APPENDIX II

The Shipman Inquiry & Luce Review

Harold Shipman practised as a GP in England, and was convicted in 2000 of the murder of 15 of his patients (although there were allegations that he actually killed many more) over a period of 24 years. A public inquiry was established in 2001, chaired by Dame Janet Smith, to investigate Shipman's activities and identify any steps which should be taken to protect patients in the future.

The 3rd Report of the Shipman Inquiry concluded that it was clear the current arrangements for death registration, cremation certification and coronial investigation in England and Wales had failed either to deter Shipman from killing his patients or to detect his crimes after they had been committed, and that consequently arrangements for death and cremation certification and the coronial system required radical change.

While the remit of the Shipman Inquiry was confined to England and Wales, and did not therefore directly criticise death certification processes in Northern Ireland, it did highlight weaknesses in similar processes in England and Wales.

The main recommendations from the third Shipman Report which relate to death certification are as follows:

• There should be one system of death certification applicable to all deaths, whether the death is to be followed by burial or cremation;
• A requirement that the fact that a death has occurred should be confirmed and certified;
• The introduction of 2 new forms – Form 1 to be completed by the person who confirmed that death had occurred (e.g. a doctor, accredited nurse or paramedic or a trained and accredited coroner's investigator); and Form 2 to be completed by the registered medical practitioner who treated the deceased during his/her last illness or the deceased's general practitioner.
• All deaths should be reported to the Coroner Service, which would take responsibility for certification of the death and for deciding whether further investigation was necessary. Deaths where the registered medical practitioner completing the second form (Form 2) had expressed an opinion as to the cause of death would be considered for certification by a coroner's investigator after consultation with the deceased's family. All other deaths would go for further investigation by the medical coroner;
• The Coroner Service would take primary responsibility for all post-death procedures. It would relieve other agencies of some of the responsibilities that they presently carry in connection with those procedures; and
• A proportion of all deaths certified by a coroner's investigator on the basis of the opinion of the registered medical practitioner who completes Form 2 should be selected randomly for fuller investigation at the discretion of the medical coroner. This process of random investigations would itself be the subject of audit. In addition, the Coroner Service should have the power to undertake targeted investigations, both prospective and retrospective.

The Shipman Inquiry acknowledged that the present arrangements for death certification and registration have three very real advantages. ***They are speedy, cheap and convenient.***

The present system depends almost entirely on the good faith and judgement of the registered medical practitioner who signs the MCCD, or decides that the case should be reported to the coroner. It also depends on the courage and independence of registered medical practitioners, for the system places upon them some responsibility to police their colleagues - for example, by refusing to certify a death which may have been contributed to by some misconduct, lack of care or medical error on the part of a professional colleague.

Luce Review

The Luce Review was published in 2003 and relates to England, Wales and Northern Ireland. The review was commissioned to:

- Consider the most effective arrangements for identifying the deceased and for ascertaining and certifying the medical cause of death for public health and public record purposes, having regard to proposals for a system of medical examiners;
- To consider the extent to which the public interest may require deaths to be subject to further independent investigation, having regard to existing criminal and other statutory and non-statutory investigative procedures;
- To consider the qualifications and experience required, and the necessary supporting organisations and structures, for those appointed to undertake the duties for ascertaining, certifying and investigating deaths;
- To consider arrangements for the provision of post-mortem services for the investigation of deaths;
- To consider the consequences of any changes arising from the above, and to consider where Departmental responsibilities for the arrangements should be located, having regard both to coherence for bereavement services and effective accountability.

With regard to death certification in Northern Ireland, the Luce Review recommended the implementation of single system for death certification (regardless of whether method of disposal is by cremation or burial). In addition, the Review recommended the establishment of a Medical Assessor role to provide an additional form of scrutiny for deaths, and an audit of death certification.