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

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.

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

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

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.