CHAPTER FOUR

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

Introduction

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

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

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

The Role of the Ambulance Service

The Greater Manchester Ambulance Service

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

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

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

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

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

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

Ambulance Services in Other Areas

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

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

Police Attendance at the Scene of a Death

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

Initiation of a Report

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Police Attitudes Towards Attendance at the Scene of a Death

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

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

The Standard of the Initial Scene Investigation

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

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

Record Keeping

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

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

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

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

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

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

Guidance from the British Medical Association

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

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

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

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

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

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

Practice in Different Areas

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

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

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

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

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

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

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

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

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

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

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

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

The Need for Clarity

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

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

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

Further Involvement of the Police

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

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

Sudden Death Report Forms

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Skills and Expertise

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

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

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

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

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

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

Police Resources

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

Other Considerations

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

Is There a Need for Police Involvement in All Deaths?

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

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

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

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

Conclusions

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

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