# CHAPTER ELEVEN

## Cremation Certification

### Introduction

11.1 Despite the many attempts to introduce change, current procedures for obtaining authorisation to cremate a body remain little altered since their introduction in 1903. The procedures are still governed by the 1930 Regulations (as amended).

11.2 The cremation procedures require the use of a number of forms prescribed in the 1930 Regulations. However, no single 'standard' set of forms is produced and distributed by the Home Office or any other central body. Instead, each cremation authority provides its own 'personalised' set of forms. Over the years, some authorities have modified the forms, by adding explanatory notes, changing the layout slightly and, in some cases, adding supplementary questions. There is no requirement that crematoria should submit their forms to the Home Office for approval and, in general, they do not do so.

11.3 Evidence given to the Inquiry suggests that most crematoria have no formal procedure for regular review of their cremation forms. Instead, the staff tend to wait until a new supply of forms is required before introducing any changes. Supplies of forms are held by funeral directors, hospitals and by some general practices. After a new version of the forms is issued by a crematorium, it takes some time for supplies of the old forms to be exhausted. For a time (sometimes years), completed forms of both the old and the new style will continue to be submitted. When a death occurs outside the area usually covered by the crematorium where a deceased is to be cremated, it is not uncommon for the forms submitted to be issued by a different crematorium. In general, that causes no problems. However, difficulties can arise where the requirements imposed by the forms issued by the two crematoria differ. An example of this is when the crematorium where the cremation is to be held has a requirement that one of questions 5–8 of cremation Form C should be answered in the affirmative, whereas the crematorium from which the forms originate does not.

11.4 Specimen cremation forms can be seen at Appendix D to this Report. Those included in the Appendix are the forms used at the Dukinfield crematorium, where most of Shipman's patients were cremated.

### The Application for Cremation: Form A

11.5 The Application for Cremation (Form A) is usually completed by the deceased's closest relative or his/her executor. Included on the form are questions about the date, time and place of the deceased's death. The applicant is required to state whether s/he knows of any reason to suspect that the death of the deceased was due, directly or indirectly, to violence, poison, privation or neglect. The applicant is also asked whether s/he knows of any reason whatever for supposing that an examination of the remains of the deceased may be desirable. Those two questions are invariably answered in the negative; if the facts were such as to lead to either question being answered in the affirmative, the death is likely to have been reported to the coroner. The applicant is asked to state the name and

address of the ordinary medical attendant of the deceased and the names and addresses of the medical practitioners who attended the deceased during his/her last illness.

11.6 The form must be countersigned by a person who knows the applicant and is prepared to certify that s/he has no reason to doubt the truth of any of the information furnished by the applicant. In practice, Form A is frequently completed by the funeral director making the cremation arrangements (after obtaining the necessary information from the applicant) and the applicant merely signs the form. It is usual for a representative of the funeral director to countersign the form.

## The Certificate of Medical Attendant: Form B

11.7 The Certificate of Medical Attendant (Form B) must be completed by a medical practitioner who has attended the deceased before death and has seen and identified the deceased's body after death. This form asks a number of questions about the circumstances and cause of the death and about the certifying doctor's involvement with the deceased before death. Form B is usually completed by the same doctor who has issued the MCCD. If an early decision has been made by the relatives to have a cremation, Form B may be completed at the same time as the MCCD. More often, however, it is completed slightly later, sometimes after registration of the death has taken place. The doctor completing Form B receives a fee, currently recommended at £45.50. This fee is recommended by the British Medical Association (BMA) and is usually increased annually.

11.8 Included on Form B are questions about the date, time and place of the deceased's death. The certifying doctor is asked if s/he is a relative of the deceased and, if so, to state the relationship. The doctor is also asked whether s/he has any pecuniary interest in the death of the deceased. Neither the form nor the Regulations make clear what the effect of such relationship or pecuniary interest may be; in particular, there is no indication that the existence of either disqualifies a doctor from certifying. In practice, however, rarely – if ever – is either of these two questions answered in the affirmative.

11.9 The certifying doctor is asked (at question 5) if s/he was the ordinary medical attendant of the deceased and, if so, for how long. The term **'ordinary medical attendant'** can cause some difficulty when the deceased has been in hospital for only a short time prior to death. The question then arises as to whether a doctor who treated the deceased in hospital can properly be described as his/her **'ordinary medical attendant'** or whether the deceased's general practitioner (who may know little of his/her last days) is the appropriate person to certify. There appears to be no consistency of approach. However, the next question (question 6) is more important. That asks whether the certifying doctor attended the deceased during the last illness and, if so, for how long. The words **'attended'** and **'last illness'** are not defined within the cremation legislation. Nor, as I have pointed out in Chapter Five, are those terms defined in the legislation governing certification of the medical cause of death.

11.10 Question 7 requires the certifying doctor to say when (by reference to hours and days before death) s/he last saw the deceased alive. Question 8(a) asks how soon after death

the doctor saw the body and, on the Dukinfield crematorium Form B, there is a reminder that the certifying doctor must see the body after death. This is in contrast to the MCCD, where there is no legal requirement that the certifying doctor should have seen the body after death.

11.11 The Form B doctor is then asked (by question 8(b)) what examination of the body s/he has made. In Shipman's case, the reply was almost always that he had made a 'complete external examination'; other doctors use similar descriptions, some indicating that they have examined for signs of life. Form B does not require the doctor completing it to state what findings were made on examination (or, indeed, precisely what examination was carried out) and this is virtually never stated.

11.12 As I have said in Chapter Three, question 8A was introduced by the Cremation (Amendment) Regulations 1985 and asks:

> **'If the deceased died in a hospital at which he was an in-patient, has a post-mortem examination been made by a registered medical practitioner of not less than five years' standing who is neither a relative of the deceased nor a relative or partner of yours and are the results of that examination known to you?'**

11.13 The purpose of this question was to dispense with the need for Form C to be completed if the Form B doctor was aware of the results of an autopsy and had used that knowledge to inform his/her diagnosis of the cause of death. The post-mortem examination referred to is a 'consent' or 'hospital' examination, rather than an autopsy directed by a coroner.

11.14 In practice, Form B doctors rarely answer question 8A in the affirmative. Even when they do, it is not unusual for Form C also to be completed, despite the fact that it is not required. As has frequently been pointed out since its introduction, question 8A is unsatisfactory in a number of respects. The Form B doctor is not required to identify the practitioner who performed the autopsy; thus, it is not possible for the medical referee to check that the practitioner has the necessary five years' registration. It is not uncommon for trainees to carry out hospital autopsies, in which case a Form C (usually completed by the supervising pathologist) is still required. Also, question 8A contains a number of constituent parts and a negative answer can be ambiguous. For example, it is not possible to determine, if the question is answered in the negative, whether there has been no post-mortem or whether there has been a post-mortem, but the results of it are not known to the Form B doctor. Some crematoria (e.g. Newcastle-upon-Tyne) have sought to solve this difficulty by splitting question 8A into two separate questions.

11.15 Question 9 requires the certifying doctor to state the cause of death in essentially the same way as on the MCCD. Question 10 asks about the mode and duration of death. Examples of possible modes (syncope, coma, exhaustion and convulsions) are given on the form. This question has been much criticised. The medical referees who gave evidence to the Inquiry were uncertain as to the value of the question. It may originally have been intended to seek information about the surrounding circumstances of the death. Instead, it tends to provoke a one-word response, chosen from the terms listed in the question. If such a response is inserted by a doctor who was not present at the death and is merely

speculating as to how the death occurred, it can provide no assistance at all. Different doctors apply different terms to describe similar modes of death. If the question required a brief description of how the death occurred, it would be of real value.

11.16 Question 11 asks the certifying doctor to state how far the answers to the last two (in the Dukinfield crematorium version, the word **'two'** is emphasised by underlining) questions are the result of his/her own observations or are based on statements made by others. The reference to **'the last two questions'** is ambiguous. It could refer either to parts (a) and (b) of question 10 (i.e. (a) the mode and (b) the duration of death) or it could apply to questions 9 (cause of death) and 10 (mode and duration of death). Some crematoria have tried to remove the ambiguity by including an explanatory note, or additional words, on their forms. The Form B issued by Newcastle-upon-Tyne crematorium specifies that question 11 refers to the answers given in question 10. The Form B issued by Stockport crematorium contains a note which begins: **'State how far the answers to the last two questions 9 and 10 are the result ...'**. The difference can be significant. One medical referee who gave evidence to the Inquiry understood question 11 to refer to both questions 9 and 10. (This was despite the fact that a marginal note on the Form B issued by the crematorium at which he officiated stated that the Home Office had advised that question 11 referred to question 10(a) and (b).) In response to question 9, the Form B doctor states his/her views about the cause of death. Therefore, the medical referee took the view that it was essential, if the Form B was to be accepted, that the doctor should record in response to question 11 that s/he had made the relevant observation. That would indicate that s/he was relying on his/her own observations in order to assess the cause of death. If the certifying doctor inserted in response to question 11 the name of a relative of the deceased, or a nurse or carer, the form would not, in his view, be acceptable. The same witness acknowledged that, if question 11 referred only to the two parts of question 10 (relating to mode and duration of death), it would be perfectly permissible for the certifying doctor to record only the names of those people who had observed the deceased during the process of death. In summary, it is clear that there is no consistency of approach to this question.

11.17 Question 12 asks if the deceased underwent any operation during his/her final illness or within the year before death and, if so, seeks information about the nature of the operation and the identity of the person who performed it. The purpose behind this question is to ascertain whether the deceased has undergone any surgical procedure that might have caused or contributed to his/her death.

11.18 Question 13 asks for information about those who nursed the deceased during his/her last illness. Some doctors take this to mean only professional nursing care; others understand it to include care provided by relatives. One purpose of this question is to provide the Form C doctor with the names of persons whom s/he may wish to question in connection with the completion of Form C. However, no address, telephone number or other contact details are sought. Question 14 was designed for the same purpose and asks who were the persons (if any) present at the moment of death. Here also, there is no requirement to give the contact details of such persons. Presence **'at the moment of death'** might seem unequivocally to suggest that the person(s) identified should have been in the presence of the deceased when s/he drew his/her last breath. However, some doctors interpret the

phrase differently. Dr Ian Morgan, a general practitioner and crematorium medical referee, told the Inquiry that he would regard a wife as having been present at the moment of her husband's death if she had left him alive at night, gone to sleep in the next door room and found him dead the next morning.

11.19 In questions 15, 16 and 17, the certifying doctor is asked whether s/he feels any doubt whatever as to the character of the disease or the cause of death, or has any reason to suspect that the death was due, directly or indirectly, to violence, poison, privation or neglect. The doctor is also asked whether s/he has any reason whatever to suppose a further examination of the body to be desirable. As on Form A, those questions are invariably answered in the negative. If the certifying doctor had any concerns, the death would no doubt have been reported to the coroner. At the Dukinfield crematorium, a note has been added opposite question 16. The note reads, **'Death due directly or indirectly to alcohol has now to be reported to the Coroner'**. This is a 'local rule', presumably indicating that the Coroner classifies such deaths as 'unnatural'.

11.20 Question 18 asks if the Form B doctor has also issued the MCCD and, if not, who has. In most cases, this question will be answered in the affirmative. However, one might have a situation where the attending doctor is away at the time of death, a colleague is qualified to issue the MCCD and the attending doctor arrives back in time to complete the Form B; this would be perfectly permissible. There are other circumstances when such a situation might legitimately arise.

11.21 The Form B issued by the Dukinfield crematorium has an additional question, question 19, which is not on the form prescribed by the Regulations. This asks if the coroner has been notified of the death and, if s/he has, requests full details. Some of the forms issued by other crematoria contain an instruction to the certifying doctor to provide this information but do not ask a specific question. An example will serve to illustrate the purpose of the question. If a deceased person has undergone a recent operation, that fact may raise a question as to whether the operation played any part in the death. The attending doctor will contact the coroner's office and may be given 'permission' to certify the death. He or she should then record the fact of his/her contact with the coroner's office and the outcome in response to question 19 of Form B. The effect of that will usually be that the medical referee will not investigate further the possibility that the operation had a bearing on the death. Were it not for the information given in response to question 19, s/he might feel constrained to do so. A belief that the coroner (in fact, in most cases, the coroner's officer) has been informed will usually be sufficient to satisfy the medical referee, who will accept the doctor's word.

11.22 At the conclusion of Form B, the doctor is required to certify:

> **'... that the answers given above are true and accurate to the best of my knowledge and belief, and that I know of no reasonable cause to suspect that the deceased died either a violent or an unnatural death or a sudden death of which the cause is unknown or died in such place or circumstances as to require an inquest in pursuance of any Act'**.

11.23 The versions of Forms B, C and F produced by certain crematoria (of which Dukinfield is one) state that the forms are regarded as strictly confidential, the right to inspect them

being confined to **'the Secretary of State, the Ministry** [*sic*] **of Health and the Chief Officer of a Police Force'**. This reference to confidentiality does not appear on the forms issued by all crematoria. However, the forms are generally treated as confidential. Form B is never shown to the deceased's relatives, who thus have no opportunity of confirming the accuracy or otherwise of the details contained in it. Many relatives of Shipman's former patients saw the cremation forms (apart from Form A) for the first time when they were shown them by a member of the Inquiry legal team.

11.24 It is not unusual for Form B to be delivered to the crematorium with some questions unanswered. In areas where the cremation forms contain a warning about confidentiality, many funeral directors take the view that they are precluded from checking the forms before delivery to ensure that they are complete. Consequently, it is left to staff at the crematorium – sometimes the medical referee – to chase up missing information. As with MCCDs, Forms B are frequently completed by inexperienced junior hospital doctors and this can give rise to particular problems with defective forms. However, evidence received by the Inquiry suggests that most doctors complete the forms carefully and accurately.

11.25 Although a completed Form B provides much more information than a completed MCCD, it is still of limited usefulness for the purpose of the investigation of the cause and circumstances of the death by another doctor or by the medical referee. It would also be of limited usefulness if seen by the coroner (which it is not). 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.

## The Confirmatory Medical Certificate: Form C

### The Choice of Doctor to Complete Form C

11.26 Despite conflicting views about its value, completion of the Confirmatory Medical Certificate (Form C) remains a requirement for all cremations where the coroner has not issued Form E following a post-mortem examination and/or the opening of an inquest. The doctor completing Form C receives a fee set at the same level (currently £45.50) as for Form B.

11.27 In order to be able to give a Form C, the certifying doctor must have been registered in this country for not less than five years. There has been ongoing controversy over the precise meaning of this requirement. The Regulations drafted in 1989 would have included within the five-year period any period of provisional or limited registration, provided that full registration had been achieved at the time the Form C was completed.

11.28 The Form C doctor must also be independent, to the extent that s/he must not be a relative of the deceased or a relative or partner of the Form B doctor. The word 'partner' is inappropriate to the completion of Form C in a hospital setting. Indeed, it may be inappropriate in some general practices, where no partnership exists. In the early 1980s, an official from the Home Office wrote to medical referees, explaining the Department's view that the Form C doctor should be **'demonstrably independent'** of the Form B doctor. The Home Secretary was said to take the view that, in the case of a death occurring in

hospital, the Form C doctor should not have been in charge of the patient or directly concerned in his/her treatment. The letter indicated that the **'spirit of the Regulations'** would usually prohibit two doctors from the same firm (i.e. the hospital team responsible for the care of the patient) from completing Forms B and C in the same case. The Forms C issued by some crematoria contain notes at the head of the form, reflecting this view. No such note appears on the version of the Form C issued by the Dukinfield crematorium.

11.29 In practice, following a death in hospital, Form C is frequently completed by a pathologist, even where there has been no autopsy. Examination of the Dukinfield cremation register revealed that the same doctors employed at the Tameside General Hospital appeared time and time again as signatories of Forms C for deaths at the hospital. It appears that many hospitals have a small pool of doctors who complete Forms C on a rota system. The fees consequent upon membership of the pool can, it would appear, be quite significant. The Form C doctor must state the office (on the Dukinfield crematorium form, the word 'appointment' is used) that s/he holds.

11.30 When a death occurs in the community, it is usually the attending (Form B) doctor who chooses which of his/her colleagues should complete the Form C. Occasionally, the choice will lie with the funeral director. This might happen if the body is lying at a funeral director's premises some distance from the attending doctor's surgery and from his/her local colleagues. In those circumstances, it may be more convenient for the funeral director to select a Form C doctor who practises nearby and can attend to view the body without inconvenience.

11.31 Where the Form B doctor is responsible for the choice, it is often one of convenience. It is often the case that two doctors, or two general practices, operate a reciprocal arrangement whereby each signs the other's Forms C. Sometimes, the arrangement is more complex. Shipman, for example, used members of the Brooke Practice to sign virtually all his Forms C, save where it would have been geographically inconvenient for them to do so. Three members of the Brooke Practice reciprocated by asking Shipman to sign their Forms C; the other two members went elsewhere. The relationship between the Form B and Form C doctors is often a close one, sometimes social as well as professional. Such a relationship does not encourage the Form C doctor to approach the task of assessing the evidence about cause of death with a critical eye. Instead, s/he is likely to embark upon his/her assessment with a degree of confidence that all will be well. Indeed, even if s/he were tempted to probe (e.g. by inspecting the medical records), s/he is likely to be discouraged from doing so for fear of appearing to question the judgement (or even the honesty) of a friend and/or colleague. Furthermore, the doctor who undertakes a minute examination of the medical history before completing Form C may well find that, in the future, the task of completing Form C goes to one of his/her less conscientious colleagues.

11.32 Evidence heard by the Inquiry suggests that, although doctors are aware of and comply with the requirement that the Form C doctor should be independent of the Form B doctor, most doctors have not thought about the reasons for it and have not appreciated the need for true independence of mind. It appears that the requirement for independence is regarded by most as a technical matter.

11.33 As I have already explained in Chapter Three, the original concept of the Form C doctor was of a practitioner holding a prestigious public appointment that would have set him/her apart from the doctor who had completed Form B. Such a practitioner would – or should – have had the necessary detachment, authority and confidence to express disagreement with the Form B doctor, had s/he thought it right to do so. The position of such a practitioner would have been very different from that of a doctor in the community performing the same function today.

**The Personal Inquiry**

11.34 Before completing Form C, the doctor should examine Form B and make a **'personal inquiry'** into the death. The nature of that **'personal inquiry'** is identified in the series of questions posed in Form C. I have already set out (at paragraph 3.25) the eight questions that appear in Form C, as prescribed in the 1930 Regulations. I shall now consider these questions, and the way in which doctors answer them, in greater detail.

**Questions 1–4**

11.35 The first question asks whether the doctor completing Form C has seen the body of the deceased. The evidence received by the Inquiry suggests that, in the community setting, the Form C doctor always attends at the premises of the funeral director to view the body and complete Form C. Payment of the fee for completing the form is often made at the time of this visit.

11.36 The second question asks whether the Form C doctor has **'carefully examined the body externally'**. Although that question is invariably answered in the affirmative, it is evident that the nature and extent of the examination undertaken varies widely. Often, conditions at the funeral director's premises are not conducive to a full and careful examination. At one of the Inquiry's seminars, Dr John Grenville, a general practitioner, gave a graphic account of the conditions that had prevailed at the premises of a busy funeral director when he had attended there the previous day. Those conditions would have made a thorough examination of the naked body difficult, if not impossible. Sometimes, the body to be examined is already dressed and in a coffin and there is a reluctance on the part of the funeral director to remove and strip it. According to the funeral directors who provided evidence to the Inquiry, the extent of the examination varies from doctor to doctor. Some carry out a thorough examination of the front and back of the body. At the other extreme, some confine their examination merely to checking the identifying tag or bracelet and viewing the face. The rest fall somewhere in between. The variations in practice described by the funeral directors were confirmed by the evidence of doctors accustomed to completing Forms C.

11.37 Even if carried out conscientiously, a physical examination will not, in the majority of cases, assist in diagnosing the cause of death. Signs of emaciation may tend to confirm a diagnosis of death caused by terminal cancer. Yellowing of the skin may indicate liver disease. Surgical scars may confirm a history of recent illness requiring operative treatment. But an examination will not shed any light on whether a person died of a coronary thrombosis, a cerebrovascular accident or as a result of any one of a number of

other natural causes. It would not have led to a correct diagnosis of the cause of death of one of Shipman's victims. It may well be that it is because they realise that an examination is unlikely to yield any useful information that many doctors regard it as a mere formality which can safely be dispensed with.

11.38 A thorough physical examination, made in appropriate conditions, could be expected to reveal signs of violence such as wounds, bruising and (possibly) petechiae (the tiny haemorrhages which are often observed after a death from suffocation or strangulation) or signs of possible neglect, such as pressure sores and malnutrition. There is no way of knowing how frequently such signs have gone unnoticed in the past because no proper physical examination has taken place. However, the examination by the Form C doctor is not the only opportunity to observe signs of violence or neglect. In many (if not most) cases, the funeral director will see the body unclothed in the course of preparation for burial or cremation. He or she is in a good position to notice any abnormal signs and the Inquiry was told that it is not unusual for a funeral director to refer a death to the coroner if abnormal signs are observed. Some of the doctors who gave evidence suggested that a representative of the funeral director would usually be present when they attended to view the body and they would expect that person to mention any unusual signs that had been noticed.

11.39 The third question on Form C asks whether the certifying doctor has made a post-mortem examination. Unless the doctor is a pathologist who has undertaken a hospital post-mortem, this will rarely be answered in the affirmative. The Inquiry is aware of one general practitioner in Hyde who regularly gave an affirmative answer to this question, on the basis that an external examination made after death was, strictly speaking, 'a post-mortem examination'. He was, however, the exception. Where a hospital post-mortem has been carried out and the result is known to the Form B doctor, this should of course be indicated in response to question 8A of Form B and no Form C is then necessary. Fewer hospital post-mortems have been carried out in recent years and they are, in any event, rare where a patient dies in the community.

11.40 Question 4 of Form C asks whether the certifying doctor has seen and questioned the Form B doctor. For practical reasons, such conversations frequently take place on the telephone and doctors answer the question in the affirmative even when they have not met the Form B doctor face to face. Forms B and C are delivered to, or collected by, the Form C doctor, who takes them (in fact, they are often joined in a single document in booklet form) to the funeral director's premises. Alternatively, the forms may be left with the funeral director for the Form C doctor to view when s/he attends.

11.41 The evidence received by the Inquiry suggests that some discussion between the certifying doctors invariably takes place. Most Form B doctors know the type of explanation of the clinical history which is expected of them and provide the necessary information.

11.42 It is clear from the evidence available to the Inquiry that it is not usual practice for a doctor completing Form C to inspect the deceased's medical records before giving the certificate. Dr Ian Morgan, Medical Referee at the Robin Hood crematorium, Solihull, told the Inquiry that to request to see another practitioner's medical records in a general

practice setting would imply a degree of suspicion. It would not be seen as a neutral enquiry. He contrasted that with the position at the hospice where he is Medical Director. There, the records are left out, as a matter of course, for the Form C doctor to examine. In my view, this is good practice.

11.43 There is no statutory requirement that any of the questions contained in Form C must be answered in the affirmative if a cremation is to be authorised. The Regulations drafted in 1989 would have introduced such a provision in relation to questions 1, 2 and 4; those Regulations never became law. However, as I have already said, the version of Form C issued by every crematorium in the country (so far as the Inquiry is aware) contains a note to that effect.

11.44 Affirmative answers to questions 1, 2 and 4 usually indicate that the doctor has 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 (e.g. in the terminal cancer case). 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 evidence, 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.

11.45 The pathologist who has given an affirmative answer to question 3 will, of course, be in a completely different position. He or she will have undertaken an autopsy and will have had the opportunity of comparing the findings of that examination with the clinical history given by the Form B doctor.

**Questions 5–8**

11.46 Questions 5–8 of Form C ask whether the certifying doctor has seen and questioned:

- any other medical practitioner who attended the deceased
- any person who nursed the deceased during his/her last illness
- any person who was present at the death
- any of the deceased's relatives
- any other person.

The doctor is also asked to give names and addresses and is asked whether s/he has seen the person(s) alone.

11.47 The obtaining of evidence from a source separate and independent from the Form B doctor was an important element of the system described in the 1903 Departmental Committee Report. It constituted the only effective check on the Form B doctor. It seems, however, that the significance of this evidence, and therefore the importance of questions 5–8, was rapidly forgotten, certainly after the relaxation of the rules (as a result of the 1930 Regulations) governing those qualified to complete Form C. Even in 1935 (see

paragraphs 3.24 to 3.29), it was reported that some Form C doctors invariably failed to question anyone except the Form B doctor; indeed, it was claimed that some did not even do that. The Home Secretary's letter of that year, which emphasised the need for affirmative answers to questions 1, 2 and 4, made no mention of questions 5–8.

11.48 From time to time over subsequent years, as I have explained in Chapter Three, various individuals and organisations drew attention to the fact that the investigations referred to in questions 5–8 afforded the Form C doctor an important opportunity to obtain evidence from an independent source and therefore provided an essential safeguard. In 1960, Dr John Havard, then Assistant Secretary of the BMA, claimed on behalf of the Association that potential criminals were deterred by the knowledge that an independent doctor questioned relatives, nurses and other persons in every case. In reality, even at the time Dr Havard made that claim, it is evident that many members of the BMA were carrying out no such questioning.

11.49 Despite these references, attention was more generally directed at the reported failure of doctors to carry out even the investigations required in order to answer questions 1, 2 and 4 affirmatively and at ways (e.g. by means of the draft Regulations circulated in 1962) in which they might be compelled to carry out their duties (i.e. to see and carefully examine the body and to question the Form B doctor) properly.

11.50 The Brodrick Committee, which reported in 1971, also recognised the potential importance of the questioning of persons other than the Form B doctor. The Committee found that many Form C doctors were not taking the opportunity to carry out their own investigations. This fact, coupled with evidence that the physical examination carried out was frequently inadequate or non-existent, led the Committee to the conclusion that Form C was valueless and should be abolished as soon as possible. The Committee does not appear to have considered the imposition of a requirement that independent investigations should be made in every case. It may be that members of the Committee did not believe that, even with such a requirement, effective investigations would be made. In any event, their view must have been coloured by the fact that they did not accept that there was a real risk of cremation being used to conceal evidence of homicide.

11.51 In July 2002, the Inquiry received a letter from Dr Derek North, a general practitioner from Gosport, Hampshire. He enclosed a copy of the Form C used at the Portchester crematorium, which serves his local area. He pointed out the note on that form which reads as follows:

> **'The Medical Referee requires that at least one of the questions No. 5–8 should be answered in the affirmative.'**

11.52 Dr North had visited the Inquiry website and noticed that the cremation forms from the Dukinfield crematorium that appeared there did not bear a similar note. In his letter, he commented as follows:

> **'This simple requirement on the crem**[*ation*] **form I am sure would have made it much harder for Harold Shipman to commit his murders. I and my partners have never signed a form C without having answered at least one of those questions in the affirmative. I have been a GP for 20**

> **years and I have always ensured that I could answer one of the questions in the affirmative. I was quite amazed to see that as recently as 1997 that** [*sic*] **Doctors filling in form C were answering No to all of those questions**'.

11.53 The Inquiry had previously been aware that some of the doctors practising in Todmorden in the 1970s had, before completing Form C, questioned relatives of the deceased in most cases. This had become evident when examining the cremation forms completed by Shipman during his time at Todmorden. Cremation forms dating from his time in Hyde revealed very few instances of a Form C doctor questioning anyone other than Shipman. The Inquiry team assumed that the practice of questioning persons other than the Form B doctor had lapsed with time.

11.54 Once Dr North's communication had been received, further enquiries were made. They revealed a number of other crematoria with a similar requirement to that imposed by the Portchester crematorium. Enquiries of those crematoria have shown that, in some cases, a marginal note setting out the requirement has appeared on their Forms C for as long as anyone can remember. However, the Halton Medical Referee, Dr David Robertson, was responsible for its introduction at the Warrington crematorium, and (with a colleague) at the Widnes crematorium, in the 1990s. He gave his reasons for the change as:

> **'... dissatisfaction on my part with the standard of information being provided and the level to which many forms failed in my view to accurately confirm the facts on Form B. There was no third party corroboration and the only dialogue reported was that between the two doctors. Potentially scope was present for abuse and collusion.'**

11.55 The Darlington Medical Referee, Dr Louis Rosin, introduced a similar requirement in about 1970, for similar reasons. Conversely, the Medical Referee at the Carlisle crematorium, Dr Peter Tiplady, removed the requirement recently, after objections from doctors from neighbouring areas who were not accustomed to it.

11.56 Enquiries have been made of those employed at the crematoria concerned, as well as of the Home Office and the Cremation Society of Great Britain, in order to discover whether any advice or guidance was issued which may have prompted the decision by some crematoria to impose the requirement of an affirmative answer to one of questions 5–8. No evidence of any such advice or guidance has been found although the similarity of the wording on the forms issued by different crematoria strongly suggests a common source. It seems that officials currently employed in the relevant section of the Home Office were unaware that any crematoria imposed this requirement until informed by the Inquiry.

11.57 Investigations by the Inquiry suggest that, where a local requirement to answer one of questions 5–8 in the alternative is imposed, it is complied with in all but a few cases; those few cases may well relate to deaths occurring in neighbouring areas where no such requirement exists. Often, a medical referee will not enforce the requirement where a doctor has completed a Form C issued by a different crematorium in good faith. Such a doctor may not realise that there is a local requirement at the crematorium where the cremation is to take place. Where no local requirement is in force, questions 5–8 are

answered in the negative in most cases. Crematoria in one area have had a requirement since about 1996 that one of the questions 6–8 should wherever possible **'contain details of an enquiry sufficient to help satisfy the Medical Referee that sufficient enquiry has been made'**. The Medical Referee has told the Inquiry that general practitioners usually provide satisfactory information, but hospital doctors invariably fail to comply.

11.58 Where the crematorium requires the Form C doctor to question someone other than the Form B doctor, a significant proportion of Form C doctors question relatives, as opposed to the other categories of person named on the form. This is no doubt because, if a deceased person has not been in hospital and has not received nursing care from persons other than family, there will be no one else available with knowledge of the death. If the death occurs in a nursing home or similar setting, questions may be asked of the staff.

11.59 The Inquiry obtained evidence from a number of doctors who practise in areas where the local crematorium requires an affirmative answer to one of questions 5–8. They were asked about their experience of speaking to relatives. It had previously been suggested to the Inquiry that it was impracticable to question relatives because it would cause undue distress. In general, the experience of the doctors who provided evidence was that, so long as relatives are informed in advance that another doctor would be contacting them, and so long as they fully understand the purpose of the contact, they are happy to assist. In practice, the Form B doctor usually informs relatives that another doctor will be in touch with them. The doctors did not report any difficulty with speaking to relatives, nor any signs of hostility, resentment or distress at the approach. Many of them saw the contact as offering a valuable opportunity for relatives to voice any concerns or doubts that they might have about the death.

11.60 In Scotland, the Form C prescribed by the Cremation (Scotland) Regulations 1935 requires the form to be completed by a doctor who has seen and examined the deceased's body and spoken to the Form B doctor. In other words, the equivalent of an affirmative answer to questions 1, 2 and 4 of the Form C prescribed for England and Wales is a prerequisite to completing the Scottish form. The questions which the Form C doctor has to answer relate only to whether s/he has performed a post-mortem examination (question 1) and whether s/he has questioned a third person, other than the Form B doctor (questions 2–5). There is no statutory requirement that any of the questions on the form should be answered in the affirmative. However, marginal notes indicating a requirement for one (sometimes two) affirmative answer(s) appear on the Forms C used by many Scottish crematoria. The importance of the requirement for at least one of the questions to be answered in the affirmative was emphasised in a letter sent by the Scottish Office Home and Health Department to all medical referees and deputy medical referees in Scotland in September 1995.

11.61 The Dukinfield crematorium imposes no local requirement for affirmative answers to any of questions 5–8 and it is the local practice for questions 1, 2 and 4 only to be answered in the affirmative. It is clear from the Inquiry's investigations that the practice at Dukinfield is typical of that prevailing in the majority of crematoria throughout England and Wales.

**Prevalent Attitudes to Form C**

11.62 Evidence heard by the Inquiry suggests that many doctors regard the completion of Form C as a technical requirement only. Just as they have never thought about why it is necessary for the Form C doctor to be independent of the Form B doctor, they have never thought about what Form C is designed to achieve. They do not see themselves as carrying out an independent investigation of the cause and circumstances of the death. A common perception, among doctors who I am sure are in other respects entirely conscientious, is that they must listen to the history and decide whether the Form B doctor's conclusion as to the cause of death is a reasonable one. If they know the doctor to be inexperienced, they might approach the task with some expectation that s/he might be wrong. However, if they know the doctor and believe him/her to be competent, the strong expectation will be that the Form B doctor will be right. 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. This lack of understanding of the purpose of Form C and the doctors' function in completing it is not altogether surprising since it appears that doctors do not receive any formal education or guidance about the purpose or completion of Form C. However, it is disappointing that they do not have a greater understanding. The BMA has been stressing the importance of Form C in representations made on behalf of its members to Government Departments and independent committees of enquiry for over 50 years.

11.63 The Inquiry heard evidence about the degree of care and attention that Form C doctors apply to their task. It appears that it is quite common for the Form C doctor to rely almost completely on the oral account given by the Form B doctor and not to scrutinise what has been written on Form B in any detail. This seems to come about in part because, quite often, the Form C doctor does not see either Form B or Form C until s/he reaches the premises of the funeral director where s/he is to view the body. By that time, s/he will have heard the oral account and will have made up his/her mind that the death was natural and that the cause of death was as explained by the Form B doctor. What the doctor has put on Form B does not, by then, appear important. When Shipman's forms were examined, it was found that the Form C doctor had often failed to notice that Form B contained internal inconsistencies that would have been obvious on careful examination.

11.64 It appeared from the evidence that many, although not all, Form C doctors regard the physical examination of the body as a mere formality, no more than a hoop to be jumped through before signing the form. As I have explained, this attitude is to some extent understandable, as examination of the body is unlikely to provide much information relevant to the cause of death. However, it might provide evidence of injury, ill treatment or lack of care. Once again, it is disappointing that doctors appear to have so little understanding of what they should be looking for or why, particularly given that their representative body has in the past laid such stress on the importance of the Form C procedure.

### Attitudes to Questions 5–8

11.65 As I have said, some crematoria require that one of questions 5–8 should be answered in the affirmative. Where this is so, the Form C doctor must question someone with knowledge of the death who is independent of the Form B doctor. In areas where the provision of an affirmative answer to one of questions 5–8 is not compulsory, it is unusual (although not unheard of) for a Form C doctor to make any enquiry of a person independent of the Form B doctor. Some doctors say that they would question a relative or carer if they had any doubts about the cause of death but that this rarely, if ever, occurs. Others say that they never do it, as questioning would be intrusive and would cause additional distress to relatives. However, the evidence of those who practise in areas where such enquiries are made suggests, as I have already said, that relatives do not find such questions intrusive or distressing. Of course, much will depend on the sensitivity of the questioner. However, it appears that, if the bereaved family knows that a doctor will contact them to ask questions about the death and that this is normal procedure, no offence is caused.

### Could Questions 5–8 Provide a Useful Safeguard?

11.66 As I have said, the Dukinfield crematorium was not one of those where a positive answer was required to one of questions 5–8. In the vast majority of cases, the doctors who completed Forms C for Shipman did not question anybody independent of Shipman. 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 or as a means of detecting Shipman's activities. The question is whether it would have been useful in either respect if there had been a requirement that one of questions 5–8 should be answered in the affirmative.

11.67 During Phase One of the Inquiry, it became apparent that Shipman frequently explained a death to the deceased's family in one way and described the circumstances on Form B in quite a different way. He would often pretend that the death was expected by the family, who had been in attendance. On Form B, he would name or describe a particular person, a relative, carer or warden, who, he said, had been present at the death. If the Form C doctor had been obliged to ask questions of a person independent of Shipman, it is highly likely that s/he would have spoken to that person. In many cases, there would have been a real prospect that the Form C doctor would have discovered that Shipman had not told the truth about a purely factual matter.

11.68 By way of example, in the case of Miss Maureen Ward, whom Shipman was convicted of killing and who lived in sheltered accommodation, Shipman claimed that the warden was present at the death. Had the warden been asked, she would have told the Form C doctor that she most certainly was not present at the death and that Shipman had come to find her to tell her that he had found Miss Ward dead in her flat. She would also have added that she was most surprised about the death because she had seen Miss Ward earlier that day, out and about and apparently quite well. This would have been quite inconsistent with Shipman's claim that Miss Ward had died as the result of carcinomatosis resulting from a secondary tumour in the brain.

11.69 In the case of Mrs Joyce Woodhead, whom I found that Shipman killed, Shipman stated on Form B that Mrs Woodhead had died as the result of a coronary thrombosis and that her sister had been present at the moment of death. In fact, her sister, Mrs Freda Hibbs, was not present and, had the Form C doctor questioned her, she would have said so and would have added that she had been very surprised to find her sister dead in bed. She might also have added that her sister looked very peaceful. If questioned, she would have said that, so far as she knew, her sister had no previous history of heart disease. The Form C doctor should then have realised that Shipman had not only told a lie on Form B, but also appeared to have certified the cause of death on inadequate grounds.

11.70 Another example is the case of Mrs Eileen Crompton. Shipman killed her by giving her a lethal injection in the presence of Mrs Patricia Heyl, the Deputy Manager of Charnley House, a residential home for the elderly. Shipman stated on Form B that **'the Matron'** was present at the death. Had the Form C doctor spoken to Mrs Heyl, she might have learned the surprising information that, before administering the injection, Shipman had said that he was giving a 'kill or cure' injection. That information should have puzzled and alarmed the Form C doctor.

11.71 Quite apart from the cases in which Shipman told demonstrable lies on Form B, there are a very great number of cases in which a relative, when questioned sympathetically by a Form C doctor, would have confided that s/he was extremely surprised by the suddenness of the death. I think it likely that many would have given an account of the deceased's previous state of health which would have caused the Form C doctor to question Shipman's ability to certify the death. I do not suggest that all the relatives would have expressed their concerns; some were so completely taken in by Shipman's explanation for the death that they would have done no more than repeat it to the Form C doctor. However, I believe there were many who would have confided their surprise and concern if questioned directly. There is a world of difference between giving a relative a direct opportunity to express a concern and merely leaving it to the relative to contact the coroner or the police. Most people would not approach the coroner or the police unless they had strong suspicions or concerns based on specific factors. On the other hand, if given the opportunity, a relative might well express surprise or puzzlement about a death, even in the absence of actual suspicion of wrongdoing.

11.72 I do not suggest that, merely because a Form C doctor discovered that some aspect of Shipman's account was factually inaccurate, or heard an expression of concern from a relative, s/he would immediately suspect wrongdoing. However, if conscientious, s/he could not merely complete Form C. He or she would at least have to speak to Shipman again and ask further questions. He or she might well feel it necessary to refuse to sign Form C and to advise Shipman to report the death to the coroner. If a Form C doctor had had to query cases with Shipman on a regular basis, this should have attracted notice. What would have happened if a Form C doctor had refused to sign the certificate is not clear. Shipman would not have wished to approach another doctor to sign Form C as, when s/he consulted the family member or carer, s/he would be likely to hear the same information as the first Form C doctor, together with the fact that another doctor had been asking questions. Shipman might have promised to speak to

the coroner and have returned with the claim (which might or might not have been true) that the coroner had approved the cause of death. He might have had to report the death to the coroner and risk the possibility that an autopsy might not provide a plausible cause of death and that toxicology would follow.

11.73 I cannot say precisely how the Form C doctors would have responded to the discovery that Shipman's Forms B contained serious inaccuracies or that he appeared willing to certify deaths in a number of cases where relatives and carers were concerned, surprised or puzzled. However, I do think that it would have been much more difficult for Shipman to deceive. I think it likely that he would have appreciated the difficulties he would face if he told lies on Form B or gave a different account to the relatives from that given to the Form C doctor. I think he would have recognised the risk he would run that either the Form C doctor or a relative or carer might realise that he had lied and that he had been present alone with the deceased at the moment of death. I think this recognition would have acted as a real deterrent. As I explained in my First Report, Shipman was able to control his urge to kill when he perceived himself to be at risk of discovery. If there had been a requirement at Dukinfield crematorium that the Form C doctor should answer at least one of questions 5–8 in the affirmative, I think it likely that Shipman would have killed fewer patients.

11.74 Further, if Shipman had taken the risk of killing despite the knowledge that the Form C doctor would be likely to question relatives and carers, I believe that the chances of his being detected would have been increased. I cannot say that, on the first occasion on which a doctor declined to complete a Form C for Shipman, the death would have been reported to the coroner, an autopsy and toxicology would have followed and that morphine would have been found and he would have been discovered. But, if he had taken the risk often enough, the chances of detection would have been greatly increased. Quite apart from the actual process of a report to the coroner, autopsy and toxicology, the Form C doctors should have noticed that relatives often had concerns about a death involving Shipman. I cannot say that they would have done but, if they had heard a similar story, often repeated, their suspicions might well have been aroused. 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 questioning relatives and carers would have led to Shipman's detection at some stage, whereas the system as operated never did.

## The Authority to Cremate: Form F

### The Medical Referee

11.75 Authority to cremate a body is given by a medical referee or (in his/her absence or if s/he has been the deceased's medical attendant) a deputy medical referee. The post of medical referee is a part-time one. The medical referee (or deputy) attends the crematorium office for a short time on weekdays as necessary. If s/he is still in other employment, s/he will fit in his/her visits to the office with the demands of his/her employment. If the medical referee is retired, s/he will attend the office when and for as

long as is necessary. A medical referee is remunerated for each cremation authorised. The current recommended rate is £5.50 per cremation. Rates at privately owned crematoria may be higher. There are currently about 550 medical referees and deputy medical referees, covering over 240 crematoria.

**The Appointment of Medical Referees**

11.76 Medical referees and deputy medical referees must be registered medical practitioners of not less than five years' standing and, in the words of Regulation 10 of the 1930 Regulations:

> **'... must possess such experience and qualifications as will fit them for the duties required of them ...'**.

11.77 If appropriately qualified, a medical referee or deputy medical referee may also be a coroner. The Inquiry is not aware of any medical referee who currently holds both positions. The 1930 Regulations also provide that the medical referee or deputy medical referee may be a medical officer of health. It is a common arrangement for a director of public health to act as medical referee to a local crematorium. In some areas, the posts of medical referee and deputy medical referee, when vacant, have traditionally been filled by doctors from the public health department at the local health authority. In other areas, medical referees and their deputies have always been appointed from among doctors working in general practice.

11.78 Provided that s/he fulfils the other qualifications, a medical referee or deputy medical referee can complete Forms C and F in respect of the same death. The Inquiry was told by Dr Morgan that this happens at the crematorium where he officiates. The 1930 Regulations specifically provide for this eventuality. As I explained in Chapter Three, at the time when the rules for cremation were first devised, an arrangement whereby the medical referee carried out a personal investigation into a death was considered ideal, although not possible to achieve in every case. It was because of the practical difficulties (in particular, difficulties of geography) that it was decided to place responsibility for personal investigation on the Form C doctor, rather than the medical referee.

11.79 The Regulations provide that:

> **'The Secretary of State** [*i.e. the Home Secretary*] **shall appoint as Medical Referee and Deputy Medical Referee such fit persons as may be nominated by the Cremation Authority.'**

11.80 The system is that, when a vacancy occurs, the cremation authority notifies the Home Office of the name of the doctor who the authority proposes should fill that vacancy. Sometimes, a curriculum vitae accompanies the notification. The Home Office checks that the doctor fulfils the registration requirement but makes no further check on the suitability of the proposed appointee. In effect, the part played by the Home Office in the appointment process is merely a 'rubber-stamping' exercise. At paragraph 3.22, I explained how the Home Office had become concerned, prior to 1930, at the manner in which the cremation authorities were exercising their power to appoint. It was because of that concern that the power to appoint was transferred to the Home Office by the 1930

Regulations. It is not clear to what extent, if at all, the Home Office ever sought to use that power in order to regulate the quality of appointees to the post of medical referee.

11.81 The failure by the Home Office to carry out any enquiry into applicants' suitability for the role of medical referee has been the subject of complaint and comment from time to time over the years. The Home Office has openly admitted that it has no machinery to 'vet' nominations for the post. The stance of Departmental officials has been that the Department is not in a position to make meaningful enquiries into the qualifications and experience of medical practitioners. Instead, the Home Office has relied on the cremation authorities to carry out all necessary checks.

11.82 The draft Regulations circulated in 1962 (which, as I have explained, were largely overtaken by the work of the Brodrick Committee and were, therefore, not implemented in their original form) would have removed from the Home Office the responsibility for appointing medical referees. This responsibility would then have passed entirely to the cremation authorities, thus bringing England and Wales into line with the position in Scotland. The BMA opposed the proposed change strongly, questioning the extent to which cremation authorities (in particular private authorities) could be relied upon to make appropriate appointments and emphasising the importance of the role of the medical referee. The BMA argued that the effect of placing the power of appointment entirely in the hands of the cremation authority would be to compromise the independence of medical referees. The BMA urged the Home Office to retain the power of appointment itself and to introduce proper machinery for selection. The 1965 Regulations, when implemented, did not introduce any change to the system of appointment, which has remained the same ever since. The Brodrick Committee recognised the reality of the Home Office's role in the appointment process and observed that **'... the approval of the Home Secretary amounts to little more than a ''rubber stamp'''**.

11.83 In 1997, an 'efficiency scrutiny' of government procedures was undertaken, in order to examine the statutory arrangements whereby certain local authority powers were subject to approval by central government. At the conclusion of that process, it was recommended that the power of the Home Office to appoint medical referees should be removed. This was because it was recognised that, in reality, the Home Office exercised no independent judgement in relation to such appointments. The Home Office declined to comply with the recommendation, relying on the point previously made by the BMA, namely that the lack of accountability of private cremation authorities made it inappropriate for the power of appointment to be entirely vested in them. There was, however, no change in the way appointments to the post of medical referee were made.

11.84 The Inquiry has not undertaken any detailed survey of cremation authorities, in order to discover whether any authorities appoint medical referees by means of open competition and/or after a detailed enquiry into the experience and suitability of the various candidates for the post. It may be that there are some authorities that do have proper selection procedures. However, the evidence received by the Inquiry suggests that, at most crematoria, the post of deputy medical referee is virtually in the gift of the existing medical referee. He or she usually seeks candidates for the post from the health authority by which s/he is, or was formerly, employed or from the general practice of which s/he is or was a

member. Since the deputy medical referee usually succeeds to the post of medical referee, in effect, the medical referee chooses his/her successor. It does not appear that much consideration is given to the issue of whether the experience and professional background of the potential applicant fits him/her for the position. A striking example of this was the appointment of Dr Betty Hinchliffe as Deputy Medical Referee, then Medical Referee, of the Dukinfield crematorium. She had spent her entire career (save for two years working in hospital immediately post-qualification and two years as a locum general practitioner) in the field of child health, where she had a special interest in paediatric audiology. When appointed as Deputy Medical Referee in the late 1970s, she had had no experience of general practice or of the care and treatment of elderly people, for over 20 years. She had not completed a Form B for even longer and had completed perhaps two Forms C during her entire professional career. Her deputy, Dr Jane Holme, had no experience whatsoever of general practice or of the care or treatment of elderly people. She also had spent her professional life working in the field of child health.

11.85 Home Office officials have said that they saw no reason not to rely on cremation authorities to make proper enquiries before appointing medical referees. However, there is no evidence that the Department made any enquiry about the selection procedures being used or offered any advice as to how the process of appointment should be carried out. Nor does the Department appear to have taken any steps to ensure that cremation authorities fully understood the functions of the medical referee and his/her role within the cremation certification system as a whole.

11.86 The lack of any proper selection procedure prior to the appointment of a medical referee creates the impression that the position is an unimportant one, which can satisfactorily be filled by any doctor with the requisite registration. That impression is confirmed by the lack of training and support provided once a medical referee has been appointed.

**Training and Support for Medical Referees**

11.87 The Home Office provides no formal training for new appointees and little ongoing support. There is no handbook or other reference material; new recruits are usually given a copy of the Cremation Act and Regulations by their cremation authority but, except insofar as it is produced locally, no explanatory material is available. Those appointed learn by observing and talking to their colleagues at the crematorium. The Home Office has always taken the view that, given their medical expertise, medical referees should be able to carry out their task without the need for instruction. So far as the medical aspects of the job are concerned, that is of course so. However, in order to do the job effectively, it is important that a medical referee understands the role which s/he is required to perform and the roles of others (in particular, the Form C doctor) who also play a part in the system of cremation certification. As I shall explain later in this Chapter, it is evident that some (perhaps many) do not. One reason for this may be that their predecessors also had no understanding of their role and so were not in a position to pass on that knowledge to those who followed them.

11.88 Medical referees are subject to no monitoring or audit procedures. It is true that they attract few complaints. However, the public is largely unaware of their role and existence,

as the Shipman case has demonstrated. The only time when a medical referee is likely to attract criticism is when s/he requests an autopsy or takes any other action which disrupts, or threatens to disrupt, arrangements for a cremation. This rarely occurs.

### Contact between Medical Referees and Others

11.89 In the past, medical referees around the country were in contact with each other through the Association of Crematorium Medical Referees. I have referred to the Association in Chapter Three, in connection with representations made by its members to the Home Office over the years. The Association became defunct in 1974 and thereafter, for a period of 28 years or so, medical referees had no forum for the exchange of ideas or the discussion of common issues and problems. Certain enthusiastic medical referees attempted, through the Home Office, to initiate moves to encourage contact but the Home Office took the view that it was for the referees themselves to undertake any necessary organisation and therefore took no active steps to assist. Recently, and in the face of the obvious threat to their existence posed by the aftermath of Shipman's criminal activities, there have been moves, under the auspices of the BMA, to re-launch the Association.

11.90 The lack of any contact between medical referees has led to them becoming isolated and unaware of different practices in operation elsewhere in the country. This is no doubt one reason why the contents of the cremation forms issued by different crematoria have become so divergent. Similarly, medical referees have little or no contact with other professionals involved in operating the post-death procedures. The evidence given to the Inquiry suggests that they rarely, if ever, speak to their local coroner. The coroner may have no understanding of the role and functions of the medical referee. The medical referee is unlikely to have occasion to speak directly to the registrars in his/her district. The cremation system operates in virtual isolation (save for the exchange of forms and contact of a purely administrative nature) from the death certification, death registration and coronial systems.

### Advice and Guidance for Medical Referees

11.91 Over the years, the Home Office has issued some advice and guidance. Examples are the advice about the need for affirmative answers to questions 1, 2 and 4 of Form C and the requirement for the Form B and Form C doctors to be **'demonstrably independent'**. However, such guidance has been minimal and, where not concerned with a forthcoming change in the law, has usually been issued only in response to a direct request for advice. In his oral evidence, Mr Robert Clifford, Head of the Coroners Section of the Animals Procedures and Coroners Unit, which deals with cremation-related matters, emphasised that the Home Office was concerned not to encroach upon the independence of medical referees in relation to individual decisions that they might make. That is of course understandable and proper. However, such a consideration would not have precluded the issuing of general guidance and advice as to the approach to be adopted by medical referees. In particular, it would not have precluded advice and guidance as to the role that the medical referee was required to play within the cremation certification system as a whole.

11.92 A few medical referees have produced their own guidance notes for use locally. Dr Gordon Pledger told the Inquiry about guidance that he had prepared, setting out what was required of the referee and deputy referees at the crematorium at Newcastle-upon-Tyne, where he is Medical Referee. He also issues guidance for doctors completing cremation forms; a copy of his guidance notes accompanies every blank set of forms sent out by the crematorium. In 1997, the Medical Referee at the Central Durham crematorium, Dr Clive Buxton, issued his own guidance notes for doctors completing Forms B and C. Those notes were subsequently reproduced in Resurgam, the journal of the Federation of British Cremation Authorities. They sought to clarify some of the common uncertainties about the meaning of questions appearing on Form B.

**Duties of Medical Referees**

11.93 The duties of the medical referee are set out in the 1930 Cremation Regulations (as amended). Regulation 12 provides that:

> **'(3) He shall, before allowing the cremation, examine the application and certificates and ascertain that they are such as are required by these Regulations and that the inquiry made by the persons giving these certificates has been adequate. He may make any inquiry with regard to the application and certificates that he may think necessary ...**
>
> **(5) He shall not allow the cremation unless he is satisfied that the fact and cause of death have been definitely ascertained; and in particular, if the cause of death assigned in the medical certificates be such as, regard being had to all the circumstances, might be due to poison, to violence, to any illegal operation, or to privation or neglect, he shall require a post-mortem examination to be held, and if that fails to reveal the cause of death, shall decline to allow the cremation unless an inquest be opened and a certificate given by the Coroner in Form ''E'' ...**
>
> **(8) He may in any case decline to allow the cremation without stating any reason.'**

These duties have remained virtually unchanged since 1903.

11.94 Having satisfied him/herself as required by regulation 12(5), the medical referee completes the Authority to Cremate (Form F). In doing so, s/he certifies:

> **'... I have satisfied myself that all the requirements of the Cremation Acts 1902 and 1952, and of the Regulations made in pursuance of these Acts, have been complied with, that the cause of death has been definitely ascertained and that there exists no reason for any further inquiry or examination ...'**.

11.95 Except where the coroner has certified the cause of death after autopsy or where an inquest has been opened, the medical referee will have inspected the completed Forms A, B and C. The only exception is that, where the Form B doctor is aware, when completing

Form B, of the result of a hospital post-mortem examination (so that no Form C is required), only Forms A and B should be submitted to the medical referee.

11.96 The time limit for delivery of the forms varies from crematorium to crematorium. At Dukinfield crematorium, forms must be delivered not later than 11am on the working day (Monday–Friday) before the cremation. (The note on Form B suggests that forms can be delivered on a Saturday but the Inquiry was told that this was not in fact the case.) Sometimes, perhaps because of delay on the part of doctors in signing the forms or for other reasons, the forms are delivered late. Occasionally, they are delivered on the very day of the cremation. Late delivery can cause great practical difficulties in contacting doctors and others in connection with queries arising from the forms. In those circumstances, it is, of course, open to the medical referee or superintendent registrar of the crematorium to insist that the cremation be postponed because there is insufficient time to complete the formalities. In practice, however, they will do everything possible to avoid this, because of the distress that such postponement would cause to the deceased's relatives. One solution, resorted to occasionally, is to allow the funeral service to go ahead, but postpone the actual cremation until all the formalities have been complied with. Even this, however, is avoided if at all possible.

11.97 The result is that a medical referee is under considerable pressure to approve the forms speedily and to ensure that any enquiries that s/he makes are limited to those that can be accomplished within the restricted time available. This does not tend to encourage the making of detailed enquiries. Under the Regulations, the medical referee has wide-ranging powers. He or she can make any enquiry that s/he thinks necessary. He or she can require a post-mortem examination, refer the death to a coroner or simply decline to authorise a cremation without giving any reason. In reality, however, the evidence received by the Inquiry suggests that the last power is never used (it is hard to imagine the circumstances in which it could properly be) and medical referees rarely exercise their powers to order a post-mortem examination or even to report a death to the coroner. As I have already indicated at paragraphs 3.76 and 3.77, the Brodrick Committee reported similar findings in 1971 and the Committee's view was that medical referees were being asked to perform an impossible task for which they were given neither the time nor the facilities.

11.98 In addition, the medical referee's examination of the forms takes place at a time when registration of the death has occurred (so that the registrar has, implicitly, 'approved' the cause of death) and when one doctor has certified, and a second doctor has confirmed, the cause of death. The applicant has signed a form, stating that s/he has no reason to believe that the death was suspicious. In some cases also, the medical referee will be aware that the death has been 'discussed with the coroner' (in fact, more likely, a coroner's officer) who has also, it might be inferred, 'approved' the cause of death. The medical referee's place, at the end of this chain of persons scrutinising the death, must inevitably affect the way s/he approaches his/her task.

11.99 There are three other aspects of the medical referee's task that I should mention. First, it is unrealistic that s/he should have to certify, on the basis of assertions contained in the cremation forms, that s/he is satisfied that the cause of death has been **'definitely**

**ascertained'**. In the vast majority of cases, the cause of death cannot be **'definitely ascertained'** without an autopsy and sometimes not even then. The fact that the level of confidence required on the part of the medical referee is unrealistically high affords no encouragement to a medical referee to exercise a great degree of care when scrutinising the forms and making enquiries.

11.100 Second, in the event that a medical referee orders a post-mortem examination, there can be difficulty over who should pay for it. Some cremation authorities are willing to meet the cost; others require the family to pay, which is obviously extremely unpopular. The cost of the examination is, of course, in addition to the distress and inconvenience caused by the requirement for a post-mortem examination so near to the funeral. The alternative course is for the medical referee to refer the death to the coroner. However, if the coroner declines to act in circumstances where the medical referee feels that the death should be investigated further, the medical referee can be left with little choice but to order the examination at the family's expense. In one case of which the Inquiry is aware, a medical referee who found himself in that position (not an isolated case, he said) discovered that the body had already been embalmed, rendering a post-mortem examination of little or no value. In these circumstances, the power to order a post-mortem examination can be somewhat illusory.

11.101 Third, if a medical referee indicates his/her intention to order a post-mortem examination or refer the death to the coroner, it is open to the applicant to dispose of the body by burial (for which only the registrar's disposal certificate is necessary) or to make an application to another crematorium where the medical referee may be prepared to permit the cremation. The Inquiry is aware of cases where this has happened. The ability of an applicant to 'shop around' in this manner is obviously highly damaging to the authority and effectiveness of the medical referee.

### Certificate after Post-Mortem Examination: Form D

11.102 If a medical referee does exercise his/her power to order a post-mortem examination and the pathologist can identify a cause of death, the pathologist will complete a Certificate after Post-Mortem Examination (Form D), stating that s/he is satisfied that the cause of death is as stated on Form D and that there is no reason for making any toxicological analysis or for an inquest. The medical referee will then give authority to cremate on the basis of the information contained in Forms A and D.

### Coroner's Certificate: Form E

11.103 If a death is referred to the coroner and the coroner has ordered an autopsy, after which s/he is satisfied that no inquest is necessary, or if the coroner has opened an inquest into the death, the coroner may issue the Coroner's Certificate (Form E). On the certificate, the coroner states which of the two circumstances referred to above applies and certifies that s/he is satisfied that there are no circumstances likely to call for a further examination of the body. The certificate does not state the cause of death; in the case of a death where an inquest has been opened, no cause of death will yet have been determined. The provision whereby a Form E can be issued (and a cremation allowed to proceed) before the

conclusion of an inquest was, as I have explained in Chapter Three, introduced by the Cremation Regulations 1965 in order to avoid the distress caused to families as a result of having to wait many months for an inquest to be concluded before being permitted to cremate their dead.

11.104 A sizeable proportion of the cremations dealt with by medical referees are authorised by a coroner's Form E. The medical referee gives authority to cremate on the basis of Forms A and E. Neither contains information relating to the cause of death. Yet the medical referee must complete Form F, in which s/he states that s/he is satisfied that the cause of death has been **'definitely ascertained'**. The medical referee also has the disposal certificate issued by the registrar. However, this does not give information about the cause of death either. The authority to cremate given in these circumstances amounts to no more than a 'rubber-stamping' of the decision made by the coroner. This anomaly was identified in the Brodrick Report. The draft Regulations of 1989 would have made it unnecessary for a medical referee to authorise cremation where a coroner had issued a Form E. However, those Regulations never became law and, thus, the anomaly remains. Again, the fact that a medical referee has no choice but to ignore the requirements of Form F when dealing with this large group of cases does little to encourage a more careful approach when dealing with others.

**Variability of Practice among Medical Referees**

11.105 The lack of Home Office guidance and contact between medical referees in different parts of the country has had important effects on the efficacy of the system. I have already described one important difference in relation to the completion of questions 5–8 on Forms C.

11.106 The Inquiry also found that medical referees approached their task in different ways. In effect, there are two schools of thought about what the task should entail. All medical referees who gave evidence to the Inquiry agree that the forms must be carefully checked to ensure that all the questions have been answered and that the factual information (such as names, address and dates of birth and death) is consistently stated throughout. In some crematoria, such clerical checks are carried out by administrative staff. It is also generally agreed that, in satisfying him/herself before completing the declaration on Form F, the medical referee must rely principally on reading the cremation forms submitted. He or she will not usually embark on any independent enquiries. The differences of view arise over what, if any, mental process the medical referee must go through in order to satisfy him/herself **'that the cause of death has been definitely ascertained and that there exists no reason for any further inquiry or examination'**.

11.107 Some medical referees take the view that their statutory duty requires them to scrutinise the forms (mainly Form B) with a view to seeing whether the 'picture' created or the 'story' told by the forms hangs together and makes medical sense. Dr Pledger and Dr Morgan described their functions in this way, although they did not, even so, see their role as an investigative one. Plainly, such an operation requires medical expertise. On the other hand, some medical referees take the view that theirs is essentially a clerical function. They say that their task is to check that the forms have been properly completed, that all

questions on Forms A and B are answered, that there are affirmative answers to questions 1, 2 and 4 on Form C and that the causes of death on Forms B and C are the same. They are not required, they say, to consider the content of the forms and do not seek to discover whether the picture presented makes medical sense. They consider that the cause of death has been **'definitely ascertained'** by the two doctors who have completed Forms B and C. The medical referee, they say, is entitled to assume that those two doctors have done their job conscientiously.

11.108 Dr Holme, formerly Deputy Medical Referee at the Dukinfield crematorium, described her duties in this way. So did the medical referee of a crematorium that I visited personally, for the purpose of seeing a medical referee at work. He told me that his function was to ensure that all the boxes on the forms had been completed. He did not examine the content of the forms. That, he said, was not his function. He had only to ensure that the information was there and would be preserved in case it should be required for any future investigation. When asked why, if the duties were purely administrative, it was necessary for the medical referee to be a medical practitioner, this medical referee said that, when, as became necessary from time to time, a medical referee had to telephone a doctor who had failed to complete part of a form, it was necessary for such a conversation to be conducted by a medically qualified referee as, otherwise, the certifying doctor might refuse to co-operate.

11.109 In my view, it is clear that the clerical approach cannot be what is envisaged. First, the requirement that the medical referee should be a practitioner of at least five years' standing makes it clear that there is an expectation that some medical expertise is to be exercised by a doctor with some experience and authority. I cannot accept as reasonable the suggestion that a doctor is required so that an uncooperative certifying doctor can be brought into line. Second, the medical referee is given the power to order a post-mortem examination. It seems clear that a medical referee who performs only a clerical check would never have occasion to order a post-mortem examination or, for that matter, to refer a case to the coroner. I leave out of account the fact that the wording of Form F requires the medical referee to be personally satisfied that the cause of death has been definitely ascertained. As I have said, that seems to be an unrealistic goal.

11.110 I am satisfied that these differing views about the functions of the medical referee are genuinely held. It appears that the Home Office was for many years unaware of these differing views and practices. This dichotomy of view (and misunderstanding by some) could not, I think, have survived if medical referees had undergone any training or appraisal, had received written guidance or had met regularly for discussion of their professional duties and problems. There are documents in existence, such as the Report of the Departmental Committee responsible for drafting the Cremation Regulations 1903, which explain the function and purpose of the medical referees' task. Those documents, or a summary of their contents, could easily be disseminated to all medical referees.

### Does the Medical Referee Perform a Useful Function?

11.111 I have described the two schools of thought as to how the medical referees' work should be performed. It is obvious that, if the task is essentially a clerical check, it can provide no effective scrutiny of the accuracy and validity of the cause of death; nor can it do anything to detect cases of concealed homicide or neglect.

11.112 If the task is carried out as Dr Pledger and Dr Morgan described it, the operation should have some value. However, it appears that medical referees very rarely exercise their powers to stop a cremation and order a post-mortem examination. Research published in 1995 showed that, although 10% of 250 Forms B from a single cremation authority showed errors in the cause of death, none had resulted in a referral to the coroner, a post-mortem examination or an approach to the Form B doctor for clarification.[1]

11.113 Only rarely will the medical referee even speak to the coroner's office. In the overwhelming majority of cases, the forms are approved and the cremation proceeds. This may well be because the papers are in order and there is no cause for concern. The task of looking for one case with 'something wrong' out of thousands that are in order is a thankless one and it cannot be easy to maintain an appropriate standard of vigilance. It seems to me that, even where the medical referee approaches his/her task in the right way, the sheer monotony of the task is likely to result in some faults being overlooked.

11.114 There are other reasons why even a conscientious medical referee might miss a case in which cremation should not be allowed. As I have observed, the scrutiny takes place at the end of the cremation certification process. The effect of what has gone before is to engender a degree of confidence in the validity of the application to cremate. Dr Pledger spoke of the feeling that his position was that of a longstop, who was looking only to see if something had gone 'hideously wrong'. Far from expecting to find anything, he would have an expectation that all would be in order. For him to question an application would be, in effect, to question the judgement of a range of other people who had dealt with the death previously.

11.115 Another factor that may well affect the medical referee's approach to his/her task is the pressure of time, to which I have already referred. The fact that, if detailed enquiries are to be made or an autopsy undertaken, the cremation would have to be postponed, with consequent disruption and distress to the family, must inevitably have the effect of discouraging a medical referee from taking such steps. There is a tension between the requirement that the statutory procedure should be properly satisfied and the need to avoid disruption.

11.116 The scope of the medical referee's task is very limited. It is a paper exercise and does not involve any independent investigation. Even if the documentation is completed conscientiously, the forms frequently 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 of the circumstances of the death. Such an account would be most useful to the medical referee. As I have previously explained, the Inquiry has become aware of inconsistencies in the way in which different doctors complete the forms. The only enquiries which most medical referees make are of the Form B doctor, if some aspect of the form is unclear. Often, it is not easy to contact the doctor and there is a temptation for the medical referee to make assumptions, sometimes unwarranted, to 'fill the gaps'. The system is based upon trust in

[1] James, DS (1995) 'An examination of the medical aspects of cremation certification: are the medical certificates required under the Cremation Act effective or necessary?', Medical Law International, Vol 2, pp 51–70.

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.

11.117 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

### The Actions of the Home Office prior to Shipman's Conviction

11.118 It has been known for over 50 years that the system of cremation certification was not working as was intended. The Home Office has certain responsibilities in relation to cremation procedures. In particular, it has responsibility for keeping under consideration the need for changes to cremation legislation. I have had to consider whether, in permitting the cremation system to remain virtually unchanged for a century, the Home Office properly discharged its responsibilities.

11.119 It seems likely to me that the high standards expected in the early days of the last century gradually fell out of use. I suspect, for example, that it was usual practice in the early days for one or more of questions 5–8 to be answered in the affirmative. By 1950, it was known that standards of completion of Forms C were poor and the Interdepartmental Committee recommended that the Form C procedure should be strengthened. Nothing was done and, in 1971, the Brodrick Committee recommended that the entire system of cremation certification should be abolished as soon as the system of medical certification of the cause of death had been strengthened. The Committee also recommended that Form C should be abolished forthwith, even if their main recommendations could not be immediately implemented. The Form C doctor simply relied on the Form B doctor's opinion, so that the second certificate was, in effect, worthless. In any event, it was, in the Committee's opinion, unnecessary as the risk of concealed homicide was minimal.

11.120 As I have explained in Chapter Three, in 1975, the Government of the day accepted the Brodrick proposals (albeit with some modification to satisfy the Director of Public Prosecutions) as its policy. Following the change of Government in 1979 and throughout successive administrations, implementation of the Brodrick recommendations remained the aim. The requirements for medical certification of the cause of death were to be strengthened and the separate system of cremation certification was to be abolished. As I have said, there were a number of stumbling blocks in the way to legislation but the main reason why the policy was not implemented was that the Government Law Officers and the BMA objected to the abolition of the Form C procedure. Many attempts were made to reach a consensus on the way forward. None succeeded. However, as I have already said, the implementation of the Brodrick proposals, which relied completely upon the integrity of the single certifying doctor, would not have deterred Shipman from killing; nor would it have led to his earlier detection.

11.121 I can well understand why little attention was paid to the operation of the cremation system during the many years in which it was hoped and intended that it would be abolished. The focus of attention was on its replacement. Although the Law Officers and the BMA wished

to see a system that retained some form of second certification, as a safeguard against concealed homicide, only the BMA positively wished to preserve the Form C procedure. It is apparent that there were those in Government who were sceptical of the BMA's motives. They thought that the BMA wanted to keep Form C because the income from it was attractive to doctors. It is not for me to say what lay behind the BMA's stance. They certainly advanced their arguments on the basis that the completion by a doctor of a second certificate provided a safeguard against a risk of concealed homicide. However, I can understand why some were sceptical of the doctors' position.

11.122 Many of the doctors who have given evidence about the Form C procedure stress that they do not regard the fee they receive as a 'perk'. They say that, although the form is simple to complete, they often have to travel some distance to view the body. The money, they say, is not an attraction at all. It is simply reasonable remuneration for their effort. I find that hard to accept, for several reasons. First, the nickname for the Form C fee is 'ash cash'. The expression is redolent of the notion that the fee is a 'perk'. Second, doctors often ask their friends to complete Forms C for them. I have not been told that doctors have to ask their friends because no other doctor will accept the burden. I have heard that doctors in multi-handed practices take turns to share out the Forms C that come to the surgery. I have not been told that they are sharing out the burden so that no one doctor has to shoulder more than his/her fair share; far from it, I have the impression that doctors guard their right to Forms C. Furthermore, in hospitals, where the majority of deaths occur, there is less inconvenience and potentially greater income from this source.

11.123 Form C was never abolished, as the Brodrick Committee had advised. Although there are few overt references to it within the Home Office documents, and although Mr Clifford was anxious not to be indiscreet on the subject, it is apparent to me that there was in Government a reluctance to 'take on' the medical profession. It seems that successive Governments regarded cremation certification as a matter for the doctors. For example, although, since 1952, the Home Secretary has had the power to fix the fees payable for issuing cremation certificates, he has never exercised this power, but has always left it to the BMA to recommend the appropriate rates.

11.124 Twenty seven years elapsed between the publication of the Brodrick Report and the discovery of Shipman's crimes. Had the Brodrick proposals been implemented, and had Shipman still committed serial murder undetected over a period of 24 years, it would have been impossible to criticise the Government for operating a system that had failed to detect him. It would have been entirely reasonable for them to implement a Report of such authority and standing. However, they did not; they tried but, in the end, their efforts came to nothing. All the while, they knew that the existing Cremation Regulations were not working as they were intended to work. Ought they to have done something to improve the operation of the cremation system, given that it must at some stage have become apparent that the Brodrick recommendations were unlikely to be implemented? The only reform which, in my view, would have provided any effective safeguard against concealed homicide would have been a mandatory requirement in respect of questions 5–8 of Form C.

11.125 It seems to me that there were two stages at which the Home Office might have considered reform of the cremation certification process. The first arose in late 1988

and early 1989, following the decision to postpone attempts to abolish the Form C procedure until after legislation strengthening the death certification system had been brought onto the statute book. That process would not be speedy; consultation was necessary and it was obvious that the Cremation Regulations, including the Form C procedure, would remain in force for some time. At that stage, the Home Office intended to consolidate the various sets of Cremation Regulations and to bring in some amendments. There was an opportunity to improve the Form C procedure. One of the proposed amendments related to Form C. An affirmative answer was to be required to questions 1, 2 and 4. In fact, this would have only formalised what was already existing practice. It appears that no consideration was given to the 'strengthening' of the Form C procedure. The thinking in the Home Office at this time was that the recommendations of the Brodrick Committee were sensible and appropriate, the risk of concealed homicide was negligible and the Form C procedure was unnecessary. So there would be no point in improving it. The Government Law Officers were reluctant to see its abolition, without some compensating improvement in death certification. They still considered that Form C provided a useful safeguard against concealed homicide. However, they did not suggest that there was any need to strengthen the procedure, only to keep it. It appears that the Home Office was unaware that, at some crematoria, an affirmative answer was required to one of questions 5–8. The Home Office papers of this period reveal no discussion about the purpose to be served by questions 5–8. It does not appear that anyone suggested to the Home Office at that time that there was any need for an independent check on the account of events given by the Form B doctor, such as would be provided by consideration of questions 5–8. So, although the opportunity for strengthening the Form C procedure through amendment of the Regulations plainly presented itself, I do not think that the Home Office should be criticised for not taking that opportunity. In the event, the attempt to amend and consolidate the Regulations met with opposition and was eventually abandoned.

11.126 Given Home Office officials' actual state of knowledge and belief about the Form C procedure, I do not think they should be criticised for their failure to make any attempt to strengthen the Form C procedure. They believed it to be unnecessary and a waste of time. Their knowledge of how the system worked on the ground appears to have been gained mainly from the Brodrick Report; they did not visit crematoria to inspect them and did not have meetings with medical referees. They knew from the Brodrick Report that the Form C procedure was often carried out in a perfunctory way. They did not know that, at some crematoria, an affirmative answer to one of questions 5–8 was required. Although the Brodrick Report had drawn attention to the fact that questions 5–8 were very frequently answered in the negative, it had not been discovered that this was due to differing practices at particular crematoria.

11.127 However, in my view, the Home Office is to be criticised for its lack of awareness of how the cremation certification system was operating throughout the country. It ought not to have delegated responsibility for operation to the cremation authorities, as it did. 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 operated the system 'hands on', 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 and they should have found out why this was so. Had they known these things, they might have realised that a requirement for an affirmative answer to one of those questions would have strengthened the protective effect of the procedure. Although no one had suggested to them the need to strengthen the Form C procedure, they might have thought of it and might have proposed that improvement. I say only that they might have done these things because, as they believed the whole process was pointless, they might have thought of and rejected the idea of strengthening the procedure. Even had they proposed such an improvement, I very much doubt that it would have been successfully incorporated into the amended Regulations. The amendments, as drafted in 1989, failed to meet with the approval of interested parties. A significant strengthening of Form C would certainly have aroused strong objections. As the Home Office did not regard the Form C procedure as a whole to be important, I do not think they could have been criticised had they failed to pursue such changes with the vigour and determination that would have been necessary to overcome those objections.

11.128 The second occasion on which a particular opportunity arose, which should possibly have triggered a move towards reform of the Form C procedure, occurred in the late 1990s. It arose from a survey, conducted in Scotland and completed in September 1995, which was drawn to the attention of the Home Office in November 1997. The survey had discovered defects in the standard of completion of cremation forms. Advice was issued by the Scottish Office Home and Health Department to doctors and medical referees. One of the requirements was that at least one of questions 2–5 on Form C should be completed in the affirmative, unless the Form C doctor had carried out a post-mortem examination. As I have explained earlier, questions 2–5 on the Scottish Form C are the equivalent of questions 5–8 on the forms in use in England and Wales. Unfortunately, Mr Clifford, the official responsible for cremation issues at the time, did not understand the nature or significance of the difference between the Scottish forms and those used in England and Wales. He did not, therefore, fully appreciate the nature of the advice being given. However, even had he done so, it seems unlikely that he would have been able to bring about a change in the practice in England and Wales before 1998, when Shipman was arrested. His reaction to the Scottish research was to decide that it would be useful to conduct something similar in England. He took some steps towards this end but these progressed slowly. There had never been any reason to perceive a need for urgency. I do not think that the realisation that the Scottish system was different would have caused him to act with any greater degree of urgency.

11.129 In short, the history of Home Office supervision of cremation procedures is not impressive. The approach was to leave matters to the cremation authorities to an extent that I regard as inappropriate. Officials were concerned almost entirely with attempts to abolish the procedures – or Form C at least. That was understandable in the light of the Brodrick Report and its underlying philosophy. In any event, 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.

### Home Office Reactions since the Discovery of Shipman's Crimes

11.130 After the discovery of Shipman's crimes, steps were taken to set in motion reviews of the whole system of death and cremation certification and coroner services. There was bound to be delay before any reforms suggested by these reviews could be implemented. However, even then, no urgent attempts were made to address the inadequacies of the cremation certification system.

11.131 The only step taken was the despatch of a letter to medical referees, at the time of Shipman's conviction, reminding them of their power to refuse to authorise a cremation and their right to refer a death to the coroner if not satisfied with the application to cremate. The letter also reminded medical referees to be **'vigilant at all times'** and that they should not feel constrained from making further enquiries about a death by the wish of the family to adhere to proposed funeral arrangements.

11.132 Until very recently, it appears that the Home Office had not given any consideration to the introduction of a requirement that one of questions 5–8 on Form C should be answered in the affirmative. The Inquiry has now been informed that, on 6th February 2003, a meeting was convened, at which Home Office officials met with representatives of the cremation organisations and medical referees to discuss various proposals for the introduction of interim improvements in the operation of the cremation certification procedures. As a result, the Home Office is **'to explore the experience of those crematoria which currently require at least one mandatory affirmative answer to questions 5–8 of cremation Form C and, if necessary, to set up a controlled pilot scheme in one or more areas'**. It is said that **'these steps should provide useful information about the practicality and effectiveness of introducing such a requirement generally'**. I welcome this move, belated though it is. However, I doubt the need for a pilot scheme, given that this procedure is already operated by several crematoria in different parts of England and Wales, together with most crematoria in Scotland. It is difficult to see why a **'controlled pilot scheme'** should yield more information than an examination of current practice in those areas where an affirmative answer to questions 5–8 (2–5 in Scotland) is already required. I am also concerned to think that it is expected that a pilot scheme would prove or disprove the effectiveness of such a change of practice. At least, I would hope that the change would not be deemed ineffective simply because a pilot scheme failed to uncover a murderer.

## The Future of Cremation Certification

11.133 In my view, the cremation certification procedure, as presently carried out in most places, is of very little value. As I shall be recommending a new system of certification for all deaths, not only those to be followed by cremation, it is not appropriate to consider in detail how it might be improved. However, like the Brodrick Committee, I too realise that my main recommendations might not be implemented as rapidly or as completely as I would wish. In that event, my strong recommendation is that the cremation certification system should be preserved and that the forms should be standardised throughout the country and modernised. Above all, it should be mandatory for the Form C doctor to question at least

one person who is independent of the Form B doctor and who has some knowledge of the circumstances of the death.

11.134 If it should appear that the post of medical referee is likely to remain in existence for more than a few months from the publication of this Report, I recommend that any new appointments should be scrutinised by the Home Office and should be approved only if the applicant has suitable medical experience, as well as five years' standing. The Home Office should provide training and guidance material, explaining the medical referees' role and the way in which it should be performed, and should fund periodic meetings of an Association of Crematorium Medical Referees. Issues of this kind were discussed at the meeting in February 2003, to which I have already referred. In the event that the existing cremation certification procedure is to be retained for a significant period, I would hope that these discussions will result in the speedy introduction of the interim measures that I have suggested.