in the certification of the fact of death on duty on each ward. That member of staff would be responsible for the filling out of Form 1 for any death that occurred on the ward. The ward would not then be left understaffed when a death occurred. Training could be directed at a smaller number of staff members and those members of staff would be involved in the process of certification of the fact of death on a sufficiently regular basis to avoid becoming de-skilled.

Comment

17.109 In my view, the idea of having a person or team available to certify the fact of death and complete Form 1 is attractive. However, I think it would be feasible only in a large hospital. I accept Professor Mackway-Jones' point about deaths in accident and emergency departments.

Establishing the Fact of Death

17.110 The Inquiry invited views on the essential constituents of the examination required to confirm the fact of death. As a basis for discussion, it was suggested that, in order to certify that death had occurred, the person completing Form 1 should have observed the absence of heart sounds, carotid and femoral pulses, breathing and response to painful stimulus, together with tracking in the fundi (i.e. changes in the appearance of the veins at the back of the eye that occur after the blood ceases to circulate).

17.111 Respondents to the Discussion Paper broadly agreed with the constituents put forward by the Inquiry, with the exception of tracking in the fundi. This was thought too specialist an observation to be made by paramedics. The findings of the Feasibility Study commissioned by the Inquiry into use of the newly designed forms confirmed that the inclusion of a requirement to look for tracking in the fundi would present problems, even to doctors. Some respondents suggested that there should be prescribed time periods over which some of the observations (e.g. absence of breathing) should be made before death was confirmed.

17.112 At the seminars, Dr Paul Aylin, Clinical Senior Lecturer in Epidemiology and Public Health at Imperial College School of Medicine, Science and Technology, suggested that, in certain cases (e.g. where there was a devastating and obviously fatal injury), it might be appropriate to establish death by means other than the observations already referred to. He suggested that space should be made available on Form 1 for the certifier to record any alternative means by which the fact of death had been established.

17.113 Surprise was expressed at the seminars that no generally agreed protocol, setting out the minimum observations which must be made before a diagnosis of death can be made, appears to exist at present. Instead, different organisations work to different protocols. It does not appear that medical practitioners work to any protocol, except in special circumstances, such as the diagnosis of brain stem death. It would obviously be desirable if an appropriate protocol could be developed for agreement and adoption by all those concerned with the diagnosis of death.

Permission to Remove the Body

17.114 Initially, the Inquiry envisaged that the person completing Form 1 would be able, once satisfied that the death was expected and there was no other reason for the medical coroner to investigate, to give permission for the deceased's body to be moved to the premises of a funeral director. During the consultation process, some concern was expressed about the prospect of paramedics and nurses taking responsibility for giving that permission. At the seminars, a different system was canvassed whereby, having

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completed Form 1, the person completing Form 1 would telephone the medical coroner's office and speak to the on-call investigator. Having heard the circumstances, the investigator would then give permission to move the body to the premises of a funeral director or would direct that it be moved to a mortuary.

17.115 Professor Baker and Dr Aylin supported the suggestion. Dr Baker, for the RCGP, and Dr Pickering, representing the BMA, were concerned about the practical difficulties that might arise. They foresaw problems with contacting the coroner's office, or the member of staff on call, particularly if a number of deaths were to occur during the same out of hours period. Dr Pickersgill spoke of the difficulties which can be encountered at present in reaching a coroner's officer, even during working hours.

Comment

17.116 I do not think the difficulties outlined by Dr Baker and Dr Pickersgill will arise, provided that the coroner's office is properly resourced. During the day, there should be sufficient officers to deal with all incoming calls. For deaths occurring out of hours, telephone calls to the on-duty investigator will have to be redirected to a second and possibly a third member of staff. Modern telephone technology can provide such a facility.

Responsibility for Coroners' Investigations

The Current Role of the Coroner's Officer

17.117 As I have explained in Chapter Eight, under the current system, the role performed by the coroner's officer varies from district to district. In some districts, coroner's officers are office-bound, answering the telephone and carrying out administrative duties. In others, coroner's officers (or coroner's liaison officers, as they are sometimes called) are based outside the office and spend much of their time visiting scenes of death, attending autopsies, taking witness statements and liaising with the police. In some districts, investigations are carried out on behalf of the coroner by serving police officers who have been specifically assigned to coroner's duties. Elsewhere, coroner's investigations are carried out by officers from the local police force, as part of their general policing duties.

17.118 Some coroner's officers are civilians, often former police officers, who may be employed by either the police force or the local authority. However, people from different employment backgrounds, such as former nurses, paramedics and social workers, have also been recruited in increasing numbers to fulfil the role of coroner's officer.

The Future Role of the Coroner's Investigator

17.119 The Inquiry's Discussion Paper suggested that, under the working model, the medical and judicial coroners would be supported by a team of trained civilian investigators. They would replace the existing coroner's officers and would be employed directly by the coroner service. Views were invited as to the qualifications, experience and type of training which would be appropriate for this new investigative post.

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Experience and Training

17.120 Many respondents supported the idea of multi-disciplinary teams of investigators. Suggestions as to the type of employment backgrounds from which investigators might be drawn included existing coroner's officers, nurses, police officers, funeral directors, staff from local authority cremation and cemeteries departments, hospital bereavement officers, social workers, legal executives, mortuary technicians and personnel from the armed services. Particular emphasis was placed on the benefit of investigators having some medical knowledge. For example, in its written response to the Discussion Paper, the Faculty of Public Health Medicine suggested that all investigators should be trained at least to the level of a basic nursing degree, with some also having clinical experience.

17.121 A number of respondents suggested that the training should be complementary to the skills already possessed by the individual concerned. For example, it was suggested that a civilian would require greater training in investigative skills and forensic awareness in gathering evidence from the scene than would a former police officer. On the other hand, a former police officer would require training in the medical aspects of investigation. Some core areas, such as the legal and ethical aspects of post-death procedures, would need to be taught to all recruits.

17.122 Many respondents emphasised the fact that the investigators must have training in dealing appropriately with the recently bereaved. However, Mrs Warner, of the Coroner's Officers Association, stressed the value of previous experience in related fields in furnishing candidates with the skills and empathy necessary for speaking to bereaved families. In its response to the Coroners Review Consultation Paper, the Association suggested that a trainee coroner's officer should have at least ten years' **'life experience'** in a profession such as medicine, law, social work, teaching or the emergency services and, in addition, should undergo an entry examination.

Various Aspects of the Role of the Coroner's Investigator

17.123 In its Discussion Paper, the Inquiry envisaged a system whereby at least one coroner's investigator in each district would be on call 24 hours a day, seven days a week. The coroner's office in which Mrs Warner works provides such a service. She was asked whether any problems had been encountered in attracting staff prepared to work antisocial hours. Mrs Warner replied that there had been an average of 90 applicants for each of the last three jobs that had been advertised.

17.124 Mrs Warner described how, under the current system, coroner's officers (certainly those within her own district) take time to talk to bereaved relatives and to explain the post-death procedures. She pointed out that, quite apart from the needs of the relatives, interaction with the deceased's family can form a valuable part of the investigative process. Conversations with relatives can sometimes lead to information being volunteered that would not otherwise be available. Mrs Warner therefore believed that contact with families should continue to be made by those responsible for investigating the death, rather than by another member of the coroner's staff. Mrs Warner also observed that it is helpful for families to deal with the same person within the coroner's office throughout the whole process. Mr Burgess agreed.

17.125 There was discussion at one of the seminars about bereavement support and who should provide it. It had been suggested by some that the coroner service might be responsible for providing the support that some families so badly need. Mrs Warner pointed out that, at present, coroner's officers sometimes find themselves 'straying into the realms of' counselling (or at least offering support to the bereaved), however much they try not to do so. Both she and Mr Burgess, on behalf of the Coroners' Society, expressed the view that the coroner's office should not provide in-house bereavement counselling and support services, but should instead act as a facilitator, providing information about the availability of such services elsewhere. For the DoH, Mrs Fry acknowledged that bereavement services are not universally available, nor are they as effective as the Department would wish. She indicated that the Department was looking to support development of the services at present provided. However, the view is that these services should be located within the NHS, rather than within the coroner service, with the latter advising those in need of the services how and where they can be accessed.

17.126 At the seminars, Mrs Warner explained that the Coroner's Officers Association envisaged two distinct and separate roles for coroner's officers in the future. One would be a forensic investigative role. It was suggested that officers fulfilling that role would attend the scene of a death, determine whether there was any reason for suspicion about the death and, if so, arrange for the police to become involved. The second role would, Mrs Warner suggested, be linked to the work of the medical coroner. Officers fulfilling that role would take calls from general practitioners, liaise with families and inspect medical records. Mrs Warner could see, however, the potential for a combination of the two roles, provided that the individual concerned was willing to become involved in both types of work. For the RCPath, Dr Peter Acland expressed concern at the prospect of division of the two roles in the way suggested by the Coroner's Officers Association. He considered the role of the coroner's officer to be investigative and believed that coroner's investigators should be out and about, conducting interviews and gathering information, rather than performing duties of a purely administrative nature.

Comment

17.127 In my view, a trained corps of coroner's investigators will be crucial to the operation of the coroner service in future. They should come from varied backgrounds, although there will be a particular need for some with nursing or paramedic experience. I think they should have an investigative role and should liaise with bereaved relatives. I agree that they should not have to carry out purely administrative functions, as many do at present.

The Interface between the Coroner Service and the Police and Other Investigative Agencies

17.128 Under the current system, the police investigate all deaths where there is a suspicion of criminal involvement. Other types of death are subject to investigation by various bodies, including the Health and Safety Executive. The permission of the coroner is required in order for an autopsy to be carried out and, once the coroner is seized of a case, only s/he has power to order release of the body for disposal.

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17.129 It was suggested in the Inquiry's Discussion Paper – and generally agreed by all – that the police must continue to be responsible for the investigation of deaths where there is any suspicion of criminal activity. The other responsible agencies too should retain their responsibility to investigate in certain types of case. However, in the case of the death with no suspicion of criminal involvement, trained investigators employed within the coroner service would carry out a far greater degree of investigative work than is at present undertaken by most civilian coroner's officers. In the future, as now, it would be necessary for the coroner service to co-operate with the other investigative agencies. The agency with which the coroner service would be working most frequently would inevitably be the police. The Discussion Paper therefore invited views about the interface between the investigative work carried out by the police (together with the other relevant agencies) and the coroner service, and about any potential conflicts that might arise.

The Role of the Coroner Service When There Is a Suspicion of Criminal Involvement

17.130 Commander Baker, representing ACPO, was asked about the contribution that a coroner under the current system is able to make to a police investigation. The Inquiry has heard that it is not unusual for coroners to attend murder scenes, to go to meetings of senior police officers who are investigating a case of homicide and (even when not medically qualified) to attend autopsies. It was not clear to me, when I heard this evidence, whether or not the involvement of the coroner was of any value in these cases. Commander Baker had no experience of coroners attending at the scene of a death. However, he did not see that a coroner could usefully contribute to the early part of a police investigation, save with procedural matters such as giving the necessary direction that an autopsy should be carried out. Dr Peter Acland, a forensic pathologist representing the RCPath, had experience of the presence of a coroner at the scene of a death actually hindering the police investigation. He said that the attendance of the coroner raised issues of contamination of evidence, that sometimes the investigation had to be delayed until the arrival of the coroner and, in certain cases in which he has been involved, the coroner has made decisions which complicated the investigation. He said that he had never known an investigation that had derived any benefit from the involvement of a coroner at an early stage.

17.131 Mr Burgess, representing the Coroners' Society, saw potential problems with a coroner being physically present at the scene of a death or at an autopsy. However, he supported the principle that a coroner, or at least someone separate from the police, should have the power to authorise examination and disposal of the body. He said that this provides a degree of independence and detached oversight. Mr Burgess agreed that, in some cases, the justification that has to be given by the police for examination of the body is a very straightforward matter. However, he said that, when asked by the police to direct an autopsy, he very often discusses with them who is the most appropriate pathologist and whether or not it is right to wait for that pathologist to become available in a case where, for example, the police are holding a suspect subject to custody time limits. Further issues can arise in relation to the disposal of the body. Mr Burgess said that the coroner plays an important role in cases where there is a conflict of interest between the police, who might

have an interest in retaining the body for as long as possible, and relatives, who usually want the body released quickly. He said that, in an appropriate case, it is possible for a coroner to apply pressure on the police by setting a limit as to when the body will be released for disposal. Mr Burgess agreed that decisions about directing autopsies and authorising disposal of a body could properly be performed by a medical coroner, provided those decisions were subject to challenge, possibly to the judicial coroner.

17.132 Commander Baker did not foresee any difficulties in the police liaising with the medical coroner in much the same way as the police liaise with the coroner under the current system. Mrs Warner, representing the Coroner's Officers Association, suggested that, since (under the current system at least) most deaths initially considered suspicious were likely to proceed to an inquest, liaison should not be with the medical coroner but with the judicial coroner who would ultimately be responsible for conducting the inquest.

No Suspicion of Criminal Involvement

17.133 The current policy as to the attendance of police at the scene of a death where there is no suspicion of criminal involvement varies from force to force. The police rarely attend the scene of a death occurring in hospital. In relation to deaths occurring in the community, the police are typically summoned by someone who has witnessed a sudden death or discovered a body. The police are often summoned by the ambulance service. There is often little that can be achieved by police attendance and it is widely thought that this represents an inappropriate use of police resources. Indeed, the police will often not attend the scene of a death if, in the period between the death being reported and the attendance of an officer at the scene, a doctor is identified who is able to certify the cause of death. Similarly, if an officer has actually reached the scene, in the absence of any obvious grounds for suspicion, s/he will leave once such a doctor has been identified.

17.134 Commander Baker said that, if the current practice of police officers routinely attending at deaths where there is no suggestion of criminal involvement were stopped, that could save police resources. In order for this to be achieved, the public would need to be educated to contact the coroner's office, rather than the police, in the event of a death. However, Commander Baker went on to say that, if a coroner's investigator attended at the scene and identified any suspicion of criminal involvement (e.g. evidence of suicide or death due to recreational drug taking), the scene must be 'frozen' and the police contacted immediately to take over the investigation. If, having attended, the police find no evidence of criminal involvement, the investigation could be handed back to the coroner's office unless and until there was any further suspicion of criminal involvement. Commander Baker thought that coroner's investigators could be trained to recognise when it was necessary to involve the police. Mrs Warner, for the Coroner's Officers Association, added that, to some extent, this happens already. In districts where coroner's officers attend scenes of death, they will assess whether or not the police should be involved.

17.135 Commander Baker agreed that the categories of cases that required police involvement could be set out in protocols. Those protocols could be refined and added to over time. Mrs Warner referred to a recent document, 'Report on the Provision of Coroners' Officers',

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published in August 2002, to which I have referred in Chapter Eight. The document sets out appropriate standard operating procedures (or service level agreements) to manage the interface between coroner's officers and the police. This type of exercise would be necessary in any new system. Provision should also be made for liaison with the Health and Safety Executive and other investigative agencies, to avoid duplication of investigation or potential conflict.

17.136 In its written response to the Discussion Paper, the RCGP had expressed concern about possible conflicts that might arise between the police and the medical coroner. However, having heard the discussion at the seminars, the College's representative, Dr Baker, felt that any potential conflict would be capable of resolution by agreement.

The Provision of Mutual Assistance between the Police and the Coroner's Investigator

17.137 In cases that did not require investigation by the police, Commander Baker said that it would be possible for the police to offer assistance to coroner's investigators in a number of different ways. For example, police officers could assist coroner's investigators by exercising any powers that the coroner might be given to enter and search premises. The police could also take steps to prevent anyone from obstructing the investigators in their work and could assist in securing premises and in tracing next of kin.

17.138 Likewise, in relation to cases that are investigated by the police, it was said that coroner's officers are currently in a better position (certainly once an inquest has been ordered) to obtain medical records (particularly hospital records) than are the police. In future, coroner's investigators could continue to obtain records on behalf of the police. Mrs Warner said that, under the current system, there were a number of other ways in which some coroner's officers were able to offer support to the police: for example, in providing information about the capacity and workload of mortuaries in the area and about local and national toxicology services. They also act as a liaison for, and attend at, autopsies, where they can brief the pathologist about the circumstances of the death. Although the police have direct access to forensic services, Commander Baker said that they sometimes requested toxicological testing through the coroner in order to obtain the results more quickly.

Investigations on Behalf of the Coroner

Investigations at the Scene of Death

17.139 Under its working model, the Inquiry suggested that, in most cases to be investigated by the medical coroner (except where the death was being investigated by another agency, such as the police or the Health and Safety Executive), the coroner's investigator would attend the scene of the death. The investigator would record his/her observations of the scene and gather all available evidence, including as much information as possible from those with knowledge of the circumstance of the death. The investigation would be carried out in accordance with a protocol. Possible constituents of such a protocol were set out in the Discussion Paper and comments invited.

17.140 There was widespread support for the idea of developing a protocol, governing the way in which any investigation at the scene of a death should be carried out. Respondents to the Discussion Paper made helpful suggestions as to the possible content of such a protocol. At the seminars, it was suggested that minimum standards could be established; these could then be reviewed and added to over time. Commander Baker stressed the importance, from a police perspective, of having pictorial evidence of the scene, in the form of either a still photograph or a video. That would be valuable in the event of a criminal investigation becoming necessary in the future. Professor Baker agreed that the taking of photographs would provide a valuable record of the scene and made the point that the taking and storing of photographs would be much simpler with the advent of digital photography.

17.141 There was discussion at the seminars about whether it would be practical and desirable for a coroner's investigator to take a sample of blood from the deceased at the scene. It was suggested that this might be done for the purpose of random toxicological testing in a case that was not to be subjected to a full coroner's investigation. This is done, for example, in Maryland, USA, where toxicological testing is an important feature of the death investigation system. Dr Acland, on behalf of the RCPath, thought that, with proper training and in appropriate circumstances, it would be possible for a sample to be taken without problem. Dr Leadbeatter and a number of other pathologists expressed a contrary view. They felt that there would be real practical difficulties (such as inadequate lighting, lack of proper facilities and difficulty in finding an appropriate vein) in a large number of cases. In reply, Dr Acland said that, although there can be technical difficulties, these could be overcome with training. He pointed to the fact that, in cases where no crime is suspected, samples are often taken by mortuary technicians, rather than pathologists. He did, however, accept that there might be aesthetic problems, such as the spilling of blood at the scene, and an associated risk of disease. He said that the category of case where a sample could be taken by a coroner's investigator at the scene of death would necessarily be limited. Mrs Warner's view was that, although some coroner's officers might object to taking blood samples, the majority would not and, with adequate training, she did not see why it could not be done.

17.142 At the seminars, Professor Helen Whitwell, Professor of Forensic Medicine and Head of Department at the University of Sheffield, said that a full examination of the death scene was one of a number of investigative tools that the medical coroner could use to ascertain the cause of death. Other such investigative tools might include a thorough external examination of the body, examination of the medical records and toxicological testing. When conducted, they could provide sufficient evidence to avoid the necessity for an autopsy in certain cases.

17.143 In its written response to the Discussion Paper, the Coroner's Officers Association suggested that a coroner's investigator should attend the scene of a death only if there was likely to be an inquest into the death. That means that a judgement must be made at a very early stage as to whether an inquest is going to be required. In practice, this judgement is usually made by the police, who will inform the coroner's office about any 'inquestable death'. At the seminars, Mrs Warner said that attendance only when an inquest was expected was the practice in her district and that, although there would be

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advantages in a coroner's investigator attending the scene of every death reported to the coroner service, the resource implications of attending at the scene of all those deaths would be enormous. If the resources could be made available, she said that attendance would have considerable benefits, especially for the deceased's family. The investigator would be able to inform the family about the post-death procedures and could give the information that the family needed at the time they needed it. The family would have seen a 'friendly face' to whom they could relate during their later dealings with the coroner's office. These advantages would be in addition to the opportunity afforded to the investigator of obtaining information to assist in the coroner's investigation.

17.144 Mr Burgess agreed that, ideally, every death scene should be visited but doubted that resources would allow for that. If they did not, a decision as to whether or not to attend would have to be made on a case by case basis, dependent upon the pressures placed on the coroner's office at any particular time. He estimated that, at present, his officers attend at the scene of approximately half the reported deaths that occur at home. Many of those deaths do not go to inquest.

Comment

17.145 In my view, there will be many deaths at which there is no need for the coroner's investigator to attend. I have in mind that an investigator will speak to someone at the scene in every case, usually by telephone, and will make a decision, on a case by case basis, as to whether or not there is any need to attend in person. This might arise if it appears advisable to inspect the scene of the death or if no one else is available to confirm the fact of death. Such a visit would, as Mrs Warner observed, provide an opportunity to make contact with a relative of the deceased.

Obtaining Information from Relatives and Others with Knowledge of the Circumstances of the Death

17.146 In the Inquiry's Discussion Paper, it was suggested that a near relative of the deceased, or another person who had been close to the deceased, should complete a form (Form 3), setting out information about the circumstances of the death and the deceased's state of health before death and confirming that s/he did not have any concerns about the death. This form would be submitted to the medical coroner, together with forms certifying the fact (Form 1) and cause (Form 2) of death. It was envisaged that the person completing Form 3 would have seen the completed Forms 1 and 2 and would confirm that their contents were true. The object was to involve relatives in the information-gathering process and to give them an opportunity to express any concerns that they might have about the death. In addition, completion of a form such as Form 3 would prevent the situation whereby the doctor certifying the cause of death could give false information to the authorities in the knowledge that it would never be checked with those who knew the truth. That was a situation that occurred time and time again with deaths certified by Shipman.

17.147 If a relative were to be required to complete a form, it was clear that someone would have to give him/her the form and provide any necessary assistance in completing it. The

question was who that 'someone' should be. It seemed to the Inquiry (and a number of respondents agreed) inappropriate that the certifying doctor should have any part in administering the form. Concern was expressed about the possibility that a doctor who was trying to conceal a negligent or criminal act might be able to influence relatives and convince them that their recollection of events was either incorrect or, in any event, compatible with a death due to natural causes.

17.148 It was suggested in the Discussion Paper that the funeral director might assist relatives in completing the form. However, respondents raised a number of potential problems with that arrangement. There was concern about the ability of the family member and funeral director to understand the medical information and terminology contained in the forms that had been completed by the doctor. In addition, it was suggested that funeral directors might put pressure on the family not to report concerns about a death, in order to avoid delay. It was also recognised that, in assisting the family in verifying the information provided by the doctor, funeral directors would be privy to the deceased's medical history, which would raise issues of confidentiality. There was concern that the funeral director would not be in a position to give informed advice. Doubts were also expressed about the willingness of families to commit any concerns that they might have to paper in an 'official' document. By the time of the seminars, the Inquiry had moved away from the idea of a form being presented to relatives by the funeral director and was canvassing other ideas for securing the involvement of the family.

17.149 At the seminars, it was suggested that a member of the medical coroner's investigative team should discuss the death with a family member, take him/her through Forms 1 and 2 and ask whether s/he had any concerns about the death. The idea received broad support, although there was doubt as to whether or not it would be practicable for every interview to take place in person. The possibility of a telephone interview was discussed. A number of participants felt strongly that the interview should be conducted in person, not least because several members of the family might wish to participate. Dr Pickersgill, on behalf of the BMA, supported the idea of a face to face interview in principle but pointed out the logistical difficulties in holding such an interview in every case, particularly in rural areas where there were large distances to cover. In response, Dr Aylin made the point that, under the current system, every death is registered in person, which requires the attendance of the informant at the register office. It was suggested that, in some cases, it would be appropriate for the interview to be held over the telephone. A question was raised about the amount of time the family would have to consider the information contained in the forms before giving their response. In practice, it seems likely that there would be greater flexibility in the timing if the contact with the coroner's office were to be by telephone or face to face interview than would be the case if the family were required to complete a form.

17.150 Another idea advanced at the seminars was that the interview with the family might be conducted by the second doctor if, as suggested by some, there were to be a system that involved certification by a second doctor in every case.

Comment

17.151 It seems clear to me that it will not be practicable or appropriate to ask relatives of the deceased to complete Form 3. Consultation with the family will have to be effected in some

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other way. Ideally this should take place face to face but I can see that that might give rise to practical problems. It seems to me that the most appropriate person to consult with a family member would be a coroner's investigator.

Certifying the Cause of Death

17.152 Under the Inquiry's working model, it was envisaged that a doctor involved in the deceased's care would in every case complete a form (Form 2), either certifying the cause of death or, if the doctor took the view that s/he was unable to certify the cause of death, referring the death to the medical coroner and including on the form as much information as possible to assist in ascertaining the cause of death. The closest equivalent to Form 2 under the present system is the MCCD, which states the cause(s) of death, but contains minimal information about the surrounding circumstances. Currently, doctors report deaths to the coroner by telephone and, frequently, the reporting doctor provides no written information for the coroner's use. When the death occurs in the community, it is rare for the coroner's staff to obtain or examine the medical records.

17.153 There was almost unanimous agreement among respondents with the Inquiry's suggestion that the same certification procedures should apply to all deaths, regardless of whether the death is to be followed by burial or cremation.

Qualification to Certify the Cause of Death

Recent Contact with the Deceased

17.154 The existing statutory framework requires the doctor who attended a deceased during his/her last illness to issue an MCCD. The doctor might decide, however, that s/he cannot properly certify the cause of death, either because of uncertainty as to the cause, or because there is some other circumstance that makes the death reportable. One such circumstance will arise where the doctor has not seen the deceased either within 14 days before the death or after death (the 'either/or rule'). In Chapter Two, I explained the origin of the 'either/or rule' and its unsatisfactory effect. In the Discussion Paper, the Inquiry raised the question of whether, in any new system, there should be a requirement that a doctor must have seen the patient within a specified time before death in order to be able to certify the death.

17.155 There was a divergence of views on this issue. A number of respondents favoured a requirement that the certifying doctor should have seen the deceased after death and within 14 days before death. The BMA, however, was opposed to retaining any such restrictions. In its written response, the Association argued that: **'There are no logical grounds for requiring the certifying doctor (or a partner) to have had a consultation with the deceased within a specified period prior to the death'**. It stressed that knowledge of the patient and access to the medical records were the most important criteria. At the seminars, Dr Pickersgill, representing the BMA, said that, under the present system, if a patient of one member of a group practice dies while that member is away on holiday, a colleague at the practice will examine the medical notes to see if s/he is able to certify the cause of death. He said that, provided there is a well-documented history of

disease, which tallies with eye witness accounts of the death, the colleague will be able to give a cause of death. He or she will then contact the coroner's officer who, 'almost without exception', will give the colleague permission to certify. He pointed out that, even when a patient is terminally ill, a doctor who has been away on holiday might not have seen him/her within the fortnight before death and might therefore have to consult the coroner's officer before certifying.

17.156 Professor Baker disagreed with the stance taken by the BMA on the lack of need for there to have been a consultation within a specified period. He said that, if the only deaths to be certified were those which were truly 'expected', there should be a requirement for the certifying doctor to have had a consultation with the deceased within the 14 days before death. It should also be a requirement that the consultation was in connection with the condition that caused death. Where a death was believed to be imminent, he would expect the patient to be under fairly close medical supervision and to be visited regularly. He said that, if the condition said to have caused death had not formed part of the subject matter of the most recent consultation, that would suggest that the death had not been imminent at the time of the consultation. Professor Baker went on to observe that, if a death were expected and the usual doctor was going on holiday, he would expect responsibility for care of the patient to have been formally handed over to another member of the practice during the doctor's absence.

17.157 Dr Grenville supported the stance taken by the BMA. He pointed out that there is now a team approach to primary care, particularly in larger practices, so that the care of patients with chronic illness is a team responsibility. He gave the example of a patient with terminal cancer who might receive daily care from district and Macmillan nurses but less frequent visits from a general practitioner, particularly if the general practitioner the patient saw most regularly was away on holiday. Dr Grenville said that, in future, he would like to see the procedures simplified, so that a member of the team could certify the cause of death, based on the team's knowledge of the patient and the records kept by members of the team. He pointed out that it is not always the doctor (as opposed to other members of the team) who knows most about the patient. He would not welcome any change that made the certification process more difficult.

17.158 Dr Grenville expressed the view that the imposition of an arbitrary period within which the certifying doctor must have seen the patient may not be the right way to proceed. If a period were to be specified, it should be longer than 14 days. On behalf of the Faculty of Public Health Medicine, Dr Cook suggested that a limit of as much as six months would be appropriate for a patient known to be suffering from a chronic illness.

17.159 Dr James was opposed to the imposition of a specified period within which the certifying doctor must have seen the patient. He suggested that the focus should instead be on the underlying disease process, He favoured a system whereby a doctor was not excluded from completing Form 2 on the basis of the time which had elapsed since s/he last saw the deceased. Instead, the doctor should record on the form all the information relevant to the death (including the cause of death if s/he were able to give it) and the form should then be passed to someone independent who would speak to the family, review the contents of the form and make a final judgement as to whether there was sufficient

evidence to certify the cause of death. Dr Grenville supported this view. He observed that the independent person could be either a medical coroner or a member of a panel of second doctors, working on a sessional basis, as previously described. He observed that the imposition of an arbitrary time limit could preclude a doctor from giving a worthwhile opinion about cause of death. Such an opinion might, for example, be based on eye witness accounts of the death or contemporary diagnostic investigations. In its written response to the Discussion Paper, the GMC said that **'inflexible requirements'** about the circumstances in which doctors may or may not certify the cause of death would not be helpful. The Council's view was that what was important was that the doctor's knowledge of and involvement in the care of the patient was clearly detailed on the form that s/he was required to complete.

17.160 In its written response to the Discussion Paper, the RCP said that there should be different time limits for deaths in hospital and deaths in the community. It was suggested that, in hospital, the certifying doctor should have had a consultation with the patient within 48 hours before death. At the seminars, Dr Evans, representing the RCP, suggested that an appropriate period would be three, not two, days. He also said that the team approach described by Dr Grenville should apply in hospital because the doctor with whom the deceased had had the relevant consultation might not always be available to certify the cause of death.

Comment

17.161 I accept the views of those who suggest that there should not be an arbitrary time limit as a qualification for completing the proposed Form 2. What is important is not when the doctor last saw the patient but the quality of the doctor's knowledge about the patient. As the new system will not permit certification of the cause of death by a single doctor, there will be some check on the quality of the doctor's knowledge, either by a second doctor or by the medical coroner or a member of his/her staff. When the doctor last saw the patient will be only one aspect of that knowledge.

Period of Registration

17.162 The Inquiry's Discussion Paper invited views on the medical qualifications and experience that a doctor should have in order to qualify him/her to certify the cause of death. In particular, consultees were asked to consider whether the certifying doctor should have to be fully registered. Under the current system, all registered doctors – including first year hospital trainees with provisional registration – can complete an MCCD. The Inquiry has heard evidence of problems associated with junior doctors in hospitals certifying the cause of death, particularly just after the new intake of junior doctors take up their posts twice a year. Dr Evans said that, in hospital, the certification of the cause of death is, for the most part, left to junior doctors who are frequently left to carry out the task without any discussion with, or advice from, their seniors. Dr James agreed and expressed the view that the reason for this was that more senior doctors were not sufficiently interested to do it themselves. He said that what was required for good quality death certification was interest, familiarity with the task, training and accreditation. Attempting to create a system

whereby every doctor was fully capable of certifying the cause of death would, he suggested, involve a considerable amount of training and supervision, if indeed it were possible.

17.163 It was the view of the RCP, and the majority of consultees, that only doctors who have completed a year of post-qualification training, and have thus achieved the status of being fully registered, should be able to certify the cause of death. Dr Pickersgill, on behalf of the BMA, together with a number of other respondents, suggested a period of five years' post-registration experience, although Dr Pickersgill said it was not something about which the BMA felt strongly. The Tameside Families Support Group suggested that the appropriate period of experience should be seven years.

17.164 Professor Baker took the view that the certifying doctor should be fully registered but stressed that training in certification was more important than length of experience or qualification. There would be little benefit in delaying the time when a doctor was permitted to certify unless there was suitable training. On behalf of the ONS, Dr Cleone Rooney agreed that there was a need for training and assessment of competence in completion of death certification documentation if it were to be done properly. She said that consultants in a hospital should be responsible for supervising their junior staff. Research, to which I referred in Chapter Five, had shown that consultants were, if anything, rather less proficient in death certification than their junior colleagues. If they were required to exercise supervision over more junior doctors, Dr Rooney suggested that they might improve their own skills.

Comment

17.165 In my view, the completion of Form 2 is an important responsibility that should not be left to very junior doctors. The proposed Form 2 will require the doctor to provide a summary of the medical history and the chain of events leading to death. In my view, any general practitioner principal should be qualified to complete Form 2. Such doctors are usually at least four years post-qualification. A similar seniority would be appropriate for hospital doctors. This would result in the form being completed by a doctor with some seniority in the clinical team.

What Standard of Confidence Should Be Required to Certify the Cause of Death?

17.166 Under existing procedures, a doctor completing an MCCD certifies that the particulars set out on the certificate, and the cause of death, are correct to the best of his/her knowledge and belief. In its Discussion Paper, the Inquiry proposed that a doctor certifying the cause of death on Form 2 should state:

> **'I am satisfied that I am able to justify the diagnosis of the cause of death ... on the basis of the deceased's medical history and the circumstances of death.'**

17.167 There was general support for this form of words, both in the written responses to the Discussion Paper and at the seminars. It was suggested by the DoH, the RCP and a few others that the appropriate standard of confidence should be the balance of probabilities.

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Whilst approving the Inquiry's suggested wording, Professor Baker drew a distinction between the decision as to whether or not the death should be referred to the coroner for investigation (about which, he suggested, the certifying doctor should be 'absolutely certain') and the decision as to which clinical condition was the direct cause of death.

Comment

17.168 I am pleased that the form of words proposed in the Discussion Paper received so much support, as I regard it as appropriate.

Old Age

17.169 Under the current system, it is open to a doctor to certify the cause of death just as 'old age'. The guidance provided to doctors completing an MCCD states that 'old age' should not be used as the only cause of death, unless a more specific cause of death cannot be given and the deceased was aged 70 or over. On behalf of the ONS, Dr Rooney said that, at the time of its introduction as an acceptable cause of death in 1985, it was intended that 'old age' should be used in the case of a frail, elderly person who gradually declined, was at home, being seen by his/her general practitioner, had no particular disease but just came to the end of his/her lifespan. However, following its introduction, the use of 'old age' increased and extended to deaths occurring in circumstances other than those for which it was intended. It began to be used where the death occurred in hospital, as well as in the community. Dr Rooney suggested that this was odd, since it was unlikely that a patient would get a bed in an NHS hospital if s/he had no identifiable disease. However, she reported that, in the recent past, the use of 'old age' as a cause of death had declined. Dr Rooney agreed with the suggestion that, if a system whereby doctors certified the cause of death were retained, it should not be open to a doctor to give 'old age' as the cause of death. Instead, where there was no specific diagnosis, the patient was sufficiently old and further medical investigations were deemed inappropriate, it should be open to a medical coroner to certify the cause of death as 'old age'. However, she added that there should be a positive element to the diagnosis, i.e. there should have been a very slow general decline preceding death. There was a significant amount of support for this view. In a written response to the Discussion Paper, the Death Certification Advisory Group of the ONS suggested that, rather than defining 'old age' by reference to arbitrary age limits, it might be better to define explicitly the circumstances in which it would be appropriate to use 'old age' as a cause of death.

17.170 Professor Baker said that, in his view, 'old age' was acceptable where it was put forward as a positive diagnosis. However, if it was merely put forward in the absence of any other diagnosis, because the deceased was elderly and to avoid the need for any further investigations, he did not regard that as appropriate. He pointed out that, in the case of many elderly people, there are other conditions present that might at least be part of the picture. He did not think that a 'guess' at 'old age' was acceptable.

17.171 The view was expressed by some participants that 'old age' should continue to be an acceptable cause of death as at present, but that the minimum age limit should be significantly increased, for example to 85 or 90.

17.172 The suggestion that certification of the cause of death as 'old age' might be an automatic trigger for referral of a death to the medical coroner was supported by the BMA and the RCP, among others. However, the RCGP was concerned that, if 'old age' were not available to doctors as a cause of death, the number of autopsies might be increased. Concerns were also expressed that, in order to spare families the ordeal of an autopsy, doctors might cite other conditions as the cause of death. Those conditions might be no more specific than 'old age' (e.g. the use of 'bronchopneumonia' in a case where there is no convincing history or supporting histology) and might have the effect of rendering mortality statistics less accurate.

17.173 Some participants thought that, even with the additional safeguard of a referral to the medical coroner, the continued use of 'old age' would be unacceptable. This was the view expressed by the DoH in its written response to the Discussion Paper. However, at the seminars, Mr John Mann said that the Department recognised that, in the very elderly, it may be difficult to identify a cause of death other than 'old age', so that some flexibility might be required. Patient Concern, Age Concern and the Tameside Families Support Group were among the respondents who expressed the view that 'old age' should not be acceptable as a cause of death.

Comment

17.174 In my view, 'old age' should be an acceptable cause of death but only when it amounts to a positive diagnosis, as suggested by Professor Baker. If it were not acceptable, there might be an unwarranted increase in autopsies. I agree that 70 seems too low an age limit nowadays; 80 would be more suitable. I am attracted to the suggestion that only the medical coroner should be able to certify a death as due to 'old age'.

External Examination of the Deceased's Body

The Current Position

17.175 Under the existing system, there is no requirement for the doctor who issues the MCCD to see the deceased after death. Death may or may not have been confirmed by a doctor, paramedic or nurse. If it has, any examination conducted is likely to have been directed at ascertaining whether there are any signs of life, rather than checking for any marks suggestive of violence or neglect. When the deceased is buried, no second certificate is required, so that it is perfectly possible for the burial to take place without any examination of the body at all having taken place after death. If the deceased is cremated, the Forms B and C doctors should have seen and examined the body but the evidence given to the Inquiry suggests that such examinations are frequently very cursory, involving sight of the deceased's face and identity tag only. The likelihood is that the body will be buried or cremated, without any formal check having been made for marks of violence or neglect.

17.176 The Inquiry's Discussion Paper sought views about the value and practicability of an external examination of the body by the person completing Form 1 or by the Form 2 doctor. The object of such an examination would be to look for any marks suggestive of violence or neglect. The Inquiry also suggested that funeral directors might be required to complete a

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form (Form 4), stating that they had carried out a visual examination of the deceased's body, recording any marks or injuries observed and stating whether they had any reason for suspicion about the death. Funeral directors are, of course, in a good position to observe any suspicious marks, since it is usual for them to see the naked body in the course of preparing the deceased for burial or cremation.

Examination at the Time When the Fact of Death Is Certified

17.177 It was suggested in the Inquiry's Discussion Paper that the person certifying the fact of death should examine the body and record on Form 1 any injection marks, sutured wounds, bruising, abrasions, petechiae, lacerations or other injuries. It was not contemplated that, when a death occurred in the community (especially at the deceased's home with family members present), it would be appropriate for the body to be stripped and subjected to a full examination. However, the Inquiry envisaged that a more limited examination might be carried out. In hospital, there would be no practical problems, as mortuary facilities would be readily available.

17.178 Many respondents expressed concern at the suggestion that there should be a full examination of the body at the time when the fact of death was confirmed. At the seminars Dr Maureen Baker, representing the RCGP, referred to practical difficulties, such as inadequate lighting and the possibility of infection, which might be encountered when carrying out an examination at a deceased's home. She emphasised the distress that might be caused to relatives by the conduct of a full examination and observed that some ethnic minority groups may require examination by a person of the same gender as the deceased. She said that the RCGP would support a limited examination at the scene of the death, with the proviso that the College's view was that a 'more comprehensive' examination of the body should take place at a later stage. In its written response to the Discussion Paper, the RCGP had said that there should be an examination of the whole body to exclude signs of violence, unless the certifier was present at death or death was due to a long-standing illness and the certifier did not suspect foul play. As to the extent of the 'limited examination', Dr Baker suggested that it should be confined to the head and neck. Such an examination would not be intrusive and, indeed, might be conducted without relatives being aware that the doctor was looking for possible signs of violence or neglect. For the RCP, Dr Evans pointed out that, in the context of the Shipman case, the examination should extend to the forearms, so that any signs of a recent injection could be noted. However, he expressed reservations about the requirement to record the suggested marks, particularly in respect of a patient dying in hospital. He pointed out that bruising of the arms is common among the elderly and those taking certain medication, while most patients dying in hospital will have skin puncture marks resulting from recent injections or the taking of blood samples. The BMA was also concerned about the practical difficulties of a full external examination and about the possible medico-legal implications for a doctor who failed to notice signs of violence and neglect that were subsequently discovered to be present.

17.179 Commander Baker suggested that, in practice, it might be possible to carry out an examination at the scene in a larger number of cases than was expected, so long as an explanation was given to relatives. He was concerned, however, that, if the death were to

be followed by a criminal trial, a response on Form 1 to the effect that there were no suspicious signs (when, in fact, there had been no opportunity to carry out a proper examination) might undermine any medical evidence subsequently obtained. He suggested that the extent of any examination carried out should be recorded on Form 1 and, if it had not been possible to carry out an examination, the form should reflect this.

Comment

17.180 In my view, for deaths in the community, there should be a limited examination when the fact of death is certified. For hospital deaths, the whole body should be examined at this stage.

Examination at the Point of Certifying the Cause of Death

17.181 The Discussion Paper invited views on the practical value of requiring the doctor completing Form 2 to undertake a physical examination of the body. A wide range of views was expressed on this issue. Some respondents believed that, in every case, the doctor completing Form 2 should perform a full external examination. Others thought that this would not be necessary so long as the person completing Form 1 had performed a full examination. One group of consultees felt that, in any event, an external examination was of little practical value and would lead to unnecessary delay.

17.182 At the seminars, Dr Evans, on behalf of the RCP, expressed the view that, if the doctor completing Form 2 had not also completed Form 1, s/he should be required to examine the body. He said that the doctor should be looking for signs of criminal involvement or a lack of care, such as bedsores. He said that, when he was asked to complete a cremation Form C, he would view both sides of the deceased's naked body and look for 'pressure sores and the like'. He would expect the examination carried out by the Form 2 doctor to be similar in nature. Dr Evans agreed that such an examination would be easier in a hospital than at the premises of funeral directors (where the facilities are not always ideal), but he thought that an examination of this kind should be possible, even so. He recognised that a requirement for an examination in every case would impose a greater burden on doctors because, at present, there is an examination only where the body is to be cremated. Nevertheless, he remained of the view that it was necessary for an examination to be undertaken in every case.

17.183 For the BMA, Dr Pickersgill thought that it would be possible, but in certain cases extremely difficult, to perform such an examination in the community. He said that bodies are often dressed and in a coffin by the time the doctor attends to examine before completing a cremation form. A doctor attending the premises of a small firm of funeral directors might have no assistance in moving or undressing the body and would not be able to carry out a full examination. He thought that the problem would not necessarily be solved by imposing a rule that the body should remain undressed until the time of the examination, because this would put great pressure on doctors to attend promptly. He referred to the difficulty of 'balancing the needs of the living population against the needs of dealing with the bureaucracy in relation to the dead' and suggested that a requirement for a full examination by the Form 2 doctor would lead to considerable delay, particularly

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in rural areas where the body might be lying some distance from the doctor's surgery. Dr Pickersgill said that he was not convinced that a full examination of the body was necessary in every case. He said that an examination of the head, neck and arms would be likely to detect most problems. If there were a major feature (e.g. a pressure sore) on another part of the body, he would expect it to be drawn to his attention by the funeral director. He suggested that the doctor could assess the need for a fuller examination in each individual case, on the basis of the medical history and the account of the relatives.

17.184 Dr Grenville observed that a physical examination was rarely helpful in the diagnosis of (a natural) cause of death. He felt that it was important for the body to be examined by someone for signs of violence or lack of care. However, he did not believe that the examination need be carried out by a doctor. It could, for example, be undertaken by a funeral director or coroner's investigator. He said that the facilities and conditions at a funeral parlour might not be conducive to a doctor performing a thorough examination of a body. At the seminars, he gave a graphic account of the conditions that had prevailed at the premises of a busy funeral director when he had attended there on the previous day. The equipment ordinarily used to take bodies down from four-tier racks was not available and Dr Grenville had to examine a fully clothed body at shoulder height. Dr Baker agreed with Dr Grenville and said that requiring the examination to be carried out by a doctor would represent an inappropriate use of scarce medical resources. She thought that funeral directors could be trained to undertake the examination.

17.185 Professor Baker referred to the examinations currently undertaken by doctors completing cremation forms. His impression, like mine, is that such examinations are, in general, cursory in nature. They have not been accorded a high priority and doctors have not been properly trained in what to look for. As a result, the examinations have not been carried out well. Nevertheless, Professor Baker felt that, if properly carried out, such examinations might be of benefit. The main benefit that he envisaged was the opportunity to see whether there were any reasons (e.g. signs of possible neglect such as pressure sores or weight loss) that made it necessary to question the cause of death. He agreed that such an examination might be carried out by someone other than a doctor, provided that the person conducting it had the necessary skills.

17.186 Dr James was not in favour of a full examination in every case. He felt that it would be intrusive and unnecessary to conduct a full examination in a case where the death was expected and the condition causing the death well documented. In those cases where an examination would be of benefit, he said that it should take place in controlled conditions, with proper lighting and other facilities. The medical coroner should identify those cases in which an examination is to be carried out; they might include cases where the circumstances of the death are not completely known, where the death was unwitnessed or where the deceased has been entirely dependent on others for his/her care. The most appropriate person to carry out the examination, Dr James said, would be a pathologist, although, if a requirement for an investigation by a second doctor were introduced, the second doctor could be trained to carry out the task. However, Dr James emphasised that proper facilities would be required, together with a system of enforcement of a proper standard of examination. If no such system were in place, the current poor standard of many examinations for the purposes of cremation forms would persist. Dr James felt that

there might be public disquiet at the prospect of a coroner's investigator performing such an intimate examination. Dr Pickersgill thought that the type of examination described by Dr James would be outside the competence of general practitioners and would require specific training for those undertaking it. He suggested that the necessary training could be undertaken by a group of people other than doctors.

Comment

17.187 I do not consider that examination of the body by the doctor who is to complete Form 2 is either necessary or appropriate. Such an examination will not assist in identifying the cause of death. For community deaths, the requirement would place a substantial burden on the doctor, as the body may be some distance from the doctor's surgery. In hospital deaths, a full examination will have already taken place.

Examination by the Funeral Director or Mortuary Technician

17.188 The suggestion that funeral directors might be required to carry out a visual inspection of bodies passing through their premises, and to complete a form recording their findings, met with a mixed response from the different groups representing members of the profession. In written responses, the National Society of Allied and Independent Funeral Directors opposed the suggestion that an obligation might be placed on funeral directors to complete such a form, on the basis that they were not qualified to do so. However, the National Association of Funeral Directors did not envisage any problems in principle with completing a form such as Form 4, although the Association's response suggested that, if a statutory duty were imposed on funeral directors and hospital mortuary technicians to report to the coroner anything unusual or untoward, there would be no need for the form. The British Institute of Funeral Directors also gave broad support to the proposal. The Institute's response suggested that funeral directors could provide a further independent check in the system. It was also suggested that, in order to perform the examination, funeral directors would require specific training, which could be provided through the Institute.

17.189 A number of participants at the seminars supported the idea that an examination for signs of violence and neglect could be carried out by someone other than a doctor; some, including Dr Grenville and Dr Pickersgill, thought that funeral directors would be ideally placed to undertake the examination. Dr Evans expressed the view that such an obligation could also be placed on mortuary technicians and that a protocol or checklist could be devised to assist in the performance of the examination.

Comment

17.190 In my view, funeral directors and mortuary technicians are well placed to observe any sign of violence or neglect. I consider that if they are placed under a duty to report any physical signs giving cause for concern, there will be no need for a form to be completed.

The Interface between the Medical Coroner and the Judicial Coroner

17.191 Under the Inquiry's working model, it was envisaged that the coroner service would be a unified service. All deaths referred to the coroner system would go first to the medical

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coroner, who would institute an investigation into the circumstances and cause of death. If the police or another agency were investigating the death, the medical coroner would be responsible for conducting, or assisting in the conduct of, any necessary medical investigations. The medical coroner would then review the evidence and certify the cause of death if able to do so. Alternatively, the medical coroner would order a medical examination, such as an autopsy, after which s/he would again review the evidence to see whether the cause of death could be certified. It was envisaged that the medical coroner would refer a death to the judicial coroner only in a case where the factual issues surrounding the death were uncertain, or in dispute, or might otherwise require resolution by way of a judicial hearing.

17.192 There was wide agreement among participants at the seminars that, whatever the internal arrangements within the coroner service, there should be a single service encompassing legal and medical expertise. The public should have a single point of entry to a unified coroner service.

17.193 There was less agreement about the more difficult question of internal division of responsibility for investigation and decision making between the two coroners. At the seminars, the discussion about the interface between the medical coroner and the judicial coroner, and their respective spheres of responsibility, was illustrated by reference to several different types and levels of investigation that might arise.

17.194 At the seminars, it was suggested by Leading Counsel to the Inquiry that a death might be investigated in the first instance by a coroner's investigator, under the direction of the medical coroner. If the investigation were concluded and the medical coroner decided that s/he was able to certify the cause of death without autopsy, and provided that there was no reason for the coroner service to be further involved (i.e. the family had no concerns, there were no public interest considerations, etc.), the medical coroner would certify the cause of death and the judicial coroner would not be involved. That approach was generally accepted. On behalf of the Coroners' Society, Mr Burgess said that a considerable number of deaths would fall into this category. In such cases, the investigations would be undertaken, and the decisions made, by the medical coroner and his/her staff, without any, or any substantial, input from the judicial coroner.

17.195 The discussion then moved on to the case where an autopsy would be required in order for the cause of death to be determined. Mr Burgess accepted that, if the medical coroner were an independent office-holder, it might be appropriate for him/her to make the decision as to whether an autopsy should or should not be held. That decision should, however, be subject to challenge by a properly interested party, usually a member or members of the deceased's family. It was suggested that the challenge, on an issue of fact or law, should be directed to and determined by the judicial coroner.

17.196 The third type of case discussed at the seminars had an additional element, namely that there was something about the circumstances or cause of death that required further investigation. Counsel gave an example that might arise. The deceased had apparently died after falling from a ladder whilst carrying out do-it-yourself work at home. Participants were asked to assume that an inquest in such a case was not mandatory, as it would be under the current system. They were asked for their views as to whether it might be

appropriate for the medical coroner to carry out or direct the investigation into the circumstances of the death, and then (provided that there was no public interest or other element making an inquest necessary) to write a report setting out his/her findings as to the circumstances and cause of death.

17.197 Mr Burgess felt that it would be appropriate for the judicial (rather than the medical) coroner to investigate the circumstances of the death and to reach conclusions thereon. Issues of fact which were essentially non-medical were outside the medical coroner's sphere of expertise and would be better understood by the judicial coroner. In the example given by Counsel, he pointed out that the ladder might have been defective or of poor design. Those possibilities would have to be investigated and it would be appropriate for that investigation to be done by the judicial coroner. It was suggested that protocols might be developed to assist in the 'standard' type of investigation. Such a protocol might, for example, provide that, in every case where the death was associated with use of a piece of equipment (such as a ladder), the coroner should arrange for that equipment to be tested for defects. Mr Burgess was asked whether, if that were done, straightforward investigations of this sort would really need the input of a judicial coroner. In reply, he questioned the usefulness of protocols and reiterated his belief that, if the investigation involved matters going beyond medical issues, it should be directed by the judicial coroner. Representing the Coroner's Officers Association, Mrs Warner agreed with the stance taken by Mr Burgess and said that, once a death had been classified as 'unnatural', according to the current understanding of the word (which would embrace the example referred to above), responsibility for the investigation should pass to the judicial coroner. Dr Leadbeatter agreed that, where there was any factual issue that might have a bearing on the death, the death should be referred to the judicial coroner.

17.198 On behalf of the RCPath, Dr Acland expressed a contrary view. Taking the example of the man falling from a ladder, he could not see why a medical coroner would not be able to participate in and lead such an investigation. The medical coroner could attend the scene if necessary, make an assessment of it and, 'just as anyone else is capable of doing', could arrange for the ladder to be inspected by an appropriate expert. He agreed that a case that appeared likely to be controversial or the subject of litigation should be referred to the judicial coroner. However, he envisaged that the medical coroner and the coroner's officers might have done a lot of the investigative work by the time the file went to the judicial coroner. The written response to the Discussion Paper by the Medical Protection Society expressed their view that the vast majority of cases would be capable of resolution by the medical coroner, without the need for legal expertise. The Society suggested that the duties of the judicial coroner might best be reserved to High Court Judges who, when the need arose, should direct those investigations requiring the input of legal expertise.

17.199 Professor Baker's view was that the appropriate division of responsibility would depend on the structure of the coroner's office and the extent to which individual cases were discussed between the medical and judicial coroner. He thought that it would be ideal if such discussions could take place and joint decisions could be taken on the investigative steps required. On the basis that the judicial coroner and medical coroner would work separately, with a process of formal referral from the medical to the judicial coroner, Professor Baker said he would 'verge on the side of caution' and go along with the view

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that cases involving a factual element should at least be notified to the judicial coroner. Having considered the matter further, Professor Baker referred to the need to avoid a situation whereby the medical coroner dealt only with the straightforward cases and all the more difficult cases were passed to the judicial coroner. He said that this would have the effect of making the post of medical coroner 'fairly low level' and, consequently, unattractive and unrewarding. It might also reduce the ability of the medical coroner to identify those cases about which s/he should be concerned. Dr Leadbeatter pointed out that the medical coroner's involvement would not necessarily cease once the case had been referred to the judicial coroner. He had experience of some inquests where witnesses relevant to the medical issues had not been called to give evidence. The medical coroner should be able to offer advice and assistance to the judicial coroner so as to ensure that all relevant evidence would be available.

17.200 The final type of case discussed was one in which it was obvious from an early stage that it had a public interest or public safety element, such that it was likely that a public hearing (or, at least, the determination of a factual issue by the judicial coroner) would be required. The examples given were an apparent case of suicide where there was an issue as to the provision of proper psychiatric services and the death of a young person apparently caused by inhaling solvents. Mr Burgess felt that the judicial coroner should be involved from the beginning of the investigation of such cases. He advocated that judicial coroners (but not medical coroners) should have available to them powers of entry, search and seizure of property and documents. If valuable evidence were not to be lost, the judicial coroner should be notified of the death immediately. The scene should be examined in the name of the judicial coroner and any necessary exhibits seized. At first, Mr Burgess seemed to be suggesting that the judicial coroner would have his/her own team of investigators who would collect evidence on his/her behalf. However, he later accepted that, if there were a team of investigators at district level which undertook both medical and circumstantial investigations, the judicial coroner would be able to request a member or members of that team to carry out any investigations that s/he deemed necessary over and above those already directed by the medical coroner.

17.201 Mr Burgess was asked about the desirability of the current arrangement whereby the coroner is responsible for directing the process of evidence gathering in a case in which s/he is later to assume a judicial role. He could see no alternative to that arrangement. He described how, under the existing system, a coroner often has a detailed involvement in the evaluation and preparation of the evidence. He saw no tension between that degree of involvement and the coroner's judicial role. It was suggested that, in those cases which proceeded to a public hearing, evidence gathering might be directed by a solicitor based, with the judicial coroner, in the regional coroner's office. The solicitor would be responsible for taking statements in more complex cases and for preparation of cases for hearing. Mr Burgess observed that, in his view, a properly trained coroner's investigator would be able to produce sufficient evidence to enable an inquest to proceed without the need for a solicitor. For the Coroner's Officers Association, Mrs Warner agreed that she would expect coroner's officers to fulfil this role, with the coroner being the ultimate arbiter as to the adequacy of the evidence gathered.

Comment

17.202 In my view, the medical coroner should be able to complete the investigation into a large proportion of deaths. I do not think it should be necessary for the judicial coroner to be involved just because some factual aspect of the circumstances requires investigation. I agree with Professor Baker and Dr Leadbeatter that in some cases the medical and judicial coroners should both contribute to the investigation. Plainly, the judicial coroner will take a leading role in the investigation of any death where the circumstances are complex or where the weight of the investigation relates to factual rather than medical matters.

17.203 Although Mr Burgess did not feel that there was any tension between his role as manager of the investigation and his judicial function at an inquest, I consider that there can be such tension. I would experience it myself if I had to play an active role in directing the investigations carried out for this Inquiry. I give only general directions. In my view, in any inquest case which is likely to be complex or controversial, the judicial coroner should be able to distance him/herself from the practicalities of investigation.

Registration of Death

17.204 In order to register a death under the present system, an informant, usually the nearest relative of the deceased, must attend at a register office and provide certain details to the registrar. The registrar will then create an entry in the register of deaths and provide the informant with a certified copy of the entry, generally known as the 'death certificate'. At the seminars, there was discussion as to whether or not the registration of death should continue to be performed outside the coronial system, or whether there might be some way of integrating the function of registration into the coroner service. The point was made that, if relatives were to attend the coroner's office in certain cases to discuss the circumstances of the death, it would be desirable for them to be able to register the death at the same time and thus to avoid attendance at the register office.

17.205 I referred in Chapter Six to the recent proposals for the remote registration of deaths on the Internet or by telephone. At the seminars, it was suggested that, if such a system were in operation, the information required to register the death could be obtained by the coroner's staff and passed electronically to the registrar, who could then register the death. This would remove the necessity for two personal attendances. On behalf of the ONS, Miss Ceinwen Lloyd did not welcome the proposal. She stressed the important role of the registrar in providing information to relatives about administrative issues such as obtaining state benefits, closing bank accounts and taking out probate. She felt that, even if the cause of death were to be registered on-line, the families should still have contact with the registration service in order for such practical advice to be given. Miss Lloyd also made the point that there are practical advantages in the location for the registration of both births and deaths being the same. She gave the example of the multiple birth, following which a family might need to register a stillbirth on the same occasion as a live birth. Miss Lloyd thought that only a minority of informants would use remote facilities if they were made available. Most would prefer face to face registration, which constitutes a formal recognition of the fact of the death and brings a sense of 'closure'. She suggested that it was likely to be only people such as executors dealing with deaths where there were

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no relatives who would avail themselves of the facilities for remote registration. Miss Lloyd acknowledged that the ONS had examined registration procedures in other jurisdictions where there was no requirement for a face to face interview. No problems seemed to arise with the procedures in those jurisdictions. However, she said that people in this country expect to attend the register office following a death, whereas it is not the culture to do so in other jurisdictions.

17.206 The Inquiry's Forms 1 and 2 would contain far more information about the deceased's medical history and the circumstances surrounding the death than does the present MCCD. Miss Lloyd did not think it appropriate for registrars to be given the task of analysing that information at the point of registration and of determining whether or not the death should be registered or referred to the medical coroner. She said that registrars do not have the necessary medical knowledge to fulfil this role.

17.207 Miss Lloyd thought that it might be possible for a registrar to be seconded to a coroner's office, as occurs in hospitals under the current system, so that families could register the death at the same time as attending the coroner's office for interview. Dr Leadbeatter supported the idea of the 'one-stop shop', with all the post-death processes dealt with at one physical location. Miss Lloyd mentioned a number of practical difficulties that might be associated with locating registrars in coroner's offices. These included the effects on staffing levels and possible inconvenience to the public if coroner's offices were based less locally than register offices. At the present time, coroners and registrars operate out of the same building in some areas. In his written response to the Coroners Review, Mr M J F Sheffield, HM Coroner for Teesside, said that he had found it advantageous having the registrars located in the same building as his own office.

17.208 In its written response to the Discussion Paper, the Death Certification Advisory Group of the ONS expressed concern that, under the current system, the ONS is not informed of deaths which are the subject of inquests until the conclusion of the inquest proceedings. That can be months, even years, after the death. This has an impact on mortality data which is used for public surveillance and monitoring standards of healthcare. At the seminars, Miss Lloyd said that she hoped that this matter could be addressed. The ONS would like to be informed promptly of the fact that a death had occurred and, if possible, of the cause of death. For the Coroners' Society, Mr Burgess thought that there was no reason why, under a revised system, that information could not be provided to the registrar soon after the death. He drew a parallel with the current system whereby, if an inquest is adjourned under the provisions of section 16 of the Coroners Act 1988, the coroner must provide to the registrar a certificate stating, so far as they have been ascertained at that time, the particulars required to be registered concerning the death.

17.209 There was support for the idea that information about the cause of death should not be released into the public domain and should be capable of being accessed by limited categories of person only.

The Inquiry's New Forms

Before the Seminars

17.210 In its Discussion Paper, the Inquiry proposed that four new forms should be introduced. The person certifying the fact of death should record the circumstances of death on

Form 1. The existing MCCD and cremation forms would be replaced by Form 2, to be completed by the treating doctor. A family member or other responsible person would complete Form 3, confirming the deceased's medical history and the accuracy of the accounts put forward by those completing Forms 1 and 2. Finally, having carried out an examination of the body, the funeral director would complete Form 4, confirming whether or not there were any external injuries on the body which might give rise to suspicion. I have already referred to discussion about these forms in the course of this Chapter.

17.211 Views were sought as to the desirability of introducing the forms, as to their content and as to any practical problems which might arise from their completion. Respondents to the Discussion Paper expressed a number of concerns about the content of the forms, as then drafted. By the time of the seminars, the Inquiry had moved away from its original suggestion that relatives should be required to complete a form such as Form 3. The Inquiry had also realised that Forms 1 and 2 would have to be greatly simplified if they were not going to be unacceptably burdensome to complete.

Discussion at the Seminars

17.212 With those factors in mind, a detailed discussion of the content of the forms took place at the last seminar, which was dedicated to a discussion of the forms. One of the issues canvassed was how new technology might be used to assist in the completion and transmission of the forms. The hope was shared by all that both Forms 1 and 2 might be completed electronically. Participants at an earlier seminar had pointed out that it is not unusual for employees of utility companies, for example, to visit householders to inspect boilers and other equipment and to record and transmit their findings, using a handheld computer. If that were to be done in the case of Form 1, it would enable the form to be transmitted (by the ambulance service, for example, or a deputising doctor service) straight to the coroner's office. Dr Baker, for the RCGP, suggested that Form 2, which would usually be completed by the treating doctor, might have self-populating fields linked to a patient's electronic records so that some details could be inserted on the form automatically without the need to key them in manually. That would save valuable time. Dr Evans, for the RCGP, had previously observed at a seminar that the task of completing Form 2 and sending it to the medical coroner using a computer on a hospital ward would be a great deal easier for a doctor than having to make his/her way to the hospital bereavement office to complete an MCCD or a Form B. Electronic transmission of forms would obviously speed up the whole process of getting information to the medical coroner. The possibility of sending to the medical coroner, with Form 2, a small bundle of the most significant medical records was also discussed. This is likely to become relatively easy in the near future when the categories of computerised record to be sent could be identified and selected in advance. Dr Evans suggested that, in hospital, the drug cardex could be photocopied and sent with Form 2.

17.213 One point which emerged clearly from the seminar was that the forms (in particular, Form 1) would require adaptation for use in hospital. The Inquiry has therefore designed new Forms 1 and 2 for hospital use, as well as a third version of Form 1, to be used when death occurs in, or is confirmed upon arrival at, a hospital accident and emergency department.

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17.214 At the seminar, there was discussion of the Inquiry's ideas for simplified versions of the questions on Forms 1 and 2. To a large extent, these appeared to meet the concerns which had been expressed by organisations such as the RCGP, the BMA and the RCP. Discussion also centred around the time which it would take to complete the forms. Respondents to the Discussion Paper had been very concerned about the length of time that would be required to complete the forms, particularly in the case of a patient who had suffered from a long and complex illness.

17.215 In the light of the proposed simplification of the forms, participants at the seminar expressed less concern about the time which completion of the forms was likely to take. Dr Baker, representing the RCGP, held the most pessimistic view as to the likely time required. In the light of the simplification of the forms which was proposed, she reduced her estimate to an additional one hour over and above the time at present taken to complete the MCCD and cremation Form B. She made the point, however, that she was only able to offer an estimate and that undertaking a pilot study would be the best way of establishing the time that would be required. Dr Pickersgill suggested that the completion of the forms would take, on average, an hour in total and not, as Dr Baker believed, an additional hour. He said that it would take a similar time to the process of consulting the medical records, writing the MCCD, travelling to the funeral director's premises to examine the body, completing the Form B and consulting with the Form C doctor. The latter steps, of course, assume that the deceased is to be cremated. He pointed out, that under the new system, the doctor completing Form 2 would have to speak to the medical coroner. But the total time taken would be approximately the same. The point was also made at the seminars that only one doctor would be involved in completing the proposed forms, unlike the current cremation procedures which require forms to be completed by two doctors.

17.216 At the seminars, Dr Evans, for the RCP, said that, in the context of a hospital death, the completion of Form B, on a worst case scenario, could take up to an hour. He thought that a doctor familiar with the case would be able to complete the form more quickly and suggested that the best person to complete the form would be the treating senior house officer or registrar. Dr Aylin suggested that time and resources could be saved in hospital by the forms having a dual purpose. He suggested that a copy of Form 1 could go into the patient's notes and become the final entry in the notes. A copy of Form 2 could be sent to the patient's general practitioner in place of a discharge letter, thereby removing the need for a separate discharge letter to be composed and sent. Dr Aylin's suggestion received broad support at the seminars and a number of further practical benefits flowing from it were identified. Dr Pickersgill thought that Form 2 would greatly assist general practitioners in dealing with the needs of the bereaved family members following a death. They would receive the information quickly and in far greater detail than at present. Dr Baker also agreed that Form 2 would be an invaluable tool for internal audit in general practice.

The Feasibility Study

17.217 The Inquiry commissioned a small feasibility study to be undertaken by the Department of General Practice and Primary Health Care at the University of Leicester. The Report of that study was submitted in March 2003. The aims of the study were:

- to assess the feasibility of using the new death certification forms for deaths in hospital and in the community
- to assess the views of doctors and relatives on the practical aspects of filling in the forms, information requested, ease of interpreting the questions, and usefulness of the information
- to identify any problems with the proposed forms.

17.218 The study team was provided by the ONS with details of recent deaths registered at the Leicester register office. A sample of general practitioners and hospital doctors named as having certified the deaths were invited to take part. They were asked to complete the new Forms 1 and 2 (in the form in which they appeared in the Discussion Paper) as though they were certifying the fact and cause of death. Where the doctors were able to contact a relative, the relative was invited to complete Form 3. In cases where the fact of death had been confirmed by an out of hours doctor, s/he was invited to pilot Form 1. Participating doctors and relatives were interviewed by a member of the research team to elicit their views on the proposals in general and explore any problems encountered with specific questions on the forms.

17.219 Nineteen general practitioners, ten hospital doctors, two 'out of hours' doctors and six relatives participated in the study. The study team reported that there was general support for the view that the current death and certification processes should be overhauled. However, there was less agreement about the desirability of involving relatives to the extent suggested. The relatives interviewed had had difficulty in understanding and completing the forms and several of them felt that a requirement to do so would be too emotionally traumatising. That served to confirm the view already formed by the Inquiry that it would be inappropriate to require relatives to complete a form such as Form 3.

17.220 The Report prepared by the study team made a number of specific points about the forms. It was suggested that it might be preferable to have different forms for community and hospital deaths and the need for training and supporting materials for doctors implementing any new system of certification was emphasised. There was concern about the complexity of the forms and the amount of information which was required in order to complete them. Many of those concerns have been met by the changes which have been made to the proposed forms.

17.221 The study showed that, in practice, it appeared to take less time than had been estimated for the forms to be completed, despite the fact that the original version of the forms was used. The doctors participating in the study took varying amounts of time to complete the forms. The shortest time taken to complete both forms was 20 minutes and the longest one hour, with an average of something in the region of half an hour. A number of doctors said that they thought that the time taken would reduce with familiarity. The study team concluded that the time taken to complete the forms was mainly determined by the knowledge that the doctor had of the deceased as a patient. In the study, forms were completed retrospectively, on average six to eight weeks after the death and the point was made by some participating doctors that the process would be quicker if the forms were completed immediately after the death.

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17.222 Concerns were expressed about the impact on minority groups in the event that the new system proved to be slower than the old one. Doctors participating in the study also raised the issue of payment to doctors for completion of forms. At present, doctors receive payments from relatives for completion of cremation Forms B and C but no payment for completion of an MCCD.

The Result of the Consultation Process

17.223 The exercise of publishing the Discussion Paper prior to the Stage Two hearings had the effect of crystallising the Inquiry's thinking on the detailed arrangements for a new system at that stage. That thinking underwent significant changes as I heard the oral evidence relating to Stage Two. It underwent further change as I became aware of the responses to the Discussion Paper and participated in the discussions at the seminars. The consultation process produced many ideas that had a significant effect on my thinking and, as will be evident from this Report, it has had a considerable influence upon my final recommendations.

CHAPTER EIGHTEEN

Systems of Death Investigation and Certification in Other Jurisdictions

Introduction

18.1 In the course of preparations for Phase Two, Stage Two of the Inquiry hearings, the Medical Advisor to the Inquiry, Dr Aneez Esmail, identified and visited five jurisdictions whose systems of death investigation and certification would, he felt, be of interest to the Inquiry. Those jurisdictions were the states of Victoria (Australia) and Maryland (USA), the province of Ontario (Canada) and the countries of Finland and Scotland. A representative from each of those jurisdictions was invited to attend one of the Inquiry's seminars, held on 16th–17th January 2003. Also participating in the seminar was Professor Richard Baker, Director, Clinical Governance Research and Development Unit at the University of Leicester.

18.2 Before the seminars, the representatives provided a considerable amount of written information about the systems operating in their jurisdictions. Each representative had been asked to consider a brief summary of the facts of four of Shipman's unlawful killings and to provide written comments upon how the system in his/her jurisdiction would have dealt with the death. The object of this exercise was to see whether each of the systems under examination would or might have been effective in detecting Shipman's criminal activities.

18.3 At the seminars, each representative gave a short presentation, describing the system in his/her jurisdiction. Each then answered questions put by Leading Counsel to the Inquiry. Other participants in the seminars also had the opportunity of asking questions. As with the other seminars, persons attending the seminar as observers were able to raise points through Counsel for the consideration of seminar participants.

18.4 I found the presentations interesting and highly instructive. Each has contributed to my thinking about some aspect of my proposals for the future. I wish to express my gratitude to all five representatives for their attendance, their written contributions, their oral presentations and for the lively debate in which they joined.

18.5 In this Chapter, I shall summarise the main points of the systems in the five jurisdictions about which the Inquiry heard, with particular reference to those features of the systems which might with benefit be borrowed or adapted for use in England and Wales.

The System in Victoria, Australia

18.6 Professor Stephen Cordner, Professor of Forensic Medicine and Director of the Victorian Institute of Forensic Medicine, attended the seminar and described the system in Victoria.

Background and Structure

18.7 The coronial and death certification systems differ from state to state in Australia. The eight systems all operate along broadly the same lines, but with differences of detail. All the systems are derived from that in England and Wales.

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18.8 The population of Victoria is approximately 4.8 million. The number of deaths is about 35,000 each year, of which about 10% are referred to the coroner. Autopsies are performed on behalf of the coroner in around 3000 of those cases. Toxicology is undertaken in around 2000 cases and, in about 1500 of those cases, toxicological testing extends beyond testing simply for the presence of alcohol.

18.9 The Victoria State Coroner, who is legally qualified, has responsibility for the coronial system as a whole. He is based, together with four full-time coroners, at the Coronial Services Centre in Melbourne. The Institute of Forensic Medicine ('the Institute') operates out of the same building and works closely with, but independently of, the coronial system. The Institute is an independent statutory authority, as well as a University Department. Professor Cordner observed that its functions complement each other. Its coronial service obligations inform its teaching and research functions; those functions in turn support its service obligations. Autopsies for deaths occurring within the city of Melbourne are performed at the Institute. The quality of its forensic pathology services, and the way in which they work in close partnership with the coronial service, are particularly strong features of the Victoria death investigation system. Outside Melbourne, all magistrates, who in Victoria are legally qualified judicial officers, act as coroners. If a contentious matter arises in a country area, a full-time coroner may be sent to deal with it. In those areas, because of the large distances involved, autopsies are carried out by local pathologists, acting as agents of the Institute.

18.10 Professor Cordner referred to the advantages of having a single individual, the State Coroner, responsible for the coroner system. Before that arrangement was introduced, there was considerable variation of practice between different coroners. Now, there is consistency and reliability of outcomes within the jurisdiction. The State Coroner is appointed from the magistracy for three years. He or she may be re-appointed but, if not, returns to the magistracy. As well as the leadership provided by the State Coroner, Professor Cordner also provides advice and guidance to support and assist those working in the fields of death investigation and certification.

Statutory Framework

18.11 Model national legislation was introduced in Australia in the mid-1990s in an attempt to bring national uniformity to coronial law and practice. That legislation has been implemented to varying degrees across the eight states. In Victoria, the Coroners Act 1985 (as amended) remains in force. The Act established the office of the State Coroner. It also defined the categories of death to be reported to the coroner, and the procedure to be adopted by the coroner in the investigation of death and the holding of inquests. The procedure for the registration of deaths is set out in the Births, Deaths and Marriages Registration Act 1996.

Objectives

18.12 The modern emphasis of the coroner's role is on death and injury prevention. It has been recognised in Victoria that there is an important public interest in learning lessons from preventable deaths.

Deaths Not Reported to the Coroner

18.13 Deaths that are 'not unexpected' are not reported to the coroner. Where the death is not to be reported to the coroner, the doctor must give notice of death and cause of death to the registrar and the funeral director within 48 hours of the death. The registrar is notified by post and the family need not take any further steps to register the death. There is no requirement for the family to visit the registration authorities. Any registered doctor has the authority to certify the cause of death, regardless of experience or seniority. The standard of confidence that a doctor should have when diagnosing cause of death should, Professor Cordner said, be the same standard used by that doctor when making a good diagnosis in clinical practice.

18.14 The model national legislation widened the category of doctor authorised to certify the cause of death beyond the treating doctor. It now includes partners in a group practice and any doctor, who may or may not have had previous contact with the deceased, but who has had access to the medical records. Any doctor who has seen the body after death has the authority, at least in theory, to certify the cause of death. In practice, doctors are told not to certify on the basis of an examination of the body after death without a reliable history, including a history of the circumstances of death.

18.15 Like the system in England and Wales, the certification system in Victoria is wholly dependent on the integrity of the certifying doctor. There is no audit or quality assurance of certification. Professor Cordner observed that, in Victoria, as elsewhere, the completion of medical certificates of cause of death is flawed. He referred to the lack of training in the subject and the lack of enthusiasm for it amongst medical students.

Deaths Reported to the Coroner

18.16 The categories of death requiring referral to the coroner differ from state to state but, in general, include violent, unnatural and sudden deaths, together with certain other specific categories of death. Those categories of death also include deaths in custody and deaths where no medical certificate of cause of death has been signed. The coroner's jurisdiction is limited to reportable deaths and does not extend to all deaths within the geographical jurisdiction. The statutory duty to report a reportable death is broad and extends to any person with knowledge of the death who has reasonable grounds to believe that the death has not already been reported. A criminal sanction for failure to report exists but is never imposed in practice. Professor Cordner said that there was not a high degree of awareness among the public of the duty to report. One perceived weakness of the system is its reliance upon persons reporting deaths to the coroner. Also, Professor Cordner observed that a particular emphasis is placed on the need to report deaths that are immediately identified as unnatural, with less emphasis being placed on the need to report and investigate sudden deaths which are thought to have a natural cause.

18.17 The State Coroner's Office in Melbourne is staffed by coroner's clerks. The clerks are the first point of contact for a doctor telephoning to report a death or to make an enquiry as to the need to report. They are administrators who commonly have worked as court clerks and receive no formal training in legal or medical issues. In country areas, the magistrate's

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court staff will act as coroner's clerks. When a doctor telephones to report a death, the clerk may, in some circumstances, give advice as to whether or not a doctor should report the death, or may advise the doctor to certify the cause of death. That advice might be given without formal reference to the coroner.

Death Investigation

18.18 Once a death has been reported to the coroner, investigations are undertaken by the police, acting as agents of the coroner. A small team of five police officers is seconded to the State Coroner's Office in Melbourne. Those officers oversee investigations carried out by the local police force. They also carry out investigations into particular types of death which require specific expertise and knowledge. For example, they might investigate a small plane crash or scuba diving accident. Outside Melbourne, coroners are entirely dependent on local police officers to investigate deaths. Coroners have powers to enter and inspect premises and to seize documents and other material in the course of their investigations.

18.19 The decision as to whether an autopsy should be performed is made in the first instance by the coroner. The pathologist will then form his/her own judgement as to whether an autopsy is required or whether s/he can certify the cause of death without carrying out an invasive examination. In reaching that decision, the pathologist will have an opportunity to examine the body externally and will also have available to him/her the police report containing information about the circumstances of death. Medical records are not generally available at that stage, unless the death occurred in hospital. The treating doctor will rarely be contacted unless the pathologist wishes to enquire why the doctor feels unable to certify the cause of death. If a decision is taken not to carry out an autopsy, Professor Cordner said that there will usually be some consultation with the family to ensure that they are happy with the decision.

18.20 Where it is decided that an autopsy should (or should not) be carried out, relatives have a right to object. The coroner's decision is subject to a right of appeal to the Supreme Court of Victoria; in practice, that right is rarely exercised.

18.21 Extensive toxicology, designed to identify any one of a long list of drugs (including morphine), is carried out in approximately half of the autopsy cases in Victoria. The cost of toxicology in an individual case is approximately £250.

18.22 At the end of an investigation, whatever the outcome, the family has access to a document setting out what is known of the circumstances of their relative's death. Documents arising out of the investigation are entirely public.

18.23 The process for the investigation of deaths potentially caused by adverse medical incidents is undergoing reform. In a recent article on the investigation of deaths caused or contributed to by adverse medical incidents, Dr David Ranson, the Deputy Director at the Institute, noted that a large number of such cases go unreported and those that are reported have traditionally been investigated in the same way as all other deaths investigated by the coroner. The investigation consists of the police taking statements from doctors involved in the provision of treatment, and from other witnesses. Also, a

pathologist will carry out an autopsy, on the basis of the information obtained by the police. Dr Ranson observed that the police have little direct experience or knowledge of the specialist medical issues involved in such a death. A potential problem might be missed because the doctors who are interviewed may not be forthcoming in identifying system failures. He also observed that the issues might not be picked up by the coroner's pathologist, who is unlikely to be aware of current practice issues in the entire range of specialist areas.

18.24 A medical death investigation team has recently been established in Victoria. This adopts a very different approach to the investigation of deaths occurring in a medical setting. Cases are first screened by nursing staff against a set of diagnostic criteria and audit filters, to identify cases where there is a high likelihood that an adverse medical event has occurred. The information from the screening process is then passed, with the medical records, to the forensic pathologist conducting the autopsy. Once the results of the autopsy are available, the death will be reviewed by two clinical medical specialists from different clinical disciplines, who are employed on a part-time basis at the Institute. The specialists evaluate the records and identify areas where it would be prudent to obtain relevant witness statements. The specialists also draft specific questions to be put to witnesses and, if required, to an independent medical expert. The new investigative approach is still in its infancy but it is hoped that, in time, the process will lead to improvements in the safe delivery of healthcare.

Judicial Investigation of Death

18.25 The majority of inquests in Victoria are held at the coroner's discretion, usually because there is a matter of public interest to be investigated. There are certain limited categories of mandatory inquests in cases of homicide, deaths where the deceased person is held in care and cases where the deceased is unidentified. Inquests into suicides are rare, as are inquests into deaths sustained in road traffic accidents, unless an issue of public safety and death prevention arises. Deaths that occur in the workplace commonly result in an inquest because of the potential for learning from the death and preventing future accidents of a similar nature. The views of the family are an important factor when taking a decision whether or not to proceed to an inquest. Inquests in Melbourne are presided over by full-time coroners. Outside Melbourne, magistrates sit in non-controversial cases. There is provision in the legislation for juries to sit on inquests, but no jury has sat for many years. Verdicts following an inquest are descriptive. Recommendations may be made, particularly if a number of deaths have occurred in similar circumstances. In some states, although not in Victoria, the appropriate authority is under an obligation to respond to recommendations made.

Cremation

18.26 If a death is reported to the coroner, the coroner will authorise cremation. Otherwise, a cremation form is completed by the medical practitioner who was responsible for the deceased's medical care immediately before death. A second doctor and the crematorium medical referee must also complete cremation forms. The second doctor is

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required to examine the body, but will rarely contact the deceased's relatives or carers. Professor Cordner observed that his impression was that any independent enquiry by a second doctor in a cremation case was a rarity.

National Coroners Information System

18.27 The National Coroners Information System (NCIS) is a computer database, which was established in 2000 and is based at the Monash University National Centre for Coronial Information, Melbourne. The NCIS receives and records information on the 18,000 or so deaths reported to coroners in Australia each year. Prior to the introduction of NCIS, the collection and analysis of coronial data was a slow process. For example, a Commission set up in 1989 to look at work-related deaths spent six years visiting each of the eight states collecting data, much of which was outdated by the time the Commission reported in 1998. Professor Cordner said that the NCIS has transformed the way in which such information can be obtained and studied.

18.28 The database provides coroners with information about deaths occurring in other parts of the country. It allows coroners to identify patterns in preventable deaths which, on the basis of the limited information within an individual coroner's jurisdiction, might otherwise go unnoticed. The database also reduces repetition of work. For example, one coroner might not hold an inquest into a particular type of death if s/he knows that a coroner in another state has already investigated that type of death in detail and that the lessons in terms of death prevention have already been learned.

18.29 Data from the NCIS is made available, not only to coroners, but also to Government agencies and other public sector organisations, particularly those involved in health policy. They use the NCIS to monitor particular types of death and identify health and safety issues.

Detecting Shipman

18.30 On the basis of the summaries describing the circumstances of four of Shipman's unlawful killings, Professor Cordner formed the view that Shipman's activities would not have been detected by the Victoria system. In relation to the case of Mrs Kathleen Grundy, he said that there would be an issue as to whether the death could properly have been certified as due to 'old age'. This cause of death might or might not have been queried by a registrar. However, if the death had been reported to the coroner, the coroner's clerk might well have encouraged the doctor to certify the cause of death, on the ground that, even though the death was possibly unexpected, it was apparently (on the doctor's account) natural. If an autopsy had been carried out, so long as there was sufficient coronary artery disease to account for death, further investigation would probably not have been ordered. In the absence of heart disease, histology would have been ordered and samples for toxicology taken, to be analysed only in the event that the cause of death was not established by histology.

Comments

18.31 The modern role of the Victoria coroner system in the field of death and injury prevention is one which, in my view, the system in England and Wales should also embrace. In order for that to be done, a system such as the NCIS is plainly necessary.

18.32 The evident quality of the independent forensic pathology services in Victoria, their position at the centre of the death investigation and certification system and the close working relationship between the coronial and forensic pathology services are all important features of the system in Victoria. They provide a model which could, with benefit, be adapted for use in England and Wales.

18.33 I was also most interested in the proposals for the identification and investigation of deaths associated with medical care. I shall recommend that similar measures be considered for the investigation of that type of case in England and Wales.

18.34 I was also impressed by the evidence of leadership offered by both the State Coroner and by Professor Cordner, as Director of the Institute with responsibility for forensic pathology. It is clear that the leadership which they offer is of great benefit in achieving consistency, as well as in encouraging good practice and in supporting the work of those with day-to-day responsibility for the operation of the coronial and death certification systems.

The System in Ontario, Canada

18.35 Dr James Young, Chief Coroner for the Province of Ontario and Assistant Deputy Minister of the Solicitor-General, attended the seminar and described the system in Ontario.

Background and Structure

18.36 Each of the provinces and territories in Canada has a Chief Coroner or Medical Examiner, who acts as the head of the coronial and death certification system. Ontario has a population of 13 million, spread over an area of one million square kilometres. Much of the population lives in a relatively densely populated area within 100 miles of the US border, but there are vast areas of the province which are sparsely populated. The geography and climate of Ontario present significant challenges to the coronial system. Approximately 60,000 deaths occur each year, and the Chief Coroner's Office investigates and reports on around 20,000 of those deaths. A limited investigation is carried out in relation to a further 10,000 deaths, which occur in nursing homes and residential homes for the elderly. Autopsies are performed in around 7000 cases, which represents a little over a third of those deaths formally investigated.

18.37 The Chief Coroner has overall responsibility and control over the province-wide system. Authority is delegated to three deputy chief coroners and ten regional supervising coroners, each of whom covers one of the ten geographical areas into which the province's coronial system is divided. There are then about 350 investigating coroners, who attend scenes of death and who are supervised by the regional supervising coroners. All coroners in Ontario are licensed physicians. The investigating coroners have a variety of medical backgrounds, both within and outside hospital, and undertake their coronial duties as part-time additional work for which they are remunerated on a case-by-case basis. Local arrangements are made for rota cover to provide a service 24 hours a day, seven days a week. A system of 'first on call' and 'second on call' is operated, so that a member of staff is always available when needed. Standards in the office require that an investigating coroner should be able to attend at the scene of a death within two to three

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hours. Despite the antisocial hours, recruiting for the post of an investigating coroner apparently presents no problems.

18.38 The Chief Coroner is responsible for establishing standards for death investigations. He also directs, controls and supervises death investigations, together with the delivery of forensic pathology services. He offers advice and guidance, both personally and through his deputies and the regional supervising coroners. There is a clear line of authority and accountability within the coroner service in Ontario.

18.39 There is obvious potential for tension where a doctor in a small, rural community acts as an investigating coroner. He or she may be called upon to investigate deaths of patients of colleagues who are well known to him/her. Investigating coroners are given clear advice about this and are advised to refer a death upwards to the regional supervising coroner, even to the Chief Coroner's Office, if any potential conflict arises. They are also reminded of the importance of considering the 'worst case scenario' in relation to every death, even when dealing with the death of a colleague's patient.

18.40 It is evident from the documents with which the Inquiry has been provided that the coronial service in Ontario seeks, and, is successful in securing for itself, a high public profile. That profile ensures that the public is aware both of the existence of the service and of the mechanism of investigating deaths about which there is any concern or problem. This acts as a positive encouragement to report deaths about which any concern arises.

Statutory Framework

18.41 The statutory framework for the Ontario system is contained in the Coroners Act 1990 and the Anatomy Act 1980.

Objectives

18.42 The motto of the Ontario Chief Coroner's Office is **'We Speak for the Dead to Protect the Living'**. In practical terms, the objective of providing protection to the people of Ontario is achieved by implementing high quality death investigation and using the findings to generate recommendations to improve public safety and to prevent further deaths occurring in similar circumstances. The ethos is that no death should be overlooked, concealed or ignored. The Chief Coroner's Office is assisted in achieving its objectives by the high public awareness of the coroner system. Individuals and organisations are encouraged to 'over-report' deaths, even at the risk of time being wasted investigating deaths which might in the event be found to have been entirely natural.

Deaths Not Reported to the Coroner

18.43 Where a doctor is able and willing to certify the cause of death, the coroner will not become aware of the death until after disposal. A body can be removed to a funeral home only when a certificate as to cause of death has been issued by a doctor or nurse practitioner, or where an investigating coroner has attended and authorised removal of the body. A nurse practitioner can certify the cause of death only in limited circumstances, namely in a case of expected death at home (i.e. not in a nursing home etc.), where the nurse

practitioner has had primary responsibility for care, an established diagnosis of a terminal illness has been made and the patient was receiving palliative care. Any registered doctor is authorised to certify the cause of death in an appropriate case, regardless of experience or seniority. There is no formal requirement for a doctor to examine the body in order to certify the cause of death. The standard of confidence for certifying the cause of death is similar to that in Victoria, i.e. the same standard as for diagnosing a condition in a living patient.

18.44 Although only certain deaths must be reported to the coroner in the first instance, the death certificates in relation to all deaths are ultimately sent to the Chief Coroner's Office. Individual certificates are audited to see if the death should, in fact, have been reported. The ambit of the audit is necessarily limited, since it will detect only errors which are evident on the face of the death certificate.

Deaths Reported to the Coroner

18.45 The coroner's jurisdiction is limited to 'reportable deaths' and does not extend to all deaths within the geographical jurisdiction. The categories of reportable deaths are wide and contain a provision that **'any death requiring investigation'** should be reported. A statutory duty to report deaths to the coroner extends to every person with reason to believe that a person died within a list of particular circumstances, including sudden death, death caused by violence, negligence and other similar categories, as well as some broader categories such as **'death by unfair means'**. The duty is subject to a criminal sanction which is rarely imposed. Literature produced by the Chief Coroner's Office acknowledges that the categories of reportable deaths tend to be **'confusing'**.

18.46 The Coroners Act provides that all deaths that occur in residential or in-patient institutions must be reported to the coroner. In practice, this legislative requirement is fulfilled by requiring nursing homes to keep a book of all deaths and to report every tenth death to the coroner. Those deaths are then investigated by means of a paper review. They are then available for audit, or further investigation at a later time if necessary. A death reportable for any other reason must be reported to the coroner in the usual way. An institutional patient death record is completed following any death in a nursing home. The record addresses issues relevant to the need to report, such as whether the death was accidental, sudden and unexpected, and whether the family has raised concerns. The form is then sent to the coroner's office. Where required, the frequency of deaths to be reported by an institution can be altered and, if there are real concerns, the institution can be required to refer every death to the coroner. There are special requirements for deaths in mental hospitals and developmental homes for children.

18.47 Dr Young told the Inquiry how, on one occasion, his office had a report of a higher than normal death rate at a developmental home. A committee was set up and audited every death which had occurred at the home over a period of five years. This revealed a pattern of withdrawal of medical treatment, leading to death, which could not have been detected in connection with any single death. The coroner's office will carry out similar exercises in relation to a doctor about whom there is concern.

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18.48 Deaths caused or contributed to by medical negligence or malpractice fall within the category of reportable deaths. Hospitals are encouraged to err on the side of over-reporting deaths. Dr Young expressed the view that, if deaths where there was an issue about medical care were not reported, this only produced problems in the future. Hospitals within the province have an audit system in place to assess whether or not a death should be reported to the coroner. Often, nursing staff report deaths. Dr Young observed that they tended to be more reliable than doctors in reporting deaths to his office.

18.49 A doctor unsure as to whether or not a death should be reported may contact the coroner. In a straightforward case, the coroner may be happy to allow the doctor to certify the cause of death. However, Dr Young made the point that, once an investigative coroner has invested a certain amount of time in a case, it is in his/her financial interests to take the case on, because of the case-by-case basis by which coroners are paid. Coroners are contacted via 'dispatchers' who act as coroner's clerks or intermediaries. The dispatchers are experienced and will be able to answer questions from doctors about, for example, the content of statutory provisions. However, they will not be expected to exercise judgement as to whether or not a death will be accepted by the coroner. Such judgements are left to the coroners themselves.

Death Investigation

18.50 Following a report of a death, investigating coroners are instructed to attend the scene of death unless there is good reason for not doing so. An investigating coroner should complete a certificate, confirming that s/he has legally seized the body. Investigating coroners are instructed to consider the worst possibility (or **'think dirty'**) and to liaise with the family in investigating the death. The investigating coroner undertakes and directs a medical investigation and, in a case where there is no suggestion of criminal involvement, will interview witnesses, often in the presence of the police. Extensive written guidance is provided for the investigating coroner. Where there is a hint of criminal involvement, the police take over the investigation, so as to avoid the risk of an investigating coroner tainting the criminal investigation. However, even in such cases, the coroner's office works closely with the police and will provide the necessary medical expertise.

18.51 If the coroner is minded not to require an autopsy, s/he will undertake a full external examination of the body *in situ* to ensure that there are no signs of violence. When such an examination is carried out at a person's home, relatives are asked to leave the room and experience has shown that families do not object to such an examination being carried out. There is a practical benefit to families in that, if it is decided that an autopsy is not required, then the body can be released to a funeral home, allowing the relatives to make arrangements for the funeral. The scene, and the body, may be photographed. The coroner has power to seize any evidence necessary for the purposes of his/her investigation.

18.52 The delivery of forensic pathology is controlled by the Chief Coroner. When a decision is taken that an autopsy is required, the investigating and regional coroners will consider what level of pathology expertise is necessary. Local facilities are available for

straightforward cases and, where greater expertise is required, the body is transported to one of the larger regional centres. If necessary, a case can be referred to one of the major centres, such as Toronto or Ottawa, where forensic pathology services are available. In some circumstances, where the circumstances of death are clear, a thorough external examination takes the place of an invasive autopsy, although the use of this technique is restricted to the larger forensic centres. Medical records are obtained in every case which involves a medical issue or where an autopsy is to be performed. The relevant sections of the medical record are photocopied and forwarded with the body to the mortuary.

18.53 Under the Coroners Act, certain defined categories of family member are entitled to information relating to the investigation of a death. A report will be made available to the family, but will not become a public document. If no inquest or regional review (see 18.57–18.59 below) is carried out, there is usually an opportunity for the family to discuss with the coroner any issues relating to the death.

Public Investigation of Death

18.54 The number of inquests held in Ontario each year is low in comparison with England and Wales. The aim of the system is to hold a small number of representative inquests which examine issues in detail, as opposed to a larger number of routine inquests, which allow for only superficial examination of the issues and give limited scope for learning lessons in public safety. The statute allows for one inquest to be held into a number of deaths where they have arisen from the same event or from a common cause. Inquests are mandatory in certain categories of case, for example, deaths in custody and construction and mining deaths. Discretionary inquests are held when the public interest requires it. In 2002, there were 54 mandatory inquests, together with 18 discretionary inquests. Included in the statutory list of considerations taken into account when determining whether or not the public interest would be served by the holding of an inquest, is the likelihood that **'recommendations directed to the avoidance of death in similar circumstances'** will arise out of the proceedings. Recommendations, typically numbering between 1200 and 1500 each year, are made following both mandatory and discretionary inquests. The public have a right of challenge against a decision not to hold an inquest. Such a challenge is determined by a Government Minister.

18.55 Inquests in Ontario are presided over by coroners, who do not have formal legal qualifications. The category of coroner that can sit on an inquest is limited to the Chief Coroner, his three deputies, the ten regional supervising coroners and 50 of the most experienced investigating coroners. The more senior members of that group conduct inquests in the most complex cases. Some limited legal training is provided and a detailed inquest manual is provided to assist the coroners while acting in their judicial capacity. Crown attorneys are appointed to act as counsel to the coroner at the inquest hearings and interested parties are often represented by lawyers.

18.56 Juries sit on all inquests and are responsible for reaching a verdict and making recommendations in the light of the evidence and submissions from interested parties. In many cases, the submissions will include suggested recommendations, which can be adopted in full or in part and supplemented by the juries' own recommendations. The

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coroner then produces a letter of explanation, setting out the circumstances of death, the procedural history of the inquest, his/her interpretation of the significant parts of the evidence and the jury's rationale for making each of its recommendations. The letter is intended to supplement, not replace, the verdict of the jury.

18.57 In more complex cases, detailed reviews will be undertaken by standing committees of experts. These include an Anaesthetic Death Review Committee, a Paediatric Death Review Committee, an Obstetrical Care Review Committee and a Geriatric and Long Term Care Review Committee. The committees are chaired by deputy chief or regional coroners and their members are, in general, experts in the field concerned. The Paediatric Death Review Committee has a particularly diverse membership, reflecting the complexity of the topic. The committees review cases at the request of the Chief Coroner.

18.58 In medical cases, the committees usually look at the hospital notes, the autopsy results and the coroner's investigation to date. One member of the committee will conduct an initial review and the case is then discussed with the whole membership of the committee. A preliminary opinion and set of concerns are formulated and passed on to the regional and investigating coroners. No formal witness statements are taken at that stage.

18.59 The review is often followed by a meeting between the review committee, the regional coroner and the institution and doctors, or other professionals, involved in the case. A detailed discussion ('a regional review') takes place and this will frequently result in a set of recommendations being agreed. The family is then informed of the results of the review and a decision taken as to whether the case needs to proceed to a public inquest. If such an inquest is thought necessary, the committee member who reviewed the case first is usually retained as an expert witness for the inquest.

18.60 The advantage of the review committee system is its ability to examine complicated subject matter in a relatively informal manner, more efficiently than the inquest process. Thus, effective recommendations for improvement to systems can be made expeditiously. Dr Young said that the success of the review system was such that hospitals would sometimes report deaths themselves and ask that a review be undertaken, knowing that it would result in useful recommendations.

18.61 The coroner is under a statutory duty to forward recommendations to any organisation whose failures may have caused or contributed to the death. There is no legal obligation on the organisation to respond. However, in practice, a report is forwarded to the coroner about 12 months later, describing the steps taken to implement the recommended steps. The report is made public and failure to take appropriate preventative measures will receive widespread critical coverage in the press.

Registration

18.62 The practical aspects of registration are carried out by the funeral director. The certificate of the cause of death, or the coroner's death certificate in cases where the coroner has become involved, is taken to the funeral home. The family will complete a request for burial at the funeral home and the funeral director will take the forms (together with the cremation certificate if relevant) to the registrar, who will register the death. A short form death

certificate is available for administrative purposes. This does not include any details of the circumstances of death or cause of death.

Cremation

18.63 The authorisation of the coroner is required for cremation. Before authorising cremation, the investigating coroner will attend at the funeral home and review the relevant documentation, including the certificate of cause of death and a form filled out by the family. He or she will speak to the funeral director and enquire whether there are any problems associated with the death. The investigating coroner will rarely examine the body.

Coroners Information System

18.64 Data about deaths is entered into the coroners information system by the local investigating coroner and is subsequently checked by personnel at the offices of the regional coroner and Chief Coroner. The information is used for research projects into public safety issues, such as drinking and driving, or drownings. A Canada-wide database is currently being built which will facilitate the collection of statistical data on the circumstances of deaths.

Detecting Shipman

18.65 On the basis of the summaries describing the circumstances of four of Shipman's unlawful killings, Dr Young expressed the view that there was some prospect that Shipman's activities would have been detected by the Ontario system. For example, the sudden and unexpected nature of Mrs Grundy's death would probably have caused the friends who discovered her body to contact the police, who in turn would have called the coroner. The investigating coroner, if following procedures correctly, would have spoken to Mrs Grundy's daughter. She would undoubtedly have expressed surprise at the sudden nature of the death. It is most likely that an autopsy would have been ordered with histology. If the cause of death had not been established at autopsy, toxicology would have been ordered. In any event, a blood sample would have been taken, frozen and kept for five years. 'Old age' is not, according to Dr Young, a cause of death which is usually accepted in Ontario. He said that the issue of whether or not the case would have come to the coroner would probably have depended upon the level of concern felt and expressed by the family.

Comments

18.66 Dr Young expressed the view that the best way of ensuring that the coroner service learned of all relevant deaths was to ensure that it had a high public profile and to make the public aware that there was a mechanism for reporting suspicious deaths. I agree that it is vital that the public has a high degree of awareness of the coroner service, together with the confidence to approach the service in the event of concern.

18.67 It is evident to me that the Ontario coroner service has strong leadership, together with a positive philosophy, which enables it to meet the practical difficulties presented by the

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state's geography and climate. The high element of medical expertise available to the service is plainly a strength, as is the emphasis (similar to that in Victoria) on public safety issues and the benefits of learning from deaths which have occurred in the past. I shall suggest that in England and Wales, deaths should be selected for inquest, as in Ontario, on the basis of public interest, with particular emphasis on the prevention of death and injury in future.

18.68 I also regard as extremely significant the ethos that encourages all concerned to have a high index of suspicion when viewing the circumstances of any particular death. It is essential, if any system of death investigation is to work, that the personnel employed within the system do not approach their task on the assumption that all will be well. If they do, there is a real risk (exemplified by the Shipman case) that they will fail to detect problems which are there to be seen.

18.69 I was impressed by the robustness of some of the investigative methods, such as attendance at the scene of the death, the taking of photographs and the taking and preservation of blood samples.

18.70 I was particularly interested in the system by which medical mishaps are investigated, using the services of standing committees of experts. It seems to me that this type of system might well be adopted in England and Wales. It would complement the identification and investigation methods being developed in Victoria, which I also found interesting.

18.71 I think it highly desirable that England and Wales, like Ontario and Australia, should have a computerised information system.

The System in Maryland, USA

18.72 Dr David Fowler, Chief Medical Examiner, attended the seminars and described the system in Maryland.

Background and Structure

18.73 The organisation of post-death procedures differs from state to state in the USA. Some states, including Maryland, have a medical examiner system, others have a coroner system and some hybrid arrangements exist. Maryland is a state with areas of high and low population density. The overall population is 5.7 million. Around 10,000 deaths are referred to the medical examiner each year, which represents just less than 25% of all deaths. Investigations are carried out in about 8000 cases and autopsies are performed in about half of those cases. Toxicology is performed in almost every case where an autopsy is performed, as well as in a small number of other cases.

18.74 The medical examiner system is controlled and operated by the Post Mortem Examiners Commission ('the Commission'), which is a statutory body established to ensure independence from the state. On the Commission sit the Heads of Pathology from each of the major teaching hospitals in the state, the Superintendent of the State Police, the Commissioner of Health for Baltimore City and the Secretary of Health for Maryland.

The Commission therefore comprises representatives from the spheres of academic pathology, law enforcement and public health. The Commission takes all operational decisions and deals with staffing issues. In Baltimore, death investigations are run from the central Office of the Chief Medical Examiner (OCME). Based at the OCME are the Chief Medical Examiner, his two deputies, seven assistant medical examiners, ten forensic pathologists, and 14 full-time investigators, together with support staff, including seven toxicologists. All autopsies in the state are carried out at the OCME.

18.75 The full-time death investigators investigate deaths that occur within Baltimore City. In the outlying counties, deputy medical examiners, who work on a part-time basis, have responsibility for the control and review of the provision of local services. Individual deaths are investigated in the first instance by part-time forensic investigators, who report to the deputy medical examiners. Forensic investigators usually have a paramedic background and their training includes forensic medicine, anatomy, physiology and interview techniques. Employed paramedics often work as part-time forensic investigators by way of secondary employment. The medical examiner system provides cover 24 hours a day, seven days a week.

18.76 Dr Fowler has a significant educative role. He lectures law enforcement agencies about the work of the medical examiner system. As part of his/her training, every police recruit in Maryland receives lectures from staff from the OCME and will visit the OCME. They also receive continuing education.

Statutory Framework

18.77 The statutory framework is operated on a state, not a federal, level. In Maryland, the main statute regulating the medical examiner system is the Health-General Article. Title 5 of the statute establishes the Commission and also defines its composition, powers and duties. The statute defines cases to be examined by the OCME and authorises the Commission to issue guidelines on the categories of reportable cases. The statute also covers autopsy procedures, forensic investigation, record keeping and death certification.

Objectives

18.78 The system in Maryland has an emphasis on law enforcement issues. Police recruits are told to report every death that is not 'solely' and 'exclusively' due to natural causes. They are told that 'solely' and 'exclusively' are not negotiable terms. They are encouraged to approach deaths with a high index of suspicion, keeping in mind the possibility that there may be suspicious circumstances. Medical investigations carried out within the medical examiner system support the work of the police. The service works in very close co-operation with the police.

18.79 Dr Fowler stressed that the objective of the system was purely to discover the cause of death, not the circumstances.

18.80 There is a high public awareness of the OCME and the work of the Chief Medical Examiner is widely publicised in the press.

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Deaths Not Reported to the OCME

18.81 In practice, most deaths occurring outside a hospital or hospice are referred to the medical examiner. It is rare for a doctor to attend the home of a living patient in Maryland and, if a person dies at home, it is unlikely that a doctor will attend in the first instance. It is more likely that the emergency services will be summoned to the death and will contact the OCME. If a doctor is contacted first, s/he is likely to advise the caller to contact the emergency services.

18.82 Only doctors licensed to practise in Maryland are able to certify the cause of death and, because obtaining a licence is a relatively expensive process, very few junior doctors have such a licence. There is no set period within which a doctor must have seen a patient in order to certify the cause of death. Doctors will rarely certify a home death. Indeed, the problem in Maryland is in persuading doctors that they are able to certify the cause of death, rather than restraining them from doing so. Dr Fowler explained that this was largely because of concern about medico-legal issues which might arise from an inaccurate certification of the cause of death.

18.83 Registration of the death is done by the funeral home. The death certificate must be filed with the Vital Records Department. No personal attendance by the family is required.

18.84 Although only certain categories of death must be reported to the medical examiner in the first instance, an audit of deaths not reported to the OCME is undertaken by the Vital Records Department. A process of screening of death certificates is in place, checking for proscribed words in the certified cause of death. A list of proscribed terms is drawn up by the OCME and, if terms from that list appear on a death certificate, the Vital Records Department forwards the death certificate to the OCME for further investigation. Each year, around 2000 death certificates are referred to the OCME by the Vital Records Department in this way.

Deaths Reported to the OCME

18.85 The Chief Medical Examiner's jurisdiction is limited to 'reportable deaths' and does not extend to all deaths within the geographical jurisdiction. There is a long list of reportable deaths. This list includes, for example, categories such as death due to violence or suicide, and deaths which are sudden and unexpected, deaths which are **'unusual'** and deaths which occurred **'suddenly while in apparent good health'**. There is a statutory duty on all doctors, funeral directors and any other person who believes a death is suspicious, or has occurred in unusual circumstances, to report the death to the police who, in turn, report the death to the OCME.

18.86 When a death is reported to the OCME, a decision is taken as to whether or not jurisdiction is to be accepted. In a case which does not obviously fall within the medical examiner's jurisdiction, discussion will take place between the deceased's doctor and, in the first instance, a forensic investigator. Ultimately, a medical examiner will discuss the case with the doctor and determine whether or not the death should be the subject of an investigation. Jurisdiction is accepted in approximately four out of every five cases that are referred.

Death Investigation

18.87 When jurisdiction over a death is accepted, a variety of investigative steps can be taken. These steps are set out in a series of detailed protocols. In the first instance, a forensic investigator will go to the scene to inspect the body and undertake an investigation as to the circumstances of the death. Forensic investigators have a comprehensive manual which directs the investigation at the scene. Members of the family and other witnesses are interviewed. The body will be examined thoroughly and photographs taken. In an appropriate case, the body is released to the family, so that it can be taken to a funeral home. The permission of the medical examiner is required in order to remove a body from the scene of death. This will be given only in a case where no further investigation is required. Where it is not possible to examine the body at the scene, or the deceased's relatives object to the examination, the body will be removed and taken to the mortuary for detailed external examination or autopsy. Where there is some doubt on the part of the forensic investigator, s/he will consult the medical examiner as to the future conduct of the investigation. In some cases, a blood sample will be taken for future toxicological investigation. The OCME encourages the police to carry out as much of the investigation as possible, even in cases where no criminality is suspected. Often, the scene investigation is carried out in company with the police. This results in some duplication of resources. However, Dr Fowler said that it provided a valuable safeguard and that he found the team approach between the medical examiner service and the law enforcement agencies to be most effective.

18.88 An investigation report is completed by the forensic investigator, providing details of the scene, what is known about the circumstances of the death and the medical history. If the body has to be transported by the funeral director, s/he must have a copy of that report, together with the death certificate, with him/her whilst transporting the body. On the basis of that report, the medical examiner will then either certify the cause of death or order that an autopsy be carried out. If an autopsy is not to be carried out, the investigation report will also be reviewed by a fellow in forensic pathology, who is someone with at least five years' pathology training. It will then be reviewed separately by a chief investigator. Finally, the medical examiner will have an opportunity to review the case before deciding whether or not to certify the cause or whether further investigation is required.

18.89 Outside Baltimore, if a forensic investigator decides that a case does not require autopsy, s/he will telephone a forensic investigator at the OCME to discuss the case and the two of them may well have a conference call with the on-call medical examiner. If it is determined that the body should not undergo autopsy and is to be released to a funeral home, the investigation report is sent to a deputy medical examiner at county level who will sign the death certificate. If that deputy is not satisfied that s/he is able properly to certify the cause of death in the absence of an autopsy, s/he will telephone the Chief Medical Examiner or one of the two deputy chief medical examiners and request arbitration. In any event, prior to disposal, one of the two deputy chief medical examiners, or one of the two most senior forensic pathologists, will review such cases on paper.

18.90 One category of case is dealt with differently, by a process called 'approval'. Where a deceased person had been in hospital for an extended period prior to death, in a case

which would otherwise be reportable to the medical examiner (e.g. in the case of a driver in a single-vehicle collision with a bridge who had died from his injuries), the case might well be suitable for approval. The reasoning behind the process is to avoid carrying out an autopsy in circumstances where the injuries are well identified during life. The death certificate is signed by the hospital doctor and approved by the medical examiner who will have had sight of the deceased's medical records.

18.91 The decision as to whether or not an autopsy is to be carried out is made in the first instance by the medical examiner. The deceased's family has a right to challenge the decision to carry out an autopsy. Such a challenge is typically made on four or five occasions each year, usually on grounds of religion. Discussions take place to see if the autopsy can be avoided altogether or steps can be taken to remove or minimise the objection to the autopsy. If the objection cannot be met and it is still proposed to carry out an autopsy, there is a right to challenge a decision before a judge, whose ruling is final.

18.92 Prior to an autopsy being carried out at the OCME, the salient points of the history are discussed by a group of pathologists and trainee pathologists, who convene at the OCME each morning. The autopsies are then performed and the meeting reconvened in the afternoon, when the autopsy findings are presented to the entire pathology staff and the cause of death is discussed. Partial autopsies are rarely carried out.

18.93 Toxicology is carried out in virtually every case where an autopsy is performed, as well as every case where the body is taken to the OCME for external examination. Toxicology is also taken in some cases which do not reach the OCME; forensic investigators have toxicology kits available to them and, if directed to do so by the medical examiner, can obtain a sample of blood at the scene which is sent to the toxicology laboratory at the OCME for screening. Around 200 samples are sent in from the counties and tested in this way each year. Having a toxicological laboratory at the OCME means that results are available very quickly. The fact that toxicology is performed in a relatively large number of cases reduces the cost of the testing in an individual case and also has demonstrated the implication of drugs in a number of deaths in which it had not been suspected. After the seminars, Dr Fowler provided the Inquiry with details of a number of cases where drugs had been found in babies, young children and the very elderly. In one of those cases, that of a 91 year old woman who died in a nursing home, the death was found to have resulted from homicide.

18.94 The medical examiner will examine a death retrospectively, if a concern arises, for example, about a particular nursing home or physician. Dr Fowler said there was no reason why a medical examiner should not investigate certain categories of death prospectively also.

Judicial Investigation of Death

18.95 There is no such thing as an inquest under the Maryland system. Findings of fact as to the circumstances of death are not made, just findings as to the cause of death. Medical examiners have the power to administer oaths and take affidavits as part of the investigative process, but they do not have the ability to subpoena witnesses. An expression of opinion is given at the end of the autopsy report, which includes comment

about the circumstances of death. However, although the opinion is expressed in good faith, it holds no legal status and, in subsequent criminal or civil litigation, is commonly redacted out of the report. An interested person can seek a review of the cause of death, as found by the medical examiner. The review is carried out by the Chief Medical Examiner, and is itself subject to review by an administrative judge and, thereafter, there is a final right of appeal to a circuit court judge.

18.96 With deaths relating to medical care, the medical examiner will gather all relevant information and obtain expert specialist advice on the case. That information is then passed to the Board of Physician Quality Assurance, which is the body responsible for monitoring the standard of care given by doctors.

18.97 Although there is no formal judicial investigation of death, information obtained during the course of the medical investigation is harnessed for the purpose of improving public safety and passed on to a number of relevant bodies, usually the local health officer who is responsible for injury prevention and community health. Industrial accidents are investigated, not only by the OCME, but also by the occupational safety administration. The OCME contributes information to a national clearing house for information relating to product failures.

Cremation

18.98 The same standards of investigation and the same procedures apply, regardless of the method of disposal. Cremation is used much less than burial as a means of disposal in Maryland.

Detecting Shipman

18.99 On the basis of the summaries describing the circumstances of four of Shipman's unlawful killings, Dr Fowler formed the view that Shipman's activities would have been detected by the Maryland system. In relation to the case of Mrs Grundy, he said that, as hers was a death at home discovered by friends, it is likely that the emergency services would have been summoned and the OCME would have been informed of the death. Unless a medical history to support a cause of death had been established, the medical examiner would have ordered that an autopsy be carried out, which would automatically have included toxicological testing. If no autopsy had been carried out, there would have been an external examination together with toxicology. Prior to the hearings, Dr Fowler put the summaries in the four cases to his two deputy chief medical examiners and seven assistant medical examiners. In relation to three of the cases, all nine would have ordered an autopsy and, in relation to the fourth, seven out of nine said they would have done so. 'Old age' is not an acceptable cause of death in Maryland and would be rejected by the Vital Records Department. Even had the death not otherwise come to the attention of the OCME earlier, it would have been referred to the OCME as part of the routine screening process of death certificates. However, this might not have been done until after disposal of the body.

Comments

18.100 The systems for death investigation in Maryland appear highly developed and extremely robust. The level of training of forensic investigators is high. The Inquiry was told that, as in Ontario, their philosophy is to approach deaths critically and with a degree of suspicion. The forensic investigation of the circumstances of death runs in tandem with the medical investigation. The use of external examinations and toxicology, both alone and in combination, constitutes a valuable investigative tool.

18.101 I noted with interest the views of Dr Fowler and his staff that the Maryland system would have detected Shipman. However, this is at least in part due to the fact that doctors do not visit patients at home in Maryland, that the emergency services are likely to be summoned to any death at home and that such deaths are highly likely to be reported to the medical examiner. I can see that once that happens, the investigation is so robust that detection of wrongdoing is highly likely. I consider that those responsible for setting up the new systems of death investigation in England and Wales could learn much from studying the methods used in Maryland. I was particularly interested in the use made of toxicology.

18.102 Another strength of this system appears to be its highly developed procedures for audit and quality assurance.

The System in Finland

18.103 Professor Antti Sajantila, Professor of Forensic Biology, Deputy Head of the Division of Forensic Pathology and Director of the Laboratory of Forensic Biology at the Department of Forensic Medicine, University of Helsinki, attended the seminars and described the system in Finland.

Background and Structure

18.104 Finland has a medical examiner system and there are 13 medical examiners spread over the whole of Finland, six of whom are based in the largest province of South Finland. The population of South Finland is around 1.4 million. About 10,000 deaths occur in the province each year and forensic autopsies are performed in about a quarter of those cases.

18.105 Those involved in the certification of death are provided with extensive training. All medical students are required to undertake modules in forensic medicine and the completion of death certificates. The module consists of 22 hours of small group teaching on the completion of death certificates and external examination of the body. As part of university final examinations, medical students are required to complete five death certificates on the basis of hypothetical medical histories and information as to the circumstances of death. All students attend five forensic autopsies and specialist seminars on forensic pathology. In order to become a forensic pathologist, further comprehensive post-graduate training is undertaken in forensic pathology, clinical forensic medicine and clinical histopathology.

18.106 In South Finland, most of the medical examiners are based at the Department of Forensic Medicine at the University of Helsinki. The medical examiners have the same training as forensic pathologists and check all death certificates. They also have responsibility for educating doctors in medico-legal matters. Certain academic staff from the university forensic medicine departments are accredited to carry out forensic autopsies. Toxicology services in Finland are centralised and all toxicological testing is done at the University of Helsinki. Testing is carried out in 5000 cases each year, in addition to some limited biochemical analysis.

Statutory Framework

18.107 Statutes 1973/459 and 1973/948 specify the circumstances in which police, medical examiners and forensic teams are required to investigate deaths. In addition, separate regulations relating to the notification of death and burial of the deceased, payment of costs associated with certification and autopsy, disclosure of information and other provisions relating to autopsy and forensic examination are contained within statutes 1991/114, 1992/1131, 1997/858 and 1998/99.

Objectives

18.108 Death certification is considered to be an important aspect of medical practice in Finland. The aim of the system is to form as accurate and detailed information as possible about the cause of death, in order to inform future public health policy. Emphasis is placed on the importance of ascertaining the cause of natural, as well as unnatural, deaths and on the importance of the accurate death certificate to society, as well as to members of the deceased's family.

Preliminary Death Investigation

18.109 There is a duty on every person in Finland to report, to either a doctor or a police officer, the fact that a death has occurred. A police officer attending at a scene of death will summon a doctor from the public healthcare centre or a police surgeon. In some cases, the doctor will be able to certify the cause of death without the need to refer the death to the medical examiner or the need for further medical or police investigation. If further investigation is required, two types of investigation can be pursued. The first is a medical investigation as to the cause of death, which will not involve the medical examiner or the police. The second is a forensic, or medico-legal investigation, into the cause of death, which will be ordered in any case that is 'reportable' to the medical examiner. The medical examiner has no investigative role in respect of the factual circumstances surrounding the death and such investigations are carried out by the police.

Deaths Not Reported to the Medical Examiner and Not Investigated by the Police

18.110 If a doctor is able to certify the cause of death without further medical investigation, s/he will complete a death certificate, certifying the cause and manner of death. The Finnish death certificate is comprehensive and contains a considerable amount of information. The deceased's personal details are recorded, together with the certified causes of death.

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The cause of death is then classified into one of eight categories (disease, occupational disease, accident, medical treatment or investigative procedure, suicide, homicide, war or 'obscure'). Further classification is required in the case of an accident. A question is then asked as to whether, in the four weeks prior to death, anything more than a minor medical procedure has been carried out. There is then a large section of the form in which the doctor provides a narrative as to the circumstances of death, including the health of the deceased prior to the immediate events leading up to death, essential test results and treatment, and a detailed description of any injury or poisoning linked to the death.

18.111 The signing of a death certificate is taken very seriously in Finland and is seen as analogous to giving evidence under oath in court. In order to complete the form properly, it is necessary for the certifying doctor to make enquiries of relatives and carers and to read the deceased's medical records. Professor Sajantila was unaware of any complaints or problems arising out of the comprehensive nature of the death certificate or the amount of time taken to make investigations and complete each certificate. The Inquiry has seen examples of completed death certificates from Finland and they provide an excellent account of the medical events leading up to death. They are usually completed in typed form. Most certificates are filed within the recommended period of three months from the death and, if no autopsy is required, are generally completed within a few days of death.

18.112 The certifying doctor authorises disposal, then forwards the completed death certificate to the population register centre in order for the death to be registered. The families of deceased persons are entitled to see the death certificate. If not satisfied, they can report the death to the Bureau of Medico-Legal Affairs, which will then refer it to the medical examiner.

18.113 Where a doctor is satisfied that a death is natural, but requires further investigation in order to determine the precise cause of death, s/he can request that a clinical autopsy be performed. The permission of the next of kin is required in order for a clinical autopsy to be carried out, unless the deceased consented during life to the carrying out of the autopsy. Permission can also be obtained from the medical examiner. A clinical autopsy is carried out by a clinical pathologist or a histopathologist (as opposed to a forensic pathologist), on behalf of the clinician, to enable the clinician to certify the cause of death. The cause of death is not certified by the pathologist, in contrast to the position following a forensic autopsy. Although the clinical autopsy is a full invasive autopsy, toxicological analysis is almost never carried out. If, during a clinical autopsy, there is any indication for a medico-legal investigation, the pathologist will contact the police and a forensic investigation will be ordered.

18.114 Although not all deaths are reported to the medical examiner in the first instance, death certificates are audited by the medical examiner, who checks the certificate in every case. In addition, Statistics Finland, the body responsible for collecting mortality statistics, carries out an administrative check of all death certificates. If defects (e.g. relating to the coding of the cause of death) are found in a death certificate, this may be brought to the attention of the certifying doctor.

Deaths Reported to the Medical Examiner and Investigated by the Police

18.115 Certain categories of death are reportable to the medical examiner and fall to be investigated by the police. The police are under a statutory duty to investigate any death

that is not caused by illness, or where the deceased was not attended by a doctor during his/her last illness, together with those caused by crime, accident, suicide, poisoning, etc. and those caused by occupational disease. Although the medical examiner's jurisdiction is strictly limited to 'reportable deaths', s/he can ask for all deaths of a certain category (for example, from a particular nursing home) to be investigated and referred to him/her. The police investigate the death and, as part of the investigation, may instruct a forensic pathologist to perform an external examination or an autopsy. Although the decision whether or not to request an autopsy is for the police, they will be guided by the pathologist in reaching their decision. The family does not have the right to challenge the decision taken by the police to carry out a forensic autopsy.

18.116 In an appropriate case, the pathologist will certify the cause and manner of death on the basis of an external examination, together with the information contained in the police report and the deceased's medical records. Otherwise, a forensic pathologist will perform a full autopsy. If necessary, the pathologist can request that further investigative steps be taken by the police, for example that further medical records be obtained or that photographs of the scene of death be taken.

18.117 The body is released to the family for disposal soon after autopsy, commonly on the same day. The pathologist will inform the population register centre of the death and provide a preliminary autopsy report. Then, usually within a period of three months, the pathologist will produce a full autopsy report, a death certificate and a final written statement. A death certificate provided by one pathologist will be checked by a second pathologist.

18.118 Toxicology is not automatically ordered in the case of every forensic investigation and a decision as to whether toxicology will be ordered is generally taken following the autopsy. Professor Sajantila orders some form of toxicology in around 80–90% of the forensic autopsies he undertakes. The relatively extensive toxicological testing undertaken in Finland has produced unexpected results and demonstrated otherwise unsuspected links between deaths and alcohol, illicit drugs and even medically prescribed drugs.

Judicial Investigation of Death

18.119 Although information gathered in forensic and medical investigations is passed on to various government institutions and organisations, the medical examiner does not hold any judicial hearing into the circumstances of a death and will not make any formal recommendations in the interests of public safety.

Cremation

18.120 There is no distinction in the investigative and procedural requirements according to the method of disposal, and bodies to be disposed of by way of cremation are dealt with in exactly the same way as bodies disposed of by way of burial.

Detecting Shipman

18.121 Professor Sajantila commented on the summaries describing the circumstances of four of Shipman's unlawful killings. In relation to the case of Mrs Grundy, he said that, in Finland,

a forensic investigation should have been ordered because she had led an active life, was not known to suffer from any terminal or life-threatening illness and her death would have had to be regarded as sudden. If a forensic autopsy had been carried out, histology would have been ordered as a matter of course and, although the decision to order toxicology would have depended on the findings of the autopsy, there is extensive use of toxicological testing, which would probably have been carried out. However, before a forensic investigation was ordered, it would have been necessary for the death to have come to the attention of the police. Mrs Grundy's case was reported to the police. However, my understanding of Professor Sajantila's evidence was that, if Shipman had been able to provide a plausible explanation for the death then, even if the police had become involved, they would not have initiated a forensic examination. This is because of what Professor Sajantila described as a natural tendency on the part of police officers to trust the opinion of a doctor. He thought that it would only be in an extreme case that the police officer would challenge the opinion of a doctor. 'Old age' would be an unacceptable cause of death. If certified, it would have been picked up by the medical examiner or Statistics Finland during routine review of the death certificate. However, as Professor Sajantila pointed out in his written evidence, in most cases the body will have been disposed of by the time the check is carried out.

Comments

18.122 The most impressive aspect of the Finnish system of death certification was the emphasis on the importance of accurately ascertaining the cause of death, even where the death was apparently natural. This is of considerable significance, not only for the deceased's family, but also for society generally; it has significant implications for public health. The importance accorded to death certification is demonstrated by the attention paid to the topic of forensic medicine in the training of the medical profession in Finland and in the continuing education offered.

18.123 I was particularly interested in the design of the Finnish death certificate and the detail with which the examples I saw had been completed. This brought home to me how useful a careful summary of the medical history and chain of events leading to death would be for certification or investigation.

The System in Scotland

18.124 Ms Elizabeth Anne Paton, Procurator Fiscal Principal Depute, Crown Office and Procurator Fiscal Service, Edinburgh, attended the seminar and described the system in Scotland.

Background and Structure

18.125 The Crown Office and Procurator Fiscal Service (COPFS) is a Department within the Scottish Executive, headed by the Lord Advocate, assisted by the Solicitor-General, and is responsible for independent public prosecution and deaths investigation in Scotland. The COPFS headquarters are based at the Crown Office, in Edinburgh. The Procurator Fiscal Service is divided into 11 areas and the boundaries conform as closely as possible

to the boundaries of the Scottish police forces. Those 11 areas are divided further into a total of 49 districts. In larger districts, the district procurator fiscal is assisted by a procurator fiscal depute. Both are legally qualified. The Lord Advocate and Solicitor-General are assisted by Crown counsel, who are senior members of the Scottish legal profession, seconded to the Department for a period of about three years. Crown counsel prosecute in the High Court and review and advise on individual cases dealt with by the procurator fiscal.

18.126 In Edinburgh, the Crown Office has a deaths department, with a Procurator Fiscal and a Procurator Fiscal Depute (Ms Paton), who are assisted by a part-time member of the legal staff, an administrator and a secretary. Approximately 2000 deaths are reported in the Edinburgh district each year and autopsies are carried out on approximately half that number. Although the Procurator Fiscal directs investigations, s/he does so with police assistance, particularly in the undertaking of preliminary enquiries, which enables the Procurator Fiscal to take decisions as to the future conduct of an investigation. The Edinburgh police force has a dedicated team of inquiry officers. However, outside Edinburgh, preliminary investigations are undertaken by all police officers.

Statutory Framework

18.127 The Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976 defines the statutory duties of the procurator fiscal in respect of the investigation of deaths. The Registration of Births, Deaths and Marriages (Scotland) Act 1965 provides a statutory framework for the registration of deaths.

Objectives

18.128 The Scottish system bears many similarities to the system in England and Wales. However, it focuses on the holding of a public inquiry in a case giving rise to serious public concern.

Deaths Not Reported to the Procurator Fiscal

18.129 Only certain categories of death are reported to the procurator fiscal. In those cases where the death is not reported, the deceased's treating doctor certifies the cause of the death. The certification procedure for those deaths is similar to the procedure in place in England and Wales, in that a doctor who has treated the deceased during his/her last illness is under an obligation to issue an MCCD. One significant difference in the Regulations is that, under the Scottish system, there is no provision making reportable to the procurator fiscal a death where the certifying doctor has not seen the deceased within a specified period. There is no requirement on the doctor to examine a body after death in order to certify the cause of death; however, Ms Paton said that good practice dictates that this should be done.

Deaths Reported to the Procurator Fiscal

18.130 A large number of specific categories of death are reported to the procurator fiscal for investigation, including any uncertified death. The procurator fiscal also retains a broad

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discretion to examine any death where it is in the public interest for him/her to do so. Deaths are generally reported by general practitioners, hospital doctors and the police, and, to a lesser extent, registrars of deaths, where reportable deaths have progressed to the stage of registration. Occasionally, reports are received from members of the public. A telephone call from a person reporting a death will often be put through directly to the procurator fiscal; otherwise, in the first instance, the call will be taken by an administrator or secretary. Details of the report of death are noted on a specifically designed form, recording administrative details as well as the history. Only a member of the legal staff is authorised to advise a doctor to certify the cause of death. The procurator fiscal may ask the police to verify certain factual matters before allowing a doctor to certify.

Death Investigation

18.131 In cases where a death is to be investigated, the procurator fiscal will typically instruct the police to carry out preliminary enquiries. In some areas, dedicated police officers (or 'inquiry officers') are available to carry out investigations on behalf of the procurator fiscal. The police will then submit a report, containing the deceased's personal details, information as to the circumstances of death and the medical history. The procurator fiscal will then determine what further investigative steps should be taken. The precise investigative steps will, of course, depend on the circumstances of the individual case. If there is no certificate of cause of death, the next step is likely to be an autopsy. In most parts of Scotland, however, the procurator fiscal would have the opportunity of a 'view and grant' as an alternative to an autopsy. The Inquiry has received evidence on the 'view and grant' procedure, which derives its name from the fact that a pathologist will view the external aspects of the body, and if s/he can confidently provide a cause of death, grant an MCCD. When carrying out the examination, the pathologist will have available to him/her the police report and the deceased's medical records.

18.132 Further witness statements might be taken by the procurator fiscal or a member of the legal staff. Potential witnesses might be called in for interview to the procurator fiscal's office, a process known as precognition. The procurator fiscal might also meet the families of the deceased. Medical advice might be sought from a pathologist in the first instance and, in a case where the death is associated with medical care, an independent expert with appropriate expertise will be instructed to review the case and prepare a report. As in England and Wales, the investigation is directed by a lawyer, not a doctor.

18.133 In Edinburgh, autopsy services are provided under a block contract with the Department of Forensic Medicine at the University of Edinburgh. Two full-time forensic pathologists carry out the autopsies and are also available to provide medical advice when the need arises. This is the only medical expertise immediately available to the procurator fiscal. The decision to order an autopsy is made by the procurator fiscal and, although there is no formal right on the part of the family to object to the carrying out of an autopsy, in practice any objections made will be taken into account during the decision-making process. The procurator fiscal will request histology or toxicology in an appropriate case and, where the need arises, the pathologist will approach the procurator fiscal and request permission to carry out further investigation. If there is a suspicion of criminal involvement, the autopsy will be carried out by two pathologists. If not, a single-doctor

autopsy will be ordered. Following an autopsy, the pathologist prepares a report, which is significantly more comprehensive and detailed than the equivalent report produced following a coroner's autopsy in England and Wales.

18.134 In the Edinburgh district, the practice is to carry out full autopsies in every case. The 'view and grant' system is not available in Edinburgh. One further noteworthy exception to the full autopsy in Scotland was the practice adopted following the murder of a number of children at a school in Dunblane in 1996. They were shot by a gunman who went on to take his own life. In those circumstances, and on the basis that there could be no subsequent criminal proceedings, the murderer having taken his own life, x-ray examinations of the bodies were taken, in place of autopsies.

18.135 The procurator fiscal is under an obligation to report certain categories of death to the Crown Office, for Crown counsel to decide as to the future conduct of the case and as to whether it is necessary for a prosecution to be brought or a fatal accident inquiry to be held. If the case does not fall into one of those categories, at the conclusion of the investigation the procurator fiscal will make an order that there be 'no further proceedings'.

18.136 When a death is first reported to the procurator fiscal, a provisional cause of death will be provided where possible and the registrar informed of the provisional cause. At the conclusion of the procurator fiscal's investigations, the registrar will either be told that the provisional cause of death is confirmed or be informed of the amended cause. Personal attendance for the purposes of registration is required in Scotland, as in England and Wales.

Judicial Investigation of Death

18.137 The closest equivalent in Scotland to the inquest that is held in England and Wales is the fatal accident inquiry. There is only a relatively small number of fatal accident inquiries and, in the year 2001–2002, only 64 were held, out of a total of 13,625 deaths reported to the procurator fiscal. Fatal accident inquiries are chaired by a sheriff, who is a legally qualified judge, and the case is presented by a procurator fiscal. Fatal accident inquiries are held in public.

18.138 Fatal accident inquiries are mandatory in the case of a death caused by an accident in the course of employment or in the case of a death in legal custody. Fatal accident inquiries are also held at the Lord Advocate's discretion, which is guided by a number of principles, including whether the death occurred in circumstances such as to give rise to serious public concern. In the case of a discretionary inquiry, the views of the bereaved family as to the holding of an inquiry are taken into account. Where a death is apparently caused by a system failure, it is more likely that an inquiry will be held than if it appears to have been caused by an individual failure. The purpose of the inquiry is to establish where and when a death took place, the cause of the death and, in general terms, the cause of any accident that resulted in the death. Findings will be made about any reasonable precautions that might have prevented the death. Following a fatal accident inquiry, it is open to the sheriff to make recommendations for the purposes of future public safety. The recommendations are forwarded to the relevant body or organisation by the procurator

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fiscal. Although the recommendations do not have legal status, they apply political pressure to implement changes in furtherance of public safety.

18.139 Where there is no fatal accident inquiry, no formal report or document is prepared summarising the investigation carried out by the procurator fiscal. However, the procurator fiscal will hold discussions with the family and, where the family is interested in receiving further information, details of the investigation and the evidence obtained can be provided. In addition, the autopsy report will be made available to the family. Where appropriate, the report can be sent to a general practitioner in order for the medical aspects of the report to be explained. Alternatively, the family will be invited to a meeting with the procurator fiscal and a pathologist, who will explain the medical aspects of the report.

Detecting Shipman

18.140 On the basis of summaries describing the circumstances of four of Shipman's unlawful killings, Ms Paton formed the view that Shipman's activities would probably not have been detected by the procurator fiscal system, as it is implemented in Edinburgh. In relation to the case of Mrs Grundy, she said that 'old age' would have been acceptable as a cause of death because Mrs Grundy was over 80 years of age. Although the death should have been reported to the procurator fiscal, on the basis that it was sudden, the doctor could have certified the cause of death without reporting it. Even if the death had come to the attention of the procurator fiscal, depending on the precise circumstances and discussion with the treating doctor, the procurator fiscal might well have given the treating doctor permission to certify the cause of death. It is possible that the police would have been instructed to undertake a preliminary investigation into the circumstances of death, but neither the procurator fiscal nor any member of his/her staff would necessarily have made any direct enquiries of the family.

18.141 In relation to the death of Mrs Ivy Lomas, who was unlawfully killed by Shipman on his surgery premises, Ms Paton said that the list of reportable deaths to the procurator fiscal had been amended in the light of Shipman's crimes to include deaths that occur in a general practitioner's surgery. At the time of the death, however, the death might well not have been brought to the attention of the procurator fiscal and, in any event, as in the case of Mrs Grundy, the investigation would have been unlikely to have uncovered Shipman's unlawful activity.

Comments

18.142 The system in Scotland is similar in many respects to that in England and Wales. However, the discretion to select for public hearing only those cases which raise issues of serious public concern has the effect of reducing the number of cases in which a public hearing is necessary and of ensuring that hearings are not held in cases where they can serve no useful purpose.

18.143 I was also interested to hear about the involvement of families in the decision as to whether or not a public hearing should take place and, in the event that no such hearing is thought appropriate, of the arrangements made to inform the family about the deceased's death and its cause.

CHAPTER NINETEEN

Proposals for Change

Introduction – the Problems Summarised

19.1 The present systems of death and cremation certification failed to detect that Shipman had killed any of his 215 victims. Many of the deaths occurred suddenly and unexpectedly and, under the present procedures, should have been reported to the coroner. Yet Shipman managed to avoid any coronial investigation in all but two of the cases in which he had killed. He did this by claiming to be in a position to certify the cause of death and by persuading relatives that no autopsy (and therefore no referral to the coroner) was necessary.

19.2 The present system is almost completely dependent upon the professional integrity and competence of the medical profession. In general the profession can be relied upon, but not always. The Shipman case has shown that the present procedures fail to protect the public from the risk that, in certifying a death without reporting it to the coroner, a doctor might successfully conceal homicide, medical error or neglect leading to death. It is said by some that Shipman is unique; there will never be another like him. I hope that is so, but other, less prolific killers have been detected in the medical profession and it is not possible to determine how many killings or how many errors by a health professional have gone undetected. Certification of the cause of death by a single doctor is no longer acceptable. Cremation certification, as presently practised, is ineffective.

19.3 After many Shipman killings, relatives of the deceased were surprised and puzzled by the sudden death of their relatives. In Tameside, as would have been the case in most parts of the country, they were not consulted during the certification processes or given any specific opportunity to discuss the death. They never saw the cremation Form C doctor. They were not asked for their account of events. Those who were concerned about the death of their relative were too diffident to contact the coroner's office. Thus a source of information, which might have resulted in Shipman's detection, was not utilised. The relatives' concerns were unresolved. In future, the family of the deceased must play a full part in the processes of investigation and certification.

19.4 As I have said, only two of the deaths of Shipman's victims were investigated by the coroner. Most of these deaths were sudden and wholly unexpected by the relatives of the deceased. They should have been reported to the coroner but were not. For that reason alone, it is no longer acceptable that the decision on referral should be made by a single certifying doctor. In any event, research has shown that, even when acting honestly and making a genuine effort to recognise a death that should be reported to the coroner, many doctors fail to do so. Some means must be found to ensure that those deaths that require full investigation by the coroner receive it.

19.5 In the two concealed Shipman killings investigated by the coroner, the investigation failed to uncover the truth. Those investigations were inadequate. The Inquiry has found other examples of poor coronial investigation. If coronial investigation is not thorough, there is a danger that wrongdoing will go undetected. There are several possible explanations why coroners' investigations are not as thorough as they should be. One is that the coroner

may have insufficient time and inadequate resources to ensure that reported deaths are properly investigated. Often the coroner does not have medical knowledge or ready access to medical advice. He or she may therefore have an imperfect understanding of the issues. Many coroners lack the support of trained investigators.

19.6 In short, the present systems are failing to protect the public and to meet the reasonable expectations of society. There can be no doubt that change is needed. The changes that I shall propose are based upon the evidence I have heard and read, the responses to the Inquiry's Discussion Paper and the contributions made during the seminars. At times, in earlier Chapters of the Report, I have presaged some of my conclusions. In this Chapter, I shall describe my proposals for change and the new system that I recommend.

The Fundamental Review of Death Certification and the Coroner Services

19.7 The Terms of Reference of the Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland ('the Coroners Review') overlapped to some extent with those of this Inquiry. Mr Tom Luce, Chair of the Review, has been most helpful to the Inquiry. He provided the Inquiry with the responses to the Review's Consultation Paper. He agreed to make a public statement at one of the Inquiry's seminars, in which he outlined the Review's current thinking on a number of issues of common interest. Also, he has permitted me to read the Review's Report before publication. This has enabled me to identify those areas where the Review's conclusions coincide with mine and where we differ. I am pleased to report that there are many topics on which we are in agreement. Where we do not agree, I shall take the opportunity to explain why I differ from the Review's proposals. I hope that this approach will be of assistance to those whose task it will be to decide upon the form of change to be made.

19.8 It will be apparent to any reader of this Report and the Report of the Coroners Review that I have not covered several important issues that are covered by the Review. For example, I have not mentioned the special arrangements presently made for the certification and registration of stillbirths and neonatal deaths. I have not discussed whether special provision should be made for the investigation of the death of a child. I have not considered the procedures governing the disposal of bodies brought in from overseas or the granting of permission to remove a body for disposal overseas. I have not mentioned Northern Ireland. I have not touched upon these subjects because they have not arisen in my consideration of the deaths of Shipman's patients and the operation of the systems by which those deaths were investigated and certified. Those topics in effect fell outside the Inquiry's Terms of Reference.

19.9 There is one very important set of issues, covered fully by the Coroners Review, which I shall touch upon only briefly. This is the scope and conduct of inquests. As the Report of the Coroners Review makes plain, this is an area in which changes are necessary. I have not delved deeply into these issues for two reasons. First, they have not been prominent in the Inquiry's consideration of the deaths of Shipman's patients. No death of a victim of Shipman's was subject to an inquest until after his conviction. The deaths of very few of his patients were even reported to the coroner, let alone examined at inquest. For that reason, the Inquiry has received little evidence about inquests. The issues surrounding

the scope and conduct of inquests have arisen largely from consideration of the responses to the Coroners Review's Consultation Paper and the Inquiry's own consultation procedures. Second, as the results of the consultation have led me to form views similar to those expressed by the Coroners Review, it seems sensible that I should simply endorse the Review's conclusions, rather than explain my own at any length. In Chapter Nine (paragraph 9.76), I have listed those parts of the Coroners Review where I am in agreement with the views expressed.

Should a Coronial System Be Retained?

19.10 In any modern society, there must be a system for the investigation of the cause and circumstances of death. In England and Wales, for well over a century, coroners have been at the heart of the system of death certification and investigation. Although many deaths are certified by a single doctor, Parliament has provided that certain deaths requiring investigation are to be reported to the coroner with a view to an inquest being held unless the coroner decides, after an autopsy, that an inquest is not necessary. In earlier Chapters of this Report, I have been critical of the ways in which the coronial system operates at present. I have pointed to the poor quality of many coroners' decisions and the superficiality of investigation. Although I have not covered in depth the conduct of inquests, I am aware of many criticisms of them and I observe that the Coroners Review has concluded that they are unsatisfactory in many respects.

19.11 In the light of these deficiencies, ought I to recommend the abolition of the coronial system? Is there any need in the system for a hearing conducted by a judicial figure? Although some states and countries (e.g. Finland and Maryland, USA) complete death investigation and certification without any judicial involvement, many systems incorporate some form of judicial proceeding for the uncovering of uncertain facts. It seems to me that the availability of some form of judicial enquiry is highly desirable, if not absolutely essential. I think that the tradition of the coroner's inquest is so well rooted in this country that most members of the public would regret its loss, even though they are critical of the way it is operated at present.

19.12 I have concluded that the coronial system should be retained. In that, I am in agreement with the Coroners Review. However, in my view, there must be radical reform and a complete break with the past, as to organisation, philosophy, sense of purpose and mode of operation. The new Coroner Service that I shall recommend will be barely recognisable as the offspring of its parent.

The Aim and Purposes of the New Coroner Service

19.13 The aim of the Coroner Service should be to provide an independent, cohesive system of death investigation and certification, readily accessible to and understood by the public. For every death, it should seek to identify the deceased, to discover where, how and why the deceased died and should provide an explanation for the death to those associated with the deceased or having a proper interest in understanding the cause and circumstances of the death. It should seek to ensure that all the necessary formal details relating to the death are correctly and accurately recorded. Its procedures should be

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designed to detect cases of homicide, medical error and neglect. It should seek to meet the needs and reasonable expectations of the bereaved, including those from minority groups who wish to dispose of their dead within a short time after the death. The Service should also provide a thorough and open investigation of all deaths giving rise to public concern. It should ensure that the knowledge gained and lessons learned from death investigation are applied for the prevention of avoidable death and injury. It should provide accurate information about causes of death for the purpose of maintaining mortality statistics and to assist in the planning of healthcare provision and public health strategies.

19.14 It will be observed that I have not sought to draw any distinction between 'natural' and 'unnatural' deaths. This is a distinction that sometimes causes practical difficulty and results in decisions that are difficult to justify logically. The aim of the Coroner Service should be to investigate all deaths to an appropriate degree. With many, it will be sufficient to confirm and record uncontroversial basic information about the deceased and the medical cause of death. With others, there will be a need for investigation of the circumstances of the death and its medical cause. There should not be fixed categories of deaths that require and do not require in-depth investigation. Coroners should receive guidance about what types of death are likely to merit detailed investigation but the extent of the investigation in an individual case should depend upon the circumstances and any concerns expressed.

The Need for Leadership, Training and Expertise in the Coroner Service

19.15 As I described in Chapter Seven, coroners follow markedly differing practices and provide services of variable quality. In future, the Coroner Service should provide leadership, training and guidance for coroners, with the aim of achieving consistency of practice and a high quality of service throughout the country. This should be provided by means of a unified national Service, centrally governed and operating through regional and district offices.

19.16 In my view, the Coroner Service requires medical, legal and investigative expertise. A coroner should not, as now, carry out all coronial functions regardless of whether s/he is legally or medically qualified. In future, s/he should perform only those functions for which s/he is professionally qualified. Coroners should have the support of trained investigators. All coroners and investigators should be given initial and continuing education relevant to their functions and all must be trained in dealing with the bereaved and in the issues affecting minority groups. Such training should be compulsory.

19.17 Many times in this Report, I have drawn attention to the need for medical expertise in the coroner's office. At present, although most coroners are legally and not medically qualified, they carry out functions that require medical expertise. The conduct of inquests apart, the job of coroner requires medical knowledge far more often than legal knowledge, and entails a medical judgement far more often than a legal one. The coroner must decide whether a death falls within his/her jurisdiction. This is not usually a difficult legal issue but requires an assessment of the known facts, a process which often, although not always, depends upon medical knowledge and judgement. The coroner often has to decide whether to certify a cause of death, on the basis of an autopsy, without an inquest. The

interpretation of the autopsy results, in the light of other available evidence, is essentially a matter of medical rather than legal judgement. In any event, in my view, the identification of the cause of death in a case of uncertainty need not and should not always automatically entail the conduct of an autopsy. Consideration by a medically qualified person of other materials, such as medical records and information about the circumstances of death, should, in many cases, sufficiently identify the cause of death. Apart from the conduct of inquests and the investigation that precedes some of them, most of the coroner's functions call for medical expertise. In my view, there is a need, within the coroner system, for a medically qualified person to exercise many of the functions presently carried out by coroners who have, in the main, no medical expertise.

19.18 Sometimes, although not always, the task of directing an investigation into the circumstances of a death requires legal expertise. So, obviously, does the conduct of an inquest. My proposals in relation to the cases in which an inquest should be held would, if adopted, result in a substantial reduction in the number of public inquests. I envisage that many coroner's investigations would result in a written report rather than an inquest. At the present time, it appears to me that most such investigations and reports would not require the attention of a coroner with legal expertise. I shall discuss this topic in greater detail below. However, there would be other functions in the new system that I propose which would call for legal expertise. I envisage that a legally qualified coroner would be required in order to exercise a number of special powers, such as authorising the right to enter premises and seize property and documents relevant to the investigation of a death, which I am proposing should be available to coroners. A legally qualified coroner would also be required to exercise a number of appellate functions, which I am proposing should be introduced, particularly relating to issues affecting a citizen's rights. Plainly, there will be a need for legally qualified persons in the Coroner Service as well as for those with medical qualifications.

19.19 What should these medically and legally qualified persons be called? In my view, they should both be coroners, as both would fulfil what have traditionally been regarded as coronial functions. In the Discussion Paper, the Inquiry team tentatively gave them the names of 'medical coroner' and 'judicial coroner'. The Coroners Review, which has also concluded that there is a need for medical expertise in the coroner's office, proposes that the coroner should be legally qualified and that the person with medical expertise should be called the 'statutory medical assessor (SMA)'. The differences between these two proposals are not merely of nomenclature. I envisage a different role for the 'medical coroner' from that which is proposed for the 'statutory medical assessor'. The 'medical coroner' would take many coronial decisions and would manage and be responsible for the operation of the district office. He or she should be an independent office-holder under the Crown with the status of the present coroner. The titles 'medical coroner' and 'judicial coroner' fit the functions that I propose. I shall therefore continue to use those expressions throughout the remainder of this Report. When referring to the proposals of the Coroners Review, I shall use their terminology. However, I stress that there is agreement between us that someone with medical expertise (whatever s/he is to be called and whatever the precise ambit of his/her role) is needed in the coroner's office.

19.20 At present, coroners depend for support on coroner's officers who are almost completely without training or management. In future, the coroner's support should come from a corps

of trained investigators, who would be the mainstays of the new system. The coroner's investigator would replace the coroner's officer but the role would be much enhanced and the coroner's officer's more routine functions would be performed by administrative staff. Investigators would come from different employment backgrounds and would bring a variety of skills and experience to the work. For example, some might have a background in criminal investigation. Others would have a paramedic or nursing background. The essential attributes would be an independent and enquiring mind, good interpersonal skills and particularly the ability to work with the bereaved. All investigators would be required to handle certification of deaths, in the way that I shall describe below, exercising powers delegated by the medical and judicial coroner. I envisage that some investigators (those with a medical background) would become accredited to certify the fact of death and would specialise in the investigation of the cause of death. Others would develop skills for the investigation of the circumstances of deaths, for example deaths in the workplace. All would be trained to approach every death with an open mind rather than a confident expectation that the death will be natural. In other words, like investigators in Ontario, they should be trained to 'think dirty'.

Proposals for the Structure and Operation of the Coroner Service

Central Organisation

19.21 The Terms of Reference of the Coroners Review required it to consider where departmental responsibility should lie for the provision of any new or changed arrangements for death certification and the role of coroners. The Inquiry's Terms of Reference contained no such specific requirement. The Inquiry has not heard evidence or received representations about the way in which the changes I am to recommend should be effected. However, I have formed some views about what should happen and why.

19.22 In my view, if coroners and the Coroner Service are to command the confidence of the public, they must be and must be seen to be independent of Government and of all other sectional interests. Although coroners investigate on behalf of the state, they might well reach verdicts and make recommendations unwelcome to Government and sectional interests. For example, coronial decisions critical of hospital practice might be unwelcome to the National Health Service. In the past, there has been no suggestion of interference by Government in the judicial independence of the coroners. They have, as I have observed, been left to their own devices. However, I now propose that coroners should have the benefit of leadership from a supervisory and supporting structure. The body which is to provide that leadership and support must be seen to be independent of Government. In my view, it would no longer be satisfactory for the coroner service to be administered from within a Government Department. Instead, the new Coroner Service should be a body at 'arm's length' from Government, that is an Executive Non-Departmental Public Body (ENDPB). Such bodies are formed in association with, but are independent of, the Government Department through which they are answerable to Parliament.

19.23 At present, responsibility for coroners lies with the Home Office, although the Lord Chancellor has the power to discipline them. It seems likely that the association with the Home Office arose because, historically, coroners were an adjunct to the criminal justice system. This is no longer the case. The Home Office is also responsible for cremation certification. Death certification is carried out either by coroners or by doctors. The doctor's duty arises under the Births and Deaths Registration Act 1953 and not from his/her employment within the National Health Service. Government responsibility for registration lies with the Office for National Statistics (ONS), which falls under the control of the Treasury. The Department of Health (DoH) (in Wales, the National Health Service Wales Department of the National Assembly for Wales) has an interest in death certification and in many aspects of the work of coroners (the use of pathologists is an example). This fragmentation of control and interest has led to difficulty in effecting reform in the past. As appears from the history I recounted in Chapter Three, one of the reasons why the recommendations of the Brodrick Report were not carried into effect was that there was insufficient political will; the interests and priorities of the various Departments pulled in different directions. That problem is likely to continue as, inevitably, several Government Departments will continue to have a policy interest in the various aspects of death certification, investigation and registration. However, I believe that the problems of fragmentation would be alleviated if the Coroner Service had the status and independence that enabled it to co-ordinate the various Departmental policies into a coherent overall policy.

19.24 If the Coroner Service is to be an ENDPB, as I suggest, with which Government Department should it be associated? The Coroners Review has suggested that the Coroner Service should be administered directly by the Lord Chancellor's Department (LCD) and should have the benefit of a Coronial Council to monitor its performance. Since the Review's Report was published, the Government has announced the formation of a new Department for Constitutional Affairs, which will take over many of the functions of the LCD. At the time of writing, it seems likely that the new Department will be responsible for the administration of the courts and, in conjunction with a Judicial Appointments Commission, for the selection of the judiciary. I agree that the LCD would have been in many respects, a suitable Department to be associated with the Coroner Service. The Department was very experienced in the appointment of judges of all levels and well understood the need to protect judicial independence. However, there are some aspects of the work of the Coroner Service that would not have fitted comfortably with the functions of the LCD. The Coroner Service will have to recruit medical coroners or statutory medical assessors or some medically qualified persons, whatever title they are given. The LCD had no experience of such functions and no connection with the medical profession. The Coroner Service will also have an investigative function. The LCD would have been ill equipped to offer support in that respect also. In some respects, the DoH (and its equivalent in Wales) would be a more appropriate choice. It will be important for the Coroner Service to establish links with public health and to ensure that its medical coroners do not become isolated from current medical knowledge and practice. I cannot at present see any advantage in the Coroner Service being associated with the Home Office.

19.25 It seems to me that the ideal solution would be for the Coroner Service to be an ENDPB associated with both the new Department for Constitutional Affairs and the DoH or its

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Welsh equivalent. It would in that way be able to draw upon the relevant expertise available in both Departments and would yet maintain a high degree of independence. I realise that an ENDPB is usually associated with only one Department. However, it appears to me that there are particular reasons why the usual practice should be abrogated in the case of the Coroner Service. Devolution issues may have to be addressed.

19.26 As an ENDPB, the Coroner Service would be governed by a Board. I have said that the Coroner Service requires three forms of expertise. I suggest that the Service should be managed by a Chief Judicial Coroner, a Chief Medical Coroner and a Chief Coroner's Investigator, who would be members of the Board and would provide the executive core of the Service. I suggest that the Board might have two or three other independent members with relevant knowledge and experience.

19.27 The Board would be responsible for the formulation of policy, the strategic direction of the Service and the provision of the necessary facilities, buildings and personnel. It should seek to secure adequate funding from Parliament. An important central function would be to promote the education of the public about the work of the Coroner Service. It is desirable that the Coroner Service should have a high public profile. I would suggest also that the Board should make provision for a national coronial information system, organised along the lines of that in Australia.

19.28 The Chief Judicial Coroner would provide leadership for the judicial coroners operating throughout the country. He or she would be responsible for the continuing education of judicial coroners and for the promotion of nationwide consistency of good practice. He or she would also exercise some judicial functions and might conduct some inquests. I suggest that the first appointee might be an existing judge or senior member of the legal profession, rather than an existing coroner, and the post should be of the status of a senior circuit judge. I consider it vital that there should be a complete break with the ethos of the existing coronial system.

19.29 The Chief Medical Coroner would provide leadership for medical coroners and regional medical coroners throughout the country. He or she would be responsible for the provision of the facilities necessary for the operation of the medical coroner service at regional and district level. He or she would be responsible for continuing education and the promotion of good practice. He or she would establish links at a high level with those concerned with public health and public safety. The position would call for a doctor with administrative ability and some knowledge of or experience in the fields of public health and forensic medicine.

19.30 The Chief Coroner's Investigator would be responsible for the provision of a corps of suitably trained and experienced coroner's investigators for deployment in the regional and district offices. He or she would devise and arrange training courses. He or she would also devise and promulgate protocols for the conduct of investigations. He or she would be responsible for the maintenance of high standards of investigative work. The position might suit a former senior detective police officer or a solicitor with experience of investigative work. I shall describe the operation of these officers and the central, regional and district offices in greater detail at Appendix L.

19.31 The Service should have the benefit of an Advisory Council, which should provide policy advice on all issues. This might comprise, in addition to the members of the Board, representatives of the DoH, its Welsh equivalent, the Department for Constitutional Affairs, the Home Office, the General Register Office, the ONS, organisations representing doctors, nurses and those providing pathology services, the Association of Chief Police Officers, an Ambulance Trust and an organisation such as Cruse Bereavement Care.

Regional and District Organisation

19.32 The Coroner Service should be administered through a regional and district structure, with a regional medical coroner and at least one judicial coroner assigned to each region. I envisage that there would be ten regions in England and Wales (coinciding with the ten administrative regions). The Coroner Service should have jurisdiction over every death that occurs in England and Wales and over every dead body brought within the boundaries. Jurisdiction should not depend upon a report being made or upon the need for an inquest. A death should be investigated in the district office most convenient in all the circumstances.

19.33 The principal functions of the judicial coroner would be the conduct of inquests and the direction of more complex investigations. The main functions of the regional medical coroner would be the provision of regional services of a specialist nature such as forensic pathology, paediatric pathology and toxicology. He or she would also undertake investigations into the more difficult or complex medical cases, where appropriate, in conjunction with the judicial coroner. I suggest that there might also be a regional investigator who would supervise the investigative teams within the region and would manage a small team of investigators at the regional office.

19.34 Each region would be divided into districts. I have in mind that each region would have between three and seven districts and each district would have a population of about a million. I suggest that districts should be coterminous with the boundaries of the 42 police areas (excluding the City of London), although where a police force covers a wide area or serves a large population, there would be more than one coronial district within that police area. In all, I envisage between 50 and 60 district offices. Each district office would have a medical coroner, one (or possibly more than one) deputy medical coroner (who might work part-time), a team of coroner's investigators and a small administrative staff. The service would operate for 24 hours, seven days a week, although the 'out of hours' service would be limited to the necessary minimum.

19.35 It will, in my view, be important to ensure that the medical coroner is and is seen to be independent of the medical community within the district. He or she will, in many respects, be required to 'police' the local doctors. It may well be necessary to appoint a medical coroner from an area distant from the district in which s/he is to serve.

Death Certification and the Reporting of Deaths to the Coroner

A Unified System

19.36 All the evidence received by the Inquiry and virtually all the opinions expressed during consultation suggest that the separate system of certification prior to cremation should be

abolished. It was universally recognised that we must have an improved system of death certification applicable to all deaths, whatever mode of disposal is to follow.

The Proposal in the Discussion Paper

19.37 In the Discussion Paper, the Inquiry suggested a dual system of death certification, in which a single medical practitioner would be permitted to certify the cause of death in a limited class of cases, namely 'expected deaths' that were not in any other respect reportable to the coroner. All deaths other than 'expected deaths' and all reportable deaths were to be fully investigated by the coroner. There was to be a more comprehensive list of circumstances in which a death was to be reported. Certification by a doctor would be subject to safeguards that would operate through the completion of a new set of forms. Form 1 was to record the fact of death and the circumstances in which it occurred. It was to be completed by the health professional who examined the body and ascertained that death had occurred. Form 2 was to replace the existing MCCD and was to provide additional information about the deceased's medical history. It was to be completed by a doctor who had treated the deceased during the last illness. Form 3 was to be completed by a member of the deceased's family who had had the opportunity to examine what had been said on Forms 1 and 2. It was to provide an opportunity to raise any concerns about the death, including those caused by any perceived inaccuracy in the information recorded on Forms 1 and 2. Form 4 was to be completed by the funeral director who prepared the body for disposal and who was to draw attention to any signs of violence or neglect observed. All the forms were to go to the register office; it was hoped that the detail on the form would be such that any indication of the need for a referral to the coroner would be readily apparent to the registrar. In the event, the registration service did not agree that it would, for reasons that, having heard the evidence given in Stage Two, I fully understand.

19.38 The thinking behind the Inquiry's proposal was as follows. Although I was attracted to the idea that all deaths should automatically be reported to the coroner's office (because of the difficulty doctors have in recognising reportable deaths), I feared that such an arrangement might lead to delay in the granting of permission for disposal. I thought that there would be many 'expected deaths' which could be certified quickly, simply and safely by a single doctor; there would be a sufficient safeguard against the 'Shipman factor' if the family were to have the opportunity to see what the doctor had written and to raise their concerns.

19.39 However, as a result of the consultation exercise and the feasibility study carried out on the Inquiry's behalf, this proposal has been abandoned. First, it became obvious that it was not easy to define an 'expected death'; the suggested definitions were far from simple. At the moment, most doctors apply the term to any death for which they are able to issue an MCCD. The converse, the 'sudden' or 'unexpected' death, has to be reported to the coroner. Not only was it difficult to define an 'expected death', it seemed to me that it would be extremely difficult to wean doctors from their present understanding of the term. Second, there was an unexpected degree of support for the idea that all deaths should be considered by the coroner rather than only those falling within the reporting criteria. Third, and perhaps most important, it became quite clear that, as a means of involving the family of the deceased and providing a cross-check on the certifying doctor's account, the use

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of Form 3 would be unacceptable. Families would find the form difficult and possibly distressing to complete; they would need help and could not be asked to deal with it quickly. Some means of personal contact with the bereaved family would be required.

Identifying the Basic Requirements of the System

19.40 Although the consultation exercise led to the abandonment of the suggested system of certification advanced in the Discussion Paper, it confirmed the suitability of some of the Inquiry's ideas. In particular, I became convinced that modified versions of Forms 1 and 2 should be the basis of the certification system. Before turning to the more difficult question of who should be responsible for the decision on certification, I shall explain the operation of the two new proposed forms. They are reproduced, together with explanatory notes and sample completed forms, at Appendices G–K. The purpose of the explanatory notes is to describe what each question is driving at and the type of information that should be provided. The notes are not intended to be a blueprint for the explanatory notes that would have to be provided for the doctors and health professionals who would complete the forms. The completed sample forms have been prepared to illustrate the type of information that should be provided. These forms contain the Inquiry's ideas about what is required. They will almost certainly have to be redesigned by experts. However, I strongly recommend that the information sought in the forms eventually used should be substantially the same as is suggested in the Inquiry's Forms 1 and 2. The Inquiry has not attempted to design forms for special circumstances (such as stillbirths and neonatal deaths), which would clearly be required.

Form 1

19.41 In my view, there should be a requirement that the fact that a death has occurred should be confirmed and certified. At the seminars, there was unanimous support for the proposal that there should be an official record of the fact and circumstances of death. The Coroners Review makes a similar proposal. For this purpose, the Inquiry proposes Form 1, which would be completed by the health professional or coroner's investigator who confirms the fact of death. I recommend that, in addition to doctors, accredited nurses and paramedics should be authorised to confirm the fact of death and to complete Form 1. Coroner's investigators should also be trained and accredited for the purpose of certifying the fact of death. The Coroners Review has suggested that a nurse employed in a care home should not be permitted to certify the fact of a death occurring at that home. The Review proposes that a nurse should be provided by the local Primary Care Trust for that purpose. I do not think that such a limitation is necessary, provided that the nurse is properly accredited.

19.42 Different versions of Form 1 are suggested for deaths in the community, in hospitals and in accident and emergency departments. All versions of Form 1 require a description of the circumstances of death, including a statement as to who was present, together with contact details. All require that some external examination of the body should take place and the findings be recorded. For deaths in hospital, the whole body should be examined for signs which might be indicative of violence or neglect. For deaths in the community,

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where conditions for examination are often difficult, there should be an examination of the head, neck and arms to the elbow. A special form is suggested for use in accident and emergency departments because of the particular pressures of work in such places. A patient might be dead on arrival or die very soon after admission. The fact of death might be certified by a doctor and the body moved from the department to make way for other patients. It seemed sensible that the examination of the body and the provision of information about the circumstances of death and the contact details should be made later, by someone other than the doctor who has certified the fact of death. Also, the circumstances of a death in an accident and emergency department are likely to be different from those of a death on the ward, in that the events leading to admission to the department are likely to be more relevant than those which took place in the department itself.

19.43 An issue arises as to whether a doctor or nurse who owns or has a financial interest in a care home or private hospital in which the death occurred should be permitted to complete Form 1. The concern was raised that such a person might be tempted to conceal some form of wrongdoing by him/herself or a member of staff. It appears to me that a doctor or nurse in that position ought to be allowed to complete Form 1. The main purpose of this form is to certify that the patient has in fact died. That is purely a question of medical fact and there is no reason to suppose that anyone would lie about it. It is possible that the person completing the form might tell lies about the circumstances of death. However, if the owner of the care home is not permitted to complete Form 1, some other health professional will have to attend to do so. That person will be dependent on the member of staff, probably the owner of the care home, for information about the circumstances of death. If the owner intends to deceive, s/he will be able to do so. The only way in which such deception might be uncovered would be by checking the information with some other person (if there is one) with relevant information.

19.44 It should be possible for Form 1 to be transmitted promptly to the district coroner's office on-line or by fax.

Form 2

19.45 It seems to me clear that the certification process should include the preparation of a brief summary of the deceased's recent medical history and the chain of events leading to the death. That would be provided on Form 2, which would be completed by a doctor who had treated the deceased during the last illness or, if no doctor had treated the deceased in the recent past, by the deceased's usual medical practitioner. It might well be completed by the doctor who had completed Form 1. The forms for hospital and community use are substantially the same, although the form for use in the community requires the doctor to describe any nursing or other care the deceased had been receiving before death. I suggest that it should become usual practice for the doctor to attach to Form 2 any important extracts from the medical records (e.g. the result of a test or a consultant's opinion). In future, with the increased use of computerised records, it should be possible for such extracts to be sent on-line, with Form 2, to the district coroner's office. Form 2 also provides a box in which the doctor can draw any relevant matter to the attention of the coroner.

19.46 The form also contains a box where the doctor has the option to express an opinion as to the cause of death. This should be done only if the doctor is able to express an opinion with a high degree of confidence. The declaration relating to that part of the form requires the doctor to say that s/he is **'able to justify the cause of death specified** [*above*] **on the basis of the deceased's medical history and circumstances of death'**. The doctor giving an opinion as to the cause of death should be capable of justifying the diagnosis to the medical coroner, by reference to the medical history and circumstances of the death, in the same way that s/he would expect to have to justify a diagnosis relating to a live patient in discussion with his/her peers. Even if the doctor cannot give such an opinion, s/he must still complete the remainder of the form. If the doctor is uncertain of the cause of death, it would be plain that the death required full investigation by the coroner. I should point out that Form 2 is not a certificate of cause of death. It provides only information and possibly the doctor's opinion. Certification would take place at the coroner's office.

19.47 Form 2 does not specifically require the doctor to state when s/he last saw the deceased alive, although the date of the last consultation with a doctor is almost bound to appear as part of the medical history. It is not intended that a doctor should be disqualified from expressing a professional opinion as to the cause of death simply on account of the lapse of time since the last consultation. However, when the doctor's opinion comes under scrutiny, as it must, the length of time since the last consultation would be a material factor for the person considering whether the diagnosis was reliable.

19.48 In my view, the completion of Form 2 is a very important function and should not be carried out by junior or inexperienced doctors. I have referred to the problems presently experienced when newly qualified house officers are given the task of completing an MCCD. It seems to me that the doctor who describes the medical history, expresses an opinion as to the cause of death and gives any other information to the coroner should have some experience and authority. A doctor will not usually become a principal in general practice until s/he has been qualified for about four years. In my view, any principal in general practice (but not a trainee) should be eligible to complete Form 2. In the hospital setting, I consider that the certifying doctor should have a comparable degree of experience and authority. I suggest that, to be eligible to complete Form 2, a doctor should have been in practice for four years since qualification. For doctors qualified overseas, I recommend that they should not be eligible to sign Form 2 until they have been in medical practice for four years (whether in the UK or not), are registered with the General Medical Council (GMC) and have been trained in the requirements of death certification in this country.

19.49 In my view, it will be necessary to impose a statutory duty upon a doctor so as to ensure that Form 2 is completed. If the death occurs in a hospital, the statutory duty should lie upon the consultant responsible for the care of the deceased at the time of the death. The duty need not be fulfilled personally but would be satisfied if the form were completed by a suitably qualified member of the consultant's clinical team (or firm). For deaths occurring elsewhere than in a hospital, the statutory duty would fall upon the general practitioner with whom the deceased had been registered. Here again, the duty could be fulfilled by another principal in the practice (who might, for example, have seen the deceased more recently than the doctor with whom the deceased was registered). If in future, the

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procedure of registering with an individual general practitioner were to be changed and patients were to be registered with a practice, the statutory duty would have to lie on all principals within the practice, until fulfilled by one of them. For deaths occurring very shortly after admission to hospital, for example in an accident and emergency department, it might be appropriate for the duty to complete Form 2 to lie upon the deceased's general practitioner. It might be thought sensible to impose a time limit within which Form 2 should be completed.

19.50 If the deceased were not currently registered with a general practitioner and the death did not occur in hospital, there would be no one to complete Form 2. In those circumstances, the death would be investigated by the medical coroner. He or she could obtain any relevant past medical records that were available and speak to any doctor with whom the deceased had been registered in the past.

19.51 I recommend that the GMC should impose upon doctors a professional duty to co-operate with the death certification system by providing an opinion as to the cause of death on Form 2 in cases where it is appropriate to do so. A failure to co-operate would be a disciplinary matter.

19.52 With Form 2, as with Form 1, an issue arises as to whether a doctor who owns or has a financial interest in a care home or private hospital where the death occurs should be eligible to complete Form 2, to provide the medical history and to suggest the cause of death. If the doctor were to be able to certify the cause of death, I would be opposed to that being done by a doctor who might find him/herself in a position of conflict of interest. If the doctor were only to express an opinion, and if the death were to be certified by someone else (such as the medical coroner or a coroner's investigator), I can see no harm in the doctor with a financial interest expressing an opinion, provided that the interest is declared.

One Option – Dual Certification by Doctors

19.53 Apart from the option of the system of death certification suggested in the Discussion Paper, which I have decided to abandon, two other options were considered at the seminars. Both received a good deal of support. Under the first option, which I shall call the 'dual certification' system, the Form 2 doctor would consider whether s/he was able to express an opinion as to the cause of death to the high degree of confidence required by Form 2. If not, the death would be investigated fully by the coroner. If s/he was confident of the cause of death, a second doctor would review the first doctor's opinion. The second doctor would be a member of a panel selected by the medical coroner and would therefore be independent of the first. The second doctor would attend the medical coroner's office on a sessional basis and, for that time, would give the whole of his/her attention to the work of certification. Those contributors to the seminars who supported this option recognised that the second doctor must not be expected or permitted to squeeze the work of certification into the interstices of an ordinary working day. The second doctor would speak to and question a member of the deceased's family and possibly a carer, check with them the accuracy of what the first certifying doctor had said about the death and ascertain whether they had any concerns. The second doctor might also examine the

deceased's medical records. Some seminar participants suggested that the second doctor might make a physical examination of the body. However, most opposed that idea; they regarded such an examination as impracticable (the facilities at many funeral directors' premises being inadequate) and pointless unless carried out by a doctor with special training. It would also be very time-consuming.

19.54 If the second doctor were satisfied with the results of his/her enquiries, both doctors would sign the certificate of cause of death. Registration would take place on the basis of the dual signatures on that certificate. The registrar would give permission for disposal as now. If during the process, any circumstance were discovered to suggest that investigation was required, the death would be referred to the coroner. This system would be similar to cremation certification, as it was originally intended to operate. Plainly, if such a system were to be adopted, there would have to be safeguards to prevent the kind of deterioration in standards that occurred with cremation certification. In the event, this 'dual certification' system is similar, although not identical, to the system proposed by the Coroners Review. As a variation on the 'dual certification' system, the BMA suggested that all deaths should be reported to the medical coroner and investigated on his/her behalf by a second doctor. If that doctor agreed with the first certifying doctor, the cause of death would be certified. If not, or if any other reason emerged, the death would be investigated further by the medical coroner.

The Second Option – Coroner's Certification

19.55 The second option considered at the seminars was that responsibility for all death certification should come under the control of the Coroner Service. The coroner's office would be notified of all deaths and Forms 1 and 2 would be considered, initially by a coroner's investigator. If the doctor completing Form 2 had given a professional opinion as to the cause of death to the high standard of confidence required by Form 2, the coroner's investigator would then question one or more of the deceased's relatives or carers. The object would be to ascertain whether there was any inconsistency between the family's understanding of events and the accounts given on Forms 1 and 2. In general, the family member would be allowed to see Form 1 but would not necessarily see Form 2, which might contain medically confidential information. However, the family member would be asked questions that would elicit his/her state of knowledge about the deceased's medical history. In this way, possible inconsistencies would be brought to light. The family would have the opportunity to raise any concerns. If no problems emerged, the coroner's investigator would certify the cause of death (using the cause given by the Form 2 doctor) and authorise disposal of the body. Registration might take place on-line from the coroner's office, thus avoiding the need for attendance at the register office. Alternatively, the family member/informant might attend the register office in person. If the Form 2 doctor were uncertain of the cause of death, if the family or any other person expressed concern or if any other circumstance were discovered that made further investigation appropriate, the death would be referred for further investigation by the medical coroner and, where appropriate, by the judicial coroner. I shall call this system the 'coroner's certification' system.

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Common Features

19.56 It will be noted that both suggested options make use of the knowledge and understanding of the doctor, if there is one, who has treated the deceased in the period immediately before the death. That doctor will almost always be the person with the best knowledge available. The essential difference between the two systems is the issue of who is to review the Form 2 doctor's account and opinion – a second doctor or a coroner's investigator.

19.57 Under both proposals, there would be provision for certification of some deaths without, in the case of a community death, there being any requirement for a full external examination of the body. (For hospital deaths, there would be a full external examination at the stage of completion of Form 1.) Although a full external examination carried out in good conditions by a doctor with the necessary skills is desirable, I think it is impracticable for all deaths in the community. Often the facilities at a funeral director's premises are not suitable for a visiting doctor to examine the body. Many doctors do not have the requisite skills, although I accept that these could be taught. Even a full examination is of limited use in determining the cause of death, although it can help to detect signs of violence or neglect. Under either proposal, if any concern is expressed by a member of the deceased's family or a carer, the death would be referred for further investigation and it would be open to the medical coroner to order a full external examination by a pathologist under proper conditions in a hospital mortuary. Also, I shall suggest that all funeral directors should be placed under a duty to report to the coroner any signs of violence or neglect that they observe while preparing the body for disposal.

My Preferred Option – the Coroner's Certification System

19.58 For reasons that I shall now explain, I strongly recommend the second of these two proposals, the coroner's certification system, under which all deaths would be reported to the Coroner Service, which would take responsibility for certification and for deciding whether or not further investigation was necessary. Cases in which the Form 2 doctor expressed an opinion as to the cause of death would be considered for certification by the coroner's investigator after consultation with the deceased's family (construed widely, as I explained at paragraph 12.24). All other deaths would go for further investigation by the medical coroner. I shall describe the way in which the system would operate in practice in some detail at Appendix M.

19.59 I have said that the essential difference between the two options is who is to review the Form 2 doctor's account and opinion, a second doctor or the coroner's investigator. I consider that it is preferable for this review to be carried out by a coroner's investigator. There are several reasons for this. First, the coroner's investigator will be manifestly independent not only of the first doctor but also of the medical profession as a whole. I have reservations about the feasibility of ensuring the independence of a second certifying doctor, even if selected and approved by the medical coroner. In rural areas, the medical community is likely to be small, and friendships and allegiances are inevitable.

19.60 Second, the task of checking the factual content of Forms 1 and 2 with the account given by the family, and of allowing the family the opportunity to express any concerns, does not

call for medical expertise. In effect, such a task could be described as a 'waste' of the second doctor's time, a scarce and valuable resource. The task could be perfectly well undertaken by a coroner's investigator and, as such a person would be accustomed to dealing with the bereaved on a daily basis, I consider that s/he might well do it better than many doctors would. The work of the investigator would be directed by a protocol, with which s/he would become very familiar. The information received could be recorded in writing. I was impressed by the way in which ambulance paramedics confirming the fact of death operate under a protocol and complete a record of their findings.

19.61 I acknowledge that a coroner's investigator would not be as well equipped to check on the medical opinion of the Form 2 doctor as another doctor would be. I recognise that, for the consideration of the treating doctor's diagnosis of the cause of death, the coroner's investigator would need some medical knowledge. He or she would have ready access to the advice of a medically qualified coroner. The coroner's investigator would have to be trained to recognise when there was reason to doubt the Form 2 doctor's diagnosis of the cause of death, in which case the medical coroner would become personally involved.

19.62 The system I have proposed would not depend upon the decision of the Form 2 doctor or of the second/panel doctor as to whether the death should be referred to the Coroner Service. As I have said, research has shown that doctors are often unsuccessful in recognising circumstances in which a full investigation is required. Any list of criteria is bound to be quite long and complex, as the Inquiry found when it attempted to compile one, incorporating the suggestions made in response to the Discussion Paper. I doubt that anyone who had to consider such a list infrequently would ever become sufficiently familiar with it to make sound decisions. I accept that the panel doctor, who could receive training in this skill, might be more successful than the Form 2 doctor. However, research suggests that a trained coroner's investigator, who would consider such issues daily, would be more successful at recognising those deaths that required full investigation. In Maryland, USA, death investigators are trained to recognise those cases in which further investigation is required by the medical examiner. We could learn much from the training and operation methods employed there.

19.63 If all certificates came into the coroner's office, it would be possible for the coroner's investigator to check that Forms 1 and 2 had been properly completed and that all matters that might be relevant to the need for further investigation had been covered. The coroner's investigator would work to a protocol. Such a system would in my view reduce the risk of material information being overlooked. If it were necessary to add a new criterion for reporting a death, it would be far easier to amend the investigators' protocol than to promulgate the requirement to a large number of doctors.

19.64 Certification by the coroner's investigator would impose substantially less of a burden on doctors than would dual certification by doctors. In particular the process of consultation with the deceased's family, which I am convinced is an essential feature, would be time-consuming. In my view, this should not be imposed upon doctors. Their time is a valuable resource, presently in short supply. It is also an expensive resource. If the task can be performed as well (or better) by a coroner's investigator, as I believe it can, that is the right solution.

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19.65 Doctors would be relieved of the duty of deciding whether or not they could certify. They would have to provide factual information only; they would give an opinion only when sufficiently confident to do so. They could not then be subject to pressure to certify from families or to the temptation to provide an untrue cause of death to avoid referral to the coroner.

19.66 Under my proposal, the Coroner Service would take primary responsibility for the procedures following every death. The office would be the natural focus for all enquiries. The existence of such a focal point would remove a great deal of uncertainty. Families, funeral directors and doctors would know who to ask for information about what was to happen and when. The public would soon learn that it was normal for a death to be reported to the coroner. The anxiety the family of a deceased person now feels, on learning that the death is to be reported, would be much reduced, especially when it became known that referral did not mean that there was bound to be an autopsy.

19.67 The Coroner Service would relieve other agencies of some of the responsibilities that they presently carry. Perhaps most important, the registration service would be relieved of the responsibility for considering whether a death can properly be registered or whether it should be reported to the coroner. Those duties would rest definitively upon the Coroner Service. The registrar's duties would be purely administrative, as, in my view, they should be. I shall say more about registration below.

19.68 The police and ambulance service would be relieved of the responsibility, which they presently shoulder, of trying to locate a doctor willing and able to certify the cause of death. In a case where no criminal involvement was suspected, the responsibilities of the police would be limited to informing the coroner's office of the death and undertaking duties properly within their own province. There would, of course, always be a need for close co-operation between the Coroner Service and the police.

19.69 A further advantage of a system in which all deaths are reported to the Coroner Service would be the availability of complete data in respect of all deaths. For all deaths, there would be a minimum dataset comprising Forms 1 and 2, the investigator's record of other information received and a copy of the certificate of cause of death. For those deaths in which the medical coroner undertook further investigation, there would be additional information. The retention of this dataset would have a number of advantages. First, it would be possible to audit the process of certification. Second, it would provide an information bank, which would be an invaluable resource for public health and research and statistical purposes.

Random Checks on Deaths Certified without Further Investigation

19.70 At present, just over 60% of deaths are certified by doctors and are not reported to the coroner. I think it likely that, under the system I have proposed, a similar proportion of deaths would be certified by a coroner's investigator on the basis of the treating doctor's opinion, following consultation with the deceased's family. There are two reasons why it would be desirable that the operation of that system of certification should be subject to some form of random check. First, audit is a useful exercise in itself, to check that the system is operating as it should. Second, I recognise that any system that does not

provide full investigation of every death is potentially open to abuse, particularly where two people who take part in the process of certification collude to conceal some act of wrongdoing. For example, if a family member and doctor were to collude in the hastening of the death of an elderly or terminally ill patient, it would be almost impossible to discover the wrongdoing unless all deaths were subject to full investigation, including autopsy with toxicology, and not necessarily then. A similar problem might arise if a doctor were to collude with a nurse in charge of a care home in the concealment of homicide, malpractice or neglect. Such risks are probably very small but I do not think they can be ignored.

19.71 For those two reasons, I propose that a proportion of all deaths certified by a coroner's investigator on the basis of the opinion of the Form 2 doctor should be selected randomly for fuller investigation at the discretion of the medical coroner. Such a fuller investigation would be conducted according to a protocol which might include external examination of the body, perusal of medical or nursing records, a blood test taken for toxicological screening and a discussion with any person mentioned on Forms 1 or 2 as having knowledge of the circumstances of the death or nursing history. It would not, unless a specific reason arose, entail an autopsy. The medical coroner would be under a duty to carry out a specified number of such fuller investigations and his/her performance of them would itself be the subject of audit.

19.72 I consider that a general awareness of such a system of random investigation would act as a deterrent to misconduct and would promote good certification practice.

Targeted Checks

19.73 One of the shortcomings of the present system is that a coroner cannot investigate any death unless it is individually reported. He or she cannot, for example, investigate all the deaths certified by a particular doctor or all those occurring at a particular care home. I recommend that, in future, the Coroner Service should have the power to undertake targeted investigations both prospectively and retrospectively. The Coroner Service might examine the targeting methods adopted in Ontario, Canada, which I described in paragraphs 18.46 and 18.47.

The Two-Doctor System Advocated by the Coroners Review

19.74 The Coroners Review has proposed a dual system of certification of death. It would operate slightly differently for hospital and community deaths. However, in each case, two doctors would consider the cause of death and whether the death should be reported to the coroner. In respect of hospital deaths, the first certifier would be any fully registered doctor who had treated the deceased in the last illness. The second certifier would be a doctor of consultant status from a different 'firm' within the hospital and would have to be 'approved' by the SMA. In the community, the first certification could be carried out by any doctor in the general practice looking after the patient, provided that the certifying doctor or another member of the practice had seen the patient within 28 days before the death. If there was a doctor willing and able to certify the cause of death, that doctor would then contact a second doctor, who would be a member of a panel selected by the SMA and trained for the work. The second doctor would review the decisions of the first certifying

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doctor, both as to the cause of death and as to the decision not to report the death to the coroner. For these purposes, the second doctor would speak to the first doctor and examine the most important extracts from the clinical notes. If the two doctors disagreed about the cause of death, or if either of them thought that the death should be reported to the coroner, that would be done. If both agreed about the cause of death and that there was no need to report it, the second doctor would countersign the MCCD and would issue a disposal certificate, permitting disposal by burial or cremation. Registration would take place later. There would have to be safeguards to ensure that registration took place. At present, the incentive to register the death is that, without registration, there can be no disposal.

19.75 This proposal bears a strong resemblance to the old system of cremation certification, with some improvements. First, instead of the second doctor being any doctor registered for five years, s/he would be selected by the SMA and should, in theory, be independent of the first certifying doctor. However, this would depend upon how the panel doctor was selected for the individual case. At present, the proposal is that the first doctor should 'choose' the second doctor and, either him/herself or through his/her practice staff, inform the deceased's family of the second doctor's name and contact details. Second, the panel doctors would receive training in death certification procedures and in the recognition of which cases ought to be investigated by the coroner. Under cremation certification procedures, the Form C doctor was not even required to consider whether the death should be reported to the coroner.

19.76 The proposal that the cause of death should be certified and permission to dispose of the body be given by the second doctor would have the beneficial effect that the registration service would be relieved of the duty to consider whether or not the death should be reported to the coroner. Whether that duty should rest solely upon doctors, in my view, requires further consideration. In any event, there are real dangers inherent in the proposal that disposal certificates should be allowed out of the control of the register office or Coroner Service. Although the proposal is that only 'approved' doctors would be on the panel and would be trusted with disposal certificates, it must be recognised that Shipman himself would certainly have applied for and received approval as a panel doctor. He was highly respected in the area by colleagues as well as patients. Many people considered him to be the best doctor in Hyde.

19.77 My main concern about this proposal is that it is not intended that the second doctor should contact the family of the deceased. Instead, it is intended that the family should be made aware that the second doctor is available to them, in the event that they wish to express any concern. I draw particular attention to that aspect of the proposal because the evidence heard by the Inquiry (to which I referred in Chapter Twelve) suggested that families are often either reluctant or too shocked to take the initiative to express a concern to a stranger, even if they are conscious of one. In many of the Shipman cases, the family members were not aware of any reasons for concern, even though they were in possession of information which, if known to the second doctor or some other person with an overview of the case, would have signalled a cause for concern. Also, many people are intimidated by the thought of telephoning a doctor's surgery and asking to speak to the doctor personally. Arrangements for a consultation might have to be made through the

surgery staff and the doctor would have to fit the relative in among his/her patients. If the Coroners Review proposal were amended to require the second doctor to question a member of the deceased's family or other person with knowledge of the recent history and circumstances of the death (a feature that I regard as vital), the system would place a heavy demand on the time of the panel doctors. It would also be costly for that reason. I also consider that, if a relative wished to express a concern about the treatment provided by the doctor providing the first certificate, s/he would probably find it easier to do so to a coroner's investigator than another doctor.

19.78 I have other reservations. I note that it is not intended that the second doctor should devote him/herself to certification duties for specific sessions, although no doubt that could be required. I do fear that a doctor who tries to fit certification into an ordinary working day may not give it the care and attention it warrants. I have already explained the reasons why I doubt that it is possible to ensure true independence on the part of the second or panel doctor. In rural areas, where the medical community is small, independence would be impossible. Even in urban areas, there could be no real independence if it were left to the first certifying doctor to select which panel doctor s/he contacted. The Coroners Review suggests a rota system, although I am not sure how it is proposed that that would work in practice. In my view, to ensure independence, individual cases would have to be allocated by the SMA to a doctor from a different locality from that of the first certifying doctor. I think this would give rise to inconvenience and practical difficulty. I note that the Coroners Review proposal is that, for hospital deaths, the second doctor would be a consultant employed in the same hospital as the first. I doubt that such a proposal would be acceptable to consultants and I fear that doctors of a lower status would be authorised. In those circumstances, I doubt that the second doctor could be sufficiently independent, even though approved by the SMA. In short, I consider that this proposed scheme is far too closely related to the current system of cremation certification, which manifestly failed to protect Shipman's patients or to detect Shipman as a murderer.

Registration

19.79 I have already said that Form 2 is not a medical certificate of cause of death; it provides information and, possibly, an opinion. There would be a need for a certificate of cause of death, on which registration would be based. The Inquiry has not attempted to devise such a certificate. The ONS has particular views about what information should be provided in such a certificate and how it should be presented. The layout and content of that form should be a matter for discussion between the Coroner Service and the ONS. However, the fact that this certificate would be completed in the coroner's office, rather than by a doctor, would provide an opportunity to include information and classifications of the death for statistical purposes which would not otherwise be possible. The certificate would be completed by trained staff, under instructions, whose work would be susceptible to quality control. The certificate might include such information as whether the death was industrial or whether there had been an operative procedure within, say, the last 30 days.

19.80 At present, apart from the cause of death, which comes from the MCCD, the particulars required for registration (together with other information required for statistical purposes) are provided by the informant during a visit to the register office. If an inquest is held, the

coroner provides all the information required for registration. Under my proposed scheme, a member of the deceased's family would usually, although not always, attend the coroner's office for a discussion about the death. It seems to me that, in cases where that occurred, the opportunity could be taken to obtain the particulars required for registration and any other necessary information. If this were done, it might avoid the need for the informant to visit the register office as well as the coroner's office. As I explained at the end of Chapter Six, changes are proposed for the registration service. It is contemplated that registration might take place on-line or by telephone. If such a facility were to be made available, registration of deaths could be conveniently effected from the coroner's office at the time of the visit. Once the cause of death had been certified (whether by the investigator or the medical coroner), the particulars required could be obtained from the family member, the death could be registered on-line and a disposal certificate and a certified copy of the entry in the register of deaths obtained by return. Such an arrangement would provide the 'one-stop shop' advocated by many respondents to the Inquiry. For those who seek early disposal of their dead, such as members of religious and ethnic minorities, it should be possible for the investigator to issue a disposal certificate at a weekend, at a time when the register office is closed, and send the particulars on-line to the register office on the next working day. For those families who do not attend the coroner's office for a face to face discussion about the death, registration could take place as now, by attendance at the register office or, if the facility were available, on-line or by telephone. The certificate of cause of death could be sent direct from the coroner's office to the register office. Whether on-line registration will be brought in remains to be seen but the intention has been announced.

19.81 At present the registration service uses the informant's visit as an opportunity to provide information and advice about post-death formalities. If registration were to be carried out from the coroner's office, it might not be possible in many cases for the registrar to fulfil that function. However, I do not see why such information should not be made available at the coroner's office. Moreover, if on-line registration is to be permitted, some informants would not visit the register office in any event. It seems to me that discussions should take place between the interested parties in order to establish some arrangement whereby bereaved families are provided with the advice they need, the registration service receives accurate information and, if possible, families are not required to visit two separate places or discuss the death with more than one public official.

The Next Stage – Further Investigation

19.82 I now turn to describe my proposals for the treatment of deaths which are not certified on the basis of the treating doctor's opinion but which, for some reason, require further investigation. In this area, there is much common ground between my proposals and those of the Coroners Review.

Criteria

19.83 The Coroners Review has suggested a list of criteria for determining which deaths should be reported to the coroner and has suggested that the definitive list should be compiled

and promulgated by the body with overall responsibility for the Coroner Service. As I recommend that all deaths be reported to the coroner, there would be no need for a list of reportable cases. However, coroners would need some guidance as to which types of case would call for further investigation and would not be suitable for certification by a coroner's investigator, even if the cause of death were sufficiently known. In my view, the list suggested by the Coroners Review would be a good starting point from which to prepare that guidance. In summary, this includes all traumatic deaths, the deaths of all detained persons, deaths due to any listed communicable disease, deaths due to occupational disease, deaths due to medical error, defective treatment, neglect and adverse drug reactions, deaths associated with childbirth, deaths of vulnerable children, drug-related deaths and deaths of which the cause is uncertain or in respect of which there is concern about the circumstances.

19.84 In my view, it will be extremely difficult to provide a list that encompasses all those deaths which require further coronial investigation. However, it should, in my view, be quite possible to train coroner's investigators to recognise the type of circumstances that call for investigation. Under my proposals, a coroner's investigator would consider the circumstances of deaths daily, if not several times a day, and would make a decision on whether further investigation were required. Familiarity with the concepts and frequent repetition of the decision process should, in my view, lead to a far higher degree of accurate recognition than would be achieved by doctors undertaking the task much less frequently.

19.85 I am also of the view that there should be some flexibility as regards the referral of a death for further investigation. A death should not be certified just because it does not fit into one of the criteria if there is some reason why it should be looked at more closely. For example, where a young, fit person succumbs rapidly to a virulent infection, the cause of death might be established by autopsy and ancillary tests and the death might not fall within any category calling for further investigation. However, in such a case, it might well be worth trying to discover how the deceased was infected, what the signs were and what treatment was given. Such an investigation could be of value to medical science. If such a death were brought to the attention of the medical coroner, s/he would have the option of taking the investigation further.

19.86 I agree with the Coroners Review that the coroner's investigators' guidance or the doctors' list of reportable criteria should be kept under constant review. It is not possible to foresee all the circumstances that might call for death investigation. For example, a year ago, no one would have foreseen the need for a sudden death from pneumonia to be investigated by the coroner. Yet today, no one would disagree with the proposition that a death in this country from severe acute respiratory syndrome (SARS), which is a form of pneumonia, should be investigated by the coroner, not because it is an unnatural death (it plainly is not) but because it would be in the public interest to discover how it had been contracted, the course of the disease and where and how it had been treated. Under the existing requirements, a death from SARS would not be reportable. Under the list suggested by the Coroners Review, SARS could be included by amendment of the list of reportable communicable diseases.

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The End Product of Further Investigation

19.87 In Chapter Nine, I said that in general there should be an inquest only in a case in which the public interest requires a public investigation for reasons connected with the facts and circumstances of the individual case; an inquest should not be held merely because the case falls within a broad category such as those defined by section 8 of the Coroners Act 1988. I suggested that there should be a few quite narrow categories in which an inquest would be mandatory; otherwise the decision as to whether the public interest required an inquest would be for the judicial coroner and would be subject to appeal. Such a system would allow a proper balance to be held between the public need to know about some deaths and the right of bereaved families to privacy in cases in which no issue of public interest arises. As I have said, I am in agreement with many of the views expressed in the recent Report of the Coroners Review relating to the outcome, scope and conduct of inquests. I have identified at paragraph 9.76 the precise areas of agreement.

19.88 In a case in which there is no sufficient public interest to warrant an inquest, the product of the further investigation would be the provision of a coroner's report explaining how and why the deceased died. The report would also set out any recommendations which the coroner thought appropriate for the avoidance of death and injury in future. The report would be prepared by the medical or judicial coroner who had undertaken the investigation. Occasionally, they might write a joint report. The report should be primarily for the benefit of the family of the deceased but should also be provided to any party or public body with a proper interest in its receipt. The question of whether such a report should be available to the general public is a difficult one and, in my view, requires careful further consideration. I note the views of the Coroners Review. I myself do not feel that this issue has been covered in sufficient detail during the Inquiry for me to be able to express a concluded opinion. I suggest that there should be close consideration of the practice followed in Ontario, Canada, which I referred to in Chapter Eighteen.

19.89 The report of the death would append the result of an autopsy or other special investigation or expert opinion. If the family wished to have the decision explained in a face to face interview at the coroner's office, this could be done either by a coroner's investigator or, in a more complex case, by the medical coroner and, possibly, the pathologist who had conducted the autopsy.

19.90 The report prepared by a medical coroner alone would also contain a statement that the medical coroner did not consider that there was any reason to refer the death to the judicial coroner. If a member of the family wished the judicial coroner to consider the death with a view to further investigation of the circumstances of the death or the holding of an inquest, the death would be so referred. If the judicial coroner declined to investigate, an appeal could lie to the Chief Judicial Coroner.

19.91 An important objective of further investigation (whether conducted privately or publicly at inquest) should be to learn from past experience, in particular in seeking to avoid the repetition of avoidable injury and death. At present, the coroner's power to make a recommendation, useful though it is, lacks force. I suggest that the recommendation of a medical or judicial coroner should be submitted to the Chief Coroners. If they ratified it, they would then be responsible for taking it forward, at a high level, first by submitting it to

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the appropriate body and then by pursuing that body until a satisfactory response had been received and action taken. This procedure would give recommendations greater authority than at present. The process could be dealt with speedily where necessary.

Procedures

19.92 The framework for the investigative procedures to be followed once a death had been identified as requiring further investigation would be for the Board of the Coroner Service to determine. In any individual case, the course to be followed would be a matter for the individual medical or judicial coroner to decide. The remarks in the following two paragraphs are by way of suggestion only.

19.93 I would suggest that any death that required further investigation should be considered first by the medical coroner. If uncertainty arose as to the medical cause of death, the medical coroner's first duty would be to establish the cause, if possible. He or she would give instructions as to what was required. If it appeared that the cause of death was known but that there were factual circumstances requiring investigation, the medical coroner might refer the case directly to the judicial coroner or could consult with the latter as to how to proceed. If it appeared that issues of both a medical and a circumstantial nature arose, the medical and judicial coroners would decide together what investigations were to be carried out and by whom. I do not envisage that the judicial coroner would have to be involved in every death in which any need arose to investigate the circumstances. After all, doctors are accustomed to making diagnoses in the context of the surrounding factual circumstances. They do not approach the medical issues in isolation. By way of example, a death following an injury caused by a fall would not usually require consideration by the judicial coroner. It would be possible to develop protocols for the investigation of the most commonly occurring types of death. For example, a protocol might require that, in any death which involved a piece of equipment in which a defect might have caused the death, the equipment should be inspected by an expert.

19.94 In general, the medical coroner would retain responsibility for all investigations in which it appeared likely that s/he would be able to reach a conclusion about the cause and circumstances of the death and in which there would be no need for an inquest. In any case in which it appeared to the medical coroner that there should be an inquest, or if it appeared that the judicial coroner might wish to order an inquest in the public interest, the investigation would proceed under the joint direction of the judicial and medical coroners, at least until the cause of death had been established. At any stage thereafter, the judicial coroner might decide to assume total responsibility for the further conduct of the case. The judicial coroner might still use the services of the district investigative team or s/he might call upon the regional facilities, including the regional investigator.

19.95 The judicial coroner should, in my view, exercise the powers to order entry and search of premises and seizure of property and documents relevant to a death investigation, which powers should be made available, as I suggested in paragraph 9.71. The medical coroner should have the power to seize medical records and drugs relevant to a death investigation. The judicial coroner should hear appeals from certain decisions made by a medical coroner, such as a decision to order or not to order an autopsy or the seizure of medical records or drugs.

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Investigation of the Medical Cause of Death

19.96 In cases where the medical cause of death is to be investigated, there should not be an automatic resort to autopsy. The medical coroner would have a variety of investigative tools at his/her disposal. He or she might direct that there be an inspection of the scene of the death and that witnesses, including the deceased's family and any carers, be interviewed. He or she might examine the medical records and discuss the case with any doctor with knowledge of the case. A pathologist might be instructed to carry out an external examination of the body. In some cases, a full autopsy with histology and toxicology might be necessary. In others, toxicological screening from a blood or urine sample might be carried out, without autopsy. That might be done, for example, after a road traffic accident, where the cause of death might be obvious, but there was a need to see whether drink or drugs might have contributed to the cause.

19.97 Where the medical coroner was considering ordering an autopsy, s/he or the investigator involved in the case would speak to the next of kin or family member with whom contact had been established, to explain why an autopsy was considered necessary. As I have said in Chapter Twelve, the evidence I heard suggested that, if the need were explained, there would rarely be any objection. However, in some cases, there will be an objection, whether for religious or cultural reasons or as a matter of personal conviction. In my view, there should be an opportunity for that objection to be advanced, so that the medical coroner could make his/her decision in the light of it. Then, if the medical coroner nevertheless decided that an autopsy was necessary, there should be a right to appeal the decision to the judicial coroner. Conversely, in a case in which the medical coroner had reached a conclusion that the cause of death had been identified and that no further investigation was required, but the family were of the view that there should be an autopsy, there should be a right to make representations to the medical coroner and to appeal to the judicial coroner. Indeed, I consider that there should be a general willingness to receive representations from families whenever a significant decision about the conduct of the investigation is made.

19.98 In general, the medical coroner should seek to establish the cause of death to a high degree of confidence, comparable to that envisaged by Form 2. However, in an appropriate case, it should be open to a medical coroner to certify the cause of death to a lower degree of confidence. In my view, provided that the medical coroner has satisfied him/herself that there is no other reason why the death should be investigated further, it should be sufficient that the cause of death be established on the balance of probabilities. In such circumstances, it is undesirable that there should be exhaustive investigation, including an autopsy, designed to establish which of two or more potentially fatal conditions from which the deceased suffered had actually caused the death. In some cases, it might be appropriate for the medical coroner to certify that the death was due to 'unascertained natural disease process'. I recommend that such a cause should not be certified without toxicological screening of a blood or urine sample.

19.99 Such cases would most often arise with the death of a very elderly person, where it is frequently difficult to determine which condition has proved fatal and often inappropriate to conduct an autopsy for that purpose. It should be rare for the death of a younger person

to be certified to this lower standard of confidence. In making this distinction, I am not suggesting that lower standards should suffice for the elderly; far from it. However, it must be recognised that many elderly people have multiple pathologies, any one of which might be fatal. The safeguard for the elderly must be not so much to ascertain the precise cause of death as to ensure that the circumstances of the death give rise to absolutely no cause for suspicion or concern.

19.100 I would also suggest that a medical coroner should be permitted, in an appropriate case, to certify that a death was due to 'old age'. In the event that a system of certification by doctors were to be retained, I would not be in favour of allowing a treating doctor to certify a death as due to that cause. Although, if strictly applied, the criteria for certifying a death as due to 'old age' can amount to a positive diagnosis of a cause of death, in general, the term implies a degree of uncertainty as to which organ failure has precipitated the death. In those circumstances, certification of the cause of death to the high degree of confidence required by Form 2 would seem impossible.

19.101 A medical coroner might on occasions have to certify that the cause of death was unknown, but that should, in my view, be acceptable only after a full autopsy with toxicology had been carried out.

19.102 Some investigations might be quite long and complex. Some might entail consultation with or referral to the regional medical coroner or the judicial coroner. The medical coroner should always seek to allow the disposal of the body at the earliest appropriate time. This could be done as soon as the body has been identified and it has been decided that it will not be required for further investigations. Usually, it would, as now, be possible to permit disposal of the body before investigation of the circumstances of death is complete and possibly before a conclusion has been reached as to the cause of death. If the medical coroner was satisfied that the cause of death was known, but the investigation into the death was not yet complete in other respects, s/he would inform the family and the register office of that cause. If there remained any uncertainty about the cause of death, which could not be resolved until the circumstances had been fully investigated, the medical coroner should provide the register office with a provisional cause. At the seminars, the ONS stressed the need for them to receive details of deaths, with provisional causes, more promptly than is often the case at present.

Investigation by the Judicial Coroner

19.103 I have said that the main function of the judicial coroner would be the conduct of inquests and the direction of the preceding investigation, possibly in conjunction with a medically qualified coroner. In addition, the judicial coroner would direct the more complex investigations into the circumstances of deaths where an inquest was not envisaged. In those cases in which both medical and circumstantial investigations were required, the two coroners would work together, each applying his/her professional expertise to the problem.

19.104 I think, although I cannot be certain of this, that fewer judicial coroners would be required than at present and I envisage that they would operate from the regional offices rather than being present in every district office.

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19.105 As I said in Chapter Seventeen , I consider it desirable that judicial coroners who have to conduct inquests should be relieved of the day-to-day responsibility for the pre-inquest investigation. They should direct the investigation but responsibility for the collection of evidence should devolve onto a legally qualified person in the regional office. I also consider it desirable that the judicial coroner should have the assistance of that person or, in the more complex cases, counsel to the inquest, who would present the evidence and call the witnesses.

Inquests Arising from Criminal Cases and Deaths Investigated by Other Agencies

19.106 Where the police suspected criminal involvement in a death, the Coroner Service would co-operate with their investigation, for example by ordering an autopsy. The Service would not in any way interfere with the police investigation. If criminal proceedings were commenced, there should be no need for an inquest to be opened and adjourned, as is the present practice. If the proceedings resulted in a conviction, the medical coroner would usually need to do no more than write a report recording the fact of the conviction, the cause of death and the brief circumstances of the death. In a rare case, a public interest issue might arise, in which case an inquest would be appropriate, but in most cases there would be no need for an inquest in any case following a conviction for murder, manslaughter, infanticide or causing death by dangerous or careless driving. If the proceedings led to acquittal, the death would be referred to the judicial coroner for inquest.

19.107 If any other agency (such as the Health and Safety Executive) were to investigate a death, the medical coroner would normally await the report of that investigation before proceeding with any investigation other than that necessary to establish the cause of death. When the other agency's investigation was complete, the report and the result of the medical coroner's investigation of the cause of death would be sent to the judicial coroner, who would decide whether any further investigation was required and whether an inquest should be held. If no inquest were to be held, the judicial coroner would write a report.

Allegations of Medical Error or Neglect

19.108 The evidence suggests that cases in which death was or might have been caused or contributed to by medical error or neglect are under-reported. It also appears that many doctors consider that it would be wrong for the coroner to examine the possibility that medical error might have contributed to a death. I cannot accept that doctors should be treated any differently from others whose errors lead to death. A driver whose negligence causes death is likely to face criminal prosecution and the death will be investigated by means of a coroner's inquest. If a workman dies as the result of a fall from an unsafe place of work, the employer responsible is likely to face criminal prosecution and a coroner's investigation. I cannot see why mistakes made by doctors should not be investigated by the coroner. Yet, at present, it appears that many cases of potential medical error are not reported to or investigated by coroners. The coroner's conclusions would not be determinative of civil liability.

19.109 At the international seminar, I learned that similar reporting problems had been experienced in Victoria, Australia, where a system of identifying and investigating cases of potential medical error is being developed. I recommend that the Coroner Service should study that system with a view to introducing something of a similar nature in this country.

19.110 At present, cases of possible medical error or neglect are usually brought to the coroner's attention as the result of an expression of concern by a member of the deceased's family. Sometimes, such cases are reported by hospital staff. Under the new system, I would suggest that, in any such case, the medical coroner should carry out an initial investigation. If s/he were to conclude that the allegation had some foundation and that the error or neglect complained of might have caused or contributed to the death, s/he would refer the case to the regional office for investigation by the regional medical coroner and judicial coroner. In my view, such investigations are likely to be time-consuming and also require special expertise. They should not in general be dealt with by the medical coroner, who will usually be busy with his/her daily caseload and the management of the district office. If, after initial investigation, it appeared to the medical coroner that there was no evidence of medical error or neglect, or that any such error or neglect could not have caused or contributed to the death, the medical coroner would advise the family that s/he intended to certify the cause of death without further investigation. It would be open to the family to appeal to the judicial coroner against that decision. The medical coroner would also advise the family of the possibility of making a complaint to any relevant authority. He or she would write a report of the investigation, including an account of the original expression of concern.

19.111 Cases transferred to the regional office would be investigated under the direction of a legally qualified person. There should be a small team of investigators at every regional office who can develop expertise in medical cases. Appropriate expert opinions would be obtained. At the Inquiry seminars, there was discussion of the idea that the coroner might refer a case to a multi-disciplinary committee of experts, similar to those set up by the National Confidential Enquiry into Perioperative Deaths. That seems to me to be a good idea in a case where more than one or two expert opinions would be required for proper investigation. I was also interested in the method of investigation adopted in Ontario, Canada, where standing committees of experts are used to review cases of possible medical error and also review the treatment provided in various types of case, where lessons might be learned from examination of the treatment provided before death. A system of investigation is also being developed in Victoria, Australia, which I described in paragraph 18.24. I recommend that the Coroner Service should consider all these ideas.

19.112 At the end of the investigation, the judicial coroner would decide whether or not an inquest should be held. In cases in which s/he decided not to do so, the judicial coroner and the regional medical coroner would agree between themselves as to which of them should write the report or whether they should write a joint report.

Funding, Resources and Recruitment

19.113 Implementation of my proposals would require adequate funding and resources for the Coroner Service. A new improved service is bound to cost more than the old, which in

some places appears to have been run on a shoestring and does not, in any event, provide good value for money. I have not commissioned work on costings for the reasons I explained in Chapter One. I recognise that my proposals will not work satisfactorily and will lead to unacceptable delays in death certification and in the disposal of bodies unless the system is properly funded.

19.114 There are a number of features common to the system I propose and to that proposed by the Coroners Review. Under both proposals, there will be a need for a central organisation. Under both, all deaths will be subject to some degree of scrutiny. Under both, there will be a need for medically qualified persons in the district coroner's office. It is likely that the rather more responsible position that I envisage for the medical coroner will be slightly more expensive to fill than the post of SMA, proposed by the Coroners Review. It may be that the status, managerial responsibility and higher remuneration of the medical coroner would prove more attractive to candidates of a high calibre than the more limited and routine functions of the SMA. Both sets of proposals recognise the need for trained coroner's investigators.

19.115 The resource implications of the choice between my proposals for certification and those of the Coroners Review are, I think, quite considerable. Under both sets of proposals, a substantial percentage of deaths (currently about 40%) would require full investigation by a coroner. The cost of such investigation is likely to be similar under each set of proposals. However, the remaining 60% (about 320,000 deaths per year) would be certified either by a coroner's investigator on the basis of the Form 2 doctor's opinion (my proposal) or by a second doctor who had reviewed the first certifying doctor's opinion (the Coroners Review proposal). It seems to me that my proposals have resource advantages because they place a lesser demand upon the services of doctors than do the Coroners Review proposals, even as presently envisaged. However, if the Coroners Review system were amended to include a requirement that the second doctor must question a member of the deceased's family (which I believe is essential), it would then place very heavy demands on the doctors. It seems to me that there are two resource advantages in using coroner's investigators rather than doctors. First, the coroner's investigator is likely to be a less expensive resource than a doctor. Second, a fully trained coroner's investigator could be, within a relatively short time, a less scarce resource than a doctor.

19.116 At all stages of the Inquiry, concern has been expressed about the shortage of doctors and the pressures on their time. I have tried to take those factors into account. Both my proposals and those of the Coroners Review will require the full-time appointment of doctors to the Coroner Service. At the seminars, both the BMA and the DoH representatives expressed the view that, if the position of medical coroner had sufficiently attractive terms and conditions of service and if steps were taken to avoid professional isolation, there would be a pool of suitable applicants seeking a career change and these would be doctors who were likely to leave clinical practice in any event. They would not, therefore, be lost to practice as a direct result of the creation of the role of the medical coroner. Whether an adequate supply of second certifying doctors could also be provided, I cannot say. Both my proposals and those of the Coroners Review would require the appointment of investigators, some of whom should come from a medical or nursing background. My proposals would require more such investigators than would

those of the Coroners Review. I recognise that there is also a severe shortage of nurses. However, I believe that many nurses retire from hospital work at a relatively early age. I envisage that some nurses and paramedics, who might in any event give up their work in, say, their 40s or early 50s, might be attracted to a new career (possibly part-time) in which their medical knowledge could be used.

19.117 I have been anxious to avoid any proposal that would significantly increase the time spent by doctors on death certification. It seems to me that the absolute minimum that must be provided by doctors is the medical history. The completion of Form 2 might take a little longer than the conscientious completion of an MCCD and cremation Form B. I recognise that this requirement would be imposed in all cases and not only those to be followed by cremation. If the doctor also completed Form 1, there would be additional work, but there is some overlap, and parts of Form 2 are not to be completed if Form 1 has, to the knowledge of the Form 2 doctor, been correctly completed. When I take into account the time presently spent by doctors in visiting mortuaries and funeral directors' premises for the purpose of completing cremation Forms C, I do not think that my proposals will impose much additional burden on the medical profession. In any event, if there is an additional burden, I think that the importance of the function is such that the increase must be borne.

19.118 I do not think it appropriate that I should suggest whether and, if so, how doctors should be paid for the completion of Forms 1 and 2. At present, they receive no payment for the completion of an MCCD. Cremation certification is paid for by the deceased's family or estate. What should happen in future should be a matter for Government. However, consideration could be given to the idea, which received some support at the seminars, that the responsibility of the National Health Service towards patients, which at present ceases at the moment of death, should continue until disposal of the body. In that way, a doctor's duty to complete Forms 1 and 2 could become a contractual duty, rather than merely a professional one.

Pathology Services

19.119 Under the system I have proposed, I hope and anticipate that there would be a reduced demand for routine coroner's autopsies. If so, there would be less pressure on the existing resources and it should be possible for autopsies to be carried out to a consistently high standard, which is not always possible at present. In my view, all autopsies should be carried out to the standards recommended by the Royal College of Pathologists (RCPath) in their document 'Guidelines on autopsy practice' that I referred to in Chapters Nine and Ten. I endorse the suggestion made by Dr Peter Goldblatt of the ONS that the content of a properly conducted autopsy should be formally recognised, possibly by the production of a code of practice with statutory force. This could be negotiated between the Coroner Service and the RCPath. Pathologists should be provided with improved background information about the deceased's medical history and the circumstances of the death, so that they can interpret their findings in context. They should be free to carry out whatever special examinations they consider necessary for the completion of a thorough and accurate report, provided that there is proper medical justification for the conduct of those examinations. It should not be acceptable for coroners to restrict the professional freedom of the pathologist. I would also endorse the suggestion made at the pathology seminar that

it should be acceptable for a coroner's autopsy to be conducted by a trainee, provided s/he was properly supervised. Now that so few hospital autopsies are carried out, such a practice is essential if a proper supply of trained pathologists is to be maintained.

19.120 It seems to me that greater use should be made of toxicology in the investigation of deaths of which the cause is not immediately apparent. I say that not only in the light of experience of the Shipman case. Evidence about the medical examiner system operated in Maryland, USA, convinced me of its general usefulness. Dr David Fowler said that their system of toxicological screening exposed a number of drug-related deaths that had been wholly unsuspected. The objection is that toxicology is expensive and slow. The experience in Maryland persuaded me that the process need not be slow, at least if what is required is a preliminary screening process, generally using chromatography. Once the equipment has been purchased for such screening, the more it is used, the cheaper each test becomes. Only in the minority of cases, where screening has revealed something of real concern, would there be a need for the more expensive and delaying quantitative analysis. It should be the aim of medical coroners to move towards the use of toxicology in virtually all autopsies and in some cases in which no autopsy is conducted.

19.121 During the seminars, there was little support for the proposal that a limited autopsy should ever be carried out in a case where the cause of death was not known. I accept that such a procedure risks the failure to discover the true cause of death. I also respect the view expressed by Professor Margaret Brazier, Chair of the Retained Organs Commission, that there would be little call for a partial autopsy if the reasons for and benefits of the autopsy procedure were fully explained to the family. However, it is clear that some people express a strong wish that their bodies should not be invaded after death and some families and religious or ethnic groups are strongly opposed to an autopsy. I am of the view that it should be possible for the medical coroner to authorise a partial autopsy. Any limitation would have to be very clearly defined and would have to be subject to the stipulation that, if the pathologist needed to go beyond what had been authorised, in order to reach a satisfactory conclusion as to the cause of death, s/he would be free to do so.

19.122 It appears to me that non-invasive diagnostic techniques, such as magnetic resonance (MR) scanning, may well be able to make a real contribution in the future. At present, they are of limited use. Under my proposals, it would be open to a medical coroner to make use of such methods, although I do not think it could be expected at present that such a facility should be provided at public expense. If the medical coroner were satisfied that an MR scan provided a sufficiently certain cause of death, s/he could certify the death on that basis.

19.123 I do not propose to say much about the retention of organs and tissues following a coroner's autopsy. Plainly this issue will have to be addressed at some stage and guidance provided for coroners by the Coroner Service. It seems to me that the principles should be similar to those I have suggested in connection with the autopsy itself. The medical coroner must have the power to order retention of organs and tissues if such is necessary for the purpose of his/her investigation. However, there must be complete honesty with the family of the deceased and they must have the opportunity to object to retention and to appeal to a higher level within the Coroner Service if dissatisfied with the

medical coroner's decision. I anticipate that, provided the principles explained by Professor Brazier at the pathology seminar are followed, little difficulty is likely to be encountered. Professor Brazier's experience is that, provided that families are told the truth and the reasons why the organ or tissue is needed are fully explained, most will not object.

19.124 The shortage of pathologists, particularly those with a special expertise, gives rise to concern. The particular problems caused by a shortage of forensic pathologists has been recognised and, as I reported in Chapter Ten, considered in a Home Office Review. The proposal is that there should be a national forensic pathology service integrated into the Forensic Science Service (FSS), which is an Executive Agency of the Home Office. The Review rejected the alternative suggestion that the forensic pathology service should be within the jurisdiction of the DoH and should be given a measure of independence by the creation of a Special Health Authority. One of the reasons why the Home Office Review opted for integration with the FSS was the close association of forensic pathologists with the criminal justice system. That I can well understand. Another reason, however, was the association between the forensic pathologists and the coroners, who presently fall within the remit of the Home Office. However, if either my proposals for the new Coroner Service or those of the Coroners Review are implemented, coroners will no longer be associated with the Home Office but will either be run by the Department for Constitutional Affairs or be an ENDPB associated with either or both of the Department for Constitutional Affairs and the DoH (or its Welsh equivalent). The rationale for the integration of the forensic pathology service into the FSS would be much weakened. From the seminar discussions, it appeared to me that there are strong arguments to suggest that the criminal justice system and the Coroner Service would both be well served by a pathology service which included both forensic pathologists and those histopathologists who conduct most coronial autopsies and which operated under the auspices of a Special Health Authority.

19.125 The Home Office Review also suggested that the pathology service should attempt to set up regional 'centres of excellence'. These would make the best possible use of the scarce resources of forensic pathology and other specialist services. Such a suggestion would fit well with my proposal for regional coroner's offices where deaths raising more difficult or complex issues or requiring such special facilities would be investigated. A close association between the Coroner Service and specialist pathology services, such as exists in Victoria, Australia, would be of immense benefit.

The Duty to Report Concerns to the Coroner

19.126 The imposition of a statutory duty to report matters of concern to the coroner was discussed at length during the seminars and is reported at paragraphs 17.74 to 17.84. In my view there should be a statutory duty on any qualified or responsible person to report to the Coroner Service any concern relating to the cause or circumstances of a death of which s/he becomes aware in the course of his/her duties. In the class of 'qualified' persons, I include doctors, nurses, midwives and paramedics. In the class of 'responsible' persons, I include hospital and hospice managers, registrars, care home owners and managers, police officers, firefighters, funeral directors, embalmers and mortuary technicians. The duty upon such a person should be to report to a coroner or coroner's

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investigator, as soon as practicable, any information relating to a death believed by that person to be true and which, if true, might amount to evidence of crime, malpractice or neglect. The duty upon funeral directors, mortuary technicians and embalmers would obviously be related to any signs of violence, medical malpractice or neglect which they might observe when preparing the body for disposal or autopsy.

19.127 I do not think that unqualified persons or those without any specific responsibility for a deceased person or in respect of any post-death procedure should be under a statutory duty to report concerns about a death to the coroner. All relevant employers should, however, encourage employees to report any concerns they may have and should ensure that such reports as are made to them are passed on to the appropriate quarter without delay and without any possibility of the reporter being subject to criticism or reprisal.

19.128 At present, all citizens are under a common law duty to report to the police or coroner any information likely to lead to an inquest. The existence of this duty is not well known, although everyone knows that they should report suspicions of crime to the police. I recommend that the Coroner Service should seek to educate the public about the functions of the Service and, at the same time, encourage members of the public to report any concerns about a death.

Audit and Appeal

19.129 At present there is virtually no audit of any post-death procedure. The registration service carries out some inspection procedures but there is no audit of death certification by doctors or of any aspect of the work of coroners.

19.130 Under the new system that I propose, there should be systematic audit of every function. First, there must be audit of the certification procedures. This will include examination of the standards of completion of Forms 1 by health professionals and Forms 2 by doctors as well as the quality of the notes kept by investigators of their conversations with doctors, relatives and others providing information. There must be audit of the decision taken whether to certify the cause of death or to pass the case to the medical coroner for further investigation. Most importantly, the quality of in-house certification must also be audited, as must the time taken to complete the post-death procedures. Such work could be carried out by 'an auditor' working in either the district or regional office.

19.131 The efficiency and effectiveness of the investigative procedures of the medical and judicial coroner's office should also be capable of audit. So could the quality of information provided in a medical or judicial coroner's report of a death. This form of audit should be a function of the central office of the Service. However, the correctness of the decisions made by a coroner cannot be subject to audit, as this would tend to interfere with his/her independence of judgement.

19.132 Any decision made by a medical or judicial coroner could be subject to judicial review. However, a quicker and cheaper means of appeal could and, in my view, should be provided, whereby decisions (whether in a report or at inquest) that are wrong in law or plainly wrong on the facts or fail to set out the facts found or give reasons for the conclusions can be set aside. I would suggest that the Chief Judicial Coroner should

decide such appeals, if appropriate with the Chief Medical Coroner acting as medical adviser. From his/her decision, there should be a statutory right of appeal to the Divisional Court on a point of law only.

The Human Rights Act 1998

19.133 In the course of this Report, I have not specifically adverted to the provisions of the Human Rights Act 1998 or the European Convention of Human Rights. I have, however, borne the provisions of the Act and the Convention in mind at all times. I have sought to make proposals which not only comply with human rights law but fully respect its underlying principles and ideals.

Transitional Arrangements

19.134 I am aware that the proposals I have advanced would require legislation and the allocation of increased resources. I am conscious that the Coroners Review has suggested changes that, although similar to and compatible with mine, are different in some important respects. We have both recognised similar problems and seek to secure the same objectives. We both hope that radical changes will be made. If changes are to follow, important decisions must be made as to which proposed solutions should be adopted.

19.135 All this will take time. Meanwhile the existing systems must continue to function. They could, in my view, function better than they do by the adoption of some measures that would not require legislation. Moreover, some such improvements would be compatible with the proposals for change and would amount to steps towards reform.

19.136 I have already suggested that, if the current system of cremation certification is to be maintained for even a few months after the publication of this Report, which seems likely, the procedures should be tightened up in the respects I have advocated in paragraphs 11.133 and 11.134. The Home Office has already begun to take steps towards these ends. The requirement that the Form C doctor should question someone other than the Form B doctor and should provide a positive answer to one of questions 5–8 would strengthen the cremation certification process.

19.137 The Home Office should provide funding and support for improved training for coroners, in conjunction with the Judicial Studies Board. New practices should be introduced into coroner's offices, for example allowing for greater involvement of the relatives of the deceased. Improved methods of investigation could be introduced, so that, for example, a coroner need not accept the opinion of a pathologist in isolation but would consider it in the context of other evidence. Coroners could develop and promulgate protocols for the work of coroner's officers. Recruitment policies could be changed to reflect the relevance of medical knowledge and experience to the work of the coroner's officer.

19.138 Funding should be provided for better pathology services with increased use of histology and toxicology. Coroners should ensure that pathologists provide full reports but that the opinions expressed are limited to the scope of their expertise. A pathologist should not be expected to act as an 'all purpose' medical expert to the coroner.

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19.139 Training should be provided for coroner's officers and coroner's liaison officers. The work of the Coroner's Officers Association should be funded, supported and expanded upon. The Association should be encouraged to develop protocols of good practice.

19.140 In suggesting that these steps be taken, I would not wish that these suggested improvements to the present arrangements should be pursued at the expense of progress towards more radical reform. It seems to me that the essential step is to decide what the structure of the Coroner Service is to be. Legislation to provide broad enabling powers could be passed and appointments made to provide the leadership which both the Coroners Review and I agree is vital.

19.141 Before the final form of the new system is decided, it may be that it will be suggested that my proposals and those of the Coroners Review should be tested in pilot schemes. I agree that the proposed Forms 1 and 2 could be tried out alongside existing certification procedures. The Inquiry commissioned a small feasibility study in respect of an earlier version of these forms. Further studies would, I think, be useful. However, there would be considerable difficulty in running a satisfactory trial of the certification system. To be realistic, a medically qualified coroner and some suitably trained coroner's investigators would have to be involved. It simply would not work without appropriate personnel.

19.142 In 1971, the Brodrick Committee recommended wide-ranging changes to the current systems of death and cremation certification and coroner investigations. Hardly any of its proposals were implemented. I explained why in Chapter Three. As it happens, I do not think that implementation would have prevented the Shipman tragedy. But, in many respects, the systems would have been improved. Today, the systems do not meet the needs of society. There is a groundswell of opinion in favour of change. It is to be hoped that the proposals of the Coroners Review and of this Inquiry do not, as did those of Brodrick, end in stalemate.

APPENDIX A

Participants in Phase Two, Stage Two of the Inquiry and Their Representatives

Counsel to the Inquiry

Miss Caroline Swift QC

Mr Christopher Melton QC

Mr Anthony Mazzag

Mr Michael Jones

instructed by Mr Henry Palin, Solicitor to the Inquiry

Participants	Representatives
Dr Norman Beenstock Dr Geraint Brown Dr Stephen Farrar Dr Murtaza Husain Husaini Dr Stephen Proctor Dr Vikram Tanna	Mr David Pittaway QC, instructed by Mr Chris Horsfield, Beachcroft Wansbroughs Solicitors, Leeds, West Yorkshire
Dr Graham Bennett Dr Peter Bennett Dr Susan Booth Dr Jeremy Dirckze Dr Alastair MacGillivray Dr Rajesh Patel	Mr Philip Gaisford, instructed by Ms Sarah Woodwark, Radcliffes Le Brasseur Solicitors, Leeds, West Yorkshire
The General Register Office/ The Office for National Statistics	Mr Jason Beer, instructed by Ms Shiela Eisa, Office of the Solicitor, Department of Health
Greater Manchester Police	Mr Michael Shorrock QC and Miss Kate Blackwell, instructed by Mrs Sandra Pope, Greater Manchester Police Force Solicitor
The Home Office	Mr James Maxwell-Scott, instructed by Mr Barrie McKay, Treasury Solicitor's Office
Medical Referees at Dukinfield Crematorium	Mr Michael Ryan, Ryans Solicitors, Cheadle Hulme, Cheshire
Dr Michael Overton	Mr S Young, Bois Bois Solicitors, Jersey

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Participants	Representatives
Mr John Pollard HM Coroner, Greater Manchester South District	Miss Alison Hewitt, instructed by Mr Christopher Welton, Solicitor and Deputy Coroner, Greater Manchester South District
Mr Peter Revington HM Coroner, Greater Manchester South District and Mrs Mary Evans (both now retired)	Miss Alison Hewitt, instructed by Mr Mike Halsall, Litigation Manager, Stockport Metropolitan Borough Council
Tameside Families Support Group	Mr Richard Lissack QC, Mr Paul Gilroy, Mr Andrew Spink (now QC) and Miss Harriet Jerram, instructed by Ms Ann Alexander, Alexander Harris Solicitors, Altrincham, Cheshire
Staff employed at Tameside register office	Mr Geoffrey Tattersall QC, instructed by Ms Sylvia Roberts, Borough Solicitor, Tameside Borough Council
West Pennine Health Authority Dr David Lyle Bee Mr Roger Butterworth Dr Siong Sih Lee Mrs Lynn Nuttall Dr Rachel Pyburn Dr David Shepherd Dr Chithambaram Veerappan Dr John Wright	Mr Gerard McDermott QC and Mr David Eccles, instructed by Mr Charles Howorth, George Davies Solicitors, Manchester

APPENDIX B

Specimen Medical Certificate of Cause of Death

RLIT0001826_0539

MED A 22 007539

COUNTERFOIL

For use of Medical Practitioner, who should complete in all cases.

Name of deceased

Date of death

Age

Place of death

Last seen alive by me

Post-mortem* 1 2 3 4
Coroner

Whether seen after death* a b c

Cause of death:—

I (a)

(b)

(c)

II

Employment? Please tick where applicable

B. Further information offered?

Signature

Date

*Enter appropriate digit(s) and letter

MED A 22 007539

BIRTHS AND DEATHS REGISTRATION ACT 1953
(Form prescribed by the Registration of Births and Deaths Regulations 1987)

MEDICAL CERTIFICATE OF CAUSE OF DEATH

A For use only by a Registered Medical Practitioner WHO HAS SEEN IN ATTENDANCE during the deceased's last illness, and to be delivered by him forthwith to the Registrar of Births and Deaths.

Registrar to enter No. of Death Entry

Name of deceased

Date of death as stated to me day of Age as stated to me

Place of death

Last seen alive by me day of

1 The certified cause of death takes account of information obtained from post-mortem.
2 Information from post-mortem may be available later.
3 Post-mortem not being held.
4 I have reported this death to the Coroner for further action. *(see overleaf)*

Please ring appropriate digit(s) and letter

a Seen after death by me.
b Seen after death by another medical practitioner but not by me.
c Not seen after death by a medical practitioner.

CAUSE OF DEATH

The condition thought to be the "Underlying Cause of Death" should appear in the lowest completed line of Part I

These particulars are to be entered in death register

Approximate interval between onset and death

I (a) Disease or condition directly leading to death*

(b) Other disease or condition, if any, leading to (a)

(c) Other disease or condition, if any, leading to (b)

II Other significant conditions CONTRIBUTING TO THE DEATH but not related to the disease or condition causing it

The death might have been due to or contributed to by the employment followed at some time by the deceased. Please tick where applicable

*This does not mean the mode of dying, such as heart failure, asphyxia, asthenia, but it means the disease, injury, or complication which caused death.

I hereby certify that I was in medical attendance during the above-named deceased's last illness, and that the particulars and cause of death above written are true to the best of my knowledge and belief.

Signature Qualifications as registered by General Medical Council

Residence Date

For deaths in hospital: Please give the name of the consultant responsible for the above-named as a patient

MED A 22 007539

(Form prescribed by the Registration of Births and Deaths Regulations 1987)

NOTICE TO INFORMANT

I hereby give notice that I have this day signed a medical certificate of cause of death of

Signature

Date

This notice is to be delivered by the informant to the registrar of births and deaths for the sub-district in which the death occurred.

The certifying medical practitioner must give this notice to the person who is qualified and liable to act as informant for the registration of death (see list overleaf). Where the informant intends giving information for the registration outside of the area where the death occurred, this notice may be handed to the informant's agent.

DUTIES OF INFORMANT

Failure to deliver this notice to the registrar renders the informant liable to prosecution. The death cannot be registered until the medical certificate has reached the registrar.

When the death is registered the informant must be prepared to give to the registrar the following particulars relating to the deceased:

1. The date and place of death.
2. The full name and surname (and the maiden surname if the deceased was a woman who had married).
3. The date and place of birth.
4. The occupation (and if the deceased was a married woman or a widow the name and occupation of her husband).
5. The usual address.
6. Whether the deceased was in receipt of a pension or allowance from public funds.
7. If the deceased was married, the date of birth of the surviving widow or widower.

THE DECEASED'S MEDICAL CARD SHOULD BE DELIVERED TO THE REGISTRAR

APPENDIX B 527

RLIT0001826_0541

PERSONS QUALIFIED AND LIABLE TO ACT AS INFORMANTS

The following persons are designated by the Births and Deaths Registration Act 1953 as qualified to give information concerning a death, in order of preference they are:

DEATHS IN HOUSES AND PUBLIC INSTITUTIONS

(1) A relative of the deceased, present at the death.

(2) A relative of the deceased, in attendance during the last illness.

(3) A relative of the deceased, residing or being in the sub-district where the death occurred.

(4) A person present at the death.

(5) The occupier* if he knew of the happening of the death.

(6) Any inmate if he knew of the happening of the death.

(7) The person causing the disposal of the body.

DEATHS NOT IN HOUSES OR DEAD BODIES FOUND

(1) Any relative of the deceased having knowledge of any of the particulars required to be registered.

(2) Any person present at the death.

(3) Any person who found the body.

(4) Any person in charge of the body.

(5) The person causing the disposal of the body.

*"Occupier" in relation to a public institution includes the governor, keeper, master, matron, superintendent, or other chief resident officer.

Complete where applicable

A

I have reported this death to the Coroner for further action.

Initials of certifying medical practitioner .....

B

I may be in a position later to give, on application by the Registrar General, additional information as to the cause of death for the purpose of more precise statistical classification.

Initials of certifying medical practitioner .....

The death should be referred to the coroner if:

- the cause of death is unknown
- the deceased was not seen by the certifying doctor *either* after death *or* within the 14 days before death
- the death was violent or unnatural or was suspicious
- the death may be due to an accident (whenever it occurred)
- the death may be due to self-neglect or neglect by others
- the death may be due to an industrial disease or related to the deceased's employment
- the death may be due to an abortion
- the death occurred during an operation or before recovery from the effects of an anaesthetic
- the death may be a suicide
- the death occurred during or shortly after detention in police or prison custody

LIST OF SOME OF THE CATEGORIES OF DEATH WHICH MAY BE OF INDUSTRIAL ORIGIN

MALIGNANT DISEASES		Causes include
(a)	Skin	– radiation and sunlight – pitch or tar – mineral oils
(b)	Nasal	– wood or leather work – nickel
(c)	Lung	– asbestos – chromates – nickel – radiation
(d)	Pleura and peritoneum	– asbestos
(e)	Urinary tract	– benzidine – dyestuff manufacture – rubber manufacture
(f)	Liver	– PVC manufacture
(g)	Bone	– radiation
(h)	Lymphatics and haematopoietic	– radiation – benzene

POISONING		
(a)	Metals	e.g. arsenic, cadmium, lead
(b)	Chemicals	e.g. chlorine, benzene
(c)	Solvents	e.g. trichloroethylene

INFECTIOUS DISEASES		Causes include
(a)	Anthrax	– imported bone, bonemeal hide or fur
(b)	Brucellosis	– farming or veterinary
(c)	Tuberculosis	– contact at work
(d)	Leptospirosis	– farming, sewer or under-ground workers
(e)	Tetanus	– farming or gardening
(f)	Rabies	– animal handling
(g)	Viral hepatitis	– contact at work

CHRONIC LUNG DISEASES		
(a)	Occupational asthma	– sensitising agent at work
(b)	Allergic alveolitis	– farming
(c)	Pneumoconiosis	– mining and quarrying – potteries – asbestos
(d)	Chronic bronchitis and emphysema	– underground coal mining

NOTE.—The Practitioner, on signing the certificate, should complete, sign and date the Notice to the Informant, which should be detached and handed to the informant. Where the informant intends giving information for the registration outside of the area where the death occurred, the notice may be handed to the informant's agent. The Practitioner should then, without delay, deliver the certificate itself to the Registrar of Births and Deaths for the sub-district in which the death occurred. Envelopes for enclosing the certificates are supplied by the Registrar.

APPENDIX C

Registrars' Forms

Blank Entry in Register of Deaths *531*

Disposal Certificate *532*

Form 52 *533*

Forms Provided by the Registrar General for the Use of Coroners

Form 100A *535*

Form 100B *537*

Form 99 *539*

RLIT0001826_0543

Blank Entry in Register of Deaths

DEATH	Entry No. 1
Registration district Sub-district	Administrative area
1. Date and place of death	
2. Name and surname	3. Sex 4. Maiden surname of woman who has married
5. Date and place of birth	
6. Occupation and usual address	
7.(a) Name and surname of informant	(b) Qualification
(c) Usual address	
8. Cause of death	
9. I certify that the particulars given by me above are true to the best of my knowledge and belief.....	Signature of informant
10. Date of registration	11. Signature of registrar

RLIT0001826_0545

Disposal Certificate

Unless this document is delivered intact to the person mentioned overleaf, the burial or cremation may be delayed.

PART B DIS 27 000000

Births and Deaths Registration Act 1953, s. 24(1)

CERTIFICATE FOR BURIAL OR CREMATION
(Issued *after* registration)

I, the undersigned registrar, do hereby certify that the death of

aged who died on

at

has been registered by me at Entry No. Date

Signature ..... (Registrar of Births and Deaths)

Registration District Sub-district

CERTIFICATE FOR BURIAL
(Issued *before* registration) **(This certificate is not available for purposes of Cremation)**

I, the undersigned registrar, do hereby certify that the death of

.....

aged ..... who died on .....

at .....

.....

has been notified to me. Date .....

Signature ..... (Registrar of Births and Deaths)

Registration District ..... Sub-district .....

IMPORTANT. If the death has not been registered it must be registered within 14 days of the date on which it happened by a relative of the deceased or by one of the other people required by law to give information.

If the burial or cremation is to take place outside England or Wales the Coroner must be notified before the body is moved. The registrar who issued this certificate can provide a form on which to notify the Coroner.

PART C DIS 27 000000

NOTIFICATION OF BURIAL OR CREMATION (see back)

Births and Deaths Registration Act 1926, s. 3(1) (Form prescribed by the Registration of Births and Deaths Regulations 1987)

This is to notify that the body of .....

deceased, who died on ..... at .....

was buried*/cremated* on..... at .....

Signature ..... on behalf of .....

Date .....

*Strike out whichever does not apply

PART A

Name of deceased .....

Certificate after*/before* Registration / Coroner's Order*/Certificate E* issued on ..... Duplicate issued on .....

Death registered on ..... in Register Book No. ..... at Entry No. .....

Notification of burial or cremation received on ..... Whether burial*/cremation*

Date of burial or cremation ..... Place of burial or cremation .....

.....

Enquiry due on ..... Enquiry made on .....

*Strike out whichever does not apply

DIS 27 000000

FORMS OF REPORT OF DEATH TO CORONER

NOTE

This form must be used to report to the coroner any death which is reportable under Regulation 43 or 51, including any death where it may appear that the deceased person had a relevant association with a visiting force or an international headquarters or defence organisation (see sections VII.D, IX.F and IX.I of the Handbook for Registration Officers).

Rep to Cor
Form 52

(20 FORMS)

M35 OPCS

RLIT0001826_0547

COUNTERFOIL

Name of deceased ..... Sex.....

Age.....Place of death.....

Date of death.....
Cause of death

Name of coroner.....Date reported.....
Result: Form 99 REV; Form 99A; Form 120; Form 100 Pt A/B; Form 90 received on.....

REPORT OF DEATH TO HM CORONER

To H M Coroner for .....

Particulars of deceased person

Date and place of death.....

Name and surname ..... Sex .....

Occupation ..... Age .....

Cause of death

Name of certifying medical practitioner

Under the Registrar General's Regulation I am required to report the above death for the following reason:*

So that the death can be registered, will you please send to me as soon as possible either

A. your Certificate after Inquest (form 99 REV 99A or 120); or

B. your Notification of No Inquest (form 100) ; or

C. your Visiting Force, etc (form 90).

Signed..... *Date*.....

Registrar of births and deaths for.....*sub-district*

*Insert here reason for report eg "Cause of death as stated", Not medically attended in last illness", Alleged still-birth", etc. If deceased was connected with a Visiting Force or an International Headquarters or Defence Organisation this should be stated.

FORM 52 *M35 OPCS*

RLIT0001826_0548

Form 100A

NOTIFICATION TO THE REGISTRAR BY THE CORONER that he does not consider it necessary to hold an inquest

FORM A - NO POST-MORTEM HELD

To be completed by Registrar	
Register No.	
Entry No.	

To the _____ Registrar of Births and Deaths

PARTICULARS OF THE DECEASED

Name and Surname	
Sex	
Age (or Date of Birth)	
Date of Death	
Place of Death	
Cause of Death	I (a)
	(b)
	(c)
	II

(Where this notification relates to a stillborn child, this should be stated)

CORONER'S CERTIFICATE

The circumstances connected with the death of the above person have been reported to me and I do not consider it necessary to hold an inquest

Date	
Signed	
Name	
Appointment	
Jurisdiction	

INSTRUCTIONS TO REGISTRAR OVERLEAF

Form 100A
SB30/4 1/93 R

RLIT0001826_0549

INSTRUCTIONS TO THE REGISTRAR

1. This death must be registered in the presence of a qualified informant

2 Spaces 1-7 should be completed in accordance with the information given by the informant and not copied from this form.

3. If the deceased was attended during his last illness by a registered medical practitioner the cause of death must be entered from the certificate issued by him and not from this form.

Form 100B

NOTIFICATION TO THE REGISTRAR BY THE CORONER that he does not consider it necessary to hold an inquest

FORM B - POST-MORTEM held under Section 19 of the Coroner's Act 1988

To be completed by Registrar	
Register No.	
Entry No.	

To the _____ Registrar of Births and Deaths

PARTICULARS OF THE DECEASED

Name and Surname

Sex

Age (or Date of Birth)

Date of Death

Place of Death

CORONER'S CERTIFICATE

I certify that a post-mortem examination of the body of the above person was made by the pathologist named below, whose report disclosed that the cause of death was:

Cause of Death

I (a)

(b)

(c)

II

and I am satisfied that an inquest is unnecessary
(Where this notification relates to a stillborn child, this should be stated)

Pathologist

CERTIFICATE FOR CREMATION (Details to be entered if Certificate issued)

Issued on

To

Address

Is a histological or bacteriological examination to be made?

Date

Signed

Name

Appointment

Jurisdiction

INSTRUCTIONS TO REGISTRAR OVERLEAF

Form 100B
SB29/5 1/93

RLIT0001826_0551

INSTRUCTIONS TO THE REGISTRAR

1. This death must be registered in the presence of a qualified informant

2 Spaces 1-7 should be completed in accordance with the information given by the informant and not copied from this form.

3. The cause of death must be entered from this form as in Example No 5 in D5 of the Handbook.

4 If the particulars overleaf relate to a still-birth the pathologist's certificate should have been received. If not, you must make enquiries of the Coroner.

Form 99

CORONER'S CERTIFICATE AFTER INQUEST
furnished under section 11(7) of the Coroner's Act 1988

To be completed by Registrar	
Register No.	
Entry No.	

To the _____ Registrar of Births and Deaths

Inquest held on
at
Was a post-mortem held?

PART I PARTICULARS OF DECEASED (Not still born - see separate Form 99A)

1 Date and place of death

2 Name and surname

3 Sex

4 Maiden surname of woman who has married

5 Date and place of birth

6 Occupation and usual address

Cause of death I(a)

(b)

(c)

II

Verdict

PART II VISITING FORCES
The inquest was adjourned on

{ *under section 7 of the Visiting Forces Act 1952
*and has not been resumed

PART III BURIAL/CREMATION
I have issued†
on
to
of

†Enter Order for Burial/Certificate E for Cremation

PART IV MARITAL CONDITION etc. All persons aged 16 and over
Insert appropriate number in box. 1 Single 2 Married 3 Widowed 4 Divorced 5 Not Known

If married enter date of birth of surviving spouse

Day		Month		Year	

I certify that the findings of the inquest were as above.

Date Signed

Name

Appointment

Jurisdiction

*Delete as necessary

Form 99(REV)A
SB17/2a 1/93

RLIT0001826_0553

Name and surname of deceased	To be completed by Registrar	
	District & SD Nos.	
	Register No.	
	Entry No.	

PART V ACCIDENT OR MISADVENTURE (including deaths from neglect or from anaesthetics)

1. Place where accident occurred†
   0. Home
   1. Farm
   2. Mine or quarry
   3. Industrial place or premises
   4. Place of recreation or sport
   5. Street or highway
   6. Public building
   7. Resident institution
   8. Other specified place
   9. Place not known

2. To be completed for all persons aged 16 and over
   When injury was received deceased was†
   1. On way to, or from work
   2. At work
   3. Elsewhere

3. Details of how accident happened:

4. If motor vehicle incident, deceased was†
   0. Driver of motor vehicle other than motor cycle
   1. Passenger in motor vehicle other than motor cycle
   2. Motor cyclist
   3. Passenger on motor cycle
   4. Occupant of tram car
   5. Rider of animal; occupant of animal-drawn vehicle
   6. Pedal cyclist
   7. Pedestrian
   8. Other specified person
   9. Not known

5. Interval between injury and death†
   1. Less than one year
   2. One year or more

†Please insert appropriate number in box.

Form 99(REY)B
SB17/26 1/93

APPENDIX D

Cremation Forms

Form A *542*

Form B *543*

Form C *545*

Form D *546*

Form E *547*

Form F *549*

RLIT0001826_0555

Specimen Cremation Form A

DUKINFIELD CREMATORIUM
HALL GREEN ROAD, DUKINFIELD SK16 4EP
Telephone : Registrar & Superintendent 0161 330 1901

Form A

CREMATION ACTS, 1902 AND 1952

APPLICATION FOR CREMATION

PURSUANT TO THE REGULATIONS MADE BY THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

This application should be made by an executor whenever possible.

I (name of applicant) .....
(Christian Names must be stated in full)

(Address) .....

(Occupation or Description) .....

apply to the Tameside Metropolitan Borough Council to undertake the Cremation of the remains of:

(Name of Deceased) .....
(Christian Names must be stated in full)

(Address).....

(Occupation) .....
(If retired please state previous occupation)

(Age) ..... *(Sex)* ..... *Whether married, widow, widower, or unmarried* .....

The true answers to the questions set out below are as follows:

ALL THE QUESTIONS should be carefully read and answered.

1. Are you an executor or the nearest surviving relative of the deceased? (Answer "Executor" or "Nearest surviving relative" if either).	
2. If not, state - (a) Your relationship to the deceased (b) The reason why the application is made by you and not by an executor or any nearer relative.	(a) (b)
3. Have the near relatives (1) of the deceased been informed of the proposed cremation?	
4. Has any near relative of the deceased expressed any objection to the proposed cremation? If so, on what grounds?	
5. What was the date and hour of the death of the deceased?	
6. What was the place where the deceased died? *(Give the address and say whether own residence, lodgings, hotel, hospital, nursing home, etc.)*	
7. Do you know, or have you any reason to suspect,that the death of the deceased was due, directly or indirectly, to (a) violence: (b) poison; (c) privation or neglect?	(a) (b) (c)
8. Do you know any reason whatever for supposing that an examination of the remains of the deceased may be desirable?	
9. Give name and address of the ordinary medical attendant of the deceased.	
10. Give names and addresses of the medical practitioners who attended deceased during his or her last illness.	

(1) The term "near relative" as here used includes widow or widower, parents, children above the age of 16, and any other relative usually residing with the deceased.

(2) Extract from Statutory Instruments, 1965 No. 1146: The application shall be verified by being countersigned by - a HOUSEHOLDER to whom the applicant is known who shall certify that the applicant is known to him or her an that he or she has not reason to doubt the truth of any of the information furnished by the applicant.

I Declare that to the best of my knowledge and belief the information give in this application is correct and no material particular has been omitted.

Date..... Signature .....

The applicant is known to me and I have no reason to doubt the truth of any of the information furnished by the applicant.

Date..... Signature .....

Capacity in which signatory has signed .....

Note signatory must be a householder confirming with marginal Note 2).

Address.....

This form when complete should be forwarded with the Certificate for Disposal (after Registry) to The Registrar, Dukinfield Crematorium, Hall Green Road, Dukinfield, SK16 4EP.

This form is issued by
DUKINFIELD CREMATORIUM
Telephone: 061-330 1901.

Forms B C & F

CREMATION ACTS, 1902 and 1952.

Statutory Rules and Orders, 1930 and 1952.

These Forms are Statutory. All the questions must be answered therefore, to make the Certificate effective for the purpose of Cremation.

These medical certificates are regarded as strictly confidential. The right to inspect them is confined to the Secretary of State, the Ministry of Health and the Chief Officer of a Police Force.

Form B

CERTIFICATE OF MEDICAL ATTENDANT.

(1) This form is not to be used in the case of a Coroner's Inquest.

I am informed that application is about to be made for the cremation of the remains of:–

(Name of Deceased) .....

(Address) .....

(Occupation or Description) ..... (Age) .....

(2) NOTE – The answers to the questions should be as concise as possible. Figures may be used instead of words. ALL the questions must be answered.

Having attended the Deceased before death, and **seen and identified the body after death,** I give the following answers to the questions set out below:–

1. On what date and at what hour, did he or she die?	
2. What was the place where the deceased died? (Give address and say whether own residence, lodging, hotel, hospital, nursing home, etc.)	
3. Are you a relative of the deceased? If so, state the relationship.	
4. Have you, so far as you are aware any pecuniary interest in the death of the deceased?	
5. (a) Were you the ordinary medical attendant of the deceased?	(a) .....
(b) If so, for how long?	(b) .....
6. (a) Did you attend the deceased during his or her last illness?	(a) .....
(b) If so, for how long?	(b) .....
7. When did you last see the deceased alive? (Say how many days or hours before death).	
	(The doctor must see the body after death).
8. (a) How soon after death did you see the body?	(a) .....
(b) What examination of it did you make?	(b) .....
8A. If the deceased died in a hospital* at which he was an in-patient, has a post-mortem examination been made by a registered medical practitioner of not less than five years' standing who is neither a relative of the deceased nor a relative or partner of yours and are the results of that examination known to you?	

SEE NOTE OVERLEAF.

(3) If the death has been reported to Coroner for any reason, this should be stated in answer to question 18.

9. What was the cause of death?

I

Immediate cause. (a) .....

Morbid conditions, if any, giving rise to immediate cause (stated in order proceeding backwards from immediate cause). due to (b) ..... due to (c) .....

II

Other morbid conditions (if important) contributing to death but not related to immediate cause. .....

.....

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Specimen Cremation Form B (Continued)

10. (a) What was the mode of death? (Say whether syncope, coma, exhaustion, convulsions, etc.) (b) What was its duration in days hours, or minutes?	(a) ..... (b) .....
11. State how far the answers to the last two questions are the result of your own observations, or are based on statements made by others. If on statements made by others, say by whom.	
12. (a) Did the deceased undergo any operation during the final illness or within a year before death? (b) If so, what was its nature and who performed it?	(a) ..... (b) .....
13. By whom was the deceased nursed during his or her last illness? (Give names and say whether professional nurse, relative, etc. If the illness was a long one this question should be answered with reference to the period of four weeks before the death).	
14. Who were the persons (if any) present at the moment of death?	
15. In view of the knowledge of the deceased's habits and constitution, do you feel any doubt whatever as to the character of the disease or the cause of death?	
16. Have you any reason to suspect, that the death of the deceased was due, directly or indirectly, to (a) Violence ... ... (b) Poison ... ... (c) Privation or neglect	*Death due directly or indirectly to alcohol has now to be reported to the Coroner.*
17. Have you any reason whatever to suppose a further examination of the body to be desirable?	
18. Have you given the certificate required for registration of death? If not who has?	
19. Has the Coroner been notified? if so please give **FULL DETAILS**	

(4) When the certificate for registration has been given by authority of the Coroner, this fact should be stated.

I Hereby Certify that the answers given above are true and accurate to the best of my knowledge and belief, and that I know of no reasonable cause to suspect that the deceased died either violent or an unnatural death or a sudden death of which the cause is unknown or died in such place or circumstances as to require an inquest in pursuance of any Act.

(Signature) .....

NAME IN BLOCK CAPITALS PLEASE .....

(Address) .....

Registered Qualifications .....

(Date) ..... *(Tel.)* .....

NOTE — This certificate must be handed or sent in a closed envelope by the medical practitioner, who signs it, to the medical practitioner who is to give the confirmatory certificate below, "except in a case where question 8A overleaf is answered in the affirmative, in which case the certificate must be so handed or sent to the Medical Referee".

"*The term "hospital" as used here means any institution for the reception and treatment of persons suffering from illness or mental disorder, any maternity home, and any institution for the reception and treatment of persons during convalescence".

Additional information regarding either of the Certificates may be given here if necessary

Has a pacemaker or any radio active material been inserted in the deceased? (YES or NO) .....

If so, has it been removed? (YES or NO) .....

CREMATION CANNOT TAKE PLACE UNTIL IT HAS BEEN REMOVED.

Forms B and C must be delivered to the Crematorium not later than 11 a.m. on the day (exclusive of Sunday) before the Cremation. Any delay in the delivery of these forms may lead to a postponement of the Cremation.

Form C

CONFIRMATORY MEDICAL CERTIFICATE

Pursuant to No. 9 of the Cremation Regulations, 1930 and 1952.

The Confirmatory medical certificate in Form C, if not given by the Medical Referee must be given by a medical practitioner who has been registered in this country for not less than 5 years and who is not a relative of the deceased or a relative or partner of the doctor who has given the certificate in Form B.

I, being neither a relative of the deceased, nor a relative or partner of the medical practitioner who has given the foregoing medical certificate, have examined it and have made personal inquiry as stated in my answers to the questions below:–

(5) Each question must be answered. The answers to Nos. (1), (2) & (4) should invariably be in the affirmative.

See note above

		The doctor must see the body of the deceased.
1.	Have you seen the body of the deceased?	
2.	Have you carefully examined the body externally?	
3.	Have you made a post mortem examination?	
4.	Have you seen and questioned the medical practioner who gave the above certificate?	
5. (a)	Have you seen and questioned any other medical practioner who attended the deceased?	(a) .....
(b)	(Give names and addresses of persons seen and say whether you saw them alone.)	(b) .....
6. (a)	Have you seen and questioned any person who nursed the deceased during his or her last illness, or who was present at the death?	(a) .....
(b)	(Give names and addresses of persons seen and say whether you saw them alone).	(b) .....
7. (a)	Have you seen and questioned any of the relatives of the deceased?	(a) .....
(b)	(Give names and addresses of persons seen and say whether you saw them alone).	(b) .....
8. (a)	Have you seen and questioned any other person?	(a) .....
(b)	(Give names and addresses of persons seen and say whether you saw them alone).	(b) .....

I am satisfied that the cause of death was .....

Here insert cause of death. .....

and I certify that I know of no reasonable cause to suspect that the deceased died either a violent or an unnatural death or a sudden death of which the cause is unknown or died in such place or circumstances as to require an inquest in pursuance of any Act.

(Signature) .....

NAME IN BLOCK CAPITALS PLEASE ..... *(Address)* .....

.....

(Date) ..... *(Tel.)* .....

Registered Qualifications ..... *Year*.....
(One of which must be of 5 years standing as above).

Appointment held .....

NOTE– These Certificates, after being signed by both medical men, must be handed or sent in a closed envelope to the **Registrar and Superintendent, Dukinfield Crematorium, Hall Green Road, Dukinfield,** by one or other of the Medical Practitioners by whom the Certificates are given. (Telephone: 061-330 1901).

Forms B & C must be delivered to the Crematorium not later than 11-0 a.m. on the day (exclusive of Sunday) before the Cremation. Any delay in the delivery of these forms may lead to a postponement of the Cremation.

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FORM D.

Certificate after Post-Mortem Examination.

I hereby certify that, acting* *on the instructions of* Medical Referee to the I made a post-mortem examination of the remains of

(*Name*)

(*Address*)

(*Occupation*)

The result of the examination is as follows :—

I am satisfied that the cause of death was and that there is no reason *for making any toxicological analysis*† *or* for the holding of an inquest.

(*Signature*)

(*Address*)

(*Date*)

(*Registered qualifications*)

*Where the Medical Referee himself gives this certificate, strike out the words in italics and insert " as."

†The words in italics should be omitted where a toxicological analysis has been made and its result is stated in this certificate or in a certificate attached to it.

PART A

Name of Deceased .....

.....

Certificate issued on .....

TO -
(Name) .....

.....

(Address) .....

.....

.....

PART B

CORONER'S CERTIFICATE 'E' FOR CREMATION

Form prescribed by Regulations made under the Cremation Act, 1902, by the Secretary of State

I *(full name)* ..... certify that

*(a) I have opened an inquest on the body of the undermentioned deceased person.

*(b) a post-mortem examination of the body of the undermentioned deceased person has been made by my direction or at my request and as a result thereof I am satisfied that an inquest is unnecessary.

I am satisfied that there are no circumstances likely to call for a further examination of the body.

PARTICULARS OF DECEASED PERSON

Full names *(if known)*	
Sex	
Age	
Date of Death	
Place of Death	
Registration district and sub-district in which the death is to be registered	

Date ..... *Signature* .....

Coroner for the ..... *of* .....

* *Delete whichever is inapplicable*

NOTE - This Certificate is issued for the purposes of cremation only and must be delivered to the Medical Referee appointed by the Cremation Authority. The cremation cannot be proceeded with unless this Certificate is so delivered.

Form 102

PART C

Being the detachable portion of a Certificate 'E' given by the Coroner for the cremation of the body of

..... deceased.

The Registrar of Cremations must, on the cremation of the body, notify the date and place of cremation on the prescribed form below to the Registrar of Births and Deaths at

.....

.....

NOTIFICATION OF CREMATION

(Births and Deaths Registration Act 1926, s.3 (1))

This is to give notice that the body of

.....

deceased, who died on .....

at .....

.....

was cremated on (a) .....

at (b) .....

.....

Signature .....
(Registrar of Crematorium)

Date .....

(a) State date of cremation
(b) State place of cremation

(SEE OVER)

Specimen Cremation Form E

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Specimen Cremation Form E (Continued)

Note to Part C

Regulations Made by the Secretary of State under the Cremation Act provide as follows:

"..... the registrar *(of cremations)* shall, within 96 hours of the cremation of the body of any deceased person, send to the registrar of births and deaths for the sub-district in which the death took place or, if the death took place elsewhere than in England, to the registrar of births and deaths for the sub-district in which the crematorium is situated, a notification of the cremation of the body and of the date and place of such cremation....."

"Where the body has been cremated after inquest or a post-mortem examination made in pursuance of Section 19(1) of the Coroners Act 1988, such notification as aforesaid shall be sent upon the detachable portion of the certificate given by the Coroner in Form 'E'."

The Registrar of Cremations must therefore, within 96 hours of the cremation of the body of the deceased person to whom this Certificate 'E' relates, fill up the form of notification on the other side hereof, detach it from the Certificate 'E', and deliver it to the Registrar of Births and Deaths.

If, however, the Certificate relates to the remains of a still-born child, no notification need be sent.

Specimen Cremation Form F

CREMATION ACT, 1902 & 1952

Form F

Required by the Regulations made by the Secretary of State for the Home Department, 1930 & 1952.

TO BE LEFT BLANK. THIS CERTIFICATE WILL BE OBTAINED BY THE CREMATION AUTHORITY

Authority to Cremate

Whereas application has been made for the Cremation of the remains of

† Name .....

Address .....

.....

Occupation .....

And whereas I have satisfied myself that all the requirements of the Cremation Acts, 1902 and 1952, and of the regulations made in pursuance of these Acts have been complied with, that the cause of death has been definitely ascertained and that there exists no reason for any further inquiry or examination:–

I hereby authorise the Superintendent of the Crematorium at Dukinfield to cremate the said remains.

(Signature) .....
Medical Referee to the Dukinfield Crematorium

(Date) .....

†In the case of a stillborn child, in place of the name, address and occupation, insert a description sufficient to identify the body, and in place of the words "that the cause of death has been definitely ascertained" insert the words "that the child was stillborn."

No. ..... Name ..... Cremated .....

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APPENDIX E

Respondents to the Inquiry's Discussion Paper

Organisations	Author (if named)
Action for Victims of Medical Accidents	Ms Liz Thomas, Policy & Research Manager
Age Concern	Mr Micky Willmott, Health Policy Officer
Alzheimer's Society	Mr Tarun Pamneja, Policy Officer
Association of Burial Authorities	Mr Sam Weller, Chairman
Association of Chief Police Officers	Commander Andre Baker, London Metropolitan Police
Association of Chief Police Officers Homicide Working Group	Assistant Chief Constable Jon Stoddart
Association of Chief Police Officers in Scotland	Deputy Chief Constable David Mellor, Fife Constabulary
Association of Clinical Pathologists	Dr R M Young, Chairman of Council
Association of Crematorium Medical Referees	Dr W D S McLay, President
Association of Personal Injury Lawyers	Miss Annette Morris, Policy Research Officer
Association of Police Surgeons	Dr W D S McLay, Honorary Treasurer
Association of Private Crematoria & Cemeteries	Mr Andrew P Helsby, Secretary
Board of Deputies of British Jews	Mr Laurence Brass, Elected Member
British Association in Forensic Medicine	Dr William Lawler, President
British Institute of Embalmers	Mrs Karen Caney
British Institute of Funeral Directors	Mr John M G Payne, Chief Executive Officer
British Medical Association	Dr David Pickersgill, Treasurer Ms Sally Watson, Director of Political & Representational Activities
Churches' Funeral Group	Ms Sue Moore, Assistant Secretary
Commission for Health Improvement	Dr Linda Patterson, Medical Director
Commission for Racial Equality	Ms Maureen Fraser, Head of Public Policy
Confederation of Burial Authorities	Mr R N Coates, Chief Executive
Coroner's Officers Association	Mrs Aline Warner, Honorary Secretary
Coroners' Society of England and Wales	Mr Michael Burgess, Honorary Secretary

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Organisations	Author (if named)
Court Service	Mr Rod Knight, Family & Probate Service Group Manager
Cremation Society of Great Britain	Mr Roger N Arber, Secretary
Cruse Bereavement Care	Mrs Anne Viney, Chief Executive
Department of Health	Mr John Mann, Senior Section Head, NHS Human Resources Directorate
Department of Health, Social Services & Public Safety, Belfast	Dr Ian Carson, Deputy Chief Medical Officer
Faculty of Public Health Medicine	Professor Sian Griffiths OBE, President
Federation of British Cremation Authorities	Mr Bernard McHale, Secretary
Foundation for the Study of Infant Deaths	Ms Joyce Epstein, Director
General Medical Council	Ms Jane O'Brien, Head of Standards Section
Greater Manchester Ambulance Service NHS Trust	Professor Keith Mackway-Jones, Medical Director
Greater Manchester Police	Assistant Chief Constable Alan Green, Crime Operations
Greater Manchester Strategic Health Authority	Ms Rosamund Roughton, Director of Corporate Affairs
Hampshire Care Association	Mr Ronnie Cairnduff, Chair
Health & Safety Executive	Mr Chris Taylor, Head of Health Services Unit
Institute of Burial & Cremation Administration	Mr Tim Morris, National Secretary
Institute of Population Registration	Mr Barry Hodgkinson, Registrar
Intensive Care Society	Dr A R Bodenham, Consultant in Anaesthesia & Intensive Care
Jewish Representative Council of Greater Manchester	Mr David Arnold, President
Law Society	Mrs Hilary Siddle, Chair of Law Reform Board
Manchester Beth Din	The Rev Y Brodie, Registrar
Manchester Local Medical Committee	Dr Peter R Fink, Honorary Secretary
Marie Curie Cancer Care	Dr Teresa Tate, Medical Adviser
Medical Defence Union	Miss Christine Freedman, Solicitor Dr John Gilberthorpe, Medico-Legal Advisor

Organisations	Author (if named)
Medical & Dental Defence Union of Scotland	Dr I G Simpson, Chief Executive & Secretary
Medical Practitioners' Union	Ms Carol English, National Secretary
Medical Protection Society	Dr Gerard Panting, Communications & Policy Director
Muslim Burial Council of Leicestershire	Mr Ebrahim Ahmed Jasat, Secretary
Muslim Council of Britain	Dr Shuja Shafi, Chair, Health and Medical Committee
National Association of Funeral Directors	Mr Nigel Rose, Executive Member
National Association of GP Co-operatives	Dr Jamie MacLeod, General Practitioner & Secretary
National Confidential Enquiry into Perioperative Deaths	Mrs Christobel Hargraves, Chief Executive
National Society of Allied & Independent Funeral Directors	
Nestor Healthcare Group plc	Dr William Holmes, Group Medical Director
Notaries Society	Mr Peter J Lawson
Nursing Midwifery Council	Ms Sarah Thewlis, Chief Executive
Office for National Statistics	Dr Peter Goldblatt, Chief Medical Statistician Miss Ceinwen Lloyd, Branch Manager, Births & Deaths Registration
Patient Concern	
Patients Association	Mr Michael Summers, Trustee
Policy Advisory Board for Forensic Pathology	
Public Health Laboratory Service	Dr Hilary Pickles, Director of Public Health Policy
Rabbinic Board of the Union of Liberal & Progressive Synagogues	Rabbi Harry M Jacobi, Chairman
Retained Organs Commission	Professor Margaret Brazier, Chair
Royal Brompton & Harefield NHS Trust	Mr Mark Taylor, Chief Executive
Royal College of Anaesthetists	Professor Peter Hutton, President
Royal College of General Practitioners	Dr Maureen Baker, Honorary Secretary
Royal College of Midwives	Dame Karlene Davis, General Secretary

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Organisations	Author (if named)
Royal College of Nursing	Mr Ian Hargreaves, Regional Director
Royal College of Obstetricians & Gynaecologists	Professor Allan Templeton, Honorary Secretary
Royal College of Paediatrics and Child Health	Dr Patricia Hamilton, Honorary Secretary
Royal College of Pathologists	Professor James Underwood, President
Royal College of Physicians	Dr Christopher Evans, Academic Vice-President
Royal College of Physicians of Edinburgh	Dr R H Smith, Fellow and Secretary
Royal College of Radiologists	Ms Hazel Beckett, Administration Manager
Royal College of Surgeons Edinburgh	Mr D A D Macleod, Vice President
Salford Quays Forensic Pathology	Dr Naomi Carter, Forensic Pathologist Dr John Rutherford, Forensic Pathologist Dr Charles A Wilson, Forensic Pathologist
Scottish Executive	Mr Trevor Jones, Head of Department & Chief Executive
Small Practices Association	Dr Tom Heyes, Member
Society of Registration Officers	Ms Karen Knapton, Honorary General Secretary
South Yorkshire Police	Detective Chief Superintendent Hudson, Force Crime Manager
Standing Medical Advisory Committee	Dr Deirdre Cunningham, Chair
Tameside Families Support Group	
Tameside & Glossop Community Health Council	Mr Dave Owen, Chief Officer
Victim Support	Ms Teresa Reynolds, Head of Policy
Welsh Assembly Government	Mr Mike Ponton, Director of Health Services Policy & Development Division
West Midlands Police	Mr W H Blocksom, Coroner's Co-ordinator
World Council of Hindus – UK	Dr G L Bhan, Chairman

Individuals	Position Held/Reason for Interest in the Inquiry
Mr R D Atkinson	HM Coroner, Jurisdiction of West Lincolnshire
Dr Paul Aylin	Clinical Senior Lecturer in Epidemiology & Public Health, Imperial College School of Medicine, Science & Technology, London
Professor Richard Baker OBE	Director Clinical Governance, Research & Development Unit, University of Leicester
Dr Eve M Borland	Medical Referee, Dunfermline Crematorium
Professor A Busuttil	University of Edinburgh, Department of Medicine, Forensic Medicine Section
Dr N D Chapman	HM Coroner for Nottinghamshire
Mr Steven Charteris	Head of Coroner's Unit & Support Services Manager, Hertfordshire County Council Corporate Services
Dr Gary Arnold Cook	Consultant in Public Health & Consultant Epidemiologist & Director General of Clinical Effectiveness Unit, Stockport NHS Trust
Professor Stephen Cordner	Professor of Forensic Medicine, Director of Victorian Institute of Forensic Medicine, Australia
Mr John M Corkery	Honorary Senior Research Fellow, The National Programme on Substance Abuse Deaths
Dr Andrew M Davison	Senior Lecturer in Forensic Pathology, University of Wales College of Medicine
Ms Pam Dawson	Bereavement Co-ordinator for Borough of Bromley, former Chairman of National Association of Bereavement Services
Mr Christopher P Dorries	HM Coroner for District of South Yorkshire (West)
Dr J S Elkington	General Practitioner, Oxfordshire
Dr Stewart Findlay	Chairman of Professional Executive Committee, Durham Dales NHS Primary Care Trust
Dr David Fowler	Acting Chief Medical Examiner, Office of the Chief Medical Examiner, Baltimore, USA

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Individuals	Position Held/Reason for Interest in the Inquiry
Dr John Grenville	General Practitioner, Derbyshire
Mr Andrew Haigh	HM Coroner for Staffordshire South
Mrs A G Harrison	Niece of Mr Michael Connors, Deceased
Mr Gerald Harrop	Husband of Mrs Jean Harrop, Deceased
Dr Tim Helliwell	Reader & Consultant Pathologist
Mr Thomas Hennell	Senior Analyst, Department of Health, Government Office for the North West
Dr Holden	General Practitioner, The Medical Centre, Haydock
Mr D P M Jackson	Son of Mrs Nancy Jackson, Deceased
Dr Ryk S James	Senior Lecturer Forensic Pathology, University of Wales College of Medicine
Dr Michael Jarmulowicz	Consultant Histopathologist, Royal Free Hospital
Dr I M Jessiman	Retired General Practitioner
Mrs Ann Johnson	
Dr Stephen Leadbeatter	Director, Wales Institute of Forensic Medicine, University of Wales College of Medicine
Mrs Selena Lynch	HM Coroner for Inner South District, Greater London
Dr Linda Mahon-Daly	Primary Care Cancer Lead
Mr Robin Mair	North Yorkshire County Council Business and Community Services
Professor James McEwen	Emeritus Professor of Public Health
Mr R J Mifflin	Autopsy Technician, Leighton Hospital
Mrs J A Moulton	
Mr D A Mulligan	Superintendent Registrar, Royal Kingston Register Office
Dr Rory O'Conor	Consultant Clinical Epidemiologist, Mid Yorkshire Hospitals NHS Trust
Dr O'Donnell	General Practitioner, The Medical Centre, Haydock

Individuals	Position Held/Reason for Interest in the Inquiry
Dr Rajesh Patel	General Practitioner, Brooke Practice Surgery, Hyde
Ms Elizabeth Paton	Procurator Fiscal Principal Depute, Crown Office & Procurator Fiscal Service, Edinburgh, Scotland
Professor Antti Sajantila	Professor of Forensic Biology, Deputy Head of Division of Forensic Pathology, Director of Laboratory of Forensic Biology, Department of Forensic Medicine, University of Helsinki, Finland
Dr Gordon Pledger	Medical Referee, Newcastle-upon-Tyne
Dr J Procter	General Practitioner, The Hollies Surgery, Dukinfield
Mr Stuart Putney	Head of Trading Standards & Regulatory Services, North Yorkshire County Council
Dr Stephen P Robinson	Senior Police Surgeon, GMP and Co-ordinating Director of the Forensic Academic Group in the North
Mr Michael R Rose	HM Coroner for Western District of Somersetshire
Dr A Shafi	Advisor on Issues of Risk Management in Healthcare
Mr Jack Shelmerdine	Son of Mr Jack Leslie Shelmerdine, Deceased
Mr Ian Smith	HM Coroner for Cumbria
Mr Ian Stewart Smith	HM Coroner for Metropolitan Borough of Walsall
Ms Patricia Stanley	Coroner's Officer, Telford
Ms Sylvia Stern	Relative of Miss Beatrice Clee, Deceased
Dr Mark Sterrick	Medical Referee Depute to Dunfermline Crematorium
Dr Christopher Stretton	Crematorium Medical Referee
Dr Vikram Tanna	General Practitioner, Clarendon Medical Centre, Hyde
Mr Andrew Tweddle	HM Coroner for North District of Durham

Individuals	Position Held/Reason for Interest in the Inquiry
Mr P S Wagstaff	Son of Mrs Laura Kathleen Wagstaff, Deceased
Mrs J A Waldrum	
Dr D Wayte	Consultant & Home Office Pathologist
Dr T E T West	Consultant Physician, Princess Royal Hospital NHS Trust
Mr R L Whittaker	HM Coroner for West Yorkshire
Professor Helen Whitwell	Professor of Forensic Pathology, University of Sheffield
Dr Roger B Williams	Consultant Histopathologist, Wrexham Maelor Hospital
Mrs A & Mr D P Woodruff	Daughter and Son-in-Law of Mrs Kathleen Grundy, Deceased
Dr James G Young	Chief Coroner for Province of Ontario, Assistant Deputy Minister of the Solicitor General, Ontario, Canada

APPENDIX F

Participants in the Inquiry Seminars: 13th – 24th January 2003

Organisations	Representative(s)
Association of Chief Police Officers	Commander Andre Baker, London Metropolitan Police
Board of Deputies of British Jews	Mr Laurence Brass, Elected Member
British Association in Forensic Medicine	Dr William Lawler, President
British Medical Association	Dr David Pickersgill, Treasurer Dr Anne Thorpe Dr Alan Williams
Coroner's Officers Association	Mrs Aline Warner, Honorary Secretary
Coroners' Society of England and Wales	Mr Michael Burgess, Honorary Secretary
Cruse Bereavement Care	Mrs Anne Viney, Chief Executive
Department of Health	Dr Ian Barnes, Pathology Modernisation Adviser Mrs Marcia Fry, Divisional Head, Clinical Quality, Ethics & Genetics Mr John Mann, Senior Section Head – NHS Human Resources Directorate
Faculty of Public Health Medicine	Dr Gary Arnold Cook, Member
Greater Manchester Ambulance Service NHS Trust	Professor Keith Mackway-Jones, Medical Director
National Confidential Enquiry into Perioperative Deaths	Mrs Christobel Hargraves, Chief Executive
Nestor Healthcare Group plc	Dr William Holmes, Group Medical Director
Office for National Statistics	Dr Peter Goldblatt, Chief Medical Statistician Miss Ceinwen Lloyd, Branch Manager, Births & Deaths Registration Dr Cleone Rooney, Medical Epidemiologist
Retained Organs Commission	Professor Margaret Brazier, Chair
Royal College of General Practitioners	Dr Maureen Baker, Honorary Secretary
Royal College of Pathologists	Professor James Underwood, President Dr Peter Acland Professor Helen Whitwell
Royal College of Physicians	Dr Christopher Evans, Academic Vice President

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Individual Participants	Positions Held
Dr Paul Aylin	Clinical Senior Lecturer in Epidemiology & Public Health, Imperial College School of Medicine, Science & Technology, London
Professor Richard Baker OBE	Director, Clinical Governance, Research and Development Unit, University of Leicester
Professor Stephen Cordner	Professor of Forensic Medicine, Director of Victorian Institute of Forensic Medicine, Australia
Ms Pam Dawson	Bereavement Co-ordinator for Borough of Bromley, former Chair, National Association of Bereavement Services
Dr David Fowler	Acting Chief Medical Examiner, Office of the Chief Medical Examiner, Baltimore, USA
Dr John Grenville	General Practitioner, Derbyshire
Mr Thomas Hennell	Senior Analyst, Government Office for the North West
Dr Ryk James	Senior Lecturer in Forensic Pathology, University of Wales College of Medicine
Dr Stephen Leadbeatter	Director, Wales Institute of Forensic Medicine, University of Wales College of Medicine
Professor Kevin Park	Professor of Pharmacology and Therapeutics, Head of Department of Pharmacology and Therapeutics, University of Liverpool
Ms Elizabeth Paton	Procurator Fiscal Principal Depute, Crown Office and Procurator Fiscal Service, Edinburgh, Scotland
Professor Antti Sajantila	Professor of Forensic Biology, Deputy Head of Division of Forensic Pathology, Director of Laboratory of Forensic Biology, Department of Forensic Medicine, University of Helsinki, Finland
Dr Roger Start	Consultant Histopathologist, Chesterfield & North Derbyshire Royal Hospital NHS Trust
Professor Helen Whitwell	Professor of Forensic Pathology & Head of Department, University of Sheffield
Dr James Young	Chief Coroner for the Province of Ontario, Assistant Deputy Minister of the Solicitor General, Ontario, Canada

APPENDIX G

Form 1 (Community)

Inquiry's Proposed Form 1 (Community) *563*

Explanatory Notes: Form 1 (Community) *565*

Sample Completed Form 1 (Community) *569*

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Proposed Form 1 (Community)

Form 1: Certificate of Fact of Death and Statement of Circumstances of Death

Part A: Personal details of deceased

1. Deceased's family name(s) Deceased's forename(s)			2. NHS No. (if known)
3. Deceased's previous name(s) (if any known)	4. Gender (M/F)	5. Date of birth	6. Religion (if applicable)
7. Usual address (house name/no. and street)	Town/City	County	Postcode
8. Name and surgery address of usual GP/practice (if known)			9. GP Practice no. (if known)

10. Name and contact details (including telephone no.) of a person willing to provide information to the coroner's office. *State relationship, if any, of that person to the deceased.*

Part B: Statement as to the fact of death and details of examination

Answer either 11A or 11B
In my opinion, the above-named person is dead.
11A. I have observed all the following features: *tick each box as observed*

- ☐ the absence of heart sounds
- ☐ the absence of breathing
- ☐ the absence of carotid or femoral pulses
- ☐ the absence of response to painful stimulus

OR
11B. I have ascertained the fact of death by other means, namely:

12. Time and date at which death was confirmed.

13. Brief description of the position of the deceased's body (including state of dress), identifying any features which might be relevant to the cause of death. *If the body has been moved since death, include also a brief description of its position at time of death (if known).*

Answer either 14A or 14B
14A. I have examined the deceased's head, neck and arms to the elbow and have ☐ have not ☐ observed the following: wound(s), bruising or other injuries, injection marks or petechiae. *If any such features are observed, include a brief description of the site(s) and appearance of the features observed.*

OR
14B. I have not examined the deceased's head, neck and arms because

Part C: Circumstances of death

15. Address where death occurred with a brief description of the type of place (e.g. own home, cottage or community hospital, care home, shop, etc.). *If the death occurred whilst the deceased was resident temporarily or permanently in a care home, state the date or approximate date, if known, of admission to such accommodation.*

If the body is no longer at the site where death occurred, state where it is at the time of signing this form.

Answer either 16A or 16B (overleaf)
16A. If a person or persons is/are known to have been present with the deceased at the moment of his or her death:
(a) Name(s) and contact details (including telephone no(s).) of the person(s) present and relationship (e.g. daughter, neighbour, friend), if any, to the deceased or relevant professional capacity (e.g. police, paramedic, etc.).

(b) Date and time when the death occurred.

(c) Brief description of the circumstances of the death.

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OR

16B. If no person is known to have been present with the deceased at the moment of his or her death:

(a) Name(s) and contact details (including telephone no(s).) of the person(s) who discovered the death and relationship, if any, to the deceased or relevant professional capacity.

(b) Date and time when the death was discovered.

(c) Brief description of the circumstances in which the death was discovered.

(d) Date and time when the deceased is last known or believed to have been seen alive.

(e) Name(s) and contact details (including telephone no(s).) of the person(s) known or believed to have last seen the deceased alive.

Part D: Recent history leading to death

17. Brief outline of the deceased's state of health before death (including details of any relevant medication, if known) as described by those available to give information to the signatory. State who provided the relevant information.

Part E: Details of attendance by signatory

18. Name and contact details (including telephone no.) of person who identified the deceased to the signatory (if the deceased was not already known to signatory).

19. Name(s) and contact details (including telephone no(s).) of any other person(s) present at scene of death (other than those already named) who have provided information contained on this form. If the death occurred in a care home, give the name of the senior member of staff on duty at the time when the death occurred.

Part F: Other relevant information

20. I wish to draw the following information to the attention of the coroner's office:

Part G: Declaration

I hereby certify that the contents of this form are true and accurate to the best of my knowledge and belief.

Signed
Name and qualifications
(in capital letters)
Professional address

Date

GMC No.
Nurse's PIN No.
Ambulance Call No.
On-Call Doctor Job No.

Part H: Permission to remove the deceased's body

The deceased's body may be removed:

☐ to the premises of a funeral director at (*insert address*)
☐ to the mortuary at (*insert location*)

with the permission of *(insert name of coroner or coroner's representative).*

Explanatory Notes: Form 1 (Community)

This form is for use when a death occurs in the community, i.e. at home, in a care home or in a community or cottage hospital or a similar facility. An example of a completed Form 1 (Community) follows these Notes.

Question on Form	Explanatory Notes
Part A: Personal details of deceased	The form of these questions can be re-designed as necessary to be compatible with coding and electronic completion and transmission.
Question 2	Every person born in England and Wales is issued at birth with a unique NHS number. It is available from GP computer systems. If known, it would allow the deceased person to be immediately identified and the fact of his/her death to be communicated to other agencies which needed to be informed of the death. If the number were not known at the time Form 1 was signed, it could be inserted on Form 2 later.
Question 6	Information about the deceased person's religion (if any) might help to identify those cases where the investigation and certification processes might need to be expedited for religious reasons.
Question 9	It is expected that the GP practice number will become more widely used in the future. If the number were not known at the time Form 1 was signed, it could be inserted on Form 2 later.
Question 10	The purpose of this question is to identify a person who is willing to be a first point of contact for the district coroner's office. That person might be a close relative of the deceased person who was caring for him/her at the time of his/her death. He or she might be a neighbour who happened to be on the scene after the death and who, if the deceased person's family lived some distance away, and could not be contacted immediately, agreed to act as a contact point. If the deceased person died in a care home, the contact name could be a senior member of staff who would in due course put the coroner's office in touch with the deceased person's family.
Part B: Statement as to the fact of death and details of examination	
Question 11A	There is considerable support for the view that an agreed and recognised protocol should be developed for use by those health professionals and others who might be accredited to diagnose the fact of death. The protocol would set out a minimum set of observations that should be made before death was diagnosed (and specify the time over which those observations should be made). At present, some organisations (e.g. ambulance services) have protocols, while others do not. The observations listed in Question 11A are merely examples of constituents that might be included in an agreed protocol. If and when a protocol is agreed, its main constituents should appear in Form 1.

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Question on Form	Explanatory Notes
Question 11B	The option to record that the fact of death has been ascertained by other means is intended to cover circumstances where the fact of death was obvious (e.g. because decomposition had taken place or there had been decapitation or dismemberment) or when equipment (such as a heart monitor) was used to diagnose death.
Question 13	Information about the position of the deceased person's body, its state of dress and other features of the death scene might be of assistance in determining the circumstances and cause of death. What is sought here is a free text entry, describing the position of the deceased person, his/her state of dress (e.g. was s/he wearing light clothes or was s/he dressed as if about to go out?). Features such as an unfinished meal or furniture apparently disturbed by a fall should also be recorded. If signs such as decomposition, post-mortem stiffness and post-mortem discoloration were present, they should be recorded. They would indicate that the death had not occurred recently.
Question 14A	An examination of the deceased person's head, neck (back and front) and forearms should be perfectly feasible during the process of ascertaining that death had occurred. Any mark of the type specified should be recorded and described. It is possible that the mark could be innocent in origin (e.g. spontaneous bruising in an elderly person). It might be the result of violence or neglect. The person completing Form 1 would not be obliged to offer his/her own interpretation of the cause of the mark. However, if s/he felt able to offer any opinion as to the likely or possible cause of the mark, it would obviously be helpful if that were stated. The opinion of the person completing Form 1 would not be determinative. If a mark was present and there was a possibility that it might have resulted from violence or neglect, the medical coroner would undertake an investigation which would include an external examination of the body by a person possessing appropriate forensic skills.
Question 14B	If no examination is possible (e.g. because of the position of the deceased or a lack of proper lighting), the reason should be recorded.
Part C: Circumstances of death	
Question 15	A description of the type of premises where the death occurred would set the circumstances of the deceased person's death in context, as well as facilitating future audit of deaths occurring in certain types of premises.
Question 16	Identification of the person(s) present at the time of death or who discovered the death or last saw the deceased alive would enable the district coroner's office to seek further information from those persons at a later stage, if necessary. Information about any person(s) known or believed to have last seen the deceased person alive would, in a case where it appeared that s/he had died alone, enable the district coroner's office to contact the person(s) likely to have the best information about the deceased person's state of health prior to death. A free text description of the circumstances of the death (or the circumstances in which the death was discovered) should be given. This should include any information that might assist in determining the cause of death.

Question on Form	Explanatory Notes
Part D: Recent history leading to death	
Question 17	The purpose of this question is to obtain some basic information about the deceased person's general health prior to death, insofar as that information is available from those persons present when Form 1 is completed. Such persons should be asked about any significant medical condition(s) from which the deceased person was known to suffer, any treatment (including medication) which s/he had been receiving prior to death and about the course of events leading to death. If the persons present had no information about any medication that the deceased person might have been taking or had been prescribed prior to death, information might be available from tablet bottles, etc., at the scene of death or from district nursing or other nursing records if the deceased person was receiving nursing care.
Part E: Details of attendance by signatory	
Question 18	Information about persons able to identify the deceased person might become important if there were any uncertainty over his/her identity.
Question 19	Identification of other persons at the scene at the time when Form 1 is completed would provide the medical coroner with other possible sources of information about the circumstances of the death and/or the deceased's medical history. In general, it would be necessary only to identify those persons who had provided information to the person completing Form 1. There might be other persons at the scene who had made no contribution to the information provided and they would not need to be named. The name of the senior member of staff on duty at a care home (or community hospital and similar premises) at the time when the death occurred (who might be different from the member of staff who was caring for the deceased and who had given other information contained on Form 1) would enable the medical coroner to obtain or check information about the circumstances of the death.
Part F: Other relevant information	
Question 20	The purpose of this question is to give the person completing Form 1 the opportunity of providing any information of which s/he is aware and which might be of assistance or relevance to the medical coroner when considering the death. Any information that might be relevant should be included here. It might consist of concerns (e.g. about the unexpected nature of the death) or of information about complaints being made by the deceased's family about his/her medical care. It might consist of practical information (e.g. the fact that all members of the deceased's family lived abroad or that the deceased had no family and his/her affairs were being dealt with by a solicitor/social worker).

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Question on Form	Explanatory Notes
Part G: Declaration	The purpose of Part G is to identify clearly the person who has completed Form 1 and to obtain a declaration as to the accuracy of the information provided.
Part H: Permission to remove the deceased's body	The purpose of Part H is to record the fact that permission has been granted by the district coroner's office for the body of the deceased person to be moved to the premises of a funeral director or to a mortuary.

Completed Form 1 (Community)

Form 1: Certificate of Fact of Death and Statement of Circumstances of Death

Part A: Personal details of deceased

1. Deceased's family name(s) Jones **Deceased's forename(s)** James John			**2. NHS No. (if known)** 123456
3. Deceased's previous name(s) (if any known) N/A	**4. Gender (M/F)** M	**5. Date of birth** 01.01.1928	**6. Religion (if applicable)** C of E
7. Usual address (house name/no. and street) Flat 1, Regent Park	**Town/City** Preston	**County** Lancashire	**Postcode** PR1 000
8. Name and surgery address of usual GP/practice (if known) Dr Albert Brown, 1 Main Street, Preston			**9. GP Practice no. (if known)** N/K

10. Name and contact details (including telephone no.) of a person willing to provide information to the coroner's office. ***State relationship, if any, of that person to the deceased.***
Mrs Hilda White (Warden), Regent Park, Preston
Tel: 01772 123456

Part B: Statement as to the fact of death and details of examination

Answer either 11A or 11B
In my opinion, the above-named person is dead.
11A. I have observed all the following features: ***tick each box as observed***

- ☑ **the absence of heart sounds**
- ☑ **the absence of breathing**
- ☑ **the absence of carotid or femoral pulses**
- ☑ **the absence of response to painful stimulus**

OR
11B. I have ascertained the fact of death by other means, namely:

12. Time and date at which death was confirmed. 9am 01.04.03

13. Brief description of the position of the deceased's body (including state of dress), identifying any features which might be relevant to the cause of death. ***If the body has been moved since death, include also a brief description of its position at time of death (if known).***

He was lying in the kitchen face down, with his hands by his head. He appeared to have fallen sideways from a chair at the kitchen table. He was dressed in day clothes but wearing bedroom slippers. There was a broken mug on the floor and an unfinished plate of food on the table.

Answer either 14A or 14B
14A. I have examined the deceased's head, neck and arms to the elbow and have ☑ have not ☐ observed the following: wound(s), bruising or other injuries, injection marks or petechiae. ***If any such features are observed, include a brief description of the site(s) and appearance of the features observed.***

There was bruising on his left cheek and arm, consistent with a fall from the chair. No other marks were observed.

OR
14B. I have not examined the deceased's head, neck and arms because

Part C: Circumstances of death

15. Address where death occurred with a brief description of the type of place (e.g. own home, cottage or community hospital, care home, shop, etc.). ***If the death occurred whilst the deceased was resident temporarily or permanently in a care home, state the date or approximate date, if known, of admission to such accommodation.***
See above. Own flat (sheltered accommodation).

If the body is no longer at the site where death occurred, state where it is at the time of signing this form.

Answer either 16A or 16B (overleaf)
16A. If a person or persons is/are known to have been present with the deceased at the moment of his or her death:

(a) Name(s) and contact details (including telephone no(s).) of the person(s) present and relationship (e.g. daughter, neighbour, friend), if any, to the deceased or relevant professional capacity (e.g. police, paramedic, etc.).

(b) Date and time when the death occurred.

(c) Brief description of the circumstances of the death.

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OR

16B. If no person is known to have been present with the deceased at the moment of his or her death:

(a) Name(s) and contact details (including telephone no(s).) of the person(s) who discovered the death and relationship, if any, to the deceased or relevant professional capacity.
Warden as at 10 above.

(b) Date and time when the death was discovered.
8.30am 01.04.03

(c) Brief description of the circumstances in which the death was discovered.
Warden carrying out routine morning check. Could get no answer from doorbell. Entered flat using pass key and found deceased on floor in kitchen.

(d) Date and time when the deceased is last known or believed to have been seen alive.
6.30pm 31.03.03

(e) Name(s) and contact details (including telephone no(s).) of the person(s) known or believed to have last seen the deceased alive.
Mrs Elizabeth Rose, Flat 2, Regent Park. Tel: 01772 234567 (neighbour and friend).

Part D: Recent history leading to death

17. Brief outline of the deceased's state of health before death (including details of any relevant medication, if known) as described by those available to give information to the signatory. State who provided the relevant information.

According to the warden, Mr Jones was known to suffer from diabetes, hypertension and angina. He had seen his own GP the day before (31.03.03) because he was complaining of increasing chest pain. He had been unwell for the past few days and had not gone out as usual. Usually, he was active and went out regularly. Medication (glibenclamide, enalapril, isosorbide dinitrate and GTN) found by his bedside. He was last seen yesterday evening by his neighbour who had a cup of tea with him. According to her, he seemed fine then.

Part E: Details of attendance by signatory

18. Name and contact details (including telephone no.) of person who identified the deceased to the signatory (if the deceased was not already known to signatory).

Warden as at 10 above.

19. Name(s) and contact details (including telephone no(s).) of any other person(s) present at scene of death (other than those already named) who have provided information contained on this form. If the death occurred in a care home, give the name of the senior member of staff on duty at the time when the death occurred.

Mrs Jenkins, Flat 3, Regent Park (neighbour), Tel: 01772 345678

Part F: Other relevant information

20. I wish to draw the following information to the attention of the coroner's office:

The warden tells me that Mr Jones had no close relatives. His next of kin was a cousin living in Cornwall. Mrs White has contact details and will inform her of the death.

Part G: Declaration

I hereby certify that the contents of this form are true and accurate to the best of my knowledge and belief.

Signed		**Date**	01.04.03
Name and qualifications (in capital letters)	JOHN BLACK, PARAMEDIC	**GMC No.**	
Professional address	Ambulance Headquarters, Preston	**Nurse's PIN No.**	
		Ambulance Call No.	987654
		On-Call Doctor Job No.	

Part H: Permission to remove the deceased's body

The deceased's body may be removed:

☐ **to the premises of a funeral director at (*insert address*)**

☑ **to the mortuary at (*insert location*)** Preston District General Hospital

with the permission of (*insert name of coroner or coroner's representative*). David Smith, coroner's investigator

APPENDIX H

Form 1 (Hospital)

Inquiry's Proposed Form 1 (Hospital) *573*

Explanatory Notes: Form 1 (Hospital) *575*

Sample Completed Form 1 (Hospital) *577*

RLIT0001826_0585

Proposed Form 1 (Hospital)

Form 1: Certificate of Fact of Death and Statement of Circumstances of Death

Part A: Personal details of deceased

Name of Hospital

1. Deceased's family name(s) Deceased's forename(s)			2. NHS No. (if known)
3. Deceased's previous name(s) (if any known)	4. Gender (M/F)	5. Date of birth	6. Religion (if applicable)
7. Usual address (house name/no. and street)	Town/City	County	Postcode
8. Name and surgery address of usual GP/practice (if known)			9. Deceased's hospital identifying no. (If known)

10A. Name and contact details (including telephone no.) of a member of staff who can act as a contact point with regard to the death.

10B. Name and contact details (including telephone no.) of next of kin of deceased (if known).

Part B: Statement as to the fact of death and details of examination

Answer either 11A or 11B
In my opinion, the above-named person is dead.
11A. I have observed all the following features: *tick each box as observed*

- ☐ the absence of heart sounds
- ☐ the absence of breathing
- ☐ the absence of carotid or femoral pulses
- ☐ the absence of response to painful stimulus

OR
11B. I have ascertained the fact of death by other means, namely:

12. Time and date at which death was confirmed.

13. Brief description of the position of the deceased's body (including state of dress), identifying any features which might be relevant to the cause of death. *If the body has been moved since death, include also a brief description of its position at time of death (if known).*

14. I have examined the deceased's body and have ☐ have not ☐ observed signs which might be indicative of violence or neglect. *If any such features are observed, include a brief description of the site(s) and appearance of the features observed.*

Part C: Circumstances of death

15. Ward, department or area of the hospital where death occurred.

Answer either 16A or 16B (overleaf)
16A. If a member of staff or other person was present with the deceased at the moment of his or her death:
(a) Name(s) and contact details (including telephone no(s).) of the person(s) present and relationship (e.g. daughter, friend, etc), if any, to the deceased or relevant professional capacity (e.g. SHO, SRN, etc.). If more than one member of staff was present, record the senior member of staff present.

(b) Date and time when the death occurred.

(c) Brief description of the circumstances of the death.

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OR

16B. If no person is known to have been present with the deceased at the moment of his or her death:

(a) Name(s) and contact details (including telephone no(s).) of the person(s) who discovered the death and relationship, if any, to the deceased or relevant professional capacity.

(b) Date and time when the death was discovered.

(c) Date and time when the deceased is last known or believed to have been seen alive.

Part D: Details of admission to hospital

17. Time and date of admission to hospital.

18. Consultant responsible for the deceased's care.

19. Reason(s) for admission.

Part E: Other relevant information

20. I wish to draw the following information to the attention of the coroner's office:

Part F: Declaration

I hereby certify that the contents of this form are true and accurate to the best of my knowledge and belief.

Signed — Date

Name and qualifications
(in capital letters) — GMC No.
Professional address — Nurse's PIN No.

Explanatory Notes: Form 1 (Hospital)

This form is for completion when a person dies after admission to a hospital ward. Its purpose and contents are very similar to those of Form 1 (Community). The differences are noted below. An example of a completed Form 1 (Hospital) follows these Notes.

Question on Form	Explanatory Notes
Part A: Personal details of deceased	
Questions 1–8	See Explanatory Notes for Form 1 (Community) Part A, Questions 2 & 6.
Question 9	The deceased person's hospital identifying number (or case notes number, if thought more appropriate) would be required to facilitate the tracing of notes and records.
Question 10	The form requires the details of a member of the hospital staff who can act as a contact point for the district coroner's office with regard to the death. The staff contact point might be the hospital bereavement officer, the person completing Form 1 or a member of the nursing or medical staff on the relevant ward. The form also requires contact details of the next of kin, information that is likely to be available to the hospital if the deceased person had close relatives.
Part B: Statement as to the fact of death and details of examination	
Question 11A	See Explanatory Notes for Form 1 (Community) Part B.
Question 11B	In hospital, it might well be that death would be confirmed by a means other than the kind of observations set out at Question 11A. In that event, there would be the option of completing Question 11B, stating briefly by what means death had been confirmed.
Question 13	See Explanatory Notes for Form 1 (Community) Part B, Question 13. Most people who die in hospital do so in their bed, where they have been receiving full nursing care. In many cases the description given might go little further than that; see, for example, the completed form that follows these Notes. However, deaths can occur in other parts of the hospital, e.g. in a bathroom or while moving around the premises, and, if that occurred, an appropriate description should be included.

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Question on Form	Explanatory Notes
Question 14	In the setting of a hospital mortuary, an examination of the naked body of a deceased person, back and front, should be possible. The possibility of signs of violence or neglect (e.g. serious pressure sores) would be particularly relevant to patients who had been admitted to hospital within a short period before death. An examination of the body should be conducted and any sign that might be indicative of violence or neglect should be recorded on the form. Any signs about which the examiner has any doubt whatsoever should be recorded. The examination is intended to be a screening process only and would not be determinative of the fact that any violence or neglect had actually occurred. If any signs were recorded, the medical coroner would undertake an investigation which would include an external examination of the body by a person possessing appropriate forensic skills. If signs capable of being caused by neglect or violence (e.g. pressure sores, which are capable of being caused by neglect) were observed but the examiner was of the opinion that neglect had not been a factor, the signs should be noted on the form, together with the examiner's opinion: see, for example, the completed form which follows these Notes.
Part C: Circumstances of death	
Question 16	Identification of the person(s) present at the time of death or who discovered the death would enable the district coroner's office to seek further information from those persons at a later stage, if necessary. A free text description of the circumstances of the death should be given. This should include any information that might assist in determining the cause of death.
Part D: Details of admission to hospital	
Question 19	A short summary of the reason(s) for the deceased person's admission to the hospital should be available from those responsible for the deceased's care and/or from his/her medical records. It would enable the medical coroner to place the circumstances of the deceased's death in context.
Part E: Other relevant information	
Question 20	See Explanatory Notes for Form 1 (Community) Part F.
Part F: Declaration	See Explanatory Notes for Form 1 (Community) Part G.

Completed Form 1 (Hospital)

Form 1: Certificate of Fact of Death and Statement of Circumstances of Death

Part A: Personal details of deceased

Name of Hospital Preston District General Hospital

1. Deceased's family name(s) Jones **Deceased's forename(s)** James			**2. NHS No. (if known)** XX 123456
3. Deceased's previous name(s) (if any known) N/A	**4. Gender (M/F)** M	**5. Date of birth** GRO-C 1923	**6. Religion (if applicable)** N/A
7. Usual address (house name/no. and street) GRO-C	**Town/City** Preston	**County** Lancashire	**Postcode** GRO-C
8. Name and surgery address of usual GP/practice (if known) Dr GRO-C			**9. Deceased's hospital identifying no. (if known)** GRO-C

10A. Name and contact details (including telephone no.) of a member of staff who can act as a contact point with regard to the death.
Dr GRO-C Tel: GRO-C Pager 456

10B. Name and contact details (including telephone no.) of next of kin of deceased (if known).
GRO-C (daughter)
Tel: GRO-C

Part B: Statement as to the fact of death and details of examination

Answer either 11A or 11B
In my opinion, the above-named person is dead.
11A. I have observed all the following features: ***tick each box as observed***

- ☐ **the absence of heart sounds**
- ☐ **the absence of breathing**
- ☐ **the absence of carotid or femoral pulses**
- ☐ **the absence of response to painful stimulus**

OR
11B. I have ascertained the fact of death by other means, namely:
Lack of tracing on heart monitor, absence of breathing.

12. Time and date at which death was confirmed. 1900 hours 01/04/03

13. Brief description of the position of the deceased's body (including state of dress), identifying any features which might be relevant to the cause of death. ***If the body has been moved since death, include also a brief description of its position at time of death (if known).***

Mr GRO-C died in bed. He was receiving 24-hour nursing care. He had an IV line in his left arm and a urinary catheter in situ. He had pressure sores on his heels and L. buttock.

14. I have examined the deceased's body and have ☑ have not ☐ observed signs which might be indicative of violence or neglect. ***If any such features are observed, include a brief description of the site(s) and appearance of the features observed.***

He developed the pressure sores whilst at home. We do not believe that they were a sign of neglect.

Part C: Circumstances of death

15. Ward, department or area of the hospital where death occurred.
Ward 00, General Medicine for the Elderly

Answer either 16A or 16B (overleaf)
16A. If a member of staff or other person was present with the deceased at the moment of his or her death:

(a) Name(s) and contact details (including telephone no(s).) of the person(s) present and relationship (e.g. daughter, friend, etc), if any, to the deceased or relevant professional capacity (e.g. SHO, SRN, etc.). If more than one member of staff was present, record the senior member of staff present.

His daughter GRO-C and Staff Nurse Sally Bowles were present at the moment of death.

(b) Date and time when the death occurred. GRO-C hrs GRO-C 03

(c) Brief description of the circumstances of the death.

Had been in a coma for the past 24 hours, unresponsive. His breathing became erratic in the 4–5 hours before he died. He eventually stopped breathing.

OR

16B. If no person is known to have been present with the deceased at the moment of his or her death:

(a) Name(s) and contact details (including telephone no(s).) of the person(s) who discovered the death and relationship, if any, to the deceased or relevant professional capacity.

(b) Date and time when the death was discovered.

(c) Date and time when the deceased is last known or believed to have been seen alive.

Part D: Details of admission to hospital

17. Time and date of admission to hospital. GRO-C 03 1400 hrs

18. Consultant responsible for the deceased's care. Dr A.N. Other, Consultant in Medicine for the Elderly

19. Reason(s) for admission.

Known Ca lung. Admitted because confused and daughter could not look after him at home. Gradually stabilised but lapsed into a coma. Was awaiting discharge to a nursing home.

Part E: Other relevant information

20. I wish to draw the following information to the attention of the coroner's office:

None

Part F: Declaration

I hereby certify that the contents of this form are true and accurate to the best of my knowledge and belief.

Signed	Sally Bowles	Date	01.04.03
Name and qualifications (in capital letters)	SALLY BOWLES SRN	GMC No.	
Professional address	Ward 00 Preston District General Hospital	Nurse's PIN No.	GRO-C

APPENDIX I

Form 1 (Hospital A & E)

Inquiry's Proposed Form 1 (Hospital A & E) *581*

Explanatory Notes: Form 1 (Hospital A & E) *583*

Sample Completed Form 1 (Hospital A & E) *585*

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Proposed Form 1 (Hospital A & E)

Form 1: Certificate of Fact of Death and Statement of Circumstances of Death

PART B OF THIS FORM MAY BE COMPLETED BY A MEMBER OF STAFF OTHER THAN THE PERSON COMPLETING THE REMAINDER OF THE FORM.

Part A: Personal details of deceased

Name of Hospital

1. Deceased's family name(s) Deceased's forename(s)	2. NHS No. (if known)

3. Deceased's previous name(s) (if any known)	4. Gender (M/F)	5. Date of birth	6. Religion (if applicable)
7. Usual address (house name/no. and street)	Town/City	County	Postcode
8. Name and surgery address of usual GP/practice (if known)			9. Accident & Emergency no. (if appropriate)

10A. Name and contact details (including telephone no.) of a member of staff who can act as a contact point with regard to the death.

10B. Name and contact details (including telephone no.) of next of kin of deceased (if known).

Part B: Statement as to the fact of death

Answer either 11A or 11B

In my opinion, the above-named person is dead.

11A. I have observed all the following features: *tick each box as observed*

- ☐ the absence of heart sounds
- ☐ the absence of breathing
- ☐ the absence of carotid or femoral pulses
- ☐ the absence of response to painful stimulus

OR

11B. I have ascertained the fact of death by other means, namely:

12. Time and date at which death was confirmed.

13. Brief description of the position of the deceased's body (including state of dress), identifying any features which might be relevant to the cause of death. *If the body has been moved since death, include also a brief description of its position at time of death (if known).*

DECLARATION – This declaration need be signed only if Part B is completed by a member of staff other than the person completing the remainder of the form.

I hereby certify that the contents of Part B of this form are true and accurate to the best of my knowledge and belief.

Signed — Date

Name and qualifications
(in capital letters) — GMC No.

Professional address — Nurse's PIN No.

Part C: Details of examination

14. I have examined the deceased's body and have ☐ have not ☐ observed signs which might be indicative of violence or neglect. *If any such features are observed, include a brief description of the site(s) and appearance of the features observed.*

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Part D: Details of admission to the department

15. Time and date of admission to the department.

16. Brief outline of the events leading up to the deceased's admission to the department as described by those available to give information to the signatory.

17. Name(s) and contact details (including telephone no(s).) of the person(s) who can give information about the above events.

Part E: Circumstances of death

Answer either 18A or 18B

18A. If a member of staff or other person was present with the deceased at the moment of his or her death:

(a) Name(s) and contact details (including telephone no(s).) of the person(s) present and relationship (e.g. daughter, friend, etc.), if any, to the deceased or relevant professional capacity (e.g. SHO, SRN, etc.). If more than one member of staff was present, record the senior member of staff present.

(b) Date and time when the death occurred.

(c) Brief description of the circumstances of the death.

OR

18B. If no person is known to have been present with the deceased at the moment of his or her death:

(a) Name(s) and contact details (including telephone no(s).) of the person(s) who discovered the death and relationship, if any, to the deceased or relevant professional capacity.

(b) Date and time when the death was discovered.

(c) Date and time when the deceased is last known or believed to have been seen alive.

Part F: Other relevant information

19. I wish to draw the following information to the attention of the coroner's office:

Part G: Declaration

I hereby certify that the contents of this form are true and accurate to the best of my knowledge and belief.

Signed — Date

Name and qualifications
(in capital letters) — GMC No.

Professional address — Nurse's PIN No.

Explanatory Notes: Form 1 (Hospital A & E)

Sometimes, people die shortly after admission to the accident and emergency department of a hospital, before they have been transferred onto a ward. Some people are found to be dead on arrival at the accident and emergency department. In such cases, the train of events leading to death will have started before the time of admission to the department. The deceased person might have collapsed at home and been brought to hospital by car or in an ambulance. He or she might have sustained an accident outside the home. This situation is rather different from that of the person who dies in hospital after a period as an in-patient. A slightly different version of Form 1 has therefore been designed. An example of a completed Form 1 (Hospital A & E) follows these Notes.

Question on Form	Explanatory Notes
Part A: Personal details of deceased	See Explanatory Notes for Form 1 (Community) Part A, Questions 2 & 6.
Question 9	The deceased person's accident and emergency number would be required to facilitate the tracing of notes and records.
Question 10	The form requires the details of a member of the hospital staff who can act as a contact point for the district coroner's office with regard to the death. The staff contact point might be the hospital bereavement officer, the person completing Form 1 or a member of the nursing or medical staff in the department. The form also requires contact details of the next of kin, if known at the time Form 1 is completed.
Part B: Statement as to the fact of death	Because of the pressure of work in a busy accident and emergency department, it might be convenient for a member of staff to certify the fact of death and for the deceased person's body then to be transferred to the mortuary before the remainder of Form 1 is completed, if necessary by a second person. Accordingly, the form provides for the completion of Part B with a separate declaration of its truth and accuracy.
Question 11A	See Explanatory Notes for Form 1 (Community) Part B.
Question 11B	In an accident and emergency department, it might well be that death would be confirmed by means other than the kind of observations set out at Question 11A. In that event, there would be the option of completing Question 11B, stating briefly by what means death had been confirmed.
Question 13	In many cases where death occurs in the department, the position of the deceased person's body at the time of death will shed little light on the circumstances and cause of death. However, details of his/her state of dress and other features might be of assistance. If death occurred before the deceased arrived in the department, a description of the position in which the deceased was found, if available from witnesses, should be recorded.

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Question on Form	Explanatory Notes
Part C: Details of examination	
Question 14	In the setting of a hospital mortuary, an examination of the naked body of a deceased person, back and front, should be possible. Where a person dies shortly before or after admission to an accident and emergency department, there is the obvious possibility that s/he might have been subjected to violence or neglect before admission to the department. An examination should be conducted and any sign that might be indicative of violence or neglect should be recorded on the form. Any signs about which the examiner has any doubt whatsoever should be recorded. The examination is intended to be a screening process only and would not be determinative of the fact that any violence or neglect had actually occurred. If any signs were recorded, the medical coroner would undertake an investigation which would include an external examination of the body by a person possessing appropriate forensic skills. If signs capable of being caused by neglect or violence (e.g. pressure sores, which are capable of being caused by neglect) were observed but the examiner was of the opinion that neglect had not been a factor, the signs should be noted on the form, together with the examiner's opinion.
Part D: Details of admission to the department	
Question 16	The purpose of this question is to obtain and record a brief description of the circumstances in which the deceased person was brought to the accident and emergency department. The train of events leading to death would have started before the time of admission to the department. Information might be available from accompanying relatives or friends, from staff on duty at the time when the deceased person was admitted and from the accident and emergency department admission card.
Question 17	The purpose of this question is to identify, if possible, persons who might be able to provide information about the events leading up to the deceased person's admission to the department and his/her death.
Part E: Circumstances of death	
Question 18	Identification of the person(s) present at the time of death or who discovered the death would enable the district coroner's office to seek further information from those persons at a later stage, if necessary. A free text description of the circumstances of the death should be given. This should include any information that might assist in determining the cause of death.
Part F: Other relevant information	
Question 19	See Explanatory Notes for Form 1 (Community) Part F.
Part G: Declaration	See Explanatory Notes for Form 1 (Community) Part G.

Completed Form 1 (Hospital A & E)

Form 1: Certificate of Fact of Death and Statement of Circumstances of Death

PART B OF THIS FORM MAY BE COMPLETED BY A MEMBER OF STAFF OTHER THAN THE PERSON COMPLETING THE REMAINDER OF THE FORM.

Part A: Personal details of deceased

Name of Hospital Preston District General Hospital

1. Deceased's family name(s) GRO-C **Deceased's forename(s)** GRO-C	**2. NHS No. (if known)** N/K

3. Deceased's previous name(s) (if any known)	**4. Gender (M/F)** F	**5. Date of birth** GRO-C 1930	**6. Religion (if applicable)** Not known
7. Usual address (house name/no. and street) GRO-C	**Town/City** Preston	**County** Lancashire	**Postcode** Not known
8. Name and surgery address of usual GP/practice (if known) Dr GRO-C			**9. Accident & Emergency no. (if appropriate)** XX 321

10A. Name and contact details (including telephone no.) of a member of staff who can act as a contact point with regard to the death.
Charge Nurse Allen. Tel GRO-C A & E Department, DGH

10B. Name and contact details (including telephone no.) of next of kin of deceased (if known).
N/K

Part B: Statement as to the fact of death

Answer either 11A or 11B
In my opinion, the above-named person is dead.
11A. I have observed all the following features: ***tick each box as observed***

- ☐ **the absence of heart sounds**
- ☐ **the absence of breathing**
- ☐ **the absence of carotid or femoral pulses**
- ☐ **the absence of response to painful stimulus**

OR
11B. I have ascertained the fact of death by other means, namely:
No electrical activity on heart monitor, no breathing.

12. Time and date at which death was confirmed. 1648 hours 01.04.03

13. Brief description of the position of the deceased's body (including state of dress), identifying any features which might be relevant to the cause of death. ***If the body has been moved since death, include also a brief description of its position at time of death (if known).***

Body was clothed in day clothes. There was an IV line in situ in the left wrist, inserted by paramedics. Heart monitoring pads were on the chest wall. There was an IV infusion in the right cubital fossa. An endo-tracheal tube was in situ.

DECLARATION – This declaration need be signed only if Part B is completed by a member of staff other than the person completing the remainder of the form.

I hereby certify that the contents of Part B of this form are true and accurate to the best of my knowledge and belief.

Signed GRO-C **Date** 01.04.03
Name and qualifications (in capital letters) A. ALLEN, SRN, Charge Nurse
GMC No.
Professional address A & E Department, Preston District General Hospital
Nurse's PIN No. GRO-C

Part C: Details of examination

14. I have examined the deceased's body and have ☐ have not ☑ observed signs which might be indicative of violence or neglect. ***If any such features are observed, include a brief description of the site(s) and appearance of the features observed.***

Part D: Details of admission to the department

15. Time and date of admission to the department. 1615 hours 01.04.03

16. Brief outline of the events leading up to the deceased's admission to the department as described by those available to give information to the signatory.

Known hypertensive with IHD. Sudden onset chest pain in afternoon. GP called and he treated appropriately. Pain became worse whilst waiting for ambulance and patient collapsed. Resuscitation attempted by ambulance crew and GP – brought to A & E department, still alive.

17. Name(s) and contact details (including telephone no(s).) of the person(s) who can give information about the above events.

GP Dr GRO-C GRO-C
Paramedic Frank Simon, Ambulance Control, Preston
M GRO-C (husband) Tel: GRO-C

Part E: Circumstances of death

Answer either 18A or 18B

18A. If a member of staff or other person was present with the deceased at the moment of his or her death:

(a) Name(s) and contact details (including telephone no(s).) of the person(s) present and relationship (e.g. daughter, friend, etc.), if any, to the deceased or relevant professional capacity (e.g. SHO, SRN, etc.). If more than one member of staff was present, record the senior member of staff present.

Dr GRO-C SHO, A & E Department, DGH – GRO-C Pager 376
Charge Nurse Allen, A & E Department, DGH – GRO-C Ext. 123

(b) Date and time when the death occurred. GRO-C 03 1648 hours

(c) Brief description of the circumstances of the death.

Brought in by ambulance, heart rate present. Already intubated. Went into ventricular fibrillation. DC shock x 4, CPR + IV atropine, adrenaline + lignocaine but failed to respond.

OR

18B. If no person is known to have been present with the deceased at the moment of his or her death:

(a) Name(s) and contact details (including telephone no(s).) of the person(s) who discovered the death and relationship, if any, to the deceased or relevant professional capacity.

(b) Date and time when the death was discovered.

(c) Date and time when the deceased is last known or believed to have been seen alive.

19. I wish to draw the following information to the attention of the coroner's office:

None

Part G: Declaration

I hereby certify that the contents of this form are true and accurate to the best of my knowledge and belief.

Signed GRO-C **Date** 01.04.03
Name and qualifications (in capital letters) DR A SINGH MB BS
GMC No. GRO-C
Professional address A & E Department, Preston District General Hospital
Nurse's PIN No.

APPENDIX J

Form 2 (Community)

Inquiry's Proposed Form 2 (Community) *589*

Explanatory Notes: Form 2 (Community) *591*

Sample Completed Form 2 (Community) *595*

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Proposed Form 2 (Community)

Form 2: Medical Report on Cause of Death

Part A: Personal details of deceased

1. Deceased's family name(s) Deceased's forename(s)	2. NHS No. (if known)

Questions 3–10 can be omitted if answered correctly on Form 1. Insert below any details which have not previously been completed or have been incorrectly completed.

3. Deceased's previous name(s) (if any known)	4. Gender (M/F)	5. Date of birth	6. Religion (if applicable)
7. Usual address (house name/no. and street)	Town/City	County	Postcode
8. Name and surgery address of usual GP/practice			9. GP Practice no. (if known)

10. Name and contact details (including telephone no.) of a person willing to provide information to the coroner's office. *State relationship, if any, of that person to the deceased.*

Part B: Medical details of deceased

11. Describe the extent of your professional knowledge of the deceased and of his/her medical history and condition prior to death.

12. Give a brief chronological account of the deceased's medical history before death, including the chain of events leading to death. *Include, where relevant, details of acute or chronic conditions suffered by the deceased, accidents or injuries, hospital procedures, treatment given, results of investigations, medication and recent consultations.*

Continue on additional sheet as necessary.

13. Details of any nursing or other care which the deceased was receiving before death. *If s/he was receiving care, give the name(s), relationship (if any) to the deceased and contact details (including telephone no(s).) of the persons or agencies who provided the care most recently. If s/he was resident in a care home prior to death, name the person(s) primarily responsible for his/her care.*

Part C: Cardiac pacemakers and other devices

14. Did the deceased have a cardiac pacemaker, radioactive implant or material, electrical stimulator or defibrillator fitted before his/her death? YES/NO/DON'T KNOW

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Part D: Cause of death

Answer *either* 15A *or* 15B 15A. In my professional opinion, the deceased's death was caused as follows: CONDITION(S) CAUSING DEATH I (a) Disease or condition directly leading to death I (b) Other disease or condition, if any, leading to I (a) I (c) Other disease or condition, if any, leading to I (b) II Other significant conditions CONTRIBUTING TO THE DEATH but not related to the disease or condition causing it.	APPROXIMATE TIME BETWEEN ONSET OF CONDITION AND DEATH IF KNOWN

OR

15B. I am unable to offer a professional opinion as to the cause of the deceased's death.

Tick box if this statement is applicable ☐

Part E: Other relevant information

16. I wish to draw the following information to the attention of the coroner's office:

Part F: Declaration

I declare that:

- I am qualified to complete this form *(see explanatory notes).*
- I am not a relative of the deceased.
- I do ☐ do not ☐ have a direct financial interest in any residential institution in which the deceased was resident at the time of his/her death.
- I have read the completed Form 1 and ascertained the deceased's medical history from the available medical records.
- I am satisfied that I am able to justify the diagnosis of the cause of death specified at 15A above, if applicable, on the basis of the deceased's medical history and the circumstances of death.

I hereby certify that the contents of this form are true and accurate to the best of my knowledge and belief.

Signed Date

Name and qualifications (in capital letters)

Professional address GMC No.

Explanatory Notes: Form 2 (Community)

This form is for use when a death occurs in the community, i.e. at home, in a care home or in a community or cottage hospital or a similar facility. An example of a completed Form 2 (Community) follows these Notes.

Question on Form	Explanatory Notes
Part A: Personal details of deceased	
Questions 3–10	The doctor completing Form 2 would have Form 1 available to him/her and must sign a declaration at the conclusion of Form 2 that s/he has read Form 1. Questions 3–10 of Form 2 could be omitted if those questions had been answered correctly on Form 1. Any information that had not previously been completed, or had been completed incorrectly, should be inserted in the appropriate place on Form 2.
Part B: Medical details of deceased	
Question 11	The purpose of this question is to enable the medical coroner to assess how accurately the doctor completing Form 2 is likely to be able to diagnose the cause of the deceased person's death. The doctor in question might have attended the deceased for many years, have looked after him/her throughout a long terminal illness and seen him/her very shortly before death. On the other hand, s/he might not have attended the deceased and might be relying solely on information given to him/her by the deceased's usual doctor and/or on information contained in the medical records. The information given in response to this question should enable the medical coroner to put the information provided by the doctor completing Form 2 into context.
Question 12	The purpose of this question is to provide a brief description of the deceased person's past medical history and to help the doctor completing Form 2 to identify correctly the sequence of events leading to death. This information should be given in the form of a narrative. It is intended to provide the medical coroner with a picture of the medical events leading to the deceased's death. An account should be given of the development, diagnosis and progress of any medical condition(s) relevant to the death, together with any treatment (including medication), diagnostic investigations and recent consultations connected with the condition(s). If the deceased person had sustained any trauma or undergone any surgical or other medical procedure, which was or might have been connected with the events leading to the death, brief details should be given. Copies of the most relevant extracts from the medical records (e.g. the most recent prescription records, relevant hospital discharge letters and other consultants' letters and/or results of relevant investigation(s)) should be sent to the medical coroner with Form 2.

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Question on Form	Explanatory Notes
Question 13	Persons providing day-to-day care for a patient may be in the best position to provide information about that person's state of health prior to death. The purpose of this question is to identify and obtain details of any persons who have provided care for the deceased and who may be able to give such information. The deceased person might have been receiving care from relatives, nurses, a home help or friends. A brief description of the type of care given should be included here, together with the names and contact details of the persons or agencies (e.g. Macmillan nurses, district nursing services) who were providing the care. If the deceased person were resident in a care home, the name of the person(s) primarily responsible for his/her care should be given.
Part C: Cardiac pacemakers and other devices	
Question 14	Cardiac pacemakers and certain other implants must be removed before cremation takes place. The cremation authority will wish to ascertain from the deceased person's family whether the deceased person had any such implants and, if so, whether they have been removed. Sometimes, family members (particularly distant family members) might not have this information or the deceased person might have no family. The doctor completing Form 2 is likely to be in a position to supply this information, from his/her own knowledge of the deceased person or from the medical records.
Part D: Cause of Death	
Question 15	The doctor completing Form 2 is invited to provide his/her professional opinion as to the cause of the deceased person's death. If s/he were unable to offer an opinion to the required standard (see Notes to Part F below), s/he could so indicate. The form in which the cause of death is to be expressed is identical to that in the current MCCD and accords with World Health Organisation guidelines. The aim is to identify the underlying cause of death by stating the condition directly leading to death on the first line and working backwards in time through the antecedents of this condition until the underlying cause of death, which initiated the chain of events leading ultimately to death, is identified. The sequence of events should agree with the sequence of events described in the medical details of the deceased person at Question 12 of this form. Part II is used when one or more conditions have contributed to death, but are not part of the main causal sequence leading to death.

Question on Form	Explanatory Notes
Part E: Other relevant information	
Question 16	The purpose of this question is to identify any information that might be of relevance to the medical coroner's consideration of the death. This information might relate to the cause of death. For example, the doctor completing Form 2 might record that the deceased person had been very depressed since the death of her husband and had expressed suicidal thoughts in the past or that the death had occurred very suddenly and unexpectedly. The information might be entirely practical. For example, the doctor might record that the deceased person's husband was frail and easily confused and must be treated with care. Any information which might be of assistance to the medical coroner should be inserted here. The Form 2 doctor should record in response to this question (insofar as it does not already appear in response to question 13) any information suggestive of the fact that the deceased person may have died as a result of medical error or neglect or as a result of a condition which was occupational in origin. Form 2 contains no equivalent of the 'Spearing box' on the MCCD. However, the relevant information, if known, should be included on Form 2.
Part F: Declaration	For UK doctors, only those who had been qualified and in practice for four years would be qualified to sign Form 2. Doctors from overseas must have been in practice for four years (not necessarily in the UK), have been registered with the GMC and have been trained in the requirements of death certification in this country. The statement relating to financial interest is intended to refer to the doctor who has a business interest in the care home or other institution where the deceased person died. This is not likely to occur frequently in practice. Such a financial interest is not an absolute bar to completion of Form 2. However, it is important that the medical coroner is made aware of any interest that may exist. It may be that medical coroners will, in time, choose to maintain registers of such interests. The doctor completing Form 2 should have read Form 1 and should also have ascertained the deceased person's medical history from the available medical records. These will include the deceased person's general practitioner records. The doctor might also refer to any nursing notes that are available. The doctor completing Form 2 should be capable of justifying to the medical coroner (by reference to the deceased person's medical history and the circumstances of the death) any diagnosis of the cause of death given in response to Question 15, in precisely the same way that s/he would expect to have to justify his/her diagnosis relating to a condition in a live patient when discussing that patient's case with his/her professional colleagues.

RLIT0001826_0607

Completed Form 2 (Community)

Form 2: Medical Report on Cause of Death

Part A: Personal details of deceased

1. Deceased's family name(s) GRO-C	2. NHS No. (if known) GRO-C
Deceased's forename(s) GRO-C	

Questions 3–10 can be omitted if answered correctly on Form 1. Insert below any details which have not previously been completed or have been incorrectly completed.

3. Deceased's previous name(s) (if any known)	4. Gender (M/F)	5. Date of birth	6. Religion (if applicable)
7. Usual address (house name/no. and street)	Town/City	County	Postcode
8. Name and surgery address of usual GP/practice			9. GP Practice no. (if known) 765432

10. Name and contact details (including telephone no.) of a person willing to provide information to the coroner's office. ***State relationship, if any, of that person to the deceased.***

Part B: Medical details of deceased

11. **Describe the extent of your professional knowledge of the deceased and of his/her medical history and condition prior to death.**

I have been Mr GRO-C GP for 20 years and have attended him regularly throughout that time, most recently on the day before his death.

12. **Give a brief chronological account of the deceased's medical history before death, including the chain of events leading to death.** ***Include, where relevant, details of acute or chronic conditions suffered by the deceased, accidents or injuries, hospital procedures, treatment given, results of investigations, medication and recent consultations.***

Mr GRO-C was 75 and had suffered from non-insulin dependent diabetes for 15 years. He also suffered from hypertension and ischaemic heart disease. He was admitted to hospital in 1998 with a myocardial infarction but made a good recovery. Thereafter, he continued to suffer from angina which was controlled by medication. He attended my surgery regularly for monitoring of his diabetes and his hypertension, both of which were well controlled by medication. I last saw him the day before his death, when he was complaining of a worsening of his angina, which was not responding as well as usual to his medication. I adjusted his medication by adding isosorbide dinitrate and was due to review him again in two days.

At the time of his death, he was taking glibenclamide 5mg daily, enalapril 10mg daily, isosorbide dinitrate MR 20mg twice daily, aspirin 75mg daily and GTN 300mcg as required.

Continue on additional sheet as necessary.

13. **Details of any nursing or other care which the deceased was receiving before death.** ***If s/he was receiving care, give the name(s), relationship (if any) to the deceased and contact details (including telephone no(s).) of the persons or agencies who provided the care most recently. If s/he was resident in a care home prior to death, name the person(s) primarily responsible for his/her care.***

He received daily visits morning and evening from the warden. A home help visited twice a week. Her name is Mrs GRO-C warden has details).

Part C: Cardiac pacemakers and other devices

14. **Did the deceased have a cardiac pacemaker, radioactive implant or material, electrical stimulator or defibrillator fitted before his/her death?** ~~YES~~/NO/~~DON'T KNOW~~

Part D: Cause of death

Answer *either 15A or 15B* 15A. In my professional opinion, the deceased's death was caused as follows: CONDITION(S) CAUSING DEATH		APPROXIMATE TIME BETWEEN ONSET OF CONDITION AND DEATH IF KNOWN
I (a) Disease or condition directly leading to death	Myocardial infarction	
I (b) Other disease or condition, if any, leading to I (a)	Ischaemic heart disease	About 10 years
I (c) Other disease or condition, if any, leading to I (b)	Hypertension	
II Other significant conditions CONTRIBUTING TO THE DEATH but not related to the disease or condition causing it.	Diabetes	

OR

15B. I am unable to offer a professional opinion as to the cause of the deceased's death. ☐

Tick box if this statement is applicable

Part E: Other relevant information

16. I wish to draw the following information to the attention of the coroner's office:

Although I believe that the above was the most likely cause of death, I must say that I did not expect Mr Jones to die so suddenly.

Part F: Declaration

I declare that:

- I am qualified to complete this form *(see explanatory notes)*.
- I am not a relative of the deceased.
- I do ☐ do not ☑ have a direct financial interest in any residential institution in which the deceased was resident at the time of his/her death.
- I have read the completed Form 1 and ascertained the deceased's medical history from the available medical records.
- I am satisfied that I am able to justify the diagnosis of the cause of death specified at 15A above, if applicable, on the basis of the deceased's medical history and the circumstances of death.

I hereby certify that the contents of this form are true and accurate to the best of my knowledge and belief.

Signed

Date GRO-C 03

Name and qualifications (in capital letters)
ALBERT BROWN MB BS

Professional address
GRO-C

GMC No GRO-C

APPENDIX K

Form 2 (Hospital)

Inquiry's Proposed Form 2 (Hospital) *599*

Explanatory Notes: Form 2 (Hospital) *601*

Sample Completed Form 2 (Hospital) *603*

RLIT0001826_0611

Proposed Form 2 (Hospital)

Form 2: Medical Report on Cause of Death

Part A: Personal details of deceased

1. Deceased's family name(s) Deceased's forename(s)	2. NHS No. (if known)

Questions 3–10 can be omitted if answered correctly on Form 1. Insert below any details which have not previously been completed or have been incorrectly completed.

3. Deceased's previous name(s) (if any known)	4. Gender (M/F)	5. Date of birth	6. Religion (if applicable)
7. Usual address (house name/no. and street)	Town/City	County	Postcode
8. Name and surgery address of usual GP/practice (if known)			9. Deceased's hospital identifying no. (if known)

10A. Name and contact details (including telephone no.) of a member of staff who can act as a contact point with regard to the death.

10B. Name and contact details (including telephone no.) of next of kin of deceased (if known).

Part B: Medical details of deceased

11. Describe the extent of your professional knowledge of the deceased and of his/her medical history and condition prior to death.

12. Give a brief chronological account of the deceased's medical history before death, including the chain of events leading to death. *Include, where relevant, details of acute or chronic conditions suffered by the deceased, accidents or injuries, hospital procedures, treatment given, results of investigations, medication and recent clinical consultations.*

Continue on additional sheet as necessary.

Part C: Cardiac pacemakers and other devices

13. Did the deceased have a cardiac pacemaker, radioactive implant or material, electrical stimulator or defibrillator fitted before his/her death? YES/NO/DON'T KNOW

RLIT0001826_0613

Part D: Cause of death

Answer *either* 14A *or* 14B 14A. In my professional opinion, the deceased's death was caused as follows: CONDITION(S) CAUSING DEATH I (a) Disease or condition directly leading to death I (b) Other disease or condition, if any, leading to I (a) I (c) Other disease or condition, if any, leading to I (b) II Other significant conditions CONTRIBUTING TO THE DEATH but not related to the disease or condition causing it.	APPROXIMATE TIME BETWEEN ONSET OF CONDITION AND DEATH IF KNOWN

OR

14B. I am unable to offer a professional opinion as to the cause of the deceased's death.

Tick box if this statement is applicable ☐

Part E: Other relevant information

15. I wish to draw the following information to the attention of the coroner's office:

Part F: Declaration

I declare that:

- I am qualified to complete this form *(see explanatory notes)*.
- I am not a relative of the deceased.
- I do ☐ do not ☐ have a direct financial interest in the hospital where the deceased died.
- I have read the completed Form 1 and ascertained the deceased's medical history from the available medical records.
- I am satisfied that I am able to justify the diagnosis of the cause of death specified at 14A above, if applicable, on the basis of the deceased's medical history and the circumstances of death.

I hereby certify that the contents of this form are true and accurate to the best of my knowledge and belief.

Signed Date

Name and qualifications (in capital letters)

Professional address GMC No.

Explanatory Notes: Form 2 (Hospital)

This form is for completion when a person dies after admission to a hospital or in the accident and emergency department and where Form 2 is to be completed by a hospital doctor. If the deceased person died in hospital but Form 2 is to be completed by a general practitioner, Form 2 (Community) should be used. An example of a completed Form 2 (Hospital) follows these Notes.

Question on Form	Explanatory Notes
Part A: Personal details of deceased	
Questions 3–10	See Explanatory Notes for Form 2 (Community) Part A.
Part B: Medical details of deceased	
Question 11	The purpose of this question is to enable the medical coroner to assess how accurately the doctor completing Form 2 is likely to be able to diagnose the cause of the deceased person's death. The doctor in question might have attended the deceased during a long period of hospital admission or a series of admissions. On the other hand, the deceased might have been in hospital for a short time only before death. The information given in response to this question should enable the medical coroner to put the information provided by the doctor completing Form 2 into context. If the deceased person were in hospital for only a short time, consideration should be given as to whether Form 2 would more appropriately be completed by his/her GP. If necessary, advice could be sought from the district coroner's office.
Question 12	The purpose of this question is to provide a brief description of the deceased person's past medical history and to help the doctor completing Form 2 to identify correctly the sequence of events leading to death. This information should be given in the form of a narrative. It is intended to provide the medical coroner with a picture of the medical events leading to the deceased's death. An account should be given of the development, diagnosis and progress of any medical condition(s) relevant to the death, together with any treatment (including medication), diagnostic investigations and recent clinical consultations connected with the condition(s). If the deceased person had sustained any trauma or undergone any surgical or other medical procedure, which was or might have been connected with the events leading to the death, brief details should be given. Copies of the most relevant extracts from the medical records (e.g. the drug cardex, the most recent notes of clinical consultations, the admission card and/or results of relevant investigation(s)) should be sent to the medical coroner with Form 2.

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Question on Form	Explanatory Notes
Part C: Cardiac pacemakers and other devices	
Question 13	See Explanatory Notes for Form 2 (Community) Part C.
Part D: Cause of Death	
Question 14	See Explanatory Notes for Form 2 (Community) Part D.
Part E: Other relevant information	See Explanatory Notes for Form 2 (Community) Part E.
Part F: Declaration	For UK doctors, only those who had been qualified and in practice for four years would be qualified to sign Form 2. Doctors from overseas must have been in practice for four years (not necessarily in the UK), have been registered with the GMC and have been trained in the requirements of death certification in this country. The statement relating to financial interest is intended to refer to the doctor who has a business interest in the private hospital where the deceased person died. This is not likely to occur frequently in practice. Such a financial interest is not an absolute bar to completion of Form 2. However, it is important that the medical coroner is made aware of any interest that may exist. It may be that medical coroners will, in time, choose to maintain registers of such interests. The doctor completing Form 2 should have read Form 1 and should also have ascertained the deceased person's medical history from the available medical records. These will include the deceased person's hospital records. The doctor completing Form 2 should be capable of justifying to the medical coroner (by reference to the deceased person's medical history and the circumstances of the death) any diagnosis of the cause of death given in response to Question 14, in precisely the same way that s/he would expect to have to justify his/her diagnosis relating to a condition in a live patient when discussing that patient's case with his/her professional colleagues.

Sample Completed Form 2 (Hospital)

Form 2: Medical Report on Cause of Death

Part A: Personal details of deceased

Name of Hospital Preston District General Hospital

1. Deceased's family name(s) GRO-C **Deceased's forename(s)** GRO-C	**2. NHS No. (if known)** XX GRO-C

Questions 3–10 can be omitted if answered correctly on Form 1. Insert below any details which have not previously been completed or have been incorrectly completed.

3. Deceased's previous name(s) (if any known)	**4. Gender (M/F)**	**5. Date of birth**	**6. Religion (if applicable)**
7. Usual address (house name/no. and street)	**Town/City**	**County**	**Postcode**
8. Name and surgery address of usual GP/practice (if known)			**9. Deceased's hospital identifying no. (if known)**

10A. Name and contact details (including telephone no.) of a member of staff who can act as a contact point with regard to the death.

10B. Name and contact details (including telephone no.) of next of kin of deceased (if known).

Part B: Medical details of deceased

11. Describe the extent of your professional knowledge of the deceased and of his/her medical history and condition prior to death.

Mr GRO-C was admitted under our care, one week before his death. He was diagnosed with lung cancer whilst being investigated by our medical team. I am the registrar on the team responsible for his care.

12. Give a brief chronological account of the deceased's medical history before death, including the chain of events leading to death. *Include, where relevant, details of acute or chronic conditions suffered by the deceased, accidents or injuries, hospital procedures, treatment given, results of investigations, medication and recent clinical consultations.*

He was admitted one week prior to his death at the request of his GP. He had been diagnosed with carcinoma of the bronchus in January 2003 (confirmed histologically as adenocarcinoma). The extent of his cancer, and his own request, made him unsuitable for further treatment. He was cared for at home by his daughter, the district nursing service and his GP. He was referred to hospital because of increasing confusion and the inability of his daughter to look after him. He developed a pressure sore on his heels and L. ischial tuberosity whilst at home. At the time of admission he was dehydrated and hyponatraemic. He received IV fluids to correct his electrolytic imbalance and pain relief in the form of Fentanyl patches. Initially he improved and we thought he might be suitable for discharge to a nursing home. However, he lapsed into a coma on 31.03.03 and died on 01.04.03. He had no other significant medical conditions apart from mild bronchitis, for which he used a bronchodilator.

Continue on additional sheet as necessary.

Part C: Cardiac pacemakers and other devices

13. Did the deceased have a cardiac pacemaker, radioactive implant or material, electrical stimulator or defibrillator fitted before his/her death? ~~YES~~/NO/~~DON'T KNOW~~

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Part D: Cause of death

Answer *either* 14A *or* 14B 14A. In my professional opinion, the deceased's death was caused as follows:		APPROXIMATE TIME BETWEEN ONSET OF CONDITION AND DEATH IF KNOWN
CONDITION(S) CAUSING DEATH		
I (a) Disease or condition directly leading to death	Ca bronchus	4 months
I (b) Other disease or condition, if any, leading to I (a)		
I (c) Other disease or condition, if any, leading to I (b)		
II Other significant conditions CONTRIBUTING TO THE DEATH but not related to the disease or condition causing it.		

OR

14B. I am unable to offer a professional opinion as to the cause of the deceased's death. ☐

Tick box if this statement is applicable

Part E: Other relevant information

15. I wish to draw the following information to the attention of the coroner's office:

None

Part F: Declaration

I declare that:

- I am qualified to complete this form *(see explanatory notes)*.
- I am not a relative of the deceased.
- I do ☐ do not ☑ have a direct financial interest in the hospital where the deceased died.
- I have read the completed Form 1 and ascertained the deceased's medical history from the available medical records.
- I am satisfied that I am able to justify the diagnosis of the cause of death specified at 14A above, if applicable, on the basis of the deceased's medical history and the circumstances of death.

I hereby certify that the contents of this form are true and accurate to the best of my knowledge and belief.

Signed A. Allan **Date** 02.04.03

Name and qualifications (in capital letters)
DR A. ALLAN MB BS, MRCP

Professional address
Department of Medicine for the Elderly
District General Hospital
Preston

GMC No. 55789

Appendix L

A Blueprint for the Operation of the Coroner Service

1. The contents of this Appendix do not form part of my recommendations. In it, I shall put forward ideas of how my proposals might work in practice.

National Level

2. The Coroner Service would be controlled by its Board, comprising the Chief Judicial Coroner (CJC), the Chief Medical Coroner (CMC), the Chief Coroner's Investigator (CCI) and two or three independent members with relevant knowledge and experience. The Board would be responsible for the formulation of policy, the strategic direction of the Service and for the provision of the necessary facilities, buildings and personnel. At paragraph 19.31, I have described the nature and functions of the Service's Advisory Council. At paragraph 19.27, I have mentioned that the Board would be responsible for educating the public about the Coroner Service and for the provision of a national coronial information system. The central office would require an administrator and staff.

3. **The Chief Judicial Coroner** would provide leadership and guidance for judicial coroners. He or she would be appointed following open competition. I suggest that s/he should be of status comparable to that of a senior circuit judge. The first appointee might be an existing judge or senior member of the legal profession. Subsequent appointments might be made by a panel comprising representatives of the Board, the Advisory Council and the Department for Constitutional Affairs.

4. The CJC would be responsible for the continuing education of judicial coroners (JCs) (in conjunction with the Judicial Studies Board, which provides continuing education for all levels of the judiciary) and the promulgation of nationwide consistency of good practice. He or she should keep abreast of and learn from international developments in good practice. He or she would provide support for JCs and would ensure that they maintained links with each other.

5. The CJC would have some judicial functions. He or she would have an original jurisdiction to conduct an inquest in cases of particular public interest or concern. He or she would exercise an appellate jurisdiction from some decisions of JCs. For example, s/he would hear appeals from the decision of a JC to hold or not to hold an inquest. He or she could make the appropriate arrangements for a High Court Judge to conduct inquests into the deaths caused in a disaster. Such inquests might have specially extended Terms of Reference, so that they could fulfil the function of a public inquiry.

6. The CJC and CMC would be responsible for taking forward those recommendations made by medical coroners (MCs) and JCs which they consider would be of public benefit.

7. **The Chief Medical Coroner** would be a senior appointment for a person with appropriate medical qualification and experience. The appointee would be an office-holder under the Crown. Requirements would include some administrative experience and knowledge of, or experience in, the fields of public health and/or forensic medicine. I anticipate that the

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post might well suit an existing senior public health director, a consultant forensic pathologist or the medical director of a large hospital trust.

8. I suggest that the first appointment should be made by an *ad hoc* panel convened by the Department of Health (DoH) or its Welsh equivalent and comprising a person with a public health background, one with a background in forensic medicine and one with experience of senior public appointments. Subsequent appointments might be made by a panel comprising representatives of the DoH (or its equivalent in Wales), the Board and the Advisory Council.

9. The CMC would take executive responsibility for the provision of the necessary facilities for the work of regional medical coroners (RMCs) and MCs at both regional and district levels. This would include the provision (whether by direct employment or contractual arrangements) of necessary medical investigatory services (such as autopsy, histology, toxicology and such specialist services as neuropathology and paediatric pathology).

10. The CMC would give general directions in respect of the work of RMCs, although the latter would retain independence of judgement in respect of individual cases. He or she would take steps to promote consistency of good practice throughout the country. He or she should maintain and learn from links with medically qualified coroners and medical examiners in overseas jurisdictions. He or she would also establish links with public health and public safety bodies.

11. The CMC would be responsible for the appointment of MCs and their deputies. I envisage that interview panels would include at least one member with relevant experience from outside the Coroner Service.

12. The CMC would be responsible for the provision of training and continuing education for RMCs, MCs and deputies. I envisage the need for training in administrative skills, forensic medicine, public health and epidemiology. I anticipate that training would be provided through a university medical school. In due course, I consider that training could lead to accreditation as an MC.

13. The CMC would be responsible for the operation of the national coronial information system, the organisation of research projects and the dissemination of statistical and other information to the appropriate interested public bodies. He or she would be responsible for the audit of medical investigations.

14. **The Chief Coroner's Investigator** would be a senior appointment to the Board. The position would call for someone with administrative experience and with knowledge and experience of investigative techniques. It might well suit a former senior detective police officer or a senior solicitor with experience of homicide cases or personal injury or clinical negligence actions.

15. The CCI would be responsible for the provision of a corps of suitably trained and experienced (and eventually accredited) coroner's investigators (CIs). He or she would ensure the consistency of high standards of conduct and work. He or she would keep abreast of current investigative techniques in this country and abroad. He or she would maintain close links with the police, the Health and Safety Executive and other statutory investigatory bodies.

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16. In consultation with the CJC and CMC, s/he would devise and promulgate protocols for the conduct of coroner's investigations and would keep these under review.

17. The CCI would be responsible for the selection and recruitment of CIs and would be responsible for devising and commissioning a suitable training course, to be delivered under the auspices of, or accredited by, a university. Bearing in mind the wide variety of employment backgrounds from which CIs are likely to be drawn, I anticipate that the course would be modular. The course should lead to a diploma providing accreditation as a CI. I anticipate that the CCI would be closely involved in the course and would probably take some part in delivering it. The CCI would also be responsible for the continuing education of CIs.

18. The CCI would be responsible for the supervision and audit of investigation services.

Regional Level

19. At each regional coroner's office, there would be one or more JCs (depending on the workload), an RMC and a regional coroner's investigator (RCI).

20. **The Judicial Coroner** would be appointed after open competition. I suggest that the CJC should chair the interview panel. I suggest that a JC should have conditions of service comparable to those of a Regional Tribunal Chairman. The position would be open to those with appropriate legal qualifications. It may well be that existing legally qualified coroners would wish to apply.

21. The JC's principal function would be to conduct inquests. He or she would require the use of a suitable courtroom. I do not anticipate that it should be necessary to provide dedicated coroner's courts. Where such facilities exist, no doubt they could be utilised; where they do not, I consider that arrangements should be made for inquests to take place in existing court centres. Apart from certain limited classes of case, in which the holding of an inquest would be mandatory, the JC would have a discretion to order an inquest in cases where the public interest would be served. With the consent of the CJC, s/he would be able to conduct a single inquest into several deaths with related circumstances.

22. The JC would have the power to order the entry and search of premises and the seizure of property and documents required for the investigation of a death. He or she would exercise an appellate jurisdiction from certain decisions of an MC, for example, a challenge to the MC's decision to order or not to order an autopsy.

23. The JC would undertake responsibility for casework involving the more complex issues of fact and non-medical expertise and would write a report in cases where s/he had decided not to conduct an inquest. JCs would require training in report writing and bereavement and diversity issues.

24. At the regional office, there would be a legally qualified person, or possibly a small legal team, responsible for the co-ordination of the more complex investigations (for example, those involving allegations of medical error or neglect), the investigation of those inquest cases in which it is thought undesirable for the JC him/herself to take close control, and

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the preparation of inquest files. In some cases, a member of the legal team might present the evidence to the JC at inquest; in other cases, this might be done by counsel.

25. If, in practice, it were found necessary to provide a deputy for the JC, to cover in his/her absence, I suggest that a suitable number of district judges should be trained to carry out these functions, as and when required. Such a system might also provide preparation for appointment as a JC.

26. **The Regional Medical Coroner** would be medically qualified and would become an office-holder under the Crown. The position should attract comparable terms and conditions to those of a JC. Provision should be made for transferable pension rights from and to previous and subsequent employers. An RMC might come from a variety of medical backgrounds. In due course, the most suitable background will be successful experience as an MC. Initially, I anticipate that doctors with a background in forensic medicine or public health might be suitable. However, I envisage that most would require additional training on appointment. Courses already exist in many of the modules that would be required.

27. The RMC would supervise the organisation of the special regional facilities mentioned above. Ideally, the special facilities should be sited within the regional office. This arrangement works well at present in Sheffield where the Medico-Legal Centre houses the University Forensic Pathology Department and the coroner's office. If this is not practicable, the special facilities should be available within a reasonable distance. This proposal would fit well with the Home Office Review's proposal for 'centres of excellence' in the regions.

28. The RMC would undertake casework on more complex medical cases referred to him/her by MCs and would offer advice and support to MCs on their casework. He or she would also be responsible for the audit of all casework of MCs carried out in the region. He or she might also undertake inspections of district offices. RMCs would, like JCs, require training in report writing and bereavement and diversity issues.

29. The RMC would be responsible for the collection of mortality statistics for the region and for their dissemination to appropriate recipients. In consultation with the CMC, s/he would devise and implement research initiatives into issues of public interest arising within the region. The RMC would establish and maintain links with Directors of Public Health and with the National Health Service at Strategic Health Authority level.

30. In the absence of an RMC, cover could be provided by an MC.

31. **The Regional Coroner's Investigator** would be a senior investigator, (possibly of Civil Service Senior Executive Officer level). He or she would work within the regional office to provide regional supervision of the investigation service and would lead a small group of specialists who would investigate, for example, child deaths, workplace deaths and deaths due to medical error, at the request of the JC and RMC.

District Level

Medical Coroners

32. As I have said, I anticipate that there would be between three and seven districts per region. In some locations, it might be convenient for a district and regional office to share

a building. Each district office would be managed by an MC. I suggest that an MC might have terms and conditions comparable to those of a district judge. Conditions should include transferable pension rights. The MC might come from a variety of medical backgrounds, including forensic medicine, public health, pathology, general practice and medicine for the elderly and immediately undertake training in the various disciplines necessary for the job, including basic epidemiology, pathology and public health. He or she would also require training in report writing and bereavement and diversity issues. In due course, MCs would require accreditation. The MC would have available one or possibly more deputy MCs. The need for deputies would depend upon the population of the district and its geographical area. A deputy MC might work part-time.

33. The MC would be responsible for the supervision of the death investigation carried out by the team of investigators and would also take an active part in the investigation of some deaths. He or she would commission autopsies and other investigations, such as toxicology. He or she would make many types of decision, including the certification of the cause of death, although many such decisions would be delegated to an accredited CI. He or she would certify the cause of death and write a report in some cases in which further investigation was undertaken.

34. The MC would be responsible for the collection of mortality data at district level and, after consultation with the RMC, s/he might initiate local investigations, for example into deaths at a particular institution. He or she would be responsible for the procurement of local pathology services of a suitable quality and would establish and maintain links with the police force and other investigative agencies in the area. He or she would establish links with the National Health Service at Primary Care Trust and Hospital Trust levels and with any organisation providing services to the bereaved. He or she would ensure that any information emanating from an investigation which was relevant to public health was disseminated to the appropriate authority.

35. The MC would provide training for doctors and health professionals in the completion of Forms 1 and 2 and would be responsible for the dissemination of information about the Coroner Service within the district. He or she would seek to ensure that the local population was aware of the functions of the Service and the availability of, for example, advisory and bereavement services. He or she should also ensure that arrangements were made for those for whom English is not the first language, by the provision of interpreters.

Coroner's Investigators

36. Within the district office, there would be a team of CIs, probably of Civil Service Executive Officer grade. These might be supervised by a Senior CI of Higher Executive Officer grade. The team would be responsible to the MC for the certification of all deaths that did not require full investigation by the MC and for investigative casework in cases requiring such further investigation. They would work to protocols.

37. I anticipate that the team would comprise members with different skills and employment backgrounds. They might have some previous experience as a police officer, nurse, paramedic or legal executive. Some might work part-time. All would undergo specialised training, including the development of skills in the sensitive handling of the bereaved. An

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important element of their work would entail contact with bereaved families, providing and receiving information relevant to the investigation.

38. Most CIs would be expected to undertake some work during unsocial hours. Each district coroner's office would have at least one CI available to receive reports of deaths and to give advice and instructions on a landline for 24 hours, 7 days a week. A transferable call or 'cascade' system would be used to ensure that a CI was always available. CIs would sometimes be required to attend the scene of a death; some would be trained and accredited to certify the fact of death. Although the team of CIs would be based in the district office, some might be seconded to work from a sub-office or from a large hospital.

Appendix M

How Death Certification Would Work in Practice

1. This Appendix does not contain recommendations. It seeks only to explain how, if my proposals were implemented, the system might work in practice. For a visual aid to the understanding of this Appendix, reference should be made to the charts which follow the text.

The Aftermath of a Death in Hospital – Completion of Forms 1 and 2

2. About 70% of all deaths occur in hospitals, where, by definition, there are nursing staff on duty and medical staff on call at all times. When a death occurs, the health professional who confirms the fact of death (usually a nurse on duty) would complete Form 1 and send it to the district coroner's office on-line. The body would be taken to the hospital mortuary. On receipt of Form 1, a coroner's investigator (CI) would make contact with the deceased's family.

3. The clinical team would be aware of the death and, either immediately or (if the death occurred at night or at a weekend) on the next working day, a doctor would be designated to complete Form 2. He or she would see a copy of Form 1. Form 2 would be completed on the ward computer and sent to the coroner's office on-line. In all cases, the doctor would provide a medical history; in some but not all, s/he would express an opinion as to the cause of death; in some, but not all, s/he would draw attention to circumstances which might suggest to the medical coroner (MC) that a full investigation is required. If the clinical team wished to carry out a hospital post-mortem, they would have to inform the CI, who would seek the MC's approval. There would be an incentive for the Form 2 doctor to submit the completed form expeditiously, as the body would have to remain in the hospital mortuary at least until the CI had received and considered Form 2.

4. In the district coroner's office, a CI would consider Forms 1 and 2. If it were obvious that the death required further investigation (either because the cause of death was uncertain or for some other reason), the CI would advise the hospital and the family contact identified on the forms that the body must remain in the mortuary for the time being. If it appeared that the doctor knew the cause of death and there was no obvious need for further investigation, the CI would give permission for the body to be released to the funeral director of the family's choice. If any uncertainty arose, s/he would speak to the person who had completed Form 1 or Form 2 before making a decision. Whenever a CI was required to question a doctor or nurse, s/he would be guided as to the relevant issues by a protocol devised by the Coroner Service and in which the CI would have received training.

5. The CI would then contact the deceased's family to make arrangements for a discussion. Such discussion might take place face to face or by telephone. Usually, if face to face, it should take place at the district coroner's office, although on occasions it might be necessary or appropriate for the CI to visit the family member at home. The CI would question the family member as to his/her knowledge of the medical background and the events leading to, and circumstances surrounding, the death. The questions would not be 'leading' questions and would be designed to discover whether the family member's

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account was consistent with that provided by those who had completed Forms 1 and 2. The CI might show Form 1 to the family member but, depending on the closeness of the relationship to the deceased, would not necessarily disclose Form 2, for reasons of confidentiality. The CI would ask if the family member had any concerns (for example about medical treatment) and would also ask other questions designed to reveal the need for further investigation. For example, s/he might ask whether the deceased had been exposed to an industrial hazard. A protocol would be devised for this process also.

6. If, at the end of the discussion, the CI was satisfied that the cause of death was known to a high degree of confidence and that there was no reason for further investigation, s/he would then issue a certificate of cause of death, stating that the death was due to the cause suggested on Form 2 and would send that certificate to the register office.

7. The arrangements for registration would depend upon whether provision had been made for on-line registration of deaths. If on-line registration were available and the family member (informant) was present at the coroner's office, registration could be effected from there and a disposal certificate and a certified copy of the entry in the register could be returned. Otherwise, the family member/informant might have to attend the register office in person.

8. If the death were not certified under this procedure, it would be referred for further investigation and certification by the MC.

The Aftermath of a Death in the Community – Completion of Form 1

Death at Home

9. Where the death occurred at a private home, the procedure to be followed would, in practice, depend on who was summoned to assist. The person responsible at the scene might call the police or an ambulance, a doctor, a district or Macmillan nurse or even a funeral director. If the new Coroner Service I have proposed were to be established and the public were to be well informed about its functions, they would, in time, begin to contact the coroner's office when a death occurred.

10. If the police were called, the officer would, as now, consider whether there was any need for a police investigation and, if so, would instigate it. Usually, when the police have been summoned, an ambulance is also in attendance. If the fact of death were confirmed by a paramedic or by a doctor, the police officer would leave that person to report the death to the coroner's office and, unless there were specific reasons to remain (such as the need to secure premises or contact the next of kin), s/he would be free to leave the scene. If no suitably qualified person had attended to confirm the fact of death and it was obvious to the police officer that the person was in fact dead, s/he would inform the coroner's office. A CI would then take responsibility for any further arrangements.

11. If a paramedic were called to the scene and found, on examining the body, that death had occurred, s/he would consider whether or not there was any reason to call the police and, if so, do so. If no such reason appeared, s/he would then question those present and complete Form 1. The paramedic would then telephone the coroner's office and inform a

CI of the death. The CI would question the paramedic about the circumstances and speak to any relative or friend of the deceased who was present at the premises. The CI would then decide whether it was necessary to inspect the scene of the death before the body was removed. If it were considered necessary, s/he would attend the scene and carry out an investigation there, in accordance with a protocol. If no inspection of the scene were deemed necessary, the CI would either permit the family to have the body removed to the premises of the funeral director of their choice or arrange for the body to be removed to a mortuary. The conversation between the CI and the family member or friend would also provide an opportunity for the CI to introduce him/herself, explain what was going to happen and to answer any questions. Meanwhile, the paramedic would have been free to leave the scene and to arrange for the transmission of Form 1 to the coroner's office.

12. If the death occurred, or was discovered, during working hours, the deceased's general practitioner might be called to the scene. Under the new system, the general practitioner would establish that death had occurred and would complete Form 1. Of course, in the unlikely event of any suspicion of criminal involvement, s/he would contact the police. Otherwise, s/he would telephone the coroner's office and describe the circumstances of the death to the CI. The CI would speak to any member of the family or friend of the deceased who was present and would then decide whether to attend the scene or whether to arrange for the removal of the body to a mortuary or to permit the family to have it taken to a funeral director's premises. The CI would request the general practitioner to complete Form 2 and submit it to the coroner's office.

13. If a deputising doctor or a nurse were to be summoned to the death, s/he would follow a similar course to that taken by a paramedic. If there was any cause to suspect criminal involvement, s/he would call the police. If not, s/he would certify the fact of death and complete Form 1, then telephone the coroner's office and tell a CI of the circumstances. The CI would speak to any family member or friend in attendance and would decide whether to visit the scene, to arrange removal of the body to a mortuary or to give permission for it to be removed to the premises of a funeral director. The doctor or nurse would send Form 1 to the coroner's office. The CI would take responsibility for contacting the deceased's general practitioner to request completion of Form 2.

14. If a funeral director were to be summoned or asked for advice following a death at home, s/he would advise the caller to inform the coroner's office or, if appropriate, offer to do it him/herself. The CI would then contact the person responsible at the scene and make arrangements for someone to attend to complete Form 1.

15. If the person responsible at the scene chose to contact the coroner's office in the first instance, the CI would make arrangements for the confirmation of the death and the completion of Form 1. The CI might attend personally or call upon the services of a doctor or qualified nurse known to be available for that purpose in the relevant locality.

Death in an Institution other than a Hospital

16. In a nursing home, cottage or community hospital or hospice or other similar facility, there will always be a qualified nurse on duty. He or she should be able to confirm the fact of death, complete Form 1 and inform the coroner's office about the death. The CI would

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decide, on the basis of what s/he was told, whether there was any need to visit the scene or whether the body should be removed to the premises of a funeral director or to a mortuary. The nurse would send Form 1 to the coroner's office and the CI would assume responsibility for further steps.

17. If the death occurred in a residential home for the elderly, there would not usually be a nurse or medically qualified person on the premises. The death should be treated as a death in a private home. However, as a high proportion of such deaths would be expected, the carers would not usually summon the police or an ambulance. It is more likely that the general practitioner, a deputising doctor or a district nurse would be called.

Deaths in Public Places

18. In practice, the police and an ambulance are always called to such a death. At present, paramedics are not authorised to certify the fact of death occurring in a public place and a doctor is always called if the person is believed to be dead. In my view, a properly trained paramedic should be authorised to certify the fact of death and, with the agreement of any police officer in attendance, to arrange for the body to be moved to a hospital mortuary.

19. The person who certified the fact of death would complete Form 1, notify the coroner's office of the death and submit Form 1. The police and CI would agree who was to make contact with the deceased's relatives.

The Aftermath of a Death in the Community – Completion of Form 2

20. After the completion of Form 1, the deceased's general practitioner might or might not be aware of the death. The CI who had received Form 1 would inform the general practitioner and would send him/her a copy of that document (unless the doctor already had a copy) and would ask him/her to complete Form 2. If the deceased's usual doctor were not available and would not be available in the near future, a partner or colleague with access to the medical records would be invited to complete Form 2. In all cases, a medical history would be provided. In some cases, the doctor would express an opinion on the cause of death and/or might draw attention to circumstances that would suggest the need for a full investigation. Form 2 would be sent by fax or on-line to the coroner's office, with the most important extracts from the medical records.

21. The CI would consider Forms 1 and 2 and, if necessary, speak to the Form 2 doctor for clarification of any uncertainty. If it appeared that the doctor did not know, or was insufficiently confident of, the cause of death or if any other circumstances emerged which required that the death be further investigated, the death would be passed to the MC for his/her instructions.

22. If it appeared to the CI that the cause of death was known and that there was no apparent reason why the death required further investigation, the CI would make arrangements to speak to a family member. Those discussions would proceed as for a hospital death and, if no cause for concern arose, the cause of death would be certified on the basis of the Form 2 doctor's opinion. If the death was not so certified, it would be referred to the MC for his/her instructions.

The Police and Criminal Investigations

23. My proposals would not affect the way in which the police deal with deaths where criminal involvement is suspected. Anyone who became aware of suspicious circumstances surrounding a death would report the facts to the police as now. If a coroner's investigator who attended the scene of a death noticed anything which gave rise to suspicion, s/he would call the police. He or she would have been trained to make such observations and to avoid contaminating the scene. A police investigation would always take priority over an investigation on behalf of the coroner.

24. Because the Coroner Service would have jurisdiction over all dead bodies, the police would have to seek the authority of a coroner before conducting an autopsy. However, in my view, the police should be able to call a forensic pathologist to the scene of a death, to examine the body and take samples for forensic examination (if necessary, moving the body), without a coroner's consent.

25. The police would continue to investigate road traffic and industrial deaths. Other statutory bodies would continue to use their specialist expertise in the investigation of mining accidents, some types of industrial accident, air crashes, rail accidents and accidents at sea, etc. The Coroner Service would work in co-operation with all such investigation teams.

26. The police would continue to offer some support to the Coroner Service, although on a more limited basis than at present. The police would provide security for a CI if required to go into a potentially dangerous situation. They would continue to assist in the identification of an unidentified body and in locating the next of kin of a deceased person. They would attend premises when it was necessary to make a forced entry. They would report deaths to the coroner of which they became aware. Once their own enquiries were complete, they would hand the case over to the coroner and nothing more would be expected of them. They would not be routinely involved in investigating deaths on behalf of the coroner or in the completion of sudden death forms such as Forms 751 and 751A, which I described in Chapter Four. On occasions, if there was any risk of resistance, violence or a breach of the peace, they would exercise powers of entry, search and seizure of property on behalf of the coroner.

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Figure 1: The First Stage of Investigation of Deaths in Hospital

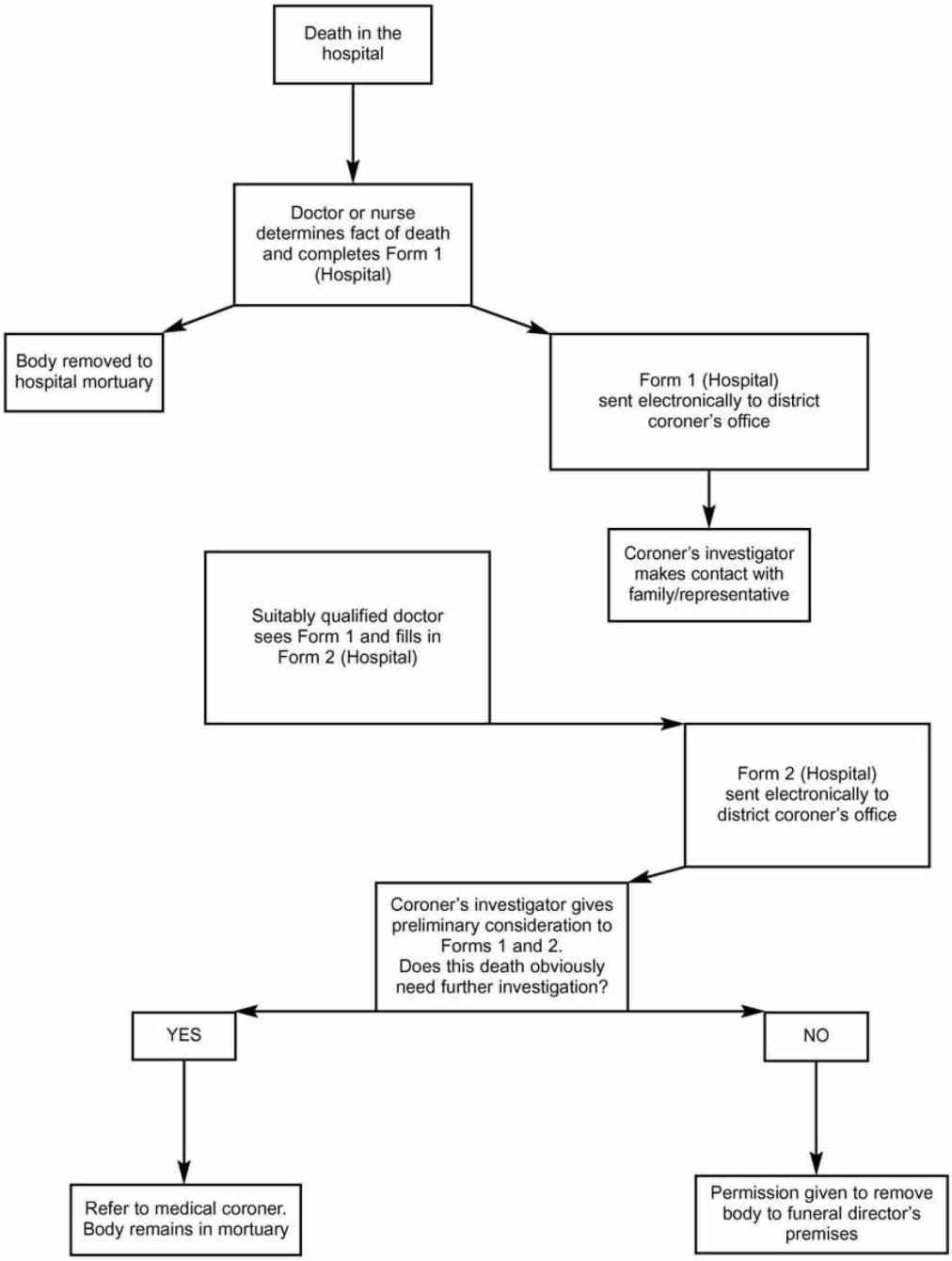


Figure 2: The First Stage of Investigation of Deaths in the Community

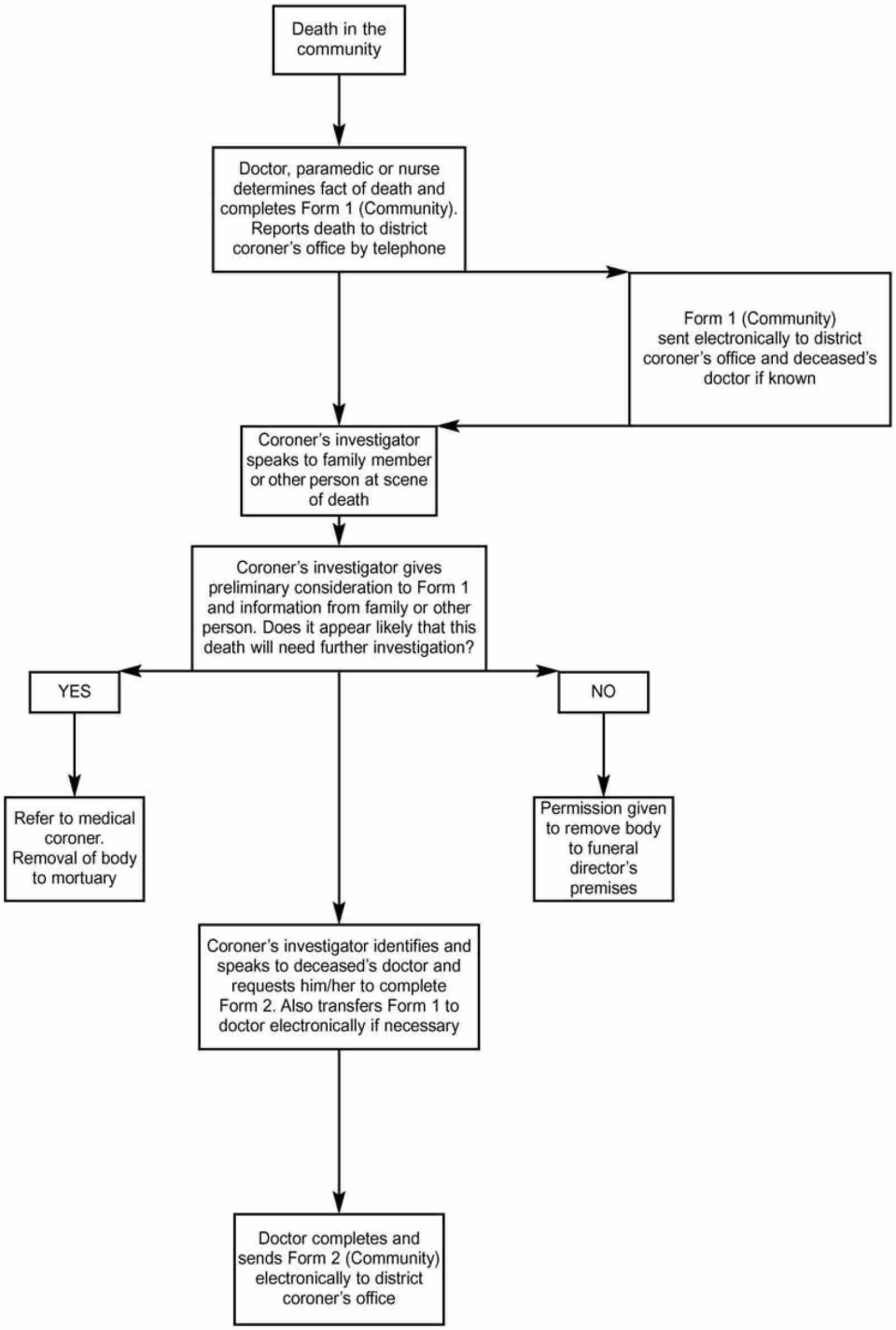
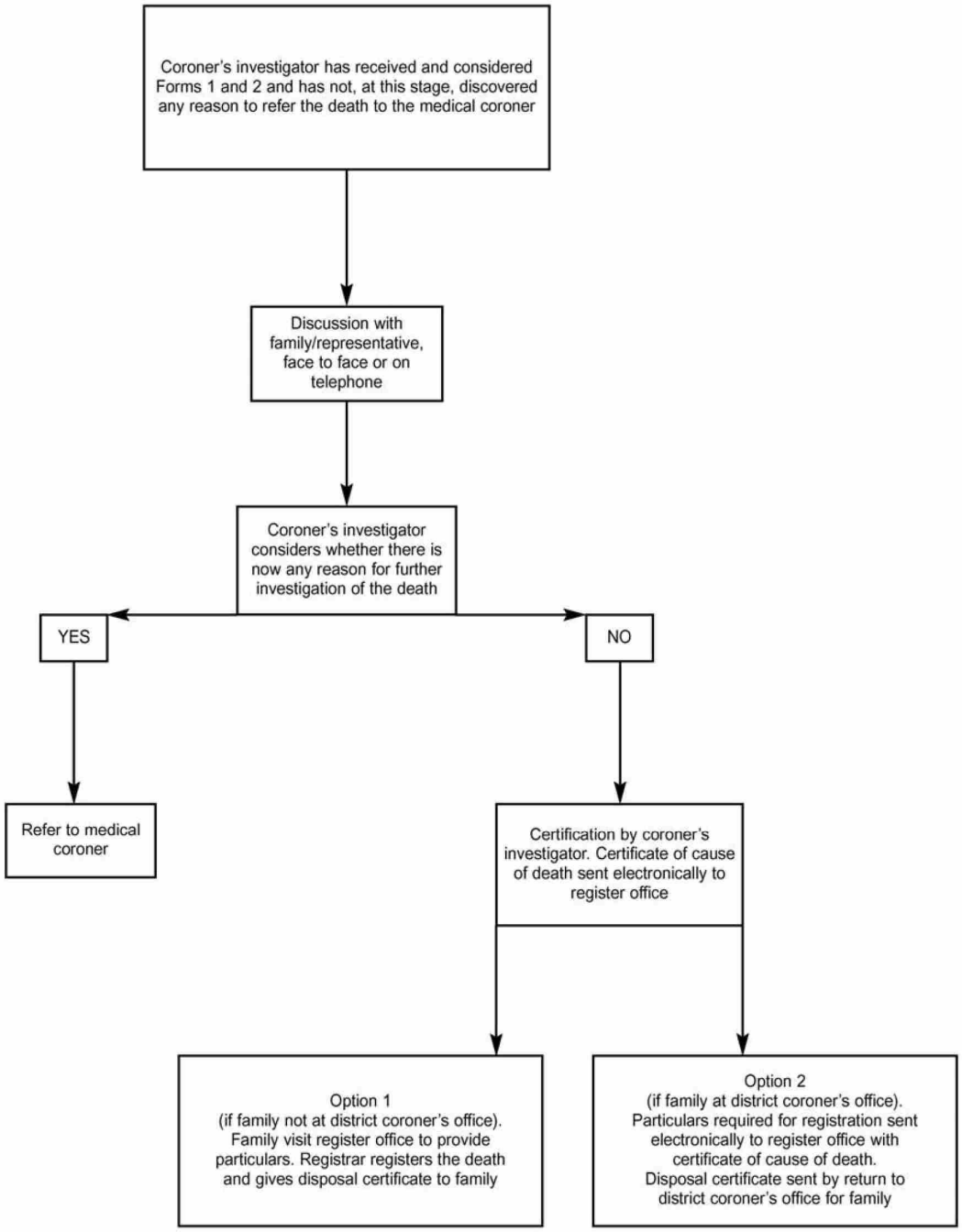


Figure 3: The Second Stage of Investigation of Deaths – Discussion with the Relatives



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