CHAPTER FOURTEEN

The Tameside Registrars and the General Register Office

Introduction

14.1 One of the principal aims of the Inquiry has been to discover whether the various agencies responsible for post-death procedures in Tameside were in any way to blame for not detecting signs of Shipman's criminal activities. Most of the deaths of Shipman's patients, including those whom he killed, were registered at the Tameside register office. It has been necessary therefore to examine procedures and practices at the Tameside register office, both generally and in relation to deaths certified by Shipman.

14.2 The first matter examined related to the number of Shipman-certified deaths registered at the office. After his criminal activities were revealed, there were suggestions that the registrars who registered those deaths should have noticed that they were registering an excessive number of deaths which had been certified by Shipman. The Inquiry has therefore examined the deaths registered by each registrar in order to ascertain whether any pattern should have been evident.

14.3 Second, suggestions were also made that the registrars had in fact noticed an excess of deaths among Shipman's patients and had talked about this between themselves but had failed to take any action or to draw their concerns to the attention of the appropriate authorities. I have examined the evidence relating to these discussions and made findings in relation to it.

14.4 Third, during the course of the evidence, there was criticism of certain procedures in operation at the Tameside register office. It was necessary for me to consider those procedures and, in particular, to decide whether they had had any effect upon the registration of deaths certified by Shipman.

14.5 Finally there was criticism of the registration procedures adopted in a number of individual cases. The Inquiry has examined those cases in order to ascertain how they were handled and whether, if they had been handled better, Shipman's activities might have been noticed earlier. In two of those cases, the registrars acted on the advice of staff at the General Register Office (GRO). It has therefore been necessary for me to consider whether that advice was correct and, if not, how it came to be given.

Should the Frequency of Registration of Deaths Certified by Shipman Have Been Noticed?

The Background

14.6 There are four registrars at the Tameside register office. Each is responsible for her own register of deaths. In the absence of a full-time registrar, some registration work is carried out by deputy registrars who usually do other administrative work. Registrars have other duties besides the registration of deaths. No registrar sees the complete picture of death registrations effected in the office as a whole. Nor is there any system in place (or indeed any duty to operate such a system) for the gathering of statistics relating to deaths, let

alone for the monitoring of the deaths of a particular doctor. Although the identity of the doctor who has certified the cause of death is recorded by the registrar, the name would not be important unless a difficulty arose because, for example, the doctor had not completed the MCCD properly. Unless the doctor frequently failed to complete MCCDs to the registrar's satisfaction, the name would be unlikely to stand out in her mind. Shipman usually (although not always) completed MCCDs quite satisfactorily.

14.7 The Inquiry team collated the numbers of Shipman-certified deaths registered by two current registrars and one former registrar from the commencement of their employment until 1998. These three registrars had been responsible for registering the greatest number of deaths certified by Shipman. The numbers were compared with the total numbers of deaths registered by the registrars during the same period. Also, the Inquiry team identified a number of short periods when the concentration of Shipman-certified deaths registered by each registrar was at its highest. The object was to see whether, during those short periods, the frequency of Shipman-certified deaths should have been noticeable.

Miss Marilyn Partoon

14.8 Miss Marilyn Partoon registered 69 deaths certified by Shipman between 1988 and 1998. During that period, she registered a total of 6734 deaths. Two three-month periods from 1996 and 1997 were analysed. These showed six Shipman-certified deaths out of a total of 199 in the first period and seven Shipman-certified deaths out of 239 in the second.

Mrs Carol McCann

14.9 Mrs Carol McCann registered 71 deaths certified by Shipman between 1985 and 1998. During that period, she registered a total of 8258 deaths. Three short periods were analysed. The highest concentration was found to be four Shipman-certified deaths out of a total of 95 during two months in 1996.

Mrs Dorothy Craven

14.10 Mrs Dorothy Craven registered 120 deaths certified by Shipman between 1978 and 1998. During that period, she registered a total of 11,711 deaths. Four short periods were analysed. I refer only to two. The two highest concentrations of Shipman-certified deaths occurred during two months in April/May 1997, when she registered seven Shipman-certified deaths out of a total of 113, and in a period of three and a half months in late 1997/early 1998, when she registered ten Shipman-certified deaths out of a total of 200.

Conclusion

14.11 I am quite satisfied that the frequency with which Shipman-certified deaths occurred would not have been noticeable to any registrar. Nor, in my view, were the clusters of greatest intensity particularly remarkable. Such research as the Inquiry team was able to carry out showed that clusters of deaths certified by an individual doctor occur with reasonable frequency.

Had Any Registrar Noticed an Excess of Deaths Certified by Shipman?

14.12 All the registrars denied that they had in fact noticed an excess of deaths certified by Shipman. There was some evidence that one or more registrars had made comments to others from which it appeared that they had in fact done so. Three such incidents were investigated.

Mrs Dorothy Craven and Miss Marilyn Partoon

14.13 In her Inquiry statement, dated 25th March 2002, Miss Partoon suggested that, prior to August or September 1998, she had a recollection that Mrs Craven might have remarked that 'a lot of Shipman's MCCDs were for old ladies'. Miss Partoon did not recall any speculation arising from that remark. Mrs Craven has always said that she has no recollection of the comment.

14.14 In evidence, Miss Partoon was adamant that the remark was made once the police investigation into the death of Mrs Kathleen Grundy was under way, at a time when a list of relevant entries in the registers of death was posted on the wall of the storeroom at the register office. That would have been no earlier than September 1998, possibly later.

14.15 The version of the incident given by Miss Partoon in oral evidence makes little sense in that, once it was known that deaths certified by Shipman were under investigation (as they were when the list of names was on the wall), any remark about the gender of Shipman's patients would have been wholly unmemorable. Moreover, it would have been a mere observation, rather than an item of information, such as Miss Partoon originally suggested she had been given. In my view, Mrs Craven probably did make a remark about the predominant gender of Shipman's deceased patients during one of the periods in which she registered a cluster of deaths certified by him. However, the remark does not suggest that Mrs Craven thought there was anything sinister about the gender distribution of the deaths of Shipman's patients.

Mrs Carol McCann and Mrs Margaret Burns

14.16 Mrs Margaret Burns worked at the register office as a clerk/receptionist. She sometimes acted as a deputy registrar. She recalled an occasion when Mrs McCann commented to her that a death was 'another one of Shipman's'. This, she said, occurred soon after both of them had been off work with 'flu and is likely therefore to have taken place in January/February 1997. Mrs McCann apparently remarked that there had been two or three deaths certified by Shipman in the past few days (two such deaths were registered on 5th February 1997 and one had been registered on 29th January 1997). The conversation then turned to the 'flu virus which was going around at the time. Mrs McCann did not seem concerned. For some reason, Mrs Burns remembered Shipman's name, although she has told the Inquiry that she had not heard of him at the time. However, she was acquainted with Mrs Margaret Walker, who was employed as a computer operator at Shipman's surgery.

14.17 Mrs McCann said that she has no recollection of the conversation. She suggested that she might have made such a remark if she had opened an envelope containing an MCCD when she had received other certificates from the same doctor very recently.

14.18 I think it likely that Mrs McCann made a comment along the lines suggested by Mrs Burns. This may very well have occurred on 5th February, when she opened the second MCCD from Shipman. I do not think that any significance can be attached to Mrs McCann's remark; it certainly does not suggest that she had noticed an abnormal number of deaths certified by Shipman or that she was concerned about them.

Mrs Margaret Burns and Mrs Margaret Walker

14.19 In her Inquiry statement, Mrs Walker said that she used to chat to Mrs Burns on the bus. She knew Mrs Burns worked at the register office and said that Mrs Burns knew that she worked at Shipman's surgery. She recalled that, one day, Mrs Burns asked her if there had been a lot of deaths at the surgery. Mrs Walker replied that there had. She believes the conversation took place prior to October 1996, during the winter; she says she attributed the high level of deaths at the time to the 'flu vaccine. Mrs Burns denies that this conversation took place. She says the most that could have happened is that she might have said that they had had a lot of deaths at the registry.

14.20 The Inquiry has not heard oral evidence from Mrs Walker. However, the conversation was related in the context of an account of her fluctuating awareness of the fact that there was a high number of deaths at the surgery. She recounted how this conversation was the first time that it occurred to her that there was a high number of deaths.

14.21 I think it likely that a conversation did take place between these two women about the number of deaths occurring at that time. I think it most unlikely that Mrs Burns asked Mrs Walker specifically about deaths among Shipman's patients. I think it likely that she was aware, probably from casual talk in the register office, that a lot of deaths had recently been registered. I think it likely that her question was a general one and was not founded upon any suspicion that there were more deaths among Shipman's patients than among those of any other doctor. I think it likely that Mrs Walker has remembered the conversation because it was the first time she realised that there were a lot of deaths among Shipman's patients and this was something she was to notice from time to time over the next few years.

Conclusion

14.22 There is no evidence from which I could reasonably infer that any of the registrars had noticed an excess of deaths certified by Shipman or that they had any other concern about him.

Procedures at the Register Office

14.23 I shall now consider three procedures which the Inquiry has heard occurred from time to time at the Tameside register office and about which some concerns have been expressed.

'Mode of Dying' Cases

14.24 I have already said in Chapter Six that the Handbook for Registration Officers advises that modes of dying do not, on their own, positively identify a cause of death. If all information

recorded in Part I of the cause of death takes the form of a mode of dying, rather than a cause of death, the death should be regarded as one where the cause of death is not known and should be reported to the coroner. Examples of statements implying a mode of dying include 'respiratory arrest', 'respiratory failure', 'cardiac arrest' and similar expressions. If, however, the mode of dying is supported by a cause of death that would not of itself be reportable, then the cause of death is acceptable. Mrs Jane West, registrar for the Boston district and Training Officer for the Lincolnshire registration service, told the Inquiry that, in her county, registrars were trained that, if a doctor had given a mode of dying unsupported by an acceptable cause of death, the death should be reported to the coroner, in accordance with the guidance contained in the Handbook.

14.25 The practice at the Tameside register office was, until recently, different. If the registrar was not prepared to accept an MCCD because the supposed cause of death was, in truth, a mode of dying, the registrar would telephone the certifying doctor to ask whether s/he was able to amend the certificate by adding an underlying cause of death or to issue a new certificate with an acceptable cause of death. As Mrs West pointed out, this is not good practice, as it puts the registrar in the position where s/he might be tempted to suggest (or be understood to be suggesting) to the doctor what to put on the MCCD. If that were to happen, the MCCD, which is supposed to contain the doctor's professional opinion, would be without value. The basis of the system of certification would be undermined.

14.26 The Tameside registrars explained to me how this practice began. If a registrar telephoned the coroner's office to report a death in which the cause of death was not acceptable, instead of taking on the death for investigation, the coroner's officer would ask the registrar to contact the doctor in an attempt to resolve the problem. The registrars, who would in some ways have preferred not to do this, agreed to do so because they felt they were helping the deceased's family, who might well become anxious if there appeared to be a problem over the registration of the death. As the reaction of the coroner's officer was always the same, eventually the registrars took to telephoning the doctor themselves, after checking with the coroner's officer that a Form 100A had not already been issued. This might have occurred if the certifying doctor had spoken informally to the coroner's office and had been given 'permission' to certify the death in the terms appearing on the MCCD.

14.27 It was common ground among other witnesses that the procedures operated at the Tameside register office did not constitute good practice. Mr Christopher Dorries, HM Coroner for South Yorkshire (West), said that he and his officers would not ask a registrar to speak to a doctor about a 'mode of dying' problem. It is a matter for the coroner's office to deal with. One of his officers would contact the doctor, tell him/her that the MCCD was not acceptable and ask the doctor to tell him about the death. If the doctor could explain and justify an acceptable cause of death, the officer would say that it was up to the doctor to write another MCCD and that the office would back that up with a Form 100A. Mr Dorries would prefer that a second MCCD were issued so as to spare the family the trouble of taking the original certificate back to the doctor for amendment. On occasions, he has known a hospital to pay for a taxi to take a replacement MCCD to the register office.

14.28 Mr John Pollard, HM Coroner for Greater Manchester South District, said that, in his District, the practice was rather different. On his instructions, the coroner's officer would

suggest to the registrar that she should telephone the doctor and ask him/her to telephone the coroner's office. The purpose of that suggestion was not, he said, that the registrar should seek to solve the problem, merely that she should put the doctor in touch with the coroner's office. That explanation does not make sense. If the registrar is speaking to the coroner's officer about an unacceptable MCCD, she is trying to report the death to the coroner. It would be quite pointless for the coroner's officer to ask the registrar to ask the doctor to report the case. I reject that explanation. In any event, the evidence of Mrs Mary Evans, who was employed in the coroner's office from 1974 until 1999, latterly as first coroner's officer, confirmed the evidence of the Tameside registrars. I am quite satisfied that this poor practice was followed for many years, until it was recently stopped.

14.29 Mrs West condemned this practice and observed that it rather looked as though the coroner's office was seeking to avoid taking responsibility for such cases. However, another possibility is that the staff in the coroner's office thought that the difficulty that arose when a doctor gave a mode of dying, rather than a cause of death, was primarily the registrar's problem. It was the GRO who would not accept a mode of dying as a cause of death; therefore, the registrar should speak to the doctor to sort out the problem. Mrs Evans agreed that she regarded a 'mode of dying' as mainly the registrar's problem, although she added, rather less certainly in my view, that the coroner should not accept a mode of dying as a cause of death either. Mrs Joan Collins, who was employed at the coroner's office from 1985 until 2002 and was first coroner's officer from 1999 until her retirement, said that such an attitude did not prevail in her day. She did say, however, that the source of the information that the coroner's office should no longer allow doctors to issue MCCDs stating a mode of death only had been the register office. I think it likely that Mrs Evans, at least, was of the view that it was up to the registrar to sort out the problem if a doctor gave a mode of dying as a cause of death.

14.30 Whatever the reason within the coroner's office, I am quite satisfied that the Tameside registrars adopted this poor practice because the coroner's office pushed responsibility onto the registrars to sort out the problem of the defective MCCD. I accept that the Tameside registrars agreed to take responsibility for obtaining a corrected or new MCCD from the doctor in order not to cause distress for relatives, who would otherwise have been left without an acceptable MCCD. In that case, the death would have had to be reported to the coroner and an autopsy might have followed.

Conclusion

14.31 Although I do not regard this practice as acceptable, I do not think that, in Tameside, the outcome of any individual case examined by the Inquiry would have been any different if the correct procedure had been followed. If that had been done, the coroner's officer, rather than the registrar, would have spoken to the doctor, but the coroner himself would never have done so. The coroner's officer would have had no more expertise in medical matters than the registrar and would have been no more equipped to handle such a conversation satisfactorily. Both the registrar and the coroner's officer would have been quite unable to probe, question or challenge what the doctor said.

14.32 I mentioned in Chapter Six that the GRO had recently written to all registrars, giving guidance about good practice in relation to a number of matters that have been explored in the course of evidence given to the Inquiry. One of those matters related to the procedures which I have just described. The circular, sent to all registrars, contained the following instruction:

> **'Registrars should refer to certifying doctors only apparent clerical errors about the medical certificate of cause of death, such as the omission of dates or signatures, possible misspellings or where clarification of abbreviations is needed. Where it appears that a death must be reported to the coroner, for example where the only cause given is a mode of dying, it is for the coroner to discuss the cause with the certifying doctor. Registrars should not address such matters directly with the certifying doctor.'**

14.33 A letter to all coroners, sent out at the same time, has made it clear that any discussion with, or enquiries of, doctors should be conducted direct with the doctor, not through the registrar.

Keeping of Written Records of Discussions

14.34 There is no written advice or guidance in the Handbook for Registration Officers about the notes which registrars should keep of discussions with doctors, the coroner's office or the GRO. Miss Ceinwen Lloyd, Branch Manager Births and Deaths Registration at the Office for National Statistics (ONS), said that GRO advice was that notes should be made of all such discussions. However, it is not certain to what extent, if at all, that advice was promulgated. The evidence suggests that it was the Tameside registrars' practice to record on the reverse of the MCCD any advice received from the GRO.

14.35 If there is a formal referral to the coroner, a record will exist on the counterfoil of Form 52. However, as I have said, it appears that informal referrals have, in the past, been preferred, not only in Tameside, but generally. If the referral is by telephone, there are no clear rules as to whether and, if so, how a record should be made. If, as a result of the referral, the coroner issues a Form 100A, this form will be retained in the register office and, in due course, forwarded to the GRO as a record of the referral. However, if no Form 100A is issued, there may be no record of the referral in the register office. Mrs West said that she would always use the formal Form 52 procedure to refer a case to the coroner. However, if that were not done, she would expect to see a record made of any informal referral. Mrs Craven, now retired, said that she would have made a record in such circumstances. However, I am by no means convinced that there is any standard practice.

14.36 The practice relating to cases resulting in the issue of an amended MCCD or a second MCCD was not uniform. A Tameside registrar, Miss Partoon, said that, if in the end she obtained an acceptable MCCD, she would not make any note of the procedures she had gone through to get it. Another Tameside registrar, Mrs McCann, said that she would usually write a note on an unacceptable MCCD if it were superseded by a second, acceptable one. However, she would not do so if the first certificate were amended and

initialled by the doctor. Mrs West said that it was good practice to make a note of what had occurred in both types of situation.

Conclusion

14.37 It is plain that there was uncertainty and lack of uniformity in the approach to the making of notes within the Tameside register office. However, in the absence of any authoritative guidance or advice on the topic, I am not critical of the individual registrars.

14.38 The recent circular sent to registrars, to which I have already referred, contains detailed guidance on the written records that should be kept by registrars. In particular, registrars are now advised that a note should be kept of any discussion with the coroner's office about a particular death and that, where an amended or fresh MCCD is issued, a note of the circumstances should be made and clipped to the certificates when returned to the GRO.

The Removal of Valid Medical Certificates of Cause of Death from the Register Office

14.39 The evidence showed that, on occasions, the Tameside registrars allowed an informant to take an MCCD back to the certifying doctor for amendment. This happened, for example, in the cases of Mrs Dorothy Andrew and Mrs Bertha Parr, to which I shall refer later in this Chapter.

14.40 The Handbook for Registration Officers provides (at Section D2):

> **'16. Except as provided in paragraphs 7 and 15, the registrar must not part with a duly completed medical certificate without the Registrar General's sanction. He/She may, however, submit it on request to a coroner on the understanding that it will be returned.'**

14.41 The phrase **'duly completed'** is ambiguous; it could mean 'valid' or 'valid and acceptable'. Mrs West took the view that a valid MCCD (even if not 'acceptable') should not be released by the register office except to the coroner; even then, the practice of her office is to send only a copy. Miss Lloyd observed that releasing an MCCD to an informant was not advisable, although she could appreciate the registrars' motives for doing so.

14.42 Miss Partoon said that she used to think that it would be acceptable to release an MCCD if it was 'not viable' (i.e. not acceptable) and the death had not been registered. However, she is now more careful and releases an MCCD only if a coroner's officer has specifically asked for the doctor to provide an underlying cause of death. In that event, she takes the view that she is releasing an MCCD with the approval of the coroner. Mrs McCann also believed that, in releasing an MCCD in those circumstances, she was doing so with the implicit agreement of the coroner's office. Mrs Craven had had no concerns about releasing an MCCD during her time at the register office.

Conclusion

14.43 The guidance contained in the Handbook for Registration Officers is ambiguous. While the reasons for the practice of not releasing an MCCD can readily be appreciated, the

registrars cannot be criticised for releasing valid, but unacceptable, certificates in the circumstances in which this occurred. The practice appears to have arisen by reason of the procedures operated between the register office and the coroner's office for contact with doctors.

Additional Duties for a Nominated Officer

14.44 In a register office where several registrars work, it is usual and approved practice for a nominated officer to be appointed to carry out a range of administrative duties. This occurs at Tameside, where the registrars take turns to be nominated officer for two weeks at a time. At Tameside, the nominated officer carries out a duty that is not standard practice, namely to screen all the MCCDs as they are brought in by informants. The nominated officer will spot any potential problems and will try to resolve them before the actual process of registration begins. The registration will be carried out, not by the nominated officer, but by another registrar.

14.45 The Tameside registrars like this screening procedure because they say that it can be very distressing for an informant to discover, part way through the process, that the MCCD is not acceptable, so that the death cannot be registered on that day. If the problem is spotted at an early stage, it might be possible to resolve it; if not, at least the informant will be told before the process begins.

14.46 Miss Lloyd was concerned about this procedure because, she said, the registrar who is to carry out the registration should be personally responsible for scrutinising the MCCD. If a nominated officer has 'passed' it as acceptable, the registrar might not examine it as carefully as s/he should and might not take full responsibility for the registration. Mrs West expressed concerns of a similar nature.

14.47 The Tameside registrars said that they do examine the MCCD carefully even though the nominated officer has seen it. However, I had the clear impression from the evidence of one of the deputy registrars that she would rely primarily on the scrutiny of the nominated officer. This is perhaps understandable in view of the fact that she would be significantly less experienced than the nominated officer.

Conclusion

14.48 Miss Lloyd and Mrs West had concerns about this practice. However, provided that each registrar understood that she bore ultimate responsibility for the registration and provided that each exercised her own judgement in respect of the MCCD on which the registration was based, it does not seem to me to be particularly objectionable. Having said that, in paragraphs 14.65 and 14.69, I shall describe two occasions on which the knowledge that the nominated officer had checked the MCCD caused the registrar who registered the death to do something different from that which she might otherwise have done.

Individual Deaths

Registrars Liaising with Doctors

14.49 The Inquiry examined two deaths certified by Shipman which illustrate the procedure then current in the Tameside register office, whereby the registrars, rather than staff at the

coroner's office, liaised with doctors who had identified unacceptable causes of death. The first death was that of Mrs Dorothy Andrew, which was a 'mode of dying' case. The second, that of Mrs Bertha Parr, had been certified by Shipman as due to 'natural causes'.

Mrs Dorothy Andrew

14.50 Shipman killed Mrs Dorothy Andrew on 12th September 1996. When he first issued an MCCD, he certified the cause of death as renal failure. When Mrs Andrew's family presented this MCCD at the register office, the registrar would not accept it. She spoke to Shipman and told him that it was not acceptable. The certificate was taken back to Shipman's surgery and he amended it, adding uraemia as the underlying cause of the renal failure and stating that 'old age' was a significant condition contributing to the death but not related to the disease or condition causing it. Mrs Andrew was 85. She had been in quite good health until her death and was active up to the end. The registrar was not certain whether to accept the amended certificate and telephoned the coroner's office. She then told Mrs Andrew's family that the coroner was not satisfied and thought that there might have to be an autopsy. This upset Mrs Andrew's daughter. The registrar advised that the family return to Shipman again. This time, Shipman issued a second MCCD, giving the cause of death as renal failure due to uraemia and old age. This was accepted and the death was registered.

14.51 This procedure was unsatisfactory in two respects. I have already said that the practice whereby a registrar speaks directly to a doctor in an attempt to obtain an improved and acceptable MCCD is undesirable. The first MCCD in this case was unacceptable and the death should have been reported to the coroner. If anyone is to discuss an amended or second MCCD with the doctor, it should be the coroner, not the registrar. However, for reasons I have explained, I do not consider that the registrars who followed this practice should be personally criticised.

14.52 The second unsatisfactory feature of this MCCD is that the causes of death Shipman gave did not make medical sense. Uraemia is a condition in which there is too much urea in the blood. It is caused by renal failure. So, uraemia is a consequence of renal failure, not a cause of it. Anyone with medical training would have realised that. Registrars do not have any medical training; they pick up some medical knowledge from their work. The registrar who failed to realise that, even in its final form, this MCCD did not make sense is not to be criticised. She did not have the training and expertise to know that. However, it is, as I have already observed, a matter of concern that registrars are expected to scrutinise MCCDs without the expertise necessary for the job.

14.53 What is even more a matter of concern is that the person in the coroner's office who advised the registrar does not appear to have realised that the causes of death advanced by Shipman did not make medical sense. This does not surprise me, in that there was no one in Mr Pollard's office with any medical expertise or training. This case underlines the need for MCCDs or their replacements to be scrutinised by someone with appropriate training or expertise and with ready access to medical advice. Only if the person in the coroner's office had realised that this certificate was nonsense, could it have become evident that this death should be investigated by means of an autopsy.

Mrs Bertha Parr

14.54 Shipman killed Mrs Bertha Parr on 11th November 1997. She was 77. When Shipman first completed the MCCD, he certified that the cause of death was 'natural causes'. In the view of Mrs West and Miss Lloyd, both of whose evidence I agree with and accept, 'natural causes' should never be acceptable to the registration service as a cause of death. The expression does not explain what has caused the death; it asserts only that the death was due to a natural disease process. In Mrs Parr's case, it appears that the nominated officer or registrar telephoned Shipman and told him that the MCCD was not acceptable. It seems that Mrs Parr's son took the MCCD back to Shipman's surgery and Shipman amended it (and the counterfoil) adding 'old age' as the underlying cause of death. The MCCD was then acceptable to the registrar and the death was registered.

14.55 I have said earlier that the practice which should have been followed was for the death to be reported to the coroner on Form 52. However, it was common practice in the Tameside register office for the registrars to seek to resolve problems of this kind without involving the coroner. As I have said, I am satisfied that they did so out of a desire to assist the family of the deceased and also because, if they contacted the coroner's office, it is more than likely that they would have been asked to contact the certifying doctor to see if s/he was prepared to amend the certificate to make it acceptable. In any event, if the death had been reported to the coroner, the coroner's officer would have asked Shipman if he were able to provide an acceptable certificate. He would have done so. The death would not have been investigated and there would have been no autopsy. The outcome would have been the same.

An Occupationally-Related Death

14.56 Concern was expressed about another death, where a registrar had failed to discover that a death was or might have been occupationally-related and should, under the provisions of regulation 41 of the Registration of Births and Deaths Regulations 1987, have been reported to the coroner.

Mr John Livesey

14.57 Shipman killed Mr John Livesey on 25th July 1997. On the MCCD, Shipman stated that the death had been caused by renal failure. However, he gave hypertension as an underlying cause of death and, with that underlying cause, renal failure is acceptable. Therefore, no 'mode of dying' problem arose. Shipman also stated that chronic obstructive airways disease had contributed to Mr Livesey's death. In the box below that (the 'Spearing box'), which allows the doctor to state that the death might have been due to or contributed to by the employment followed by the deceased, Shipman had put no tick. It happens that Mr Livesey had worked for many years in the ventilation industry and had been exposed to asbestos. Mrs Joanne Livesey-Carter, Mr Livesey's daughter, told the Inquiry that, when she attended at the register office to register her father's death, she was not asked any questions about exposure to an industrial hazard.

14.58 I have already said in Chapter Six that some registrars, on seeing a death from lung disease, make a practice of asking questions designed to discover whether the death

might have been occupational in origin. However, it does not seem that the practice is universal. It may be that it is not always followed with a common disease such as chronic obstructive airways disease. As I have explained earlier, the task of the registrar is primarily to obtain factual information about the deceased from the informant and to scrutinise the MCCD. I can well understand why, if the 'Spearing box' is not ticked, the registrar assumes that there is no history of exposure to an industrial hazard. I have the impression that if, when the registrar enquires as to the nature of the deceased's employment, s/he realises that it might have entailed exposure to an industrial hazard, s/he will ask the informant whether or not it did and might then refer the death to the coroner for investigation of whether the industrial hazard caused or contributed to the death. However, I do not think registrars are trained that they must always investigate the question of whether the deceased was exposed to a hazard.

14.59 In the present case, Mrs Livesey-Carter described her father's occupation as 'managing director', which indeed he was. Unfortunately, that would not have put the registrar on enquiry as to the possibility that his employment had involved exposure to an industrial hazard. Had the registrar asked questions and discovered that Mr Livesey had been exposed to asbestos, it might be that the death would have been referred to the coroner and that there would have been an autopsy. Whether that would have revealed that the true cause of his death was morphine poisoning, I cannot say with confidence. For reasons I have outlined in Chapter Nine, it is quite possible that the pathologist would have found some other condition capable of explaining Mr Livesey's death, in which case it is unlikely that toxicology would have been carried out.

14.60 I do not think I could criticise the registrar for failing to ask Mrs Livesey-Carter more about the nature of her father's employment. I have little doubt that Shipman knew that Mr Livesey had worked with asbestos and deliberately omitted to tick the 'Spearing box'. To do so would have been to invite the registrar to refer the death to the coroner, something Shipman would certainly have wished to avoid.

Advice from the General Register Office

14.61 The Inquiry found two deaths where registrars at the Tameside register office had sought advice from the GRO before registering the deaths. I have already explained in Chapter Six that the GRO runs an advice line, manned by members of staff from the General Section. Those members of staff have no medical background or expertise. They are recruited from other sections of the GRO and externally. They are trained on the job. They deal with written and telephone queries, ranging from simple enquiries from members of the public to more complex medical issues raised by registrars. Queries from registrars often relate to uncertainties over whether or not a death can properly be registered.

14.62 In order to assist them in answering queries, staff in the General Section have access to an annotated medical reference book, the Handbook for Registration Officers, various leaflets and internal files (known as 'P' Books) containing documents relevant to various issues, including referral to the coroner. They also have access to ONS epidemiologists in the event of complex medical enquiries; however, the evidence strongly suggests that most queries, including those from registrars, are resolved by the clerical staff. The registrar witnesses agreed that staff at the GRO are very approachable nowadays.

14.63 It does not appear that, within the documentation available to staff in the General Section in 1996, there was any unequivocal written statement to the effect that 'natural causes' was not an acceptable cause of death. Certainly, there was no such statement in the Handbook for Registration Officers. However, the Inquiry was told that the 'P' Books contained a letter, written by an ONS (then OPCS) epidemiologist in 1994 in response to a query from a coroner. The letter indicated that doctors within the OPCS did not agree as to the acceptability of 'natural causes' as a cause of death. The author of the letter said that his own reaction would be to accept an MCCD with 'natural causes' as the cause of death. He considered it to be **'self-evidently within the 'rules''**. Furthermore, he did not regard it as any less clear a cause of death than 'old age'. Anyone reading that letter might well have understood that 'natural causes' was, or at least might be, acceptable as a cause of death.

Mrs Erla Copeland

14.64 Shipman killed Mrs Erla Copeland on 11th January 1996. He certified that the cause of death was 'natural causes'. When the MCCD was presented at the Tameside register office, it appears that Miss Partoon, as the nominated officer, telephoned the GRO to seek advice about the acceptability of the cause of death. She recorded on the back of the MCCD, **'Checked with the GRO - Acceptable because of age'**. Mrs Copeland was 79. It is not known who at the GRO gave the advice. It appears that the adviser at the GRO had taken the view that 'natural causes' could be equated with 'old age'. Mr David Trembath, the manager of the General Section since October 1996, was unable to shed any light on how this advice could have been given. He suggested that, possibly, the registrar had tried to report the death to the coroner but that the coroner or his officer had been unwilling to accept it. In that event, the registrar might have sought advice from a member of staff at the GRO, who might have advised that, in those circumstances, 'natural causes' should be accepted. There is no evidence at all to suggest that that happened in this case.

14.65 The death was registered by Mrs Craven. She said that, if she had not known of the advice received from the GRO, she would have telephoned the coroner's office. She would not have made a formal report using Form 52. However, in view of the advice received from the GRO, she registered the death. She said that it would not have occurred to her to question advice from that source. I can well understand why. The giving of poor advice by the GRO in this case is worrying, as such advice disseminates poor practice. Any registrar hearing of such advice in one case would be likely to act upon that advice in other cases, without further reference to the GRO. If the GRO gave this poor advice to Miss Partoon, it is likely that it will have been given to other registrars all over the country.

14.66 I am not critical of Miss Partoon or Mrs Craven. I can well understand why they would prefer to telephone the GRO, rather than to refer the death to the coroner.

14.67 If this case had been reported directly to the coroner, I do not think that the outcome would have been significantly different from what in fact occurred. The likely outcome would have been that the coroner's officer would have requested the registrar to speak to Shipman and ask whether he was able to provide a more specific cause of death.

Alternatively, the coroner's officer would have spoken to Shipman. I am quite sure that Shipman would have obliged and would have thought of something to put on the MCCD. Indeed, it is surprising that he had been so careless as to certify the death as due to 'natural causes'; usually, he was careful to provide an acceptable (albeit untrue) cause. As Mrs Copeland's history did not reveal any obvious potential reason for her to die, I think it likely that Shipman would have certified the death as due to 'old age'. I think it most unlikely that the coroner's officer would have suggested to the coroner that he should take jurisdiction over the case and direct an autopsy. Only by speaking to those who had seen or spoken to Mrs Copeland shortly before her death could the coroner's officer have come to suspect that Mrs Copeland's death was sudden and unexplained.

Mrs Marion Higham

14.68 Mrs Marion Higham died on 19th July 1996, at the age of 84. After reviewing all the evidence relating to her death, I concluded that Shipman had probably killed her. He certified that the cause of her death was 'natural causes'. When the MCCD was presented, Mrs Craven, as the nominated officer, telephoned the GRO to ask advice about the acceptability of the cause of death. This is contrary to what she had said she would have done in the case of Mrs Copeland, six months earlier. It may well be that she felt it necessary to check with the GRO that the advice given then still held good. She recorded the outcome of her conversation with the GRO on the back of the MCCD as follows: **'SHEILA SIDES. GRO - ACCEPTABLE'**.

14.69 Mrs McCann then registered the death. Her evidence was that she would not have registered the death on her own initiative but did so in reliance on the advice of the GRO. She said that, although she does not always accept the advice of the GRO as authoritative, she did so on this occasion, probably because the advice had already been accepted by the nominated officer.

14.70 Mrs Sheila Sides had worked at the GRO for several years but, in July 1996, had worked on the advice line in the General Section for only a few weeks. It cannot have been she who advised Miss Partoon in January 1996 in respect of Mrs Copeland. Mrs Sides said that, in 1996, the policy in respect of 'natural causes' was clear; it was not acceptable. She suggested that her advice in this case could have been given as a result of a mistake or misunderstanding by her.

14.71 It was suggested by Counsel for the GRO, and accepted by Mrs McCann, that Mrs Craven might have spoken to the certifying doctor and the coroner's office before approaching the GRO. Mrs Sides suggested that one explanation for the advice that she gave might be that the registrar told her that she had already spoken to the coroner, had been told that the coroner was 'not particularly interested' (meaning that he did not want to take the case on) but that Mrs Craven was still 'unhappy' with the cause of death. In that event, Mrs Sides said, she would not have 'overruled' the coroner but would have told the registrar that she could go ahead and register the death. Mr Trembath appeared to think that was a possibility.

14.72 In my view, that suggestion does not make good sense for several reasons. First, if Mrs Craven had spoken to the certifying doctor, the doctor either would have offered to

provide a more specific cause of death on a new or amended MCCD (in which case, the death could then have been registered) or would have said that he could not identify a specific cause of death, in which case, the death would have had to be reported to the coroner. In practice, Shipman would have provided a more specific cause of death.

14.73 Second, it is highly improbable that Mrs Craven would have spoken to the coroner's office before seeking the advice of the GRO. It would not be logical to do so, unless the registrar regarded the death as clearly reportable and the coroner would not accept jurisdiction. In that event, there would almost certainly have been a note to that effect on the MCCD. There was not. In any event, the evidence of Mrs Evans, Mrs Collins and Mrs Margaret Blake, the coroner's officers at the time, was that, if a registrar had reported a death said to be due to 'natural causes', the coroner would have accepted jurisdiction. Finally, Mrs Sides' suggested explanation would be wholly inconsistent with the note written on the reverse of the MCCD that the cause of death was **'ACCEPTABLE'**.

14.74 Initially, Mrs Sides was adamant that the GRO policy towards 'natural causes' was so clear and unequivocal that there would have been little room for mistake or misunderstanding. She thought she could not have been confused by the letter in the 'P' file into thinking that 'natural causes' might be acceptable in some cases. However, she later conceded that she might have been confused by the letter.

14.75 The fact that similar (wrong) advice was given on two occasions during 1996 makes it unlikely that the GRO had a policy which was clearly understood by all staff in the General Section on the acceptability or otherwise of 'natural causes'. If such a policy did exist, it would have been easy to understand and put into practice. The fact that no such policy did exist (or was known only to some within the Section) may well be because the situation did not arise frequently. No policy was written down and, indeed, the written material which was available tended to suggest that 'natural causes' might constitute an acceptable cause of death; at the very least, it would have confused the issue.

14.76 In the absence of a clearly understood policy, no criticism can be levelled at Mrs Sides personally for her conduct in 1996. She may have given the advice on her own initiative, misunderstanding the position. Alternatively, she may have sought guidance from others who did not properly understand the position. Either way, she should not be blamed.

14.77 The suggested explanation put forward by Mrs Sides and Mr Trembath for the giving of the advice causes some concern. Both Mrs Sides and Mr Trembath suggested that, if a registrar was unhappy with the fact that the coroner was 'not interested' in taking up a case and sought the advice of the GRO, the advice would be to register the death, even if (as in the case of 'natural causes') the GRO believed the cause of death to be unacceptable. This seems to defeat the purpose of a registrar seeking independent professional advice from the GRO. Whilst, in the final analysis, it may be the case that there is little a registrar can do if the coroner refuses to act on a referral, it would at least be open to the registrar to take some further action, for example, by approaching the coroner personally or by submitting a Form 52. It would have also been possible for the GRO to make representations to the coroner on the registrar's behalf. The evidence also suggests that the GRO believes that coroners sometimes refuse to accept jurisdiction in deaths which have not been properly certificated and yet the GRO does nothing about it. The priority

appears to be to ensure that registration takes place, rather than to ensure that a satisfactory cause of death is established.

14.78 In respect of both the deaths examined, the Inquiry has been reliant on notes made by the registrars concerned. No record was or is maintained by the GRO of advice given on the acceptability of causes of death. In the light of the potential importance of the advice, this appears poor practice.

Conclusions

The General Register Office

14.79 It appears that the problems which have arisen in relation to the advice given by the GRO are caused in large part by a system whereby clerical staff without medical expertise are seeking to advise other clerical staff on matters which are essentially medical in nature. If the present system is to continue, it is apparent that improved training and guidance is required for the staff who answer queries from registrars. Also, if the advice line were to continue to operate in its present form, I would recommend that consideration be given to ensuring that one person with medical expertise is available to answer queries relating to the meaning or acceptability of a cause of death. However, if my recommendations for reform are accepted, registrars will no longer be required to decide on the acceptability of causes of death. For reasons I have already given, they are not properly equipped to carry out this function.

14.80 The recent circular to registrars advised that, where a death is reported as being due to 'natural causes', either without any other underlying cause of death or with an underlying cause of death which is also reportable, the death should be reported to the coroner. The Handbook for Registration Officers has been amended accordingly.

The Tameside Registrars

14.81 The Tameside registrars cannot be criticised for following the wrong advice given by the GRO.

14.82 As I have said, several of the procedures in operation at the Tameside register office were less than ideal. I am not critical of the individual registrars, who had not received clear training or guidance on the points of practice that arose. Nor had they any opportunity to meet registrars from other areas to discuss variations in practice. Accordingly, they had little opportunity to discover and correct any shortcomings in their own practice or to gain the necessary confidence to insist upon the correct statutory procedures. Their position was very different from that of Mrs West, who has had the advantage of exposure to contact with other registrars and the benefit of an excellent training programme. The only real opportunity afforded to the Tameside registrars to seek guidance on practice would arise when an inspector visited. However, such occurrences are not frequent and the main function of such a visit is for the inspector to satisfy him/herself that the registrar is conducting him/herself in accordance with the rules. The inspector might or might not discover an unorthodox practice during an inspection.

14.83 In any event, none of the unorthodox procedures followed at Tameside had a serious effect on the registration process. Nor would the outcome have been different in any of the cases I have considered had the procedures been correctly followed by staff at the register office.

14.84 Because of the fact that so many deaths certified by Shipman were registered at the Tameside register office, procedures at the office have been subjected to close scrutiny by the Inquiry. However, it is plain from the recent correspondence received from the GRO, to which I have already referred, that the departures from best practice about which the Inquiry has heard are not confined to Tameside. I welcome the advice and guidance which has recently been issued to registrars and hope that, in the future, it will also be possible to improve training facilities and opportunities for professional meetings for registrars and deputy registrars employed throughout the registration service.