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

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.

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,

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

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.

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 neverthless 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.

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.

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.

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,

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

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.