CHAPTER FIVE

Medical Certification of the Cause of Death

The Existing System

The Duty of the Attending Doctor to Complete a Medical Certificate of Cause of Death

5.1 The systems of certification of the medical cause of death and the registration of deaths remain much the same now as they were in 1927. The law is now governed by the Births and Deaths Registration Act 1953.

5.2 Before a death can be registered, the cause of death must be certified by a registered medical practitioner who has **'attended'** the deceased during his/her **'last illness'**; alternatively, the death must have been reported to the coroner and the appropriate certificate provided by him/her. There is no statutory definition of the terms **'attended'** or **'last illness'**.

5.3 Once a death occurs, it becomes important to identify the cause of the death. Apart from cases in which an inquest has been opened and the coroner gives specific authorisation, it is only when the cause of death has been certified that burial or cremation of the body can take place. The individual most likely to be able accurately to identify the cause of death is the doctor with the best knowledge of the deceased's medical history, in particular the history during the days and weeks immediately preceding death. In the case of a death occurring in the community, this will usually be the deceased's general practitioner; where a death occurs in hospital, it will usually be a member of the medical team responsible for the deceased's care prior to death.

5.4 Section 22(1) of the Births and Deaths Registration Act 1953 requires that:

> **'In the case of the death of any person who has been attended during his last illness by a registered medical practitioner, that practitioner shall sign a certificate in the prescribed form stating to the best of his knowledge and belief the cause of death ...'**.

5.5 This section imposes on the doctor who has **'attended'** the deceased during the **'last illness'** a duty to issue an MCCD whether or not s/he can identify the cause of death. This is not sensible and, in practice, doctors issue an MCCD only if they can identify the cause of death with sufficient confidence. If they cannot, they report the death to the coroner. There is no statutory duty upon a doctor to make such a report, but there is a common law duty on every citizen to give information which may lead to the coroner having notice of circumstances requiring the holding of an inquest. Doctors now regard it as a professional duty to report a death to the coroner if they are insufficiently certain of the cause or are aware of other reasons why the death should be reported.

5.6 One of the most common reasons for a doctor to report a death to the coroner arises from the so-called 14-day rule, which I have called the 'either/or rule'. Regulation 41 of the Registration of Births and Deaths Regulations 1987, which in this respect is in the same terms as the Registration (Births, Stillbirths, Deaths and Marriages) Consolidated

Regulations 1927, imposes on the registrar a duty to report to the coroner any death where it appears that the medical practitioner who has issued the MCCD had not either seen the deceased within 14 days before death or seen the body after death. It appears that the rule is widely misunderstood by medical practitioners, many of whom believe that they are obliged to report a death to the coroner if they have not seen the deceased within 14 days before death, regardless of whether or not they have seen the body after death.

Completion of the Medical Certificate of Cause of Death

5.7 The form of the MCCD is prescribed by the 1987 Regulations. Books of MCCDs are issued by local registrars of births and deaths to general practices, hospital wards or departments and, sometimes, to individual general practitioners. MCCDs are supplied in a book rather like a large cheque book. When a doctor has completed a certificate, s/he tears it out of the book. He or she is then left with a counterfoil in the book on which s/he records details of the certificate s/he has completed. Each book also contains notes, giving detailed guidance on completion of the certificates. Different forms of certificate are supplied for use in the case of a neonatal death or stillbirth; I shall confine my description to the certificate prescribed for use in the case of a death occurring after the first 28 days of life (Form 66). A blank MCCD can be seen at Appendix B of this Report.

5.8 The MCCD requires the doctor to state the name and place of death of the deceased, the date of the death and the deceased's age, as stated to the doctor, and the date on which the doctor last saw the deceased alive. The doctor is also required to circle the number preceding one of the statements from the following group:

> **'1. The certified cause of death takes account of information obtained from post-mortem.**
> **2. Information from post-mortem may be available later.**
> **3. Post-mortem not being held.**
> **4. I have reported this death to the Coroner for further action.'**

5.9 The first three statements refer to the possibility that a 'hospital' post-mortem examination (i.e. a post-mortem examination carried out for medical reasons with the consent of the next of kin and not pursuant to an order of a coroner) may have taken place or be planned for the future. In the majority of cases, the doctor will circle **'3'**, i.e. **'Post-mortem not being held'**.

5.10 Then, the certifying doctor must circle the letter preceding one of a further three statements, namely:

> **'a. Seen after death by me.**
> **b. Seen after death by another medical practitioner but not by me.**
> **c. Not seen after death by a medical practitioner.'**

5.11 In the majority of cases, the certifying doctor will circle **'a'** or **'b'**, i.e. **'Seen after death by me'** or **'Seen after death by another medical practitioner but not by me'**. In a relatively few cases, the answer will indicate that the deceased was not seen after death by any medical practitioner.

5.12 The doctor must then state the cause of death, listing the disease(s) or condition(s) that caused the death, in order of immediacy to the death itself. The chain of causation must be set out in accordance with World Health Organisation guidelines. Under Part I(a), the doctor should record the most immediate cause of death. At I(b), s/he should go on to identify the disease or condition that led to the immediate cause of death. If the doctor considers that there is a further link in the chain of causation, the relevant disease or condition providing that link should be recorded at I(c). By way of example, if the death had been precipitated by a brain haemorrhage, which resulted from cancer-related secondaries in the brain, caused in turn by a primary carcinoma of the lung, the cause of death should be set out as follows:

CAUSE OF DEATH

The condition thought to be the 'Underlying Cause of Death' should appear in the lowest completed line of Part I.

I	(a)	Disease or condition directly leading to death ……..	Intracerebral haemorrhage ……..
	(b)	Other condition, if any, leading to I(a) ……..	Cerebral metastases ……..
	(c)	Other disease or condition, if any, leading to I(b) ……..……..	Squamous cell carcinoma of the left main bronchus
II		Other significant conditions CONTRIBUTING TO THE DEATH but not related to the disease or condition …… causing it ……	Diabetes mellitus……

5.13 The guidance contained in the book of MCCDs states that the statement of cause of death should be as specific as possible. Hence, in the example above, the site of the primary tumour (the left main bronchus) is specified, in addition to details of the histology (squamous cell). Diabetes mellitus is identified in Part II as a condition that has contributed to the death but was not part of the main causal sequence leading to death. The guidance notes contained in the book of MCCDs make the point that Part II should not be used to list all the medical conditions from which the deceased person suffered at the time of his/her death; only those which played a part in causing the death, perhaps by hastening it, should be included. If there is only one condition that led to the death, with no antecedents, it is acceptable to identify only one cause of death (e.g. 'I(a) subarachnoid haemorrhage').

5.14 The guidance notes remind doctors that it is not acceptable to state as the only cause of death a mode of dying (e.g. heart failure). This gives no indication as to why the patient died and, if it is stated on the MCCD, should result in the death being referred to the coroner by the registrar. An underlying cause of death (e.g. myocardial infarction) must

be given. A list of terms that imply a mode of dying, rather than the cause of death, is set out in the guidance notes.

5.15 The MCCD also seeks information about the approximate interval that elapsed between the onset of each condition identified in the 'Cause of Death' section of the certificate. This information is not entered in the register of deaths (although it is valuable for statistical purposes) and provision of the information is not obligatory. As a consequence, this information is, the Inquiry was told, rarely provided.

5.16 Where the certifying doctor believes that the death was or might have been directly contributed to by the employment followed at some time by the deceased, s/he is required to tick the 'Spearing box'. Some employment-related causes of death are listed on the reverse side of the MCCD and a more detailed list appears in the guidance notes.

5.17 The certifying doctor is required to declare:

> **'I hereby certify that I was in medical attendance during the above named deceased's last illness, and that the particulars and cause of death above written are true to the best of my knowledge and belief.'**

5.18 He or she must then sign the form and state his/her qualifications, as registered with the General Medical Council. In the case of a hospital death, the name of the consultant responsible for the care of the patient must also be given.

Delivery of the Medical Certificate of Cause of Death to the Registrar

5.19 Having completed the MCCD, the doctor is then obliged to deliver to a **'qualified informant'** notice in writing that a certificate has been signed. Those persons qualified to give information for the registration of a death are specified in section 16 (where the death occurred in a house) and section 17 (other deaths) of the Births and Deaths Registration Act 1953. Usually, the informant will be the nearest surviving relative of the deceased or, if there are no relatives, the person who is making the funeral arrangements. The Act requires that the doctor completing the MCCD shall **'forthwith deliver that certificate to the registrar'**. In practice, this does not happen. Instead, the doctor hands over the MCCD (usually in a sealed envelope) to the informant or some other family member. The informant then delivers the MCCD, usually still in its envelope, to the registrar, at the same time as attending to fulfil his/her duty to report the death to the registrar for births and deaths for the sub-district in which the death occurred.

The Purposes of the System

5.20 There are three main purposes to be served by a modern system of certification and registration of deaths. One is to provide an accurate record of deaths for administrative purposes. Another is to identify, as accurately as is practicable, the cause of each death. This information is needed for the purposes of medical research and for the allocation of the resources of the National Health Service. A third is that the system should provide a safeguard against the concealment of homicide and neglect leading to death. This third purpose should be served in two related ways: first, by providing a deterrent against crime

or neglect before it takes place and, second, by providing a means of detecting crime or neglect that has already occurred.

5.21 The first of these purposes is satisfactorily achieved by the procedure of registering the death. The evidence received by the Inquiry shows that the second objective is achieved by the present system to a reasonable degree of satisfaction. Dr Cleone Rooney, a medical epidemiologist employed by the Office for National Statistics (ONS), the body responsible for the collation of data relating to causes of death, said that, although the information relating to causes of death is not entirely accurate, the present arrangements achieve enough accuracy and consistency for the purposes to which the ONS put the statistics. That is not to say that the ONS is not always anxious to improve the accuracy of information provided and to improve the speed at which the information becomes available. However, it is in respect of the third purpose that the present system is seen to have failed, in that it did not deter Shipman from killing patients over a period of 24 years; nor did it detect that he had killed any of his 215 victims.

The Strengths and Weaknesses of the System

5.22 In considering the strengths and weaknesses of the current system, I am dealing only with the system of certification, registration and reporting to the coroner that applies to all deaths, regardless of the method by which the family chooses to dispose of the body. As will already be apparent from Chapter Three, a separate system of certification applies to deaths to be followed by cremation; this imposes additional requirements. I shall consider that system further in Chapter Eleven.

The Advantages of the Present Arrangements

5.23 The present arrangements for death certification and registration have three very real advantages. They are speedy, cheap and convenient. Usually, the doctor who is going to issue the MCCD will do so within a very short time of the death. As the doctor has treated the patient during the last illness, s/he should be familiar with the medical history and the task of completing the MCCD should take only a few minutes. Most doctors will be able to complete the certificate and give it to a relative within about a day of the death. The doctor is not permitted to charge a fee for the issue of the MCCD, so there is no expense to the family. Registration is not usually inconvenient, at least for relatives who live in the same area as the deceased. The register office is open every weekday and the informant may, if s/he wishes, attend without appointment. Registration is free, although there is a charge for the certified copies of the entry in the register that will be needed to settle the deceased's financial affairs. As was apparent with many of the deaths examined by the Inquiry, it is often possible to register a death within a day or two of its occurrence. Sometimes, there is a delay if the certifying doctor is off duty or decides that s/he wishes to discuss the case with the coroner. If the death is reported to the coroner, an autopsy may result in some delay in registration. However, in the majority of cases where the doctor issues an MCCD, the formalities proceed quite smoothly. In some areas, registrars provide a special weekend service for members of minority religious groups who wish to bury their dead very shortly after death.

The Main Weakness: Dependence on a Single Medical Practitioner

5.24 The very feature that gives rise to the advantages to which I have just referred also gives rise to the major weakness, namely dependence on a single medical practitioner. Only about 38% of deaths are reported to the coroner. All other deaths are registered on the basis of an MCCD issued by a single doctor, who certifies the cause of death, saying that s/he has attended the deceased in the last illness, and provides the cause of death **'to the best of** [*his/her*] **knowledge and belief'**. If the MCCD is in order, that is, if it appears to the registrar that the certificate has been properly completed by a doctor who appears to be qualified to issue it and that the cause of death is acceptable, the death will be registered.

5.25 A doctor's decision as to whether or not s/he should report a death to the coroner or can properly certify the cause of the death is a matter for the doctor. If s/he decides to issue an MCCD and not to report the death, the decision is subject to very little check or control. Despite the recommendations of the Brodrick Committee in 1971 that there should be, there is still no statutory duty upon a doctor to report any death to the coroner. Provided that the doctor completes the MCCD fully and in appropriate terms, there is no check on the truth or accuracy of what s/he states. The registrar is under a duty to report certain classes of case to the coroner. However, in practice, as I shall explain in Chapter Six, the registrar has very little opportunity to discover whether or not the death should be reported. Similarly, although it is open to any member of the public to report a death to the coroner, this only rarely happens in practice. Many people do not even know that it is open to them to make such a report, let alone that they have a common law duty to do so in certain circumstances. Even if they did, most people would not challenge the word of a doctor who said that it was not necessary to report a death.

5.26 It follows that the present system depends almost entirely on the good faith and judgement of the doctor who signs the MCCD or decides that the case should be reported to the coroner. It also depends on the courage and independence of doctors, for the system places upon them some responsibility to police their colleagues, for example by refusing to certify a death which may have been contributed to by some misconduct, lack of care or medical error on the part of a professional colleague. It may not be easy for a junior member of the clinical team responsible for the care of the deceased to withstand the expectation that s/he will certify the cause of death, rather than report the case to the coroner for investigation.

5.27 So long as doctors do their best, in good faith, to report those cases where they are insufficiently sure of the cause of death and are vigilant in respect of signs of criminality or neglect by others, including other members of the medical profession, the present system should work. I have no doubt that the great majority of doctors perform their duties of certification conscientiously.

5.28 However, because it depends so heavily on the good faith, judgement, courage and independence of the certifying doctor, the present system of certification and registration does not provide adequate protection against the concealment of homicide by the certifying doctor him/herself. That Shipman was able to kill so many times, without triggering any alarm bells within the system, is proof of that. It is often said that there will

never be 'another Shipman' and that the system should not be changed radically just because of him. However, we have no means of knowing how many cases of homicide by doctors and other health professionals remain undiscovered. Nor do we know how many medical errors or incidents of misconduct or neglect leading to death go undetected. Ideally, the system of certification should reveal this sort of incident. In my view, that ideal is not achievable in every case. However, the system can and should be more robust than at present.

The Paucity of Information Contained in the Completed Medical Certificate of Cause of Death

5.29 In my opinion, one of the major shortcomings of the existing system of death certification is that the MCCD requires the provision of so little information. It does not call for a summary of the relevant medical history or even a brief account of the events leading to death. It requires only a bare statement of the cause of death. There is, to the right of the 'Cause of Death' box, an opportunity for the doctor to state, if s/he wishes, the period of time that has elapsed since the onset of the conditions advanced as causes of death. If that information is provided, it gives some limited insight into the deceased's medical history. However, it is often not provided. The MCCD calls for much less information than cremation Form B.

5.30 During Phase One of the Inquiry, I became aware that, in a case where the deceased had been buried and there was therefore no cremation Form B, there was no available record of any account by Shipman of the deceased's medical history or of the events leading to the death. The MCCD would provide the date on which Shipman claimed to have last seen the deceased before death but that was all the information available. Thus, even if the registrar possessed the knowledge necessary to evaluate the medical information contained on the MCCD, no history is provided. If a death is reported to the coroner, s/he has no written account of the history, only the note made over the telephone during the doctor's oral report to the coroner's officer. Although a clear medical history should be available in the medical records, this is not always the case. Often there is no account of the circumstances of the death. In any event, the medical records are not available either to the registrar or to the coroner when s/he is considering whether to take the case over or to invite the doctor to issue an MCCD.

5.31 In my view, any certificate of medical opinion concerning the cause of death should contain a short history, focussed on the condition which the doctor believes has caused the death. Such an account, including the main features of the chain of events leading to death, would serve several useful purposes. First, it would clarify the doctor's own thought processes about the underlying causes of death. Second, it would facilitate a professional evaluation of the opinion by another doctor or by a coroner. Third, if discussed with the next of kin or a family member who knew the deceased, it would prevent or deter the advancement of a false account. Indeed, I believe that, if Shipman had had to provide such an account, knowing that the family of the deceased would become aware of it, this would have been a real deterrent. Even if he had not been deterred, I think it likely that, sooner or later, discrepancies between the account he had given and what the relatives

knew to be the case would have led to enquiries being made into the circumstances of some of the deaths.

The Uncertainty about the Meaning of 'Attendance During the Last Illness'

5.32 Another shortcoming of the MCCD is the uncertainty that arises in respect of the essential qualification before a doctor may issue. This is that s/he was **'in medical attendance'** on the deceased during the **'last illness'**. The **'last illness'** is not defined and its interpretation gives rise to uncertainty. In her witness statement, Dr Rooney told the Inquiry that the basic principle is that, in order to be qualified to sign, the doctor should have been directly involved in the medical care of the patient in connection with the illness which led to the death. He or she need not have been solely responsible. Care might have been shared with other members of the clinical team in hospital or with a partner in general practice. Even a locum general practitioner may be able to issue the certificate. Dr Rooney said that the doctor could not be said to have been attending the patient **'during his last illness'** unless s/he had diagnosed the illness leading to death before the death occurred and was giving treatment or advice in respect of that condition.

5.33 It may well be that the overwhelming majority of doctors abide by these principles. However, I note that they are not explained as part of the guidance given to doctors on completion of the MCCD. I think that many doctors do not regard it as necessary to have diagnosed the potentially fatal condition before death. Many elderly people die with a variety of conditions, any one of which could lead to death. Examples are ischaemic heart disease, congestive heart failure and hypertension. However, such conditions are often treatable and are controlled by medication. The patient might live for many years with such a condition and then might die after only a brief deterioration. In many such cases, there is no identifiable **'last illness'**. I have the impression that many doctors, wishing to issue an MCCD, feel entitled to say that they have attended the deceased during the last illness if they are the patient's usual doctor. It is undesirable that a doctor should certify that s/he has attended a patient in the **'last illness'** if there is no identifiable last illness.

The Uncertainty about the Degree of Confidence Needed before Certifying the Cause of Death

5.34 A further shortcoming of the MCCD is that it is not clear how confident a doctor must be of the cause of death before s/he should feel able to issue an MCCD and submit it to the registrar, without drawing attention to any uncertainty as to the cause. As I have said, the doctor who has attended the deceased during the last illness is under a statutory duty to issue an MCCD stating the cause of death to the best of his/her knowledge and belief. Most doctors who feel insufficiently confident of the cause of death decline to certify and instead refer the death to the coroner. The statutory requirement imposes on the doctor a duty of good faith, but does not provide any guidance as to the necessary degree of confidence. No guidance is provided for the doctor in the notes contained in the book of MCCDs. Dr Rooney told the Inquiry that the doctor should be **'reasonably sure'** of the cause of death, but the Inquiry has not been referred to any official documents in which that advice is promulgated. In any event, that expression is not clear.

5.35 Nor is the doctor explicitly required to exercise his/her own professional judgement. The MCCD does not require the doctor to state the sources of his/her knowledge and belief. A doctor might issue an MCCD after a very brief personal contact with the patient, believing that what another doctor has told him/her about the patient's condition is true, but not exercising his/her own judgement.

5.36 Evidence given to the Inquiry suggests that there is much uncertainty about the standard of confidence required before a doctor should issue an MCCD. Opinions and practices vary. Some doctors say that they feel able to sign if they think that they know the probable cause of death. Others are unwilling to sign unless they feel a much higher degree of confidence. It is worth mentioning that, according to the evidence of the registrars from whom I heard, if a doctor reveals that s/he is relying on a 'probable' cause of death, the registrar will reject the MCCD on the ground that the cause of death appears to be 'unknown'.

5.37 It was suggested in evidence that good practice requires that the standard of confidence appropriate for the diagnosis of a cause of death should be the same degree of confidence that the doctor would apply when diagnosing the condition of a live patient. That may be a variable standard, depending on the nature of the condition and the treatment contemplated. However, this suggests that the standard of confidence should be higher than the mere balance of probabilities.

5.38 In my view, the existing requirement (to state the cause of death **'to the best of** [*the doctor's*] **knowledge and belief'**) is unacceptably vague. I have already mentioned that the Brodrick Committee recommended that the doctor should be required to certify the cause of death **'with accuracy and precision'**. It appears to me that that suggested an unrealistically high standard. However, I agree with the Brodrick Committee that a standard of confidence for certification should be imposed. I shall discuss what that standard should be later in this Report. One of the difficulties about certification by doctors is that of training them to assess whether the appropriate standard has been reached in any particular case. Many doctors certify a cause of death only a few times each year. Any skill that is not practised regularly is likely to decline.

Inappropriate Attitudes to Certification of the Cause of Death

5.39 Uncertainty about the degree of confidence required before a doctor should issue the MCCD may be the reason why certain doctors appear to think that their duty of certification is to some extent discretionary. Mr Christopher Dorries, HM Coroner for South Yorkshire (West), drew attention to a study published in 1993[1], which reported that 18.5% of general practitioners admitted that they might **'modify'** what they considered to be the true cause of death in order not to distress relatives. Just over 17% of general practitioners might make a similar modification so as not to involve the coroner. In research[2] in which Mr Dorries himself was involved, two doctors admitted that they would record a natural cause of death rather than report a case of potential suicide to the coroner, so as to avoid

[1] Maudsley, G and Williams, EMI (1993) 'Death certification by House Officers and General Practitioners – practice and performance', Journal of Public Health Medicine, Vol 15, No 2, pp 192–201.

[2] Start, RD, Usherwood, TP, Carter, N, Dorries, CP, Cotton, DWK (1995) 'General practitioners' knowledge of when to refer deaths to a coroner', British Journal of General Practice, April 1995, pp 191–193.

financial loss to the family. Mr Dorries and Mr Michael Burgess (HM Coroner for Surrey), both experienced coroners, suggested that some doctors certify the cause of death, even though they are doubtful about it, because they wish to save the family distress.

5.40 It appears that doctors may sometimes be put under pressure, either expressly or implicitly, by the relatives of the deceased to issue a certificate, even though they are in doubt about the cause of death. Families are often worried by the thought that the death may have to be reported to the coroner and may be distressed at the thought of an autopsy. On the other hand, the doctor should realise that, if s/he certifies a cause of death without a sufficient degree of confidence, the certificate is of little value and the rigour of the system of certification is undermined.

5.41 The Inquiry has not heard evidence from any doctor who admits that s/he is less than conscientious in the performance of his/her duty of certification. I would not expect to hear such an open admission. Nonetheless, I think it likely that such practices occur, although only with a minority of doctors. The research tends to confirm this view.

The Poor Quality of Certification and Lack of Training

5.42 Even though the requirements of the existing MCCD are very limited, it appears that some doctors have difficulty in completing it satisfactorily. Many doctors receive no advice on their duties of death certification during training although, for some, a lecture might be available. General practitioners usually receive some guidance during their vocational training. Hospital doctors, in their pre-registration year, are often expected to complete MCCDs with very little help from their senior colleagues. This is despite the guidance contained in the book of MCCDs which states:

> **'Death certification should preferably be carried out by a consultant or other senior clinician. Delegation of this duty to a junior doctor who was also in attendance should only occur if he/she is closely supervised.'**

5.43 Several witnesses told the Inquiry that, when the new twice-yearly intake of house officers arrives at the local hospital, there is a noticeable (albeit temporary) decline in the standard of certification. Mr Dorries said that he believes that hospital bereavement officers (who are not medically qualified) often have to advise doctors who are about to issue an MCCD that the death is one which ought to be reported to the coroner. He said that doctors who come to this country already qualified as medical practitioners, with no knowledge of our legal requirements, are not tested on their understanding of what is required in death certification.

5.44 The poor quality of death certification has been regularly illustrated by research conducted over the years. Research conducted recently[3] confirms that standards of death certification are still poor. Of 1000 completed MCCDs examined, only 55% were of an acceptable standard. Nearly 10% were very poor, being illogically or inappropriately completed. This research was conducted at a teaching hospital, where standards might be expected to be higher than elsewhere. In a useful review of death certification

[3] Swift, B and West, K (2002) 'Death Certification: an audit of practice entering the 21st century', Journal of Clinical Pathology, No 55, pp 275–279.

practice[4], the authors point out that education is frequently suggested as a mechanism for improving the accuracy of death certification. However, the evidence for its efficacy is sparse and not encouraging[5,6], prompting Dr Ryk James, a forensic pathologist who participated in one of the Inquiry's seminars, to conclude[7] that **'there is no ''quick fix'' for the problem'** and that even postgraduate education programmes might not result in significant improvement, assuming there was a will to institute such programmes. This view is also expressed in the article by Swift and West (see above) who observed that death certification practice had not improved despite the introduction of formal education on certification into the medical student curriculum in one UK medical school.

5.45 In my view, the completion of an MCCD is an important duty, a fact which, in the past, has received insufficient recognition from the profession and from those responsible for medical training. Moreover, there is no system of audit or review of doctors' performance of their duties in connection with death certification.

Reporting a Death to the Coroner

Difficulty in Recognising Reportable Deaths

5.46 As I have said, doctors have voluntarily assumed the primary responsibility for reporting deaths to the coroner. Many such reports are made because the doctor is uncertain about the cause of death. However, even if the doctor is quite satisfied as to the cause of death, s/he should also consider whether the death is reportable for some other reason. Because there is no statutory duty on the doctor, there is no statutory list of reportable deaths for the doctor to consult. Guidance, in the form of a list of circumstances in which a death must be reported, is provided in the book of MCCDs issued to doctors. Some coroners issue a list of the types of case that they require to be reported. These lists are broadly based on regulation 41 of the Registration of Births and Deaths Regulations 1987, which governs the categories of death that the registrar is obliged to report to the coroner: see paragraph 6.12. However, some coroners extend the scope of their lists beyond the provisions of the regulation and seek to impose additional 'local rules'. Different lists are in circulation in different coroners' districts. Doctors usually seek to comply with the wishes of their local coroner, but do not always succeed as well as they should. Particular difficulties are experienced when a doctor moves from one coroner's jurisdiction to that of another.

5.47 Studies by Dr Roger Start, a consultant histopathologist who participated in one of the Inquiry's seminars, and others (including Mr Dorries), undertaken in 1993 and 1995,[8] showed that both general practitioners and hospital doctors had difficulty in recognising the circumstances in which a death should be reported to the coroner. In the 1993 study,

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[4] Maudsley, G, Williams, G, Williams, EMI (1996) 'Inaccuracy in death certification. Where are we now?', Journal of Public Health Medicine, Vol 18, No 1, pp 59–66.
[5] Weeramanthri, T, Beresford, W, Sathiananthran, V (1993) 'An evaluation of an education intervention to improve death certification practice', Australian Clinical Review, No 13, pp 185–189.
[6] Pain, CH, Aylia, P, Taub, NA *et al.* (1996) 'Death certification: production and evaluation of a training video', Medical Education, No 30, pp 434–439.
[7] James, DS, Bull, AD (1996) 'Information on death certificates: cause for concern?', Journal of Clinical Pathology, 1996, No 49, pp 213–216.
[8] Start, RD, Delargy-Aziz, Y, Dorries, CP, Silcocks, PB, Cotton, DWK (1993) 'Clinicians and the coronial system: ability of clinicians to recognise reportable deaths', British Medical Journal, Vol 306, 17th April 1993, pp 1038–1041; Start *et al.* 'General practitioners' knowledge of when to refer deaths to a coroner' (see footnote 2, p. 121).

135 clinicians of various grades from the general medical and surgical firms of a large teaching hospital considered 16 fictitious case histories. Fourteen of the histories contained a clear indication for referral to the coroner. The clinicians were asked to decide whether the case should be referred and to give reasons. The case histories were also considered by two coroner's officers and two deputy coroners from Mr Dorries' office in Sheffield. The study found that the average percentage of correct answers for clinicians in each grade was between 56% and 69%. Consultants fared slightly worse than house officers. Senior registrars were the most successful. By way of example, 20 out of 34 consultants failed to recognise the need to report the death of a 49 year old paraplegic who had suffered spinal injuries in an accident at work 15 years earlier. He had been transferred from the spinal injuries unit suffering from septicaemia resulting from infected sacral sores. Despite treatment, he developed a chest infection and died. The death should have been reported, as the cause was plainly related to the spinal injuries sustained in an accident at work.

5.48 If this pattern of poor recognition were to be repeated in practice, it would suggest that many deaths that ought to be reported to the coroner are not. It was noted that clinicians appeared to have the greatest difficulty in recognising when to report a death associated with medical treatment. The coroner's officers and deputy coroners all identified correctly the reportable cases. Although Dr Start and his colleagues did not draw this express conclusion, it is apparent to me that the reason for this is that they are dealing with the relevant issues regularly day after day, whereas any clinician will apply his/her mind to the problem less frequently.

5.49 In the 1995 study, 196 general practitioners, two coroner's officers and two deputy coroners considered 12 fictitious case histories, ten of which contained an indication for referral to the coroner. On average, the general practitioners scored just over 70%, a rather better result than the hospital clinicians. Only six general practitioners achieved a maximum score. Fifteen and a half per cent recognised half, or fewer than half, of the reportable cases. Again, the coroner's officers and deputy coroners all achieved full marks. Mr Dorries told the Inquiry that there was no reason to suppose that doctors would perform any better today than they had done in 1993 and 1995.

5.50 The Inquiry has heard that some doctors never report a death to the coroner. It seems unlikely that this is because no death certified by them ever comes within the categories of reportable deaths. It is more likely that the doctor does not know which deaths should be reported or does know but is seeking to spare families the ordeal of a report to the coroner and a possible autopsy. It may be that the doctor has personal objections to the autopsy process.

5.51 On examination of a random selection of registrars' referrals to the South Manchester Coroner's office, the Inquiry came across an example of a doctor's failure to refer an obviously reportable case to the coroner. A young man attempted suicide by taking an overdose of insulin. The police investigated and found a note. The man was admitted to hospital, where he survived for some weeks in a coma. When he died, a hospital doctor certified that the death was caused by I(a) right basal pneumonia, (b) persistent vegetative state and II Type 1 diabetes mellitus with insulin overdose and hypoglycaemic

brain injury. The registrar queried the MCCD because of the inclusion of the words **'overdose'** and **'injury'**. The informant, the deceased's sister, told the registrar about the attempt at suicide and the subsequent investigation. The registrar reported the death to the coroner. A member of the coroner's staff spoke to the doctor and asked him why he had certified the death and had not reported it to the coroner. His response was that he had done nothing wrong. The deceased had died of pneumonia, which was a natural cause. Plainly, that doctor had no understanding at all of the circumstances in which a death should be reported to the coroner. Another example was provided by Dr Richard Hardman, Medical Referee at Stockport crematorium since 1990. He received cremation forms which revealed that the deceased had been found dead in his car. The cause of death was said to be asphyxia. Suspecting that the deceased might have committed suicide, Dr Hardman reported the death to the coroner. After an autopsy and inquest, a verdict of suicide was entered. Yet a doctor had been prepared to certify the cause of death without referring the death to the coroner, which was obviously the proper course in the circumstances.

5.52 There is no system of audit or review of those cases where the doctor certifies the cause of death and does not report the death to the coroner. The cases that I have referred to above only came to light because words indicative of an unnatural death were used in the 'Cause of Death' section of the MCCD. There may be many cases where there is no such automatic trigger and where a death that should have been reported to the coroner goes undetected. If that happens, and the deceased is to be buried, there is no subsequent procedure that would bring to light a failure to report. If the death is to be followed by cremation, it is possible that the failure might be revealed by the cremation certification procedures. However, as I shall explain in Chapter Eleven, this may well not be the case.

5.53 I conclude that the present arrangements whereby, in practice, doctors decide whether or not to report a death to the coroner, are not satisfactory. From the research, it would appear that more reliable decisions would result if coroners or coroner's officers, who deal with the issue of reportability on a daily basis, were responsible for this process. However, I recognise that the coroner's officers from Sheffield, who took part in this research, are more experienced than many and have had the advantage of working under the supervision of Mr Dorries, who is very knowledgeable about coronial law and, I think, requires high standards from his officers. If coroner's officers are to make such decisions, they must be trained and their capability tested.

When the Doctor Believes that the Death Must Be Reported

5.54 If a doctor is insufficiently confident that s/he knows the cause of death or realises that, although the cause is known, there is some other reason to report the death to the coroner, s/he will usually telephone the coroner's office. Because there is no statutory duty on the doctor to report the death, there is no formal or official means of making the report. No prescribed form is supplied for the purpose. The report is usually made informally, by telephone. The doctor will speak to the coroner's officer and will explain the reason why s/he is making the report. The coroner's officer might decide to take over responsibility for the death and might consult the coroner before making the decision. The doctor might

hear no more about it although, in some cases, s/he will be asked to provide a statement or report about the death and may have to attend to give evidence at an inquest.

5.55 The legal position is that, when the coroner is informed of a death, s/he must decide whether the death gives rise to a reasonable suspicion that the circumstances call for an inquest, i.e. that the death was violent or unnatural or occurred while the deceased was in prison or other specified forms of custody or that the death was sudden and the cause is unknown. If there is no such reasonable suspicion, the coroner has no jurisdiction to take on the case. Some doctors complain that, if they telephone to say that they are not sufficiently sure of the cause of death, the coroner (or more likely the coroner's officer) will indicate that s/he is not willing to accept the case (an oft-used phrase seems to be that 'the coroner won't be interested') and will seek to persuade the doctor to issue an MCCD. The doctor feels under pressure to do so because, if the coroner will not accept the case and the doctor refuses to issue an MCCD, the relatives are unable to register the death or dispose of the body.

5.56 Coroners deny that this kind of situation ever arises. They say that they are always willing, even anxious, to take on cases that require investigation. It may be that sometimes the problem is one of misunderstanding or of differing perceptions of the respective roles of the coroner's office and the certifying doctor. The coroner or coroner's officer might genuinely believe that the doctor is being over-cautious about certifying the cause of death. However, as I shall explain in Chapter Seven, there is evidence that doctors are sometimes put under pressure to issue an MCCD.

When the Doctor Is in Doubt about Whether to Report the Death

5.57 Many doctors make a practice of telephoning the coroner's office to discuss a death, if they are in doubt about whether they should report the death or whether it would be in order for them to issue an MCCD. Some will telephone to seek a dispensation in relation to some aspect of the rules with which they cannot comply. It is quite common for a doctor to seek and receive permission to issue an MCCD in respect of a death which the registrar would be bound to report to the coroner, for example, because the doctor has not seen the deceased within 14 days before death or seen the body after death. Although some telephone calls are made for the purpose of reporting a death, many are made for the purpose of seeking advice. Some coroners encourage such informal discussions. These discussions are, to a very large extent, controlled by the coroner. I shall discuss them in greater detail in Chapter Seven.

No Certificate of the Fact of Death

5.58 Another shortcoming of the present system is that there is no requirement that a doctor or any other health professional should certify the fact that the deceased has died. It is quite possible for a family member to conclude that death has occurred, to telephone the doctor to say so and for the doctor to issue an MCCD without seeing the body. In practice, as I have explained in Chapter Four, it is usual for a doctor or paramedic to check that the person has indeed died, but there is no legal requirement that this should be done. Nor

is there any requirement that any record should be made of the time or circumstances of the death.

5.59 As I discovered when investigating the deaths of Shipman's patients during Phase One of the Inquiry, any knowledge of the circumstances of the death is valuable. Information recorded at the time of the examination by the doctor or other suitably qualified health professional who confirms the fact of death would be particularly useful to anyone who might later be responsible for investigating the death. I have in mind information such as the time and place of death and the identity of any person present at the death or, if the deceased were alone, of the person who found the body. If someone were present at the death, a brief account of how the death occurred would be valuable. If the deceased had been found dead, a note of the position of the body and the way in which the deceased was clothed would also be helpful. When paramedics are called to a death, they record some information of this kind. In many cases, however, such information is never recorded.

5.60 The Brodrick Committee recognised the need for formal certification of the fact of death. They proposed a combined certificate of fact and cause of death. In my view, a separate document would be more appropriate. Nowadays, the doctor who knows most about the deceased's medical history might well not attend to confirm that death has occurred. As I have explained in Chapter Four, many doctors use deputising services outside normal working hours. Many deaths are also confirmed by paramedics.

5.61 In my view, there should be a requirement that the person confirming the fact that death has occurred should complete a short form providing the type of information I have suggested. In so saying, I do not suggest that it should be mandatory for a doctor to attend to certify the fact of death. In my view, a registered nurse or paramedic would be capable of examining the body, certifying that the deceased is dead and completing the form.

5.62 Not only would such a form assist in the professional scrutiny of the circumstances of death, it would also form a valuable safeguard against any attempt to provide false information about the death. Shipman often told lies about the circumstances of death. If he had had to complete a form such as I have described, and if the deceased's next of kin, family member or partner had learned of its contents, there would have been a very good chance that the falsehoods would have been noticed. Indeed, as I observed in respect of the requirement to complete a form containing the medical history, Shipman's knowledge that he would have to complete a form describing the circumstances of death would have acted as a significant deterrent.

Shipman's Manipulation of the System

5.63 Shipman's ability to certify the cause of death of the patients he had killed, without objection from anyone, enabled him to pass off the killings as natural deaths. To relatives or anyone with an interest in the deceased, who might have considered making a report to the coroner, Shipman would say that he knew the cause of death. Usually, he would give the relatives a brief explanation and tell them that there was no need to have an autopsy or report the death to the coroner. If a relative suggested to him that the death seemed

very sudden and unexpected, his usual reply was to tell the relatives that the death might have been unexpected to them but it was not unexpected to him. The relatives so trusted Shipman that they did not question his word.

5.64 There was nobody in authority with the power or knowledge to question the certificate that Shipman had issued. In the case of all but two of the killings (those of Mrs Renate Overton and Mr Charles Barlow), the Coroner for the Greater Manchester South District was not even aware of the death. In a few more (the death of Mrs Kathleen Grundy was one), it appears that Shipman probably spoke informally to a member of the Coroner's staff and was 'permitted' to issue the MCCD, stating the cause of death he had proposed. I have no doubt that, in those few cases, Shipman gave the member of staff a highly plausible account of the death.

5.65 The registrar would rarely have any basis on which to query the issue of an MCCD by Shipman. The registrar would query the certificate only if there was some fault in its completion. Shipman was usually very careful to complete MCCDs properly and only rarely gave a cause of death that was not acceptable to the registrar. A registrar might have felt it appropriate to report a death to the coroner if a relative had told him/her that, notwithstanding Shipman's certificate, the family was concerned that the death had been very sudden and unexpected. Shipman often took precautions to avoid that kind of occurrence by telling the victim's family that, if the case were reported to the coroner, it would mean that there would have to be an autopsy and that this procedure would probably delay the funeral. Relatives are often reluctant to submit the bodies of their loved ones to autopsy, if it can be avoided. Often they are anxious to make funeral arrangements and are worried that an autopsy will cause delay. So it was easy for Shipman to manipulate their feelings in this way.

Loss of Public Confidence due to Shipman

5.66 The discovery of Shipman's crimes has resulted in a substantial loss of public confidence in a system that depends so heavily on the integrity of a single doctor. I consider that, even if it were to be shown that the present system of death certification by a single practitioner was working well in most cases, the loss of confidence is such that the public will not be satisfied unless and until significant change is made. This loss of confidence is a measure of the damage that Shipman has caused to his former profession. I can well understand the sense of outrage that honest and conscientious doctors must feel.

Conclusions

5.67 In my view, the present system of death certification requires reform. My first reason for so saying is that the system is open to abuse by a dishonest doctor. An adequate system of death certification must provide some effective cross-check upon the account of events given by the doctor who has treated the deceased and who claims to be able to identify the cause of death. An account of the same events should be obtained from a family member or someone with knowledge of the circumstances of the death. Such a cross-check is needed, not only to deter a doctor such as Shipman, but also to deter any doctor

who might be tempted to conceal activity less serious than murder, such as an error or neglect by him/herself or a colleague.

5.68 I have also outlined other aspects of the system that are less than satisfactory. The Brodrick Committee advocated reform of the system of certification, even though its members believed that there was no appreciable risk of concealment of homicide or malpractice. Their perceptions of the shortcomings of the system were similar to mine. My reasons include the paucity of information gathered on the MCCD, the irrationality of the 'either/or rule', the elasticity with which doctors interpret the rules of qualification, the uncertainty about the standard of confidence required before the doctor should certify the cause of death and the unsatisfactory practice relating to the reporting of deaths to the coroner.

5.69 Some of the shortcomings I have outlined in this Chapter might be capable of resolution if doctors were to be educated in the purposes of death certification and trained how and when to complete an MCCD. However, in my view, and as the research suggests, education could not provide an answer to the more fundamental deficiencies.

5.70 I have already said that I have concluded that the present arrangements, whereby, in effect, doctors take the decision as to whether or not a case should be reported to the coroner, are not satisfactory. My conclusion is based partly upon the research by Dr Start and his colleagues, which suggests that, even when making a proper effort to reach the right decision, doctors fail to do so in an unacceptably high proportion of cases. A further reason for my view is that I am satisfied that some doctors are vulnerable to pressure not to report a death in circumstances in which they know that they should do so. Later in this Report, I shall consider whether it would be appropriate for all deaths to be reported to the coroner service, thereby removing from doctors the decision as to whether or not to report and also avoiding the need for the compilation and interpretation of a long list of circumstances in which a death should be reported.