SUMMARY

Introduction

1. Following my First Report, which set out my finding that Shipman had killed at least 215 of his patients over a period of 24 years, it was clear that the arrangements for death and cremation certification and the coronial system, which are intended to protect the public against the concealment of homicide, had failed to fulfil that purpose. The Inquiry's Terms of Reference required me to examine the present systems, together with the conduct of those who had been responsible for operating them in the aftermath of the deaths of Shipman's victims. I was also required to recommend what steps, if any, should be taken to protect patients in the future.

2. In the course of Phase Two, Stage Two, I have received a wealth of evidence, both oral and written. I have heard from many witnesses who have experience of the day-to-day operation of the existing systems. I have heard evidence from some of the bereaved relatives of Shipman's victims about their experiences and their ideas for change. I have considered the history of the systems and read many reports, reviews and commentaries, which have been written about them over the years. I have been referred to a great deal of documentary evidence concerning the systems as they operate today.

3. In addition, I have had the opportunity of reading the responses to the Consultation Papers published by two recent Home Office Reviews, the Review into Death Certification, which reported in 2001, and the Fundamental Review of Death Certification and the Coroner Services in England, Wales and Northern Ireland, whose Report was published in June 2003. The Inquiry has carried out its own consultation process. In October last year, its Discussion Paper, 'Developing a New System for Death Certification', was published. Written responses were received from 154 individuals and organisations. A series of seminars was held in January 2003, at which the Inquiry's ideas for change were discussed by representatives of organisations with a particular interest or involvement in post-death procedures and with a number of individuals who have a special knowledge of those procedures. One of the seminars was attended by representatives of five jurisdictions whose systems of death investigation and certification had features that were of interest to the Inquiry. The Inquiry conducted a small feasibility study into the use of the forms which had been designed as part of a new system of death certification.

4. I have been able to set all that material against the background of the evidence, both lay and expert, which I had received during Phase One of the Inquiry, when I considered and reported upon the circumstances and aftermath of just under 500 deaths of Shipman's patients.

The Bereaved Relatives

5. The evidence about the present post-death procedures shows that the families of deceased persons are little involved in the processes of certification and investigation of a death. It also shows that the needs and expectations of the bereaved relatives are sometimes not given the consideration they deserve. Of course, it is not just families who are affected by a death. In speaking of 'relatives' and 'families', I am intending to indicate

anyone who is sufficiently close to the deceased person to have a proper interest in the cause of his/her death and any investigation into it.

6. The evidence also shows that the present procedures fail to tap a source of information about the deceased person and the circumstances of his/her death that would be of great value to the process of death certification and investigation.

7. Any changes contemplated for the future must seek to ensure that families are kept informed about, and are consulted and involved at all stages of, the post-death procedures. However, their involvement must be handled sensitively and not intrusively. The needs of those minority ethnic or religious groups whose members wish to arrange disposal of the body as soon as possible after the death must also be borne in mind in any proposals for change.

Certification of the Fact of Death

8. At present, there is no requirement that a doctor or any other health professional should certify the fact that a person has died. In my view, there should be a requirement that the fact that death has occurred should be confirmed and certified. The person who confirms the fact of death (who might be a doctor or an accredited nurse or paramedic) should complete a form, recording information about the circumstances of the death. 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.

The Immediate Aftermath of a Death in the Community

9. 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. At present, 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 person might not be beyond resuscitation. The police might be called, especially when the death has occurred suddenly, even though there is no suspicion of criminal involvement. In other cases, relatives might contact the deceased's general practitioner. Depending on the circumstances and time of day, either the general practitioner or a doctor from the deputising service might attend.

10. It is clear from the evidence received by the Inquiry that 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. Different procedures operate in different parts of the country. There is confusion about what is expected of the police, ambulance and medical services. There is also tension between the services, each of which has justifiable concerns about the use of its resources in attending deaths where the deceased is clearly beyond medical help and where there is no suspicion of any criminal involvement in the death. All the services have what might properly be regarded as more pressing duties in relation to the living.

11. In my view, there should be a nationally agreed policy for dealing with the immediate aftermath of a death occurring in the community. There will always be a role for the police, ambulance service and doctors in dealing with the aftermath of a death. However, I consider that their roles should be secondary to, and supportive of, a service with primary responsibility for dealing with deaths in the community, whenever they occur. In my view, this service should be based in the coroner's office and the provision of such a service should be one of the duties of a team of well-trained coroner's officers.

Medical Certification of the Cause of Death

12. Since 1926, the law has required that, before a death can be registered and the body disposed of by burial or cremation, the medical cause of death must be certified by a doctor who has attended the deceased during his/her last illness or by a coroner after autopsy or inquest. The procedure for certifying the medical cause of death has remained virtually unchanged for over 75 years.

13. The current procedure has three very real advantages; it is speedy, cheap and convenient. However, it has a number of disadvantages. The most serious of these is that it is dependent on the integrity and judgement of a single medical practitioner. That medical practitioner, if s/he has attended the deceased during the last illness, must decide whether s/he should report the death to the coroner or whether s/he can properly issue the medical certificate of cause of death (MCCD).

14. One of the circumstances in which a death should be reported to the coroner is if the death is sudden and the cause is unknown. Many of Shipman's patients died suddenly in circumstances in which no honest doctor could have claimed to know the cause of death. Yet Shipman, who had killed them, was able to certify the cause of death, avoid a report to the coroner and thus also avoid any official enquiry into the death.

15. The fact that the system of certification of the cause of death depends on a single doctor does not give rise only to the risk of concealment of crime or other wrongdoing by that doctor. There may be occasions when a doctor knows that a death may have been caused or contributed to by some misconduct, lack of care or medical error on the part of a professional colleague. In those circumstances, it takes considerable courage and independence for a doctor (particularly a junior doctor) to refuse to certify a death, when s/he knows that, if s/he does refuse, the death will be subject to a coroner's investigation. Pressure might also be exerted by the relatives of a deceased person. They might try to persuade the doctor to certify a cause of death so as to avoid a referral to the coroner and the possibility of an autopsy. They might also seek to press the doctor to state on the MCCD a cause of death which is not the true one, but which will cause the family less embarrassment or difficulty than the condition from which the deceased actually died. Once again, it can be very hard for a doctor to withstand that sort of pressure.

16. Research has shown that, even when not subjected to pressures of that kind, doctors still have difficulty in recognising those deaths that should be reported to the coroner. The categories of 'reportable deaths' are not easy to interpret and the matter is complicated by the fact that different coroners operate different 'local rules' governing the deaths which

should be reported to them. Research has shown that there is likely to be a significant proportion of deaths that, under the present law, should be reported to the coroner but are not.

17. A further problem with the current system is that the quality of certification is poor. Doctors receive little training in death certification. In hospitals, certification is often done by very junior doctors (sometimes in their pre-registration year) with little or no help from their senior colleagues. The standard of certification among general practitioners appears to be rather better although since, in general, they certify relatively few deaths, some still experience difficulty on occasions. The fact that deaths are not being certified correctly has an obvious impact on the quality of the mortality statistics which inform public health policy.

18. The Inquiry has heard that some general practitioners never report a death to the coroner. It seems unlikely that this is because no death certified by them ever comes within the category 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. Research has confirmed that some doctors are willing to 'modify' what they believe to be the true cause of death in order to avoid a report to the coroner.

19. Once a doctor has certified the cause of death then, provided that s/he has completed the MCCD fully and in appropriate terms, there is no check on the truth or accuracy of what s/he states. There is no system of audit or review of those cases where a doctor certifies the cause of death and does not report the death to the coroner. The relatives of the deceased person will take the MCCD to the register office, the death will be registered and a disposal certificate issued. A burial can then take place without any further check or formality.

20. In my view, the present arrangements, whereby, in effect, doctors decide whether or not to report a death to the coroner, are not satisfactory and should not be allowed to continue.

Registration of Deaths

21. The death of every person dying in England and Wales must be registered. Except where an inquest is held, the informant (usually a close relative) must attend personally before the local registrar to give the particulars necessary for the death to be registered. In cases where there has been no autopsy, the informant takes with him/her a copy of the MCCD which s/he will have been given by the certifying doctor.

22. Registrars have no medical experience. Their role is essentially administrative. They are required to record details of births, marriages and deaths. The information received by registrars forms the basis of an important public record that is widely used for statistical and research purposes. It is vital that it is recorded meticulously and accurately. Registrars also have to deal with members of the public and to guide them through the formalities associated with the most important of all life events.

23. Registrars are accountable to the Registrar General, whose office, the General Register Office (GRO), forms part of the Office for National Statistics (ONS). The GRO provides

guidance to registrars on a range of matters, including the circumstances in which a death should be reported to the coroner.

24. In the case of the registration of a death, registrars are required to perform a function of a completely different nature from those referred to above. They have a statutory duty to report to the coroner deaths which fall within certain specified categories. In order to decide whether such a duty arises in respect of a particular death, they have to scrutinise the MCCD and assess, insofar as they are able, whether it provides an acceptable medical explanation for the death. They have to be alert to circumstances that might be mentioned in, or evident from, the MCCD and which might make a report to the coroner appropriate. The medical terminology used on the MCCD to describe the cause of death may be difficult to understand for someone without medical expertise. Some registrars told the Inquiry that they felt ill equipped to undertake this task. I can understand why that is so.

25. Registrars report comparatively few deaths to coroners. The main reason for this is probably that most obviously reportable deaths will already have been reported by doctors before the death comes for registration. However, another reason may be that the registrar has little opportunity to discover whether there are any circumstances that might render the death reportable. The MCCD itself contains very limited information. Sometimes, the informant or another member of a deceased person's family might volunteer information that suggests that the death should be reported. However, there is no requirement for the registrar formally to seek information relating to the circumstances surrounding the death. Nor is the registrar required to confirm the information given by the certifying doctor on the MCCD. If it appears to the registrar that there are circumstances that suggest that the death is reportable to the coroner, his/her duty is to make the report. However, the registrar is not required to make direct enquiries of the informant, with a view to ascertaining whether or not such a report is necessary.

26. Registrars are not trained or equipped to provide the only form of scrutiny to which MCCDs issued by medical practitioners are subjected. I have concluded that, in future, any information about cause of death provided by a doctor should be scrutinised by a person with a medical qualification, or at least by someone with special training in medical matters and ready access to expert medical advice. That person should also have the opportunity to cross-check the essential facts with a relative of the deceased or someone with knowledge of the circumstances of the death. In my view, the task of scrutinising a cause of death should no longer be that of the registrars. Theirs should be a purely administrative function.

The Tameside Registrars

27. Most of the deaths of Shipman's patients, including the deaths of those whom he killed, were registered at the Tameside register office. It was therefore necessary for the Inquiry to examine procedures and practices at the office, both generally and in relation to Shipman.

28. After Shipman's criminal activities were revealed, there were suggestions that the registrars at the Tameside register office should have noticed that they were registering

an excessive number of deaths which had been certified by Shipman. There are four registrars at the Tameside register office. Each is responsible for her own register of deaths. Some registration is carried out by deputy registrars. No registrar sees the complete picture of death registrations effected in the office as a whole. Nor is there any system (or any duty to operate such a system) for the gathering of statistics relating to deaths. The identity of the doctor who certified the cause of a death would not be significant unless some difficulty arose over the MCCD. Shipman usually took care to ensure that no such difficulty arose.

29. The Inquiry examined the numbers of Shipman-certified deaths registered by two current registrars and one former registrar. These three registrars had been responsible for registering the greatest number of deaths certified by Shipman. The numbers of deaths certified by Shipman were compared with the (very large) total numbers of deaths registered by the registrars during the same period. Also, the Inquiry looked at a number of short periods of time when the concentration of Shipman-certified deaths registered by each registrar was at its highest. The object was to see whether, during those short periods, the frequency of Shipman-certified deaths should have been noticeable.

30. That exercise having been carried out, I am quite satisfied that the frequency with which Shipman-certified deaths occurred would not have been noticeable to any registrar. Nor, in my view, were the clusters of greatest intensity particularly remarkable. Such research as the Inquiry team was able to carry out showed that clusters of deaths certified by an individual doctor occur with reasonable frequency. Nor was there any evidence from which I could reasonably infer that any of the registrars had noticed an excess of deaths certified by Shipman or that they had had any other concerns about him.

31. The close scrutiny to which the procedures in operation at the Tameside register office were subjected by the Inquiry resulted in questions being raised about some of the practices in operation within the office. One in particular – whereby registrars would contact doctors who had issued MCCDs stating unacceptable causes of death, rather than reporting the death to the coroner's office and leaving it to the staff there to sort out the problem – gave rise to particular concern. However, whilst there is no doubt in my mind that this constituted poor practice, I am satisfied that the Tameside registrars undertook responsibility for contacting doctors in these circumstances because the coroner's office put pressure on them to do so and because they believed that, in doing so, they would be assisting the bereaved relatives by ensuring that, in an appropriate case, the defective MCCD was amended or replaced as soon as possible so as to allow the registration to proceed.

32. I am quite satisfied that neither the practice I have referred to above, nor any of the other procedures in operation at the Tameside register office, had any adverse effect on the registration process in cases where Shipman had killed.

33. It is not surprising that some departures from accepted practice occurred at the Tameside register office. The registrars there had not received clear training or guidance on the points of practice that arose. They had little opportunity to meet registrars from other areas. Accordingly, they had little opportunity to discover and correct any shortcomings in their own practice, or to gain the necessary confidence to insist upon compliance with

correct statutory procedures by others. It is plain, moreover, from correspondence received from the GRO since the Inquiry hearings, that the departures from best practice about which the Inquiry has heard are not confined to Tameside. Indeed, such is the concern of officials at the GRO about variations in practice throughout the country, that they have now written to all registrars, giving guidance about good practice in relation to a number of matters that have been explored in the course of evidence given to this Inquiry.

The General Register Office

34. The GRO operates a telephone advice line, which a registrar can use if unsure whether a death should be reported to the coroner. However, the staff who operate the advice line have no medical expertise or specific training for the task and are reliant upon medical reference books and notes of past advice given or received. They have access to medical epidemiologists employed by the ONS but the evidence strongly suggests that most queries are resolved by GRO staff without recourse to medical advice.

35. The Inquiry identified two deaths in 1996, where registrars at the Tameside register office had sought advice from the GRO before registering the death. On both occasions, Shipman had killed the deceased person and certified that the death was due to 'natural causes'. When the deaths came to be registered, the registrars at Tameside were uncertain as to whether 'natural causes' constituted an acceptable cause of death. They were advised by staff at the GRO that it did and that the deaths could therefore be registered. In fact, it was agreed by all who gave evidence to the Inquiry that 'natural causes' should never be acceptable to the registration service as a cause of death. The expression does not explain what has caused the death. It asserts only that the death was due to a natural disease process.

36. No explanation was advanced for the giving of the faulty advice. No clear written advice on the acceptability or otherwise of 'natural causes' as a cause of death was promulgated by the GRO, whether for the benefit of registrars or its own staff. That deficiency has been rectified since the Inquiry hearings. It is clear that the situation did not arise very frequently in practice. However, it appears that there must have been some misunderstanding amongst staff within the relevant section of the GRO about the status of 'natural causes' as a cause of death. This is worrying, since the giving of poor advice by the GRO in turn disseminates poor practice elsewhere.

37. In my view, the problems are caused in large part by a system in which clerical staff without medical expertise are seeking to advise other clerical staff on matters which are essentially medical in nature.

38. Even had the advice of the GRO in both cases been correct, namely that the cause of death was not acceptable and the death should be reported to the coroner, I do not think that the outcome of either case would have been significantly different from what in fact occurred. Shipman would have been contacted and would have provided a more specific cause of death. That cause of death would have been duly registered. It is highly unlikely that any further investigation of either death would have followed.

Cremation Certification

39. Over 70% of deaths in the UK are now followed by cremation. In 1903, the year when the first Cremation Regulations came into force, there were 477 cremations within the UK. In 2001, there were 427,944. During that period of almost 100 years, there has been very little change in the system by which authority to cremate is granted.

The System

40. Once a death has been registered and a disposal certificate issued by the registrar, burial can take place without any further check or formality. If any suspicion arises in the future that the death was caused by an unlawful act, the body will (for a limited period at least) be available for exhumation and forensic examination. When cremation was first introduced, it was recognised that there would be no such opportunity to recover the evidence when a body had been cremated. It was therefore decided that additional safeguards should be implemented in cases where a disposal was to be by way of cremation. The attending doctor (usually the same doctor who had issued the MCCD) would complete a certificate (Form B), giving rather more information than that contained on the MCCD. A second doctor would carry out his/her own enquiry and complete a confirmatory certificate (Form C) and a medical referee, on behalf of the cremation authority which operated the crematorium, would examine the forms and satisfy him/herself that the forms were in order, that proper enquiry had been made and that the cause of death had been definitely ascertained. He or she would then grant authority to cremate. Form B and Form C doctors and the medical referee were to receive fees for their part in the procedure, paid by the deceased's estate. Currently, fees totalling just under £100 are payable to the three doctors involved in authorising a cremation.

41. When the system was first devised, it was intended that the Form C doctor (who was to be demonstrably independent and to occupy a prestigious public appointment) would carry out a personal enquiry. Form C contained questions about the nature and extent of the enquiry to be carried out. The doctor was asked whether s/he had seen and carefully examined the body of the deceased (questions 1 and 2), whether s/he had made a post-mortem examination (question 3), whether s/he had seen and questioned the Form B doctor (question 4) and whether s/he had seen and questioned any other medical practitioner who had attended the deceased, any person who had nursed the deceased during his/her last illness or who was present at the death, any of the relatives of the deceased or any other person (questions 5–8).

42. The form prescribed by the 1903 Cremation Regulations contained no requirement that any of the questions on Form C should be answered in the affirmative and that remains the position today. However, each crematorium produces its own cremation forms and every Form C seen by the Inquiry has contained an instruction to the effect that questions 1, 2 and 4 should invariably be answered in the affirmative. The Inquiry has discovered that some crematoria issue cremation forms which contain a note to the effect that one of questions 5–8 also must be answered in the affirmative. The origin of this requirement is not known but it seems that it has appeared on the forms of some crematoria for many years, certainly for as long as the current personnel at the crematoria can remember.

43. The significance of an affirmative answer to one of questions 5–8 is that it indicates that the Form C doctor has questioned someone (other than the Form B doctor) who has knowledge of the deceased and of the circumstances of the death and has therefore had the opportunity of comparing the information received from the Form B doctor with that from another source.

The History

44. Over the years which followed the introduction of the cremation certification procedures, concerns were frequently expressed about the value of those procedures and, in particular, about the value of the personal enquiry undertaken by the Form C doctor. There were suggestions that the examination of the deceased's body by Form C doctors was often perfunctory and that, sometimes, the Form C doctor did not even question the Form B doctor. From time to time, it was also observed that the importance of the questioning of a person other than the Form B doctor was being neglected. There was an ongoing debate as to whether the cremation certification procedure should be abolished or retained. There were some (chiefly the organisations responsible for running the crematoria) who contended that the certification procedures should be abolished as they were expensive and a disincentive to choosing cremation as a means of disposal. There were others (notably the Government Law Officers, the police, the British Medical Association (BMA) and the Association of Crematorium Medical Referees) who argued that the procedures constituted a valuable safeguard against the concealment of crime. No consensus on the way forward was possible and every attempt to strengthen the system and make it more effective failed. In 1965, a Committee chaired by Mr Norman (later Judge) Brodrick QC ('the Brodrick Committee') was set up to examine the system of death certification and coroners. Cremation certification was included in its Terms of Reference.

45. The Brodrick Committee reported in 1971. Members of the Committee concluded that the system of medical certification of the cause of death should be strengthened. If that were done, they recommended that the cremation certification procedures should be abolished in their entirety. Even if no immediate steps were taken to change the death certification system, the Committee nevertheless recommended that the Form C procedure, which they regarded as valueless, could be abolished immediately without risk. That recommendation – like all the recommendations of the Committee – was based on its conclusion that the risk of secret homicide, whether by the attending doctor or anyone else, was negligible. That conclusion, expressed four years or so before Shipman began his course of killing, has of course been proved wrong by the events which have followed.

46. After the Brodrick Committee had reported, the Home Office (which was responsible for cremation-related matters) and the GRO (which had responsibility for taking forward the recommendations relating to death certification) set about attempting to implement the recommendations. However, abolition of the cremation procedures was opposed by those organisations which had opposed it in the past. Meanwhile, the cremation organisations and the National Association of Funeral Directors pressed for abolition. Disputes arose also over the implementation of recommendations relating to death

certification. In 1984, plans for a Bill to implement those recommendations were shelved. Efforts to abolish the Form C procedure (the interim measure that had been recommended by the Brodrick Committee) also foundered in the face of opposition by the BMA. In November 1988, the Home Office took the decision to abandon its attempts to abolish Form C until the GRO had effected changes to the procedures for death certification. Despite further attempts over the years, those changes were never effected and, more than 30 years after the Brodrick Committee reported, the cremation certification procedures remain virtually unaltered. However, even had the recommendations of the Brodrick Committee been implemented in their entirety, including the recommendations for strengthening the system of death certification, the course of Shipman's killing would not have been affected because the system would still have been dependent on the integrity of a single doctor.

The Cremation Forms

Form B

47. The Inquiry heard evidence about the problems associated with the cremation certification procedures. The meaning of some of the questions on Form B is uncertain and ambiguous and there is no consistency of approach. Although a completed Form B provides much more information than a completed MCCD, it does not require what I regard as the two essentials for the investigation of any death, namely a brief medical history and an account of the circumstances of the death.

Form C

48. The Form C procedure does not operate as it was intended to do when the procedure was first devised. The Form C doctor, in the community at least, is generally not truly independent of the Form B doctor. The Form B doctor will usually choose the doctor who is to complete Form C; the relationship between the two doctors will often be close, sometimes social as well as professional. Many doctors regard the completion of Form C as a technical requirement only. They do not see themselves as carrying out an independent investigation into the cause and circumstances of the death. The doctors who gave oral evidence to the Inquiry admitted, when pressed about the matter, that they had never previously thought that they were in any way 'policing' their colleagues. Most had never thought that they were supposed to consider whether their colleagues might have concealed wrongdoing of any kind, whether deliberate or through lack of care. Yet this is the very purpose for which the personal enquiry by a second (Form C) doctor was designed and intended.

49. The doctor who gives affirmative answers to questions 1, 2 and 4 on Form C will have seen the deceased's body and examined it to a greater or lesser extent. That examination may have provided confirmatory evidence of the diagnosis of cause of death. More likely, the examination will have been too superficial to reveal anything of significance, or the cause of death will be one that would not give rise to visible signs, even on a thorough physical examination. Thus, the examination will have provided no independent evidence upon which the Form C doctor can rely. The Form C doctor will also have heard the account of

the clinical history and the reasons for the diagnosis of cause of death, as propounded by the Form B doctor. That account will not have been confirmed by inspection of the medical records. Nor, unless there is a local requirement to do so, will most Form C doctors have questioned anyone other than the Form B doctor.

50. There was no such local requirement at the Dukinfield crematorium. In the vast majority of cases, the doctors who completed Forms C for Shipman did not question anyone independent of him about the death. They trusted him as a respected colleague. He lied to them; they believed his account of the death and they confirmed his dishonest opinion of the cause of death. The Form C procedure, as operated, served no useful purpose as a deterrent to Shipman's activities or as a means of detecting those activities. The question is whether it would have been useful in either respect if there had been a requirement that the Form C doctor should question someone other than Shipman.

51. Had there been such a requirement, there would have been a real prospect that, in many cases, the lies which Shipman had told when completing Form B (knowing that the form would never be seen by the deceased's relatives or carers) would have been exposed. It is likely also that, had the Form C doctor spoken to some of the relatives of Shipman's victims, they would have expressed surprise, even concern, at the suddenness of the death. The fact that, on many occasions, Shipman had certified the cause of a sudden death on inadequate grounds would probably also have become clear.

52. The possibility that any of these consequences might follow a discussion between a Form C doctor and a relative or carer of a patient whom he had killed would, I think, have acted as a real deterrent to Shipman. If, despite the possible consequences, he had taken the risk of killing, I am confident that the chances of his being detected would have been increased. The kind of report that Dr Linda Reynolds made to the Coroner in March 1998 might have been made earlier and with much greater attendant detail. I cannot say when this would have happened, but I think it likely that, had relatives and carers been questioned, that would have led to Shipman's detection at some stage, whereas the system, as operated, never did.

The Role of the Medical Referee

53. The crematorium medical referee is an experienced doctor, but carries out what is essentially a paper exercise. He or she is required to examine the cremation forms and ascertain that they are in order and that the enquiry made by the doctors completing the forms has been adequate. Before authorising a cremation, the medical referee must be satisfied that the cause of death has been definitely ascertained. He or she may make any enquiry that s/he may think necessary and may, in certain circumstances, order an autopsy or refer a case to the coroner. In fact, very few cases are subjected to autopsy or referred to the coroner as a result of action on the part of medical referees.

54. There are two schools of thought about what the task of the medical referee should entail. Some medical referees believe that they are required to make an essentially clerical check to ensure that the forms have been properly completed and that the causes of death stated on Forms B and C are the same. They are not required, they say, to consider the content of the forms or to seek to discover whether the picture presented makes medical

sense. Other medical referees take the view that their statutory duty requires them to scrutinise the forms with a view to seeing whether the picture created by them hangs together and makes medical sense.

55. It is not entirely surprising that there should be variability in practice among medical referees. They operate in isolation from each other and receive no training and little guidance, save that which is provided locally. There are no monitoring or audit procedures. The Home Office has in the past had little direct contact with medical referees, save when attempting to resolve a specific difficulty or request for advice.

56. In my view, it is clear that a clerical check cannot be the task that was envisaged when the procedures were devised. It must have been intended that the medical referee should make a medical judgement about the content of the forms and the consistency of the stated cause of death with the information contained in them. Even so, the medical referee's task is very limited. The completed forms contain inadequate information to enable the medical referee to gain a clear picture of the events leading up to the death. Form B does not require the doctor to provide even a brief account of the deceased's medical history, nor much information about the circumstances of the death. The task of the medical referee does not involve any independent investigation. The system is based upon trust in the truthfulness and integrity of those taking part in the procedure. In particular, the medical referee is dependent on the integrity of the Form B doctor.

57. In summary, it seems to me that the role of the medical referee is of limited value, even when the duties are carried out, as they often are, most conscientiously. When the role is limited to that of a clerical check, it is completely without value.

The Role of the Home Office

58. It has been known for over 50 years that the system of cremation certification was not working as it was intended. As I have already explained, no significant changes to the system were made; in particular, no steps were taken to strengthen the system or to ensure that the procedures worked as had been originally intended. Given that the Home Office had responsibility for keeping under consideration the need for changes to cremation legislation, I have had to consider whether the Home Office has properly discharged that responsibility.

59. I have concluded that, given the view of the Brodrick Committee that the risk of secret homicide was negligible and that the cremation procedures should be abolished, it is not possible to criticise the Home Office, whether in the years before the Brodrick Committee reported, or in the period immediately afterwards, for any failure to strengthen the cremation certification procedures. In the period after the Committee reported, it was hoped and intended that abolition would be effected and I can well understand therefore why strengthening the procedures was not a priority.

60. However, I consider that those Home Office officials responsible for cremation matters over the years are to be criticised for their general lack of awareness of how the cremation certification system was operating throughout the country. The Home Office should have had a policy for the selection of medical referees; it should have provided training and

support for them once appointed. It should have maintained contact with them and ensured that they had contact with each other. Had the Home Office taken these steps, officials should have been aware that different practices were followed at different crematoria; they should have known that, at some crematoria, an affirmative answer was required to one of questions 5–8 of Form C and they should have found out why this was so. They might then have realised that a requirement that the Form C doctor should question someone other than the Form B doctor would strengthen the protective effect of the procedures. It is possible that they might have considered introducing such a requirement. However, in view of the fact that they believed that the cremation procedures were valueless, they might have rejected the idea. Even if they had proposed a significant strengthening of the Form C procedure, such a proposal would certainly have aroused strong objections. In the circumstances, I do not think that Home Office officials could have been criticised had they failed to pursue their proposal with all the vigour and determination that would have been necessary to overcome such objections.

61. In the circumstances, I do not consider that there is any ground on which the Home Office can be held responsible for the failure of the cremation certification system to detect Shipman's course of criminal conduct.

62. In my view, the cremation certification procedure, as presently carried out in most places, is of very little value. I am recommending a new system of death certification for all deaths, whether followed by burial or cremation. If that recommendation is implemented, the current cremation certification system will no longer be required.

The Hyde Form C Doctors

63. The Inquiry has considered whether those doctors who undertook the duty of completing most of Shipman's Forms C ('the Hyde doctors') should be criticised for their performance in connection with the completion of Forms C for Shipman's patients. I had to consider, in relation to each Hyde doctor, whether there were numbers or patterns of deaths or unusual – possibly recurrent – features of the deaths that should have been noticed and acted upon by him/her. I also had to consider whether, by checking what Shipman had written on Form B, the Hyde doctors should have noticed any unusual features, or inconsistencies between what Shipman had written and what he had told them.

64. When giving evidence to the Inquiry, the Hyde doctors related how, when they were to complete a Form C for Shipman, he would visit them in their surgery and would give a very full account of the deceased person's medical history and the events leading up to the death. Shipman was a plausible historian and gave a full and persuasive account of events. The Form C doctor would not see the medical records. However, s/he would see the Form B, examine the deceased's body and complete and sign Form C. It does not appear that the doctors always read Form B carefully, as some failed to observe strikingly unusual features or inconsistencies in the forms. I think that most of them carried out their examination of the body in a cursory way although, even had they made a careful examination of the body of a patient whom Shipman had killed, it would have revealed no cause for suspicion.

65. In my judgement, the general approach of the Hyde doctors to their Form C role, like that of a large proportion of doctors practising elsewhere in the country, was not appropriate. The purpose of the Form C doctor is that s/he should seek to reach an independent opinion as to the cause of death. Doctors should not merely accept and endorse the view of the Form B doctor. They should carry out a careful examination of the body and they should not adopt the practice of never making enquiries of third parties. However, I observe that the profession as a whole was never instructed to change the practices that were commonly adopted. It would not be fair to single the Hyde doctors out for criticism on account of their general approach to the task.

66. I considered the conduct of each of the Hyde doctors individually, applying the standard of the reasonable, competent and conscientious general practitioner. As a result of that exercise, I have been critical, to a greater or lesser extent, of six out of the ten doctors concerned. It is not possible to explain adequately the reasons for my conclusions about the performance of each individual doctor within the confines of this Summary. My analysis of their roles is set out in Chapter Fifteen. The poor performance of the six doctors I have referred to above is mitigated, although not entirely excused, by the generally low standard of Form C completion prevailing throughout the profession.

67. Even if, in the cases in which I have criticised a doctor for signing a particular Form C, the doctor had queried the propriety of Shipman's decision to certify the cause of death, I do not think that would have led to his detection. I think it likely that Shipman would have claimed that he had spoken to the coroner, who had approved the cause of death. Distrust of Shipman would not have been such as to cause the Form C doctor to verify the truth of that statement. However, if this had happened regularly, it would or should have attracted notice.

68. It is clear that the Form C procedure, as operated in this country for many decades, has been wholly inadequate as a safeguard against concealed wrongdoing by a Form B doctor. By wrongdoing, I mean, not only homicide, but also negligence and neglect. It is clear that any system which depends on the integrity of one doctor is open to abuse by that doctor, if s/he is dishonest.

69. It is a matter of regret that the Hyde doctors have still not changed their practice in relation to completion of Forms C, despite their knowledge of the way in which the system can be abused by an unscrupulous doctor.

The Dukinfield Crematorium Medical Referees

70. The Inquiry examined the work of the two doctors who were employed as medical referees at the Dukinfield crematorium during the years when Shipman killed so many of his patients. Dr Betty Hinchliffe was Deputy Medical Referee from the late 1970s until 1989, when she became Medical Referee, and Dr Jane Holme was Deputy Medical Referee from about 1989. Both retired in 1999.

71. Dr Hinchliffe and Dr Holme had worked in the field of child health for most of their professional careers and had very little experience relevant to their work as medical referees, especially in the care and treatment of the elderly. Both had little experience of

completing cremation forms. In my view, neither Dr Hinchliffe nor Dr Holme was adequately equipped by her professional experience for the work of a medical referee. This was not their fault. It was the fault of the system that permitted them to be appointed, despite their lack of relevant experience.

72. In oral evidence, Dr Holme told the Inquiry that she believed that her task was essentially to carry out a clerical check of the cremation forms. She did not consider that she should review the medical opinions expressed by the Form B and Form C doctors. She had never queried a cause of death. Nor had she ever ordered an autopsy or referred a death to the coroner.

73. By contrast, Dr Hinchliffe told the Inquiry that, in looking at the cremation forms, she assessed the whole picture and tried to fill in 'a little jigsaw puzzle'. In other words, she was suggesting that she exercised a degree of medical judgement. I regret to say that I was unable to accept that evidence for reasons which I have explained fully in Chapter Sixteen. I am satisfied that, like her colleague, Dr Hinchliffe carried out what was essentially a clerical check of the cremation forms only. Dr Hinchliffe too had never ordered an autopsy or referred a death to the coroner.

74. I am reluctant to criticise Dr Hinchliffe and Dr Holme for believing that their task was of an essentially clerical nature because this mistaken belief was not uncommon and there was no training or guidance by which such a mistaken belief could be corrected. However, I would have thought that the application of common sense to the words of the Cremation Regulations (particularly the power to order an autopsy) should have suggested to them that the task required the exercise of some degree of medical judgement and was intended to be more than a clerical exercise. I can only conclude that, like many of their colleagues, they never paused to consider the underlying purpose of the work of a medical referee, nor why, if that purpose were clerical in nature, the work had to be undertaken by an experienced medical practitioner.

75. Dr Hinchliffe authorised the cremation of the bodies of 176 of Shipman's patients; Shipman had killed 107 of those patients. The figures must be seen in the context of the total number (about 2000 a year) of deaths that Dr Hinchliffe processed. I am satisfied that neither the number nor the distribution of the deaths of Shipman's patients scrutinised by Dr Hinchliffe was so unusual that she should have found them noteworthy. Dr Holme dealt with only 31 deaths certified by Shipman over a period of eight years. There was nothing about the numbers to draw Shipman to her attention.

76. Had Dr Hinchliffe or Dr Holme undertaken an assessment of the whole picture presented by the cremation forms, they would have found some (in Dr Hinchliffe's case, many) Forms B in which the information provided by Shipman was inadequate or inconsistent. For Dr Hinchliffe, in particular, this would have meant that it was quite often necessary for her to speak to him to clarify the picture. She would have found it necessary to speak to him considerably more frequently than she had to speak to other general practitioners. Had Dr Hinchliffe assessed the whole picture, and had she had the benefit of a more appropriate medical background, she would have realised that there were unusual features among the deaths of Shipman's patients.

77. Whilst the performance of Dr Hinchliffe and, to a lesser extent, Dr Holme fell short of that which might have been expected from the best of their colleagues, I conclude that it is unlikely to have been significantly different from that of many other medical referees in England and Wales. In mitigation of their performance, they had not been given any formal training or even provided with a handbook of advice. The only instruction available had been provided by the previous medical referee. There was no contact with medical referees from other areas. Furthermore, the circumstances in which the task was performed, especially the pressure created by timing, encouraged the feeling that the job was a straightforward clerical exercise with the minimum of enquiry needed.

78. Even had Dr Hinchliffe or Dr Holme questioned Shipman, it is likely that he would have been able to proffer an explanation in any given case which would have satisfied them, just as it must already have satisfied the Form C doctor. However, had there been a repeated need to contact Shipman and to ask similar questions in relation to cases with similar characteristics, this might well have led to concerns about his competence to complete the forms, possibly about his competence as a doctor and possibly even as to his honesty. Repeated questions directed at him might have acted to deter him from pursuing his criminal activities. However, he might just have modified his form-filling techniques so as to ensure that his deaths passed through the system without question. Even had the medical referees exercised their power to order an autopsy, or referred a death to the coroner for him to do so, it would not have revealed evidence of criminal activity in the absence of toxicological tests.

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

Coroners

The Existing Coronial System and Coroners' Jurisdiction

80. According to the Home Office, there are 115 coroners in England and Wales, of whom 23 are full-time. Coroners may have a legal or a medical qualification; the vast majority are legally qualified. The coroner service is funded by local authorities, who are also responsible for appointing coroners. The resources available to coroners (even full-time coroners) in terms of office and court premises, staff and office equipment vary widely. Part-time coroners combine their coronial duties with practice, usually as a doctor or solicitor, often discharging their duties from their practice premises. Some carry out their duties from home.

81. Until recently, there was virtually no training for coroners. Recently, the Home Office began to provide some training. However, it is not compulsory and some coroners do not avail themselves of it. Many coroners, particularly part-time coroners, have little contact with their colleagues and operate in virtual isolation. In the past, they have received little advice or guidance. There is no leadership structure. The only challenge to a coroner's decision is by way of judicial review which is rare; there is no appellate body offering regular guidance on the interpretation of the relevant statutory provisions. As a consequence of all these factors, there is considerable variability of practice and standards in different coroner's districts.

82. It would be desirable to achieve a measure of consistency of practice and of high standards. To achieve these ends, there is a need for leadership, organisation and structure in the work of coroners. Coroners must also receive continuing education and training.

83. Some functions of a coroner (such as the conduct of inquests) require legal knowledge and experience. Others (such as the judgement whether a death is or is not due to a natural disease process) require medical expertise. At present, there are few coroner's offices where both legal and medical expertise is available on a day-to-day basis. Usually, the available expertise is legal only.

84. A coroner can act only if and when a death is reported to him/her. In 2001, 37.8% of all registered deaths were reported to coroners; most reports (95.7% in 2001) were by doctors. Coroners receive no information about deaths that are not reported to them. They are dependent on others to report deaths. I have already drawn attention to the present unsatisfactory arrangements whereby doctors decide whether or not to report deaths to the coroner. I have also described the difficulty which registrars experience in identifying those cases which should be reported. As Shipman has shown, it is possible for a doctor to evade the coronial system almost completely. A way must be found to ensure that all deaths receive a degree of scrutiny and investigation appropriate to their facts and circumstances.

85. When a report of a death is made, the coroner must make a decision as to whether the death falls within his/her jurisdiction, i.e. whether the death falls within one of the categories of deaths in respect of which s/he is obliged by statute to hold an inquest. These categories comprise deaths where there is reasonable cause to suspect that the death was 'violent' or 'unnatural' or was sudden and of unknown cause or occurred whilst the deceased person was in custody. The coroner might decide that the death falls within his/her jurisdiction, in which case s/he will proceed to investigate the death in preparation for an inquest, or to order an autopsy which might make an inquest unnecessary. Alternatively, the coroner might decide that the death does not fall within his/her jurisdiction, in which case s/he will take no action to investigate the death.

86. In my view, there are grounds for concern about the soundness of the decisions taken by some coroners and coroner's staff as to whether the coroner has jurisdiction. These decisions are very important as they will determine whether or not an individual death is to be subjected to any 'official' investigation. If the coroner does not assume jurisdiction, burial can follow without any further check being made. If the deceased is to be cremated, the death is still unlikely to be subjected to any significant investigation.

87. In my view, many decisions on jurisdiction are taken far too informally. The person reporting the death (usually a doctor) is not required to put anything in writing or produce any extract from the medical records. The coroner should receive written information about the circumstances of the death and the deceased's medical history in order to inform his/her decision on jurisdiction.

88. The decision as to jurisdiction is, in general, taken on the basis only of what the reporting doctor says. The coroner or a member of the coroner's staff takes what the doctor says

completely on trust. In general, no attempt will be made to verify the accuracy of the information given by the doctor from any other source. Nor will any attempt be made to speak to a relative of the deceased. In my view, such decisions should be based upon a broader knowledge of the death. Information provided by the person reporting the death should be cross-checked with a member of the deceased's family or some other person with recent knowledge of the deceased. If appropriate, other enquiries should be made.

89. The evidence received by the Inquiry suggests that many decisions about jurisdiction are taken by untrained staff without the medical knowledge necessary to equip them to do so and without any proper understanding of the correct statutory tests to be applied. The evidence suggests that, on occasions, they are influenced, whether deliberately or not, by extraneous matters. Even when coroners themselves take the decisions, they may not have the necessary medical knowledge to understand the issues and may in any event be reliant on information taken by a member of staff with no understanding of those issues. In my view, decisions of this kind should be taken by medically qualified coroners or, in the more straightforward cases, by coroner's officers with some medical background and ready access to expert medical advice.

Greater Manchester South District

90. Shipman's practice in Hyde fell within the coronial District of Greater Manchester South. Once his activities became known, there was some public disquiet that they had not earlier come to the knowledge of the Coroner for the District, Mr John Pollard. It was therefore necessary for the Inquiry to examine the practices within his office and to ascertain whether the fact that Shipman's activities had not come to his attention resulted from any fault on his part or that of his staff.

91. The procedures within Mr Pollard's office have been subjected to close scrutiny by the Inquiry. As a result, concerns have arisen about practices in operation in the office. Those concerns relate in particular to the way in which decisions, particularly decisions on jurisdiction, were made. I have also expressed concern about the extent to which members of his staff were authorised to make decisions on his behalf. I am not critical of individual members of staff, who had received no training and were no doubt doing their very best to discharge their duties in difficult circumstances. Nor am I very critical of Mr Pollard himself. He too had little training and suffered from the disadvantages of lack of leadership and guidance which I have described. I do not think that the practices within his office were any different from those in operation in many other coroners' offices up and down the country.

92. Most importantly, I doubt that the practices in operation in Mr Pollard's office had any effect on the outcome of those few deaths referred to him where Shipman had killed. It is possible that, if the practices followed in the office had been better, the outcome might have been different in those cases (we do not know how many since records would not necessarily have been kept) in which Shipman spoke to the coroner's office and 'discussed' a death. For example, in the case of Mrs Kathleen Grundy, a coroner's officer or clerk/typist might have spoken to Mrs Grundy's daughter, Mrs Angela Woodruff, before giving 'permission' for Shipman to certify the death as due to 'old age'. However, the

practice in the coroner's office can have had no effect on the vast majority of the killings, which never came to the Coroner's notice at all.

Coroner's Officers

93. The functions of coroner's officers vary from district to district. Some fulfil an investigative role. Others are office-bound. Most are serving or former police officers. Others come from a variety of different employment backgrounds, including nursing and paramedic. Some are employed by the police and others by local authorities. Until recently, when the Coroner's Officers Association began to organise and fund it, no training for coroner's officers was available. Even now, those coroners whose officers are employed by the police cannot insist on their attending the training courses which are available.

94. The service provided by coroner's officers is currently of variable quality. For too long, they have been expected to perform tasks requiring the application of skills which they do not possess and in which they have not been trained. Coroners must have the support of a team of investigators, preferably drawn from a wider variety of employment backgrounds than at present. The coroner should be able to direct and manage their work and working conditions. The investigators will require appropriate training. Other staff will supply the necessary administrative support.

The Police as Coroner's Officers

95. Under the present system, the police are frequently summoned to the scene of a death which has occurred in the community. If it appears to the police officer attending that there are circumstances suggestive of criminal involvement in the death, a police investigation will be set in motion. If there are no such circumstances and if it appears to the officer that there is a doctor willing and able to issue an MCCD, police involvement usually ceases immediately. If, however, there appears to be no doctor willing and able to issue an MCCD, the death must be reported to the coroner.

96. In that event, the function of the police officer changes and, thereafter, s/he acts in the capacity of a coroner's officer. In that capacity, s/he will carry out a limited preliminary investigation of the circumstances of the death and complete one or more sudden death report forms, recording the information obtained. Police officers sometimes carry out this same function following the report of a death to the coroner by others – for example, doctors and registrars.

97. The Inquiry examined samples of sudden death report forms completed by officers of the Greater Manchester Police (GMP). These revealed very variable standards of investigation and reporting. It was clear that the officers often had no idea why the death had been reported to the coroner or what issues the coroner would have to decide. Thus, the information contained on the forms did not focus on the issues of real relevance to any subsequent coroner's investigation. It was accepted on behalf of the GMP that the standard of investigation and reporting of deaths on behalf of the coroner was very variable. An individual officer might complete such forms 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.

98. Although I am critical of the standard of investigation and reporting by the GMP, I am satisfied that none of the shortcomings that I have identified resulted in Shipman escaping detection for killings which might have been revealed had officers acted differently. I should say also that I heard criticism of the standards of investigation and reporting by officers of other police forces besides the GMP.

99. It appears to me that there are several reasons why police officers 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. It is clear that many enquiries to be made on a coroner's behalf will involve medical issues and I am satisfied that a police officer with no medical knowledge is not an appropriate person to undertake them. Such enquiries also involve dealing with the recently bereaved, which many police officers are not used to and find difficult. Furthermore, the task of attending such deaths is time-consuming and places a heavy burden on limited police resources. Understandably, perhaps, many police officers do not regard attendance at such deaths as an appropriate use of their skills or their time.

100. In my view, what is needed is a person specially trained to investigate non-suspicious deaths. The usual role of the police should be limited to the investigation of those 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 the coroner's investigators to whom I have already referred.

Coroners' Investigations and Inquests

101. Once the coroner decides that s/he has jurisdiction over a death reported to him/her, the coroner will carry out an investigation into the death. Only two of the deaths of Shipman's victims, those of Mrs Renate Overton and Mr Charles Barlow, were subjected to a coroner's investigation. For reasons which I have set out in Chapters Nine and Thirteen, both investigations resulted in the deaths being wrongly attributed to 'natural causes'. The fact that those investigations had failed to reveal that Mrs Overton and Mr Barlow had been unlawfully killed raised the possibility that there might be more general deficiencies in the methods of investigation adopted by coroners. The Inquiry examined some of the ways in which coroners investigate deaths and the investigative tools at their disposal.

102. At present, once a coroner accepts jurisdiction in respect of a death, a subsequent decision to order an autopsy is almost automatic, without any other preliminary investigation. This immediate resort to autopsy results from the legislation. In my view, it is undesirable. An autopsy should be conducted only when there is a positive reason to do so; the decision should not be taken 'by default'. The coroner should have available to him/her a wider range of investigative methods and should be provided with the necessary powers to enable him/her to make full use of those methods.

103. The evidence received by the Inquiry suggests that, sometimes, the autopsy is not the definitive source of information it is often thought to be. Some coroners' autopsies are seriously deficient. The pathologist may have inadequate information about the death. He or she may not have the medical records or the opportunity to speak to the clinicians responsible for the deceased person's care. Pressure of time may mean that the autopsy

is conducted too quickly and best practice may not be followed. Sometimes, coroners will not give permission for samples to be taken for histology, when the pathologist thinks it necessary. The pathologist may feel under pressure to find a natural cause of death. Sometimes, pathologists are tempted – or persuaded – to go beyond their expertise in ascribing a death to 'natural causes' when they do not have all the relevant information.

104. When available, the autopsy report is often viewed in isolation. The coroner is likely to know little about the circumstances of the death or the deceased person's medical history. He or she will have no witness statements and no medical records. In the absence of any wider evidential background against which to view the autopsy report, a coroner is almost bound to accept it at face value. Nor do most coroners have the medical expertise necessary to subject the report to any critical examination.

105. My overall impression is that there is in the minds of the coroners and some of the pathologists about whose practices I heard an expectation that, if a death is not immediately identified as 'suspicious', it will be found to be due to natural causes. It is easy to see how this attitude can become entrenched. The great majority of deaths will, in fact, be natural. However, if a coroner's investigation is to be effective, there must be an ever-present readiness to keep in mind the possibility that the death might not have been natural. Quite apart from any question of homicide, the coroner should bear in mind the possibility that neglect, accident or medical error might have caused or contributed to the death. Otherwise, the expectation that the death will be 'natural' may become a self-fulfilling prophecy.

106. Following autopsy, if the cause of death is not certified on the basis of the cause of death given in the autopsy report, some investigations will be undertaken prior to the inquest. The detailed evidence which the Inquiry received about such investigations came primarily from the Greater Manchester South District. That evidence suggested that investigations were unfocussed and lacked co-ordination by a person who understood the issues and had access to all the available information. A particular problem arose in the investigation of cases involving the possibility of medical error or neglect which might have caused or contributed to the death. Such investigations require particular expertise and the availability of specialist skills.

107. There is, in my view, an urgent need for a more focussed, professional and consistent approach to coroners' investigations; this is needed from the time that the death is reported, right up to the verdict at inquest. There needs to be clarity as to the purpose and scope of the enquiries that are made. Coroners themselves, who are to direct the conduct of an investigation, require training. Legal experience, particularly as a solicitor, should provide a sound basis for the conduct of an investigation into non-medical matters, but it is apparent from the evidence that medical knowledge and experience is vital for the proper conduct of many investigations, as well as for the proper evaluation of evidence and the taking of decisions.

108. In the course of the Inquiry, I have become aware of the widespread concern about the number of inquests held and the way in which many inquests are conducted. I have considered the issue of inquests only briefly because, in the event, no death of a victim of

Shipman was the subject of an inquest until after Shipman had been convicted of murder in January 2000.

109. In 2001, inquests were held into nearly 25,800 deaths in England and Wales; that figure represents 13% of all deaths reported to coroners and nearly 5% of all registered deaths. Inquests are held into a far larger proportion of deaths in England and Wales than in other jurisdictions which the Inquiry examined.

110. Although some jurisdictions manage without inquests altogether, I think there are positive reasons to have inquests, provided that they are thorough and well conducted. There are cases in which the holding of an inquest will result in positive public health and public safety benefits. Also, where issues of public concern arise, an inquest can expose failings or engender confidence.

111. At present, it is not easy for coroners to decide whether a particular death falls within one of those categories of death which by statute require an inquest. There is a general perception that the existing categories do not include all deaths that give rise to public concern. Equally, there is a feeling that some deaths which do fall within the categories give rise to no issue of particular public interest or concern. In short, the means of selecting those deaths where the public interest requires an inquest is not satisfactory and requires change.

112. In the modern era, the purposes of the public inquest should be to conduct a public investigation into deaths which have or might have resulted from an unlawful act or unlawful acts, to inform interested bodies and the public at large about deaths which give rise to issues relating to public safety, public health and the prevention of avoidable death and injury, and to provide public scrutiny of those deaths that occur in circumstances in which there exists the possibility of an abuse of power.

113. In many cases, nothing is gained by the hearing of evidence in public. Indeed, in many cases, such exposure amounts to an unwarranted invasion of privacy and only causes increased distress to the bereaved. In my opinion, the public inquest should be limited to those deaths about which there is a real public 'need to know'. In all other cases, the end product of a coroner's investigation would be a written report. I would confine inquests to deaths where the particular circumstances are such that the public interest requires a public hearing. I suggest that, apart from a few types of situation in which an inquest should be mandatory (such as cases of homicide not followed by conviction and deaths in custody), the coroner should have discretion to decide (after consultation with interested parties) whether a public inquest should be held in that individual case or group of cases. The decision should be subject to appeal, not only by relatives of the deceased, but also by anyone with a legitimate interest in the case. Coroners should receive guidance on the types of issue that will require a public investigation at inquest.

114. I also consider that the procedure by which coroners can make recommendations for future change should be continued, but strengthened.

The Death of Mrs Renate Overton

115. Following investigation of Mrs Overton's death during Phase One, I found that Shipman had deliberately given her an overdose of diamorphine (or possibly morphine), intending

to kill her. In the event, she survived, in a persistent vegetative state, for 14 months before her death in April 1995. I was concerned to investigate precisely how the post-death procedures had operated in her case. The detailed results of that investigation are set out in Chapter Thirteen.

116. I have found that the performance of Dr David Bee, the consultant pathologist who carried out the autopsy in Mrs Overton's case, was seriously deficient. His autopsy report provided no underlying cause of death and he should have made it clear that he was unable to do so. Instead, he gave an unfounded opinion that the death was due to natural causes. I have also criticised the then Coroner for Greater Manchester South District, Mr Peter Revington, for his decision, based on manifestly inadequate information, not to hold an inquest.

117. The events of this case vividly illustrate the shortcomings of the systems for the investigation of deaths in operation in the office of the Coroner for Greater Manchester South District at the material time and lend strong support to the conclusions which I have expressed above about the inadequacy of coroners' investigations generally.

Proposals for Change

118. It is clear from the evidence I have received that the current arrangements for death and cremation certification and the coronial system require radical change. I have set out my proposals for that change in the following section.