CHAPTER SIXTEEN

The Dukinfield Crematorium Medical Referees

Introduction

16.1 In this Chapter, I shall examine the work of the two doctors who were employed as medical referees at the Dukinfield crematorium during the years in which Shipman killed so many of his patients. Dr Betty Hinchliffe was appointed as the Deputy Medical Referee in the late 1970s and became Medical Referee on the death of her predecessor, Dr Thomas Holme, in 1989. Soon after Dr Hinchliffe's appointment, Dr Jane Holme, the daughter of Dr Thomas Holme, was appointed as her deputy. Dr Hinchliffe continued as Medical Referee until 1999, when she retired. Dr Jane Holme retired at the same time.

16.2 Dr Hinchliffe authorised the cremation of the bodies of 176 of Shipman's patients. Of those patients, Shipman had killed 107. Dr Holme authorised the cremation of the bodies of 31 of Shipman's patients, of whom 23 had been killed. I shall consider whether the frequency with which these medical referees considered cremation forms completed by Shipman, or the unusual content of those forms, should have caused the medical referees to be in any way concerned about Shipman's practice. I shall also consider whether the contents of any particular forms were so strange or unsatisfactory that the medical referee who saw them should have refused to authorise cremation of the body and have ordered an autopsy or referred the death to the coroner.

Professional Experience

16.3 I have already referred briefly to the careers of the two medical referees in Chapter Eleven. Dr Hinchliffe graduated in medicine from Manchester University in 1951. She then spent two years working in hospital, followed by two years as a locum general practitioner. Thereafter, she was employed in the field of child health, eventually specialising in paediatric audiology. She had no further experience of general practice or of the care and treatment of elderly people. Before her appointment as Deputy Medical Referee, she had very little experience of cremation certification. She had occasionally completed Forms B during her two years as a house officer. She said she had completed a Form C 'perhaps on two occasions'. She was appointed at the suggestion of the previous Medical Referee, Dr Thomas Holme, with whom she had previously worked in public health.

16.4 Dr Jane Holme, Dr Hinchliffe's deputy, graduated in medicine, also from Manchester University, in 1966. She spent her pre-registration year working in hospital and then moved to local authority work in the field of child health. She never worked in general practice and had no experience of the care and treatment of elderly people. She had completed some Forms B when working as a junior doctor in hospital, but had never completed a Form C. She was appointed Deputy Medical Referee by reason of her family relationship with Dr Thomas Holme and her professional relationship with Dr Hinchliffe.

16.5 In my view, a medical referee should have some experience of patients who die. This could most easily be gained by experience in the care and treatment of the elderly, as most people die in old age. Such experience might be gained in a number of ways, for

example in general practice. It cannot be gained by experience in the field of child health.

16.6 I also think it highly desirable that a medical referee should, at least for a time, have had experience of completing Forms B and C and working with others who also have such experience. He or she would then be aware of how the system works from the doctors' point of view, what the problems are with the completion of Form B and the extent of the investigation usually carried out by the Form C doctor. In my view, neither Dr Hinchliffe nor Dr Holme was adequately equipped by her professional experience for the work of a medical referee, who has to assess the information provided on cremation Forms B and C.

The Task to Be Undertaken

16.7 In Chapter Eleven, I set out the duties of the medical referee, as provided by the Cremation Regulations. I can summarise those duties briefly. The medical referee should seek to satisfy him/herself that the forms have been duly completed, that the enquiry made by the persons completing the forms has been adequate, that the fact and cause of death have been definitely ascertained and that there is no reason why the body should be examined further. In Chapter Eleven, I pointed out that the requirement that the medical referee should be satisfied the cause of death has been definitely ascertained is unrealistic and unachievable.

16.8 In Chapter Eleven, I also explained that there appeared to be two schools of thought about how the duties of the medical referee were to be carried out, some believing that the task was of an essentially clerical nature and others believing that they were under a duty to review, and form an independent judgement upon, the information in the forms. I concluded that the powers given to the medical referee, and the requirement that s/he be a medical practitioner of five years' standing, make it clear that s/he must undertake more than a clerical check. It is not clear from the Regulations how much more should be done or how the medical referee is to satisfy him/herself that the cremation should be authorised. As it appeared that it was the intention of Parliament that the medical referee should not usually undertake independent enquiries of his/her own, I expressed the view that the process of review described by Dr Gordon Pledger and Dr Ian Morgan, two medical referees who gave oral evidence to the Inquiry, seemed a reasonable one. Their approach entails a review of all the information given in the documents (especially Form B) and consideration of the 'whole picture', in order to assess whether the cause of death is consistent with that picture. I have already pointed out (see paragraph 11.116) that, even if completed conscientiously, the documents frequently contain inadequate information to enable the medical referee to gain a clear picture of the events leading up to death. Form B does not require the doctor to provide even a brief account of the deceased's medical history, nor of the circumstances of the death. Nevertheless, it is evident from the forms examined by the Inquiry that some impression of the circumstances (e.g. whether the death followed a terminal illness or occurred suddenly) can usually be gained. If the information is so sparse that this is not possible, it is open to the medical referee to make enquiries of the certifying doctor.

16.9 Form B provides most of the information upon which the medical referee will base his/ her judgement. In respect of Form C, the medical referees at most crematoria (including

Dukinfield) would expect to see only that the second doctor had carefully examined the body externally, questioned the Form B doctor and confirmed the latter's opinion as to the cause of death. It appears that most medical referees would deem that to be an adequate enquiry, although, as I have explained in Chapters Three and Eleven, there are some crematoria where an enquiry of a person other than the Form B doctor is required before authority to cremate will be given. I would expect that the medical referee would appreciate that the Form C doctor would probably not have examined the medical records and would have accepted the Form B doctor's account as honest. In other words, I would expect the medical referee to appreciate that the decision of the Form C doctor to confirm the Form B doctor's opinion as to cause of death would have entailed only a consideration of whether the opinion was a reasonable one, bearing in mind the history as given by the Form B doctor. At Dukinfield, as at most crematoria, there was no requirement for the Form C doctor to make an enquiry of a person independent of the Form B doctor, to check on the accuracy of the history provided by the Form B doctor.

Dr Hinchliffe's Perception of Her Task

16.10 Dr Hinchliffe's evidence was that, as well as a clerical check, she carried out the exercise of assessing the 'whole picture' as described by Dr Pledger and Dr Morgan. She described herself as 'trying to fill in a little jigsaw puzzle'. She also sought to make sure that every question had been answered, that there was consistency between the details (name, cause of death, date of death, etc.) contained in the various forms and that there was nothing on the face of the forms which would render the case reportable to the coroner. She told the Inquiry that she had never had occasion to order an autopsy, refer a death to the coroner or decline to allow a cremation to take place.

16.11 I regret to say that I am unable to accept Dr Hinchliffe's evidence that she carried out such an exercise. I reach that conclusion for several reasons. The first is that it was not until she came to give oral evidence that Dr Hinchliffe suggested that she had ever carried out a review of the 'whole picture'. In her first Inquiry witness statement, she described the procedure she would follow in some detail. At only one stage did she suggest that the task was anything other than administrative. She spoke of the need to check that the death was not due to trauma or a medical procedure, such as would make it reportable to the coroner. I accept that she did that. However, she did not suggest that she reviewed the information to see whether the cause of death was reasonable and consistent with the surrounding circumstances and with the picture as a whole. Twice in her Inquiry witness statements, Dr Hinchliffe described the task of a medical referee as **'clerical'** in nature. She observed that the task did not involve **'a review of the medical opinions expressed on the forms'**.

16.12 My second reason is that Dr Holme received her informal training from Dr Hinchliffe and her evidence was that Dr Hinchliffe had not taught her that the task was anything more than a clerical job.

16.13 Third, if Dr Hinchliffe had carried out the exercise of looking at the 'whole picture' or completing 'a little jigsaw puzzle', she would have been bound to observe that, in respect of a number of cases which she considered, the information contained in Form B was

either inconsistent with the stated cause of death or was not adequate for the purpose of forming any view as to the consistency between the cause of death and the surrounding circumstances. Faced with a Form B which contained either inconsistent or inadequate information, she would have had to make further enquiries of the Form B doctor before she was able to decide whether or not to authorise cremation. She made no such enquiries in those cases.

16.14 Dr Hinchliffe said that she did not make such enquiries because she assumed that, if she had enquired, a satisfactory explanation would have been provided. She also said that it was acceptable for her to rely on such an assumption, rather than making further enquiries herself, because she believed that the Form C doctor would have made any necessary enquiries and would have satisfied him/herself that there was an acceptable explanation for any apparent inconsistencies or omissions. If this were indeed her approach, then any attempt by her to assess the 'whole picture' was completely without purpose. Even if that assessment revealed a glaring omission in the 'jigsaw', on her account, she would take no action, confident in the belief that the Form C doctor would have done so. There is a fundamental inconsistency between her claim that she was trying to see the 'whole picture' and her claim that it was reasonable for her not to make any enquiry of the doctor if she noticed inadequate or inconsistent information on Form B.

16.15 Fourth, it was Dr Hinchliffe's practice to make a note on the form if, for any reason, she had to speak to the Form B doctor to obtain additional information before she could take a decision whether or not to authorise cremation. Examination of a large number of forms reveals that they bear a number of endorsements in her hand, relating to such matters as the date on which the Form B doctor had last seen the deceased alive or, in a case where, for example, the doctor had not seen the deceased for more than 14 days before death, whether the death had been discussed with the coroner. However, no form bears any annotation relating to enquiries about the cause of death.

16.16 Finally, Dr Hinchliffe said that she dealt with each form individually. Yet she never gained any impression of the overall proportion of deaths that occurred in hospital and in the community. Nor had she formed any impression of the proportion of deaths referred to the coroner. She said she had never thought about these issues. If Dr Hinchliffe had indeed seen the 'whole picture' of every death, I would have expected that she would have gained at least a general impression of the profile of the deaths dealt with at the crematorium.

16.17 My conclusion that Dr Hinchliffe did not carry out a review of the information contained in the cremation forms is consistent with her general approach to her task. She had a very uncritical view of the whole process of cremation certification. She placed her trust in the Form C doctor as an 'independent source' but did not know that the Form B doctors selected the Form C doctor; it had not occurred to her therefore that the Form C doctor might not be independent of the Form B doctor. She did not know whether a Form C doctor ever examined the deceased's medical records, although she assumed (mistakenly in most cases) that the Form C doctor would have had access to them. She was unaware that the physical examination of the body by the Form C doctor was sometimes cursory. She did not consider the difficulties which might be experienced by a Form C doctor in disagreeing with a forceful, possibly more senior, colleague. It had never occurred to her

that a Form C doctor who gained a reputation as being a 'stickler' might not be invited to complete a Form C again in the future.

16.18 It appeared to me that Dr Hinchliffe's main concern and preoccupation was that the families of the deceased should not be distressed or inconvenienced by any delay in the funeral arrangements. Her objective was to ensure that the cremation forms could be approved in time. Whilst this is, of course, important, the medical referee also has a duty not to authorise a cremation until properly satisfied as to the cause of death. I am sure that Dr Hinchliffe thought it appropriate to authorise a cremation in every case where the forms had been properly completed. Her consideration of the cause of death was, I am confident, confined to checking that the cause given on Form C tallied with that stated on Form B.

16.19 I conclude that Dr Hinchliffe has persuaded herself that she used to carry out more than a clerical check of the forms whereas, in fact, she did not do so. In persuading herself of this, she might have been influenced by the evidence of Dr Pledger and Dr Morgan. Also, when she came to examine the forms for cremations she had authorised, and to reflect on the declaration which she had made on Form F in those cases, she might have come to realise that the medical referee's duties must consist of more than a clerical check. She has persuaded herself that she used to undertake the task of scrutinising the cremation forms in the way described by Dr Pledger and Dr Morgan. I am sure that she did not. Dr Hinchliffe believes that she carried out her duties conscientiously. In my view, she did indeed carry out her duties, as she then saw them, with a proper degree of care. However, she did not perform them as she should have done, because she did not realise, until shortly before she came to give evidence, that more than a clerical check was required of her. It is unfortunate that Dr Hinchliffe so persistently and unrealistically claimed in evidence that she had done more than she ever had.

16.20 I am reluctant to criticise any medical referee who, until recently, believed the task to be of an essentially clerical nature, because this mistaken belief was not uncommon and because there was no training or guidance by which mistakes could be corrected. However, I would have thought that the application of common sense to the words of the Regulations (particularly the power to order a post-mortem examination) should have suggested to Dr Hinchliffe that the task required the exercise of some degree of medical judgement and was intended to be more than clerical. I can only conclude that, like many of her colleagues, Dr Hinchliffe never paused to consider the underlying purpose of the work of the medical referee, nor why, if that purpose were essentially clerical in nature, the work had to be undertaken by an experienced medical practitioner.

Dr Holme's Perception of Her Task

16.21 Dr Holme's evidence was that her task was essentially to carry out a clerical check. She did not consider that she should review the medical opinions expressed by the Form B and Form C doctors. The only context in which she looked at the cause of death was to ensure that the same cause of death was given on both Forms B and C. She also looked out for indications that the death might be reportable to the coroner, for example because it had been caused by an accident. Although she sometimes spoke to the Form B doctor,

to fill in a space on a form which had been left blank or occasionally to clarify a point, she never on any occasion queried the cause of death. Nor did she ever order an autopsy, refer a case to the coroner or decline to allow a cremation to take place.

16.22 Dr Holme thought that it was the duty of the Form C doctor to satisfy him/herself that the cause of death was appropriate and consistent with the medical history and circumstances. She seemed uncertain as to the way in which this might have been done. This is not surprising, given her own lack of experience as a Form C doctor.

16.23 Examination of the forms she considered shows that, within the limits she set herself, Dr Holme carried out the clerical check conscientiously. However, had Dr Holme undertaken a full assessment of the cremation forms, rather than a clerical check, such an assessment of many of Shipman's forms would have revealed inconsistencies and inaccuracies which would have required enquiries to be made before the cremations could properly be authorised.

16.24 Like Dr Hinchliffe and many of her colleagues, Dr Holme does not appear to have given any thought to the underlying purpose of the work done by the medical referee. Had she done so, she should surely have realised that the role involved the exercise of a degree of medical judgement, rather than just a clerical check.

Should the Medical Referees Have Noticed Shipman's Activities?

The Number and Distribution of Deaths

16.25 The number of Shipman-certified deaths dealt with by Dr Hinchliffe must be placed in the context of the total number (about 2000 per annum) of deaths that she processed. Moreover, whilst Shipman certified clusters of deaths at various times, it is apparent from the research carried out by the Inquiry that he was not alone in this.

16.26 The most remarkable cluster of deaths certified by Shipman occurred on 13th March 1995, when three of the 12 sets of forms examined by Dr Hinchliffe were for patients of Shipman. Because she was authorising so many cremations, and because other doctors also certified clusters, I accept that it was not unreasonable for Dr Hinchliffe to attribute to coincidence the fact that she was called upon to authorise the cremations of three of Shipman's deceased patients on the same day. I shall consider later whether Dr Hinchliffe should have noticed anything unusual about the circumstances of those three deaths.

16.27 I conclude that neither the number nor the distribution of Shipman's patient deaths scrutinised by Dr Hinchliffe were so unusual that she should have found them noteworthy.

16.28 Dr Holme saw only 31 of Shipman's Forms B and these were spread over eight years. There were no clusters. There was nothing about the numbers to draw Shipman to her attention.

The Failure to Recognise Inadequately Completed and Internally Inconsistent Forms

16.29 I have said that Dr Hinchliffe authorised cremations following 107 deaths where Shipman had killed. In some of those cases, even the most careful scrutiny of the forms would have

failed to reveal any inadequacy or inconsistency or, indeed, anything unusual about their contents. However, such features would have been apparent in the contents of a significant number of the forms examined.

16.30 I have already explained that I am sure that, before giving authority to cremate, Dr Hinchliffe carried out what was essentially a clerical check only on the cremation forms. In oral evidence, however, she contended that she had reviewed the forms in order to 'fill in a little jigsaw puzzle' and assess whether the picture as a whole was consistent with the cause of death. At the Inquiry hearings, she was referred by Leading Counsel to the Inquiry to the forms relating to a number of cases in which she had authorised cremations. Dr Hinchliffe was asked, in respect of each case, to explain the picture which had emerged from her review of the forms and the basis upon which she had felt able to authorise the cremation without further enquiry.

16.31 Dr Hinchliffe was asked in some detail about a number of such cases. However, I do not propose to lengthen this Report by a detailed exposition of the facts of each case in which Form B was unsatisfactory, the problems raised and Dr Hinchliffe's explanation for her decision to allow cremation. There were many such cases, including those of Mrs Marjorie Parker, Mr John Molesdale, Mr Joseph Shaw, Mrs Netta Ashcroft, Mrs Lily Bardsley and Miss Brenda Ashworth. In all these cases, Dr Hinchliffe authorised cremation without making any enquiry of Shipman. In the case of Mrs Erla Copeland, whose death Shipman had attributed to 'natural causes' (an unacceptable cause of death), Dr Hinchliffe claimed that she had spoken to Shipman before authorising cremation. However, I do not think she can have done, as there is no note on Form B of any conversation or additional information. I shall refer in detail to only two cases about which Dr Hinchliffe was asked in evidence, those of Miss Ethel Bennett and Mrs Eileen Robinson, by way of illustration.

Miss Ethel Bennett

16.32 According to the first page of the Form B completed by Shipman, Miss Bennett died at her home at about 4pm on 19th December 1988. The cause of death was said to be bronchopneumonia. Shipman said that he had been her doctor for 12 years. He said he had attended her for six hours during her last illness and had last seen her alive about six hours before her death. Dr Hinchliffe agreed that that implied he had visited her on one occasion during her pneumonia and that that visit had taken place six hours before death, i.e. at about 10am. Shipman also stated that he had seen the body about one and a half hours after death, which would have been at about 5.30pm.

16.33 On the second page of Form B, Shipman said that Miss Bennett had been in a coma for **'hour only'** before death. He wrote: **'Seen by self at 1300 hrs, found by son at 1830. Neighbour heard her at 1500 hrs moving about, then found sat in chair'**. He also stated that Miss Bennett had not been receiving nursing care and that no one had been present at the moment of her death.

16.34 It is immediately apparent that the timing of events given on the first page is inconsistent with that on the second. Dr Hinchliffe said that, when she reviewed the form, she had not noticed this inconsistency. There were also two inconsistencies between Form B and the information in Form A. Form A had been completed by Mr Alan Roy Bennett,

Miss Bennett's nephew, who stated that he was her nearest surviving relative. If that were right, Miss Bennett did not have a son who could have found her dead at 6.30pm. Second, on Form A, the time of death was said to be 6pm, whereas in Form B it was said to be 4pm. Dr Hinchliffe said that she had not noticed either of those inconsistencies.

16.35 Perhaps more serious was Dr Hinchliffe's failure to notice the inherent implausibility of Shipman's account of this death. The picture that Dr Hinchliffe should have pieced together was of an elderly woman whom Shipman visited at about 10am, but apparently left alone without any nursing care. From that, one would infer that she was not seriously ill at that stage. Shipman might or might not have seen Miss Bennett again at 1pm; the information is contradictory. Miss Bennett was apparently still **'moving about'** at 3pm, when she was heard by a neighbour. Yet, at about that time, she appears to have been lapsing into a coma that lasted for an hour before her death at about 4pm. Given that bronchopneumonia is not an extremely acute condition and that death is usually preceded by at least several hours of grave illness, this picture simply does not make sense. Yet, Dr Hinchliffe failed to realise this and could give no explanation for her failure. I can only conclude that, when reviewing the forms, she did not attempt to look at the 'whole picture' of this death, as she claimed. Nor, I am bound to observe, does she appear to have performed a particularly careful clerical check.

Mrs Eileen Robinson

16.36 Mrs Robinson died in December 1993, at the age of only 54. According to the Form B completed by Shipman, she died at home at about midnight on 22nd December. Shipman said he had been her doctor for 17 years and had attended her for four months during her last illness. He said that he had last seen her alive about 12 hours before her death, which would have been at about noon on the 22nd December. He stated that the cause of death was coronary thrombosis due to hypertension and that the death had been preceded by a collapse lasting **'seconds only'**. That information was said to be the result of his own observations. He said that nobody had nursed Mrs Robinson in her last illness and no one had been present at the death. He explained the circumstances in which Mrs Robinson had been found as follows: **'Broke in with police found on floor dead'**.

16.37 When asked what she thought must have been the 'last illness' for which Shipman had been attending Mrs Robinson for four months, Dr Hinchliffe replied that it must have been for some cardiac reason and then added that it might have been for hypertension. However, she seemed to agree that hypertension is a risk factor for coronary thrombosis, but could not properly be described as a 'last illness'. Dr Hinchliffe then suggested that the last illness might have been angina. However, this was pure speculation.

16.38 Dr Hinchliffe was then asked how, if Shipman had been treating Mrs Robinson for hypertension and she had been found dead on the floor, having apparently died alone, it would have been possible for him rationally to conclude that her death was due to coronary thrombosis, as opposed to some other cause such as a cerebrovascular accident. Dr Hinchliffe was driven to suggest that Mrs Robinson might have had a previous coronary thrombosis and that the Form C doctor would have discussed all these problems with Shipman and resolved them.

16.39 This case clearly demonstrates that Dr Hinchliffe did not look at the 'whole picture' when reviewing the cremation forms and thus did not notice the inadequacy of the information upon which Shipman had apparently based his diagnosis of the cause of death. In seeking to provide explanations for what Shipman had written, she was driven, when giving evidence, into speculation and unwarranted assumption.

16.40 I shall also consider two sets of cremation forms completed by Shipman, which related to cases in which Dr Holme had authorised cremations. These are the cases of Mrs Elsie Godfrey and Mrs Mary Coutts.

Mrs Elsie Godfrey

16.41 Mrs Godfrey was found dead at her home on 8th May 1996, at the age of 85. According to the Form B completed by Shipman, she died at home at 6.30pm on 7th May. Shipman said that he had been her doctor for 19 years and had attended her for over six weeks during her last illness. He said that he had last seen her alive on 3rd May and had seen her body about 18 hours after death, which would have been at about 12.30pm on 8th May. Shipman stated that the cause of death was old age, with hypertension and diabetes mellitus being other conditions contributing to the death but not related to the immediate cause. Shipman said that the mode of death was **'syncope'** lasting **'seconds only'**. He said that Mrs Godfrey had been **'Found by warden dead in chair by body temp died 1830 7.5.96.'** He said that no one had nursed Mrs Godfrey in her last illness and no one had been present at the death.

16.42 According to the form, Mrs Godfrey had died of old age. That would imply a gradual decline and deterioration, leading to death. Yet, she had received no nursing care (although she was in warden-controlled accommodation) and had died alone. Moreover, Shipman claimed to have attended her for only six weeks during her 'last illness'. He had last seen her four days before her death, yet was able to say she had died of a **'syncope'** lasting **'seconds only'**. He was also apparently able, 18 hours after her death, to estimate the time of the death with accuracy.

16.43 When asked about the death, Dr Holme said that she would not have formed a picture of the circumstances of the death and would not have considered whether the diagnosis was correct. Nor did she think she would have noticed the attempt to estimate the time of death. Had she done so, she might have ascribed it to a 'rather old-fashioned doctor'.

Mrs Mary Coutts

16.44 Mrs Coutts died in April 1997, at the age of 80. According to the Form B completed by Shipman, she died at home at 2.15pm on 21st April. Shipman said that he had been her doctor for 15 years and had attended her for two hours during her last illness. He said that he had last seen her alive at about 1pm on the day of her death. He said that he had seen the body about an hour after death, which would have been at about 3.15pm. He stated that the cause of death was bronchopneumonia, with chronic lymphocytic leukaemia being a condition contributing to death but not related to the immediate cause.

16.45 Shipman went on to say that the mode of death had been **'syncope'** lasting **'minutes only'**. He recorded that the observations about the mode of death were his own and those

of neighbours. He also recorded that Mrs Coutts had been **'found by neighbour dead in chair'**. No one had nursed her during her last illness and no one had been present at her death.

16.46 According to the form, Shipman left Mrs Coutts about one and a quarter hours before her death from bronchopneumonia. She was not being nursed and she died alone. Given the short time which was to elapse before her death, and the nature of the condition from which she died, Mrs Coutts must have been very ill indeed when Shipman left her. Upon reading the form, one is left wondering how a doctor came to leave her in that state and what arrangements he had made for the support and care she must obviously have needed.

16.47 Again, Dr Holme said that she would not have marshalled the facts so as to provide the sort of picture which I have set out above. Therefore, it would not have occurred to her that there was anything abnormal about the contents of the form.

Examination by Other Medical Referees

16.48 The Inquiry invited two experienced medical referees, Dr Pledger and Dr Morgan, to examine a number of cremation forms relating to Shipman's patients. They were requested to do so as if they were viewing the forms in the course of their normal duties at their crematoria. They were asked, as far as possible, to put from their minds the knowledge that Shipman is a known murderer. I bear in mind that that is a difficult condition with which to comply. Nonetheless, I am satisfied that both made a genuine effort to examine the forms objectively. Both medical referees found many forms that contained inadequate information upon which to form a judgement about the basis on which the cause of death had been diagnosed. In some, there were internal inconsistencies. Of the 33 sets of Dr Hinchliffe's forms examined by Dr Pledger, he would have accepted six without further enquiry. He would have wished to speak to Shipman in the other 27 cases. He recognised that, if Shipman had given a satisfactory and plausible account of the medical background, he might well have authorised cremation. However, he thought that, in four of those 27 cases, his level of concern would have led him to consider ordering an autopsy. Of the 60 sets of forms examined by Dr Morgan, he would have wished to speak to Shipman for clarification of some point in 17 cases. He too recognised that Shipman might have reassured him about most of those cases. However, in two cases, he thought that his level of concern would have been such that he would have referred the death to the coroner.

Conclusions

16.49 Had Dr Hinchliffe undertaken a review of the forms so as to see the 'whole picture' and had she not always been prepared to assume (as she was when giving evidence to the Inquiry) that the Form C doctor had considered and been satisfied by Shipman's explanation for any *lacuna* or inconsistency in the information he had provided on Form B, she would have found it necessary to contact Shipman to discuss the content of Form B on many occasions. Although I have little doubt that Shipman would, on each occasion, have provided a plausible explanation for the cause of death he had given, I do not think that

Dr Hinchliffe could have failed to notice the frequency with which she had to contact him. I believe that, had it been her practice to scrutinise the 'whole picture', she would from time to time have had to contact other doctors besides Shipman. The Inquiry examined a large number of Forms B completed by other doctors practising in the Hyde area. From that examination, it appears to me most unlikely that Dr Hinchliffe would have had to contact any other doctor anything like as frequently as would have been necessary with Shipman.

The Failure to Recognise Unusual Features Apparent from the Forms

16.50 Shipman's Forms B showed that he was present at 42 deaths for which Dr Hinchliffe authorised the cremations. Her evidence about whether she had noticed that Shipman was often present at the deaths of his patients was somewhat confused. Initially, she said that she had not noticed this feature but that, if she had, she would have attributed it to her belief that he was an attentive doctor who was willing to visit his patients. Later, she said that she had noticed this feature and had attributed it to this belief. I think it unlikely that she had in fact noticed this feature at all.

16.51 Dr Hinchliffe also believes that she noticed the cluster of three deaths, which I have already mentioned, for which she authorised cremation on 13th March 1995. These were the deaths of Mrs Netta Ashcroft, Mrs Lily Bardsley and Mrs Maria West. Dr Hinchliffe does not appear to have noticed the common features of these deaths. They were all deaths at home, occurring in the presence of or very shortly after a visit from Shipman and all were sudden in nature; as a group, they were therefore very unusual. This was in stark contrast to the nine other cremations that Dr Hinchliffe authorised that day. Those deaths all occurred in a hospital or other institution. All nine had a cause of death that suggested a prior illness of some duration. By contrast, Shipman's three patients appeared to have died suddenly of coronary thrombosis or cardiovascular accident of short duration. Yet Dr Hinchliffe attributed this cluster of deaths to coincidence. I accept that coincidences do occur and I have already accepted that it might be a coincidence that three out of 12 deaths in one day had been certified by one doctor. However, if Dr Hinchliffe had considered the 'whole picture' of each death, she would surely have noticed that all three of Shipman's deaths were different from the other nine. If she had had any personal experience of dying patients, she would surely have realised that the circumstances of Shipman's three cases were most unusual.

16.52 In all the circumstances, it is not surprising that Dr Hinchliffe did not notice these features. As she was performing little more than a clerical check, her knowledge of each death would have been of a piecemeal nature, so that she would not readily have noticed the common features of the death. Had she been looking at the 'whole picture', it is possible that, in particular when clusters of deaths occurred, Dr Hinchliffe would have become aware that the deaths of Shipman's patients had unusual characteristics. However, having regard to her lack of experience of general practice or of patients who had died, it is also possible that she might not have appreciated that the characteristics were indeed unusual. She might have continued, for example, to attribute one of the most striking of such characteristics, presence at or shortly before death, to Shipman's habit of visiting his patients on demand.

16.53 As Deputy Medical Referee, Dr Holme did not deal with the same number or similar clusters of deaths. Shipman was present at or shortly before the deaths of 13 of the patients whose cremations she authorised. It is unlikely that she would have noticed the fact of Shipman's presence, or any other unusual characteristics of the deaths, for the same reasons as Dr Hinchliffe. In any event, she saw far fewer Shipman deaths and had a correspondingly smaller opportunity of observing their characteristics.

Other Medical Referees

16.54 The Inquiry also examined the forms relating to cremations of Shipman's patients that were authorised by other medical referees and deputy medical referees who officiated at the Dukinfield and Stockport crematoria. They dealt with few such deaths and even fewer cases where Shipman had killed. On the basis of their evidence, and the comments of Dr Pledger and Dr Morgan, who had looked at the forms, I did not regard it as appropriate to level any criticism against those referees in respect of the cremations which they authorised. I did note that one of them described in his Inquiry statement how he had reported deaths to the coroner on a number of occasions, usually because the deceased had undergone an operation shortly before death. On one occasion, he reported a death because he suspected (correctly, as it turned out) that the deceased had committed suicide.

16.55 The Inquiry conducted some very small-scale research into the performance of medical referees at other crematoria. Cremation forms covering two periods of three months were obtained from four crematoria. Analysis of those forms showed that, at three of the four crematoria, no notes made by medical referees on Forms B related to queries about the cause of death. Whilst the Forms B were generally completed to a reasonably good standard, the fact that no questions about the cause of death were raised, even in those cases where the picture was not completely clear or consistent, suggests that the medical referee concerned may not have adopted a very critical or enquiring approach.

Conclusions

16.56 I have already referred to the limited amount of information contained on completed cremation forms. However, it is usually possible to gain some impression of the circumstances of the death, based on the information provided by the Form B doctor. Neither Dr Hinchliffe nor Dr Holme undertook any assessment of the 'whole picture' presented by the cremation forms. Dr Hinchliffe claimed that she did but I have rejected her evidence. Dr Holme never claimed to have done so.

16.57 Had either of them done so, they would have found many Forms B in which the information provided by Shipman was inadequate or inconsistent. For Dr Hinchliffe, in particular, this would have meant that it was quite often necessary for her to speak to him to clarify the picture. Dr Hinchliffe would have found it necessary to speak to him considerably more often than she had to speak to other general practitioners.

16.58 Had Dr Hinchliffe carried out such an assessment and had she had the benefit of a more appropriate medical background, including greater experience of general practice, she

would have realised that there were unusual features among the deaths of Shipman's patients. In particular, I think she would have probably noticed the common features of the three sets of forms that she examined on 13th March 1995.

16.59 I have already said that I am reluctant to criticise either of these medical referees for the way in which they approached their duties. Nor can I criticise them personally for their lack of relevant medical experience. It was the fault of the system that they were appointed, despite such lack of experience. They were not given any formal training or even provided with a handbook of advice. The only instruction available was from the previous Medical Referee. It may well be that Dr Thomas Holme was under the same misapprehension about his role and passed this on to Dr Hinchliffe, who in turn passed it to Dr Jane Holme. There was no contact with other medical referees, with consequent absence of the means of learning that others might be carrying out the job differently and more effectively elsewhere. Further, the circumstances in which the job was performed, especially the pressure created by timing, encouraged the feeling that the job was a straightforward clerical exercise with the minimum of enquiry needed.

16.60 The evidence available to the Inquiry suggests that there are medical referees who perform their duties as they ought and who use their powers to institute appropriate enquiries and even to order autopsies on occasions. However, it appears that there are many (possibly the majority) who are not so active. This was certainly the view of the Brodrick Committee. The results of the survey conducted by the Home and Health Department of the Scottish Office in 1994/5, to which I have referred in Chapter Three, suggested that medical referees in Scotland were not performing to a high standard. There is no reason to suppose that practice has been any better south of the border. This is not surprising, given the lack of training or guidance and the isolation in which medical referees operate.

16.61 I conclude that, whilst the performance of Dr Hinchliffe, and (to a lesser extent) Dr Holme, fell short of that which might have been expected from the best of their colleagues, it is unlikely to have been significantly different from that of many other medical referees in England and Wales.

16.62 Had Dr Hinchliffe and Dr Holme had the benefit of relevant medical experience and had they realised that they were expected to undertake a careful assessment of the forms, they would have found inadequacies and inconsistencies in many of them. This should have led them to question Shipman. It is highly likely that, in any given case, he would have been able to proffer an explanation which would have satisfied them, just as it had already satisfied the Form C doctor. However, had there been a repeated need to contact Shipman and to ask similar questions in relation to cases with similar characteristics, this might well have led to concerns about his competence to complete the forms, possibly about his competence as a doctor and possibly even as to his honesty. Repeated questions directed at him might have acted to deter him from pursuing his criminal activities. However, the real possibility exists that he would merely have become more careful, would have modified his form-filling techniques to meet the requirements of the medical referees and would have thus ensured that his deaths passed through the system without question. He would have known that he could enter false information on the forms

at little risk of any cross-check being made as to the accuracy or truth of that information. Even had the medical referees exercised their power to order an autopsy, or referred a death to the coroner for him to do so, it would not have revealed evidence of criminal activity in the absence of toxicological tests.

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