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Secretary of State for Health
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The Rt. Hon. David Blunkett MP
Secretary of State for Home Affairs
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10 June 2003

Dear Secretaries of State,

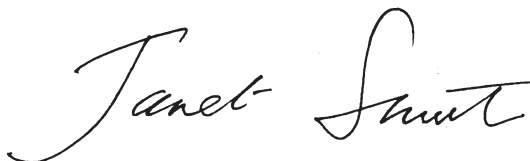
Shipman Inquiry – Third Report

As you know, in January 2001, I was appointed to conduct an Inquiry into the issues arising from the conviction of Harold Shipman, a general medical practitioner, for the murder of fifteen of his patients. In July 2002, I published my First Report, dealing with the extent of Shipman's unlawful activities.

I now submit my Third Report, which deals with death certification and the investigation of deaths by coroners. The Inquiry's Terms of Reference require me to recommend what steps should be taken to protect patients in future. When work began, it soon became apparent that the existing systems have failed not only to protect patients but also to meet the needs and expectations of the wider public and society in general. I have sought to make recommendations that will protect patients and will also meet these broader objectives. My proposals entail radical change and would require primary legislation.

Mr Tom Luce, Chair of the Coroners Review, was asked to co-operate with the Shipman Inquiry. He allowed me to see the Review's Report in draft at a time when my own Report was still in preparation. I am pleased to say that there are many issues upon which the Review and the Inquiry have reached similar conclusions and made compatible recommendations.

Policy decisions will be required before change can be effected. In Chapter Three, I have set out the history of events following the publication of the Brodrick Report in 1971, in which the issues of death certification and the coroner system were comprehensively reviewed. The recommendations were not implemented because the conflicting views of interested parties were never resolved by the making of a clear decision on policy. I urge you now to ensure that the work of the Review and this Inquiry do not meet the same fate.



Janet Smith