FOREWORD

In the First Report of the Shipman Inquiry, I disclosed my finding that Shipman had killed at least 215 of his patients over a period of 24 years. It was clear that the current arrangements for death registration, cremation certification and coronial investigation in England and Wales had failed both to deter Shipman from killing his patients and to detect his crimes after they had been committed. The failure of the existing system prompted Parliament to set up the Shipman Inquiry, with Terms of Reference requiring me to examine the present arrangements and to make recommendations for changes that would protect patients in the future.

The focus of the Inquiry has therefore been primarily on the protection of patients from the actions of a homicidal doctor. Yet, there are other important aims and objectives that must be served by a system of death investigation and certification besides the protection of patients, important though that is. The system must seek to protect the public from harm of other kinds and to expose the wrongdoing of others besides an occasional aberrant health professional. A sound system will advance medical science, through the better understanding of causes of death. It will assist in planning for the better use of the huge resources now expended on the National Health Service. It will serve the interests of private individuals by providing a proper understanding of the cause and circumstances of a death in which they have an interest. It will assist in the prevention of avoidable deaths and injuries in the future. My task has been to make recommendations for a system that will meet the needs and legitimate expectations of society.

In the course of the Inquiry's work, I invited views about how a new system might be devised. Many individuals and organisations responded to my invitation with interesting and constructive ideas for change. However, some respondents sought to persuade me not to propose any radical changes to the system just because one doctor had been able to evade the existing safeguards. I was urged to accept that the system was working reasonably well; a few minor changes was all that was needed. There would never, it was said, be another Shipman.

It seems to me that there are two reasons why those arguments should not prevail. The first is that we do not know that Shipman is unique. We know that he has killed more people than any other serial killer yet identified, but we do not know how many other doctors have killed one or more patients. Some such killings have come to light; others may remain hidden. If Shipman was able to kill for almost 24 years before he was discovered, who can say with confidence that there are not other doctors, still unknown, who have killed in the past? Who can say that there will be none in the future? If there is a risk that a doctor might kill in the future and if, as is now clear, the present system would neither deter nor detect such conduct, surely the system must be changed.

The second reason is that my investigations have satisfied me that the system is not working as well as it should. The evidence received by the Inquiry suggests that there is much dissatisfaction with the present arrangements. It is said that the existing system is fragmented, is not sufficiently professional, is applied to very variable standards in different parts of the country and does not meet the needs of the public, especially the bereaved. It is said that it does not satisfy the public interest in the discovery of the true causes of death in the population. It does not contribute, to the extent that it should, to the improvement of public health and safety. If these complaints are well founded, as I have found they are, then there are good reasons for radical change, quite apart from the need to ensure that, so far as possible, homicide does not go undetected.

In July 2001, while this Inquiry was working on Phase One, Mr Tom Luce was appointed to chair a Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland (the Coroners Review). His Terms of Reference overlapped, but were not coterminous with, those of the Shipman Inquiry. He was asked to co-operate with the Inquiry. That he has done and I am most grateful for the openness with which he shared the Review's developing ideas with the Inquiry, by speaking at one of our seminars in January 2003 and by allowing me to read his Report in draft.

I also wish to express my gratitude to those individuals who have attended to give evidence and to take part in the seminars. I must mention particularly those who came from overseas to participate in the seminar relating to systems of death investigation and certification in other jurisdictions. I thank, too, all those who wrote to the Inquiry giving their views about the present system and their ideas for change and improvement. Many individuals and organisations have provided witness statements, records, reports and other documentary material, thus enabling the Inquiry to assemble a huge amount of evidence. All have been generous with their time and effort, for which I am very grateful.

I must also thank Counsel, Dr Aneez Esmail, Henry Palin and other members of the Inquiry team, who, as in Phase One, have worked with energy, determination and good humour and without whose support this Report could not have been written.

This Inquiry was set up in the wake of a tragedy that shocked the world. It is my hope that some good may now come from those tragic events and that in the future we will have, in this country, systems of death investigation and certification that will bring real benefits in the fields of public health and safety and will meet the needs and expectations of private individuals, especially the bereaved. It is my earnest hope that the recommendations of this Report, together with those of the Coroners Review, will lead to radical change.

Janet Smith
June 2003