CHAPTER FIVE

The Existing Procedures for Death Registration and Cremation Certification

5.1 It has been necessary, in the course of investigating the deaths of Shipman's patients, to examine the existing procedures for establishing, certifying and registering the fact and cause of death and for obtaining, where appropriate, the necessary authority to cremate the deceased; the documents created in the course of those procedures have formed an important body of evidence available to the Inquiry.

5.2 This is not the time to embark on a detailed evaluation of the working of the current system, nor of the respects in which it might be improved; those matters will be fully considered in the course of Phase Two, Stage Two of the Inquiry and I shall report upon them, and upon my recommendations for change, if any, in a further Report. For the purpose of this First Report, it is necessary merely to set out an account of how the existing systems operate, so as to provide a background against which the circumstances surrounding the individual deaths can be viewed.

5.3 Since all but a few of the deaths which have been investigated by the Inquiry have occurred outside hospital, the account will be based upon the procedures which are followed in the event of a death at home or elsewhere in the community. Furthermore, this account of the system is not concerned with the case where the circumstances of the death are such as to arouse immediate suspicion of violence, giving rise to an early referral to the coroner and a criminal investigation. No such suspicion was reported in the immediate aftermath of the death of any of Shipman's patients.

Death Registration

Confirming the Fact of Death

5.4 Where a death is sudden and/or unexpected, an ambulance is frequently summoned and the attending paramedics carry out a series of tests to confirm that death has indeed occurred. In other cases, a doctor is usually summoned to confirm the fact of death. Whilst the paramedics will record their findings on a form and a doctor will usually note the death in the deceased's medical records, there is no requirement for any formal document, certifying the *fact* of death, to be completed.

5.5 If the death is discovered during surgery hours, the doctor summoned to confirm the fact of death will frequently be the general practitioner with whom the deceased is registered; at other times, it is highly likely that a deputising doctor with no knowledge of the medical history of the deceased will attend.

Certifying the Cause of Death

5.6 Once the fact of death has been established, the priority then becomes to identify an appropriate cause of 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.

5.7 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 the death. That will usually be the deceased's general practitioner, who may or may not be the same doctor who has confirmed the fact of death. 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…'**.

5.8 The form of the certificate (see Appendix C), which is entitled ' Medical Certificate of Cause of Death' (' MCCD'), is prescribed by the Births and Deaths Regulations 1987 and requires the doctor signing it 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'**.

5.9 When a doctor is confronted by the sudden death of a patient, he or she must first decide whether he or she can properly be said to have ' attended' the deceased during the last illness. That decision depends, of course, on the doctor being able to identify the cause of death and, therefore, the ' last illness' referred to. Where the attending doctor can state the cause of death with confidence, he or she may properly complete the MCCD and state what he or she believes to be the cause of death. This would happen in the case of a patient who has plainly died of terminal cancer where the doctor has treated the patient throughout the various stages of the illness, or in the case of a patient with a long history of heart problems who has died after exhibiting the classic signs of a coronary thrombosis. In some cases, a doctor will telephone the coroner's office and seek advice as to whether he or she (the doctor) should sign the MCCD.

5.10 If the doctor concerned cannot identify the cause of the deceased's death with sufficient confidence, he or she should decline to complete the MCCD. Although there is no statutory requirement on the doctor to do so, in those circumstances, he or she will usually report the death to the coroner at that stage.

5.11 If the doctor is confident that he or she can properly complete the MCCD, he or she will enter on it the deceased's name, age and date of death, together with the place of death. The doctor is also required to state the date on which he or she last saw the deceased alive and to ring one of the assertions from each of the following two groups:

' **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'.

and

‘ **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’.

In the vast majority of deaths which have been investigated by the Inquiry, Shipman ringed **‘ 3’**, i.e. **‘ Post-mortem not being held’**, and **‘ a’**, i.e. **‘ Seen after death by me’**.

5.12 In that section of the MCCD which deals with cause of death, the doctor is required to certify the chain of causation leading to death in the manner accepted by the World Health Organisation. Under Part I(a), the doctor should record the most immediate cause of death. At I(b), he or she should go on to identify the disease or condition which led to the immediate cause of death; the most common examples amongst the MCCDs completed by Shipman are ischaemic heart disease (I(b)) leading to coronary thrombosis (I(a)) and hypertension (I(b)) leading to cerebrovascular accident (I(a)). 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); an example of this would be hypertension (I(c)) leading to atherosclerosis (I(b)) leading to cerebrovascular accident (I(a)).

5.13 Under Part II, the doctor should record any other significant condition(s) contributing to the death but not related to the disease or condition causing it. On occasions, Shipman listed under Part II a condition which the deceased undoubtedly suffered from, but which could have made no contribution to the death. The Inquiry is, however, aware that this is not a practice which is confined to Shipman; it seems that there is a widespread misunderstanding of the purpose of this section of the MCCD and that conditions wholly irrelevant to the death are frequently listed under Part II.

5.14 The certifying doctor is also invited (but not obliged) to state the approximate interval between the onset of each of the diseases or conditions identified under Parts I and II. He or she must also indicate if the death might have been due to, or contributed to by, the employment followed at some time by the deceased.

Causes of Death

5.15 According to Dr Grenville, it is never appropriate for a doctor to certify death as being due to ‘ natural causes’. This would signify that the doctor does not know what the cause of death was, only that he or she feels satisfied that it was not due to *unnatural* causes; that decision is, he says, for the coroner – not the doctor – to make.

5.16 ‘ Old age’ as a cause of death is permissible, indeed it is specifically mentioned in the books of blank MCCDs issued to doctors. The relevant paragraph currently reads:

> **‘ Old age, senility – 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’**.

5.17 In his oral evidence, Dr Grenville said this:

> **' 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'**.

5.18 Dr Grenville went on to say that it would be the invariable case that somebody for whom it was appropriate to certify death as being due to old age would have been bed-fast for some time. He added:

> **' I would not be prepared to certify old age or senility in someone who had been active up to the day of death or even, indeed, a day or two before death. If a person who had been active and not particularly ill was suddenly to become ill and then to die within a few days, I would want to know what the specific cause was because that is not a general gradual deterioration involving multiple organs, it is a specific deterioration of something. I may not know what it was but it seems to me that it implies that a particular system has failed'**.

5.19 Shipman certified ' old age' as the primary or only cause of death in Part I in 49 cases and I have found that 15 of those deaths were unlawful killings. There are also cases in which he certified that ' senility' was the cause of death but those were either cases from the 1970s or early 1980s or cases in which there was a suggestion of dementia. Many of the patients certified as having died of ' old age' were very far from being in the state described by Dr Grenville. An obvious example is Mrs Kathleen Grundy, who was in good health for her age and was expected to attend as a helper at a day centre for the elderly on the very day of her death. Mrs Elsie Godfrey had suffered a chest infection a few weeks prior to her death but had spent the weekend with her family, returning home on the day of her death and going straight to have lunch at Pensioners' House; she had been planning to attend a bingo session that evening but, as I have found, was killed by Shipman during the afternoon. Mrs Elizabeth Baddeley had visited her sister in Canada only a few weeks before her death and, on the very day she died, she had cleaned her car and used it to take a friend out to lunch, to visit another friend and to go to the local library.

5.20 ' Natural causes' was cited by Shipman as the primary or only cause of death in only four cases. I have found that he was responsible for two of those deaths and that there is a suspicion that he was also responsible for the other two. Shipman certified in one of those cases, that of Mr Arthur Bent, that the cause of death was ' Natural Causes (Old Age)'.

Reporting the Death to the Registrar

5.21 The 1953 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 a member of the deceased's family or, if there is no family involvement, to the person who is making the funeral arrangements. That person (or some other family member) then delivers the MCCD, usually still in its envelope, to the registrar at the same time as attending to fulfil his or her duty to report the death to the registrar for births and deaths for the sub-district in which the body was found.

5.22 The informant of the death must give to the registrar certain specified information about the deceased. Provided that the registrar is satisfied that he or she can properly proceed to register the death, that information, together with the cause of death as set out in the MCCD, is entered in the register of deaths and signed by the informant. The registrar will then issue a certified copy of the entry in the register (often known as the ' death certificate', although that term is also used – incorrectly – to describe a MCCD), and will issue a certificate giving authority for burial or to apply for a cremation. This process is commonly known as ' registering the death'.

The Registrar's Duty to Report a Death to the Coroner

5.23 In certain circumstances, a registrar will not register the death, but will instead report it to the coroner. A registrar has a duty to report a death on the approved form (Form 52) if the death is one:

- where the deceased was not attended during his last illness by a doctor; the words ' attended during his last illness' are not defined; or
- where the registrar has not been able to obtain delivery of a duly completed MCCD; or
- where it appears from the MCCD that the doctor who has certified the cause of death did not see the deceased *either* after death *or* within 14 days before the death; or
- where the cause of the death appears to be unknown; or
- where the registrar has reason to believe the death was unnatural or caused by violence or neglect or by abortion or to have been attended by suspicious circumstances; or
- where the death appears to have occurred during an operation or before recovery from the effects of an anaesthetic; or
- where the death appears from the MCCD to have been due to industrial disease or industrial poisoning.

5.24 Such formal reports from the registrar to the coroner account for only about four per cent of deaths referred to the coroner. Most deaths which registrars would be obliged to report (e.g. where the deceased's doctor cannot comply with the attendance requirement or has not seen the deceased within the prescribed periods, or where the

doctor cannot identify the cause of death) will have been reported to the coroner by others (usually the deceased's general practitioner) before the death comes to the attention of the registrar. Much more common are informal approaches by registrars to the coroner's office for advice, for example as to whether a particular cause of death can be accepted.

5.25 One of the circumstances in which the registrar must report a death to the coroner arises when it appears from the MCCD that the certifying doctor did not see the deceased either after death or within 14 days before the death. It should be noted that these two requirements are expressed in the alternative, so that, if the doctor saw the deceased's body after death but has not seen the deceased during the fortnight before death, the registrar is under no duty to report the death, provided that the doctor has certified that he or she has been in attendance during the deceased's last illness.

5.26 In the event that a doctor has not seen the deceased after death, nor within a fortnight before, the registrar will frequently consult the coroner to see whether, in the circumstances, the coroner is prepared to extend the 14 day period and allow the death to be registered without a formal report to the coroner; it appears that some leeway is usually available, although the extent of that leeway varies widely from coroner to coroner. When a coroner is prepared to allow a death to be registered in these circumstances, it is usual for the coroner to issue a Form 100A, notifying the registrar that the circumstances connected with the death have been reported to the coroner, that he or she does not consider it necessary to hold an inquest and that no post-mortem examination has been held. Receipt of Form 100A enables the registrar to proceed to register the death.

5.27 There is a widespread and mistaken belief amongst members of the public, and even some medical practitioners, that the effect of the ' 14 day rule' is to require all deaths occurring more than 14 days after the certifying doctor's last contact with the deceased to be reported to the coroner. When he gave evidence to the Inquiry in May 2002, the South Manchester Coroner, Mr John Pollard, said that the registrars would not (and, he said, should not) register the death if the doctor stated on the MCCD that he or she had not seen the deceased within the 14 days prior to death; this would be the case even if the doctor had seen the body after death and had been the treating doctor during the last illness. In that event, Mr Pollard said that he would, in an appropriate case, issue a Form 100A ' to cover it'. So far as he was aware, his predecessor, Mr Revington, followed the same practice. Shipman was plainly aware of the practice. The Inquiry has looked at many cases where he claimed to have seen the deceased during the fortnight before death when plainly he had not. He did this in many cases where he had seen the deceased's body after death and so would, at least in that respect, be qualified in law to certify the death. It is clear that his conduct must have been directed at avoiding a referral by the registrar to the coroner. He did not necessarily do this for sinister reasons in every case; I have noticed that, even when a death was natural, he would sometimes avoid a referral to the coroner if he could; what is not clear is whether he did this in order to spare the relatives further distress, to save himself time and trouble or because he preferred to ' keep control' of the post-death procedures.

5.28 In the case of a death which the registrar has reported to the coroner, or which he or she knows has been notified to the coroner, or which he or she 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 he or she has received either a coroner's certificate after an inquest or a notification from the coroner that it is not intended to hold an inquest. Such notification is delivered by means of Form 100A if there is to be no post-mortem examination or inquest, or by means of Form 100B, if there has been a post-mortem examination which has revealed a natural cause of death, thereby rendering an inquest unnecessary. Receipt of Form 100A or Form 100B enables the registrar to proceed to register the death.

Cases Reported to the Coroner

5.29 When a death is reported or referred to the coroner, he or she must make preliminary enquiries in order to determine whether a post-mortem examination and/or an inquest should be held. If the cause of death is at first unknown, but post-mortem examination establishes a natural cause of death, the coroner will inform the registrar of this fact on Form 100B and the registrar will then proceed to register the death. If an inquest is required, that must of course take place before death can be registered, although, having opened the inquest, the coroner will usually release the body for burial or cremation.

Cremation Certification

5.30 Because cremation removes any possibility of recovering the deceased's body for future examination, the requirements for obtaining authority for disposal by cremation are more extensive than those which must be met before a deceased can be buried. Potentially, the most significant requirements are for a second doctor to confirm the cause of death and a third doctor (known as the medical referee) to examine the cremation documentation before authorising the cremation.

5.31 In the case of a death where there has been no post-mortem examination and no inquest, four cremation forms, Forms A, B, C and F, must be completed. The precise wording of the forms used is not uniform across the country. Specimen forms used by Dukinfield Crematorium, where most of Shipman's patients were cremated, can be found at Appendix D.

Form A

5.32 An application to cremate is made on Form A, usually by the deceased's closest relative or 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 he or she knows of any reason to suspect that the death of the deceased was due, directly or indirectly, to violence, poison, privation or neglect. The form must be countersigned by a person who knows the applicant and is prepared to certify that he or she has no reason to doubt the truth of any of the information furnished by the applicant. In practice, Form A is usually completed by the undertakers dealing with the death and the applicant merely signs the form. It is usual for a representative of the undertakers to countersign the form.

Form B

5.33 The application to cremate must be accompanied by two medical certificates, the certificate of medical attendant (Form B) and the confirmatory certificate (Form C). Form B must be completed by a medical practitioner who has attended the deceased before death and 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 the certifying doctor's involvement with the deceased before death. For the purposes of the Inquiry's investigations, some parts of the form have proved particularly significant.

5.34 The first question concerns the date and time of the deceased's death. Shipman's usual practice was to insert a specific time of death (rather than a bracket of times), often qualified by the word ' about' or ' approximately'. Where a relative or some other person was present at the moment of death, there will be often be no difficulty in ascertaining an accurate time of death. However, when it is said that no one was present at the time of death, it is difficult to see how that time can be specified with confidence, particularly when the death is not discovered until some hours later. Yet, Shipman frequently purported to estimate the time of death in circumstances where there can have been no possible scientific basis for such an estimate: see paragraphs 6.97 and 6.98. Shipman's purpose in doing this in cases where he had killed was to suggest a time of death which would give the largest possible interval between that time and an earlier visit by him.

5.35 The certifying doctor is asked (at question 6) whether he or she attended the deceased during his or her last illness and, if so, for how long. The words ' attended during his or her last illness' are not defined. The Inquiry has investigated many cases where the deceased's death was sudden and unexpected and preceded by no history which could properly be described as a ' last illness'. One such example of this is Mrs Margaret Waldron, whose death was said by Shipman to have been caused by a coronary thrombosis and whom I have found he killed. In Form B, he claimed to have attended her for three months during her ' last illness'; in fact, she had suffered no ' last illness' and, in particular, had no history of cardiac problems prior to the day of her death. The only problems for which she had sought medical advice in the three months prior to her death were hyperlipidaemia (raised blood fats), catarrh, a facial mole and sciatica, none of which could possibly have merited the description ' last illness'.

5.36 Questions 7 and 8(a) of Form B have assumed particular significance during the Inquiry's investigations. These relate to the time when the certifying doctor last saw the deceased alive and how soon after death he or she saw the deceased's body. In many cases, Shipman answered question 7 by saying that he had seen the deceased alive a few hours before his or her death. He would usually attempt – by giving a specious estimate of the time of death and/or by lying about the time of his visit – to create the longest possible time interval between his visit and the time of death. Sometimes, his attempts to construct a timetable resulted in obvious inconsistencies in the history revealed by the contents of Form B.

5.37 In the case of Miss Ada Warburton, for example, Shipman stated that he had attended Miss Warburton for five hours during her ' last illness' (a cerebrovascular accident), that he had last seen her alive at ' about 17.30 hours' and that she died also at ' about 17.30

hours'. That would suggest that he was present at the death, but he went on to claim that the only person present at the moment of death was a neighbour and that he (Shipman) had seen Miss Warburton's body ' about 45 minutes' after death. On the Form B relating to the death of Mrs Deborah Middleton, Shipman gave the time of death as about 5pm and his previous visit as about two hours before death (i.e. about 3pm) but went on in the same form to state that Mrs Middleton had been found by her daughter at 2.30pm and that the ambulance had arrived and the paramedics found her dead at 3pm. All the entries about timing are heavily overwritten and, when read together, make no sense at all. I have found that Shipman killed both Miss Warburton and Mrs Middleton.

5.38 By question 8(b) of Form B, the certifying doctor is asked what examination of the deceased he or she has made. Shipman's response to this was virtually always to the effect that he had performed a ' complete external' examination. In reality, he was never observed by relatives to perform a thorough examination and, frequently, the relatives said that he did not touch or go near the body at all. Other local doctors completing Forms B used a variety of descriptions for their examinations, including ' external', ' full external', ' routine' and ' examined for vital signs'.

5.39 Question 10 asks about the mode and duration of death. Examples of possible modes (syncope, coma, exhaustion, convulsions) are given on the form. Shipman's usual reply was that the mode of death was ' syncope' lasting ' seconds' or ' minutes'; sometimes he cited ' coma' lasting ' minutes' or ' hours'. Dr Grenville observed that the description of a ' coma' lasting ' minutes' makes no sense since, by definition, a coma is a state of unconsciousness lasting at least several hours and, more often, days, weeks or even months. The obvious difficulty which arises is that, if no one is present at the death, any statement about the mode and duration of the death must be based on the doctor's supposition only. If a person is found dead on the floor, it may be reasonable to deduce that they suffered a ' collapse' of short duration. There is no such clue with the deaths of many of Shipman's patients, which occurred when they were sitting peacefully in chairs or on sofas. In his oral evidence, Dr Grenville said that, before entering ' collapse' as the cause of death, he would require:

> **' ..evidence that the patient had collapsed while doing something else. I might well fill that in if I found the patient collapsed on the floor obviously heading for the bed or for the telephone or something like that, perhaps with a cup of tea spilt or whatever. I think one can then say this person appears to have collapsed; it will only have lasted a few seconds. But someone who is in bed or on a chair, I think it is impossible to say that this was syncope lasting a few seconds or a lapse into unconsciousness lasting maybe an hour'**.

5.40 When giving evidence in the case of Mr John Howcroft, Dr Grenville said that, in certain circumstances, ' if everything else is right', it would be reasonable to infer a mode and duration of death from the surrounding circumstances although, if he were completing the Form B, he would make clear that he was drawing an inference, rather than stating a fact. Dr Grenville did make the point that a failure to give an answer to the question can

cause a problem, as a medical referee may refuse to ' pass' the form and authorise cremation. It may not be uncommon, therefore, for a doctor completing Form B to speculate as to the mode and duration of death. The Inquiry will be looking at this and other problems associated with completing Forms B during Phase Two, Stage Two.

5.41 Form B further requires the certifying doctor to state whether his or her answers relating to cause, mode and duration of death are the result of that doctor's own observations or based on the statements of others, and if so, whose. It is not obligatory for the names or contact details of the relevant persons to be specified, and Shipman rarely did so. The question was presumably designed to elicit information about persons who had nursed the deceased and been present at the death, and who would, therefore, be able to tell the certifying doctor that the deceased had, for example, been in a coma for 24 hours before death, or had suddenly collapsed and died in a matter of minutes. However, Shipman would frequently answer this question by claiming to rely on statements made by paramedics, neighbours and family members who had come on the scene only after the death, and could not, therefore, have had any useful information to give about the mode and duration of the deceased's death. Reference to such persons was obviously intended to give the impression that there were people who had firsthand knowledge about the circumstances of the death when, in fact, there were not. Shipman would sometimes indicate in response to this question that someone had seen the deceased alive shortly prior to death, thus giving the impression that there had been a sighting of the deceased alive between an earlier visit by him and the time of death.

5.42 Question 13 of Form B asks who nursed the deceased during his or her last illness. The certifying doctor is asked to give the names and capacities (e.g. professional nurse, relative, etc), but not contact details, for the person(s) who nursed the deceased. Sometimes, Shipman falsely claimed that a deceased person had been receiving nursing care; one such case was that of Mr Sidney Smith, whom Shipman stated had been nursed by his brother, Mr Kenneth Smith; in fact, Mr Kenneth Smith had severe mobility problems, as a result of which his brother cared for him. Usually, however, Shipman's response to this question stated (correctly) that the deceased had received no nursing care. This was frequently the case even when he certified the cause of death as ' old age'. Bearing in mind that ' old age' implies a high degree of frailty and eventual multiple organ failure, it would be surprising if such a person had not been receiving any nursing care; indeed, the absence of such care should perhaps, as Dr Grenville pointed out, raise questions as to whether there had been an element of neglect which may have contributed to the death and which might, of itself, necessitate a referral to the coroner.

5.43 Question 14 of Form B asks who were the persons (if any) present at the moment of death. Here also it is not obligatory to give the name or contact details of such persons and Shipman rarely did. Often, he referred only to their connection with the deceased, describing them, for example, as ' a neighbour'. Frequently, he responded by saying that no one was present. However, the Inquiry has investigated many deaths where Shipman falsely claimed that persons were present at the death when it was clear that they were not. Sometimes, the people recorded as present came on the scene after the death; perhaps the most striking example of this is the case of Mrs Dorothy Long, where

paramedics came on the scene over 36 hours after the time of death (on Shipman's own account); Shipman claimed on Form B that they were ' present at the moment of death'. On occasions, Shipman's claim would be that ' a neighbour' was present at the death, whereas relatives were unaware of any such person and detailed enquiries subsequently failed to trace such a neighbour; it is clear in many of these cases that no such person ever existed.

5.44 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'**.

5.45 The preamble to Form B makes clear that it, together with Forms C and F, are regarded as ' strictly confidential' and states:

> **' The right to inspect them is confined to the Secretary of State, the Ministry of Health and the Chief Officer of a Police Force'**.

5.46 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 for the first time when they were shown them by a member of the Inquiry legal team.

Form C

5.47 A note to Form B directs:

> **' 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'**.

The confirmatory certificate is known as Form C and is completed by a medical practitioner who has been registered in this country for not less than five years and is not a relative of the deceased, nor a relative or partner of the doctor who has completed Form B. In practice, the ' Form C doctor' is selected by the doctor completing Form B, usually on a reciprocal basis. A doctor completing Form C receives a fee (currently recommended at £45.50) so that a reciprocal arrangement between two doctors with practices situated near to each other has obvious advantages for each.

5.48 The doctor completing Form C must view the body of the deceased and ' carefully examine' it. This is usually done at the premises of funeral directors where conditions are not always ideal for a thorough examination. The Inquiry will be considering, during Phase Two, Stage Two, evidence about the nature and extent of the examination usually made by a Form C doctor; it is, however, already clear that, whilst an external examination may be useful in excluding obvious signs of violence, its value in identifying a natural cause of death is somewhat limited.

5.49 The other requirement of the doctor completing Form C is that he or she must see and question the doctor who completed Form B. This is intended to give an opportunity for the Form B doctor (usually the deceased's general practitioner) to inform the Form C doctor about the deceased's medical history, possibly by reference to the medical records.

5.50 Form C also asks whether the doctor completing the form has seen and questioned any other person (whether medical practitioner, person who nursed the deceased, person who was present at the death, relative of the deceased or anyone else) about the death. It invites the doctor to provide the names and addresses of those persons and to specify whether they were seen by the doctor alone or together. When Shipman was in Todmorden, confirmatory certificates were provided by the late Dr Stella Brown, who frequently responded that she had spoken to the deceased's relatives and other people and confirmed the details on Form B. Once at Hyde, however, the answers to these additional questions were virtually always in the negative. No contact was made by Form C doctors with any relatives from whom the Inquiry has heard, and, indeed, most relatives were completely unaware until recently that any doctor other than Shipman was involved in the certification process.

5.51 Finally, the Form C doctor has to state the cause of death of which he or she is satisfied. The practice is to reproduce the primary cause of death identified by the Form B doctor, sometimes, but not always, mentioning other conditions named in Form B as causative or contributory. The Form C doctor must then certify in these terms:

> **' ..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'**.

Form F

5.52 Form F is the certificate giving authority to cremate and is completed by the medical referee at the crematorium where the cremation is to take place. The post of medical referee is a part-time one, usually held by a retired or practising general practitioner or a doctor holding a position in public health. Remuneration is paid for each completed form (the current recommended rate is £5.50 per form). The medical referee scrutinises the cremation forms and then, if all is in order, certifies as follows:

> **' 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 ……to cremate the said remains'**.

5.53 If the medical referee is not satisfied with the contents of the forms, he or she may make any enquiry with regard to them as he or she thinks necessary. It is not uncommon for

the medical referee or a member of the cremation staff to raise questions relating to the forms with the certifying doctor; the most common reason for this appears to be a failure to answer one of the questions on Form B. The medical referee can in certain circumstances require a post-mortem examination to be held, and, if that fails to reveal the cause of death, he or she must decline to allow the cremation without an inquest. The medical referee is specifically empowered to decline to allow a cremation without stating any reason. Again, the medical referee has no contact with the deceased's relatives, who are usually completely unaware of the fact that such an official plays any part in the cremation procedure. Once the medical referee has signed Form F, the cremation can proceed.

The Future

5.54 The procedures for certifying and registering deaths – and, in particular, those for obtaining authority to cremate – are intended to provide some safeguard for the public against concealment of the fact that a person has been unlawfully killed. However, even with those procedures in place, I have found that Shipman was able to kill 215 people over a period of 23 years. It is clear, therefore, that the existing procedures provided no safeguard at all, either because they were flawed in themselves, or because they were not properly implemented or, possibly, by reason of a combination of both these factors. These issues – and any proposals for changes to the existing procedures – will be fully examined by the Inquiry during Phase Two, Stage Two and will be the subject of a further Report.