

**HERTFORDSHIRE COUNTY COUNCIL**

**COMMUNITY SERVICES SCRUTINY COMMITTEE  
TUESDAY 14 OCTOBER 2003 10.00 A.M.**

Agenda Item No.

**3**

**FUNDAMENTAL REVIEW OF CORONER SERVICES AND  
THE SHIPMAN INQUIRY**

Report of the County Secretary

Author: Steve Charteris, Head of Coroners Unit

Tel: 01707 897400

**1. Purpose of Report**

The purpose of this report is to advise members of the main recommendations of the Fundamental Review of Coroner Services report and The Shipman Inquiry report on Death Certification and the Investigation of Deaths by Coroners, which was requested as part of the Best Value Review implementation monitoring.

To advise members of their effects on the Coroner Service in Hertfordshire.

**2. Summary**

Following the conviction of Harold Shipman for murder and other high profile incidents (Allitt inquiry, Marchioness disaster, Alder Hey inquiry and Bristol inquiry), the government commissioned two enquiries. One into the future of the Coroner Services in England and Wales and the other to investigate the circumstances in which Harold Shipman was able to commit the murder of his patients.

This committee report details the main findings from the reports and highlights key differences between the two reports.

**3. Conclusions**

- 3.1 It is suggested that there is continued monitoring of the further work being undertaken to reconcile the two reports.
- 3.2 It is suggested that there is continued involvement at the Local Government Association (LGA) and Home Office Coroner Service Consultative Committee in order to ensure Hertfordshire's voice is heard.
- 3.3 Members are invited to review and comment on this issue.

## **4. Key Differences**

4.1 The reports examine the same issues. Management summaries are attached. However in a number of areas the reports recommend different proposals for change.

### **4.2 Referrals.**

4.2.1 The Fundamental Review proposes only certain categories of death should be referred to the Coroner Service, as defined by the Coronial Council.

4.2.2 The Shipman Inquiry proposes that the Coroner Service should have jurisdiction over all deaths.

### **4.3 The Medical Profession.**

4.3.1 The Fundamental Review proposes the appointment of doctors as Statutory Medical Assessors, who will work alongside the Coroner and support and audit other doctors in the death certification process. A two tier certification system will apply. The first certificate will be signed by the doctor treating the person who has died. The second will come from a panel chosen and supported by the Statutory Medical Assessors at the Coroner's Office.

4.3.2 The Shipman Inquiry proposes the appointment of Medical Coroners. They will decide if a post-mortem is necessary, if the case has been referred to them by the Coroner's Investigation. The Medical Coroners will randomly audit the investigations of Coroner's Investigators. They would also decide if a case should be referred to the Judicial Coroner for further investigation.

### **4.4 Districts.**

4.4.1 The Fundamental Review proposes the number of Coroner Districts be reduced from the present number of 136 to 60 districts, a number broadly in line with the Police authorities. There would be a Coroner and a Statutory Medical Assessor in each district.

4.4.2 The Shipman Inquiry proposes the establishment of 10 coroner regions based on regional government boundaries. There would be approximately 60 districts, a number broadly in line with police authorities. There would be a full time Medical Coroner in each district and a full time Judicial Coroner in each region.

### **4.5 Ownership.**

4.5.1 The Fundamental Review proposes that the Coroner Service will become the responsibility of the department for Constitutional Affairs.

It will be resourced, financed and managed by either the Court or Tribunal Services.

- 4.5.2 The Shipman Inquiry proposes that the Coroner Service should become an Executive Non-Departmental Public Body (ENDPM) associated with the Department for Constitutional Affairs and the Department of Health.

#### **4.6 Certification and Investigation System.**

- 4.6.1 The Fundamental Review proposes a two tier certification system for all deaths. The first certifier should usually be the doctor looking after the person who died. The second should be a Doctor from a panel chosen and supported by the Statutory Medical Assessor at the Coroner's Office. The Coroner will decide the scope of the investigation.

- 4.6.2 The Shipman Inquiry proposes that there will be two forms for all deaths. Form 1 will be an official record of the fact of the death. Form 2 will be a brief summary of the deceased's recent medical history and the chain of events leading to the death. Form 1 will be completed by the health professional who confirms the fact of death. Form 2 should be completed by an experienced Doctor. The Coroner's Investigator will investigate the death and if necessary refer it to the Medical Coroner. Inquest cases will be referred to the Judicial Coroner.

#### **4.7 Inquests**

- 4.7.1 The Fundamental Review proposes public inquests for a number of categories of death such as public transport deaths. Other inquests would be dealt with administratively.
- 4.7.2 The Shipman Inquiry proposes a very narrow category of deaths, which would require mandatory inquests such as deaths in custody and where "public interest" requires a public investigation. Other inquest cases would be dealt with administratively and the Judicial Coroner will produce a report explaining how and why the deceased died.

### **5. The Effect On Hertfordshire**

- 5.1 The effect on the service currently provided by Hertfordshire would, under either option, be that the service is delivered by another provider.

### **6. The Way Forward.**

- 6.1 The government has asked Mr Tom Luce who chaired the Fundamental Review to look at reconciling the two reports.

- 6.2 A Home Office reform team has been created to consider preparations for change and the interim provision of services prior to legislative change. Hertfordshire Coroner service is in contact with the team and has offered to pilot new initiatives.
- 6.3 The Coroner's Manager chairs the LGA Working Group of Coroner services and is a member of the Home Office Coroner Service Consultative Committee. Hence Hertfordshire are aware of new developments within the service.

## **7. Rural Implications.**

There are no specific rural implications.

### Background papers used by the author when compiling this report

The Shipman Inquiry – Death certification and the Investigation of Deaths by Coroners.

Death Certification and Investigation in England, Wales and Northern Ireland – The Report of the Fundamental Review 2003.