Shipman Inquiry

Following the activities of the mass murderer, Harold Shipman, Dame Smith was asked to carry out an inquiry into the deaths of his patients, and to look into systems and procedures that may have allowed him to remain undetected for so long.

The third report of the Inquiry, 'Death certification and the investigation of deaths by Coroners', (www.official-documents.co.uk/document/cm58/5854/5854.htm) was issued in July 2003.

Dame Smith relied on evidence from a number of sources, including Tom Luce, and she prepared this report with the benefit of Luce's report.

She found that the current system offered the following benefits;

- Speed
- Cost (relatively cheap)
- convenient

However, it had the following disadvantages;

- it depends entirely on the integrity and judgement of a single registered medical practitioner
- the quality of death certification is poor (lack of training)
- some doctors never report a single death to the Coroner
- once a doctor has certified (MCCD) there is no check on the truth or accuracy
- there is no system of audit or review of cases certified by MCCD but not referred to a coroner

She concluded therefore, that the current system was not satisfactory, and should not be allowed to continue (in much the same way that Luce thought that it was 'not fit for purpose').

Common ground between Shipman and Luce

- Central organisation - Both Luce and Dame Smith agree that there needs to be more central organisation of the Coroner system, such as by the Department of Constitutional Affairs, or another non-governmental type organisation.

- Increase the number of deaths to be scrutinised – approximately 40% fully (rest to be certified by 2nd doctor (Luce) or investigator (Shipman)

- Medical assistance (full time basis) to be provided for Coroners – SMA (Luce); Medical Coroner (Shipman)

- Better trained Investigators (medical or nursing background)

- Death certification – more time/ effort to be put into certifying deaths, and to include basic details of medical history

- Autopsies – reduced number; better quality; better information to be provided prior to autopsy (Shipman); partial autopsies may be acceptable (both)

- Histology – pathologists should be free to carry out whatever special tests/ examinations they consider necessary for the completion of a thorough and accurate report (provided there is medical justification for the conduct of these examinations)(Shipman); professional matter for the pathologist (Luce)

- Professional freedom – Coroner not to restrict professional freedom of pathologist, and there should be increased funding for histology and toxicology (Shipman)

- Toxicology – greater use to be made of this in all cases (screening)(Shipman)

- Audit – at all stages of the death certification and investigation process (Shipman)

Dame Smith recognises that her recommendations may cost more money (having a medical as well as a Judicial Coroner), and hopes that the recommendations for change will not meet the same fate as those made by previous inquiries, such as the Broderick Inquiry (1971).

The Shipman Inquiry website can be found at www.the-shipman-inquiry.org.uk.

- Follow the Shipman murders investigation with the BBC at The Shipman files.
- Follow the Shipman story with the Panorama team at Panorama
- Further details of the Fundamental review can be found at www.coronersreview.org.uk.