

THE SHIPMAN INQUIRY

Chairman: Dame Janet Smith DBE

Second Report

The Police Investigation of March 1998



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*Presented to Parliament by the
Secretary of State for the Home Department and
the Secretary of State for Health
by Command of Her Majesty
July 2003*

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The Rt. Hon. Alan Milburn MP
Secretary of State for Health
Richmond House
79 Whitehall
London
SW1A 2NS

The Rt. Hon. David Blunkett MP
Secretary of State for Home Affairs
Queen Anne's Gate
London
SW1H 9AT

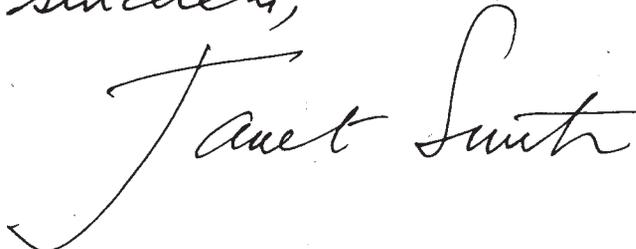
10 June 2003

Dear Secretaries of State,

Shipman Inquiry – Second 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 Second Report, which deals with the investigation conducted by the Greater Manchester Police in March and April 1998, five months before Shipman was arrested. That investigation, which followed a report made by a general practitioner who suspected that Shipman might be killing his patients, failed to uncover any evidence that he was doing so. This Report examines the conduct of the investigation and the reasons why it failed to uncover evidence that was there to be found. I have concluded that the lives of three of Shipman's patients would probably have been saved if the investigation had been properly conducted and supervised.

Yours sincerely,


Janet Smith

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SUMMARY

Introduction

1. On 31st January 2000, Harold Fredrick Shipman was convicted of the murder of 15 patients and of forging the will of one of them. His trial was the culmination of an investigation which began in July 1998 into the death of Mrs Kathleen Grundy.
2. Shipman had, however, been the subject of an earlier police investigation. On 24th March 1998, Dr Linda Reynolds, a principal of the Brooke Practice, which practised from premises opposite Shipman's surgery, reported to Mr John Pollard, HM Coroner for the Greater Manchester South District ('the Coroner'), her concerns, and those of her partners, about the number of Shipman's patients who were dying and the circumstances of their deaths. At the request of the Coroner, a confidential investigation was carried out by the Greater Manchester Police (GMP or 'the Force'). That investigation was conducted by Detective Inspector (DI) David Smith under the supervision of Chief Superintendent (CS) David Sykes.
3. DI Smith concluded that there was no substance in Dr Reynolds' concerns and his investigation ended on 17th April 1998. After that time, Shipman killed three more patients before his arrest. They were Mrs Winifred Mellor, Mrs Joan Melia and Mrs Grundy. After Shipman's trial, there were concerns about the thoroughness with which the first police investigation had been carried out and whether, if it had been conducted differently, Shipman's course of killing could have been stopped earlier and the lives of three of his victims saved.
4. In the course of hearings which took place between May and July 2002, the Inquiry conducted a detailed examination of the evidence relating to the March 1998 police investigation. This Second Report records my findings as to what occurred during this investigation and provides my opinion as to whether or not, in performing their duties, the conduct of the various public servants involved fell below the standard which the public is entitled to expect.

Dr Reynolds Makes her Report

5. When Dr Reynolds made her report to the Coroner, she mentioned two particular grounds for concern. First, she told him that she knew that Shipman, who was a single-handed practitioner, had signed 16 cremation Forms B in the previous three months, whereas the Brooke Practice, with a patient base of 9500, had had only 14 patient deaths during the same period. Shipman had a patient list which was approximately one-third the size of the Brooke Practice list. Moreover, the figure of 16 cremations within his practice would not include:
 - deaths which had occurred in hospital
 - deaths followed by burial
 - deaths certified by the coroner
 - deaths where Shipman had asked a doctor other than one from the Brooke Practice to complete Form C.

6. The effect of these factors was that, if Shipman's practice followed the usual pattern, those cremations which members of the Brooke Practice were aware of were likely to represent no more than about 21% at most of Shipman's total deaths during the relevant period. Given the fact that Shipman had a patient list which was approximately a third the size of that of the Brooke Practice, it is apparent that the disparity between the number of deaths of patients in Shipman's practice and in the Brooke Practice was potentially very large indeed. It was this disparity which concerned Dr Reynolds and the other members of the Brooke Practice.
7. The second cause of concern was the presence of features which appeared to characterise the deaths, namely that the deceased persons were elderly women who had been found dead at home, apparently alone, fully dressed. They did not appear to have been ill. Shipman often found them dead. These features were unusual. It is more common for deaths to be more or less equally distributed between men and women. Most deaths at home occur after a period of illness, with the patient confined to bed and relatives and friends in attendance. It is not common for a general practitioner to be present at the death of a patient or to find a patient dead. Mrs Deborah Bambroffe (nee Massey), a partner in the firm of Frank Massey and Son, Funeral Directors (Masseys), had expressed concern to Dr Reynolds about those features. Mrs Bambroffe did not want her name to be disclosed and Dr Reynolds informed the Coroner of this fact. She did not disclose the identity of Mrs Bambroffe to him.
8. Dr Reynolds also told Mr Pollard that she had signed a cremation Form C for one of Shipman's patients a few days before. Mr Pollard did not discover the identity of that patient, nor did he explore the possibility that the body might still be available for autopsy.

The Investigation Begins

9. The Coroner communicated Dr Reynolds' concerns to CS Sykes and DI Smith. He told them that Dr Reynolds had advanced two explanations, either of which might account for the factors giving rise to her concerns. The first was that Shipman was a caring doctor, who looked after his elderly and sick patients in their own homes, rather than having them admitted to hospital, and who visited them frequently when he knew them to be ill. The second was that he was killing his patients.
10. DI Smith began his investigation by interviewing Dr Reynolds. During the period of four years which elapsed between the investigation and the Inquiry hearings, he gave a number of accounts of that interview. I have found that, in his earlier accounts, DI Smith sought to diminish the seriousness and credibility of Dr Reynolds' concerns as explained to him; I have concluded that he did so in the hope of avoiding criticism in respect of his conduct of the investigation. In his oral evidence to the Inquiry, DI Smith abandoned his previous attempts to diminish Dr Reynolds' concerns. He admitted for the first time that Dr Reynolds had told him early in their meeting that she thought Shipman was killing his patients, either through lack of care or by murdering them and that, if he was murdering them, he was doing it by giving them some sort of drug.
11. DI Smith denied, however, that Dr Reynolds had told him that there were two bodies lying at the premises of funeral directors, which would be available for autopsy. As a result of

notes made in his own daybook (the book in which he made notes in connection with his work: see Appendix A) and other contemporaneous evidence, I have concluded that Dr Reynolds did indeed give DI Smith that information. The bodies were those of Mrs Lily Higgins and Miss Ada Warburton. I have previously found that Shipman killed both of them. However, DI Smith failed to pursue with the Coroner the possibility of autopsies on either or both of their bodies. I think it likely that, if asked, the Coroner would have agreed to that course. Had he been made aware, either by DI Smith or Dr Reynolds, of Dr Reynolds' belief that, if Shipman was killing his patients, he was doing it by administering a drug, the Coroner would have ordered an autopsy with toxicological examination. I think it likely that this would have happened. In that event, the presence of morphine in either or both of the bodies would have been detected. Mrs Higgins was cremated on 25th March 1998. Miss Warburton's body was available for autopsy until her cremation on 30th March 1998.

12. In the course of his interview with Dr Reynolds, DI Smith failed to ask many important questions. He did not discover the basis of her concerns about the disparity between the death rates of Shipman's practice and her own, nor did he ask to see the records from which the rates had been derived. He did not ask why the features of the deaths which Dr Reynolds had identified gave rise to concern. He did not seek to find out more about the circumstances of the individual deaths for which she had completed Forms C. He did not seek an explanation of the procedures for death and cremation certification. He did not ask to meet Dr Reynolds' partners. As a consequence of these failures, DI Smith left the interview, uncertain about the basis for Dr Reynolds' concerns and, in particular, with no understanding of the potential importance of the comparative death rates about which Dr Reynolds and her partners were so troubled.

The Tameside Register Office

13. DI Smith next went to the Tameside register office and requested Mr Frederick Loader, the Superintendent Registrar, to provide him with copies of all the entries in the registers of deaths relating to deaths certified by Shipman over the previous six months. During that period, Shipman had certified 31 deaths. On 26th March 1998, Mr Loader handed to DI Smith a bundle of copy death certificates. Mr Loader and his staff say that, since there had been 31 deaths in the relevant period, 31 certificates must have been handed over. DI Smith maintains that he was given significantly fewer certificates; he now says that the number was 20. If DI Smith is correct, the register office staff were at fault. If they are right and DI Smith was given all 31 certificates, he must have lost 11 or 12 of them almost immediately and failed to find them again at any time during the investigation.
14. I have concluded that it is more likely that there were errors in the register office, resulting in an incomplete bundle of certificates being given to DI Smith. If that conclusion is correct, it seems to me likely that Mr Loader was responsible for the errors. However, I do not think that a high degree of blame should attach to him.
15. Because DI Smith did not understand the significance of the number of deaths or the comparative death rates reported by Dr Reynolds, he did not recognise that the number of copy death certificates which he received from the register office (19 or 20, covering

a period of six months) was incompatible with the number of cremation forms signed for Shipman's patients by members of the Brooke Practice (16 in three months). It is because of that lack of understanding – and the fact that DI Smith attached no importance to the numbers or death rates – that I have concluded that the error made by the register office staff had no significant effect on DI Smith's conduct of the investigation.

Dr Alan Banks

16. DI Smith visited the Hyde office of the West Pennine Health Authority and sought access to the medical records of 17 of the 19 or 20 deceased persons for whom he had copy death certificates. Since he did not have the consent of the next of kin or personal representatives of the deceased, he was told he could not have access to the records. Instead, it was arranged that Dr Alan Banks, Assistant Director of Primary Care and Medical Adviser to the Health Authority, would examine the records; in the event, 14 of the 17 sets of records were available for examination. A 15th set became available at a later stage. I have concluded that the main task which Dr Banks believed he had to perform was to ascertain whether the medical records confirmed or denied the presence in all the deaths of the pattern of 'common features' reported by DI Smith to Mrs Janet Parkinson, the Consumer Liaison Manager for the Health Authority. These common features were that the deaths were of elderly females; all had been found at their homes by Shipman who had apparently called on them unannounced; all had been found during the day and in their day clothes and all had been certified as having died from stroke or heart disease. In addition, Dr Banks looked to see if the causes of death, as disclosed by the records, were generally compatible with the medical histories.
17. Dr Banks claimed that he did not realise that the concern being investigated by the police was that Shipman might be killing his patients. I do not accept that claim. I find that he must have known that the underlying concern was that Shipman was killing patients, either deliberately or by gross negligence. However, Dr Banks found the suggestion so incredible that it is doubtful that he contemplated it as a real possibility.
18. Dr Banks examined the medical records on 26th–27th March 1998 and compiled a chart (Appendix D) on which he sought to show the presence or absence of the common features which had been identified to him. On 1st April 1998, he met DI Smith to discuss the results of his examination. At that meeting, I am satisfied that Dr Banks told DI Smith that there were two or 'a few' deaths in which he considered there was insufficient information in the medical records to enable a proper diagnosis of the cause of death to be made. I am further satisfied that he said that he himself would have referred those deaths to the coroner. I do not accept that he said that such a referral would have been mandatory or that any reasonable doctor would have made the referral. Dr Banks suggested that the insufficiency of information might be caused by the limitations of the computerised records. The overall impression which he created was, I am confident, one of reassurance.
19. In my view, Dr Banks failed, when examining the medical records, to recognise features within them which tended to support the concerns which had been identified to him. He did not recognise as unusual the fact that 13 out of the 14 deaths for which he initially

examined records were of female patients. Although he noted on his chart that Shipman had been present around the time of death in ten out of the 14 cases, he did not draw that to DI Smith's attention. It does not appear that he noticed that Shipman had visited seven of the patients not long before the death was discovered. The medical records did not disclose any serious concern about the patients' condition yet, within a short time, the patients had been found dead. Dr Banks does not seem to have noticed that 12 out of the 14 deaths occurred at the patients' homes, with only two in residential or nursing homes.

20. I have concluded that Dr Banks' prior knowledge of, and respect for, Shipman made him an unsuitable person to carry out the task of examining the medical records. It is unfortunate that he did not recognise that fact. Because he approached the records on the basis that all would be normal, his search for the 'common features' was superficial. When he realised that not every feature of concern was present in the circumstances of all the deaths (an expectation which was illogical, had he paused to consider it), Dr Banks erroneously concluded that there was no 'pattern' to be found. He failed to see the unusual features which characterised many of the deaths. If he did notice anything which struck him as odd, he immediately found an innocent explanation for it. He approached his examination of the records in the belief that there would be no cause for concern and was simply unable to open his mind to the possibility that Shipman might have harmed a patient. He failed to appreciate the potential significance of the fact that Shipman was not referring deaths to the coroner which he himself believed should have been referred.
21. In mitigation of his failures, I accept that Dr Banks was not given all the information he could and should have been given. In particular, he was not told about the comparative death rates of the Brooke Practice and Shipman's practice. I think there is a real possibility that, if Dr Banks had been fully informed, his mind might have not been quite so tightly closed against the possibility of Shipman's guilt.
22. If DI Smith had received all 31 copy death certificates from the Tameside register office and Dr Banks had been made aware of most or all of them, the chance that he would have realised that the death rate among Shipman's patients was abnormal would have been increased. The additional records which would have been available for Dr Banks to examine contained a number of unusual features which tended to support the concerns that had been raised. However, I cannot say with confidence that Dr Banks would have realised the significance of this additional material even had he seen it. It is possible that he would have done so and would have expressed real concern to DI Smith but I cannot say that it is probable that this would have happened.
23. DI Smith was indeed reassured by what Dr Banks told him. I am satisfied that the receipt of Dr Banks' opinion effectively marked the end of this investigation.

The Dukinfield Crematorium

24. Nevertheless, later on 1st April 1998, DI Smith visited the Dukinfield crematorium. Whilst there, he asked no questions about the system of cremation certification. He failed to discover the fact that the crematorium held a bundle of certificates for each cremation which contained information supplied by the certifying (Form B) doctor about the circumstances of death. He did not look at the cremation register as he should have done.

Had he looked, he would have found that the name of the certifying doctor appeared in the record of each death. Had DI Smith looked back over the previous six months, he would have found entries for the 11 deaths of which he was at that time unaware. Also, because he asked no questions about cremation procedures, he remained unaware of the existence and role of the crematorium medical referee. He therefore lost the opportunity to interview Dr Betty Hinchliffe, Medical Referee at the crematorium. It is fair to say, however, that, if he had interviewed her, he would have received an assurance that Shipman always completed his Forms B satisfactorily and that his patients' deaths gave rise to no ground for suspicion.

Masseys

25. DI Smith also ascertained that nine of the funerals had been dealt with by Masseys; in discussion with Mr Michael Gurney, Senior Registrar at the crematorium, he came to the (correct) conclusion that the unidentified female undertaker of whom Dr Reynolds had spoken was Mrs Bambroffe, formerly Miss Deborah Massey.
26. On 2nd April 1998, Mrs Bambroffe's father, Mr Alan Massey, had been to see Shipman in his surgery. Initially, when Mrs Bambroffe and her husband, David, had voiced their concerns to Mr Massey, he did not share them. He was further reassured by a conversation which he had with Dr Alastair MacGillivray, of the Brooke Practice, which probably took place towards the end of February 1998. However, Mr Massey and his family have said that, by the end of March or the beginning of April, Mr Massey himself was concerned about the number of deaths among Shipman's patients and the circumstances surrounding those deaths. He wanted to seek an explanation from Shipman and therefore decided to make an appointment to see him.
27. At that time, Mrs Bambroffe was aware that her concerns and those of the Brooke Practice doctors had been reported to the Coroner. It is likely that she had been told that the police had been informed; certainly she would have known that, given the involvement of the Coroner, the police might well be involved also. I am satisfied that, by 2nd April, she had told her father of the report to the Coroner and that he too was probably aware that the police would also be involved.
28. In my judgement, Mr Massey went to see Shipman because he thought that, with the report to the Coroner, things had 'gone too far' and that Shipman should know what was being said about him. At the time he went, I have no doubt that Mr Massey was convinced that Shipman had done nothing wrong. I am satisfied that he did not intend to 'tip off' Shipman. Nor do I think that he went so far as to tell Shipman that there had been a report to the Coroner. I believe that he gave Shipman to understand that people were talking about the number of deaths among his patients and to make plain that he himself did not share the suspicions which were being voiced by others. Shipman's response was to produce his book of Medical Certificate of Cause of Death counterfoils and show Mr Massey various names and causes of death. He told Mr Massey that the book was available for inspection by 'anybody concerned'. He was relaxed, confident and apparently unconcerned by the deeply distressing (to an innocent person) gossip which was circulating about him. Mr Massey was entirely reassured by Shipman's response, although he had, of course, not received the explanation he claimed to have sought.

29. The effect of Mr Massey's visit was to alert Shipman to the fact that he was under suspicion, possibly even under investigation. I think the consequence was that Shipman stopped killing for a time before resuming and killing his last three victims on 11th May, 12th June and 24th June 1998. In my judgement, Mr Massey's action in speaking to Shipman did not lead to any loss of life and may indeed have saved lives. I am sure that he acted with good intentions when he went to see Shipman. His mistake was that he trusted, admired and respected Shipman and could not believe that the suspicions harboured by his daughter and the Brooke Practice doctors could have any foundation. I think he has found it very hard, indeed impossible, to accept that this was once his state of mind.
30. About two weeks after Mr Massey's visit to Shipman, probably on 15th April 1998, DI Smith met Mr and Mrs Bambroffe and Mr Massey. DI Smith confirmed that Mrs Bambroffe was the undertaker who had expressed concerns to the Brooke Practice doctors. He told Mrs Bambroffe of Dr Reynolds' concerns, as related to him, and of what he had done to investigate them. He asked Mrs Bambroffe if she had anything to add. His manner was reassuring and he gave the impression that he had made a thorough investigation and found nothing untoward. The family got the impression that the investigation was approaching its conclusion. DI Smith did not ask Mrs Bambroffe to elaborate upon her concerns, nor did he seek information about the deaths which she and other members of the family had attended. He did not seek access to the records kept by Masseys. Had he done all these things, he would have elicited a great deal of information, including the fact that there were five deaths dealt with by Masseys during the preceding six months, of which he was unaware. This meeting was not an evidence-gathering exercise; rather, the interview consisted of DI Smith imparting information. I can well understand, given the nature of the meeting and DI Smith's attitude, why Mrs Bambroffe did not feel able to repeat and expand upon the concerns which she had previously expressed. By the end of the meeting, DI Smith had learned nothing new.

The End of the Investigation

31. At about this time, DI Smith discussed the investigation with CS Sykes and it was agreed that it should be closed. There was no detailed discussion of the evidence collected by DI Smith and he submitted no written report. In effect, CS Sykes delegated the decision to close the investigation to DI Smith.
32. During the course of the investigation, DI Smith had made no check on the Police National Computer to ascertain whether or not Shipman had any previous convictions. He said that he forgot to do so. I doubt that he forgot and think it more likely that he thought his search of the Greater Manchester Police Integrated Computer System would be adequate, because a man like Shipman would not have any criminal convictions. Had he enquired, he would have discovered that Shipman had previous convictions for drug offences involving dishonesty, committed in the early 1970s. DI Smith claimed that, even had he known about Shipman's criminal record, it would not have affected his view of Shipman. I do not accept that assertion. Of course, the knowledge that Shipman had past drugs convictions would not immediately have led to the conclusion that he was killing his patients. However, when considered with Dr Reynolds' suggestion that Shipman might be

killing his patients by giving them some sort of drug, knowledge of his convictions would have raised the index of suspicion of any reasonable police officer.

33. On 16th April 1998, DI Smith visited Dr Reynolds and told her that he had found no evidence to confirm her suspicions. I am satisfied that he mentioned the apparent absence of motive; Dr Reynolds was disappointed at the emphasis on this aspect of the enquiry as she was concerned, not about motive, but about the disparity in death rates between the two practices. DI Smith gave no explanation for that disparity; he was not in a position to do so.
34. On 17th April 1998, DI Smith spoke to Mr Pollard by telephone. He mentioned the fact that he had had medical records examined; two sets had been 'questioned' but there had been nothing that 'gave any indication of any criminal acts'. He had 'inspected' the 'cremation records' of 20 people and seen the female undertaker of whom Mr Pollard had been told. He informed Mr Pollard that Shipman tried to get all his patients out of hospital and visited them without prior appointment. Mr Pollard accepted what was said and did not think deeply about it or question whether the proffered explanation could satisfactorily account for the startling disparity between the death rates. He did not take any steps to discover whether Dr Reynolds was satisfied with the result of the investigation. He accepted that the police enquiry had revealed nothing of concern and put the whole matter out of his mind. Thus ended the March 1998 police investigation.

Conclusions

Chief Superintendent David Sykes

35. The Inquiry was told that DI Smith, although an experienced detective, was not accustomed to working without direction and supervision. CS Sykes should have known that or, if he did not, he should have discovered it. He should have instructed a suitably experienced detective officer to undertake this unusual and potentially serious investigation. He should have realised also that he himself did not have the necessary experience to direct and supervise the investigation. He should have consulted Detective Superintendent Bernard Postles (now Detective Chief Superintendent Postles) who would have advised as to the appropriate level of seniority to which the concerns should be reported. I am satisfied that, had that been done, a properly directed investigation would have taken place.
36. Once the investigation was under way, CS Sykes failed to recognise that DI Smith was out of his depth. He failed to discuss the issues with DI Smith in any detail. If he had done so, he would have realised the extent of DI Smith's lack of understanding. He should not have left it to DI Smith to decide whether and when the investigation was to be closed. If, even at that stage, he had asked a senior detective officer to scrutinise the information that DI Smith had gathered, the outcome would have been different.

Detective Inspector David Smith

37. DI Smith himself made many mistakes in the course of the investigation. Some of those were the result of his lack of experience of criminal investigations of a non-routine nature.

He was wrong to continue with his investigation, pretending that he knew what he was doing when, as he admitted in evidence, he did not know 'where to go'. He should have sought the advice of a senior detective officer. As a consequence of his failure to seek advice, he never understood the issues, never had a plan of action, had no one to help him analyse the information he received, had no one to make suggestions as to the information he should seek from the available witnesses and was allowed to close the investigation before it was complete. However, he should have had, without needing to ask for it, the benefit of supervision by a senior detective officer. In addition, he was not assisted by the poor advice which he received from Dr Banks, nor by the failure on the part of the Tameside register office to provide him with a complete bundle of copy death certificates.

38. Although I do not consider that DI Smith is primarily responsible for the failure of the investigation, in two respects his inaction contributed directly to the adverse result. The first was his failure to collect detailed information from Dr Reynolds and the second was his failure to report to the Coroner the fact that the bodies of Mrs Lily Higgins and Miss Ada Warburton were available for autopsy if the Coroner thought fit to order one.
39. In addition, DI Smith's lack of frankness about his part in the investigation merits strong criticism. In the various accounts of his investigation given to the police, he consistently sought to attribute its failure to the fault of others. He told lies in those accounts and repeated some of those lies in statements made to this Inquiry. In oral evidence, he told the truth about some matters, for which he deserves credit. However, he has continued to the end to lie about the circumstances in which he learned of the death of Miss Warburton. He did so in an attempt to evade responsibility for his failure to arrange an autopsy on her body.

Dr Alan Banks

40. In my judgement, Dr Banks must also bear some responsibility for the failure of the investigation, although I consider that his contribution is substantially less than that of CS Sykes and DI Smith. I have already referred to the inadequacies of his examination of the medical records and to the fact that he was unable to open his mind to the possibility that Shipman might have killed his patients or even that he might have given them substandard care. That mindset would have been excusable if he had not known that the reason why the police were making enquiries was because a concern had arisen that Shipman might be killing his patients. I accept that Dr Banks' knowledge of, and respect for, Shipman made it even more difficult for him to have an open mind. The 'credibility gap' amounts to mitigation for Dr Banks' failures, but cannot provide an excuse in the case of a professional man asked for his professional opinion.

A Different Outcome?

41. Had CS Sykes put the investigation in the hands of a more senior detective officer, one who had experience of devising and supervising a criminal investigation, and if that officer had acted with reasonable expedition, the whole course of the investigation would, in my view, have been very different. I think it likely that the opportunity would have been taken

to conduct an autopsy, with toxicological tests, on the body of Miss Warburton or of Mrs Martha Marley, of whose death on 24th March 1998 DI Smith remained ignorant throughout the investigation. Had that been done, morphine would have been found, an inquest would have been ordered and Shipman would have come to learn that he was under suspicion. I do not think he would have killed any more patients after that.

42. Even if the opportunity for an autopsy had been lost then, I believe that, in due course, suspicions would have been such that the police would have applied for an exhumation and autopsy, with toxicological tests. It is probable that, by that time, concerns would have arisen about the death of Mrs Bianka Pomfret, and that her body would have been exhumed. Morphine would have been found. It would not have been long before Shipman became aware of the investigation and I do not think he would have killed again.
43. Although I cannot be certain of this, I think that, if the police and the Coroner had moved with reasonable expedition, the lives of Shipman's last three victims would probably have been saved.
44. If CS Sykes had initially instructed DI Smith to carry out the investigation but had subsequently discovered that he was out of his depth, then it is more difficult to say what the probable outcome would have been. It would depend on how much time had elapsed before the discovery was made and the investigation was put into the hands of a more senior detective officer. Plainly, the later the change of officer in charge, the poorer the chance that Shipman would have been stopped before he killed again.

The Greater Manchester Police

45. At an early stage in the later police investigation into the death of Mrs Kathleen Grundy, it was discovered that there was no written report about the March 1998 investigation. Subsequently, DI Smith submitted two written reports, setting out details of the investigation. I have found that, in those reports, he sought to diminish the seriousness of Dr Reynolds' original concerns and to suggest that Dr Banks had raised no concerns whatever about the medical records. Clearly, DI Smith was seeking to deflect possible criticism of his conduct of the investigation. By the end of 1998, the GMP had good reason to suspect Shipman of being a serial killer, whom the first police investigation had failed to detect. The potential for criticism of the Force was recognised. Nevertheless, on the basis of DI Smith's reports alone, senior officers in the GMP concluded that the March 1998 investigation had been 'appropriate at that time'.
46. Immediately after Shipman's conviction, it was announced that there would be an Inquiry into the Shipman affair, including the first, failed police investigation. In preparation for the Inquiry, Detective Superintendent (Det Supt) Peter Ellis was instructed to prepare a 'comprehensive document' recording, as accurately as possible, a detailed account of the March 1998 investigation. The document was prepared following interviews with CS Sykes and DI Smith. The account given by DI Smith to Det Supt Ellis was different in a number of respects from his oral evidence to the Inquiry. Most notably, he told Det Supt Ellis that Dr Reynolds had at no time said that she suspected that Shipman was killing his patients. That was in contrast to his oral evidence to the Inquiry. In general, the account given to Det Supt Ellis, like DI Smith's previous reports, tended to minimise the

seriousness of the concerns being expressed and excused DI Smith's failure to find evidence to substantiate those concerns.

47. Having recorded DI Smith's account of the investigation, Det Supt Ellis then proceeded to make a series of 'observations', all of which had the effect of exculpating DI Smith. He excused DI Smith's failure to ascertain whether Shipman had previous convictions. He criticised Dr Reynolds and Mrs Bambroffe in a number of respects without querying the account he had been given. He emphasised the limitations placed on the investigations by the constraints of confidentiality. His conclusions echoed the view previously expressed by senior members of the Force that the investigation was 'appropriate at the time'. He pointed out the potential for criticism in DI Smith's failure to keep records of his enquiries but mitigated this by suggesting that written records might have been kept if any evidence supporting the suspicions had come to light.
48. Det Supt Ellis should not have been given the task of preparing the report, which should have been written by a more senior officer. He was not in a position to investigate the actions of CS Sykes, still less form a judgement about his supervision of the investigation. He was heavily influenced by the views of more senior officers, of which he was aware. Nevertheless, Det Supt Ellis' report was accepted by senior officers in the GMP, who maintained their view that DI Smith's investigation had been as thorough as possible. After the report had been submitted to this Inquiry, the witness statements submitted by officers of the GMP continued to reflect the same view.
49. On the first day of the Inquiry hearings of the evidence relating to the March 1998 police investigation, it was conceded on behalf of the GMP that the March investigation had been seriously flawed in a number of respects. That conclusion was prompted by a review of the investigation which was then being carried out by Detective Chief Superintendent (DCS) Peter Stelfox; that review constituted a careful, detailed and objective analysis of the evidence relating to the first investigation. DCS Stelfox was deeply critical of DI Smith for his conduct of the investigation and of CS Sykes for his failure properly to direct and supervise it.
50. In my view, the GMP should not have waited until 2002 to undertake a searching enquiry into the failure of the first investigation. It should have been carried out in late 1998 or early 1999. Instead, over a period of more than three years, they accepted DI Smith's own account and subjected it to no critical analysis whatsoever. On discovering that DI Smith had not made any proper record of an investigation that was known to have failed, I do not think that continued unquestioning confidence in his veracity should have been maintained. I am driven to the conclusion that, had it not been for the Shipman Inquiry, the GMP would never have made any more thorough enquiry into the matter than had been carried out by Det Supt Ellis. However, once DCS Stelfox had investigated, they accepted his conclusions without reservation. The gravity of their earlier failure to face up to the shortcomings of the first investigation is to some extent mitigated by that fact and by my recognition that the natural instinct of individuals and organisations is to seek to avoid criticism where possible.

Final Thoughts

51. I must and do feel sympathy for those few who have been found responsible for the failure of this investigation. They must live with that responsibility for the rest of their lives.

Although their predicament was of their own making, it should be recognised that it was their misfortune ever to be caught up in the consequences of Shipman's criminality. There must be many others who would also have failed if put in the position in which these men found themselves.

52. My final word must be for the families of Shipman's last three victims. For them, these hearings and the reading of this Report will have been profoundly distressing. Once again, I can only offer them my deepest sympathy.

CHAPTER ONE

Concerns Are Raised

Introduction

- 1.1 As is now well known, on 31st January 2000, Harold Fredrick Shipman was convicted of the murder of 15 patients and of forging the will of one of them. His trial was the culmination of an investigation which began in July 1998, when Mrs Angela Woodruff reported to the police that she suspected that a will had been forged in the name of her mother, Mrs Kathleen Grundy, who had been found dead on 24th June 1998. Under the will, Shipman was the sole beneficiary of Mrs Grundy's estate. Shipman fell under suspicion of forgery. Soon afterwards, Mrs Grundy's body was exhumed and morphine was found in the tissues. On 7th September 1998, Shipman was arrested and charged with the murder of Mrs Grundy and with other offences associated with the forgery of her will. The police investigation widened to include the deaths of other patients of Shipman who had died suddenly and unexpectedly. Fifteen deaths (including that of Mrs Grundy) were, in due course, selected for charge and trial. In 2001, this Inquiry embarked on the task of discovering the full extent of Shipman's criminal activities. In July 2002, I reported that he had killed at least 215 patients.
- 1.2 The investigation that began in July 1998 was not the first occasion on which the police had looked into the possibility of criminal conduct by Shipman. On 24th March 1998, Dr Linda Reynolds, a general practitioner and principal at the Brooke Practice, 20 Market Street, Hyde, reported to Mr John Pollard, HM Coroner for the Greater Manchester South District ('the Coroner'), her concerns about the number of Shipman's patients who were dying and about the circumstances of their deaths. At the request of the Coroner, a confidential investigation was carried out by the Greater Manchester Police (GMP or 'the Force'). That investigation was conducted by Detective Inspector (DI) David Smith under the supervision of Chief Superintendent (CS) David Sykes. At the end of it, DI Smith concluded that there was no substance in the doctor's concerns. He communicated his view to Dr Reynolds and to the Coroner and there the matter rested.
- 1.3 After the closure of that first investigation, Shipman killed three more patients before his arrest. They were Mrs Winifred Mellor, who died on 11th May 1998, Mrs Joan Melia, who died on 12th June 1998 and Mrs Grundy, whom he killed on 24th June 1998. Following Shipman's trial, questions arose about the thoroughness with which the earlier police investigation had been carried out and whether or not, if it had been conducted differently, Shipman's course of killing could have been stopped earlier and the lives of three of his victims saved.
- 1.4 In the course of hearings which took place between May and July 2002, the Inquiry conducted a detailed examination of the March 1998 police investigation. The Inquiry considered the parts played, not only by DI Smith and CS Sykes, but by all those who contributed to the investigation. They included the Coroner who reported Dr Reynolds' concerns to the police, the registrars who provided information about the deaths of Shipman's patients and Dr Alan Banks, Medical Adviser to the West Pennine Health Authority (WPHA or 'the Health Authority'), who examined the dead patients' medical

records. This Second Report records my findings as to what occurred during this investigation and provides my opinion as to whether or not, in performing their duties, the conduct of the various public servants involved fell below the standard which the public is entitled to expect.

The Dangers of Hindsight

- 1.5 From the outset, the Inquiry recognised the need to look at events in the light of what was known at the time. We now know that Shipman was a serial murderer who, over the course of 23 years, killed at least 215 patients. To those involved in March 1998, however, Shipman was a well-respected general practitioner with a reputation for giving his patients a high standard of care. It cannot have been easy for those involved in the first investigation to give serious consideration to the idea that Shipman might be killing his patients.
- 1.6 As the daughter of Mrs Grundy, Mrs Woodruff has particular reason to wish that the March 1998 investigation had been successful in revealing Shipman's criminality. If it had been, her mother might have been alive today. Yet, in her statement to the Inquiry, Mrs Woodruff said this:

'I ... understand extremely well from my own experience ... just how difficult it was to believe that an especially respected GP could have deliberately murdered his own healthy patients. I can also understand how difficult it would be to find any clear evidence for any wrongdoing without access to Dr Shipman's actual patient records (complete with the computer audit trail) and/or discussing the circumstances of deaths with the patients' relative [sic]. There is little doubt that such enquiries would have come to the notice of Dr Shipman himself and quite possibly the media ... Whilst I believe that it is appropriate to establish exactly what did happen in this earlier enquiry, I do feel that the events must be judged on the basis of the circumstances at the time and not with the benefit of hindsight.'

- 1.7 Mrs Woodruff is right. It would be quite unfair to criticise any person for a failure of duty if that failure were to be considered with the benefit of hindsight.

Death Registration and Cremation Certification

- 1.8 A brief explanation of the systems of death registration and cremation certification must now be given. A fuller explanation was provided in Chapter Five of the First Report.
- 1.9 When a person dies at home in circumstances that are not obviously suspicious, the usual procedure is for the general practitioner to be informed. That doctor decides whether s/he can certify the cause of death or whether the death should be reported to the coroner.
- 1.10 If the doctor is confident that s/he knows the cause of death, s/he will sign a certificate known as the Medical Certificate of Cause of Death (MCCD). MCCDs are supplied in a book rather like a large cheque book. When a doctor has completed a certificate, s/he

tears it out of the book. S/he is then left with a counterfoil in the book, on which s/he records details of the certificate s/he has completed.

- 1.11 Usually, the doctor hands the completed MCCD to the person (most frequently a relative of the deceased) who is to be responsible for registering the death. That person takes the certificate to the register office. If all is in order, the registrar will register the death. The same procedure is followed if a death occurs in hospital; the doctor signing the MCCD will, in those circumstances, usually be a hospital doctor.
- 1.12 In some circumstances laid down by statute, or if the doctor is not confident that s/he knows the cause of death, the case is reported to the coroner. Usually, there is then a full invasive examination of the internal organs (known as an autopsy or post-mortem examination), after which the coroner might issue a burial order or cremation certificate to allow disposal of the body without an inquest. Sometimes, s/he will formally open and adjourn an inquest before permitting disposal.
- 1.13 The deceased person's own doctor will sign an MCCD (or 'certify the death', as it is colloquially known) only when the deceased has died outside hospital and when the death has not been formally reported to the coroner. As a very rough guide, 60% of all deaths occur in hospital and, of the remaining 40% that occur in the community, about a quarter are reported to the coroner. So, on average, for every 100 patient deaths, a general practitioner will certify the cause of only about 30.
- 1.14 The proportion of deaths followed by cremation has increased steadily over recent years and is now about 70%. The procedure for obtaining authority to cremate a body starts with the completion of the Application for Cremation (Form A) by the person seeking the cremation, usually the deceased's nearest relative. The Certificate of Medical Attendant (Form B) must then be completed by a doctor who has attended the deceased before death and has seen and identified the body after death. For deaths out of hospital, Form B is usually completed by the general practitioner who has issued the MCCD. Because only about 70% of bodies are cremated, it follows that the general practitioner will sign fewer Forms B than MCCDs. So, for every 100 patient deaths, a general practitioner will expect to sign about 30 MCCDs and, in about 21 of those deaths, he will also sign a cremation Form B.
- 1.15 The Confirmatory Medical Certificate (Form C) must be completed by a second doctor who is neither a relative of the deceased nor a relative or partner of the Form B doctor. Form C requires the doctor completing it to have seen and '**carefully examined**' the body of the deceased and to have seen and questioned the Form B doctor about the death. The usual practice is for the first doctor (the Form B doctor) to speak to the second doctor, either face to face or by telephone, and to explain the circumstances of the death and any relevant medical history. The first doctor then either hands the completed Form B to the second doctor or leaves it at the funeral director's premises, where the second doctor goes to examine the body and complete Form C.
- 1.16 At the end of Form C, the second doctor states what s/he believes to have been the cause of death and goes on to certify 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.’

- 1.17 The relatives of the deceased pay fees to the doctors who complete Forms B and C. Forms A, B and C are then sent to the crematorium, where they are examined by a medical referee. The medical referee is a doctor, who works part-time at the crematorium and whose responsibility it is to ensure that the forms have been properly completed and that the cause of death has been **‘definitely ascertained’**. If so satisfied, the medical referee signs the Authority to Cremate (Form F), which is the final step in the process of obtaining authority to cremate the body.

Shipman’s Arrangements for the Signing of Cremation Forms C

- 1.18 It is not uncommon for neighbouring practices to develop reciprocal arrangements for the completion of Forms C. Shipman began to practise single-handed from his own premises at 21 Market Street, Hyde, in August 1992. His departure from the Donneybrook Practice had been acrimonious. Not long after he set up alone, a group of doctors from the Clarendon House Practice (which had shared a building with the Donneybrook Practice) moved to premises at 20 Market Street, directly opposite Shipman’s surgery. Their practice became known as the Brooke Practice. Soon afterwards, an informal arrangement was made between the two practices for the provision of mutual support and assistance, as and when necessary. In particular, Dr Alastair MacGillivray, Dr Jeremy Dirckze and Dr Susan Booth regularly asked Shipman to sign cremation Forms C for their patients and Shipman would almost invariably ask the Brooke Practice doctors to sign his.
- 1.19 The Brooke Practice kept a record of the Forms C signed by the partners. That record shows that, between September 1993 and September 1998, all but five of the Forms C signed by members of the practice related to the deaths of Shipman’s patients. This demonstrates that the Brooke Practice was not providing a regular service for signing Forms C to any doctor other than Shipman.

Concerns at the Brooke Practice

Dr Reynolds’ Observations

- 1.20 Dr Reynolds joined the Brooke Practice on 1st September 1996. The existing partners were Dr MacGillivray, Dr Dirckze, Dr Booth and Dr Rajesh Patel. Dr Reynolds had previously been a principal in a general practice in Reddish, Stockport, for a period of 19 years. As I have already indicated, she was to play an important role in the events surrounding the first police investigation. Sadly, she died in March 2000, not long after Shipman’s conviction. Before her death, she provided statements of her evidence to the police and had also written a statement for distribution to members of the press, who were anxious to interview her at a time when she was extremely ill. For her account of events, the Inquiry has relied on those written statements and also on the recollections of her widower, Mr Nigel Reynolds. It is clear that Dr Reynolds told her husband a great deal about her concerns and he has a good recollection of the events of early 1998. He was a most careful

witness and I have no hesitation in accepting his evidence, notwithstanding its hearsay nature.

- 1.21 In the months following her appointment at the Brooke Practice, Dr Reynolds began to notice that she was asked to sign a cremation Form C rather more often than she had been accustomed to do at her former practice. Also, when reading the Forms B completed by Shipman, which gave details about the circumstances of the deaths, she noticed that, on several occasions, he had been present at the death. Dr Reynolds realised that this was odd since, in her experience, the presence of a doctor at the death of a patient was unusual; it had happened to her only two or three times in 19 years of practice. Towards the end of 1997, she mentioned this apparent oddity to her partners but was assured that Shipman had a lot of elderly patients and was well known as a doctor who would visit his patients unannounced when he was concerned about their condition, so his presence at their deaths was not surprising. She remained conscious of the frequency with which she was asked to complete a Form C for Shipman and still felt it was unusual for a general practitioner to be present at a patient's death.
- 1.22 None of the other Brooke Practice doctors had observed anything odd about the circumstances of the deaths of Shipman's patients. Dr Patel had noticed that Shipman had been present at the time of at least one of the deaths for which he was asked to sign a Form C. Dr Patel raised this with Shipman, who replied that younger doctors these days did not visit their patients in the same way that old-fashioned doctors like himself did. He said that he tried to keep his patients at home to allow them to die with dignity rather than allow them to have an 'undignified end' in the hustle and bustle of an unfriendly hospital. He put Dr Patel firmly in his place, implying that the old ways were best and that doctors who visited at home were providing a better standard of care for their patients than their younger colleagues. Dr Patel accepted Shipman's explanation.

Mrs Bambroffe Voices her Concerns

- 1.23 On 23rd February 1998, Dr Booth visited the premises of Frank Massey and Son, Funeral Directors (Masseys), to complete a Form C in respect of Miss Maureen Ward. On that occasion, Mrs Deborah Bambroffe (nee Massey), who worked in the family business together with her father, Mr Alan Massey, and her husband, Mr David Bambroffe, told Dr Booth that she was concerned about the number of deaths among Shipman's patients, compared with those among the patients of other doctors. According to Dr Booth, Mrs Bambroffe also said that she was concerned about some unusual features of the deaths; the worrying deaths were of elderly women who had died at home, apparently alone, and had been found sitting up in a chair, fully dressed. They did not appear to have been ill. This was unusual, in Mrs Bambroffe's experience. She was more accustomed to finding that the death had occurred while the person was in bed and surrounded by the paraphernalia of illness. Usually in such cases, a relative or friend was present. In cases of sudden death, Mrs Bambroffe was accustomed to seeing the deceased person on the floor or showing some other sign of a sudden collapse. Mrs Bambroffe had also noticed that Shipman often seemed to be present at or shortly after the death; she had sometimes wondered how he had gained access to the premises. Mrs Bambroffe wanted to discuss

her concerns with one of the Brooke Practice doctors but was afraid that her concerns would not be taken seriously. She chose Dr Booth as the most approachable.

- 1.24 Dr Booth promised Mrs Bambroffe that she would discuss her concerns with the other members of the Brooke Practice. As soon as Dr Booth returned to the surgery, she told Dr Patel about her conversation with Mrs Bambroffe. They decided that they would discuss what Dr Booth had been told with the other partners. Whether they did so immediately is not clear. Dr Reynolds was away on holiday at the time. It seems likely that the matter was mentioned to Dr MacGillivray and Dr Dirckze. A few days later, Dr MacGillivray attended at Masseys' premises and spoke to Mr Massey, who was aware that his daughter, Mrs Bambroffe, was worried about the deaths of some of Shipman's patients. Dr MacGillivray had known Shipman for a very long time and held him in high regard. He believed that Shipman liked to keep his elderly patients at home, rather than have them admitted to hospital. He also believed that Shipman had a large number of elderly patients on his list. To him, there seemed to be a perfectly rational explanation for the large number of Shipman's elderly female patients who, as Mrs Bambroffe had observed, died in their own homes. Dr MacGillivray gave Mr Massey his opinion about Shipman and Mr Massey passed it on to his daughter, who felt reassured to some extent.

Dr Reynolds and Dr Booth Speak

- 1.25 At about this time, Dr Reynolds began to feel increased concern about the frequency with which she was asked to complete a Form C for Shipman. She mentioned her concerns to Dr Booth. Dr Booth told her that Mrs Bambroffe had spoken of her similar concerns. According to both Dr Booth and Dr Reynolds, they visited Mrs Bambroffe and discussed their joint concerns. Mrs Bambroffe has no recollection of this meeting. Dr Booth says that, on this occasion, Mrs Bambroffe repeated to Dr Reynolds much of what she had previously said to Dr Booth. The two doctors agreed that the circumstances described by Mrs Bambroffe were unusual and worrying. Mr Reynolds also recalled his wife telling him of this meeting. Mr Massey (who, if the meeting took place, was not present) thinks that such a meeting occurred, as he recalls hearing about it. There is no doubt that such a meeting took place. However, I am uncertain whether it occurred at this stage of events, as the doctors recall. The issue is not of great importance. I am satisfied that, at some stage, Dr Reynolds learned of Mrs Bambroffe's concerns and shared the view that the circumstances in which Mrs Bambroffe had seen the bodies of Shipman's patients were unusual and worrying. Combined with her own observations about the frequency of deaths among Shipman's patients and of his presence at or around the time of death, Mrs Bambroffe's concerns served to heighten those of Dr Reynolds.

The Practice Meeting

- 1.26 As a result of the discussions between themselves (with or without Mrs Bambroffe), Dr Reynolds and Dr Booth decided that they must discuss their concerns with their partners. A practice meeting took place in a public house in Heaton Moor, near Stockport, and was attended by all the partners save Dr MacGillivray.
- 1.27 When they first gave statements to the Inquiry, the doctors believed that this meeting probably took place in the week beginning 9th March 1998. Eventually, they suggested

that it must have taken place in the following week. Also, the doctors recalled that, at that meeting, they were able to compare the number of Forms C that they had signed for Shipman during the previous year or so with the number of their own patients for whom they had completed MCCDs during that period. I accept that the meeting probably took place during the week beginning 16th March but, for reasons that will become apparent, I do not think that the comparative figures were then available.

- 1.28 It appears to me that an important factor in raising the level of Dr Reynolds' concern was Shipman's request that she should sign a cremation Form C in respect of Mrs Lily Higgins, who died on Tuesday, 17th March 1998. [My decision in respect of her death is in Volume Four of my First Report. I found that Shipman had killed her.] Dr Reynolds signed the Form C on Thursday, 19th March. I am satisfied that, having signed that form, Dr Reynolds was worried about whether she should have done so. Mr Reynolds recalled a time at which his wife became extremely worried about the Shipman situation and said that they talked 'round and round' the topic. Dr Reynolds was wondering what she ought to do. Mr Reynolds said that he asked her whether she really thought it possible that Shipman might be killing his patients. At first, she replied, 'No', then, after a few moments, she said, 'No, I know he is killing his patients.' I think this conversation probably took place soon after Dr Reynolds had signed Mrs Higgins' Form C. I think it spurred Dr Reynolds into action and that the practice meeting followed shortly afterwards. I think it likely that the practice meeting took place on either Thursday, 19th March or Friday, 20th March. However, the date is not crucial.
- 1.29 At the meeting, the Brooke Practice doctors discussed the concerns about the number of Shipman's elderly patients who had died in recent months. They were also concerned about the common features that Mrs Bambroffe had noticed. Although all the doctors present were concerned to some degree, some were less so. Some thought that Shipman had a large list with many elderly patients and so could be expected to have more patient deaths. It was pointed out that he favoured nursing patients at home rather than admitting them to hospital. However, there was also a discussion about the possibility that Shipman might be killing patients, either intentionally or unintentionally by negligence. The doctors debated what, if anything, they should do about their concerns. Dr Reynolds was the most seriously worried of the four. She was able to draw on her previous experience in another practice. She had a strong feeling that something was wrong and was anxious to take some action. Eventually, it was agreed that Dr Reynolds would communicate the concerns of members of the practice to the coroner, having first sought advice from the Medical Defence Union (MDU).

Dr Reynolds Takes Action

Discussions with Mrs Bambroffe

- 1.30 Telephone records show that, on Sunday, 22nd March, Dr Reynolds telephoned Masseys' premises. I think it likely that she wanted to speak to Mr Massey about her concerns over Shipman and to tell him that she had decided to make a report. Mr Massey was not available, as he was away on holiday. The call lasted only 26 seconds. Mrs Bambroffe remembers taking the call. She told Dr Reynolds that her father was away. On thinking

about the call afterwards, she realised that Dr Reynolds had probably telephoned in connection with Shipman. Consequently, two days later, Mrs Bambroffe telephoned Dr Reynolds to ask why she had wanted to speak to Mr Massey. I shall return to that telephone call in Chapter Three.

Discussions with the Medical Defence Union

- 1.31 On Monday, 23rd March, Dr Reynolds telephoned the MDU advice line and spoke to Dr Susan Gough, who was then a medico-legal adviser to the MDU. Dr Gough's contemporaneous note records that Dr Reynolds told her that all five doctors at the Brooke Practice were concerned at the **'apparently large'** number of deaths among elderly patients in Shipman's practice and that a local undertaker had discussed her concerns with one of the doctors. I note, in passing, that that would suggest that Dr Reynolds had not at that time spoken to Mrs Bambroffe. Dr Reynolds mentioned to Dr Gough that she was concerned that she had recently signed a further Form C for a patient of Shipman's (which must have been that for Mrs Higgins). Dr Gough gained the impression that Dr Reynolds had decided she must take some action and wanted advice as to whether she should report her concerns to the coroner or to the police. I observe that Dr Gough did not note that Dr Reynolds told her of the comparative figures for the deaths certified in the Brooke Practice and the numbers of Forms C signed for Shipman. That suggests to me that Dr Reynolds was not then in possession of the figures. I say that because, once she was aware of them, the evidence is that they were uppermost in her mind. That is why I doubt the doctors' recollection that the comparative numbers were discussed at the practice meeting, which, as I have explained, took place before the conversation with Dr Gough.
- 1.32 Dr Gough decided to consult with a more senior colleague at the MDU. She agreed to speak to Dr Reynolds later that day and asked that, in the meantime, Dr Reynolds should find out the name of the medical referee at the local crematorium and discover when the funeral/cremation of the recently deceased patient was to take place.
- 1.33 Dr Gough and Dr Reynolds spoke by telephone again in the late afternoon of the same day. Dr Gough's note records that, in the interim, Dr Reynolds had had a discussion with a local undertaker. From the context, this must have been with Mrs Bambroffe. There is no record of a telephone call from the Brooke Practice Surgery to Masseys' premises and Mrs Bambroffe does not recall meeting Dr Reynolds on that day. However, it is possible that the meeting was in person. I have considered whether, notwithstanding the recollections of those concerned to the contrary, the meeting between Dr Booth, Dr Reynolds and Mrs Bambroffe, described as having occurred some time earlier, in fact took place on that day.
- 1.34 According to Dr Gough's note, it appeared that the undertaker's concerns were that the deceased patients were all women and had died without any history of previous illness. They were often found dead by the doctor, not long after he had paid them a visit at home **'of his own volition'**. They were found fully clothed. This is plainly a description of Mrs Bambroffe's concerns. Dr Gough's note also refers to the fact that most of the bodies had a grey coloration. In evidence, Mrs Bambroffe agreed that she might have mentioned

that to the doctors but said that it had not been a cause for concern. Mrs Bambroffe must have been the undertaker referred to in Dr Gough's note. I think it likely that the only meeting between the three women took place on that day. Dr Gough also noted that Dr Reynolds had discovered that Mrs Higgins' funeral was to be held on 26th March. In fact, it was to take place on 25th March and a mistake must have been made by Dr Gough, Dr Reynolds or the funeral director of whom enquiry was made. Again, there is no reference to the comparative figures in this second note. I infer that Dr Reynolds still did not have them. If she had, I am sure she would have mentioned them to Dr Gough.

The Comparative Figures

- 1.35 Dr Reynolds must have resolved to speak to the Coroner on the following day. By the time she spoke to him, she was certainly in possession of the comparative figures. In my view, it is probable that the figures were extracted from the surgery records in the late afternoon or early evening of 23rd March. I think it is likely that Dr Dirckze examined the records to ascertain how many Forms C the Brooke Practice doctors had signed for Shipman in the previous months and how many MCCDs they had signed in the same period. However, although Dr Dirckze agrees he carried out this exercise, he does not believe that he would have had time to do it on that Monday. He cannot recall exactly how he obtained the information about the Brooke Practice patients. He believes he might have used the surgery computer. I think it likely that Dr Dirckze decided to extract the comparative figures because, on that Monday, 23rd March, Shipman asked him to sign a Form C for Miss Ada Warburton, who had died on 20th March. [My decision about her death is in Volume Six of my First Report. I found that Shipman killed her.] This request to sign a Form C would have raised his own level of concern and alerted him to the availability of the comparative figures. It is possible that Dr Reynolds also looked at the figures. Certainly, she made a note of them. Long after her death, her husband found a note, written in her hand, which appears to be an *aide memoire* to assist Dr Reynolds in her conversation with the Coroner. It contains what seems to be a note of the number of deaths of patients at the Brooke Practice and the number of cremation Forms C signed for Shipman during the previous three months. It also contains a reference to the death of Miss Warburton and a brief description of some of the features of the deaths that had given rise to Mrs Bambroffe's concerns.
- 1.36 The figures showed that the Brooke Practice doctors had signed 16 Forms C for Shipman in the previous three months, including the Form C for Miss Warburton, completed that day. That number would not include any patients of Shipman who had died in hospital or who had been buried or whose cause of death had been certified by the coroner. The Brooke Practice doctors could not accurately estimate the total number of deaths among Shipman's patients in that period but realised that, if his practice followed the usual pattern, it was likely to be much higher than 16. The note showed that either 14 or 15 patients of the Brooke Practice had died in that three-month period. Dr Reynolds had changed the number written in her note from 14 to 15. This number included deaths that had occurred both in hospital and in the community, not just deaths where the Brooke Practice doctors had completed the MCCD. Over the previous year, the Brooke Practice doctors had completed 16 MCCDs. The Brooke Practice, with five doctors, had a list of

about 9500 patients. The Brooke Practice doctors did not know the size of Shipman's list but they knew that he practised alone. They thought he might have about 3000 patients. Taking these figures together, it would appear that the death rate among Shipman's patients was very much higher than that for the Brooke Practice. At the very least, it appeared to be about three times the Brooke Practice rate and some of the doctors, including Dr Dirckze, considered that the death rate for Shipman's practice might be as much as eight or nine times higher than that of the Brooke Practice. Now that the comparative figures were available to Dr Reynolds, they were, as will be seen, in the forefront of her mind.

CHAPTER TWO

The Coroner Becomes Involved

Dr Reynolds Informs the Coroner

- 2.1 Dr Reynolds telephoned the Coroner's office early in the morning of Tuesday, 24th March, before Mr Pollard had arrived at work. Mrs Mary Evans, the first coroner's officer, realised that Dr Reynolds was very concerned about something. Dr Reynolds telephoned the office again at about 10.25am. She told Mrs Margaret Blake, the member of staff to whom she spoke on that occasion, that it was important that she spoke directly to Mr Pollard and was put through. Mr Pollard made a contemporaneous note of what Dr Reynolds told him. This note is consistent with his recollection that Dr Reynolds told him that she and her partners were concerned about the number of deaths among Shipman's patients. She told him that she herself had signed a cremation Form C on the previous Thursday. He said that she also reported that one of the local undertakers was concerned about the deaths of some elderly female patients who appeared to have been found dead by Shipman. Mr Pollard noted the figures that Dr Reynolds gave him. He recorded that the Brooke Practice, with 9500 patients, had had 14 patient deaths in three months but that Shipman, who was a sole practitioner, had signed 16 cremation forms (i.e. Forms B) in the same period. That this was the first time Dr Reynolds is recorded as having mentioned the comparative numbers confirms my view that they had only recently come into her possession.
- 2.2 Mr Pollard said that he understood that Dr Reynolds was concerned about the number of deaths and also because the patients were found dead at home during the day and Shipman was often present at the time. Dr Reynolds made it plain to Mr Pollard that she was concerned that Shipman might be killing his patients. She thought that there were two possibilities: either Shipman was a very caring doctor (who visited so frequently that he happened to be with the patient at or shortly before the time of death) or he was killing his patients. Dr Reynolds wanted the Coroner to investigate her concerns but she asked him not to disclose her name as the source of the information. She was anxious that the investigation should be discreet because, if her concerns were unfounded, there would be an obvious risk to her professional relationship with Shipman should it become known that she had expressed concerns of such a serious nature about him.
- 2.3 Mr Pollard told the Inquiry that he understood the nature of Dr Reynolds' concerns about the differing death rates. He realised that Shipman's practice would have had no more than about 3000 patients. He also understood that Dr Reynolds was drawing a distinction between cremations and deaths, so that the 16 cremation certificates from Shipman's practice would not include those deaths where the bodies had been buried. He seems to have realised that the 16 cremations would not include any patient of Shipman who had died in hospital, although I do not think he realised the full potential impact of that factor. He told the Inquiry that he thought he had appreciated that there might be other deaths among Shipman's patients for which the cremation Form C had been signed by a doctor from a practice other than the Brooke Practice. He did not realise that the 14 deaths from the Brooke Practice were the total deaths among their 9500 patients, not just the ones for whom they had signed the MCCD. In fact, they had signed only three MCCDs during the

previous three months. In short, Mr Pollard appreciated the fact that there was a disparity between the numbers for the two practices, but I am not sure that he really understood its significance. He realised that it appeared that Shipman's practice had a death rate at least three times higher than that of the Brooke Practice. He recognised that these concerns merited prompt action and decided to report them to the police.

- 2.4 Mr Pollard did not suggest a face to face meeting with Dr Reynolds. On the telephone, he did not discuss with her the possibility that the cremation of the deceased person for whom she had completed Form C the previous week might be halted and an autopsy carried out. He said that Dr Reynolds did not give him the names of either Mrs Lily Higgins or Miss Ada Warburton, who had very recently died and whose bodies had not yet been cremated. Certainly he did not note them. He did not ask Dr Reynolds about any specific deaths. Mr Pollard said that he did not consider that a specific death was being reported to him and he did not explain to Dr Reynolds that he was not able to initiate an investigation into a death unless it was formally reported to him and the body was lying within the district over which he had jurisdiction. He assumed, without asking, that the body of the deceased person mentioned by Dr Reynolds had already been cremated. He said that, if Dr Reynolds had mentioned Mrs Higgins by name and had said that she was worried that the cause of death as certified might not be correct and that the body had not been cremated, he would have been prepared to order an autopsy. He pointed out, however, that, had this been done, Shipman would have had to be informed and might well have realised the source of the report.
- 2.5 Mr Pollard also said that he assumed that the death mentioned by Dr Reynolds must have been natural because two doctors had certified the death. This demonstrates that he had only a superficial understanding of Dr Reynolds' concerns. If, as Dr Reynolds suspected, Shipman was killing his patients, one would not have expected that Shipman would certify that the death had been anything but natural, either on the MCCD or on cremation Form B. Here was the doctor who had herself signed Form C, saying that she was worried that Shipman might be killing his patients. It should have been apparent to Mr Pollard that, in the case of the death for which Dr Reynolds had recently signed Form C, she was expressing (or at least implying) concern that the cremation certification procedure might not have provided any protection against concealed homicide. Mr Pollard did not suggest that, if Dr Reynolds or her partners had any concerns about future requests from Shipman to sign a Form C, they might wish to contact him.
- 2.6 Immediately after receiving the telephone call from Dr Reynolds, Mr Pollard went into the general office and informed his staff (Mrs Evans, Mrs Blake and the second coroner's officer at the time, Mrs Joan Collins) what Dr Reynolds had told him and of his intention to ask the police to investigate. He did not instigate any other enquiry of his own. It did not occur to him to look in the records held by his own office to see whether they revealed anything unusual about Shipman. He did not, for example, look to see when Shipman had last reported a death to him. He agreed that, had he done so, he would have found that no death had been reported formally within the previous six months. That would have been unusual. Mr Pollard said that, since his appointment in 1995, about 3000 deaths had been reported to him each year out of a total of about 8000 deaths that occurred in his district.

So, if Shipman had signed 16 MCCDs and cremation certificates within three months and had not reported any deaths to the Coroner, that fact would have been worthy of note.

The Coroner Informs the Police

- 2.7 Shortly after speaking to Dr Reynolds, Mr Pollard telephoned Chief Superintendent Sykes, Commander of the Tameside Division of the GMP. The two men knew each other personally and were on first name terms. Mr Pollard and CS Sykes disagree about how much detail was given by Mr Pollard during their telephone conversation but it is clear that they agreed to meet at Divisional Police Headquarters, Ashton-under-Lyne ('Ashton'), a short time later. It seems likely that Mr Pollard gave CS Sykes some indication of the nature of the matter he wished to discuss, as CS Sykes asked Detective Inspector Smith to attend the meeting.
- 2.8 CS Sykes says that Mr Pollard told him in some detail about the nature of the concerns expressed. He wished to take advice from Detective Superintendent (Det Supt) Bernard Postles, who was the senior divisional detective and acted as CS Sykes' crime adviser. However, he discovered that Det Supt Postles was on leave that day, so he decided to instruct DI Smith, the senior sub-divisional detective, to attend the meeting, with a view to him conducting the investigation that he understood would be required. CS Sykes said that he chose DI Smith because he was the only detective officer of the rank of inspector available to him. However, he regarded him as suitable for the work. He believed him to be a very good operational detective. He regarded him as calm and level-headed. He thought that DI Smith could undertake this investigation effectively. If he had not thought so, he could and would have requested a suitably qualified officer from another part of the Force.

The Meeting Between the Coroner and the Police

- 2.9 In evidence, Mr Pollard said that, when the three men met, he related to the police officers all that Dr Reynolds had told him of her concerns. He told them that Dr Reynolds was worried about the number of cremation certificates she and her partners had been asked to sign for Shipman's patients. He said that Dr Reynolds had signed a cremation certificate for one of Shipman's patients on the previous Thursday. He told the police the comparative numbers of deaths and cremations for the two practices and he believes that he explained the significance of the comparative numbers, although he doubts that he explained the difference between a 'death' and a 'cremation'. He told the police that the Brooke Practice had 9500 patients and said that Shipman was a sole practitioner but does not believe that he discussed the possible size of Shipman's practice. He thinks that he told the police that Dr Reynolds' partners shared her concerns. He said that he told the police that an undertaker (who was not identified, at Dr Reynolds' insistence) was also concerned about deaths among Shipman's patients, who were elderly females, were found in their day clothes and were found dead by the doctor. Mr Pollard cannot now recall whether or not he mentioned that Shipman was sometimes present at the death. He did not explain why Dr Reynolds regarded these features as unusual or worrying. Indeed, I am not sure that Mr Pollard himself understood why Dr Reynolds and the undertaker were worried about

these features. In view of these uncertainties in Mr Pollard's mind, it is perhaps not surprising that, at the end of the meeting, DI Smith did not have a completely clear idea of the nature of Dr Reynolds' concerns.

- 2.10 Mr Pollard said that he made plain to the police officers that any investigation should be conducted with the utmost discretion and that, in particular, Shipman must not know anything about it. The undertaker was not willing to disclose her name. He said that Dr Reynolds was concerned that Shipman might be killing his patients but recognised that it was possible that there was nothing amiss and that Shipman was a good and caring doctor. Mr Pollard said that there was no discussion at this meeting about the possibility of holding an autopsy on any body that was then available. Nor was any consideration given to what might be done about arranging an autopsy in the event of another death occurring that gave rise to any concern.
- 2.11 In evidence, DI Smith agreed that Mr Pollard told him about the number of cremation certificates that the Brooke Practice doctors had signed for Shipman and the number for the Brooke Practice itself but said that he had not understood the distinction between deaths and cremations. He thought he was being asked to compare like with like and that the figures given were the numbers of cremations within the last three months in each practice. He did not know the size of Shipman's patient list but he did realise that Shipman was a sole practitioner and would have a much smaller list than the Brooke Practice. He did not understand the significance of the common features noted by the undertaker. Like Mr Pollard, he said that there was no discussion about the possibility of an autopsy. He accepted that it was made plain to him that the concern was that Shipman might be killing his patients, although it was said that he might just be a very caring doctor. DI Smith did not recall that the Coroner told him that Dr Reynolds' partners shared her concern. He said that the Coroner suggested that he might begin his enquiries by obtaining the death certificates of Shipman's recently deceased patients. Mr Pollard did not think that he had made any such suggestion. Wherever it came from, the suggestion was plainly a good one.
- 2.12 CS Sykes had very little recollection of this meeting but what he recalled was broadly in line with the recollections of Mr Pollard and DI Smith. He understood that Dr Reynolds had two distinct concerns. One was that the death rate among Shipman's patients appeared to be far higher than that at the Brooke Practice. He did not appreciate that there was a distinction between the number of deaths and the number of cremations. He, like DI Smith, thought that the figures represented a comparison between like and like. However, he knew that Shipman was a sole practitioner. He would have realised that, if Dr Reynolds had even only one partner, it would suggest that Shipman's death rate might be double that of the Brooke Practice. CS Sykes said that he did not understand why some of the features of the deaths gave rise to concern. He did not recall any discussion about the bodies being fully dressed in day clothes. He realised that Dr Reynolds' concern was that Shipman might be killing his patients but he knew also that she had told the Coroner that there might be another explanation for the high number of deaths. This was that Shipman, being a very caring doctor, liked to keep his elderly patients at home rather than have them die in hospital.

- 2.13 CS Sykes did not recall any discussion about the signing of Forms C. He frankly admitted that, at that time, he knew nothing about death or cremation certification. He thought that two doctors certified all deaths. He said that he understood that Dr Reynolds had recently been involved in some way in helping to certify the death of one of Shipman's patients and that this would have raised the possibility that there might still be a body available for autopsy. However, there was no discussion about the availability of a body or bodies. He said that it would have been helpful if he had been told that the most recent patients to die had not yet been cremated.
- 2.14 The only contemporaneous note of this important meeting is to be found in DI Smith's daybook, the hard-backed A4 book in which he made notes in connection with his work. Mr Pollard, who was imparting the information, understandably did not take a further note, but referred to the note he had made during his telephone conversation with Dr Reynolds. CS Sykes did not make any record. A facsimile of the relevant pages of DI Smith's daybook, as they appeared at the end of the investigation, appears at Appendix A to this Report. It can be seen that the information recorded in the middle and to the left of the right-hand page (page 143) relates to what Mr Pollard says he told the police. There is other information, mainly names and telephone numbers, on the right and towards the bottom of the page. When asked to look at DI Smith's daybook, Mr Pollard said that he had not given DI Smith these names and telephone numbers. He had not mentioned Mrs Janet Parkinson (then Consumer Liaison Manager for the WPHA), Gill (a receptionist at the Brooke Practice), Mr Frederick Loader (the Superintendent Registrar at the Tameside register office) or the personnel at the General Register Office (referred to in the note as the **'Registrar General Office'**). He said he did not mention Dowse Catterall, Jordan and Robinson, Armitages or Masseys, all of which are firms of funeral directors in the Hyde area. Nor had he mentioned the names **'Lily Higgins'** and **'Ada Warburton'**, which appear on the right of the page. I am satisfied that only part of the information recorded on that page was written at the meeting between the police and the Coroner on 24th March. Some of it was written later that day and the rest on the following day or days.

The Arrangements for the Investigation

- 2.15 Following the meeting with Mr Pollard, CS Sykes confirmed his instructions to DI Smith that he was to investigate Dr Reynolds' concerns. He also resolved to supervise DI Smith's work on this project himself. CS Sykes had been a uniformed officer for 30 years. As Divisional Commander, he was responsible for determining the strategy for the division on such topics as budget, resources and policy. He did not have extensive experience of crime detection or criminal investigation. He said that if, in the course of his duties, he needed advice on a criminal matter, he would turn to Det Supt Postles.
- 2.16 CS Sykes accepted that he shouldered overall responsibility for this investigation. He said he was nominally responsible for all investigations in his division. However, he said the number of ongoing criminal investigations and the nature of his other duties meant that he could not usually take direct responsibility for supervision; that would be taken by a Criminal Investigation Department (CID) officer. CS Sykes explained that his personal duties would not allow time for him to read the files and keep up sufficiently with the detail of what was happening. Sometimes, he would attend a briefing session in a criminal

investigation, but this was to keep himself generally informed, rather than to enable him to undertake any active supervisory role. However, he decided not to instruct any other CID officer to supervise DI Smith's work on this investigation. Mr Pollard had spoken directly to him and, having been present at the initial meeting with him, he knew more details about the matter than he usually would. Whilst he retained overall responsibility for supervision, CS Sykes did not give DI Smith any instructions or advice as to how he was to go about the task of investigation. He did not see that as part of his function. He left him to his own devices. He realised that DI Smith would have to undertake a 'learning exercise' but, if he was in doubt or difficulty, there were many people to whom he could turn for advice. He told DI Smith to keep him and the Coroner informed of progress.

- 2.17 Detective Chief Superintendent (DCS) Peter Stelfox explained to the Inquiry how a criminal investigation should be supervised. He said that, in an investigation such as this one, which was not of a routine nature, the supervising officer should give the officer undertaking the investigation specific instructions as to whom s/he should interview and what information should be sought. The supervising officer should ensure that the investigating officer understands the purpose of what s/he is asked to do. At frequent intervals, the supervising officer should find out what the investigating officer has discovered. Usually, the investigating officer would submit a written report of what he had done and found out, which the supervising officer would discuss with him.
- 2.18 It is most unfortunate that DI Smith did not have the advantage of an experienced detective supervising his work. It is now clear that, although DI Smith was accustomed to working as part of a team in major criminal investigations, his work had always been supervised by a senior detective officer and he had never before been left to devise the way in which an investigation should be carried out. Also, it is now clear that he did not fully understand the nature and significance of Dr Reynolds' concerns. He did not appreciate the significance of the apparent disparity in the death rates within the two practices. Nor did he understand why the common features mentioned by the undertaker gave rise to concern. He told the Inquiry that he thought that what the Coroner had related was 'a bit wishy-washy'. This was, of course, a very different type of investigation from that which DI Smith was accustomed to undertake. There was no definite reported 'crime'. The task was to investigate whether or not a crime or crimes might have been committed. A different technique was required from that which he was accustomed to deploy.
- 2.19 DI Smith decided to undertake the investigation alone. He told the Inquiry that he thought that, if he involved any other officer, there would be a danger that the nature of the investigation might leak out. This, he said, had to be avoided because of the requirements of strict confidentiality imposed by the Coroner and Dr Reynolds.
- 2.20 Accordingly, DI Smith embarked on this investigation with a poor understanding of the issues and without the benefit of direct supervision by a more experienced senior detective officer. Nor did he have the advantage of a colleague with whom to discuss the conduct of the investigation.

CHAPTER THREE

The Investigation Under Way

The Evidence of Detective Inspector Smith

- 3.1 Detective Inspector Smith's first action was to arrange a meeting with Dr Reynolds. It took place in the afternoon of 24th March 1998. Before considering the evidence of what was said at that meeting, or indeed during any of the later encounters that I shall consider, it is necessary to say something of DI Smith's reliability as a witness.
- 3.2 It is a matter of regret and an obvious focus of criticism that DI Smith made no proper notes of his conversations with any of the people to whom he spoke in the course of the investigation. He made some brief notes on three pages of his daybook; he also created a chart or spreadsheet on his computer. He kept no diary note of his movements. Indeed, it was extremely difficult for the Inquiry to work out a chronology of the investigation until the records of the telephone used by DI Smith were obtained. At the end of the investigation, DI Smith made no written report. I shall consider the effects of these failures in greater detail later in this Report. At this stage, I draw attention to them to highlight the evidential difficulties they have caused.
- 3.3 Although DI Smith made very few contemporaneous notes, he was later asked to provide an account of what had occurred. In August 1998, Detective Superintendent Postles, who had taken charge of the new police investigation into the death of Mrs Kathleen Grundy, discovered that DI Smith had not written a report on the first investigation. On instruction, DI Smith wrote his first account, dated 17th August 1998. In November 1998, again at Det Supt Postles' request, DI Smith amplified some aspects of his earlier account. In April 2000, DI Smith was interviewed by Detective Superintendent (Det Supt) Peter Ellis, who has since retired from the police force. Following Shipman's convictions, Det Supt Ellis had been instructed by Detective Chief Superintendent Alan Boardman (himself acting on the direction of one of the assistant chief constables) to write a report on the first, failed police investigation. Det Supt Ellis recorded DI Smith's account and reproduced much of it in his report. In August 2000, DI Smith provided a statement for the WPHA for use in proposed disciplinary proceedings against Dr Banks, their Medical Adviser, who had taken part in the investigation of March 1998. In November 2001, DI Smith provided a written statement to the Inquiry. He subsequently provided two further statements to the Inquiry, dealing mainly with his responses to the evidence of other witnesses.
- 3.4 The passage of time and the lack of any contemporaneous records of his investigation caused genuine difficulties for DI Smith, when asked by Det Supt Postles, Det Supt Ellis and the Inquiry to give an account of his actions and thinking. They were, of course, difficulties of his own making in that, as an experienced police officer, he knew of his duty to keep proper records and to write a report at the end of an investigation. By the time DI Smith came to the Inquiry to give oral evidence, he had read or heard what a number of other witnesses recalled of the first investigation. When he gave oral evidence, his account was different in many respects from those he had given on earlier occasions. He also sought to advance new explanations for his conduct and decisions. It appeared that he had modified his version of events in the light of the documents and the accounts of

witnesses, which had become available as a result of the Inquiry's investigation. He said that the evidence of others had prompted recollections of matters he had previously forgotten.

- 3.5 The first impression created by these changes of tack was extremely poor. It seemed that this was a witness who would say almost anything in order to provide a convenient answer to the point then being put to him. However, his counsel urged me to accept that DI Smith was an honest witness, who had had grave difficulty in recalling the detail of events. He had made a genuine effort to 'work out' what had really happened, in the light of the fresh evidence with which he had been confronted.
- 3.6 In the end, my conclusions about DI Smith lie between these two extremes. It must be a matter of regret and adverse comment that I cannot accept the oral evidence of an officer of his rank as honest and accurate without having to undertake detailed consideration of the various previous and sometimes inconsistent accounts he has given. As he was the pivotal character in this investigation and, therefore, a most important witness, the potential unreliability of his evidence has created considerable difficulties for me. In respect of some incidents, I regard him as being reasonably reliable. However, on some issues I have had to reject his evidence as untrue. I shall discuss later the extent to which DI Smith did his best to recall events accurately and the extent to which he tried to exculpate himself and the GMP from responsibility for the failure to detect signs of Shipman's unlawful actions during the first investigation.

Detective Inspector Smith's First Meeting with Dr Reynolds

Before the Meeting

- 3.7 I return to DI Smith's visit to Dr Reynolds. He telephoned the Brooke Practice at 12.51pm on Tuesday, 24th March and made an appointment to see her at 3pm the same afternoon. As can be seen, he noted in his daybook (see Appendix A) the name of the Brooke Practice receptionist, Gill. As a small example of the many inconsistencies within DI Smith's evidence, he claimed in his Inquiry statement that he had been so concerned about the need for confidentiality in the investigation that, when making this appointment, he had not revealed to the receptionist that he was a police officer. Examination of the Brooke Practice appointment sheet showed that he had. In oral evidence, he admitted that this aspect of his statement was wrong.
- 3.8 Shortly before DI Smith's arrival, Dr Reynolds received a telephone call from Mrs Bambroffe, who asked why she had wanted to speak to Mr Massey on the previous Sunday. Mrs Bambroffe says that, in the course of their conversation, Dr Reynolds told her that she had spoken to her union (the MDU) about her concerns over Shipman. Mrs Bambroffe also recalls Dr Reynolds telling her either that she was about to contact the Coroner or that she had already done so. I find that Dr Reynolds told Mrs Bambroffe that she had contacted the Coroner. I think it likely that Dr Reynolds also said that the concerns were to be looked into by the police. Mrs Bambroffe says that she cannot remember that being said but she agreed that she must have realised that, if the Coroner were involved, the police might well be also.

Detective Inspector Smith's Oral Evidence to the Inquiry about his First Meeting with Dr Reynolds

- 3.9 The evidence of what was said at the meeting between Dr Reynolds and DI Smith came almost entirely from him. Dr Reynolds never provided a detailed account of it. When asked questions by his own counsel at the start of his evidence before the Inquiry on 27th May 2002, DI Smith said that he went through the information given to him by the Coroner and that Dr Reynolds confirmed to him that it was correct. DI Smith said that Dr Reynolds then told him that she thought that Shipman was killing his patients and that he was either doing this through lack of care or by murdering them. She thought that, if he was murdering them, he was doing it by giving them some sort of drug. He did not ask her what sort of drug this might be and she did not volunteer any opinion. She also told him about her concerns that many of the patients were found dead by Shipman himself. She said that there was an undertaker (who did not wish to be named) who was also concerned about certain common features of the deaths of Shipman's patients. These were that the deaths were mainly of elderly people, who were found wearing day clothes. DI Smith also said that the figures that had been compiled 'did not sit happily' with Dr Reynolds. The fact that the undertaker was also concerned had convinced her that she must come forward and make a report.
- 3.10 DI Smith said that it did not appear to him that any one particular aspect of Dr Reynolds' concerns was of greater importance than the others. He did not perceive, for example, that she was especially concerned about the numbers of cremation certificates that members of the Brooke Practice were signing for Shipman. He said that she did not say that her partners shared her concerns. He did not ask her about this but said that he had the impression that the partners were aware that she had decided to make a report, but that they did not actively share her concerns or support her decision to act. He said that, at one stage, Dr Reynolds said that she was not sure whether she was doing the right thing by making the report.
- 3.11 DI Smith said that Dr Reynolds gave him some general background information about Shipman. She said that he was an odd character who was not easy to get on with. He had fallen out with the doctor who used to sign his cremation Forms C for him. That was why he now used the Brooke Practice. That was quite inaccurate and cannot have been what Dr Reynolds said; it is perhaps more likely that she mentioned his acrimonious departure from the Donneybrook Practice. DI Smith said that that was all Dr Reynolds told him.
- 3.12 When questioned by Leading Counsel to the Inquiry, DI Smith said that he had not understood the significance of the death rates that Dr Reynolds had reported to the Coroner. He did not see the number of deaths as an important aspect of the investigation. As far as he was concerned, Dr Reynolds suspected that Shipman was killing his patients and that was what mattered. He did not understand the significance of any of the unusual features of the deaths, about which Dr Reynolds and the unnamed undertaker were concerned. He did not understand why Dr Reynolds was concerned that Shipman appeared to have been present at a number of deaths or to have been the person who first found the body. He said that he was wholly unfamiliar with the procedures for death and cremation certification. He had not asked Dr Reynolds any specific questions, save

to confirm that the information he had been given by the Coroner was correct. He had also asked her for some general information about Shipman, at which time she told him that Shipman ran a scanner appeal. He was anxious to stress to the Inquiry that he had taken Dr Reynolds' concerns very seriously and that he regarded her as a responsible and sensible person. His failure to make any record of his interview with her was not, he said, a reflection of any lack of seriousness with which he was treating the investigation. He had not, he said, regarded the concerns as being just too incredible to have any foundation and he had not regarded Dr Reynolds as a woman with a 'bee in her bonnet'.

Detective Inspector Smith's August 1998 Account of his First Meeting with Dr Reynolds

3.13 DI Smith's first written account of his conversation with Dr Reynolds, prepared in August 1998, five months after the event, was different in several respects from that given in oral evidence.

3.14 DI Smith reported that the basis of Dr Reynolds' concerns in March had been that, from the time of her move to the Brooke Practice, there had been **'general banter'** among her partners about the fact that Shipman could always be relied on to supply extra **'pocket money'**, by asking the doctors to countersign his cremation certificates. She had also become concerned about certain features of the deaths of Shipman's patients. These were that the deceased appeared to be mostly female; they were discovered dead by Shipman; they were wearing day clothes when found; most were later cremated. DI Smith said that Dr Reynolds had mentioned that she had spoken to a local female undertaker who had become aware of the circumstances of the deaths of Shipman's patients. He continued:

'Indeed it became apparent that it was common gossip amongst doctors, nurses and undertakers that Dr Shipman appeared to have more elderly female deaths than other practices, although there was no evidence to support this rumour.'

3.15 DI Smith finished by saying that the undertaker did not wish to be identified and that Dr Reynolds herself did not wish her name to be made known during the investigation. She had made the report for **'peace of mind'** after consultation with her partners.

3.16 It will be noted that DI Smith referred to the high death rate among Shipman's patients as amounting to no more than a rumour. He did not mention the comparative figures supplied by Dr Reynolds. Nor was there any reference to the serious nature of Dr Reynolds' concerns, in that she suspected that Shipman might be killing his patients and doing so by giving them some sort of drug. It is hard to resist the inference that, in August 1998, DI Smith was 'playing down' the seriousness of the concerns he had been asked to investigate and was seeking to attribute Dr Reynolds' report to gossip, banter and rumour. By August 1998, the police had real grounds to suspect that Shipman had killed Mrs Kathleen Grundy. They knew that morphine had been found in her body. They had also learned of his previous convictions. Suspicions about other deaths were beginning to emerge and the police had decided to look at those deaths of which they were aware in March 1998. DI Smith must have been aware of the possibility that he had missed

something important earlier in the year. It appears to me that, in August 1998, he was seeking to deflect possible criticism.

Detective Inspector Smith's Account of his First Meeting with Dr Reynolds as Given to Detective Superintendent Ellis in April 2000

- 3.17 DI Smith's account of his meeting with Dr Reynolds, as recorded by Det Supt Ellis in April 2000, was also different in material respects from his evidence to the Inquiry. However, he did tell Det Supt Ellis that Dr Reynolds had given the Coroner the number of patients on the Brooke Practice list (9500) and had said that the practice had had 14 deaths in three months, whereas there had been 16 deaths in Shipman's practice. I think it unlikely that DI Smith volunteered this information and believe that it was probably given in answer to Det Supt Ellis' questions about the numbers written in DI Smith's daybook.
- 3.18 DI Smith's description of his conversation with Dr Reynolds did not reflect the serious nature of her concerns. He said that Dr Reynolds seemed uncertain about whether she had been right to make a report. She had told him that, since she had joined the Brooke Practice, there had been **'banter'** amongst the partners about Shipman providing pocket money. Although Dr Reynolds said that she had consulted her partners before making her report to the Coroner, DI Smith had formed the opinion that she was acting alone and did not have their support. The partners were still countersigning cremation certificates for Shipman. The implication was that, if they were still doing that, they could not share her concerns. DI Smith told Det Supt Ellis that Dr Reynolds had outlined her concerns, as relayed by the Coroner, and had highlighted a number of **'alleged features'** of the deaths that gave rise to concern. These were that the persons appeared to be mainly female; they were discovered dead by Shipman; they were wearing day clothes when found; the majority appeared to have been cremated. Dr Reynolds had been prompted to make her report after a discussion with an undertaker, **'THE IDENTITY OF WHOM SHE REFUSED TO DIVULGE'** (written thus by Det Supt Ellis, as if to suggest that it were of some importance).
- 3.19 DI Smith told Det Supt Ellis that he had spoken to Dr Reynolds for about 45 minutes. At no time had she suggested that she and her partners had done any calculations or suggested that Shipman's patients were three times more likely to die than patients of the Brooke Practice. Nor had she said that she suspected that Shipman was killing his patients. She had not provided any **'figures or other documentary evidence'**.
- 3.20 I make two observations about this account. First, it plainly diminished the seriousness and credibility of Dr Reynolds' concerns. Her concerns were presented as vague and unfocussed. It made her sound like a woman who was 'out on a limb', expressing concerns which her partners did not share and which even she was unsure whether or not to voice. It made her appear reluctant to co-operate with the police by providing the name of an important witness. Her failure to provide **'figures or other documentary evidence'** appeared to indicate either lack of co-operation on her part or the absence of available evidence. Second, this account was inconsistent in important respects with DI Smith's evidence on oath to the Inquiry. Most significantly, to Det Supt Ellis he asserted that Dr Reynolds had not said that she suspected Shipman of killing his patients whereas, in evidence, he admitted that she had said this at an early stage of their meeting.

Detective Inspector Smith's Account of this Meeting in his Inquiry Statement

3.21 DI Smith's account of his first meeting with Dr Reynolds, put forward in his Inquiry statement of November 2001, did not correct the misleading impression he had given to Det Supt Ellis. He again spoke of Dr Reynolds' refusal to reveal the name of the female undertaker who was said to share her concerns. He did not say that, in refusing, Dr Reynolds was obeying a restriction placed on her by the undertaker herself. He said that Dr Reynolds' conversation with the undertaker had **'supported gossip and banter which she had become aware of during her 18 months with the Practice'**. DI Smith said that Dr Reynolds had said that it was a standing joke among the partners that, if a general practitioner were 'on cover', Shipman would be likely to come in asking for a cremation form to be signed, for which the doctor would receive about £30 as **'Ash Cash'**. She had told him what little she knew about Shipman, which included the fact that he ran a **'Scanner appeal'**. He claimed that Dr Reynolds had said nothing of which it was worth making a note and nothing of any evidential value. He repeated that he did not believe that she had the support of her partners. She had not told him of the existence of a cremation book kept by the Brooke Practice and no such book was produced to him. In short, even as late as November 2001, DI Smith's account sought to diminish the seriousness and credibility of Dr Reynolds' concerns and to blame her, implicitly, for not volunteering useful evidence, whether oral or documentary.

The Effect of these Inconsistent Accounts

3.22 It will now be apparent that the account DI Smith gave in oral evidence amounted to a significant change of stance. He no longer sought to diminish Dr Reynolds' concerns. He no longer attributed them to gossip or banter. In the light of the evidence already heard by the Inquiry from Mr Reynolds, Dr Gough, the Coroner and the doctors from the Brooke Practice, such a stance would have been untenable. DI Smith at last admitted frankly that Dr Reynolds had told him that she suspected Shipman of killing his patients. In effect, DI Smith was driven to admit that all his earlier accounts had been inaccurate and misleading.

3.23 My general conclusion about this part of DI Smith's evidence is that his oral evidence is much closer to the truth than any of his previous statements. The differences are so great that I do not think that he can have had an honest belief in the accuracy of his earlier accounts at the time they were given. I regret to say that I have come to the conclusion that he gave these misleading accounts in the hope of avoiding any criticism in respect of his conduct of the first investigation. He did this by putting the blame on Dr Reynolds for failing to provide evidence and by giving the impression that her concerns were based on rumour and banter.

The Deaths of Mrs Lily Higgins and Miss Ada Warburton

3.24 There is, however, at least one important respect in which it appears that even the oral evidence of DI Smith might be wrong. This relates to his denial that, on 24th March 1998, Dr Reynolds had told him that there were two bodies then lying at funeral directors' premises, on which it might be possible to arrange autopsies. This suggestion was put to

him by Leading Counsel to the Inquiry. In support, she drew attention to the right of the right-hand page of DI Smith's daybook (see page 143), where there appears a list of four firms of funeral directors. Under the first name, '**Dowse Catterall**', is written the name '**Lily Higgins**' and the word '**stroke**'. Mrs Higgins had died the previous week. The MCCD, signed by Shipman, attributed the death to a cerebrovascular accident (colloquially known as a stroke). Dr Reynolds had signed the cremation Form C and, according to Dr Gough's note, made the previous day, believed that the funeral was to take place on Thursday, 26th March. In fact, it was to be held on Wednesday, 25th March. The point is that, at the time when Dr Reynolds spoke to DI Smith, she believed, correctly, that Mrs Higgins' body had not yet been cremated and was lying at the premises of Dowse Catterall. The second firm of funeral directors listed was '**Jordan and Robinson**'. Underneath their name appears the name '**Ada Warburton**' and, underneath that, the word '**stroke**'. Miss Warburton had died on 20th March. Shipman had certified that her death was due to a cerebrovascular accident. Dr Dirckze had signed her cremation Form C on 23rd March. On 24th March, Miss Warburton's body was lying at the premises of Robinson and Jordan. The third firm of funeral directors listed on the right-hand side of the page was '**Armitages**'; the fourth was '**Masseys**'. There is no note of the name of a deceased person below the names of these last two firms of funeral directors. Examination of the Brooke Practice records shows that the last four cremation Forms C which Dr Reynolds had signed prior to 24th March 1998 related to Mrs Lily Higgins, Mr Harold Eddleston, Mrs Laura Linn and Mrs Alice Black. The funeral directors listed in DI Smith's notebook were the four firms involved in those four deaths.

- 3.25 Leading Counsel to the Inquiry suggested to DI Smith that Dr Reynolds had given him the information he recorded in his daybook during their conversation on 24th March. He denied that that was so. Counsel also suggested that Dr Reynolds had given him the information he recorded in the context of a discussion about bodies that were available for autopsy.
- 3.26 In rejecting Counsel's suggestions, DI Smith claimed that he had noted down the names of the four funeral directors and the two recently deceased patients, Mrs Higgins and Miss Warburton, when he visited the crematorium on a later occasion. He claimed that he had noted the names of Mrs Higgins and Miss Warburton because he had been minded to visit the funeral directors to enquire about those two deaths. However, he had not done so. It can be seen that, at some stage, DI Smith wrote the names and telephone numbers of all four funeral directors on the left-hand page of his daybook (see page 142), opposite the page on which he made the notes of his meeting with the Coroner. It is not clear when those names and telephone numbers were written. It is possible that DI Smith obtained the numbers from the Brooke Practice receptionist, as he left his meeting with Dr Reynolds; he could have found them in a telephone book; it is possible that he was given them at the crematorium. It will be seen that, on the right-hand page where the names of the funeral directors appear in the lower right corner, the name of Miss Warburton's funeral director is written as '**Jordan and Robinson**'. In fact the name is Robinson and Jordan. The error appears to have originated in the Brooke Practice record of Forms C, where the funeral director for Miss Warburton is written as '**Jordan and Robinson**'. The error recurs on the left-hand page of DI Smith's daybook. However, as will later appear, in the list of funeral

directors made at the crematorium, DI Smith has written the name correctly, as **'Robinson and Jordan'**. That would seem to suggest that DI Smith did not write the list of names and telephone numbers at the crematorium. Further, the correlation of the names of the four firms that DI Smith recorded on the right-hand page of the daybook with the firms involved in the last four deaths for which Dr Reynolds signed Forms C strongly suggests that Dr Reynolds provided the names of the four firms.

- 3.27 On the basis of the notes written on the right-hand page, it seems to me likely that Dr Reynolds did tell DI Smith about the presence of two bodies lying at funeral directors' premises. However, there is some further evidence suggesting that she did, and that she did so in the context of a discussion about possible autopsies. First, the name **'Ada Warburton'** appears on the small handwritten note made by Dr Reynolds to which I referred earlier and which Dr Reynolds had probably used to refresh her memory when speaking to Mr Pollard. I think Dr Reynolds had that note with her when she saw DI Smith. She wrote his telephone and pager numbers on the back. If she had the note with her, it is likely that she would have mentioned to DI Smith the information recorded in it. Second, on 30th March 1998, Dr Reynolds telephoned Dr Gough of the MDU to give a progress report. Dr Gough's contemporaneous note records that Dr Reynolds told her that she had reported her concerns to the Coroner, who had taken them seriously. She had also seen a senior CID officer (which must be a reference to DI Smith) and it was intended that there would be an autopsy of the body of the deceased person who had been identified by Dr Reynolds. This examination would probably be conducted by a Home Office pathologist. I accept that Dr Reynolds must have said something like that to Dr Gough. Dr Reynolds must have got her impression from somewhere. It can only have been from either the Coroner or DI Smith. In view of the note in his daybook, it is far more likely that it was the latter. Third, there is also evidence from Dr Patel that he recalled Dr Reynolds telling him that she had told the police about the availability of two bodies at the premises of funeral directors. Dr Booth also thought that Dr Reynolds had told the police about the availability of a body for autopsy.
- 3.28 My conclusion on this issue is that Dr Reynolds did tell DI Smith that the bodies of Mrs Higgins and Miss Warburton had not yet been cremated and that DI Smith must have said something from which Dr Reynolds understood that there would be an autopsy. This conclusion is supported by further evidence that I shall consider in Chapter Eleven.

The Shortcomings of Detective Inspector Smith's First Interview with Dr Reynolds

- 3.29 There were many things that DI Smith did not find out from Dr Reynolds during this first conversation. He said that, by the end of the interview, he still did not recognise the importance of the comparative death rates. Dr Patel and Dr Dirckze said that they were sure that Dr Reynolds would have wished to impress on DI Smith the importance of the disparity in death rates. Dr Patel said that the figures were 'the most significant factor' and Dr Dirckze said that they were the 'fundamental reason' for making the report to the Coroner. Mr Reynolds said that the statistics were his wife's 'greatest concern'. I think it highly likely that Dr Reynolds did stress the importance of the figures but it is clear that DI Smith either did not understand the figures or did not appreciate the significance of them. He did not ask Dr Reynolds to explain why she was worried about the number of

deaths. He did not ask where the figures had come from or ask to see the records from which they had been derived.

- 3.30 DI Smith did not understand why Dr Reynolds and the undertaker were concerned about the 'unusual features' of the deaths of Shipman's patients or even why they were concerned that Shipman was often present at or just after the death. Yet he did not ask Dr Reynolds to explain this to him. Nor did he ask her about the circumstances of the individual cases in which she had recently signed a Form C. He did not ask to interview any of the other Brooke Practice doctors. He could have done so, without breaching the constraints of confidentiality under which he was operating. Had he done so, they would have been willing to assist and could have told him of their own concerns and of the deaths for which they had recently signed Forms C.
- 3.31 DI Smith did not understand the system of death certification and the different system of cremation certification. He did not know what was involved in the completion of an MCCD or cremation Forms B and C or what information they contained when completed. He did not know to what extent, if any, the Form C doctor had independent evidence upon which to make his/her own judgement about the cause of death. He did not know where the completed Forms B and C were stored after the cremation had taken place nor from where he might be able to obtain them. He did not know of the existence or role of the medical referee at the crematorium.
- 3.32 DI Smith did not discuss with Dr Reynolds what she or her partners should do if they received another request to sign a Form C for Shipman. However, it appears that he did give Dr Reynolds his telephone and pager numbers. I infer that he invited her to contact him if she wished to do so.
- 3.33 It is not a matter of criticism that DI Smith did not know about the systems of death and cremation certification or that he did not immediately understand, for example, why it should be a cause for concern that a number of dead bodies were found in day clothes. He could not be expected to know all these things. My criticism is that he did not ask, either then or at any time during the investigation. I am quite sure that, had he asked any questions of Dr Reynolds or her partners, they would have been pleased to give a full explanation. They would have provided access to their records to demonstrate the origin of the comparative figures. I do not criticise DI Smith for not asking all these questions on this first occasion. It might not have been convenient, either for him or for Dr Reynolds, to spend the time together necessary for him to gain a proper understanding of her concerns. DI Smith said that he regarded this meeting as an opportunity to obtain basic information. However, he never went back to Dr Reynolds for an in-depth discussion of the issues and the procedures underlying them.
- 3.34 Although DI Smith told Det Supt Ellis that his interview with Dr Reynolds lasted about 45 minutes, I am quite satisfied that it lasted no more than 20 minutes. This can be calculated by reference to the time of a telephone call made by DI Smith at 3.43pm, following his return to Ashton police station. His interview with Dr Reynolds began soon after 3pm. When it was over, he drove to Dukinfield, a journey of about five to six minutes. He went to the Tameside register office and talked to the Superintendent Registrar, Mr Loader. They spoke for about ten minutes. From there, DI Smith drove to Ashton police station, which

he said took about five to six minutes. I infer that he must have left Dr Reynolds' surgery soon after 3.20pm. When giving evidence to the Inquiry, Det Supt Postles (who had, by then, been promoted to the rank of Detective Chief Superintendent and whom I shall, to avoid confusion, in future call Mr Postles) said that an interview of about an hour and a half would have been necessary if all the important issues were to be covered. I conclude that DI Smith's interview with Dr Reynolds was brief and inadequate.

- 3.35 DI Smith's interview with Dr Reynolds was crucial to the success of his investigation. It was his opportunity to ensure that he fully understood the nature of her concerns and to assess their strength. DI Smith told the Inquiry that, at the end of it, he did not really know 'where to go', by which he meant that he did not know how to go about investigating Dr Reynolds' concerns. Yet, when he reported back to CS Sykes, he did not say that he was in any difficulty. Nor did he seek the advice of any other detective officer.
- 3.36 Chief Superintendent Sykes recalled that DI Smith told him that he had seen Dr Reynolds. This conversation must have taken place either during the late afternoon of 24th March or on the morning of 25th March. DI Smith said that he had discovered that Shipman ran a scanner appeal to which some of the deceased might have made legacies. CS Sykes said that DI Smith did not give him the impression that he did not believe Dr Reynolds or was not taking her concerns seriously.
- 3.37 Mr Reynolds recalls that, when his wife told him that she had seen a police officer who was to investigate her concerns, she seemed very relieved, as she felt she had laid down the burden of responsibility for deciding what should be done. She felt that her concerns were being taken seriously. It appears to me that DI Smith gave the impression that he fully understood the nature and importance of Dr Reynolds' concerns and assured her that they would be looked into. But, in truth, he was setting out on a difficult voyage without a map, compass or guide.

The Possibility of Arranging an Autopsy

- 3.38 It is clear that DI Smith did not take any steps to arrange an autopsy on the body of any of Shipman's former patients. He said that he was not aware of the availability of any bodies but, even if he had been, he would not have known whether the Coroner would be able or willing to order an autopsy unless there were grounds for suspicion in the individual case. He did not attempt at any stage to discuss the issue either with the Coroner or even, according to CS Sykes, with him. Given the Coroner's interest in the investigation, the appropriate course would have been to discuss the matter with him. Mr Pollard said that, if told that there was a body available, he would, if asked, have been prepared to order an autopsy (probably to be conducted by a pathologist approved by the Home Office) and, at that time, would have been prepared to do so without giving reasons for his decision. As I have already said, he pointed out that, if he had ordered an autopsy, Shipman might well have realised who had reported the death to the Coroner and Dr Reynolds might not have been able to maintain her anonymity.

CHAPTER FOUR

The Register Office

The Request for Copy Death Certificates

- 4.1 On leaving Dr Reynolds' surgery, Detective Inspector Smith drove to the Tameside register office at Dukinfield Town Hall. There, he saw Mr Loader, the Superintendent Registrar, and asked to be provided with copies of all entries in the registers of deaths relating to deaths certified by Shipman during the previous six months. DI Smith had decided to investigate the deaths over a period of six months, although the figures provided by the Brooke Practice covered only the previous three months. That was not an unreasonable decision although, in the event, it proved unfortunate, as it gave rise to considerable confusion.
- 4.2 DI Smith would have been entitled as of right (on payment of a fee) to obtain a certified copy of the entry in the register of deaths in relation to any identified deceased person. However, DI Smith did not know the names of the deceased persons in whom he was interested. He wanted the register office staff to search the registers to find all the deaths certified by Shipman. He wanted photocopies to be provided, preferably free of charge. Before Mr Loader could comply with his request, authority had to be obtained from the General Register Office (GRO) at Southport. Mr Loader advised DI Smith to contact the GRO direct, to obtain the necessary authority. He provided the telephone number and DI Smith wrote it in his daybook.
- 4.3 DI Smith then returned to the police station at Ashton and made two telephone calls to the GRO. As I have already said, the first of these was timed at 3.43pm. DI Smith had some difficulty in locating the right person at the GRO but it appears that, in due course, he was advised that photocopies of the relevant entries would be provided, free of charge, if a formal written request were received from a senior police officer.
- 4.4 DI Smith recalls that he typed an appropriate letter and had it signed by a senior officer. Both Chief Superintendent Sykes and Mr Postles claim that they signed it. DI Smith says he sent it to the GRO. No trace of that letter can be found either at the GRO or at Ashton police station. However, there is no reason to believe that it was not sent. It is not clear whether the letter was written in the late afternoon of 24th March and sent by post or was sent by fax during the late morning of the following day.
- 4.5 During the morning of 25th March, there were several telephone calls between the Tameside register office and the GRO in Southport and between DI Smith, the Tameside register office and the GRO. By about lunchtime, it appears that authority had been given for Mr Loader to provide the copy entries to DI Smith. Together with those of his staff who were available for the task, Mr Loader made a search of all the registers of deaths covering the last six months. Mr Loader said that all relevant entries were photocopied and were handed to DI Smith.
- 4.6 Each of these documents was a photocopy of the relevant entry in the register of deaths. Certified copies of the entry are provided to a deceased's family at the time of registration

and are commonly known as 'death certificates'; DI Smith used the same term to describe the photocopies he obtained. I shall therefore refer to them as 'copy death certificates'.

The Issue

- 4.7 Within the previous six months, Shipman had, in fact, certified the cause of death of 31 of his patients. DI Smith said that, on the morning of Thursday, 26th March, he received a bundle of copy death certificates from Mr Loader at the register office. Unfortunately, neither he nor Mr Loader made any record of how many were handed over. Before the Inquiry, an issue arose as to how many copy death certificates Mr Loader gave to DI Smith.
- 4.8 Mr Loader and his staff maintain that, as there were 31 relevant entries, he must have provided 31 copy death certificates. DI Smith has always claimed that he was not given 31 certificates. Until shortly before the Inquiry hearing, he contended that he had been given particulars of 19 deaths. Recently, he claimed that he was given 20 certificates but, for the moment, that slight difference does not matter. The issue is whether he was given 31 certificates or significantly fewer.
- 4.9 The question of how many copy death certificates Mr Loader handed over to DI Smith occupied a good deal of the Inquiry's time. The issue was of some importance to those concerned. The register office staff felt strongly that they had been wrongly accused of incompetence in failing to provide a complete set of certificates. They pride themselves on the accuracy and care with which they perform their duties.
- 4.10 DI Smith contended that his investigation was blighted from an early stage because he was misled by the register office into thinking that only 19 or 20 of Shipman's patients had died during the previous six months. If that were so, it would mean that Dr Reynolds' claim that 16 of Shipman's patients had been cremated in three months was probably wrong and that the death rate among Shipman's patients might not have been worryingly high. DI Smith might properly claim that he had been lulled into a false sense of security by the register office's mistake.
- 4.11 I have already indicated that, when DI Smith left Dr Reynolds' surgery on 24th March, he did not regard the number of deaths among Shipman's patients as a particularly important aspect of the investigation. He thought that Shipman had had 16 patient deaths in three months. That being so, it may be thought that, even if DI Smith had received 31 – rather than 19 or 20 – certificates in respect of the six-month period, he would probably not have appreciated that this figure gave rise to any cause for concern.
- 4.12 In the event, I have decided that, so far as possible, I must resolve the issue of how many certificates were provided. Apart from the position of DI Smith and the registrars, the number of deaths among Shipman's patients also came to the attention of Dr Banks, Medical Adviser to the WPHA. If he had been aware of the true number, it is possible that his level of concern might have been raised.

The Rival Contentions: DI Smith

- 4.13 DI Smith advanced the following contentions. First, he said that, after he received the copy death certificates, he returned to Ashton police station, sorted them into chronological

order and made a list or chart of all the names. Later, the chart was transferred to the computer. The manuscript chart has not survived but the computer spreadsheet is available and contains 19 names. In August 1998, the spreadsheet was adapted for use in the later police investigation and four versions of it were made available to the Inquiry. However, I am satisfied that the only version which represents DI Smith's work during the first investigation is that reproduced at Appendix B of this Report. DI Smith initially claimed that, as his spreadsheet contained only 19 names, he must have received only 19 copy death certificates. Certainly, it is hard to see why, if he had received 31 certificates, he only ever entered 19 onto his spreadsheet. However, the position is not as straightforward as that analysis would suggest. Later on the afternoon of 26th March, DI Smith visited the premises of the WPHA and provided Mrs Parkinson with a list of 17 names. He has advanced explanations for why he did not give her all the names he had. The position is further complicated by the fact that DI Smith has, at times, suggested that he received the 19 certificates in two batches on two separate occasions and yet, ever since shortly before he gave oral evidence to the Inquiry, he has claimed that he received 20 certificates, all at the same time. These changes do nothing to enhance his standing as a reliable witness. I shall have to return to those issues later but I am impressed by the evidence that only 19 names were entered on DI Smith's spreadsheet and therefore, by inference, on the manuscript chart which he prepared soon after collecting the copy death certificates from the register office.

- 4.14 DI Smith's second contention was that it had been shown that members of the register office staff were capable of making errors when asked to search the registers of deaths. In August 1998, when the second police investigation was under way, the police asked the staff to search the registers for deaths certified by Shipman since the death of Mrs Lily Higgins. One entry (that relating to Mr Vernon Nield) was missed by the staff. Incorrect information was given in respect of another entry from February 1998 (that of Mrs Irene Berry). Because of concerns that there may have been more deaths among Shipman's patients within the six-month period than DI Smith had recorded on his spreadsheet, the police then sent in a team to search the registers for deaths which had occurred over the past year. The entry relating to Mrs Irene Chapman was not found but it was not clear whether this happened because the police were not given the relevant register or whether they were given the register and missed the entry themselves.
- 4.15 The point was also made that the register office had previously admitted that they had not provided a full set of certificates in March 1998. They could not now be heard to claim that they had in fact done so. The evidence showed that, at the time of the August 1998 searches, Mrs Brenda Clayton, Additional Superintendent and Mr Loader's deputy, appeared to have accepted that the register office had failed to supply a full set of copy death certificates in the March. She suggested that the shortfall must have been due to human error within the register office. I am satisfied that that admission was made. However, at that time, the attention of the police and register office staff was focussed on their current enquiries and I do not think it would be right to attach much weight to Mrs Clayton's admission. Also, it appears that Mrs Clayton may have believed that the register office had provided a list of entries rather than a bundle of copy certificates and so accepted, without further thought, that the mistake must have been that of the register

office staff. What was surprising, in view of the seriousness with which the register office staff treat the present suggestion that they made mistakes, is the low level of concern apparently felt by the staff in August 1998, when it was suggested to Mrs Clayton that they had missed a number of entries the previous March.

The Rival Contentions: the Register Office Staff

- 4.16 The register office staff contended first that it was unthinkable that they could make so many mistakes as to miss 11 or 12 out of 31 relevant entries. They said that care and accuracy are fundamental requirements of their work. They might accept that, being human, one of them might have made the odd mistake. However, if as many as 12 entries were missed, they were missed from three different registers, which would suggest that more than one member of staff must have been at fault. That, they claimed, would be inconceivable.
- 4.17 Second, the register office staff suggested that DI Smith could have lost 11 or 12 of the certificates. It is common ground that they were handed to him in an envelope. It is not fanciful to suggest that DI Smith might have lost some of them. He explained that, although he was supposed to have an office to himself at Ashton police station, in practice, many other people used it and there were often piles of exhibits lying on the desk or even on the floor. On occasions, he would go to another office and work wherever there was an empty desk. From this description, it does seem to me possible that he could have mislaid some of the copy death certificates. However, I do not think that he had 31 certificates with him when he visited the premises of the WPHA in the afternoon of 26th March. If he lost any certificates, he had lost them by then. I think it is highly unlikely that he would have mislaid any certificates so quickly. I also think it unlikely that he would have lost them altogether. Had some been mislaid, I think it likely that they would have turned up later. If that had occurred, I think that DI Smith would have added the extra names to his chart.
- 4.18 The third argument advanced by the staff of the register office was that, if DI Smith had received only 19 or 20 certificates, he would immediately have recognised that this number was inconsistent with the information given to him by Dr Reynolds. She had told him that the Brooke Practice doctors had signed 16 cremation forms for Shipman in the previous three months. One would therefore expect that there had been about 32 deaths in the six-month period. In fact, one might have expected there to be more, because the deaths known to the Brooke Practice doctors would not have included any patients who had been buried or any patients whose Forms C had been signed by a doctor other than one from the Brooke Practice or any that had been certified by the coroner. On the other hand, one might have expected that the death rate would be higher during the winter months of January, February and March than in the previous three months. In any event, submitted Mr Geoffrey Tattersall QC, on behalf of the register office staff, the provision of only 19 or 20 certificates would have struck DI Smith as obviously wrong and he would have realised immediately that he had not been given as many as he had been expecting. Moreover, when he examined the dates of death, he would have realised that there were not 16 cremations (or deaths) in any three-month period. In short, if he had received only 19 or 20 certificates, it would have been so obvious that his bundle was incomplete that he would have either contacted the register office to see whether there should have been

more certificates or returned to Dr Reynolds to query the accuracy of her figures. Mr Tattersall submitted that the fact that DI Smith did neither of these things showed that he must, in fact, have received 31 certificates.

- 4.19 This last argument is attractive and would have much persuasive force if I thought that DI Smith had understood the significance of the numbers of cremations and deaths he had been given by Dr Reynolds or that he had formed any view as to the number of certificates he might expect to receive for the six-month period. But I am afraid that he did not. He does not seem to have been struck by the disparity in the figures even when he wrote them down. I cannot draw the inference that he must have received a full set of certificates merely because he did not realise that 19 or 20 deaths in six months was inconsistent with Dr Reynolds' figures.

The Search of the Registers

- 4.20 The arguments that I have just considered leave me quite undecided as to where the truth lies. The most persuasive factor is that DI Smith entered only 19 names onto his spreadsheet and gave significantly fewer than 31 names to Mrs Parkinson, when he visited the WPHA on the afternoon of 26th March. However, I must consider in detail the evidence about the way in which the search was conducted by the register office staff, to see whether it throws any light on the likelihood of a mistake or mistakes having been made.
- 4.21 In order to explain what happened at the register office, it is necessary to describe the system of entering and keeping records in the registers of deaths. In 1998, there were four registrars at the Tameside register office, each of whom had a separate register of deaths. The four registrars were Mrs Carol McCann, Miss Marilyn Partoon, Mrs Dorothy Craven and Mrs Caroline Dewhurst. The registers are lettered A, B, C and D. Each register has a number, as well as its initial, and contains the particulars of 300 deaths. There are two entries on each page, set out side by side. When the book is open, four entries are visible at the same time. Each entry contains particulars about the deceased person, the person reporting the death (the 'informant'), the causes of death and the identity of the person (i.e. the doctor or coroner) who has certified the cause of death. In 1998, each registrar's current register was kept in her own office. When a registrar was absent for any reason (and some staff worked part-time), a deputy registrar might use her office and carry out registrations using the absent registrar's current register. When a register was full, it was retained in the registrar's office for a few weeks, then transferred to a secure storeroom.
- 4.22 Mr Loader accepted that he organised the search of the registers for entries relating to the deaths certified by Shipman, although his memory of the event is patchy. I am satisfied that the search took place during the afternoon of Wednesday, 25th March. Mrs Margaret Burns (who did administrative work in the main office but who also worked as a deputy registrar when one of the registrars was absent) appeared to have a good recollection of the search. She said that it took place that afternoon. Mrs Sandra Brown (also an administrative worker and part-time deputy registrar) left the office at about 1.15pm that day; she is sure that she did not take part in the search and no one else recalls her doing so. I am satisfied that the search started shortly after 1.30pm. It seems likely that

it was completed before 3.27pm, at which time Mr Loader telephoned Mr David Trembath at the GRO. Mr Trembath was the manager whose authority was required before the photocopies could be provided.

- 4.23 Eight registers had to be searched, i.e. four current registers and each registrar's immediate past ('deposited') register. Errors could have occurred either when the registers were searched or during the photocopying process. If, as DI Smith has for the most part contended, he was given only 19 copy certificates, this would mean that 12 entries were missed during the search or not copied as they should have been. If he was given 20, 11 were missed or not copied. It is also possible that some copies were mislaid after they had been prepared but before DI Smith collected them.
- 4.24 Comparison between the spreadsheet on DI Smith's computer and the full list of deaths certified by Shipman during the six-month period permitted the identification of those entries that had or might have been missed, not copied or lost. The result was as follows:

Register A52 (Mrs McCann's deposited register)

All relevant entries were found.

Register A53 (Mrs McCann's current register)

Some relevant entries were found in this register but either three or four entries were missed, not copied or lost. If three were missed, they were the entries for Mrs Alice Black, Mrs Irene Chapman and Mrs Martha Marley (whose death had occurred on 24th March and had been registered by Mrs McCann on the morning of 25th March). If four were missed (i.e. if DI Smith received only 19 certificates, rather than 20) the entry for Miss Ada Warburton was also missed, not copied or lost. Her death had been registered by Mrs McCann on 24th March.

Register B50 (Miss Partoon's deposited register)

Three relevant entries were found but two were missed, not copied or lost.

Register B51 (Miss Partoon's current register)

All four relevant entries were found.

Register C46 (Mrs Craven's deposited register)

There was no relevant entry in this register.

Register C47 (Mrs Craven's current register)

Four relevant entries were found but six were missed, not copied or lost.

Registers D49 and D50 (Mrs Dewhurst's deposited and current registers)

All relevant entries were found in both registers.

- 4.25 The evidence to the Inquiry focussed mainly on who had been responsible for searching A53 (Mrs McCann's current register), B50 (Miss Partoon's deposited register) and C47 (Mrs Craven's current register). I also regarded the evidence about the photocopying process as significant.

How Long Did the Search Take?

- 4.26 Mr Loader said that the search was not difficult but it was very time-consuming and presented something of a problem, as he was short of staff at the material time. Mrs Craven was absent and I accept that the staff had a reasonably busy day and, to that extent, the office could be said to be short of staff. However, I do not accept that the task was as onerous as he suggested. The task of searching is simple because the layout of the registers is such that the position of the certifier's name is always the same. On each open double page of the register, the searcher can run a finger across the page, about two-thirds of the way down, where the certifier's name is readily visible. Moreover, as is a point of professional competence and pride among registrars, the writing in the registers I saw was always clearly legible.
- 4.27 Mrs McCann said that it was possible to search a register in about five minutes. She had timed herself. She said that, whenever she was asked to search a register, she would always do so twice. She was of the view that it would take about ten minutes to search a full register twice. Mr Loader said that it would take about 40 minutes to check a register once and agreed that normal practice would require a double check. Mrs Burns said it would take her about 15 minutes to do a double check of one register. Because of the differences between the various witnesses, I timed the task myself and found I could make one check in seven minutes. I think Mr Loader gave a gross overestimate. I think perhaps Mrs McCann works faster than I could and possibly faster than other register office staff. However, I do not think it would take more than about 15 minutes to do a double check of each full register and to note any relevant entries either by placing a marker in the register or by recording the entry numbers in a list. In fact, in this search, the current registers were not full and only part of each deposited register had to be searched, because DI Smith only wished the search to go back six months. I conclude that the search could not have taken more than two man-hours and, given the experience of the staff involved, may well have taken less. However, I do accept that there were other tasks to be carried out that afternoon and no one was free to sit down and go through registers without having to attend to other matters. It may well be that members of staff had to break off in the middle of a register to attend to another task. Opportunities for error arise in such circumstances, although a mistake should be picked up when the second check is made.

Who Searched Which Register?

- 4.28 Initially, there was some uncertainty about who had taken part in the search. However, once the time of the search had been established, it was clear that only four members of staff were present during the Wednesday afternoon: Mr Loader, Mrs McCann, Miss Partoon and Mrs Burns. Mrs Burns, who, as I have said, seemed to have the clearest recollection, said that she remembered taking part in a search in the secure storeroom. Mr Loader was also involved and Miss Partoon was in the room at some stage.
- 4.29 Mr Loader said that, when organising the search, he would have asked all those members of staff who had the time to search the registers, to take photocopies of any

relevant entries and put them in a pile in the storeroom. The photocopier was situated in the storeroom. Mr Loader could not remember who had taken part in the search or whether he had actually searched any registers himself but accepted that he probably did. He was adamant that he would have searched only the deposited registers, not the current ones. He said that he would have asked each registrar who was at work that day to search her own current register. Mrs McCann, who kept Register A and Miss Partoon, who kept Register B, were both working that afternoon. Mrs Craven, who kept Register C, was absent from work at this time. Mrs Dewhurst, who kept Register D, worked part-time and was not at work on the day of the search, although she would have been in the office the following morning.

- 4.30 If Mr Loader is right, Mrs McCann and Miss Partoon would have searched their own current registers. Mr Loader maintained that it would not have been appropriate for him to search any current register, as he was not the custodian of the current registers, only of the deposited registers. The registrars were the custodians of their own current registers. The registrars agreed that they are the custodians of their current registers but said that they had never heard the suggestion that it would be inappropriate for Mr Loader to search their current registers if it was not convenient for them to do so themselves.
- 4.31 Mrs McCann was adamant that she did not search her current register or take part in the search at all. She had no recollection of doing so and believed she would have remembered such an unusual request. She was very busy that day. She registered six deaths during the day and also officiated at a marriage ceremony, which took her out of her office from shortly before 2.30pm until about 3pm. Mrs McCann was of the view that it was likely that someone came into her office while she was officiating at the marriage and searched her register. She said it would be entirely appropriate for someone else to search her register in her absence. She would have expected Mr Loader to do it. In passing, she pointed out that, considering her position hypothetically, had she been asked to search for entries relating to deaths certified by Shipman, she would hardly have failed to notice and include the entry for Mrs Marley, whose death she had registered that very day. Mrs McCann cannot remember whether that death was registered before or after she conducted the marriage ceremony but, from its position in the register, it seems very likely that it was before.
- 4.32 Miss Partoon also had a busy day. She registered nine births. She was also the 'nominated officer' for that day, which involved additional administrative tasks besides registrations. She said that she remembered walking into the storeroom and seeing Mrs Burns and Mr Loader engaged in a search of registers. Mrs Burns told her what was happening. She could not remember taking part in a search in that room. She thought it unlikely that Mr Loader would have asked her to help in the storeroom unless he was 'really struggling'. Nor did she think it likely that she would have offered to help, as she was so busy with registrations and her nominated officer duties. She acknowledged that her current register was searched and thought it likely that she searched it herself. She said that she did not recall searching either Mrs McCann's or Mrs Craven's current register and thought she would have remembered it, had she done so. When she checked her own register, her method of work would be to do a double check and to

put a marker in the relevant pages or make a list of entries. If she had put markers in the register, the logical thing would have been for her to take her register to the photocopier in the storeroom and make the copies herself. However, she has no recollection of doing that and believes it is more likely that she made a list of entries and gave it to someone else to photocopy. She said that registrars are trained to be very careful and accurate and she could not understand how anyone could check through a register and miss as many as six relevant entries.

- 4.33 Mrs Burns worked in the general office unless she was needed as a deputy registrar. On Wednesday, 25th March, it appears that her only duty as a deputy registrar was to assist Mrs McCann at the marriage ceremony at 2.30pm. Like Mrs McCann, Mrs Burns would have been occupied with that from just before 2.30pm until about 3pm. Mrs Burns recollected taking part in the search of deposited registers in the storeroom that afternoon. She remembered searching the register that recorded the death of Mrs Bianka Pomfret. She knew Mrs Pomfret and it came as a shock to learn of her death. Mrs Burns must have been searching register D49, Mrs Dewhurst's last deposited register. Mrs Burns could not remember whether or not she searched any other register. I think it likely that she did. She said that she certainly did not search any current registers. She thought she would have remembered that. She remembered that, at some stage, Miss Partoon came into the storeroom to give some help. Mrs Burns' method of searching a register would be to make a double check and to write down the numbers of the relevant entries on a piece of paper. She was adamant that she did not make any photocopies; she would definitely have made a list and given it to Mr Loader.
- 4.34 It is far from clear who checked each of the three registers from which entries might have been missed. It is possible, but unlikely, that Mrs McCann searched her own current register. If, as seems likely, it was searched while Mrs McCann was officiating at the marriage, Mrs Burns cannot have searched it, as she was with Mrs McCann. It is unlikely that Miss Partoon searched it. I think it is most likely that Mr Loader searched it. I do not think it was in any way inappropriate for him to do so. I reject his evidence on that point. I think it is far more likely that he would search it himself than that he would have asked a deputy registrar to do so, as he claimed he would have done. In any event, there was no deputy registrar available while the marriage was taking place. I reach the same conclusions in respect of Mrs Craven's current register; I think Mr Loader probably searched it. I note also that Mr Loader was the only person with no specific duties that afternoon. I am not saying that he did not have other duties but I think he had more time for the search than the others. As for Miss Partoon's deposited register, it seems likely that this was searched by either Mr Loader or Mrs Burns and I cannot say who was the more likely to have done so. If, as Mr Loader says, it is unlikely that more than one person would make an error, it would seem that he is the one most likely to have made any errors that occurred. However, that is not necessarily so. In any event, it is possible that errors arose, not at the checking stage, but during photocopying. I am satisfied that Mr Loader did most, if not all, of the photocopying. I am quite satisfied by Mrs Burns' evidence that she did not do her own photocopying.
- 4.35 Although all the register office staff stressed that care and accuracy are of fundamental importance in their work, I did have the distinct impression that the way in which this

task of searching was carried out left room for mistakes. I have little doubt that both Mr Loader and Mrs Burns had to break off from their searches to do other duties, including attending to members of the public who came into the office. Mrs Burns probably had to break off the search to undertake her duties at the marriage ceremony. It is quite likely that Mr Loader had to break off while photocopying. These interruptions do not make errors inevitable but they do make them more likely.

Conclusion

- 4.36 After reviewing the whole of the evidence on this topic, I conclude that it is more likely that there were errors in the register office, so that an incomplete bundle of copy death certificates was given to DI Smith, than that he lost some certificates soon after collecting them. However, my conclusion is not certain. If my conclusion is correct, it seems to me likely that Mr Loader was responsible for the errors. It is possible that Mrs Burns may have made some contribution.
- 4.37 I do not think that a high degree of blame should attach to Mr Loader. I am not sufficiently certain that he was directly responsible for the errors to suggest that he should be censured. I had the impression that he is generally a conscientious man who is something of a stickler for rules and regulations. I think it likely that he made an error or series of errors, most likely because he was under pressure.
- 4.38 I think it would have been prudent for Mr Loader to keep a record of which copy certificates he provided to DI Smith. He was aware that the police request was important and that a confidential investigation was being carried out, although I accept that he did not realise that the police suspected that Shipman might have been murdering a number of his patients. He regarded all searches performed for the police as important. He knew that this request was unusual and that the Coroner was involved in the enquiry. If DI Smith's request had been dealt with in a more formal manner, the later uncertainties would have been avoided.
- 4.39 For reasons that I shall explain in Chapters Five and Fifteen, I think it unlikely that the errors made in the register office had any effect on the outcome of the investigation.

CHAPTER FIVE

The Next Steps in the Investigation

The First Progress Report

- 5.1 As I have said, Detective Inspector Smith made his first informal report to Chief Superintendent Sykes in the late afternoon of 24th March or the following morning. At some time on 25th March, CS Sykes telephoned Mr Pollard to tell him that DI Smith had seen Dr Reynolds. Mr Pollard's note does not record the time of this conversation but says only that DI Smith had found that Shipman was running an appeal for a scanner and that most of the deceased were **'making legacies'**. The police would **'therefore** [*in fact, a symbol meaning 'therefore']* **pursue** the investigation. This seems to imply that DI Smith would not have proceeded with his investigation had he not found out about the scanner appeal, which might appear to provide some sort of financial motive for Shipman killing his patients. However, CS Sykes said in evidence that the investigation was to proceed in any event and Mr Pollard accepted that his note did not give a true impression. I feel bound to infer that the only factor that CS Sykes mentioned to Mr Pollard was the scanner appeal and it seems likely that CS Sykes' interest in it was a reflection of the significance that DI Smith attached to the information. It appears that DI Smith may have been looking for a motive rather than gathering evidence. It is clear that there was no discussion during this conversation about the possibility of arranging an autopsy on the body of one or more of Shipman's recently deceased patients.

Detective Inspector Smith Collects the Certificates

- 5.2 In the late afternoon of 25th March or, more likely, on the morning of 26th March, DI Smith collected the bundle of copy death certificates from the register office. He then returned to Ashton police station and sorted the certificates into date order. At some stage (possibly immediately after his return but certainly within a day or two), he prepared his written list or chart of all the deaths of which he was aware. That written chart was later abandoned in favour of the computer spreadsheet: see Appendix B. The computer spreadsheet contains the names of 19 deceased patients, listed in order of the date of death. It does not contain the name of Miss Ada Warburton.
- 5.3 I have already mentioned DI Smith's conflicting accounts as to how many certificates he received from the register office at the time of his second visit. In August 1998, he said that he had been given 19 certificates on that day. To Detective Superintendent Ellis in April 2000, he said that he had received about 10 or 12 certificates on that occasion and, some days later, was given a few more, making 19 in all. In August 2000, he said he had collected 17 at his second visit and received two more later. He repeated that account in his first two Inquiry statements. These changes seemed to demonstrate nothing more than that DI Smith did not have a clear recollection of how many certificates he received and when. This is not surprising, as he made no contemporaneous record.
- 5.4 In his third Inquiry statement, however, signed on 27th May 2002, the day on which he began his oral evidence, DI Smith claimed for the first time that he had received

20 copy certificates, all on the same occasion. The exact number of certificates he received would not greatly matter, save that DI Smith's credibility is under scrutiny. If he received only 19 certificates, as his spreadsheet suggested, that of Miss Warburton would not have been among them. But, if he received 20 certificates rather than 19, he must have received hers. During his oral evidence, Leading Counsel to the Inquiry suggested to DI Smith that his claim to have received 20 certificates, rather than 19, was a recent invention, designed to explain how he had come to learn of the death of Miss Warburton. It will be recalled that DI Smith denied that Dr Reynolds had told him of this death at a time when her body had not yet been cremated. It was suggested by Counsel that DI Smith was anxious to persuade the Inquiry that he had not learned of the death from Dr Reynolds because he hoped to avoid the criticism that he had failed to take any steps to arrange an autopsy of her body.

- 5.5 I have already said that I have found that Dr Reynolds did tell DI Smith about Miss Warburton's death. However, as there is further relevant evidence to be reviewed, I shall defer the full explanation for that conclusion until Chapter Eleven. There is also further evidence to consider relating to the question of whether Mr Loader provided 19 or 20 copy certificates to DI Smith. My conclusion is that he provided 19 but I shall defer the full explanation for that conclusion until later.

The Significance of the Number of Deaths

- 5.6 DI Smith claimed in oral evidence that, after receiving the copy death certificates, he thought that, as there were only 20 (or 19) deaths over the last six months, this 'brought down the average' death rate among Shipman's patients below that which Dr Reynolds had suggested for a three-month period. He said that he assumed that Mr Loader had given him all the relevant copy certificates. That was a reasonable assumption. He said that it did not strike him that there was any inconsistency between the number of copy certificates that Mr Loader had provided and the information from Dr Reynolds. This, he said, was because he did not know on which three-month period Dr Reynolds' figures were based.
- 5.7 I doubt that DI Smith noticed that the average death rate over the six-month period appeared to be lower than the rate described by Dr Reynolds. If he had, he would also have noticed the marked imbalance between the two periods: 16 deaths in one three-month period and only three or four in the other. If, as he assumed, Mr Loader had indeed provided all the certificates for the six-month period, the imbalance would be so marked that it would appear likely that Dr Reynolds had overstated the number of deaths in whatever period of three months she was using. Yet DI Smith did not think of returning to Dr Reynolds to ask her to check her figures or to allow him to see the records from which she had taken them.
- 5.8 DI Smith said that he could not remember his thought processes at this time but postulated that either he concluded that Dr Reynolds' figures were overstated (and did nothing about it) or he thought that both Dr Reynolds' figures and those from the register office were right.

This, he thought, could have been the case if there had been a lot more deaths in one period of three months than the other.

- 5.9 Whatever his thought processes at the time, it is clear to me that DI Smith did not think carefully about the information he had received from Mr Loader when compared with that provided by Dr Reynolds. Either he did not notice any potential inconsistency at all or, if he did, he explained it to himself without giving it careful thought. This is consistent with his own admission that he did not regard the death rate as being of any particular importance. I am satisfied that he never understood its significance.
- 5.10 It follows that DI Smith did not realise that it would be necessary for him to investigate the validity of or basis for Dr Reynolds' concern about the death rate. I think he understood that she was concerned because the death rate was high; that was one of the things that had prompted her to make her report. But he thought that her real concern was that Shipman was killing his patients and that his task was to investigate these suspected murders. I think he believed that he should investigate them in the same way as he investigated other murders, i.e. by taking evidence from people who could speak directly of a killing of which they knew. Of course, he could not approach this investigation in that usual way. No crimes had been reported. He could not speak to the relatives to find out what they knew of Shipman's involvement in the deaths. He could not speak to members of Shipman's practice staff. He could not speak to funeral directors, save for the one known to have expressed concern.
- 5.11 DI Smith's view of what he should do was misconceived. He did not realise that he ought to find out whether the death rate among Shipman's patients was abnormally high and whether, if it was, it suggested unlawful conduct. I do not think he realised that it would be possible to find out what the usual death rate was and to compare it with that in Shipman's practice.
- 5.12 It is unfortunate that DI Smith did not appreciate the importance of the death rate. If he had done so, he would have realised that the number of copy death certificates he had received was not readily compatible with Dr Reynolds' information and he would have gone back to her to check the accuracy of her figures. Had he done so, he would have found that her records contained the names of deceased patients about whom he had not been told by the register office. He would immediately have realised that he was short of certificates. The register office's error would have been discovered. A second search would have been made and I have little doubt that more copy certificates would have been produced.
- 5.13 It is because DI Smith did not appreciate the importance of the number of deaths, or the comparative death rates of the two practices, that I have concluded that the error made by the register office staff had no significant effect on the outcome of the investigation. I think that DI Smith asked for the copy death certificates because the Coroner (or possibly someone else) had suggested that he should do so. It seemed a good place to start. But if Mr Loader had handed him 31 certificates, instead of 19 or 20, I am satisfied that it would not have made any real difference to DI Smith's approach to his task. I do not think he would have tried to find someone who could tell him whether the death rates were abnormal or worryingly high.

The Death of Mrs Martha Marley

- 5.14 I mentioned earlier that DI Smith did not make any arrangement with Dr Reynolds about what was to happen in the event that Shipman made any further requests for a Form C to be signed. This omission was, in the event, of particular significance because, during the afternoon of 24th March (the day on which DI Smith met Dr Reynolds), Shipman killed again. At 6.45pm, Mrs Martha Marley was found dead. She was found sitting in her chair, wearing her day clothes and looking peaceful. Shipman certified that her death was due to old age. In fact, she had been well the day before. In other words, if enquiries had been made about this death, it might well have been recognised as an example of the type of death that had given rise to Mrs Bambroffe's concerns. [My decision about the death of Mrs Marley is in Volume Five of my First Report. I found that Shipman killed her.]
- 5.15 On 26th March, Dr Patel completed the Form C for Mrs Marley. He told the Inquiry that Shipman came across to the Brooke Practice Surgery with the medical notes and told him about the medical history while Dr Patel was looking at Form B. Shipman told him that Mrs Marley had declined steadily over the last year. She was 88 at the time of her death. According to the Form B, Shipman had last seen Mrs Marley 12 days before her death. The form showed that the body had been discovered, not by Shipman, but by Mrs Marley's daughter. The fact that she had died had been confirmed by paramedics. Dr Patel knew about Mrs Bambroffe's worries and realised that this death had some of the features that had given rise to her concerns. Mrs Marley was an elderly female who had been found dead sitting in a chair. Nevertheless, Dr Patel did not feel that he should refuse to sign the Form C. There was no medical reason to refuse, either in the history given or on the face of Form B. A refusal might have drawn Shipman's attention to the fact that he was under suspicion. Dr Patel understood that the doctors at the Brooke Practice were expected to continue to act in the usual way. He did not remember whether this was an instruction from DI Smith or something the partners had agreed between themselves. He believed that the police and Coroner would be informed of the death and would be able to make any enquiries they thought fit. So, Dr Patel went to see the body and then signed Form C.
- 5.16 I accept Dr Patel's explanation as truthful and reasonable. Dr Patel is not to be criticised for signing Mrs Marley's Form C. In fact, Dr Patel's assumption was erroneous; the Coroner and the police were not aware of the death of Mrs Marley. DI Smith remained unaware of this death throughout his investigation. Mrs Marley was cremated on 31st March.

CHAPTER SIX

The Approach to the Health Authority

Detective Inspector Smith Seeks the Medical Records

- 6.1 By midday on Thursday, 26th March 1998, Detective Inspector Smith had decided that it would be a good idea to obtain the medical records of Shipman's recently deceased patients. Somebody (he thinks the Coroner) had suggested this course of action to him. It is possible that this suggestion was made by the Coroner when Chief Superintendent Sykes spoke to him on 25th March. It is also possible that the Coroner made the suggestion to DI Smith himself during a telephone call on 26th March. DI Smith said that he spoke to the Coroner that day, as he had been instructed to keep him informed. The telephone records confirm a call from DI Smith's number to the coroner's office just after midday. However, Mr Pollard does not think DI Smith spoke to him that day and, in contrast with the other telephone conversations between these two, Mr Pollard has no note of such a call, so it is quite possible that DI Smith spoke to a member of the Coroner's staff. Moreover, Mr Pollard said that he would not have known where the medical records of deceased people were kept but thought that his staff might know. I think it likely that the idea of obtaining medical records came from the Coroner, either directly to DI Smith or indirectly through CS Sykes. I am also satisfied that, on 26th March, DI Smith learned (probably from a member of the Coroner's staff) that the medical records of deceased persons would be in the possession of the WPHA.
- 6.2 Shortly after his telephone call to the coroner's office, DI Smith telephoned Selbourne House, the Hyde office of the WPHA. He must have enquired about the procedure for obtaining the medical records of deceased patients. He was referred to Mrs Parkinson, who was then the Consumer Liaison Manager and was responsible for dealing with requests for access to medical records. DI Smith made an appointment to see Mrs Parkinson at 2.15pm that afternoon and noted the time and place on the right-hand page of his daybook: see Appendix A. I do not think that DI Smith had a very clear understanding of why it would be a good idea to obtain the records or what he would do with them when he got them.

The Relevant Health Authority Personnel

- 6.3 Before describing DI Smith's meeting with Mrs Parkinson, it is convenient to explain the functions of the various WPHA personnel who were to become involved with DI Smith's request. As Consumer Liaison Manager, Mrs Parkinson's main job was to receive complaints about doctors and other practitioners (such as opticians) involved in primary care. She was also responsible for handling requests for access to medical records. Her line manager was Dr Banks, then Assistant Director of Primary Care and Medical Adviser. He shared both these positions with Dr Frances Bradshaw. This arrangement had come about as the result of the amalgamation of two smaller health authorities. Although their responsibilities were theoretically coterminous, in practice they divided their duties. Dealing with requests for access to medical records was one of Dr Banks' responsibilities. Both Dr Banks and Dr Bradshaw worked from Selbourne House, Hyde. Their line

manager, Mrs Jan Forster, the Director of Primary Care, worked at the main office of the Health Authority, in Oldham.

- 6.4 At this time, there was in existence a draft local protocol, 'Access to Medical Records Procedures', defining the process by which requests for access to records should be handled and the criteria by which requests should be granted or refused. Although the protocol had not yet been fully approved, Mrs Parkinson was using it as a guideline and had its provisions in mind when she met DI Smith on 26th March. Mrs Parkinson made a contemporaneous note of her meeting with DI Smith. A facsimile of the note, together with other records made by her around this time, can be seen at Appendix C of this Report. Mrs Parkinson's evidence about the meeting owes its reliability largely to her note. DI Smith made no note and his evidence about the meeting is sketchy. In the event of any conflict or uncertainty, I prefer the evidence of Mrs Parkinson.

Detective Inspector Smith Meets Mrs Parkinson and Dr Bradshaw

- 6.5 Mrs Parkinson said that DI Smith wanted to know how to gain access to some deceased patients' records. He explained that he had been contacted by the Coroner as a result of concerns expressed by a local general practitioner, whose name was not divulged. This doctor was concerned about the number of cremation forms s/he had countersigned for Shipman. There had been 16 in three months. Mrs Parkinson knew of Shipman but did not know him personally. She knew of him first because he was her mother's general practitioner. Second, she had received a number of complaints from him about the record keeping standards of other general practitioners. This was an unusual type of complaint and she remembered it. Third, she knew of Shipman's reputation within the WPHA as a good doctor and knew also that he was a member of the Local Medical Committee, a statutory body that represents general practitioners in dealings with the Health Authority.
- 6.6 Mrs Parkinson said that DI Smith then told her that all 16 cremations had had similar features or circumstances. She listed these in her note. The deaths were all of elderly females; all had been found at their homes by Shipman who had apparently called on them unannounced; all had been found during the day and in their day clothes; all had been certified as having died from stroke or heart disease. DI Smith also told her that Shipman ran a scanner appeal and some of the 16 deceased patients had made donations to that appeal either before death or by will.
- 6.7 Although DI Smith had obtained the copy death certificates from the register office, the figures he quoted to Mrs Parkinson were those provided by Dr Reynolds and did not represent the content of the bundle of certificates. I infer that, at this time, he had not made a careful examination of the bundle. However, as will become apparent, he had put them into chronological order.
- 6.8 Mrs Parkinson asked if DI Smith had the consent of the next of kin or personal representatives of the deceased patients to see the medical records. If he had, the draft protocol would have permitted her to release the records, subject only to a check by Dr Banks to ensure that there was nothing particularly sensitive within them, which should

not be disclosed. DI Smith did not have such consent and explained why he would be unable to obtain it; the investigation was confidential and he could not approach the families.

- 6.9 Mrs Parkinson was worried by the serious nature of the enquiry and was anxious to assist DI Smith but did not know what to do. Even if DI Smith had provided a formal letter of request, the protocol would not have allowed her to release the records. She went in search of Dr Banks but he was not available. Dr Bradshaw was in the office and went with Mrs Parkinson to see DI Smith. The whole story was retold. During this second hearing, Mrs Parkinson realised fully that what was being suggested was that Shipman might be killing his patients. She was most concerned, as her mother and stepfather were both patients of Shipman and her mother had given money to his scanner appeal. She told DI Smith of her worries. She said that he seemed quite 'laid back' about it and told her not to worry. DI Smith agrees that he reassured her. He said he was in a difficult position, as he did not wish to create alarm, which might be unfounded.
- 6.10 Dr Bradshaw confirmed to DI Smith that, without the written consent of the next of kin or personal representatives of the deceased, he could not have access to the medical records. The position in law is most unsatisfactory. There is no power by which the police can obtain the release of medical records in the initial stages of a criminal investigation unless the patient or, if the patient has died, the next of kin consents to their disclosure. It appears that doctors sometimes exercise a discretion (which I do not think they have) to disclose records to the police without the consent of the patient or next of kin. Also, it appears that, in some areas, doctors and health authorities will accede to a letter of request from the coroner. However, the coroner has no power to order production or seizure of medical records, at that stage or at any time until inquest. This problem will be addressed in my Third Report.
- 6.11 There is some confusion about exactly what was said when it was realised that Mrs Parkinson could not release the records. The recollections of Dr Bradshaw, Mrs Parkinson and DI Smith differ and the point is not covered in Mrs Parkinson's note.
- 6.12 Dr Bradshaw said that, by the end of the meeting, it had been decided that the relevant medical records would be collected together and the request for release would then be put to Dr Banks for decision.
- 6.13 Mrs Parkinson said that it had been explained to DI Smith that the records could not be released. It was agreed that Dr Banks would be asked to examine the records himself to see if they revealed evidence that the deaths shared the common features and circumstances, identified by DI Smith, which had given rise to concern.
- 6.14 DI Smith said that Mrs Parkinson suggested that one of the two general practitioner advisers at Selbourne House might look at the records instead of him taking them away. He told Mrs Parkinson that he was content with this suggestion and that he would wish the doctor to see if the records provided any evidence to support the allegations being made. The salient features to be examined were whether or not Shipman was present at the death, whether the deceased were found in their day clothes and whether there was any evidence of them being killed or neglected. He said that, when he left the meeting, it had

been agreed that a doctor would examine the records in accordance with his wishes and would contact him when the job had been done. In his previous accounts, DI Smith had always maintained that he had asked that the doctor should examine the records to see if the cause of death was consistent with the treatment previously prescribed. When he gave oral evidence, his accounts varied. In general, he accepted that he had asked only that the doctor should search for signs of the common features that had given rise to concern. However, at other times, he maintained that what he had really wanted was that the doctor should examine the records for consistency between the cause of death and the previous treatment.

- 6.15 I am satisfied that, after a discussion of the problem, it was decided that either Dr Bradshaw or Mrs Parkinson would tell Dr Banks about DI Smith's request and, if Dr Banks were not prepared to agree to release the records themselves, he would be asked to examine them. In the mind of Mrs Parkinson, who was the person who did in fact speak to Dr Banks, the purpose for which Dr Banks would look at the records, if he agreed to do so, was to see whether there was any evidence in them of the common features which had given rise to concern.
- 6.16 Before the end of the meeting, Mrs Parkinson agreed to arrange for the relevant records to be collected together so that they could be shown to Dr Banks. DI Smith had with him the bundle of certificates from the Tameside register office. He gave Mrs Parkinson the names, addresses and dates of birth of 17 deceased patients of Shipman. That was the only information she would need in order to locate the records. She wrote the information down. The list of names can be seen at Appendix C. The names are listed in chronological order of death, although Mrs Parkinson did not write down the dates of death or the causes of death, as recorded on the certificates. DI Smith was adamant that he told Mrs Parkinson the cause of death in each case but I am quite satisfied that he did not. If he had done, she would have written down this information.
- 6.17 Mrs Parkinson warned DI Smith that the records of the patients who had died most recently might not yet have been returned to the Health Authority. She asked whether she should request Shipman's practice to return them immediately. DI Smith told her not to do so, as Shipman was not to be made aware of the investigation.
- 6.18 It will be noted that DI Smith did not include in the list he gave to Mrs Parkinson the names of Mr Harold Eddleston and Miss Maureen Ward. Nor, if he had it, as he claimed in oral evidence, did he give the name of Miss Ada Warburton. Before the hearings for this part of the Inquiry began, when DI Smith was contending that he received the certificates in two batches, he claimed that he omitted the names of Mr Eddleston and Miss Ward because he had not at that time received their copy death certificates from the register office. Later, he abandoned that explanation and suggested another reason for their omission. In oral evidence, he suggested that he omitted them because those two deaths were certified by Shipman as having been due to cancer; therefore, because they were not said to be due to coronary thrombosis or stroke, it could be seen without further examination that they did not conform to the pattern of suspicious deaths. However, some of the other deaths for which he obtained the records had other causes; for example, Mrs Elizabeth Battersby was said to have died of a pulmonary embolism, Mrs Bertha Parr of 'natural causes' and Mrs Cissie Davies of bronchopneumonia.

- 6.19 I am unable to reach a clear conclusion about why DI Smith omitted to mention the names of Mr Eddleston and Miss Ward and to seek advice about their medical records at this stage. Neither of the two possible explanations is entirely satisfactory. I do not think DI Smith received the copy death certificates in two batches; I think he received them all on his second visit to the register office. He could not identify another visit or any other means by which they had been conveyed to him. I think the second explanation is the more plausible. I think DI Smith believed that he was only expected to investigate deaths that clearly conformed to the pattern of suspicious deaths. It may be that he had got hold of the idea that only deaths certified as due to stroke or coronary thrombosis were suspicious; or it is possible that he thought that deaths due to cancer sounded 'natural' and should be excluded from his enquiry. In the event, the records of Mr Eddleston did come to the attention of Dr Banks, although not at the time when he considered the first tranche of records. How and why they did so remains something of a puzzle.
- 6.20 DI Smith also suggested, in oral evidence, that he had omitted the name of Miss Warburton from the list he gave to Mrs Parkinson because her death was so recent that the records were unlikely to be available. However, Miss Warburton died only a few days after Mrs Dorothy Long and Mrs Lily Higgins, whose names he included. DI Smith claimed that he had discussed with Mrs Parkinson and Dr Bradshaw which sets of records should be sought and they had suggested that those of Mrs Long and Mrs Higgins might be available but those of Miss Warburton would not. Mrs Parkinson could not recall any such conversation and Dr Bradshaw said that she was not present when the list was compiled. I do not think that any such conversation took place.

The Records Are Put Before Dr Banks

- 6.21 After DI Smith had left, Mrs Parkinson asked a colleague to collect the medical records together for her and she then kept them in a locked cabinet before passing them on to Dr Banks. Only 14 sets were found. The records for Mrs Margaret Waldron, Mrs Long and Mrs Higgins (who had died on 6th, 13th and 17th March 1998 respectively) were still with Shipman and were not available for examination.
- 6.22 When Dr Banks returned to the Hyde office later that afternoon, Mrs Parkinson told him about DI Smith's visit and request. Neither of them took a note of that conversation and neither has a clear recollection of what was said. Mrs Parkinson showed Dr Banks her note of the meeting with DI Smith and told him what had transpired. I am satisfied that Dr Banks agreed that release of the records was not possible without the consent of relatives or personal representatives. I am also satisfied that Mrs Parkinson said that DI Smith would be content not to pursue his request for access to the records if Dr Banks would look at them to see if they contained evidence of the common features.
- 6.23 It is clear that Dr Banks agreed to examine the 14 sets of records. He decided to do so without discussing the wisdom of taking this course with Mrs Forster, his line manager, or with Dr Ellis Friedman, Director of Public Health Medicine for the WPHA. I will return in due course to consider whether he should have consulted either or both of those persons. Dr Banks undertook the task without requiring DI Smith to make a formal written request and without speaking to DI Smith directly to ensure that he had a full understanding of what

was required. Dr Banks claimed, at one stage, that he had asked Mrs Parkinson to find out exactly what the police wanted. However, he was not certain of this and there is no record of a telephone call from Selbourne House to the police. Nor did Mrs Parkinson make a note of any such request from Dr Banks or of its outcome. In my view, it is most unlikely that Dr Banks sought any clarification of his task.

CHAPTER SEVEN

The Examination of the Medical Records

Dr Banks' Functions and his Knowledge of Shipman

- 7.1 Dr Banks qualified as a doctor in 1973 and, after various training posts, settled into general practice in Norwich, where he remained for 18 years. In 1993, he joined the Tameside Family Health Services Authority as Medical Director. From April 1996, when the Tameside and Oldham Family Health Services Authorities were merged and taken over by the new West Pennine Health Authority, he shared the positions of Medical Adviser and Assistant Director of Primary Care with Dr Bradshaw. However, his job did not change significantly.
- 7.2 Dr Banks regarded his position as Medical Adviser as a 'bridge' between the local general practitioners and the Health Authority. His main duties related to the monitoring of prescribing practices. He would assist in setting the general practitioners' prescribing budgets and monitor how they were spent. He would visit general practitioners to advise them on prescribing practice. There were about 200 general practitioners in the area and Dr Banks would visit each about once a year, or more, if a doctor were not complying with what was seen as 'good prescribing practice'. In this context, Dr Banks had met Shipman on a number of occasions. Shipman did not always comply with the official guidance on prescribing. He was unwilling to prescribe generic drugs and preferred to prescribe various new and expensive products, in particular for the treatment of heart disease and raised cholesterol levels. Dr Banks had the unenviable task of seeking to persuade Shipman to reduce his drugs bill, which was consistently 60% above the average for the Health Authority. He found Shipman difficult to persuade. Shipman would produce scientific papers showing the efficacy of the drugs in question and would argue for his right to prescribe them. This type of disagreement and arguments about the sums to be allowed for the support of Shipman's practice led to a degree of tension between the two men. On occasions, Shipman wrote quite strongly worded letters to the Health Authority. Despite these tensions, Dr Banks respected Shipman. He knew that Shipman was well liked by his patients and had a high reputation in the area. He thought Shipman had good staff and ran his practice efficiently.
- 7.3 Dr Banks' duties also included the giving of initial advice about any complaint made against a general practitioner as to whether the complaint contained any substance and fell within the Health Authority's remit. The only ground on which the Health Authority could bring disciplinary proceedings against a general practitioner was for a breach of the doctor's Terms of Service. Most general practitioners are self-employed and provide services to the National Health Service on terms set out in a statutory instrument. The provisions relating to payment for the various services are set out in the Statement of Fees and Allowances, generally known as 'the Red Book'. Dr Banks believed that Shipman was very knowledgeable about all the rules and regulations applicable to general practice.
- 7.4 Another aspect of Dr Banks' work was to represent the WPHA on a number of committees, including the Local Medical Committee, of which Shipman was a member. On occasion, the two men were also members of the same panels interviewing applicants for vacancies in single-handed practices.

- 7.5 Dr Banks was aware that Shipman had previously been a member of the Donneybrook Practice. It will be recalled that Shipman was a member of that practice from 1977 until 1992. Dr Banks believed that Shipman had left following a disagreement about fundholding. (In fact, there had been no disagreement until after Shipman had announced his intention to leave.) As time went on, Dr Banks became aware of the mutual dislike which Shipman and his former colleagues at the Donneybrook Practice felt for each other. Later, he learned that there had been a financial problem between Shipman and the other doctors. Shipman told Dr Banks that the others had 'robbed him'. Then Dr Banks heard the Donneybrook doctors' side of the story and learned that the dispute had been about the division of a tax bill. When, on a prescribing visit in about 1997, Shipman spoke to him about his former colleagues, Dr Banks was surprised by the strength of feeling he seemed still to have, five years later. He had the impression that Shipman hated the Donneybrook doctors, almost venomously.
- 7.6 By 1998, Dr Banks' view of Shipman was that he was an able man and a good doctor but was arrogant, prickly and difficult to deal with.

Dr Banks' Understanding of his Task

- 7.7 As I have mentioned, one of Dr Banks' duties related to the handling of requests for access to medical records. Although such requests were dealt with in the first instance by Mrs Parkinson, Dr Banks had two roles. If Mrs Parkinson were in doubt about whether a request should be granted, she would refer it to Dr Banks for decision. Further, in cases where the request would clearly be granted, Dr Banks would examine the records to ensure that there was no sensitive material within them that ought not to be disclosed. He was therefore accustomed to reading medical records kept by other general practitioners. He was familiar with some of the computer systems then in use, although not the Microdoc software system used by Shipman. He was quite experienced at deciphering doctors' handwriting and abbreviations.
- 7.8 Dr Banks recalled that, when Mrs Parkinson told him about Detective Inspector Smith's request for access to records, he agreed that, as the police could not provide the consents necessary for release of the records, he would be prepared to look at them himself. He could not remember being handed Mrs Parkinson's note of her conversation with DI Smith but is confident that he must have looked at it. He thought that the police wanted information about the cause of death, the place of death and who was present around the time of death. He was handed 14 sets of records. He was not given any separate information about the causes of death as certified by Shipman. His task was to look in the records for the features that Mrs Parkinson had noted. He was to see whether the information in the records fitted with that pattern of features. He understood that he was looking to see if the features were present in all cases.
- 7.9 Dr Banks said that, although he saw the number of deaths recorded by Mrs Parkinson in her note (16 cremations among Shipman's patients in three months), that number did not strike a chord in his mind as being high. If he had thought about it, he would have realised that this number might be only a proportion of the deaths among Shipman's patients and that there would be other deceased patients who had been buried or whose deaths had

been certified by a hospital doctor or the coroner. However, he did not think about that. He said that he had very little knowledge of death rates and did not know the annual crude death rate for patients in UK general practice. Nor did he know the proportion of deaths usually followed by burial and cremation. Dr Banks realised that the 14 sets of records he was asked to look at were from a list of 17 deaths that had occurred over a period of six months. He said that he noticed that 17 deaths over six months represented a much lower death rate than 16 deaths over three months, as noted by Mrs Parkinson. However, he assumed that the initial figures given to Mrs Parkinson must be wrong. It did not occur to him to ask that the figures for deaths of patients in Shipman's practice be checked either by DI Smith or using data held by the Health Authority, as would have been possible. Nor did he think of finding out what the 'usual' death rate was.

- 7.10 Dr Banks claimed that he did not realise that the police request was connected with a report that Shipman was suspected of killing his patients. I find that most surprising. Mrs Parkinson knew the nature of the underlying concern. She knew Dr Banks very well. They saw each other every day at work and were on good terms. It seems highly likely that she would have told him what she knew of the underlying nature of the concerns and of the fact that she was worried because her own mother was a patient of Shipman. In any event, I would have expected Dr Banks to realise that there was a suspicion that Shipman was harming his patients. Why else would the police and Coroner be involved? Why else would the police mention that Shipman had had 16 cremations in three months? Why else had the police bothered to mention the scanner appeal and the fact that some of the deceased had made donations to it? It seems to me that he must have known.
- 7.11 When pressed by Leading Counsel to the Inquiry about his insistence that he did not understand what lay behind the police enquiries, Dr Banks acknowledged that it was possible that he had understood on a rational level the suggestion that was being made but found it too incredible to contemplate. At one stage, he described the suggestion that Shipman was harming his patients as 'just too incredible a leap from one's belief system'. Dr Banks also said that he had had no previous experience of the type of concern raised by the unknown general practitioner and he had not previously known of one doctor complaining about another's incompetence. He said that he thought it almost inconceivable that Shipman would harm his patients. It occurred to him that the report made to the Coroner might have been malicious and might even have been made by one of the Donneybrook doctors with whom Shipman had 'fallen out'. He agreed that it was possible that he might have dismissed the allegation as mischief making.
- 7.12 I find that Dr Banks must have known that the police investigation related to the possibility that Shipman was killing his patients, either deliberately or by gross negligence. However, he found the suggestion quite incredible and it is doubtful that he contemplated it as a real possibility.
- 7.13 Dr Banks took the records home with him and worked on them during the evening of Thursday, 26th March. The following morning, he returned to his office and completed the task that day. He estimated that he spent about five hours on the task, including the preparation of a chart on which he entered his findings. That chart can be seen as Appendix D to this Report.

- 7.14 Dr Banks said that his main task, as he understood it, was to see whether the medical records confirmed or denied the presence in all the deaths of the pattern of features that Mrs Parkinson had noted. I accept that that was what he thought he had to do. The headings of his chart are consistent with an investigation into the presence or absence of those features. The headings were the name and date of birth, the date of death, '**CAUSE** [*meaning cause of death*]' and '**Where**'. Dr Banks intended to use that last column to record the place of death. However, he agreed that he had rather lost sight of where the death had occurred and instead used this column to record miscellaneous items of information, often relating to the medical history. The final column was headed '**Who Saw** [*meaning who was present at or about the time of death*]'. Dr Banks said that, in addition to looking for the common features, he also looked to see if the cause of death, as given in the records, was generally compatible with the medical history. He did not have the death certificates and did not know the causes of death certified by Shipman.

Dr Banks' Conclusions

- 7.15 On the afternoon of 27th March, Dr Banks was working on his computer in his office at Selbourne House and had the records about him on the floor. Mrs Parkinson asked him if he had found anything of concern and noted his response: see Appendix C. She wrote that Dr Banks had gone through the records and had not seen any evidence of anything odd. Most of the cases involved patients who had been treated for diabetes or high blood pressure. Two had been found by ambulancemen, two by the deputising service and one by the deceased's son. Mrs Parkinson wrote, in capital letters, '**NO 2 CASES ARE THE SAME**'. She added: '**Only concern is that in a couple of cases, Dr Banks felt insufficient history to make an accurate diagnosis**'. Mrs Parkinson recalled that, when Dr Banks told her about the '**couple of cases**' in which there was insufficient history in the records to make an accurate diagnosis, he said that he would have expected the doctor to refer those deaths to the coroner.
- 7.16 In evidence to the Inquiry, Dr Banks confirmed that his findings were that no two cases were the same. No single feature was present in every case. This is consistent with what he must have told Mrs Parkinson. He said that there were 'a few' cases in which the evidence in the records was not such as to permit a diagnosis of the cause of death. He was concerned about those cases. It is not possible to identify, from the entries on his chart, the deaths about which Dr Banks was concerned. Dr Banks suggested that the expression '**a couple of cases**' was probably intended to mean 'a few' rather than 'two'. He was of the view that these deaths should have been reported to the coroner. He found it difficult to say now which cases had given rise to this concern. However, eventually, he said that he was sure he had mentioned to DI Smith the cases of Miss Mabel Shawcross, Mrs Cissie Davies and Mrs Winifred Healey. He agreed that an MCCD should not have been signed in the case of Mrs Bertha Parr but did not claim that he had mentioned this to DI Smith. He also identified a number of other cases in which, on the information available, he personally would not have certified the cause of death but would have reported to the coroner. He was less clear about whether he had mentioned these to DI Smith. In the light of Mrs Parkinson's note, it seems unlikely that he did.

- 7.17 He said that, although he thought there were 'a few' cases that should have been reported to the coroner, this did not strike him as significant or worrying. He said it had not occurred to him that a doctor who was killing his patients might wish to avoid a referral to the coroner. I find that remark most surprising and it seems to me to demonstrate that Dr Banks had not opened his mind to the possibility that Shipman might be killing his patients. Dr Banks added that he had found that most of the causes of death recorded in the notes were broadly consistent with the medical history.
- 7.18 During the afternoon of Friday, 27th March, Mrs Parkinson telephoned DI Smith's number. The call lasted only 21 seconds. I think it likely that DI Smith was not available and Mrs Parkinson left a message on his answerphone. DI Smith was off duty over the weekend of 28th and 29th March. Early on Monday morning, 30th March, he telephoned the Health Authority number. I am satisfied that, on that occasion, he spoke to Mrs Parkinson and arranged to attend Selbourne House at 10.30am on Wednesday, 1st April to receive the results of Dr Banks' examination of the records.

CHAPTER EIGHT

Further Enquiries

What Detective Inspector Smith Probably Did from 27th to 31st March

- 8.1 There is no clear evidence that Detective Inspector Smith was actively engaged on his investigation into Dr Reynolds' concerns on Friday, 27th, Monday, 30th or Tuesday, 31st March 1998. No telephone calls relevant to this investigation are recorded, save for the brief call to Mrs Parkinson on 30th March. DI Smith might have been engaged on a different enquiry, although he did not think that he was. He might have worked on other police duties of a routine nature. However, at some stage, DI Smith undertook some further enquiries into Shipman and it seems likely that they were made during this period.
- 8.2 DI Smith said that he asked the Charities Commission whether a scanner appeal run by Shipman was registered as a charity. He found that it was not. The Charities Commission has no record of his enquiry.
- 8.3 DI Smith also recounted how he attempted to discover whether the police had attended any of the deaths of which he was aware. When a sudden death occurs, the police are frequently called. If necessary, they will trace and notify the deceased's next of kin. Provided that there are no obviously suspicious circumstances surrounding the death, they will also try to contact the deceased person's general practitioner to see if s/he is prepared to issue an MCCD. If the doctor agrees to do so, then police involvement comes to an end. However, an incident log recording the attendance of the police is made and retained. For the first 28 days after the death, the log is readily available on the police computer. After 28 days, the log is archived and the process of recovery is more time-consuming. In the archive, each topic has a code reference; the code for sudden death reports was, at the time, 84.
- 8.4 DI Smith said that he retrieved two or three incident logs relating to deaths of Shipman's patients which had occurred within the previous 28 days but found no evidence of suspicious circumstances. DI Smith seems to have thought that this showed that the deaths were not in fact suspicious. However, given the nature of the suspicion against Shipman, that he might be killing his patients by giving them a drug of some kind, one would not expect to find overt evidence of suspicious circumstances in a sudden death report. The potential value of these reports to DI Smith's investigation into Shipman was that they identified the police officer who had attended the scene of the death. That officer would have seen the body and might have had the opportunity to speak to a relative or neighbour who knew something of the circumstances surrounding the death. As DI Smith needed information about the individual deaths but could not approach relatives, he should have recognised the potential benefit of contacting the officers who had attended the deaths. Some of them might well have remembered information which was not recorded in the incident log.
- 8.5 DI Smith did not speak to the police officers who had completed the incident logs he retrieved. Moreover, he chose not to attempt to recover the archived logs. He said he regarded the coding system as unreliable. That it may have been, and it is possible that

an archive search would not have produced all the relevant incident logs. However, it would have produced some. The Inquiry caused a search of the archive for the six-month period in which DI Smith was interested. Incident logs were found for seven of the 20 deaths of which DI Smith became aware. Examination of the documents themselves would have revealed that all the deceased patients were women. One was said to have been found sitting in a chair. Others were said to have been on the floor. In six of the seven cases, it was apparent that the doctor (Shipman) had been willing to issue an MCCD. In other words, it was clear that none of those six deaths was referred to the coroner.

- 8.6 If DI Smith had bothered to find these reports and to speak to the officers who had attended the scenes of the deaths, he would have obtained a wealth of useful information. He would have learned of the position of the deceased, whether they were in day clothes and whether they were showing signs of illness before death. He might well have discovered whether relatives and friends regarded the death as sudden and unexpected. In my view, the unreliability of the coding system was not a valid reason for DI Smith's decision not to make the attempt. This was an important opportunity to obtain evidence about the deaths without breaching the requirement of confidentiality imposed by the Coroner at his original meeting with Chief Superintendent Sykes and DI Smith.
- 8.7 DI Smith also checked the Greater Manchester Police Integrated Computer System (GMPICS) to see whether there was any intelligence known about Shipman. He found that there was not. However, he did not access the Police National Computer (PNC) to ascertain whether Shipman had any previous convictions. He said that he forgot to do so. He also remarked that a check of the PNC was less convenient than one on the local system. However, he well knew that GMPICS would cover only intelligence and information about matters that had occurred in the Manchester area. I doubt that he forgot to search the PNC and think it more likely that he thought his search of GMPICS would be adequate, because a man like Shipman would not have any criminal convictions. This is borne out by a short passage in the Ellis report, to which I shall refer later, from which I infer that DI Smith told Detective Superintendent Ellis that he had made a conscious decision not to search the PNC. Had DI Smith searched the PNC, he would have discovered that Shipman had previous convictions for drugs offences involving dishonesty, committed in the early 1970s.
- 8.8 DI Smith claimed that knowledge of these convictions would not have affected his view of Shipman; the offences were a very long time ago and, he said, it is not uncommon to find doctors who have stolen drugs. I cannot accept that evidence. Shipman had a very high reputation and, in my view, the discovery that he had previous convictions would have come as a great surprise to anyone, including DI Smith. Examination of the record would have revealed that the offences had taken place over a considerable period of time and involved acts of dishonesty. Of course, the knowledge that Shipman had past drugs convictions would not immediately lead to the conclusion that he was killing his patients. However, it would have meant that his reputation was called into question. When considered together with the suspicion that he might be killing his patients by giving them some sort of drug, as Dr Reynolds had suggested, knowledge of these convictions would have raised the index of suspicion of any reasonable police officer.

- 8.9 DI Smith said that he did not contact the General Medical Council (GMC) in connection with his enquiries into Shipman. At one stage, the Inquiry considered that he might have done, as a telephone call was made to the GMC from Ashton police station at 9.09am on 14th April. It lasted only 52 seconds. However, DI Smith said that he did not make this call in connection with Shipman. The call might have been made by him or by another officer in connection with another case. The GMC has no record of the call, which, they say, must, from its length, have been a routine enquiry. DI Smith ought to have asked the GMC whether Shipman had been the subject of disciplinary proceedings. This enquiry should be made as a matter of routine in any criminal investigation into the conduct of a doctor. Had he made a proper formal enquiry and had the GMC been prepared to assist, it may be that DI Smith would have found out about Shipman's convictions through that route.

What Detective Inspector Smith Did Not Do During the Same Period

- 8.10 During this period at the end of March, DI Smith did not attempt to locate or interview the unknown female undertaker. She was plainly an important potential witness, provided that she was willing to speak to him. He had no reason to suppose that she would not; he knew only that she did not wish her identity to be disclosed. It is hard to understand why DI Smith did not request Dr Reynolds to ask 'the unknown undertaker' whether she would speak to him in confidence. He said that he asked Police Constable (PC) Peter Napier, a coroner's liaison officer, if he knew of any female undertakers. PC Napier gave him two or three names, including that of 'Debbie Massey' (now Mrs Bambroffe). However, PC Napier said that he did not provide Mrs Bambroffe's name. PC Napier said that, on 24th March (which was the first day of the investigation), he had passed DI Smith in the corridor at Ashton police station. DI Smith had asked him if he knew of any female undertakers in Hyde. PC Napier said that he gave DI Smith one name, but not that of Mrs Bambroffe because he thought, erroneously, that she was only an employee, and not a principal, of the firm of Masseys. However, there is no evidence that DI Smith contacted any of the female undertakers named by PC Napier.

Reporting and Supervision

- 8.11 CS Sykes said that it was usual practice for DI Smith to come to his room each morning to discuss current matters. These morning meetings occurred during this period but were not specifically related to the Shipman investigation, which would be mentioned briefly. CS Sykes remembered hearing that DI Smith had obtained some documents, probably the copy death certificates, but said he did not know about his attempts to obtain the medical records. It appears that there was never any in-depth discussion of the issues between the two men. CS Sykes said that it did not occur to him to question DI Smith about what he was doing in this investigation. It certainly did not occur to him to ask whether DI Smith had checked to see if Shipman had any criminal convictions. He gained the impression that matters were being dealt with properly but that nothing had emerged from the investigation such as to give rise to any concern.

The Lost Chance for an Autopsy

- 8.12 I noted earlier that, on 30th March, Dr Reynolds telephoned Dr Gough to give a report on progress. Dr Gough recorded that Dr Reynolds thought that an autopsy was to take place

on one of the bodies she had identified to the investigating police officer. Mrs Lily Higgins had been cremated on Wednesday, 25th March and Miss Ada Warburton was cremated on 30th March. The opportunities for autopsy had gone. The body of Mrs Martha Marley was cremated on 31st March. Her body had also been available for examination but DI Smith had never become aware of her death.

8.13 In short, no progress had been made in the investigation between 27th and 31st March.

CHAPTER NINE

Dr Banks Advises Detective Inspector Smith

Detective Inspector Smith Meets Dr Banks

- 9.1 In the morning of Wednesday, 1st April 1998, Detective Inspector Smith attended Selbourne House to meet Dr Banks. This was the first time that the two had spoken to each other. It was Dr Banks' recollection that DI Smith was accompanied by another police officer. DI Smith said that he was alone. Mrs Parkinson, who also attended the meeting, could not remember whether or not a second police officer was present. Dr Banks described the 'other officer' as older than DI Smith but apparently junior to him in rank, probably a detective sergeant or detective constable. GMP has made extensive efforts to identify an officer who might have been with DI Smith on this occasion but without success. There is some evidence that DI Smith was accompanied by another officer when he visited the crematorium later that day. If he was, that might suggest that he was also accompanied during the morning. I regret to say that I am unable to reach any conclusion as to whether or not DI Smith attended this meeting alone or in the company of another officer.
- 9.2 Mrs Parkinson did not take a note of the meeting. That is a pity, as her earlier note was valuable. She said that she did not take a note as she was attending only as an observer and did not have to take any action arising from the meeting. The Inquiry is therefore wholly reliant on the recollections of those present as to what was said. Those recollections differ considerably.

Detective Inspector Smith's Account

- 9.3 DI Smith said that he met Dr Banks in a small room downstairs. Dr Banks had the medical records with him. He said that he had gone through them and could not see anything odd or of a criminal nature. He had recorded some information on a chart, which DI Smith saw at the time; the chart is at Appendix D of this Report. DI Smith said that Dr Banks did not go through the individual deaths in detail; he just drew attention to one or two cases in which, he said, there was a lack of information in the records. Dr Banks pointed out that some of the computerised records appeared to have been made on a system that provided very limited character space within the relevant fields. There were one or two cases in which, according to Dr Banks, the cause of death was not sufficiently specific. DI Smith could not recall which cases these were but said that Dr Banks had said that, in these cases, there was insufficient information for a doctor to diagnose the cause of death. Dr Banks personally would have referred those deaths to the coroner. However, this information did not ring any alarm bells with DI Smith. He said that it had never occurred to him that, if Shipman had killed a patient, he might want to avoid referring the death to the coroner. I find it disturbing that an experienced detective could have failed to grasp the simple concept that a doctor who had murdered a patient might wish to avoid an autopsy of the victim's body.
- 9.4 DI Smith recalled that Dr Banks told him that Shipman was an old-fashioned doctor who often visited his patients at home and liked to keep his elderly patients at home rather than

send them into hospital. DI Smith said that Dr Banks told him that there was nothing in the notes to suggest criminality. He said that he felt reassured by Dr Banks' opinion. He did not discuss with Dr Banks the possibility that Shipman might be killing his patients by giving them a drug of some sort, as suggested by Dr Reynolds. Nor did he ask Dr Banks how a doctor might kill his patients. He did not appear to have realised that a discussion of how a doctor might kill a patient might have affected Dr Banks' approach to the medical records.

Dr Banks' Account

- 9.5 Dr Banks said that the meeting took place in the boardroom. He began by showing DI Smith the typical contents of a set of records and explaining what information was kept in them. He said that he handed DI Smith a copy of his chart (which he recalled DI Smith took away with him after the meeting) and showed him from where, in the records, the information had come. He said that, in allowing DI Smith to see confidential information taken from the medical records, he was exercising his discretion under the Health Authority's 'Access to Medical Records Procedures' to allow limited disclosure of medical information in the public interest. He said that he went through the chart, case by case. He told DI Smith that, in some cases, there was insufficient information to allow a reliable diagnosis of the cause of death and he expressed the view that the computerised notes might be incomplete. Dr Banks said that he told DI Smith that there were some cases that he felt should have been referred to the coroner. As I have already mentioned, Dr Banks told the Inquiry that he was sure he had mentioned to DI Smith the cases of Miss Mabel Shawcross, Mrs Cissie Davies and Mrs Winifred Healey.
- 9.6 Dr Banks could not remember whether there was any discussion of the common features of the deaths. He said that DI Smith did not ask whether there were any signs of criminality and he (Dr Banks) did not volunteer the opinion that there were none. That would not have been his function or within his expertise. He could not understand how DI Smith could claim to have been reassured by what he said.
- 9.7 Dr Banks said that DI Smith was very friendly and relaxed. He had the impression that DI Smith was taking his investigation seriously but was not making any progress. There was no sense of urgency at this meeting, although he had received an impression of urgency when told earlier about the request for access to the records. Dr Banks said that there was no discussion about death rates at the meeting. He had seen Mrs Parkinson's note and knew that DI Smith had told her that there had been 16 cremations of Shipman's patients in three months. However, it appears to be common ground that Dr Banks was not told about the comparison between the death rate in Shipman's practice and that of the Brooke Practice. This is consistent with my view that DI Smith did not regard the comparative death rates as important. Dr Banks agreed that DI Smith did not tell him that it had been suggested that Shipman might be killing his patients by giving them a drug. Dr Banks recalled DI Smith using expressions such as 'gossip between GPs and undertakers' and 'rumour and innuendo'.
- 9.8 Dr Banks had the impression that he was the last important source of information available to DI Smith. He said that he thought other sources were open to DI Smith, if he felt it

appropriate to pursue them, but he had the impression that DI Smith felt that they would lead nowhere. He also felt that DI Smith was satisfied with the information he was giving him. Dr Banks did not think that he told DI Smith that Shipman was an old-fashioned doctor (because he did not think he was), although he might have said that Shipman had a reputation for visiting his patients unannounced.

- 9.9 In 1999, Dr Banks provided a written statement for his employers, setting out details of his involvement in the March 1998 police investigation. The statement is undated. Dr Banks' line manager, Mrs Forster, believes that the statement was prepared as a result of a request from her in July 1999. However, Dr Banks believes that he wrote it earlier, probably in April. In the statement, Dr Banks said:

'I later met with Detective Inspector D Smith and a colleague where we reviewed each set of records and my findings. It was my view that there were few common features in each of these deaths. I expressed concern that in a number of cases there was insufficient evidence in the records on which to base a cause of death and that I personally would have arranged a post-mortem [sic]. Most causes of death given by HFS were consistent with the medical record.

At no time did I consider that HFS had done anything criminal.'

Mrs Parkinson's Account

- 9.10 Mrs Parkinson's recollection of this meeting was very sketchy. She recalled that Dr Banks had his chart with him but she had no recollection of the chart being handed to DI Smith or of hearing any case-by-case discussion. She had no recollection of Dr Banks expressing any concern about the records. She only recalled him saying that there were two cases where insufficient history was recorded but she did not recall him saying which they were. She could not recall him saying that there ought to have been an autopsy in some cases. She could not recall any discussion about the common features. Nor did she remember Dr Banks saying that the computerised records might be incomplete and there might be more information on the computer. She did not recall any discussion about the suddenness of the deaths; she thinks that she would have remembered that.

Were Other Topics Discussed?

- 9.11 Mrs Parkinson said that she was asked to obtain some information from the information department at the Health Authority's office at Lindley House, Oldham. She cannot remember how this came about but it would seem that there must have been some discussion about the size or make-up of Shipman's patient list. At 10.51am on 1st April, some extracts from Shipman's Practice Profile for the year ending March 1996 were faxed to Selbourne House. The Practice Profile is a document produced annually by the Health Authority for each general practice in its area and is designed to show the performance of each practice in such fields as prescribing, financial expenditure and hospital activity when compared with the average practice in Tameside. Mrs Parkinson believed that 1996 was the last year for which the figures were readily available at Lindley House, which, prior

to the creation of the WPHA, had been the office of the Family Health Services Authority. It did not matter that the information contained in the Profile was more than two years old, as, in fact, the more recent figures were very similar.

- 9.12 Neither DI Smith nor Dr Banks can remember this document being called for or received and neither has any recollection of any discussion about its contents. It would seem therefore that this material was not carefully examined. That is unfortunate, as it contained information which, although slightly stale, would have illuminated any discussion of the death rate among Shipman's patients, had one taken place. First, it established the size of Shipman's patient list. That would have clarified the significance of the comparative death rates provided by Dr Reynolds. Second, it showed that, in 1996, Shipman had 169 (or 5.49%) patients over the age of 75 years; in 1995, 6.7% of the population was over 75, so the proportion of patients over the age of 75 within Shipman's practice was not above average. That would have scotched any notion that Shipman had an unusually large number of elderly patients and could therefore be expected to have a higher than normal death rate among his patients. There was also further information that would have undermined any suggestion that Shipman had an unusually large number of elderly female patients, such as might account for the deaths of so many elderly women. The Practice Profile showed the age/sex distribution of Shipman's list, compared with the average Tameside practice list. The average Tameside practice list had just over 6000 patients, which was about twice the size of Shipman's list. Shipman had about half as many male patients over 75 as the average practice; in other words, the proportion of males over 75 in his list was the same as that of the average practice in Tameside. More significantly, he had about two-fifths of the average number of female patients over 75. This confirmed that, far from having a lot of elderly female patients, Shipman actually had a smaller proportion of such patients than the average practice.
- 9.13 I have come to the conclusion that this data was not examined at all during the meeting. I think that Dr Banks must have asked Mrs Parkinson to obtain some practice population information and that the two men continued their discussion in her absence. I think that, by the time the extracts from the Practice Profile had arrived, the discussion of the individual cases was over; Dr Banks had said that he had found nothing of concern (save for the 'couple of' or 'few' cases where there was insufficient information to diagnose the cause of death) and DI Smith was quite satisfied with the outcome. Neither man then saw any need to examine or discuss the figures. This accords with Mrs Parkinson's recollection of some discussion about the practice population, after which she telephoned the Oldham office. She does not recall any subsequent discussion.

The 'Bad Joke'

- 9.14 Dr Banks said that, shortly before the end of the meeting, DI Smith said something like 'We will just have to see if he [*Shipman*] does it again'. This must have occurred at the time when it had become apparent that perusal of the medical records had yielded nothing of significance to the investigation. Dr Banks thought this was a failed attempt at 'black humour'. Mrs Parkinson also remembers this remark and thought it was in very bad taste. She thought DI Smith had immediately regretted making it. DI Smith does not think he said it. I am satisfied that he did and that it was an attempt at humour. Dr Banks said that he

did not think this indicated that DI Smith had serious concerns that Shipman might be killing his patients. I accept that this is so; indeed I think that, by this time, DI Smith was firmly of the view that there was no foundation for Dr Reynolds' concerns. But the fact that Dr Banks understood the 'joke' means he must have realised that the nature of the concerns underlying the investigation was that someone thought Shipman might be killing his patients.

Findings

- 9.15 It is clear that there was no preliminary discussion between DI Smith and Dr Banks which might have ensured that Dr Banks was fully informed about the nature of the concerns expressed and knew exactly what information DI Smith was looking for in the records. DI Smith did not seek a preliminary discussion because, in my view, he did not have a very clear idea of what he was looking for. He did not know what kind of information was likely to be recorded in the notes. His mind was focussed mainly on discovering whether the records revealed a pattern of common features. I think he believed that, unless all the deaths showed a clear pattern of the features described by the undertaker, there was no evidence within them to support Dr Reynolds' concerns. Probably, he had conveyed that view to Mrs Parkinson, who had passed it on to Dr Banks. I do not think that, at the time of making his request, DI Smith had realised that it might be possible to form a view about whether the cause of death certified was consistent with the medical history revealed by the records. It may well be that he realised that during his meeting with Dr Banks. He was certainly aware of it when he wrote his first report of his investigation on 17th August 1998.
- 9.16 In my view, Dr Banks did not clarify his instructions from DI Smith because he believed that he knew what he was looking for, namely a clear pattern of similar features present in all the deaths. I accept, however, that he also had in mind the question of consistency between the medical history and the cause of death, as revealed in the records.
- 9.17 I find that Dr Banks began the meeting by explaining the nature of the medical records and the type of material they contained. I think he probably explained the importance of confidentiality and the reasons why he could not release the records to the police. I think it likely that, although Dr Banks was concerned about the confidentiality of the material within the chart, he allowed DI Smith to look at it while he was explaining his findings. However, I do not think that the question ever arose of DI Smith taking the chart away.
- 9.18 There is a conflict as to whether Dr Banks went through the chart case by case, as he said, or whether he discussed the cases only in a general way, as DI Smith claimed. I find that there was some discussion of the individual cases. I say that mainly because it is clear that DI Smith was able to remember some details of one case when he spoke to Detective Superintendent Ellis in April 2000, which he could not have known from anywhere else. However, I do not think the cases were discussed in depth. Nor do I think that there was any discussion about the presence of common features; rather the emphasis must have been on the absence of common features. I find that the gist of Dr Banks' opinion was very much what he had said to Mrs Parkinson on 27th March, which she had recorded in her note. This was that there was no clear pattern of features to be seen within the records. I am satisfied that Dr Banks did not draw attention to the fact that his chart revealed

that all but one of the deceased were female, that all but two (Mrs Norah Nuttall and Mrs Bianca Pomfret) were over 65 and that all but one had, on the face of the records, died at home. In fact two had died in institutions. I am sure that he did not draw attention to the fact that, according to the chart, Shipman appeared to have been present at or about the time of the death in no fewer than ten of the 14 cases. These were features that bore some relation to Dr Reynolds' concerns and, had they been mentioned, might have raised DI Smith's level of concern.

- 9.19 I am satisfied that Dr Banks told DI Smith that there were two or 'a few' deaths in which he considered that there was insufficient information in the records to enable a proper diagnosis of the cause of death to be made. He also said that he would have referred those deaths to the coroner. I do not think he said that any reasonable doctor would have referred those cases or implied that there was anything suspicious about Shipman's failure to do so. I accept that he mentioned that many of the records were computerised and that the available fields were limited. I think this was probably said in the context of providing an explanation as to why there was such limited information in the records. The implication was that more might be available if access were gained to the computer and that there might then be enough information to diagnose death. In other words, there was a potentially innocent explanation for the shortage of information in the two or 'few' cases.
- 9.20 I accept that there was some general discussion about Shipman and his reputation. I think it likely that Dr Banks revealed that he knew Shipman and respected him. I do not think it occurred to either man that Dr Banks' knowledge of and respect for Shipman rendered him unsuitable as an examiner of Shipman's records. Dr Banks found it virtually unthinkable that any doctor would deliberately harm his patients. It would be even more difficult for him to open his mind to that possibility in relation to a doctor whom he knew and respected.
- 9.21 I am satisfied that the overall impression created by Dr Banks must have been one of reassurance. Had it not been, Mrs Parkinson would have been quick to pick up any hint that her mother might be in danger from Shipman.
- 9.22 At the meeting, there was no discussion of the death rate among Shipman's patients as compared with those at the Brooke Practice. I think there must have been some brief discussion of numbers, which led to the request for the practice population information. I do not think that there was any discussion of that topic after the information had been obtained. There should have been discussion of the numbers recorded by Mrs Parkinson, which came from Dr Reynolds, and also about the comparative death rates in the two practices. DI Smith did not tell Dr Banks about the comparative figures because he did not understand them or their importance. Dr Banks did not pursue any question of the death rates because, rather surprisingly for a doctor in his position, he did not know the annual crude death rate for patients in UK general practice and the number of deaths recorded by Mrs Parkinson did not strike him as particularly high. I think it likely that Dr Banks said as much to DI Smith and further reduced his already low level of concern about the death rate. As I am satisfied that Dr Banks knew the nature of the concerns under investigation, I consider that he should have made it his business to find out the average death rate. This could easily have been discovered from Dr Friedman, the Director of Public Health Medicine, who would have realised immediately that the figures for Shipman's cremations mentioned by Dr Reynolds appeared unusually high.

- 9.23 I am also satisfied that Dr Banks did not explain to DI Smith that it was most unusual for one general practitioner to make any complaint about the conduct of another, let alone a complaint of so serious a nature as this one. Dr Friedman told the Inquiry that such concerns or complaints are very rare and I did not understand Dr Banks to disagree. I think that Dr Banks dismissed this expression of concern, made by one doctor about another, as malicious without any real basis for that belief.

The Adequacy of Dr Banks' Review of the Medical Records

- 9.24 In Chapter Fifteen, I shall consider in some detail the adequacy of Dr Banks' review of the medical records and the advice that he gave to DI Smith. At this stage, it must suffice to say that I shall conclude that he failed to notice or to advise DI Smith that there were at least four cases out of the 14 in which the circumstances revealed by the records made it mandatory that the deaths be reported to the coroner. I shall find also that there were at least five other cases where it was not clear whether a duty to report to the coroner arose. Those five, taken in conjunction with the four cases where a report was mandatory, should have raised Dr Banks' level of concern about Shipman's reporting practices. Further, Dr Banks should have noticed, but apparently did not, that certain of the features which had given rise to Dr Reynolds' concerns were present in some of the cases. I have concluded that Dr Banks' review of the records was defective because his mind was not open to the possibility that Shipman might be harming his patients. His approach was to seek for and find an innocent explanation for everything he saw.

The Outcome of the Meeting

- 9.25 As a result of what Dr Banks had told him, DI Smith left the meeting believing that there was nothing in the medical records that in any way substantiated Dr Reynolds' concerns. Dr Banks had given the impression that the records contained nothing to suggest an abnormal pattern of deaths. However, DI Smith was not entitled to deduce that Dr Banks' opinion amounted to positive evidence that Dr Reynolds' concerns were unfounded. All Dr Banks was able to say was that there was no evidence in the records to support suspicion, which is very different from saying that there was positive evidence that all was well. A moment's thought would suggest that, if Shipman were killing his patients, one would not expect there to be overt evidence of it within the medical records, which, of course, he compiled and kept. One would expect any misconduct to be concealed.
- 9.26 DI Smith appears to have placed a great deal of reliance on Dr Banks' opinion of the records. Chief Superintendent Sykes said that he had the impression that, when DI Smith had received a negative response from Dr Banks, he had virtually reached the end of the investigation. Indeed, DI Smith said so himself in his first Inquiry statement, although in oral evidence he denied that it was the case.
- 9.27 I am satisfied that, to all intents and purposes, the receipt of Dr Banks' opinion on 1st April marked the end of this investigation. By that time, DI Smith was convinced that there was nothing in Dr Reynolds' concerns. However, he still had it in mind to visit the crematorium, to find out what proportion of Shipman's deceased patients had been cremated, and to

identify the still unknown female undertaker. I am satisfied that he did not expect those enquiries to yield any evidence to support Dr Reynolds' concerns.

Later Developments

- 9.28 As a postscript to this aspect of the evidence, it appears that, at some time after this meeting had taken place, Dr Banks received the medical records of Mr Harold Eddleston, a patient of Shipman, who had died on 4th March 1998. Dr Banks reviewed them (he says in much the same way as he had reviewed the others) and prepared a memorandum of his findings, dated 6th April. The circumstances of Mr Eddleston's death are to be found in Volume Four of my First Report. I found that Shipman killed Mr Eddleston only a few days after he had been accepted onto Shipman's patient list. Dr Banks was of the view that it was unusual for a patient to change his general practitioner so soon before his death, as Mr Eddleston had done. Dr Banks was also rather confused by the entry for the day of the death. He noted that it appeared that Shipman had seen the patient at some time and that the body was found in the afternoon by Mr Eddleston's grandson. Mr Eddleston's daughter had seen him alive at 12.30pm and Shipman had certified the cause of death at 3.40pm.
- 9.29 It appears that Dr Banks was prepared to have the information contained in the memorandum imparted to DI Smith. It is not clear when Mrs Parkinson first tried to contact DI Smith to pass it on. Certainly, she had not succeeded in speaking to him at the time when the investigation was closed on 17th April. She made a note that she had telephoned him on 20th April: see Appendix C. At that time, DI Smith was on leave. He returned to duty on 2nd May but did not contact her. She tried again on 15th May, and left a message asking him to telephone her. DI Smith finally telephoned her on 21st May and told her that he had spoken to the Coroner and that the matter was not going to be pursued further. Mrs Parkinson told Dr Banks and made a note to the effect that Dr Banks was **'happy for matter to be closed'**.
- 9.30 Dr Banks told the Inquiry that he was left with general, non-specific concerns about Shipman's practice. He said that he decided that he would take the opportunity to discuss these concerns with Shipman on 27th July 1998, when he was to carry out a routine prescribing visit. He said that, on that occasion, Shipman himself raised the topic and told him that he had noticed an excess of deaths in the practice during the first quarter of 1998. Shipman said that, with the assistance of his practice nurse, Sister Gillian Morgan, he had undertaken an audit of the deaths and was satisfied that all appropriate care had been given. The Inquiry has been unable to discover any evidence that such an audit was carried out and Sister Morgan and other members of the practice staff have denied all knowledge of it. Dr Banks said that he advised Shipman that the Health Authority had become aware of these deaths and that he personally had reviewed some of the records. He advised Shipman that he should send more deaths for autopsy as, where numbers of deaths seemed excessive, it was wise to obtain confirmation of the cause of death. Dr Banks said that Shipman did not seem surprised to hear that he had examined the records; he was pleasant and was more amenable than usual to suggestions for changes in his prescribing practice.
- 9.31 It appears to me that Shipman had become aware that the excess deaths in his practice had been noticed and was anxious to allay any concerns that might persist.

CHAPTER TEN

Detective Inspector Smith's Visit to the Crematorium

The Purpose of the Visit

- 10.1 On his return from Selbourne House on 1st April 1998, Detective Inspector Smith telephoned Dukinfield crematorium and arranged to visit, probably that afternoon. He told the Inquiry that his purpose in so doing was to find out whether the proportion of cremations to burials among Shipman's patients was normal. He also wished to identify the female undertaker of whom Dr Reynolds had spoken.
- 10.2 DI Smith's interest in the proportion of cremations to burials was based on a misunderstanding of Dr Reynolds' concerns. He had somehow gained the impression that it was a cause of concern that a greater proportion of Shipman's patients was being cremated than was normal and that Shipman might, in some way, be influencing the choice of the method of disposal of the bodies of his victims in order to destroy evidence of wrongdoing. He said that he was puzzled by this supposed concern, as he could not understand how a doctor would be able to influence the relatives in favour of cremation rather than burial. He accepted that Dr Reynolds could not have told him of concerns about an abnormal proportion of cremations, as she would not have known how many of Shipman's patients had been buried; she only knew that there were a lot of cremations. It is theoretically possible that Dr Reynolds told DI Smith that Mrs Bambroffe was concerned about the proportion of cremations among Shipman's patients. However, there is no evidence that she did and no evidence that this had ever been one of Mrs Bambroffe's concerns. Although he was puzzled by the nature of this supposed concern, DI Smith did not speak to anyone in an attempt to clarify his confusion. It seems likely that Dr Reynolds told him she was concerned about the number of cremations and DI Smith assumed that she meant cremations, as opposed to burials, not appreciating that the Brooke Practice doctors were only involved in the cremations and not the burials.

The Visit

- 10.3 On his arrival at the crematorium, DI Smith met the Senior Registrar, Mr Michael Gurney. Mr Gurney said that DI Smith was accompanied by another police officer. DI Smith said he was alone. I am unable to say who is right.
- 10.4 DI Smith said that he did not tell Mr Gurney the precise nature of his enquiries; he did not mention that they were connected with Shipman, although he made it clear that he was engaged in a confidential investigation. He believed that he might have told Mr Gurney that the Coroner was involved. He had with him his bundle of copy death certificates from the register office. He did not take his spreadsheet with him. He wanted to find out which of the deceased of whom he knew appeared in the cremation register. Those who did not appear must have been buried. Mr Gurney told him that, in general, about 70% of deaths were followed by cremation. DI Smith also wanted to find out the name of the funeral director in each case.
- 10.5 DI Smith did not ask Mr Gurney to explain what records he held or what information they contained. Had he done so, he would have learned that, apart from the cremation register,

the crematorium retained the bundle of certificates relating to each individual cremation. These contained useful information about the circumstances of the death. Nor did DI Smith ask whether there were any limitations on what he would be allowed to see. Had he done so, he would have been told that, as a senior police officer, he would be given access to the register and the individual bundles.

- 10.6 Details of all cremations are recorded in the register, which is a very large book in which the columns of information are spread across double pages. On the left, the register records a cremation number, the date of cremation, the name, residence and occupation of the deceased, the age and sex and marital status of the deceased and the date of death. On the right, the columns provide for the name and address of the person who applied for the cremation, the names and addresses of the doctors who signed Forms B and C (or the identity of the coroner who permitted disposal of the body), the district where the death was registered, the signature of the minister who officiated at the service and the method of disposal of the ashes. The register does not (or did not in 1998) include the name of the funeral director.
- 10.7 In evidence, DI Smith and Mr Gurney disagreed as to how information was extracted from the register for DI Smith. Mr Gurney said that he gave the register to DI Smith and his colleague and left them to take such information as they wanted. DI Smith said that he did not look at the register, but sat opposite Mr Gurney, who had the register before him. He called out the names from his bundle of copy death certificates and Mr Gurney looked in the register and gave him the information. DI Smith entered the information in his daybook. The list of names can be seen at Appendix A. The list comprises 20 names and includes that of Miss Ada Warburton. Seventeen of the 20 deaths were followed by cremation. It is clear that Mr Gurney found and provided information about the three deaths on the list where the bodies were buried. Mr Gurney was also the Senior Registrar in charge of the eight cemeteries in the area and the interment forms were kept at the Dukinfield crematorium.
- 10.8 The names of the funeral directors who dealt with the 20 deaths are also included on DI Smith's list. These could not have been found in the register. To find them, someone must have recovered the relevant bundles of cremation certificates, filed in another part of the building. Neither man could recall how or by whom this was done. However, this operation must have taken an appreciable length of time.

A Lost Opportunity

- 10.9 On examining the cremation register, it became clear that, if DI Smith had looked at the register himself, he should have noticed that there were more deaths among Shipman's patients than he had been made aware of. That was because some of the entries relating to the deceased about whom DI Smith knew were adjacent to other entries which also contained Shipman's name as the Form B doctor. If DI Smith had noticed these other entries, he might then have realised that the information he had been given by the register office was incomplete. On the other hand, if Mr Gurney were looking at the register, he would not be looking out for other Shipman deaths, as he did not know that the enquiries related to the deaths of Shipman's patients. If it were the case that DI Smith was

accompanied by a junior officer, as recalled by Mr Gurney, it is possible that that officer looked at the register and either did not realise that he should look for other entries relating to Shipman or did realise that but failed to see any.

- 10.10 I am not sure who examined the register but I think that DI Smith's recollection is more likely to be accurate. Mr Gurney is plainly a completely honest witness. However, he was present on other occasions later in the year when the police examined the cremation registers. There is a real possibility that he has confused the occasions. DI Smith, on the other hand, only went to the crematorium once. I accept therefore that DI Smith probably did not look at the register himself, although I think he should have done. I think it likely that he told Mr Gurney the names of the deceased and Mr Gurney provided the limited information requested. Mr Gurney never realised that DI Smith was interested in all deaths of Shipman's patients where Shipman was the certifying (Form B) doctor. That is not a criticism. Mr Gurney was complying with a specific request for information and it was not for him to think about what other information he might be able to supply, unless requested to do so.
- 10.11 Unfortunately, DI Smith was thinking only about obtaining the limited information he had set out to find. He believed that his bundle of copy death certificates was complete even though, if it were, it would follow that Dr Reynolds' figures were almost certainly wrong. Had his mind been open to the possibility that he might learn more about the deaths of Shipman's patients than whether they were buried or cremated, he could have compiled a list of all the cremations within a six-month period for which Shipman had completed Form B. Had he done that (with or without Mr Gurney's help), he would have found details of all the deaths previously missed at the register office since, as it happened, every one of the patients of whose deaths he was unaware had been cremated. In the event, because DI Smith did not ask for a general trawl of the register for deaths in which Shipman had signed Form B (or examine the register himself), another opportunity to discover the error made by the register office was lost.
- 10.12 If DI Smith had asked, he would have been shown the bundle of certificates for each cremation. These would have included the Forms B, completed by Shipman, which contained a great deal of information about the deaths. Examination of the cremation forms relating to the deaths of which DI Smith was by this time aware would have revealed that Shipman had, on his own account, been present at one death and had visited seven of the patients within a period of four hours or less before the death occurred. DI Smith would have seen that seven of the patients were said to have died alone. This information would have provided some evidence of an unusual pattern among the deaths. Because DI Smith never found out how the cremation certification system worked (by asking Dr Reynolds or Mr Gurney or both), he did not realise what he was missing. The crematorium was a valuable source of information about the individual deaths under investigation. The opportunity to tap that source was missed.
- 10.13 Another consequence of DI Smith's failure to ask about the system of cremation certification was that he failed to discover the existence of the medical referee. Had he been asked how the system worked, Mr Gurney would have explained that, before a cremation is authorised, the forms supporting the application for cremation must be

examined by the medical referee, a doctor employed at the crematorium. The law requires that the medical referee should consider whether the fact and cause of death have been definitely ascertained and whether the death might be due to a non-natural cause, such as violence. A medical referee has power to require an autopsy, to decline to allow a cremation without an inquest and even to decline to allow a cremation without stating any reasons. By failing to ask about the system, DI Smith lost the opportunity to interview the Medical Referee at the Dukinfield crematorium, Dr Betty Hinchliffe, or her deputy. An interview with Dr Hinchliffe would not have breached the requirement of confidentiality. As it happens, had DI Smith spoken to Dr Hinchliffe, he would have received an assurance that Shipman always completed his Forms B satisfactorily and that his deaths gave rise to no ground for suspicion. Only if the records held by the crematorium had been analysed would it have been found that, for several years, Shipman had consistently completed more Forms B than any other general practitioner in the area. The unusual features of many of the deaths would also have been noticed; for example, that Shipman was often present when the death occurred or had been present very shortly before it was discovered.

The Results of the Visit

- 10.14 It will be seen from the list in DI Smith's daybook that the firm of Masseys had arranged the funerals for no fewer than nine of the 20 deceased persons on the list. Below the list, DI Smith has written the name '**Debbie Massey**'. At this time, although Mrs Bambroffe was married, many people still called her by her maiden name. DI Smith said that, having noticed how frequently the name 'Masseys' recurred in the list which he had compiled, he concluded that Mrs Bambroffe must be the female undertaker who had expressed concern about the deaths of Shipman's patients. In that he was right. However, he made no attempt to contact Mrs Bambroffe until two weeks later, on 15th April.
- 10.15 In Chapter Three, I drew attention to the list of four funeral directors and their telephone numbers which DI Smith had, at some stage, written on the left-hand page of his daybook, opposite the information recorded during his meeting with the Coroner. It is not absolutely clear when that information was recorded, although, as I observed in Chapter Three, the circumstances suggest that DI Smith obtained it before his visit to the crematorium. Bearing in mind the mistake in the name of Robinson and Jordan, which appears to have originated from the Brooke Practice record, it seems to me that it is more likely that DI Smith obtained this information at or shortly after leaving the Brooke Practice Surgery than from the crematorium. It seems likely that DI Smith took down the names of four funeral directors while speaking to Dr Reynolds and, at some time later, copied the four names onto the opposite page and added the telephone numbers. Whenever he obtained them, it appears that the only one he used was that of Masseys.
- 10.16 DI Smith had found that the deaths of 85% of Shipman's patients had been followed by cremation and only 15% by burial. This was higher than the 70% average suggested by Mr Gurney. However, he did not regard that as a suspicious factor and no one has suggested that it was. It may be that the fact that not every one of Shipman's patients had been cremated added to DI Smith's feeling that there was nothing amiss. The fact is that the exercise was misconceived, as the proportion of cremations had never been a cause for concern.

10.17 As I have said, this visit was a missed opportunity to find out a great deal of information about the deaths of Shipman's patients.

Postscript

10.18 After his visit to the crematorium, DI Smith entered the information he had acquired there on his computer spreadsheet: see Appendix B. The spreadsheet records 19 deaths, the last of which is that of Mrs Lily Higgins. The name, address, cause of death, age, dates of birth and death and gender of the deceased noted on the spreadsheet would all have been ascertainable from the copy death certificates; the information about funeral directors and whether the deceased was buried or cremated came from the crematorium. The column headed **'Found By'** has not been completed. As I have noted, the spreadsheet does not include any information about Miss Ada Warburton, although her name does appear on the list compiled by DI Smith at the crematorium. It appears to me that DI Smith began work on the spreadsheet before his visit to the crematorium and that the information about the funeral directors and the method of disposal was added afterwards. As I have already observed, it does not appear that DI Smith added any information obtained from Dr Banks. All the other versions of the spreadsheet contain columns and information added during the second police investigation which began in July 1998.

CHAPTER ELEVEN

Detective Inspector Smith's Knowledge of the Death of Miss Ada Warburton

The Question to be Determined

- 11.1 In Chapters Three and Five, I referred to the issue of when Detective Inspector Smith first found out about the death of Miss Ada Warburton. It will be recalled that DI Smith had denied the suggestion, put to him by Leading Counsel to the Inquiry, that Dr Reynolds told him about that death during their meeting on 24th March 1998, in the context of a discussion about bodies that were available for autopsy.
- 11.2 Until shortly before he gave oral evidence to the Inquiry, DI Smith had always said that he had received from the register office a total of 19 copy death certificates on two separate occasions; that number would not include the certificate relating to Miss Warburton. Miss Warburton's name appeared twice in DI Smith's daybook: see Appendix A. It first appears on the page on which he set out the information which he had gathered in the early stages of his investigation. It then appears in the list of names compiled by DI Smith at the Dukinfield crematorium. The question therefore arose as to the source from which DI Smith had obtained Miss Warburton's name.
- 11.3 DI Smith offered no answer to this question until shortly before he gave evidence. In a statement signed on 27th May 2002, the day on which he began his oral evidence, he alleged that he had learned of Miss Warburton's death by receiving her copy death certificate from Mr Loader on the morning of 26th March 1998. He then said, for the first time, that he recalled receiving 20 copy death certificates (including hers) on that one occasion. DI Smith's explanation for his recent change of evidence was that the hearing of evidence given at the Inquiry had jogged his memory. He had recently been able to think afresh about past events and this had resulted in a genuine change of recollection.

The Evidence

- 11.4 I have already said in Chapter Three that the evidence suggesting that DI Smith learned of Miss Warburton's death from Dr Reynolds is strong. Miss Warburton's name appears on the page of his daybook that contains information he acquired in the early stages of his investigation. Also, it appears that, on 30th March, Dr Reynolds told Dr Gough of the MDU that it was intended to proceed with an autopsy on the body of the patient she had identified. Dr Reynolds must have gathered that impression from somewhere and I concluded that she had probably gathered it from DI Smith. This suggests that there must have been a discussion about bodies (or at least one body) available for autopsy. In addition, Miss Warburton's name and details appear on the note written by Dr Reynolds, which I have previously referred to and which I believe she had with her when she saw DI Smith. It is likely that she would have mentioned to him the information contained in the note.
- 11.5 I have mentioned that, shortly after he received the bundle of copy death certificates from Mr Loader, DI Smith created a spreadsheet containing the names of the deceased

patients of which he was aware. The first available version of that spreadsheet (and the only one which came into existence during the first police investigation) is at Appendix B. Miss Warburton's name is not included. The list of names, which is in chronological order by date of death, ends with Mrs Lily Higgins, who died before Miss Warburton. DI Smith could not explain why, if he had received her copy death certificate from Mr Loader, he did not insert Miss Warburton's name in the chart with all the others.

- 11.6 Miss Warburton's name did not appear on the list of names that DI Smith gave to Mrs Parkinson on 26th March. Since the list was compiled by reference to the copy death certificates which he had in his possession on that day, the most likely explanation for the omission is that he did not have Miss Warburton's certificate, because Mr Loader had not provided it. DI Smith has recently suggested that Miss Warburton's name was omitted from Mrs Parkinson's list because it was decided between him, Mrs Parkinson and Dr Bradshaw that there was no point in including Miss Warburton's name; she had died so recently that her medical records would not be available for some time. I reject that explanation for several reasons. First, Mrs Parkinson said that she could not recall any such conversation. Second, the explanation makes no sense, as the name of Mrs Higgins, who died only three days before Miss Warburton, was included on the list. In any event, there is no reason to suppose that medical records came back to the Health Authority in strictly chronological order of death and Mrs Parkinson told the Inquiry that she was not herself familiar with the procedures for the return of medical records. Thus, it is unlikely that she would have proffered any view about the probable length of any delay in obtaining the records. Finally, DI Smith could not possibly have known, on 26th March, how long his investigation was likely to last; a decision to put Miss Warburton's name on the list, with a view to her records being obtained when available, would have made sense; a decision not to put her name on the list would not. In my view, it is far more likely that, on 26th March, DI Smith did not have Miss Warburton's copy death certificate and had forgotten that he had been told about her death on the previous day and had noted it in his daybook.
- 11.7 So far, all the evidence suggests that DI Smith did not learn of Miss Warburton's death by receiving the copy death certificate from Mr Loader. What about the possibility that he first learned of it from Mr Gurney on 1st April? Miss Warburton's name does appear on the list of 20 names that DI Smith made in his daybook while at the crematorium on 1st April. But that only shows that he knew of it by that date; it does not show that he learned of it for the first time on that date. His own evidence and that of Mr Gurney was that there was no general trawl through the register to find deaths for which Shipman had signed Forms B. DI Smith had asked only about deaths of which he was already aware. Had there been a trawl, Miss Warburton's name would have been found, but so also would the other Shipman deaths of which he remained ignorant throughout his investigation. So, if DI Smith did indeed learn of Miss Warburton's death at the crematorium, it appears that her death (but not all the other 'missing' deaths) must have been mentioned while he was there. If Miss Warburton's name were first mentioned by Mr Gurney because he had noticed it in the register and if it were new to DI Smith, one might have expected DI Smith to ask whether there were other names of which he was not aware. One might also have expected him to add Miss Warburton's name to his spreadsheet on his return to the police station. He did not do so, although he did insert other information that he had obtained from Mr Gurney.

- 11.8 The other possibility, put to him by Leading Counsel to the Inquiry, was that DI Smith had asked Mr Gurney about Miss Warburton because, while using his daybook at the crematorium, he had noticed her name on an earlier page (where, Leading Counsel suggested, it had been since the meeting with Dr Reynolds). DI Smith denied this suggestion. His explanation for the presence of Miss Warburton's name on the earlier page of his daybook was that he had noted it there, together with the name of Mrs Higgins and their funeral directors, while at the crematorium. He had done so, because he was thinking of contacting the funeral directors to ask for details of those two deaths.
- 11.9 I find that explanation implausible. First, it is difficult to see why DI Smith should have gone back to an earlier page of the daybook from that which he was using at the crematorium. Second, he did not in fact go on to make any further enquiries of the funeral directors and, by 1st April, the date of his visit to the crematorium, it is plain, as I shall explain later, that his investigation was virtually at an end. Third, the notes on the earlier page of his daybook record that both Miss Warburton and Mrs Higgins died of a **'stroke'**. That was not information available from the crematorium. Unless DI Smith had been told by someone of the cause of death, he would have had to get that information from the copy death certificates. Both certificates gave the cause of death as **'cerebrovascular accident'**. It is likely that, if DI Smith had obtained the information from the certificates, he would have noted the cause of death as 'cerebrovascular accident' in each case. Indeed, I do not think he knew that the term 'cerebrovascular accident' had the same meaning as 'stroke'. I reject DI Smith's explanation and think that Counsel's suggestion is far more likely.

Conclusion

- 11.10 All the evidence suggests that DI Smith first learned about the death of Miss Warburton in conversation with Dr Reynolds. That is my conclusion. That being so, it is my view that DI Smith ought to have investigated with the Coroner the possibility of an autopsy of her body, as well as that of Mrs Higgins. I cannot be certain that Mr Pollard would have agreed to that course, although I think it likely that he would. Nor can I be certain that Mr Pollard would have directed that toxicological tests should be performed. A routine coroner's autopsy might well have uncovered the presence of some natural disease that could account for Miss Warburton's death. However, if Mr Pollard had spoken to Dr Reynolds before ordering an autopsy, it seems likely that she would have expressed her belief that, if Shipman were killing his patients, he was doing it by giving them a drug of some sort. If DI Smith had had a full conversation with Mr Pollard, he should have passed on Dr Reynolds' view about the likely means of killing. On balance, I think it likely that Mr Pollard would have ordered an autopsy with toxicology and that morphine would have been detected in Miss Warburton's body. If a similar examination had been carried out on the body of Mrs Higgins, morphine would have been found there too.
- 11.11 It remains to consider whether DI Smith was acting in good faith when giving evidence about the circumstances in which he first learned of the death of Miss Warburton. I have already drawn attention to the possibility that he denied receiving the information from Dr Reynolds because he wished to avoid criticism for failing to arrange an autopsy. I must also consider why he changed his account shortly before giving evidence.

- 11.12 The report of Detective Chief Superintendent Stelfox, of the GMP, who undertook a review of the March 1998 police investigation between 23rd April and 15th May 2002, raised the question of how the names of Mrs Higgins and Miss Warburton came to be written on the page of DI Smith's daybook on which he had recorded information obtained in the early stages of his investigation. DCS Stelfox also pointed out that, if, whilst at the crematorium, DI Smith learned of additional deaths over and above those of which he was already aware, this new information should have alerted him to the possibility that his bundle of copy death certificates was incomplete. DCS Stelfox further pointed out that these were issues which were likely to be raised at the Inquiry. DCS Stelfox's report became available on 15th May, very shortly before DI Smith claimed that he had received Miss Warburton's copy death certificate from Mr Loader with the others, making 20 certificates in all.
- 11.13 It appears to me that there must be a connection between the completion of DCS Stelfox's report on 15th May and the change in DI Smith's account, communicated to the Inquiry in a statement signed on 27th May. It seems likely that, when DI Smith realised that he would have to explain the source of his information about the death of Miss Warburton, he sought to do so by claiming that he remembered that he had received 20 certificates from Mr Loader, including Miss Warburton's.
- 11.14 I have given careful consideration to the question of whether or not this change of tack was the result of a genuine process of recollection and deduction. It is natural that DI Smith should wish to avoid criticism. If the production of evidence by the Inquiry, including DCS Stelfox's report, enabled DI Smith genuinely to remember or work out what had happened, he would be right to put forward those fresh thoughts and recollections and I would not criticise him for changing his evidence. I regret to say, however, on considering the matter in the light of all the evidence, that I have been driven to the conclusion that DI Smith changed his evidence without any honest belief in its accuracy. I do not accept that his memory has been jogged or refreshed by the production of evidence. I think it far more likely that he changed it when he realised that he had to produce an explanation which, if accepted, would account for his knowing of Miss Warburton's death.

CHAPTER TWELVE

Mr Alan Massey Visits Shipman

Background

- 12.1 During and after the police investigation, members of the Brooke Practice noticed that the numbers of cremation Forms C which they were asked to sign by Shipman reduced markedly. In the three months from April to June, they signed only two Forms C whereas, by contrast, they had been asked to complete 15 such forms during the previous three months. Neither of the deaths in respect of which they were asked to sign Forms C aroused any suspicion in their minds and, indeed, following investigation of those two deaths by the Inquiry, both were found to be natural. In addition to those two deaths, there were four further deaths during the three months from the beginning of April to the end of June 1998, all of which were followed by burials. Three of those deaths – those of Mrs Winifred Mellor, Mrs Joan Melia and Mrs Kathleen Grundy – were the subject of convictions at the criminal trial.
- 12.2 Dr Reynolds believed that the reduction in the number of cremations had occurred because Shipman had learned of the police investigation. After Shipman's conviction, there was some speculation in the newspapers about the possibility that Shipman had been 'tipped off' about the first police investigation. Some suspicion fell upon the GMP. However, once the Inquiry began its investigations, another possibility arose, namely that Shipman had been (intentionally or unintentionally) alerted to the danger of discovery by a visit from Mr Alan Massey, the funeral director.
- 12.3 Before the Inquiry started, it had been widely reported that, because of his concerns at the number of deaths of Shipman's patients which had occurred and the circumstances of those deaths, Mr Massey (who was not himself a patient of Shipman) had visited Shipman by appointment at his surgery in order to seek an explanation. That visit was said to have taken place towards the end of 1997. When Mr Massey provided a statement to the Inquiry, he said that he could not recall when he had his meeting with Shipman. A search of the Market Street Surgery appointments sheets for 1997 and the early part of 1998 revealed no record of an appointment for Mr Massey. However, an appointment was found for noon on 2nd April 1998. This was during the first police investigation. In due course, Mr Massey accepted that that must have been the date of his visit.
- 12.4 It is clear beyond doubt that, when he visited, Mr Massey said something to Shipman about the deaths of his patients. Mr Massey has vehemently denied the suggestion that he went to give Shipman a 'tip off' about the police investigation. He asserted that, at the time he saw Shipman, he was unaware that a police investigation was in progress.
- 12.5 The Inquiry has sought to discover what Mr Massey knew at the time of his visit, why he went and what he said to Shipman. Before considering the evidence on those topics, it is necessary to say something about the Massey family.

The Massey Family

- 12.6 The firm of Frank Massey and Son, Funeral Directors, of Hyde (described in this Report as 'Masseys') was started in 1903 by Mr Alan Massey's grandfather and great-uncle. It

passed to Mr Massey's father, who in turn passed it to him. Mr Massey has worked in the business since the age of 15. In recent years, he has taken a less prominent role and day-to-day control of the business has been exercised by his daughter, Mrs Bambroffe. Mrs Bambroffe's husband, David, has also worked in the business for about ten years. The business is successful and the family is justly proud of it. Both business and family enjoy a high reputation in the Hyde area.

- 12.7 For many years before Shipman's arrest, the Massey family had held Shipman in high regard. The family might not have been aware of the fact, but it has clearly emerged in evidence before the Inquiry that Shipman also had a high regard for them. If the family of a deceased patient did not have in mind a particular funeral director, Shipman would suggest that Masseys should be instructed. The firm dealt with the deaths of many of Shipman's patients and it was inevitable that there would be quite frequent professional contact between Shipman and the Massey family. This association did not extend to friendship or any sort of social contact. When the family's general practitioner had retired in 1994, Mrs Bambroffe, her husband and mother transferred to Shipman's list. Mrs Bambroffe said that they did so as he seemed so caring and was such a nice person. During the years that followed, they were entirely satisfied with the care that he gave them.

The Origin of the Concerns about Shipman

- 12.8 It was Mr Bambroffe who first began to notice odd features about the deaths of Shipman's patients. He began to recognise a 'Shipman death', even before he knew that Shipman was the deceased's doctor. He noticed that the deceased were often sitting up dressed in their day clothes and showed no sign of having been ill. He and his wife discussed these concerns and they began to notice other strange features; they realised that Shipman often seemed to be present at or about the time of the death. In due course, Mr and Mrs Bambroffe mentioned these matters to Mr and Mrs Massey. Mr Massey did not share their anxiety. He had every confidence in Shipman.
- 12.9 As I have mentioned earlier, the time came when Mrs Bambroffe mentioned her concerns to Dr Booth of the Brooke Practice, on 23rd February 1998. Dr Booth discussed those concerns with some of her partners, including Dr MacGillivray. Not long afterwards, Dr MacGillivray visited Masseys' premises and took the opportunity to raise the subject with Mr Massey. The gist of what he said was that there was no need to worry about the deaths of Shipman's patients. Shipman had a large list of elderly patients; he liked to keep his elderly patients at home rather than admit them to hospital and he visited them much more frequently than other doctors. These factors would account for the large number of deaths and Shipman's presence at or about the time of death. In his Inquiry statement made in January 2002, Mr Massey claimed that he had not felt reassured by Dr MacGillivray's words and therefore decided to visit Shipman. I am sure he is wrong about his reaction to Dr MacGillivray and about the timing of his decision to visit Shipman. I am sure that, at the time, Mr Massey was not worried about Shipman and merely passed on the reassurance to his daughter and son-in-law. He did not visit Shipman at that point.

Mr Massey's State of Mind in March 1998

- 12.10 Mr Massey claimed that, in March 1998, he too began to have concerns about the deaths of Shipman's patients. He said that his concerns were aroused by the death of

Mrs Margaret Waldron, who died on 6th March. She was a friend of the Massey family. [My finding in respect of Mrs Waldron's death is set out in Volume Six of my First Report. I found that Shipman killed her.] Mr Massey explained why he had been suspicious about the circumstances of her death. However, his recollections bear little relation to the true circumstances of the death and what he recalled did not appear to me to form a basis for reasonable suspicion. I accept without hesitation that Mr Massey was shocked and distressed to learn of Mrs Waldron's death but I do not accept that he harboured any concerns that her death might not have been natural or might be in any way associated with Shipman. The first time he mentioned any such concern was when he gave oral evidence to the Inquiry. He had failed to mention it in his written statements. Mr and Mrs Bambroffe had no recollection of him expressing any such concern. Mrs Bambroffe said that there was no discussion about this death in particular. She recalled that the death was quite sudden although Mrs Waldron had 'been to see the doctor beforehand'. In my judgement, Mr Massey did not share the concerns of his daughter and son-in-law in March 1998. In rejecting Mr Massey's evidence on this point, I do not wish to suggest that he has attempted to deceive or mislead the Inquiry. I think that now, with the benefit of hindsight, he finds it hard to believe that he did not share the concerns of his daughter and son-in-law. He has persuaded himself that he did.

- 12.11 That is how things stood on 13th March 1998, when Mr and Mrs Massey went away on holiday for two weeks. They were away until 28th March. It was during this period that Dr Reynolds and the other Brooke Practice doctors decided to report their concerns about Shipman to the Coroner and the police investigation began.

Mr Massey Decides to Visit Shipman

- 12.12 I have already referred to the various contacts made between Mrs Bambroffe and Dr Reynolds and Dr Booth. The evidence about those contacts is not entirely clear. What is clear, however, is that Dr Reynolds spoke to Mrs Bambroffe at 2.41pm on Tuesday, 24th March, at a time when Dr Reynolds had already made her report to the Coroner and was awaiting a visit from DI Smith. In evidence, Mrs Bambroffe said that Dr Reynolds told her either that she was about to make a report to the Coroner or that she had already done so. Bearing in mind the timing of this conversation, I am satisfied that Dr Reynolds said that she had made a report to the Coroner. I think it likely that she also said that the police had become involved. Even if she did not, this does not matter, as Mrs Bambroffe said that she realised that, if the Coroner had been informed, the police also might well be involved.
- 12.13 Mrs Bambroffe said that, when her father returned from holiday on 28th March, she told him of the developments in the Shipman matter. I think she would have told him by Monday, 30th March, at the latest. Mr Massey accepted that his daughter would have told him what she knew. Within a very short time, Mr Massey had decided to visit Shipman. Mr Massey asserted that, at that time, he did not know that the police or the Coroner were involved. He, together with Mrs Bambroffe, also insisted that he would not have decided to speak to Shipman if he had known that an investigation was under way. I noticed that Mrs Bambroffe was most uncomfortable when giving this part of her evidence and think it likely that she was not sure that what she was saying was true and accurate. Mr Massey said that his daughter and son-in-law were opposed to him visiting Shipman; they told him

to 'leave it alone'. He could not offer a sensible reason for this opposition but said that he thought his daughter was being 'a bit protective' of him. Mr and Mrs Bambroffe agreed that they were opposed to the proposed visit. They were unable to explain why. They said that it was not because of any concern about the effect on their business if it were to become known that they had made unfounded allegations against Shipman.

- 12.14 In my view, Mr Massey was aware of the report to the Coroner and probably realised that the police would also be involved. In my judgement, Mr Massey decided to see Shipman because he thought that things had 'gone too far'. Now that the truth is known about Shipman, Mr Massey cannot believe that he went to see Shipman at such an inappropriate time. His daughter and son-in-law, motivated by the respect and affection in which they hold Mr Massey, have allowed themselves to be persuaded that Mr Massey could not have known of the Coroner's involvement at the time he went to visit Shipman. I think that, when Mrs Bambroffe gave evidence, she still remained in a state of conflict and uncertainty about this issue.
- 12.15 What was Mr Massey's purpose in making this visit? In his Inquiry statement made in January 2002, Mr Massey said that he wanted to see Shipman in order to satisfy himself that Masseys were not involved in **'anything untoward'**. In his Inquiry statement of April 2002, he said that he went because he had become concerned about the number and circumstances of the deaths about which his daughter was telling him. I have already said that I do not accept that Mr Massey shared the concerns of the younger generation before he went away. There is no evidence that anything occurred on his return that might have caused him to take a different view. When giving oral evidence, Mr Massey said that, when he returned from holiday, he was concerned about the number of deaths among Shipman's patients and the similar circumstances in which they were happening and decided that something had to be done. He felt that there was something 'not quite right'. Mr and Mrs Bambroffe both said that they understood that Mr Massey's motive was to ask Shipman for an explanation for the large numbers of patient deaths in his practice. I regret to say that I find none of these explanations at all convincing.
- 12.16 As I have said, Mr Massey did visit Shipman on 2nd April. He said that he was very nervous about going; he was shaking and sweating while in the waiting room. I can well understand that. Whatever his motive for going and whatever he planned to say, he might well dread the interview. He has given differing accounts of exactly what he said. In his Inquiry statement of January 2002, he said that he had told Shipman that he **'had one or two concerns about the number of deaths Masseys seem to be getting'** from him. In his Inquiry statement of February 2002, he said that he told Shipman that **'people had been talking about the high rate of deaths among his patients'**. In his statement made in April 2002, he claimed that he said **'something like "We've got concerns about the number of deaths of your patients"'**. In oral evidence, he said that, when he sat down, he told Shipman that 'they' (impliedly meaning Masseys) were concerned that they were getting a lot of deaths of elderly ladies fully clothed who were sitting up or had been out shopping. Later in his evidence, when asked about the reference in one of his statements to **'people had been talking about the high rate of deaths'**, he explained that he had used the word **'people'** to distance his own family from the concerns. Mr Massey denied

that he had said anything to Shipman about a report to the Coroner or an investigation by anyone in authority.

- 12.17 Mr Massey has consistently reported that Shipman's response was to say that the deaths of his patients were all properly recorded in his book, which Mr Massey took (no doubt correctly) to be his book of MCCDs. In oral evidence, Mr Massey added that Shipman said that the book was available for anybody to see. In his Inquiry statement of January 2002, he said that Shipman had said that the book was **'open for inspection by any of the authorities that wanted to see it'**. In his April 2002 statement, he said that the book was open for inspection by **'anybody concerned'**. Mr Massey said that Shipman took down the book from a shelf or cabinet and showed Mr Massey various names and causes of death. He was very relaxed and confident and friendly. He and Mr Massey went on to exchange pleasantries. Shipman did not seem at all worried or even concerned to know that he was being talked about. Mr Massey said that he felt reassured and that he had been given an explanation. When pressed, he agreed that he had not received an explanation for anything. He had just been reassured by Shipman's confident manner.
- 12.18 When he returned home, Mr Massey assured his family that there was nothing to worry about. Shipman had been very nice and quite relaxed. I think Mr Massey was convinced that the concerns and suspicions were misconceived.

Conclusion

- 12.19 My conclusion is that Mr Massey at no time shared the concerns of the doctors from the Brooke Practice and the younger generation within his family. I am sure he thought they were wrong about Shipman. In my view, he decided to see Shipman because he thought that to make a report to the Coroner had been to take things too far. He thought Shipman ought to know what was being said about him. I think he gave Shipman to understand that people were talking about the number of deaths among his patients. I do not think he told him that there had been a report to the Coroner.
- 12.20 I am sure that Mr Massey made it plain to Shipman that he did not share the suspicions that were being voiced by others. I think he was also anxious to avoid giving the impression that the concerns had arisen within his own family. Mr Massey says that Shipman did not ask him the identity of the people who were 'talking'. I accept entirely Mr Massey's account of Shipman's reaction. Shipman was an accomplished liar and dissembler and it was entirely typical of him that he should give the impression that he was not in the least worried about any rumour or gossip.
- 12.21 In rejecting some of the evidence of the Massey family, I do not wish it to be thought that I regard them as dishonest. I do not, for one moment, think they are. Looking at these events with the benefit of hindsight, I think that they have found it impossible to remember and to accept that Mr Massey believed that the people who suspected Shipman were making a mistake. I think they have persuaded themselves that Mr Massey shared the concerns of the younger generation. I think they have talked about these matters at great length on many occasions and have convinced themselves that Mr Massey wanted to seek an explanation from Shipman for the large number of deaths. They cannot remember

why the family was in disagreement because, on the accounts they now give, there is no explanation for the rift. They have persuaded themselves that Mr Massey cannot have known of the involvement of the Coroner because they now see that it was wrong (or at least unwise) for Mr Massey to visit Shipman at that stage, while the Coroner was involved. As they regard themselves as decent, law-abiding citizens, which they are, they cannot believe that one of them once supported the man who is now known to be a mass murderer. Mr Massey need not feel embarrassed that he once supported Shipman. So did many others. Mr Massey had received reassurance from Dr MacGillivray. In the event, the trust of both of them in Shipman was misplaced.

- 12.22 I am satisfied that Mr Massey did alert Shipman to the fact that he was under some suspicion, possibly even some investigation. I think the consequence was that Shipman stopped killing for a time. It is likely that Shipman deduced that, if the Masseys knew of people who were 'talking', it might well be that the source of the concern was the doctors from the Brooke Practice. I think that is why, when he resumed killing on 11th May, he chose a victim who would not be cremated. Mrs Winifred Mellor had made it known that she had a strong preference for burial. There is no evidence that he discovered the preferences for burial of his other two victims; indeed, Mrs Woodruff, Mrs Grundy's daughter, is adamant that Shipman could not have known what method of disposal would be chosen for Mrs Grundy, as it was Mrs Woodruff herself who chose burial. When Shipman forged Mrs Grundy's will, he specified that it was her wish to be cremated.
- 12.23 In my judgement, Mr Massey's action in speaking to Shipman did not lead to any loss of life. If anything, he may have saved lives. Shipman had been killing at the rate of one patient a week during the three months before Mr Massey's visit. If he had continued at that rate, more patients would have died than in fact did so. On the other hand, had the rate of killing continued unabated, it may be that Shipman would have been detected and stopped sooner than he was.
- 12.24 I am sure that Mr Massey acted with good intentions when he went to see Shipman. He is a thoroughly decent man. His mistake was that, like countless others in Hyde, he trusted, admired and respected Shipman and could not believe that the suspicions harboured by his daughter and the Brooke Practice doctors could have any foundation. I think he has found it very hard, indeed impossible, to accept that this was once his state of mind.

CHAPTER THIRTEEN

The End of the Investigation

Two Weeks Pass

- 13.1 Following his visit to the crematorium on 1st April 1998, Detective Inspector Smith did not take any further steps in connection with the investigation until 15th April. He had rest days on 4th, 11th and 12th April; the 10th was Good Friday, a public holiday. He was due to go on a week's holiday from the evening of Friday, 17th April. This was to be followed by a training course that would last a further week.
- 13.2 After two weeks of inactivity so far as the Shipman investigation was concerned, DI Smith suddenly sprang into action. On 15th, 16th and 17th April, there was a flurry of activity. By 17th April, the investigation had been closed. I have already said that I believe that, when he left Selbourne House on 1st April, DI Smith had concluded that Dr Reynolds' concerns were without foundation. It is hard to resist the inference that DI Smith decided to tie up the loose ends and close the investigation before leaving his desk for two weeks.

Detective Inspector Smith Meets the Massey Family

- 13.3 As I mentioned earlier, DI Smith believed that it was during, or just after, his visit to the crematorium that he came to the conclusion that he knew the name of the female undertaker who had been concerned about the deaths of Shipman's patients. On the morning of 15th April, he telephoned Masseys' premises and arranged to see Mrs Bambroffe, either later that day or possibly on the following day. There is no record of the appointment and members of the Massey family are not sure of the date of the visit. I think it highly likely that DI Smith visited on 15th April. The meeting took place at the Masseys' premises and was attended by Mr Massey and Mr Bambroffe, as well as DI Smith and Mrs Bambroffe.
- 13.4 DI Smith has given a number of accounts of this meeting. In his first written report of August 1998, he said that Mrs Bambroffe had told him that all she had done was to repeat the **'general chit-chat and gossip'** she had heard circulating about Shipman. In April 2000, Detective Superintendent Ellis reported that Mrs Bambroffe had told DI Smith that her expressions of concern were based on **'gossip, innuendo and ... coincidence'**. In his manuscript notes of his interview with DI Smith, Det Supt Ellis recorded that Mrs Bambroffe and Mr Massey had told him that they **'just laugh and joke about it'**. Mrs Bambroffe had, he said, maintained this stance despite being **'pushed'** by him. In his statement to the WPHA, DI Smith said that Mrs Bambroffe provided no substantial information; it appeared that her concerns were based on gossip. He repeated this assertion in his first Inquiry statement.
- 13.5 However, when DI Smith came to give oral evidence, he conceded that part of what he had said to Det Supt Ellis had been 'incorrect'. He accepted that Mrs Bambroffe had never said that her concerns were based on gossip or were ever the subject of jokes. His account was that, after confirming that she was indeed the undertaker who had expressed concerns to Dr Reynolds, she had listened to his account of Dr Reynolds' concerns and

what he had done to investigate them. He said that he was trying to reassure Mrs Bambroffe that she had not been disregarded. He had asked her if there was anything else she wanted to add but she had volunteered nothing. He did not ask her to elaborate upon her concerns, despite the fact that all he had at that time was a third-hand (or possibly fourth-hand) account of those concerns. He said that Mr Massey 'became more prominent' in the conversation and that he, not Mrs Bambroffe, referred to the part played by rumour and speculation. DI Smith agreed that he did not ask Mrs Bambroffe for first-hand information about the circumstances of the deaths she had attended. Nor did he ask to see the firm's records relating to the deaths of Shipman's patients. In short, it appeared from his own account in oral evidence that his purpose had been to impart information rather than receive it.

- 13.6 According to the Massey family, the discussion with DI Smith was fairly short and very general. It lasted only 10 to 15 minutes and was more of a chat than an interview. DI Smith asked whether Mrs Bambroffe was the female undertaker he was seeking and she confirmed that she was. The family said that he asked hardly any other questions and did not seek any information. His manner was reassuring and they were left with the feeling that the police had undertaken a thorough investigation. Nothing untoward had been discovered so far. The family was not told that the investigation was at an end although they got the impression that it was approaching its conclusion.
- 13.7 Mrs Bambroffe told the Inquiry that, if DI Smith had asked her to explain why she had been concerned about Shipman's patients, she would have been willing to do so. She would have said that, not only did it appear to her that there were a lot of deaths, but also that the circumstances were unusual. In her experience, it was unusual for an elderly person to die alone at home. Usually, a relative or friend was present, and the patient was in bed and appeared to have been ill. By contrast, Shipman's patients often seemed to die alone. Frequently, they were found dressed in day clothes, sitting up in a chair with no sign of illness. She and her husband had come to recognise features typical of the deaths of Shipman's patients. She was concerned also about Shipman's presence in the house at or about the time of the discovery of the death. She had sometimes wondered how he had gained access to the house. In her experience, elderly people were usually security conscious and it was often not possible to gain access when a body was lying dead. She had also noticed that there seemed to be quite a lot of unexpected deaths. Yet, instead of referring them to the coroner, as other doctors would, Shipman was always willing to certify the cause of death himself.
- 13.8 Mrs Bambroffe said that the firm held records of the funerals they had conducted and she would have been able to produce the records for all nine of the deaths of Shipman's patients which had been dealt with by Masseys and of which DI Smith was already aware. She would also have known that there were other deaths, not on his list, and would have been able to tell him about five more deaths during the preceding six months of which he was unaware. This would have alerted him to the fact that his bundle of copy death certificates was incomplete. Had DI Smith asked members of the Massey family what they could remember about individual deaths, they would have been able to provide some useful information about the circumstances in which the body was found, who was present and whether the family appeared to be shocked by the suddenness of the death. They

would also have been able to tell him that they knew of people who had given money to the scanner appeal.

- 13.9 It was common ground that, after confirming that he had found the right undertaker, the only question DI Smith asked was whether Mrs Bambroffe had anything to add. She said she had not. As he appeared to have received information from Dr Reynolds and as he had spoken so reassuringly to her, giving the impression that he was conducting a thorough investigation, I can well understand why she answered in that way.
- 13.10 Mrs Bambroffe said that at no time did she say that her concerns had been based on rumour, gossip or innuendo. I accept that she did not. However, when DI Smith told the family, as I think he probably did, that he had found no evidence to substantiate the concerns, I think it highly likely that Mr Massey repeated his view that the concerns were without foundation. DI Smith recalls that Mr Massey took a more dominant part in the conversation towards the end of the meeting. I think that is probably so. I think that, in the light of DI Smith's information and attitude, Mrs Bambroffe felt there was nothing more she could say.
- 13.11 It is clear that DI Smith did not take the opportunity offered by this meeting to advance his knowledge about the deaths of Shipman's patients. His method of recounting what he had done did not encourage the Massey family to volunteer what they knew. It is plain that this was not an evidence-gathering exercise. It is to his credit that he gave a truthful account in oral evidence. However, his earlier untruthful accounts, in which he stated that Mrs Bambroffe told him that her concerns had been based on gossip and innuendo and had been the subject of jokes within the family, do him great discredit.
- 13.12 It is common ground that no member of the Massey family informed DI Smith that Mr Massey had visited Shipman on 2nd April. They said that they had not thought to do so. I think they were embarrassed that Mr Massey had visited Shipman while an investigation was under way. I think they would have answered truthfully if asked about the visit but were probably relieved that they were not.
- 13.13 DI Smith says that, if he had learned that Mr Massey had visited Shipman and that Shipman might have become aware that he was being investigated, he would have considered seeking permission to abandon the need for confidentiality. I do not accept that evidence. DI Smith had already concluded that Dr Reynolds' concerns were without foundation. The discovery that Mr Massey had visited Shipman would not have affected that view.
- 13.14 DI Smith agreed that, at the end of this meeting, he had learned nothing new. He was no nearer an understanding of the comparative death rates. He had established that all but two of the deaths of which he knew involved female patients and that most of the deceased were elderly. He did not know which of the deceased, if any, had been found in their day clothes, as he had never asked. He did not understand the basis underlying the concerns of Dr Reynolds and the Bambroffes. Yet, he had already decided that there was no evidence to support Dr Reynolds' concerns.

Detective Inspector Smith Proposes to Close the Investigation

- 13.15 On or shortly before 16th April 1998, DI Smith discussed with Chief Superintendent Sykes his belief that there was no foundation in the concerns expressed by Dr Reynolds. It seems

to have been agreed that the matter should be closed. CS Sykes did not have a clear recollection of everything he was told about the investigation. However, he said that he did not have an in-depth discussion about the issues and the evidence. He remembered that DI Smith said that Dr Banks had found no evidence of criminality in the medical records. He had the impression that that marked the end point of the investigation. He could not recall what had been said about the visit to the Masseys, although he remembered DI Smith using the expression 'gossip and innuendo'. He could not remember whether those words were used in connection with the Masseys.

- 13.16 It appears that the decision to close the investigation was taken without any detailed discussion of the issues raised. DI Smith was not required to explain to CS Sykes how and why he had reached the conclusion that Dr Reynolds' belief that Shipman's death rate was very high was unfounded. He was not required to explain, for example, that he was satisfied that Dr Reynolds' figures were wrong or that, although the death rate might be high, there were good explanations for it. Nor was he required to explain what steps he had taken to find evidence of the common features. In short, CS Sykes delegated to DI Smith the decision to close the investigation. In this, he breached an important tenet of criminal investigation, which is that the supervising officer should make the decision to close an investigation. That decision should be independent of the advice of the officer who has conducted it. CS Sykes did not ask DI Smith to write a report, which would be the normal procedure upon the closure of any criminal investigation.

Detective Inspector Smith's Second Visit to Dr Reynolds

- 13.17 DI Smith tried to contact the Coroner on the morning of 16th April. He also telephoned Dr Reynolds' surgery and made an appointment to see her later that day.
- 13.18 In her statement, Dr Reynolds said that, when they met, DI Smith told her that he had been unable to find any evidence to confirm her suspicions. He said that Shipman was well loved by his patients. DI Smith had found no apparent motive, financial or otherwise, for Shipman to harm his patients. He said that he had investigated her concerns and that no further action would be taken at present.
- 13.19 DI Smith said that he explained the outcome of his enquiries to Dr Reynolds and told her that there was insufficient evidence to justify further investigations. He had found no evidence of criminality. He did not recall mentioning the lack of motive, although he agreed that it had been a consideration in his thinking. He believed that he told Dr Reynolds that he had had 20 sets of medical records examined. He said that he mentioned the possibility of conducting an autopsy in the future. He did not remember asking whether there had been any further deaths since he had last seen her. He said that he told her there was nothing further he could do at that time.
- 13.20 DI Smith said that he had the impression that Dr Reynolds was disappointed with what he told her and that she remained concerned. This impression is confirmed by Mr Reynolds and by the other doctors at the Brooke Practice. Mr Reynolds recalled that, after this second meeting with DI Smith, his wife told him that the emphasis appeared to be on the apparent absence of any motive for Shipman to kill his patients. She was concerned, not

with possible motive, but with the disparity between the death rates in her practice and that of Shipman. She had been disappointed not to have any explanation for that. She had also been surprised that DI Smith had not spoken to her partners.

- 13.21 I find that DI Smith did mention that Shipman did not appear to have any motive for harming his patients. I think it unlikely that he said that he had had 20 sets of medical records examined. If he did make that claim, it would have been inaccurate, as, at that time, he had had only 15 sets examined, and had not yet received the result on the 15th set. It is possible that he told Dr Reynolds that he had had 14 or 15 sets examined, in which case she might well have thought that these were 14 or 15 of the 16 deaths about which she had told the Coroner and which had occurred during the previous three months. Had DI Smith mentioned 20 deaths, said to have occurred over a period of six months, I think Dr Reynolds would have queried his figures. I am quite satisfied that DI Smith did not give any explanation for the disparity in death rates; he was plainly not in a position to do so. For reasons that I shall explain shortly, I do not accept that DI Smith told Dr Reynolds that it might be possible to arrange an autopsy if any further deaths were to occur.

Detective Inspector Smith Speaks to the Coroner

- 13.22 On the following day, Friday, 17th April, DI Smith telephoned the Coroner at 10.13am. Again, the call was brief and it seems likely that he left a message for Mr Pollard. Soon after 2pm, Mr Pollard telephoned DI Smith. Mr Pollard's note of the conversation records that DI Smith referred to a visit to Dr Reynolds and to the **'FP Cttee'**, by which he must have meant the Family Practitioner Committee of the WPHA. The note mentions that two sets of records had been **'questioned'**. This must have been a reference to the two sets of records that Dr Banks thought did not disclose sufficient information to allow a proper diagnosis of the cause of death. Mr Pollard recorded that there had been nothing that **'gave any indication of any criminal acts'**. The note says that DI Smith had seen the cremation records of 20 people and that, of those people, there was an approximately 70% to 30% split between cremation and burial. In fact, this was inaccurate, as the split was 85% to 15%. The note also says that the undertakers had been seen by the police. Most funerals had been done by Masseys of Hyde. DI Smith had **'seen Debbie @ the u/takers:'**. Finally, it is noted that:

'Dr S tries to get all his patients out of hospital. He works v. much like the old GP who will call in @ homes without appointment.

All is OK.'

- 13.23 When going through his note in evidence, Mr Pollard said that he was not told the reason why the doctor who had examined the medical records had **'questioned'** two cases and he did not ask. He thought he ought to have been told if, in fact, the reason these two cases had been questioned was because the doctor thought there was insufficient information to make a diagnosis of the cause of death so that the deaths should have been referred to the coroner.
- 13.24 Mr Pollard said that, when he was told that the cremation records showed a 70% to 30% split between cremation and burial, he thought that this meant that the cremation figures

which had initially been reported to him (16 in three months) had not included the burials, so that the total number of deaths must have been higher than Dr Reynolds had realised. Mr Pollard did not record the period over which the deaths had occurred. It appears that he never realised that DI Smith had been looking at the deaths over a six-month period rather than the three months considered by Dr Reynolds. Mr Pollard did not gain the impression that DI Smith attached importance to the cremation/burial split for any other reason than that it showed that the number of deaths was higher than had been thought.

- 13.25 Mr Pollard's overwhelming impression of the conversation was that DI Smith was telling him that he had carried out a full investigation, so far as confidentiality allowed, and was satisfied that there was nothing to justify further police involvement. DI Smith's explanation for the high number of deaths was that Shipman liked to keep his elderly patients out of hospital. Also, he was an old-fashioned doctor who called on his patients unannounced. The first explanation might account for a higher than usual number of deaths at home among his elderly patients. The second explanation would not account for a high death rate but might explain why Shipman was often present at or about the time of death. Mr Pollard told the Inquiry that he accepted the explanation as adequate because he relied entirely on the probity of the investigation conducted by DI Smith.
- 13.26 DI Smith made no notes of his conversation with Mr Pollard. However, he said that, over the telephone, he told Mr Pollard what he had done during the investigation. He had seen Mr Loader, Mr Gurney and the Health Authority. He said that he concluded that the concerns seemed to stem mainly from rumour and speculation. He had asked Dr Banks to analyse the medical records but he had found nothing untoward in the causes of death. DI Smith said that he took Mr Pollard through the list of the deceased, identifying the causes of death. He said that he did not go into detail about the individual cases. I am sure that is right; he could not possibly have done so. DI Smith thought that he had told Mr Pollard that there were some cases where the Health Authority doctor believed that the death should have been reported to the Coroner. Mr Pollard had no recollection of any such remark; nor did he note it. I do not think this was said; if it had been, Mr Pollard would have noted it.
- 13.27 DI Smith claimed that he told the Coroner that he had gone as far as he could in investigating the allegations on a confidential basis. He said he suggested that, if the matter were to proceed further, there were two possible courses of action. One was to have an autopsy carried out on the next patient of Shipman to die. The other was to speak to some of the relatives of those who had died, or of the next one to die, to see if they had any concerns about the death. DI Smith told the Inquiry that he was not advocating that these steps be taken, as they would entail moving away from a confidential investigation and he did not think this was justified. He was just suggesting possible options for the future if the Coroner were minded to continue the enquiry. However, he said that the Coroner did not take him up on either of these suggestions. In April 2000, DI Smith had told Det Supt Ellis that he had suggested the possibility of an autopsy in future but the Coroner had been opposed to the idea.
- 13.28 Mr Pollard said that he had no clear recollection of this conversation other than that which had been recorded in his note. He did not recall DI Smith saying that the concerns had

been based on rumour and speculation but he accepted that was possible. Mr Pollard had no recollection of DI Smith going through a list of deceased patients and telling him the causes of death. Nor did he remember any suggestion that there might be an autopsy in the future. He pointed out that such a suggestion would have been quite inconsistent with the general thrust of DI Smith's message, which was that there was nothing to be concerned about. I accept Mr Pollard's evidence on that. I am sure that DI Smith did not suggest a future autopsy, either to Mr Pollard or during his conversation the previous day with Dr Reynolds. Mr Pollard said that he had no recollection of DI Smith suggesting that relatives should be approached. Once again, he pointed out that such future action would be inappropriate if DI Smith had come to the conclusion that there was no cause for concern. I find that DI Smith made no such suggestion.

- 13.29 Mr Pollard said that he did not think deeply about the explanations that DI Smith had put forward. He said that the result of the enquiries did not come as a surprise to him; Dr Reynolds had always recognised the possibility that Shipman might be an exceptionally caring doctor. It did not occur to him to question whether the proffered explanations could satisfactorily account for the startling disparity in death rates. He did not think of asking whether Dr Reynolds was satisfied with the results and he did not contact her again. Nor did he make any enquiries about more recent deaths among Shipman's patients. In short, he accepted without question that the police enquiry had revealed nothing of concern and put the whole matter out of his mind.
- 13.30 The first police investigation was now at an end.

CHAPTER FOURTEEN

Internal Enquiries by the Greater Manchester Police

Chief Superintendent Sykes Speaks to Mr Postles

- 14.1 Chief Superintendent Sykes said that he discussed the closure of the investigation with Mr Postles. He said that it was not possible to discuss the issues in detail, as there were no written records and he was dependent on his recollection of what Detective Inspector Smith had told him. He said that Mr Postles was satisfied that the investigation had been properly conducted. Initially, CS Sykes appeared to suggest that this conversation took place before the decision to close the investigation was taken; however, in his oral evidence to the Inquiry, he seemed to accept Mr Postles' assertion that it took place some time after the decision had been taken.
- 14.2 Mr Postles told the Inquiry that he recalled a conversation with CS Sykes. He said that it had occurred 'some weeks' after he had first learned of the investigation, which was on 25th March 1998. He recalled that CS Sykes told him that the information elicited from various sources did not point to any wrongdoing by Shipman. In particular, he was told that, in the case of all the deaths that DI Smith had established had occurred within the last six months, the cause of death was, according to the Health Authority, consistent with the individual's medical condition.
- 14.3 In his Inquiry statement, Mr Postles also said that CS Sykes told him that DI Smith had established with the Health Authority that the number of deaths for which the register office had supplied details was not believed to be inordinately excessive. This is puzzling, as there is no evidence that Dr Banks and DI Smith discussed the death rate among Shipman's patients. There is, however, evidence that they discussed the size of Shipman's patient list and it is likely that Dr Banks expressed a view that the death rate did not seem inordinately high. CS Sykes does not remember saying anything of this nature to Mr Postles. In oral evidence, Mr Postles said that he was unsure about this aspect of his statement and thought he might have been referring to knowledge gained at a later time. I think that is probably the case.
- 14.4 I think the conversation between these two officers must have been of a fairly casual nature and I doubt whether CS Sykes was formally seeking Mr Postles' approval of his decision to close the investigation. Had that been the case, Mr Postles would have called for DI Smith's report and would have discovered that no such report existed. I am satisfied that Mr Postles did not realise until August 1998 that DI Smith had not written a report.
- 14.5 It is most unfortunate that CS Sykes did not call for a written report at the time of the closure of the investigation or soon afterwards. If DI Smith had written a report while events were still fresh in his mind and before he realised that he had reached the wrong conclusion, I am sure that the report would have been more detailed and accurate than the one written in August 1998. At that time, in April or May 1998, DI Smith would have had no motive (whether conscious or sub-conscious) to understate the seriousness of Dr Reynolds' concerns. It is likely that a report written at that time would have included reference to the comparative death rates provided by Dr Reynolds. These were not mentioned in

DI Smith's report of August 1998. If the report had been seen by CS Sykes, as it should have been, and if it had contained no reference to the comparative death rates, he would surely have noticed the omission. If Mr Postles had become aware of the comparative death rates, he would, I am sure, have wished to discuss with DI Smith how that aspect of Dr Reynolds' concerns had been resolved. He would have found that it had not been. That might well have resulted in the re-opening of the first investigation.

August 1998

- 14.6 No report of any kind had been written when, in August 1998, Mr Postles was put in charge of the investigation into the death of Mrs Kathleen Grundy. That investigation rapidly widened to include enquiries into the deaths of more of Shipman's former patients. Mr Postles wished to draw on the information uncovered in the first investigation. He then found that DI Smith had not kept any written records save for the scanty notes in his daybook and had not submitted a written report. He asked DI Smith to make good that omission. That is how the first of DI Smith's written accounts came into existence. The first report was dated 17th August 1998. DI Smith reported that:
- (a) He had acted on a request from the Coroner who said that Dr Reynolds had raised concerns about deaths certified by Shipman. Since her arrival in Hyde in 1997 (in fact, she arrived in September 1996), there had been '**general banter**' amongst her practice partners that Shipman supplied them with '**pocket money**' by asking them to countersign his cremation certificates. In addition, there was concern about a number of '**alleged features**' of the deaths. These were that the persons were mainly female; they were found dead by Shipman; they were found wearing day clothes and the majority appeared to have been cremated.
 - (b) At interview, Dr Reynolds had repeated the information she had given to the Coroner. She had said that a local undertaker, who did not wish to be identified, had become aware of the circumstances of the deaths and it appeared that it was common gossip among doctors, nurses and undertakers that there were more deaths among Shipman's elderly female patients than in other practices. There was no evidence to support this rumour. Dr Reynolds did not wish her name to be made known during the investigation. She had made her report for peace of mind after consultation with her partners.
 - (c) DI Smith had later learned that Shipman had had a disagreement with his '**previous practice partner** [*sic*]' and was now a sole practitioner. This had created problems for Shipman, who now asked members of the Brooke Practice to countersign cremation certificates.
 - (d) Mr Loader had identified 19 deaths as the result of a search for all the deaths certified by Shipman during the previous six months.
 - (e) Enquiries at the crematorium had shown that, of those 19 deceased, 16 had been cremated and three buried. The usual proportion was 70% cremations. The funeral directors were various local firms.

- (f) The undertaker mentioned by Dr Reynolds had been identified and interviewed but had said that she was only repeating **'general chit-chat and gossip that had been circulating for some time'**. This was supported by her father, who was present.
- (g) An approach had been made to the **'Family Practitioners'** at Selbourne House, Hyde, with a view to examining patient records of the deceased persons. DI Smith had requested that each set of records be examined with a view to identifying whether the cause of death was consistent with the treatment being prescribed. There did not appear to be any cause for concern.
- (h) DI Smith claimed that enquiries into the **'finding of the bodies'** were commenced but that, due to the limited sources of information available, it was difficult to identify all the circumstances. It was established that, at some of the deaths, other persons had been present such as the police, ambulance personnel and doctors from the emergency service. Some of the deceased had died in nursing homes.
- (i) Shipman was regarded as being of the 'old school'. He made a lot of house calls and spent time with his patients. He would call unannounced. He was popular and there was a queue of people seeking acceptance onto his patient list.
- (j) The investigation had not revealed any evidence to indicate that the deaths were anything but normal. Due to the requirements of confidentiality, it had not been possible to pursue all lines of enquiry (the nature of which were not specified) to a satisfactory conclusion.
- (k) The findings were passed to Mr Pollard who was satisfied.

14.7 It will be noted that this account was very different from that given by DI Smith to the Inquiry. His references to gossip, banter and chit-chat were untrue. They diminished the seriousness of Dr Reynolds' concerns to the point where any police officer reading the report would think that this investigation had amounted almost to a waste of police time. It will be noted that the account made no reference to the high death rate about which Dr Reynolds had expressed concern to both the Coroner and DI Smith. No numbers were quoted, despite the fact that these appeared in DI Smith's daybook as one of Dr Reynolds' prime concerns. I note also that the report gave the impression that the undertaker (Mrs Bambroffe) was interviewed at an early stage, whereas in fact she was seen right at the end. The account of her evidence was untrue. DI Smith's claim that he had made enquiries into the circumstances of the **'finding of the bodies'** was misleading, although probably not deliberately so. He had found some evidence from Dr Banks (which is quoted) but had failed to make any other enquiry, although other sources of information were available to him. I accept that he had failed to think of the other sources of information such as the Massey family, the police officers who had attended at sudden deaths and Dr Reynolds herself. He did not know that information was available in the Forms B held at the crematorium.

November 1998

14.8 A few weeks later, Mr Postles asked DI Smith to provide further information about his investigation and, in particular, the role played by the WPHA. DI Smith wrote a second report dated 9th November 1998, in which he recorded that:

- (a) Mr Loader had provided 19 copy death certificates resulting from a search for all the deaths certified by Shipman over a six-month period.
- (b) DI Smith had taken the certificates to **'the Family Practitioners'**, Hyde, and had asked that the medical records for each of the 19 persons be examined to establish whether the cause of death was consistent with the treatment and medication recorded within the records. He said that **'a couple'** of sets of records were not available, as they were still with Shipman's practice. Dr Banks had examined the records over a number of days.
- (c) He had returned to see Dr Banks, who told him that there did not appear to be any discrepancies between the records and the causes of death and, although the causes of death given by Shipman were of a **'general nature'**, there did not appear to be cause for concern.
- (d) He had told the Coroner of Dr Banks' findings and had given him four other items of information, namely: that the activities of Shipman were the subject of **'innuendo and gossip'**; that each of the cremation forms had been countersigned by a second doctor who had not raised any concerns about the deaths; that there was nothing to indicate foul play from what was known of the circumstances of the deaths or the discovery of the bodies, and that a variety of undertakers had been used.
- (e) In view of the fact that **'the information appeared to be based on innuendo and gossip'**, he had not thought it appropriate to approach the families of the deceased persons, a decision with which the Coroner agreed.

14.9 I note that DI Smith did not then claim that he had received 20 certificates from Mr Loader, as he was to tell the Inquiry. He gave the impression that 17 of the 19 sets of records had been examined; in fact only 14 were examined before his meeting with Dr Banks. He did not mention that Dr Banks had told him that there were some cases in which the information in the medical records was insufficient to diagnose death or that Dr Banks would have reported such deaths to the coroner. Again, he advanced the idea that the report against Shipman was based on innuendo and gossip. In short, he sought to 'play down' the seriousness of Dr Reynolds' concerns and to exaggerate the extent to which his investigations had provided real reassurance that all was well.

14.10 On 17th November 1998, Mr Postles sent DI Smith's two reports to Detective Chief Superintendent (DCS) Anthony Keegan, Head of Crime Investigations. He attached a copy of DI Smith's spreadsheet listing the 19 deaths and ending with the name of Mrs Lily Higgins. The format of the spreadsheet had changed slightly since April 1998, in that further columns had been added, but no information had been inserted into the new columns. Mr Postles also enclosed a list of 11 further deaths which, it was said, the register office had failed to identify at the time of DI Smith's original request. There was also a list of seven deaths which Shipman had certified since the request was made; three of those deaths had resulted in exhumations and murder charges. Mr Postles warned that there may be some potential for criticism of the police in respect of the first investigation. He said that he was not suggesting that the investigation was not completed as thoroughly as possible, given the restrictions placed upon it. He merely wished to keep DCS Keegan informed, because he thought that the Shipman case might well result in a public inquiry.

December 1998

- 14.11 DCS Keegan passed the reports and enclosures to Assistant Chief Constable (ACC) David McCrone (now Deputy Chief Constable McCrone), who was then Head of Crime Operations. According to a memorandum dated 8th December 1998, from DCS Keegan to Mr Postles, ACC McCrone was satisfied that the actions of DI Smith were **'appropriate at that time'**. In view of the potential for criticism in the future, DCS Keegan suggested that Mr Postles should liaise with the Coroner with a view to establishing **'an agreed protocol/press liaison strategy'** for use if necessary.
- 14.12 Thus it was that the GMP formed the view that the first investigation had been properly conducted. DI Smith was not to be criticised. I accept that, at this time, in December 1998, the senior officers involved with the Shipman case were much occupied with the main investigation and the failure of the first investigation was not their first priority. However, it seems to me that it was inappropriate to make a decision of this kind on the basis of the account of the one officer who, it appeared at that time, might be open to criticism. The view formed in December 1998 was in fact based on deeply flawed information. DI Smith's two reports were inaccurate and incomplete. In some respects they were untruthful. It must be accepted that a senior police officer will not usually approach the report of a more junior officer with suspicion that it is not honest. However, by this time, the GMP had good reason to suspect that Shipman was indeed a serial killer and that the first police investigation had failed to uncover him. They knew that the Force might face criticism in this very serious matter. Yet, it appears that the decision that the first investigation was **'appropriate at that time'** was made without any officer speaking to DI Smith about the issues that arose during the investigation or the ways in which DI Smith tackled them and reached his conclusions. No one, for example, ever asked him what he had done to find out whether the death rate among Shipman's patients (which was recorded in his daybook) was, in fact, abnormal. In my judgement, this was a failure on the part of the GMP. There should have been a more searching enquiry into the reasons why the first investigation had failed to uncover any cause for suspicion. This should have taken place in late 1998 or early 1999. The need for an early investigation should have been the more obvious, as it was known that DI Smith had not kept any proper record of what he had done. I accept that the police had pressing concerns at this time but, nonetheless, the failure of the first investigation should have been critically examined while events were reasonably fresh in the minds of those involved.

The Police Decide to Record What Had Happened in March/April 1998

- 14.13 These matters rested until shortly after Shipman's conviction. On 1st February 2000, the Secretary of State for Health, The Rt. Hon. Alan Milburn, MP, announced that an Inquiry, chaired by Lord Laming of Tewin, would be held into the Shipman affair. It was clear from the announcement that the Terms of Reference of the Inquiry would include an examination of the first, failed police investigation.
- 14.14 Assistant Chief Constable (ACC) Vincent Sweeney, then Head of the Crime Operations Department, recognising that the conduct of the first investigation had not been properly recorded, issued a written instruction that a factual account should be prepared. In that

document, he said that this should be **‘a comprehensive document recording, as accurately as possible, the times and dates and content of all enquiries made, supported wherever possible by documents’**. The report should be in **“story book’ format’** and should cover the investigation from beginning to end. I observe that it should not have been necessary for the Force to begin finding out what had happened so long after the event. ACC Sweeney said that the objective of this operation was **‘to ensure that we are in a position to give a truthful and open account of our activities, and to ensure that we are not confronted by any further surprise revelations/allegations’**. This reference to **‘further surprise revelations/allegations’** related to post-trial press coverage of what was said to have happened during the first investigation. Among other things, Dr Reynolds had made a statement to the press about her role in the first investigation. Members of the Massey family had also told the press that they had expressed concerns about the circumstances of the deaths of Shipman’s patients.

- 14.15 In his instruction, ACC Sweeney listed a number of points to be covered, based on allegations which had recently been aired in the media. They included the following issues:
- (a) Whether or not Dr Reynolds had told DI Smith that she and her partners had calculated that the patients of Shipman were three times more likely to die than if they had been patients of the Brooke Practice.
 - (b) Whether or not Dr Reynolds had told DI Smith that she suspected that Shipman was killing his patients and whether or not she had said that the local undertaker could **‘corroborate’** this suggestion.
 - (c) Whether or not, when DI Smith had visited Dr Reynolds to tell her the result of his investigation, she had **‘made one last attempt to convince him’** by inviting him to go to the mortuary where two bodies of Shipman’s patients lay.
 - (d) Whether or not DI Smith had asked Dr Reynolds if she had a problem working with male doctors.
 - (e) Whether or not Dr Reynolds had identified Masseys as the relevant firm of undertakers and, if not, how they had been identified.
 - (f) Which members of the Massey family had been spoken to and what had they said? Also, whether or not any statements had been taken from them or any other person and whether any documentation had been prepared.
 - (g) Whether or not Dr Reynolds or anyone else had identified any other potential witnesses.
 - (h) What enquiries had been made with reference to death certificates and in respect of cross-referencing of medical records? What were the agencies (presumably the register office and Health Authority) asked to do?
 - (i) What flaws were revealed during the second investigation in respect of information given during the first investigation and how were those flaws revealed?

- (j) What background checks (criminal or professional) were made on Shipman during the first investigation?
- (k) What was said at the conclusion of the investigation when DI Smith was briefing CS Sykes and the Coroner?
- 14.16 ACC Sweeney concluded by assuring those involved that the task was not to be a **'witch hunt'** but a **'collation of facts'** to enable the police to prepare for the questions they would be asked by the Laming Inquiry. The objective was **'to find the truth and not to criticise individuals'**. He concluded:
- 'If we have failed to do something then let us simply say that we have failed to do it and not cover anything up – we must be absolutely truthful in everything we say and only in this way can we learn from the findings of the Enquiry [sic] and play our role in ensuring that practices and procedures are changed so that the chances of such an occurrence happening again are minimised.'**
- 14.17 In oral evidence, ACC Sweeney said that his request for a report in **'story book' format** was not intended to preclude observations by the writer on the adequacy of the first investigation. He wanted the Force to learn from any mistakes that had been made. He wanted officers (in particular, DI Smith) to be open about their involvement and not to feel inhibited by the fear of disciplinary proceedings. Police Regulations provide that, before any police officer is questioned about a matter that might lead to disciplinary proceedings, s/he must be warned that s/he need not answer the questions. ACC Sweeney said that the job of the officer assigned to the task of writing the report would have been impossible if senior officers had contemplated disciplinary proceedings against those involved. Although DI Smith had been given no categorical assurance that he would not be disciplined, there was at the time no suggestion that he had acted other than in good faith. There was therefore no immediate prospect of disciplinary action being taken against him. However, ACC Sweeney said that, if the investigation had found evidence of gross professional misconduct or wilful neglect, senior officers would have had to reconsider their views about the need for disciplinary proceedings.
- 14.18 There was to be a necessary limitation on the thoroughness of the exercise. ACC Sweeney directed that only police officers should be questioned. Any approach to a witness outside the Force might amount to an interference with the processes of the Laming Inquiry. I observe that this limitation would not have been necessary had the police carried out an investigation a year earlier.
- 14.19 The intention of ACC Sweeney, as expressed in this document, was entirely creditable. However, by this time, the GMP knew that their first investigation had failed to detect a serial killer and they were aware, from the media, of allegations that DI Smith had failed to follow up leads and information given to him in March 1998. Although I accept that senior officers would not normally suspect that an officer's report on an investigation would be seriously inaccurate, allegations were being made in the media which were implicitly inconsistent with DI Smith's account. The Force was on notice that DI Smith's account might not be true. It was known that DI Smith had not made any notes of what he had done

and had prepared no final report. It must have been known that CS Sykes had not asked for one. Yet, the senior officers in the Force still did not instigate a thorough and probing investigation into the conduct of the March 1998 investigation.

- 14.20 Detective Superintendent Ellis, who was instructed to prepare the report, said that he did not consider himself to be charged with the task of an investigation. Moreover, it was made plain to him that he need not warn the officers whose accounts were to be recorded that they might face disciplinary proceedings. It is plain that disciplinary proceedings had been effectively ruled out before the process began. For one thing, a detective superintendent would not be a suitable rank of officer to undertake a disciplinary inquiry into CS Sykes.

The Ellis Report

- 14.21 On 21st February 2000, Det Supt Ellis received instructions to prepare a written narrative of the first investigation. He understood that his task was to prepare an account of the facts, to assist the future independent Inquiry. He told this Inquiry that he 'was not to comment or criticise in any way, shape or form' DI Smith's investigation but was rather to present to the Laming Inquiry DI Smith's viewpoint of that investigation. Det Supt Ellis was aware of ACC Sweeney's memorandum, in which he spoke of his wish for openness and the need for the Force to learn from mistakes. However, he was also aware that senior officers in the Force had already reached the conclusion that DI Smith's investigation had been properly conducted. This was to influence his approach to his task. For, as we shall see, Det Supt Ellis did not confine himself to telling the story of the first investigation; he was to write a justification of it. In a structured organisation such as a police force, it is asking a great deal of a middle-ranking officer to take an independent approach to any issue on which he already knows the views of those senior to him.
- 14.22 On 4th April, Det Supt Ellis interviewed CS Sykes; he made no notes of the interview, because, he said, CS Sykes said 'very little'. On 5th April, he interviewed DI Smith; the interview was noted in longhand but not recorded. He had prepared a checklist of issues to be covered. He invited DI Smith to give his own account of what he had done. When that was complete, Det Supt Ellis went through the checklist to ensure that all topics had been covered. He did not challenge or probe DI Smith's account in any way.
- 14.23 I have already said that the oral evidence which DI Smith gave to the Inquiry was different in some important respects from accounts given by him on earlier occasions, including that given to Det Supt Ellis. There are also some important differences between what DI Smith had said in his reports of August and November 1998 and what he told Det Supt Ellis. I do not propose to set out every detail of what DI Smith told Det Supt Ellis. The most significant features were as follows:
- (a) DI Smith told Det Supt Ellis that the Coroner had told him and CS Sykes that Dr Reynolds had explained that the patient base of the Brooke Practice was 9500 and there had been 14 deaths in the practice during the previous three months. In that period, Shipman had had 16 deaths in his practice. However, DI Smith maintained that at no time had Dr Reynolds suggested that she and her partners had

done some calculations which showed that Shipman's patients were three times more likely to die than those of the Brooke Practice. It does not appear that Det Supt Ellis asked whether or not DI Smith had found out how many patients Shipman had. There was no discussion in the report of the significance of the death rates. I draw attention to the fact that Det Supt Ellis was not aware that DI Smith had failed to mention the death rate, as one of the grounds of Dr Reynolds' concern, in his report of August 1998. Neither that report nor the report of November 1998 had been made available to Det Supt Ellis. He told the Inquiry that he was not aware of their existence.

- (b) DI Smith went on to tell Det Supt Ellis that, when he saw Dr Reynolds, she told him that she did not know whether she was doing the right thing. Since her arrival in Hyde, there had been banter within the practice about Shipman providing pocket money by asking for signatures on cremation certificates. Det Supt Ellis noted that the suggestion that the issue of cremation certificates had been the subject of a joke was contrary to what one of Dr Reynolds' former colleagues, Dr Patel, was reported in the media to have said, namely that doctors from the Brooke Practice were concerned about Shipman's activities. DI Smith told Det Supt Ellis that it was clear to him that Dr Reynolds was acting alone in making a report to the Coroner and did not have the support of her colleagues. He reported that, so far as he was aware, those colleagues were still signing cremation certificates for Shipman. When asked whether he had requested to speak directly to any of Dr Reynolds' colleagues, DI Smith replied that he had not but added that she had not offered to make them available. She had not mentioned them by name.
- (c) DI Smith also told Det Supt Ellis that Dr Reynolds' concerns related to '**alleged features**' of the deaths of some of Shipman's patients who were mainly female, were discovered dead by Shipman and were wearing day clothes when found. There was no discussion between Det Supt Ellis and DI Smith about the significance or unusual nature of these features. The majority of the deceased appeared to have been cremated. DI Smith went on to say that Dr Reynolds had consulted the Coroner, after speaking to an undertaker who had similar concerns. She refused to identify the undertaker; this latter observation appears in Det Supt Ellis' report in capital letters, as if to give it particular significance.
- (d) Dr Reynolds had not produced any documentary evidence. It does not appear that DI Smith was asked what documentary evidence she might have had, nor whether he had asked her to provide such evidence.
- (e) When asked directly by Det Supt Ellis, DI Smith stated that Dr Reynolds had at no time said that she suspected that Shipman was killing his patients. This was, of course, in contrast to his oral evidence to the Inquiry.
- (f) DI Smith said that, after seeing Dr Reynolds, he sought production of the death certificates of Shipman's patients who had died in the previous six months. Two days later, he was given '**ten to twelve**' certificates and, a few days later, Mr Loader produced several more, making 19 in all. He made a chart on the computer from information contained within the certificates. With the certificates, he went to the crematorium and found out which patients had been buried and which cremated.

Of the 19 deaths, 16 were followed by cremation and three by burial. This did not contrast sharply with the local average of 70% cremation to 30% burial. DI Smith said that he found out the identities of **'undertakers'**, by which he presumably meant the undertakers dealing with the 19 deaths. He entered the information on his chart.

- (g) DI Smith said that he searched the GMPICS 'Incident Handling' to establish whether there had been any police involvement in the deaths that he was investigating. He had found three entries but these were not helpful. He was not asked whether he had done a check on the computer archive or whether he had spoken to the officers who attended the scenes of death.
- (h) DI Smith said that he had checked the GMPICS Operational Information System but had found no relevant information about Shipman. He had not made any other check to discover whether Shipman had previous convictions. He was not asked why he had not checked the PNC.
- (i) DI Smith said that he attended at the WPHA premises and asked Dr Banks and Mrs Parkinson for access to the records of the patients whose death certificates he had. He claimed that, for reasons of confidentiality, he had not told them anything of the nature of his enquiries, not even, in the first instance, that they involved Shipman. (This was not so, as Mrs Parkinson's note later revealed.) He told Det Supt Ellis that they agreed to research his request and contact him.
- (j) DI Smith related how, on his return to the Health Authority premises a few days later, it emerged that Dr Banks and Mrs Parkinson had realised that all the records related to patients of Shipman and there was then a discussion about Shipman's style of practice; he was said to be an old-fashioned doctor who would visit patients unannounced. At this meeting, DI Smith also learned for the first time, he said, about the scanner appeal. (This was quite wrong, as the Coroner's note of 25th March has revealed.) On this second visit, some of the medical records were now available. DI Smith claimed that, there and then, he asked Dr Banks to examine the records and to tell him what the patients were being treated for, whether the treatment was appropriate and whether the cause of death on the certificate was consistent with the complaint. Most remarkably, DI Smith told Det Supt Ellis that Dr Banks had already made this examination and was ready to state his findings. (It does not appear that Det Supt Ellis ever wondered how Dr Banks could have undertaken this task if all he had known, until that moment, was that DI Smith wanted to see the records of a list of deceased patients. If he did, it does not seem that he asked DI Smith how he thought Dr Banks had been able to do the job.) DI Smith told Det Supt Ellis that Dr Banks had found that all the causes of death were associated with old age and that he was happy with the records; nothing stood out as untoward. Dr Banks commented that Shipman's use of drugs was **'on high side'** but nothing gave him concern. He did not mention that Dr Banks had said that he would have reported two of the deaths to the Coroner.
- (k) DI Smith claimed that he had returned to the Health Authority on a further occasion about a week later, when more records had been found and examined. This time he

spoke to a woman doctor. Nothing untoward had been found. (It is now known that this visit did not take place.)

- (l) Meanwhile, DI Smith had discovered from Police Constable Napier the identity of the unknown undertaker. He said that he went to see **'Debbie Massey'**. Her husband and father were present. The handwritten note prepared at the interview records that DI Smith claimed that, when confronted by him, Mrs Bambroffe and her father said that the concerns she had expressed were 'just gossip'. They had laughed and joked about it. It was coincidence. DI Smith maintained that, despite being **'pushed'** by him, Mrs Bambroffe had produced nothing of evidential value. (I observe that this account was a travesty of the truth, although Det Supt Ellis was not to know that.)
- (m) DI Smith said that he had briefed Mr Pollard fully about his enquiries. He suggested to the Coroner that they might wait until another body was available and **'secure'** it for pathology, or that they might approach the families of deceased persons but, he said, the Coroner did not want that. (I have already found that DI Smith did not make such a suggestion.)
- (n) DI Smith said that he revisited Dr Reynolds and briefed her fully. He suggested that nothing further could be done other than intervention at the **'next death'**. She seemed disappointed.
- (o) In response to a specific question from Det Supt Ellis, DI Smith said that Dr Reynolds had not at any time invited him to examine bodies available at the mortuary. This was a reference to the allegation, which had appeared in the press, that Dr Reynolds had told DI Smith that there were two bodies available for autopsy. (In fact, as I have found, Dr Reynolds did tell DI Smith, on 24th March 1998, that there were two bodies available for examination. They were those of Mrs Lily Higgins and Miss Ada Warburton. The bodies were not at the mortuary, but at the premises of funeral directors.) Det Supt Ellis added that subsequent investigation had demonstrated that there was never a time when two bodies of Shipman's former patients had been at the mortuary at the same time. This is the only occasion on which it appears that any attempt was made to cross-check what DI Smith had said.
- (p) DI Smith had not made any record of his investigation, other than the notes in his daybook and the information entered on the spreadsheet. Nor had he prepared a written report. CS Sykes had not asked him to do so and Mr Pollard had been content with an oral report. Indeed the suggestion seemed to be that CS Sykes believed that the requirement for a report would in some way breach the confidentiality of the investigation.

14.24 Pausing there, by this stage, Det Supt Ellis had fulfilled his instruction to provide a **"story book' format'** report of the first investigation. Had he stopped there, I would not have criticised him. He had recorded the account of DI Smith in some detail and that of CS Sykes very briefly. He had not challenged or probed these accounts and, save in one respect, he had not cross-checked with other sources of information. He had not made use of the information available to him on the HOLMES police computer database, which contained a huge store of information about the later Shipman investigation. His report

would therefore be of very limited use. However, he had not been given clear instructions to challenge or probe the accounts and he understood that he was not to investigate any possible disciplinary offences.

- 14.25 However, Det Supt Ellis did not stop there. He embarked upon a series of **'OBSERVATIONS'**. First, he noted what he called the **'unique'** nature of this **'highly sensitive'** investigation. He observed that the police investigation had been handicapped by Dr Reynolds' insistence on anonymity and by the Coroner's insistence that Shipman should not become aware of it. He remarked that the handicap was exacerbated by Dr Reynolds' refusal or conscious decision not to identify potential witnesses. That comment was not justified on the evidence before him. The only witness whom Dr Reynolds had declined to identify (at her specific request) was Mrs Bambroffe. DI Smith had discovered Mrs Bambroffe's identity, but had failed to ask her any relevant questions. He had also failed to ask if he could speak to Dr Reynolds' partners. I cannot think of any other witness whom Det Supt Ellis might have had in mind.
- 14.26 Det Supt Ellis then went on to pose the question **'whether the initial police investigation was as thorough as possible'**. He had not been asked to deal with this issue, although ACC Sweeney said that he did not intend him to be precluded from doing so. However, if the issue was to be addressed, it should have been dealt with fairly and objectively. It was not.
- 14.27 Det Supt Ellis first excused DI Smith's failure to check the PNC and discover Shipman's previous convictions. He said that this was excusable because, at the time, it was unthinkable that a doctor might deliberately kill his patients. No other officer in the GMP sought to support that view. CS Sykes was reluctant to criticise DI Smith in this respect but eventually agreed that the check should have been made. The flaw in Det Supt Ellis' reasoning is so obvious, that I find it amazing that the report was not sent back for amendment, as soon as it had been seen by a senior officer. The reasoning seems to be that DI Smith was investigating an allegation that could not be true; therefore there was no need to do it thoroughly. If the police are asked to investigate an excess of deaths in unusual circumstances among the patients of a particular doctor, it must be because it is suspected that he might be harming them. The fact that the allegation is most unusual cannot be an excuse for not carrying out a routine (and important) part of any criminal investigation. I note, also, that Det Supt Ellis had not established why DI Smith had not checked for previous convictions. He told the Inquiry that he had forgotten to do so. It appears that Det Supt Ellis understood that DI Smith had consciously decided not to do so.
- 14.28 Det Supt Ellis then embarked upon an indictment of Dr Reynolds. He catalogued her supposed failures. She had not told DI Smith about the comparative death rates. (This was a manifestly unjustified accusation because DI Smith certainly knew of the figures; they were in his daybook.) She had not said that she thought he might be murdering his patients. (She had.) She had not identified the female undertaker. Her claim (as reported in the media) that she had told DI Smith of two bodies available for autopsy was untrue. She had given him no documentary evidence and had identified no potential witnesses. Her bona fides were questioned; it had been claimed in the media that she and her

partners were discussing their concerns for some time before she made her report to the Coroner; yet, Det Supt Ellis noted, she herself had continued to sign cremation certificates until 17th March 1998 and her partners were signing them during the first investigation. What this list of failures implied was that Dr Reynolds had made a report and had then failed to co-operate with the investigation or to act in a manner consistent with her concerns. I accept that Det Supt Ellis had received a grossly misleading account of the part played by Dr Reynolds. However, he had reached conclusions critical of Dr Reynolds without once querying the account he had been given.

- 14.29 Det Supt Ellis observed that the Masseys had offered nothing to progress the enquiry. Indeed they had not; they had had little opportunity to do so. However, Det Supt Ellis accepted, without question, DI Smith's claim that Mrs Bambroffe had said it was all gossip and a joke, which was, as I have said, a travesty of the truth.
- 14.30 Det Supt Ellis observed that the register office had failed to provide a complete bundle of death certificates for the six-month period. However, he did not suggest that this failure had had an adverse effect on the investigation. He said only that it was difficult to see how the true figure could have influenced the officer, given the constraints of the investigation. In oral evidence, he said that it appeared to him that DI Smith had not understood or explored the significance of the number of deaths; therefore, it would not have made any difference to his investigation even if he had discovered the true number of deaths. If that was his reasoning, which I doubt, it is surprising that he did not explain it in his report. It would have been in sharp contrast to his otherwise bland acceptance that DI Smith had done a perfectly acceptable job. I think it far more likely that he meant that, as DI Smith could not interview the relatives of the 19 deceased patients of whom he knew, it would not have helped to know that there were in fact 31 patients of Shipman who had died in the previous six months. He still would not have been able to interview the relatives.
- 14.31 Without further comment or justification, Det Supt Ellis observed that DI Smith could have acted in no other way than to accept the findings of Dr Banks. In oral evidence, he accepted that he did not have the necessary information to advance an opinion in those strong terms. He also agreed that he had reached conclusions without making any critical analysis of the information he had received. In his report, he concluded that the investigation conducted by DI Smith was **'appropriate at the time'**. (I note that this was precisely the expression used in DCS Keegan's memorandum of 8th December 1998, a document which Det Supt Ellis had seen. Det Supt Ellis agreed that he was heavily influenced by the views expressed earlier by senior officers.) He went on to say that **'criticism could be levelled'** at the organisation in respect of DI Smith's failure to keep records and observed that this might give rise to difficulties at the forthcoming Inquiry. This was similar to the observation made in December 1998 in the correspondence between DCS Keegan and Mr Postles. He moderated his criticism of DI Smith's failure to keep records by suggesting that written records might have been kept if any evidence supporting the suspicions had come to light.
- 14.32 This report was accepted without criticism by senior officers in the GMP. ACC Sweeney told the Inquiry that it was 'reassuring' in that it contained no surprises. It remained the

official view of the Force that the first investigation had been 'appropriate at the time'. It appears that senior officers felt that the investigation had been hampered by two particular difficulties, the need for confidentiality and what came to be known as 'the credibility gap'. Yet, on examination, neither of these amounted to an explanation, let alone an excuse, for the failure of the investigation.

- 14.33 The need for confidentiality imposed on the investigating officer limitations that would not usually apply in a murder investigation. DI Smith could not, as would be usual practice, interview and take statements from the relatives and neighbours of the people whose deaths had given rise to concern. But that was known from the start and, as has now been recognised, there were many lines of enquiry that could have been pursued, with success and without loss of confidentiality, if only the officers involved had thought of them. Even those enquiries that DI Smith did think of, he did not pursue thoroughly.
- 14.34 By 'the credibility gap', the officers of the GMP meant the difficulty that they had in accepting that it was possible that a doctor, particularly one as well-respected as Shipman, might deliberately kill his patients. I accept the general proposition. For a person, such as Mr Alan Massey, with no professional responsibility to investigate any suspicions brought to his attention, I accept that the difficulty would be very great indeed. Mrs Angela Woodruff spoke of the same difficulty; I quoted from her views in Chapter One of this Report. However, a police officer charged with an investigation cannot perform his professional duty unless he is able to set aside these difficulties and open his mind to the possibility that the incredible allegation might be true. Mr Postles spoke of his own difficulty in believing that Shipman might have killed a large number of patients. He said that he remained in doubt even until the trial began. That may be so, but his incredulity did not prevent him from conducting a thorough and searching investigation.
- 14.35 I accept that the police will sometimes be faced by allegations of an incredible nature from a source in which they do not have much confidence. That is bound to affect the vigour with which any investigation is conducted. The Inquiry was always anxious to discover whether DI Smith or CS Sykes had ever regarded Dr Reynolds as an unreliable source. They denied it. If those denials are true, then the fact that she was raising concerns of a very serious nature imposed on them a duty to investigate thoroughly and with an open mind. If, on the other hand, they thought she was unreliable or malicious or had 'a bee in her bonnet', then it would be understandable if they failed to open their minds to the idea that Shipman might be a serial killer. But, in my view, the police cannot, at the same time, claim that they regarded Dr Reynolds as a sensible professional woman with genuine concerns and rely on the 'credibility gap' to excuse the inadequacy of their work.
- 14.36 It appeared to be the intention of the Force that the Ellis report would form the basis of the GMP's case to the Laming Inquiry. ACC Sweeney told the Inquiry that the police saw the Ellis report as 'the beginning of a process of gathering information', a process which foundered with the end of the Laming Inquiry. Whatever the earlier intentions, no further investigative work was done.

The Evidence Initially Submitted to the Shipman Inquiry

- 14.37 The Shipman Inquiry was set up in January 2001, following judicial review proceedings of the Secretary of State's decision to convene the Laming Inquiry, which was to sit in private. On 6th February 2001, in response to a request from Mr Campbell Kennedy, then the Solicitor to the Inquiry, the GMP provided copies of various documents including the Ellis report. In May 2001, I announced that the Inquiry would be conducted in phases, the first of which would be devoted to an investigation into which and how many patients Shipman had killed and that the first police investigation would be examined as part of Phase Two. In December 2001, I announced that I hoped that the hearings relating to the first police investigation would begin in May 2002. During the second half of 2001, the GMP and DI Smith submitted witness statements, the thrust of which was that DI Smith's investigation had been thorough, given the information available at the time, but had been hampered by the need for confidentiality. The Inquiry received no indication that the Ellis report did not represent the views of senior officers in the Force.
- 14.38 In March 2002, the Inquiry released to participants the CD-ROM containing the statements and documentary evidence to be relied on during the hearings in relation to the first police investigation. Meanwhile, the GMP had submitted to the Inquiry a witness statement, dated 19th February 2002, from Detective Chief Superintendent Stelfox. This dealt specifically with a series of questions posed in a letter from Miss Ita Langan, Deputy Solicitor to the Inquiry; those questions were designed to discover the rules of best practice in respect of note taking and record keeping in the course of a police investigation. DCS Stelfox provided a helpful account with references to the Code of Practice made under Section 23 of the Criminal Procedure and Investigations Act 1996, which came into force on 1st April 1997. DCS Stelfox later submitted a second statement to the Inquiry, dated 26th April 2002, in which he accepted that the Code applied to the March 1998 investigation and that the failure of DI Smith to keep adequate records amounted to a breach of the Code. He also expressed the view that the preparation of a written report at the conclusion of the investigation, although not required under the Code, would have been good practice. He pointed out that responsibility for setting the requirement for a final report, and for specifying the form in which it should be provided, had lain with CS Sykes.

The Stelfox Report

- 14.39 On 23rd April 2002, barely two weeks before the Inquiry hearings were due to begin, DCS Stelfox was instructed to undertake a complete and fundamental review of the conduct of the March 1998 investigation. He had not completed it when the hearings began on 7th May. Nonetheless, his findings were such that, when called upon to make an opening statement to the Inquiry, Mr Michael Shorrocks QC, on behalf of the GMP, admitted that the first police investigation into Shipman had been seriously flawed. In particular, he said that the strategic management of the investigation had been flawed 'due to the lack of clarity of ownership of the investigation'. By that, he meant that it had not been clear whether the investigation had been conducted on behalf of the police or on behalf of the Coroner. Mr Shorrocks also said that the investigation was flawed 'due to the lack of agreed criteria or aims and the failure to outline clear reporting mechanisms'. He continued by

accepting that collection of available information had been incomplete and not fully recorded. The interpretation of such information as had been gathered had been flawed. That was partly due to the fact that the police themselves had been provided with information which was incomplete or flawed. He accepted that there had been a failure to recognise that various pieces of information tended to support Dr Reynolds' suspicions. However, the lack of a strategic framework had, he said, deprived those conducting the investigation of a mechanism for deciding whether further and wider enquiries should have been undertaken. The investigation had terminated prematurely. Mr Shorrock declared that it was by no means certain that, if it had continued, lives would have been saved. On behalf of the GMP, he asserted the Force's determination to learn from their mistakes and to deal thoroughly and impartially with any complaints. He reminded the public of the skill and professionalism with which the later, successful investigation into Shipman had been conducted. He concluded by expressing the Force's deepest regrets to the families and friends of the victims who died at Shipman's hands.

- 14.40 I thanked Mr Shorrock and the GMP for the openness of those admissions, which had come as a complete surprise to me and the Inquiry team. I observed that it appeared that there must be some documents which had not yet been disclosed to the Inquiry. When DCS Stelfox's report became available (it is dated 15th May and was submitted to the Inquiry soon afterwards), it was found to be a careful, detailed, objective analysis of the evidence then available in respect of the first investigation. The report recognised that there were some issues on which the position would remain incomplete until oral evidence was heard. On the basis of the evidence already available, DCS Stelfox was deeply critical of DI Smith for his conduct of the investigation and of CS Sykes for his failure properly to direct and supervise it.
- 14.41 DCS Stelfox followed the evidence given at the Inquiry and, when he came to give oral evidence on 11th June, he said that his views had changed very little. He remained deeply critical of the first investigation.
- 14.42 I do not propose to set out DCS Stelfox's conclusions. They are broadly compatible with my own conclusions, save in one respect. DCS Stelfox was of the view that there had been confusion about whether the investigation was a police investigation or was being conducted on behalf of the Coroner. He thought that this had led to uncertainty about who was in charge and was responsible for making decisions. I do not agree that there was any such confusion or uncertainty. CS Sykes, DI Smith and Mr Pollard all thought this was a police investigation. In my view, it clearly was. I do not think there was any doubt that the police were in charge. CS Sykes was responsible for decisions but he delegated that responsibility to DI Smith. CS Sykes should not have taken charge because he did not have the experience or expertise required for the task. Once in charge, he should not have delegated responsibility for taking the decision to close the investigation.
- 14.43 The question arose as to why the police had waited until the eleventh hour before undertaking the objective review eventually conducted by DCS Stelfox. It was claimed on their behalf that they were unable to do so until they received the CD-ROM containing the Inquiry's evidence. It was argued that they could not embark on a thorough investigation without having access to the evidence of witnesses. It would not have been proper, it was

said, for them to seek to interview witnesses while the Inquiry was proceeding. I accept that it would not have been appropriate for them to have approached witnesses such as members of the Massey family, the doctors of the Brooke Practice or the Coroner. Had they asked permission to do so, I would have refused. There would have been a danger that a witness might be influenced by police questioning. However, I do not accept that the GMP could not have done a great deal more to investigate their own shortcomings than they did. Indeed, DCS Stelfox agreed that that was so. They could have probed DI Smith's various accounts of events, which were riddled with inconsistencies and improbabilities. They could have questioned him closely about his approach to the issue of numbers of deaths and the comparative death rates. It would have been immediately apparent that he had done nothing about them and had not understood their significance. Yet he had told no one of his difficulty. They could have found out that he had never realised that the bundle of copy death certificates he had been given was incomplete and that he had never asked Dr Reynolds whether or not she had any documentary evidence in support of her figures. They could have found out that he had not asked either Dr Reynolds or any of the Brooke Practice doctors about the individual deaths about which they were concerned. They could have asked him why he had not spoken to the Brooke Practice doctors. They could have quizzed him about how the names of Mrs Lily Higgins and Miss Ada Warburton came to be in his daybook, apparently at a time when the bodies of those patients had not yet been cremated. They could have asked him what questions he had asked Mrs Bambroffe and whether they included questions about the particular deaths she had had in mind when she shared her concerns with Dr Reynolds. They could have discovered the nature of the documentation which would have been available to him, such as cremation forms. They could have examined their own HOLMES database. They did none of these things. For over three years, from late 1998 until April 2002, they accepted DI Smith's own account and subjected it to no critical analysis whatsoever.

Findings

- 14.44 In my view, the GMP ought to have undertaken a searching enquiry into why their investigation had failed. They well knew that three lives might have been lost as the result of that failure.
- 14.45 I regret to say that I have been driven to the conclusion that, had it not been for the Shipman Inquiry, the GMP would never have made any more thorough enquiry into this matter than had been carried out by Det Supt Ellis. They submitted his report to this Inquiry without expressing any reservations about its conclusions. Until a very late stage, their stance was that DI Smith's investigation had been as thorough as was possible in the circumstances. I fear that the truth might not have emerged at all if the Shipman Inquiry had not been set up. The Laming Inquiry did not have the extensive investigative resources that enabled this Inquiry to uncover the evidence that has revealed the untruthfulness of DI Smith's account.
- 14.46 That said, once DCS Stelfox had investigated, the GMP accepted his conclusion without reservation. The conduct of the hearings on their behalf was entirely proper and at no stage did they seek to defend that which had occurred. They raised points in mitigation of their failures but only to a realistic extent.

14.47 There is a natural and understandable instinct in all individuals to seek to avoid criticism if possible. In organisations, there is a natural tendency to close ranks for mutual self-protection. That these are natural instincts goes some way towards mitigating the gravity of the failure of the GMP to face up to their shortcomings in respect of this investigation at an earlier stage.

CHAPTER FIFTEEN

An Analysis of Dr Banks' Role

Finding a Benchmark

- 15.1 It is necessary now to revert to the contribution of Dr Banks to the police investigation and to make a more detailed and critical examination of his review of the medical records.
- 15.2 When it appeared that it would be necessary for me to assess the adequacy of Dr Banks' examination of the medical records of Shipman's deceased patients and the reasonableness of his conclusions, it was decided that I should be given some benchmark by which to judge him. The Inquiry sought the assistance of Dr Frances Cranfield, a general practitioner of about 20 years' experience. On the face of it, her professional experience as a general practitioner seemed comparable to that of Dr Banks. She was asked to consider the same records as had been examined by Dr Banks in March 1998. She was told what background information Dr Banks had received (that is the information from Mrs Parkinson's note) and was asked to advise as to the adequacy or otherwise of Dr Banks' review and whether his apparent conclusions were reasonable and consistent with his professional duty in the circumstances. In evidence, Dr Cranfield said that she tried to approach her task, putting from her mind her knowledge that Shipman had been convicted of murdering his patients. If she had had only the background knowledge available to Dr Banks, she would have examined the records for signs of gross mismanagement, rather than criminality, although the presence of the police and the mention of donations to a fund might mean that she would have had the possibility of criminal behaviour in the back of her mind.
- 15.3 Unfortunately, no limit was imposed on the time Dr Cranfield was to spend on this task. It was not known at that time that Dr Banks had spent only five hours on his review. In the event, Dr Cranfield spent about 45 hours on the task and produced a very detailed analysis of what the records revealed. Simply on account of the time taken for the task, it would not have been fair for me to compare the results of her work with that of Dr Banks. However, further reasons emerged why I could not use her work as a yardstick by which to judge Dr Banks. She had undertaken some training in forensic medicine; she had acquired considerable experience as an expert witness and had a good deal of practice in writing reports.
- 15.4 For those reasons, it would be unfair for me to judge Dr Banks' work against that of Dr Cranfield. Accordingly, I shall not lengthen this Report by undertaking a review of her findings. Suffice it to say that I found her report and evidence most illuminating. She demonstrated very clearly that, if the police had instructed an expert of her calibre and expertise to examine the records in March 1998, they would have been advised that there were substantial reasons for concern about Shipman's conduct. Dr Cranfield observed many worrying features of Shipman's records. I mention only one in detail. She recognised, from the records, that several of Shipman's patients appeared to have been found dead, not long after he had visited them, and that he had apparently left them alone, not anticipating that they were about to die. Yet, when they died suddenly and unexpectedly later that day, Shipman was prepared to certify the cause of death and not

to refer the deaths to the coroner. That trend of sudden death shortly after a visit would have caused Dr Cranfield to think that Shipman's treatment of his patients was substandard. After looking at the tranche of cases which Dr Banks had seen, she said she would have suspected criminal behaviour in the form of gross negligence. In fact, she went on to examine more cases and these would have caused her to take an even more serious view. Had Dr Cranfield reviewed the medical records which Dr Banks saw, the outcome of the first investigation might well have been very different. That observation is not necessarily intended as a criticism of DI Smith's decision to accept assistance from Dr Banks, at least in the first instance.

- 15.5 The Inquiry also received a report written by Dr Nina Moorman, a general practitioner and formerly a part-time medical adviser to a health authority. In 2000, Dr Moorman had been asked, in connection with the WPHA's proposed disciplinary proceedings against Dr Banks, to review the 15 sets of medical records which Dr Banks had examined in March 1998. She had concluded that Dr Banks' review of the records was perfectly satisfactory, given the circumstances in which he was asked to undertake the task. Partly as a result of that opinion, the Health Authority discontinued the disciplinary proceedings.
- 15.6 Examination of a chart prepared by Dr Moorman revealed that she had noted that, in five of the 14 deaths, the situation revealed by the records suggested that the death should have been reported to the coroner. Yet she knew that Shipman had made no such report. To be fair, she did not know whether Shipman might have 'discussed' the death with the coroner and received 'permission' to issue the MCCD. However, she dealt with this issue in her report by saying that Dr Banks should not be criticised for any lack of care because, in her view, **'he did express concerns about a number of deaths to the Police and this might have been given more weight in the investigation by the Coroner, which appears to have been under consideration until 21 May 1998'**. It is a matter of concern to me, although I do not think that this occurred to the WPHA or those advising them, that, in giving her opinion, Dr Moorman went beyond her proper function as an expert and descended into the arena as an advocate for Dr Banks. It was for her to advise on what the records should have revealed to a medical adviser applying himself with reasonable skill and care to the task in hand. She could also properly have indicated the degree of concern which the records would have raised in her mind and the terms in which a reasonable medical adviser would have reported to the police. It would then have been for others to compare Dr Banks' actual performance with what she had said was reasonable. Many professional people, asked to express an expert view, do not fully understand the purpose and limitations of expert evidence.
- 15.7 Notwithstanding the shortcomings of Dr Moorman's report, the Inquiry decided to call her to give evidence. When the Inquiry received Dr Cranfield's report and found that she was critical of Dr Banks, it was thought that, in fairness to Dr Banks, an expert who was known to be supportive of him should also be called. When Dr Moorman gave evidence to the Inquiry, she accepted that, apart from the five cases she had identified which should in her view have been reported to the coroner, there were other features revealed by the records which gave rise to concern. She agreed that it was a cause for concern that, in seven of the 14 cases, the death appeared to occur soon after a visit by Shipman at which he had not recorded in the notes any indication that the patient was seriously ill. She

agreed that, if Dr Banks had noticed this feature, he should have mentioned it to the police. She said that it would also have been appropriate for Dr Banks to raise these concerns with Shipman on a case-by-case basis. She then added that it was her belief that he had done so. This confirms me in my view that Dr Moorman did not understand the limitations of the expert's role. Once again, she had gone beyond her remit and had taken up Dr Banks' cause.

- 15.8 I was unable to accept the opinion advanced in Dr Moorman's written report. That part of her oral evidence which consisted of true expert opinion tended to suggest that there were features to be noted in the records which should have been mentioned to the police.
- 15.9 It follows that, despite the Inquiry team's best efforts, I was left to make my own judgement of Dr Banks. Fortunately, despite some uncertainty about his ability to give evidence on account of recent ill health, Dr Banks was able to face detailed questioning about his examination of the medical records. My conclusions are based almost entirely upon admissions made by him and necessary inferences from his evidence.

Concerns about Shipman's Failure to Report Deaths to the Coroner

- 15.10 Shortly before giving oral evidence, Dr Banks was asked to reconsider the medical records he had first examined in March 1998. By this time, he had received the evidence of Dr Cranfield. He prepared a final written statement. First, having made the point that he had spent only five hours on the task and had not been able to read every single document within the records, he helpfully identified those documents which, by reference to the information recorded in his chart, he inferred he must have seen and examined at the time. Second, he identified the deaths of Mrs Bertha Parr, Miss Mabel Shawcross, Mrs Cissie Davies and Mrs Winifred Healey as deaths that ought to have been referred to the coroner because there was insufficient information in the medical records to permit adequate diagnosis of the cause of death. It should be noted that Dr Banks was not saying that he personally would have reported these cases; he was saying that any reasonable doctor would have reported them, at least if the only information available was that recorded in the notes. As all relevant material ought to be recorded in the notes, it would appear that, in each of these cases, there was cause for concern that not enough was known about the case to permit an adequate diagnosis of the cause of death.
- 15.11 In his final written statement, Dr Banks also identified five other cases in which he said that he personally would have reported the death to the coroner because he would not (on the basis of the information contained in the available records) have been sufficiently sure of the cause of death. However, he said that it would not have been universal practice to do so. He said that he was uncertain whether or not he had mentioned these cases to DI Smith but I am satisfied that he did not. These cases were those of Mr James King, Mrs Norah Nuttall, Miss Muriel Harrison, Mrs Pamela Hillier and Mrs Joan Dean. He said that these cases would not have caused him any concern in March 1998, as he would have assumed either that the medical records were incomplete or that Shipman had additional information, not recorded, from which a proper diagnosis could have been made. It appears that Dr Banks' approach to his task was affected by a readiness to find an innocent explanation for anything that might give rise to concern.

- 15.12 It is to be noted that Dr Banks did not claim that, in March 1998, he had not had time to examine the records so as to identify the four cases which should have been reported and the five cases which he personally would have reported. He was suggesting that he had in fact identified them. In three of the four cases, he said he believed that he had mentioned them to DI Smith as being reportable.
- 15.13 When giving oral evidence, Dr Banks was taken through all the sets of medical records he had examined in 1998. He stressed that, on the earlier occasion, he had not had time to examine every document within the records or to cross-check that the information which appeared on a summary card accurately reflected the detailed entries in the notes. I accept that that was so and that it was a reasonable approach to the task, as he understood it. He repeated that he had been asked to see whether the common features were present and said that he also looked to see whether or not the medical history was generally consistent with the cause of death as recorded by Shipman in the records. It seems to me that, while five hours was not long enough to undertake an in-depth study, it was sufficient to allow him to assess the adequacy of the information from which to diagnose a cause of death and to look for common features. Dr Banks did not suggest the contrary. In my view, in undertaking that limited review, he should also have had the time and opportunity to notice any strikingly unusual features which might give rise to concern of any kind. I did not understand Dr Banks to dissent from that. In any event, if Dr Banks had felt that he required more time to perform the task he had been asked to undertake, he could have asked for it.
- 15.14 Throughout his evidence, Dr Banks repeated that he had approached his task in the belief that it was unthinkable that Shipman might have harmed his patients but that he had, nonetheless, undertaken the work carefully.
- 15.15 I do not propose to lengthen this Report by a detailed consideration of each set of records examined by Dr Banks and an analysis of his opinion about them. Suffice it to say that, while giving oral evidence to the Inquiry, Dr Banks confirmed his view that there were four cases which, he said, should definitely have been referred to the coroner and six (as opposed to five) cases which he personally would have reported to the coroner, rather than certify the cause of death himself. In addition to the five cases mentioned earlier, he had identified another, that of Mrs Bianka Pomfret. However, he said that some doctors would not take that view about those six cases and would be prepared to certify the cause of death. Some doctors were much stricter than others about the circumstances in which they were prepared to certify. Some coroners, he said, imposed more stringent rules than others in respect of the cases that they required to be reported. I accept that this is so.
- 15.16 Dr Banks' evidence about his attitude to Shipman's failure to refer cases to the coroner was inconsistent. At one stage, he said that he had not thought that Shipman's failure to refer cases to the coroner was a cause for concern. He himself had not practised as a general practitioner in the Hyde area and did not know what the coroner expected. He also thought he did not have access to all the information that had been available to Shipman. He thought Shipman might have certified the cause of death because he wished to save the relatives from the additional distress of an autopsy. He thought that he ought to give Shipman some advice about his practice in relation to coroners' referrals. He felt that Shipman's practice was lax but he did not regard this as a cause for concern.

- 15.17 Inconsistently, at another stage of his evidence, Dr Banks claimed that he believed he would have been sufficiently concerned about Shipman's failure to refer the most obviously reportable deaths to the coroner that he would have mentioned the deaths to DI Smith. I do not think he can have been as concerned as he claimed. If he had identified and been concerned about the four cases which, he said, should definitely have been reported to the coroner, I do not think he would have told Mrs Parkinson on Friday, 27th March 1998 (as, according to her note, he did) that there were **'a couple of cases'** about which he was concerned. Dr Banks was anxious to persuade me that by **'a couple of cases'** he had meant 'a few'. I think it unlikely, although not impossible, that Mrs Parkinson would have written **'a couple of cases'** if Dr Banks had used the expression 'a few'. However, I find it hard to accept that Dr Banks would have used the expression **'a couple'** or even 'a few' if he had four cases in mind. I think he would probably have said there were four. If Dr Banks had had in mind that there were another five or six cases that some doctors, including him, would think it right to report, one would expect his level of concern to have been raised further. It would then be most unlikely that he would use so casual an expression as **'a couple'** or 'a few'. On the basis of his own assessment of the propriety of Shipman's certification of these ten cases (or nine, if Mrs Pomfret is excluded), it seems clear to me that Dr Banks should have felt some real concern about Shipman's willingness to certify deaths rather than refer them to the coroner. Yet, whether he used the expression **'a couple'** or 'a few', it is clear that he did not. Dr Banks agreed that he would not have used those expressions if he had had nine or ten cases in mind.
- 15.18 I note also that, whereas Dr Banks now says that four cases should definitely have been referred to the coroner, DI Smith had the impression that Dr Banks was saying that he personally would have referred them, implying that it would have been within the limits of reasonable conduct for a doctor to decide not to report such a case to the coroner. Although, for reasons I have previously explained, I do not regard DI Smith as a generally reliable witness, I am inclined to accept his evidence on this point. I say that, first, because a low level of concern is reflected in Mrs Parkinson's note made on 27th March and there would be no reason for Dr Banks' attitude to have changed by 1st April. Second, if Dr Banks had said that Shipman had failed to report even two deaths (let alone 'a few' or four) which any reasonable doctor would have known he should report, I think it is likely to have made some impression on DI Smith. Third, when writing his report for the Health Authority, which was his earliest known account of these events, Dr Banks said that he had **'... expressed concern that in a number of cases there was insufficient evidence in the records on which to base a cause of death and that I personally would have arranged a post-mortem'**.
- 15.19 It appears to me that Dr Banks cannot have identified four cases as requiring referral to the coroner. Had he done so, and had he also identified five or six other less clear-cut cases, this would have given rise to a substantial degree of concern. I am satisfied that Dr Banks' actual level of concern was low and was properly reflected by Mrs Parkinson's note. I can only conclude that Dr Banks' examination of the records, and the judgement he brought to bear, were adversely affected by his inability or unwillingness to open his mind to the possibility that any doctor might harm his patients, particularly Shipman, of whom he thought well.

Concern about the Common Features

- 15.20 Dr Banks said that he had not noticed any common features between the deaths. It will be recalled that one of the common features Dr Banks understood he was supposed to look for was Shipman's presence at or around the time of death. As he was taken through the 14 sets of records, Dr Banks' attention was drawn to the fact that, in seven cases, the records showed that Shipman had seen the patient not long before the death was discovered. In each case, the notes recorded that he had visited on the day of death (or, in one case, on the day before). The medical records did not suggest any serious cause for concern about the patient's health; certainly, there was nothing that appeared to presage death. Yet the patient had been found dead later that day (or, in one case, early the following day). These cases were those of Mrs Elizabeth Battersby, Mrs Mavis Pickup, Mrs Pomfret, Mr King, Mrs Davies, Mrs Hillier and Mrs Nuttall. Dr Banks said that he did not know whether he had noted these similarities. In my view, they were plainly very remarkable and significant. It is unusual for a patient to be found dead within a few hours of a doctor's home visit in circumstances where the doctor did not appear to have felt any concern for the patient's health. Such an event might suggest that the visiting doctor had misdiagnosed the patient's condition. If this kind of misdiagnosis were to happen once within six months, that might not be thought significant but if such an event were to occur seven times in six months, one would expect any doctor to notice it and to be concerned.
- 15.21 Yet it appears that Dr Banks did not notice this common feature. In the **'Who Saw'** column of his chart (in which he had intended to record who had been present at or around the time of death), Dr Banks noted Shipman's name in no fewer than ten of the 14 cases. However, it appears that he was interested, not in whether Shipman had been present shortly before the death was discovered, but in whether Shipman had found the body. That, he said, was not always clear from the records. In any event, he said, he did not regard it as strange that Shipman should have been around at the time of the death, as it was common for a general practitioner to be called to a death. That is plainly true and I can understand why presence after the death would not give rise to suspicion. It had been suggested to Dr Banks that Shipman often appeared to be the one to find the body and he is right to say that it was not always possible to tell from the records whether or not he had done so. However, if Dr Banks had only applied his mind to the slightly different but related question of Shipman's presence shortly before the death was discovered, he would have noticed a factor of real significance and concern.
- 15.22 In evidence, Dr Banks agreed that there were some common features to be found in the 14 sets of records. One striking feature was that most deaths involved elderly females. Of the 14 deaths, 13 were women. Given the overall population mix, that is unusual. Ten of the 14 deceased had been aged over 70; that does not seem in any way remarkable. Another concern expressed was that the deaths had occurred at home. Of the 14 deaths, 12 had died in their own private homes; the other two were in residential care or nursing homes. I would have expected that to strike Dr Banks as unusual.
- 15.23 Dr Banks said that he did not appreciate that there was a high incidence of some of the features that he had been asked to look out for. He said that he had been told that the deaths which caused concern had all the common features. So, as he found deviations

from the pattern, he concluded that there was no pattern. I find it hard to credit that a doctor of Dr Banks' experience could have taken so simplistic a view. I think this must be an attempt at an excuse which, in fact, does him little credit. Any person of even modest intelligence would realise that, if a doctor was suspected of killing his patients using a similar method each time, one would expect to see a pattern of similarities between the deaths. However, one would not expect that pattern to be found in every patient's death; one would expect that some patients would happen to die naturally; their deaths would not conform to the pattern. I do not think that Dr Banks could have taken so simplistic a view of his task. The way he put it to Mrs Parkinson was that no two cases were the same. That is very different from saying that there is no pattern of significance because there is no factor present in all cases.

- 15.24 There can be no doubt that Dr Banks should have noticed that all but one of the deaths was of a female patient. This was one of the matters of concern and it was an odd feature. I think he should also have been slightly puzzled at the high incidence of home deaths. I also think that he ought, in the circumstances, to have noticed that, although there was no clear evidence that Shipman found his patients dead, he had seen the patient shortly before the death was discovered in an unusual number of cases. I conclude that Dr Banks' search for the common features was superficial.

Signs of Substandard Care

- 15.25 Dr Banks said that he had not considered the records to see if they revealed any signs of substandard care. He had not been asked to do so and he would have thought it dangerous to do so, as he thought the records might be incomplete. He was then taken through some cases which, in the submission of Leading Counsel to the Inquiry, showed clear evidence of substandard treatment such as would give rise to concern in the mind of any doctor who examined the records with reasonable skill and care.
- 15.26 The first was the case of Mrs Elizabeth Battersby, whose records show that she died of a pulmonary embolism, supposedly following a deep vein thrombosis, for which she was not admitted to hospital but was treated at home on an oral anticoagulant. Dr Banks said that he thought the records might be incomplete and that, if they were complete, they would have shown that Shipman had taken advice from the hospital about treatment at home. In other words, it appears that his approach to the records in this case was to look for an innocent explanation for anything unusual. He agreed that, when he examined Mrs Battersby's records again, in September 1998 (by which time Shipman was under investigation for the murder of Mrs Kathleen Grundy), he expressed the opinion that Shipman's standard of care was unacceptable. His explanation for this change of view was that, by September, he had a different mindset. In March, he would have found it inconceivable that Shipman might have harmed a patient. By September, his mind was open to that possibility. In March, he had not thought that there was any reason for concern about this death and had not thought that it should have been reported to the coroner. He now accepted that the records did reveal cause for concern and a reason to refer the case to the coroner. That meant that he conceded that, in all, 11 of the 14 cases ought perhaps to have been referred to the coroner.

- 15.27 Another set of records about which Dr Banks was asked were those of Mrs Mavis Pickup. Shipman had certified that Mrs Pickup had died of a cerebrovascular accident or stroke. The records showed that Shipman visited her on the day of her death. He recorded a history of symptoms that sounded like either a transient ischaemic attack or a minor stroke, from which Mrs Pickup seemed to be recovering. No treatment had been prescribed. Mrs Pickup was said to have been confused. She was found dead later in the day. When asked whether he felt any concern on reading that Mrs Pickup had been in a confused state and yet had been left alone, Dr Banks said that it was not clear whether Mrs Pickup had been left alone. However, he agreed that it was clear that she was alone when found dead later in the day. He did not think this seemed strange or worrying. He agreed that the history, which suggested a minor stroke earlier in the day followed by an overwhelming stroke leading to sudden death, was an unusual combination and that a sudden death would not have been expected following a slight stroke. However, Dr Banks said, it was not impossible that that had occurred and he had not seen the combination as unusual at the time. If he had thought it was unusual, he would have put it down to inaccuracy in the records. He agreed that his approach was affected by his belief that Shipman was a competent and respected practitioner. In any event, Dr Banks recorded no concern about Mrs Pickup on his chart and did not think that the circumstances of her death warranted a report to the coroner.
- 15.28 It is clear from the cases of Mrs Battersby and Mrs Pickup that Dr Banks approached his examination of the medical records in the belief that there would be no cause for concern. In my view, Dr Banks' prior knowledge of Shipman made him an unsuitable person to form any judgements about Shipman's actions or competence. Dr Banks said that he thought that his prior knowledge of Shipman would have made it inappropriate for him to write a commentary on Shipman's work but he felt that it was acceptable for him to undertake the task of extracting facts from the records. I see the distinction that Dr Banks sought to draw. However, in my view, even the extraction of facts calls for the exercise of some judgement, particularly where, as here, the facts are not clearly set out and inferences have to be drawn.

Findings

On the Basis of the Medical Records that Dr Banks Actually Considered

- 15.29 In my view, Dr Banks failed to see that which was there to be seen on a careful and open-minded examination of the records. He failed to recognise features that tended to support the concerns expressed. Why? I do not think the problem was that he was lazy or did not care. I think he is a reasonably conscientious man, although I do not think he would usually exert himself beyond the call of duty. I think he simply could not open his mind to the possibility that Shipman might have harmed a patient. Accordingly, instead of searching for the odd features, he anticipated that all would be normal. For such features as did strike him as odd, he immediately found an innocent explanation. I think also that he thought that the expression of concern by the general practitioner was probably underlain by professional jealousy or some other personal animosity. That attitude too was born of his prejudice in favour of Shipman.

15.30 In mitigation of this failure, I accept that Dr Banks was not given all the information he could and should have been given. It should have been spelled out to him that a general practitioner, who appeared to be a responsible person, was concerned that Shipman might be killing his patients and that these concerns were shared by an undertaker. The Coroner had referred the matter to the police for investigation. He should have been told of the comparative death rates of the two practices concerned. I think there is a real possibility that, if Dr Banks had been fully informed, his mind might not have been quite so tightly closed against the possibility of Shipman's guilt.

On the Basis of the Medical Records that Dr Banks Might Have Considered

15.31 It remains to consider what the outcome might have been if the staff at the Tameside register office had identified all the deaths of Shipman's patients certified by him in the previous six-month period. Instead of receiving a bundle of 19 (or 20) copy certificates, DI Smith would have received 31. I have said that I do not think this would have had any significant effect on DI Smith's approach to the investigation. What would have been the effect on Dr Banks? Not only would Dr Banks have known of more deaths, he would also have examined more sets of records.

15.32 Dr Banks said that he did not know the average death rate for patients of a general practice. The figure he was given, 16 cremations in three months, did not strike him as particularly high. If that figure did not strike him as high, then it seems highly unlikely that 31 deaths in six months would have made any impression on him. However, the position is not quite so straightforward. Dr Banks said that he noticed that the 14 sets of records he looked at initially covered a period of six months and he said that he 'assumed' that the figure of 16 cremations in three months was wrong. His view that the death rate was not abnormal might have been affected by his assumption that the figures were wrong anyway. If DI Smith had had 31 copy certificates and if he had provided all or nearly all the names to the Health Authority, Dr Banks would probably have accepted the figures as accurate. It is impossible to say whether the death rate would have then appeared to him as high. I can only say that the chance that he would have thought the death rate abnormal would have been increased.

15.33 However, Dr Banks would also have examined a larger number of sets of records. It is impossible to say with certainty how many he would have seen. I think DI Smith would probably still have withheld the names of Miss Maureen Ward and Mr Harold Eddleston initially, on the grounds that the deaths were certified as being due to cancer. I think it unlikely that the records for any death occurring after 1st March 1998 would have been available. It is therefore unlikely that Dr Banks would have examined the records of Mrs Irene Chapman, Miss Ada Warburton or Mrs Martha Marley. Accordingly I estimate that he probably would have seen nine additional sets of records, making 23 in all. The additional records would have related to Mrs Bessie Swann, Mrs Enid Otter, Mrs Florence Lewis, Mrs Mary Walls, Mrs Elizabeth Baddeley, Mrs Kathleen Wagstaff, Mrs Alice Black, Mrs Laura Linn and Mrs Irene Berry.

15.34 Of these nine additional cases, it is noteworthy that all the deceased were women. Shipman had been present at three of the deaths (those of Mrs Walls, Mrs Linn and

Mrs Wagstaff) although, in the case of Mrs Linn, her husband had also been present. Shipman appeared to have been present alone with the patient at the other two deaths. This was an unusual feature and was a cause for concern. Of the nine deaths, there were six in which the question of a report to the coroner should have been raised in Dr Banks' mind. These were Mrs Swann (whom Shipman had not seen for three months), Mrs Walls and Mrs Black (in respect of whom there was no information about the cause of death), Mrs Baddeley (where it was not clear when Shipman had last seen her and the records did not support 'old age' as the cause of death) and Mrs Wagstaff and Mrs Berry (where there was no adequate correlation between the medical history and the given cause of death).

- 15.35 Although there was an abundance of relevant information available for Dr Banks to see, much of which tended to support the concerns which had been raised, I cannot say with confidence that Dr Banks would have realised the significance of this additional material if he had seen it. The same trends were present in the tranche of 14 in roughly the same proportion as they were present in the whole group of 23. Ten deaths out of 14 and 16 deaths out of 23 raised a question of a report to the coroner. Yet, Dr Banks expressed only a mild degree of concern about **'a couple'**, or possibly 'a few', of the group of ten. Of course, I recognise that the chance that Dr Banks would register some real concern would have been enhanced if he had seen 23 sets of records rather than 14. However, I cannot say that he would probably have expressed real concern to DI Smith if he had seen all the available records.

Dr Banks' Duty to Report to Senior Officials Within the Health Authority

- 15.36 Dr Banks also faced criticism for his failure to inform a more senior member of staff at the WPHA of the nature and purpose of the request that he had received from the police in relation to the examination of medical records. As I have observed, he did not mention the matter to anyone senior to him although, of course, Dr Bradshaw, his 'job share' partner, was aware of what he was doing.
- 15.37 The most obvious person Dr Banks might have told was his immediate line manager, Mrs Jan Forster, Director of Primary Care. The view of Mrs Forster, and of those senior to her in the Health Authority, was that Dr Banks should have told her of DI Smith's request and of his intention to comply. Yet, she agreed that Dr Banks' job description did not make plain the scope of his discretion to make his own decisions about his work. That is plainly so. Dr Banks said that, as he is medically qualified and Mrs Forster is not, he took it that he was entitled to undertake, without reference to her, tasks which appeared to fall within the scope of his work as a medical adviser. He said that, before the amalgamation of the Tameside and Oldham Family Health Services Authorities in 1996, he had a very large measure of autonomy. This had never been officially changed. He felt that the decision to examine these records was one he could properly take alone. He accepted that, with hindsight, it would have been better if he had consulted Mrs Forster but contended that he should not be criticised for his failure to do so.
- 15.38 I accept that submission to a large extent. I think it was an error of judgement on Dr Banks' part that he did not tell Mrs Forster. He underestimated the potential seriousness of the

request and the possible implications for the Health Authority. However, I do not think it could be said that he overstepped the boundaries of his authority.

- 15.39 If Mrs Forster had been told, there would have been two probable consequences. First, she would probably have ensured that relations between the police and the Health Authority were put on a more formal basis. I think it likely that Mrs Forster would have required the police to submit a formal written request either for disclosure of the records or for assistance with the examination of the records. Such formality would have focussed the minds of both the police and the Health Authority on what exactly was required. I think it would also have brought home to Dr Banks the seriousness of the concerns. It would have been less easy for him to dismiss the suspicions as inconceivable.
- 15.40 Second, and even more important, I think it likely that Mrs Forster would have realised that, as Shipman was known to the medical staff within the WPHA, it would be preferable for the police to seek expert advice elsewhere. DI Smith would not have known whom to consult and might well have asked the advice of Mr Postles. Had he done so, there is a real possibility that the police would have instructed someone with a greater degree of expertise (to say nothing of greater objectivity) than Dr Banks. They might well have found and instructed Dr John Grenville, whom they used when they needed advice during the second investigation. I have no doubt at all that Dr Grenville's examination of the records would, like Dr Cranfield's, have resulted in the realisation that Shipman's conduct was far from normal. That is another way in which this investigation might have reached a different conclusion.
- 15.41 Mrs Forster's main criticism of Dr Banks was that he did not keep any proper record of the request he received from the police or of what he had done and the conclusions he had reached. I accept the validity of that criticism. However, Dr Banks' failure in this respect did not affect the outcome of the investigation.
- 15.42 It was also suggested that Dr Banks should have informed Dr Ellis Friedman, the Director of Public Health Medicine, about the police request. Dr Banks pointed out that his job description required him to liaise with Dr Friedman but that he was not expected to report to him. That I accept. I do not think that Dr Banks' decision to examine the records without first speaking to Dr Friedman could be described as misconduct.
- 15.43 I have already observed that Dr Banks is open to criticism in that he did not speak to Dr Friedman about the death rate in Shipman's practice. As Director of Public Health Medicine, Dr Friedman knew a good deal about death rates. He said he would have regarded the figure provided by DI Smith to Mrs Parkinson (16 cremations in three months) as rather high. Dr Friedman would have realised that the 16 cremations would not be the total number of deaths in the three-month period. He would have realised that there would be other deaths followed by burial and still others which had taken place in hospital. I think that the figure would have rung an alarm bell in Dr Friedman's mind even if he had not been told that the unknown general practitioner had been worried by it. This concern would or should have been relayed to DI Smith, who would then have begun to appreciate the significance of the numbers and comparative death rates. He would then have known that the investigation could not be closed.

- 15.44 DI Smith shares some of the responsibility for the failure of Dr Banks to refer the issue of death rates to Dr Friedman. If, during his discussion with Dr Banks, DI Smith had mentioned the comparative death rates and the unknown general practitioner's concern about them, the matter might have been taken forward. DI Smith had never understood the importance of the comparative death rates. Here was a chance to have them explained to him. But he never even asked. I find it profoundly disappointing that these two experienced professional men should have met to discuss whether there was evidence in the medical records to support the suspicion that Shipman might be killing his patients and yet neither the doctor nor the policeman thought of discussing the death rate.
- 15.45 If DI Smith had told Dr Banks of the comparative death rates of the two practices, I think it likely that Dr Banks would have referred the matter to Dr Friedman. I cannot say so with certainty, as relations between him and Dr Friedman were not good. Indeed, had relations been better, Dr Banks might have decided to discuss the whole issue of the suspicions about Shipman with Dr Friedman. That is speculation. As I have said, I am sure that if the death rates had, for any reason, been mentioned to Dr Friedman the police would have realised that further enquiries were necessary. This is another route by which the failure of this investigation might have been averted.

Dr Banks' Suspension and the Disciplinary Proceedings Against Him

- 15.46 As Shipman's trial approached and the extent of his criminality began to emerge, senior officials in the Health Authority appreciated that the Authority might be subject to criticism for its part in the failed police investigation. Dr Banks was asked to report on what he had done. There was some difference of opinion among senior officials as to whether Dr Banks ought to have reported DI Smith's request for assistance to his line manager or to Dr Friedman. However, Dr Banks continued at work and (apart from a brief reference at a meeting, which was taken no further) there was no suggestion that disciplinary proceedings might be taken. Indeed, during Shipman's trial, Dr Banks attended the hearings as the Health Authority's representative.
- 15.47 It was not until the jury had retired and conviction appeared imminent that any suggestion was made that Dr Banks might face disciplinary action. Mr Alan Langlands, the Chief Executive of the National Health Service Executive, took the view that Dr Banks should be suspended from duty pending an investigation with a view to disciplinary action. The Health Authority was reluctant to take this course but was persuaded to do so and Dr Banks was informed of this decision on 26th January 2000. He was to remain under suspension for over seven months.
- 15.48 The disciplinary investigation revolved around three potential areas of criticism, which were eventually formulated into charges. In summary it was alleged that:
- (a) He had failed to refer the police request to the Executive Board, having regard in particular to the unusual fact that the investigation had been prompted by another general practitioner and to the high number of deaths. This was said to constitute marked inadequacy in the exercise of his medical professional competence or conduct.

- (b) He had failed to take greater care in investigating the issue, given the high number of deaths and the involvement of another general practitioner, the Coroner and the police.
- (c) He had failed to consider adequately the context of the request to examine the medical records and to assess appropriately the need for further investigation.

15.49 The Health Authority instructed solicitors to advise and they, in turn, instructed counsel. Two suitable experts were identified and were asked to consider the records examined by Dr Banks and to advise on the adequacy of his review. Dr Chris Veal was of the opinion that the medical records disclosed cause for concern which should have been brought to the attention of senior management in the Health Authority and the police. Dr Moorman thought that Dr Banks had behaved '**entirely appropriately**'. The opinions were put to counsel who, after a conference with the doctors at which Dr Veal appears to have modified his views significantly, advised that the disciplinary process should be abandoned. In view of the expert evidence and legal advice that they received, the Health Authority cannot, in my view, be criticised for their decision to abandon the proceedings. Dr Banks was reinstated on 14th August 2000 and remained at work until he suffered a heart attack in November 2001.

CHAPTER SIXTEEN

Conclusions

16.1 In the previous Chapters, I have set out my findings as to the conduct of each stage and aspect of the investigation. It will be apparent that I consider that the conduct of Chief Superintendent Sykes, Detective Inspector Smith and Dr Banks fell below the standard which the community is entitled to expect of public servants in their respective positions. In this final Chapter, I shall summarise the reasons for the failure of the investigation and shall attempt broadly to apportion the responsibility for that failure among those involved in the investigation. I shall also consider, so far as I am able, what would probably have happened if the investigation had been conducted with a reasonable degree of diligence and competence.

Who Was to Blame?

Chief Superintendent Sykes

16.2 In my view, the primary reasons why this investigation failed were that CS Sykes instructed DI Smith to undertake the investigation and kept to himself the responsibility for supervision. He was culpably wrong in both respects. He realised that the concerns raised were unusual and potentially serious. He should have realised that the investigation would not be of a routine nature. He should have discovered (if he did not already know) that DI Smith was not accustomed to working without direction and supervision. He should have realised that he himself did not have the experience to direct or supervise the investigation. His decision to retain responsibility himself was not merely a poor decision within the band of decisions open to him; it was fundamentally wrong. CS Sykes should have discussed the matter with Mr Postles, who was the divisional adviser on criminal matters. Mr Postles would have advised as to the appropriate level of seniority within the GMP to which the concerns should be reported. I am satisfied that, had that been done, a properly directed investigation would have taken place.

16.3 I am critical of CS Sykes in other respects also. Once the investigation was under way, he failed to realise that DI Smith was out of his depth. If he had discussed the issues in any detail, in the way in which Detective Chief Superintendent Stelfox said he would have discussed them, he would have realised the extent of DI Smith's lack of understanding. His failure was partly due to his own lack of experience of criminal investigation. However, even lacking such experience, I consider that he should have realised that DI Smith had not satisfied himself that the death rate among Shipman's patients was not abnormally high. CS Sykes should not have left it to DI Smith to decide when the investigation was to be closed. If, even at that stage, he had asked a senior detective officer to scrutinise the information that DI Smith had gathered, its inadequacy would have been discovered and a proper investigation could have taken place, albeit after some delay.

16.4 I have been unable to reach any firm conclusion about why CS Sykes resolved to retain control of this investigation. I suspect that he decided to retain control because he did not wish it to appear to the Coroner that he did not have the experience to control the investigation personally. In mitigation of CS Sykes' failures, I believe that he recognised

that he had made errors and that the apology that he offered to the bereaved families at the conclusion of his oral evidence to the Inquiry was genuine and deeply felt.

Detective Inspector Smith

- 16.5 I have been very critical of DI Smith in respect of many aspects of the conduct of the investigation. I recognise that many of the mistakes he made were the result of his lack of experience of criminal investigations of a non-routine nature. I can summarise my criticism of him by saying that he was wrong to continue with his investigation without seeking the advice of a senior and more experienced detective officer. He soldiered on alone, pretending to all involved that he knew what he was doing, when, as he admitted in evidence, he did not know 'where to go'. He should have acknowledged at the time that he was in difficulty. The result of his failure to seek advice was that he never understood the issues, never had a plan of action, had no one to help him analyse the information he received, had no one to make suggestions as to the information he should seek from the available witnesses (Dr Reynolds and Mrs Bambroffe) and was allowed to close the investigation before it was complete.
- 16.6 In mitigation of this fault, I believe that he should, without having to ask for it, have had the benefit of supervision by a senior detective officer. Also, he received poor advice from Dr Banks. The idea of seeking the medical records was a good one. His decision to allow Dr Banks to review the records without having any very clear idea of the purpose behind the review was unfortunate but resulted from his lack of 'direction'.
- 16.7 DI Smith was not assisted by the failure of the staff at the Tameside register office to provide him with a complete bundle of copy death certificates. However, I do not consider that this failure had any material effect on the course of the investigation.
- 16.8 I accept that DI Smith found it difficult to believe that Shipman might have murdered his patients. Many witnesses spoke of this difficulty; it became known as the 'credibility gap'. I must give this factor due weight if I am to avoid the danger of judging with the benefit of hindsight. However, I cannot accept that this difficulty can provide an excuse for the particular shortcomings I have identified above. I observe that Dr Reynolds had surmounted this difficulty and had made her complaint.
- 16.9 I do not consider that DI Smith is primarily responsible for the failure of the investigation. He was not a suitable person to be put in charge of it. However, in two respects, his inaction contributed directly to the adverse result. One was his failure to collect detailed information from Dr Reynolds. Any detective, however unaccustomed to self-direction, should have known he must do that. The second (and more crucial) was his failure to report to the Coroner the fact that the bodies of Miss Ada Warburton and Mrs Lily Higgins were available for an autopsy if the Coroner thought fit to order one.
- 16.10 Although DI Smith's conduct since April 1998 has had no effect on the course of the investigation of Shipman's crimes, I must comment upon it. His lack of frankness merits strong criticism. In the several accounts of his investigation given to the police, he consistently sought to attribute its failure to the fault of others. I well understand the natural human reaction by which we all seek to interpret events so as to absolve ourselves from

blame, but the line must be drawn when it comes to telling lies. DI Smith told lies in his report of August 1998 and when speaking to Detective Superintendent Ellis. He repeated some of those lies in statements made to this Inquiry. In oral evidence, he told the truth about some matters, thereby correcting his earlier accounts. For that he deserves credit. However, he has continued to the end to lie about the circumstances in which he learned of the death of Miss Ada Warburton. He did so in an attempt to evade responsibility for his failure to arrange an autopsy on her body.

Dr Banks

- 16.11 In my judgement, Dr Banks must bear some responsibility for the failure of the investigation, although I consider that his contribution is substantially less than that of CS Sykes and DI Smith.
- 16.12 He failed to notice the causes for concern that were there to be seen in the medical records he examined. He failed to realise that the records suggested that Shipman had repeatedly failed to report to the coroner deaths that any reasonable doctor would have reported. He failed to notice that many of the deaths contained some of the very features that had been mentioned as having given rise to concern. He failed in these respects, not because he was lazy or incompetent or because the task of reviewing the records was beyond him, but because he could not open his mind to the possibility that Shipman might have killed his patients or even that he might have given them substandard care. That mindset would have been excusable if he had not known that the reason why the police were making enquiries was because a concern had arisen that Shipman might be killing his patients. I accept that Dr Banks' knowledge of, and respect for, Shipman made it even more difficult for him to have an open mind. The 'credibility gap' amounts to mitigation for Dr Banks' failures, but cannot provide an excuse in the case of a professional man asked for his professional opinion.
- 16.13 Because he knew the nature of the underlying concern, Dr Banks ought also to have given more careful consideration to the numbers of deaths among Shipman's patients. I find it surprising that a doctor of his experience should not know the annual crude death rate for patients in UK general practice. It is ten deaths per year per thousand of the population, a very easy number to remember. If he did not know it, he should have found it out and should have alerted DI Smith to the fact that, for a single-handed practitioner, 16 deaths (and, even more so, 16 cremations) in three months seemed rather high. Instead, it is likely that he gave DI Smith the impression that the numbers did not strike him as particularly high.
- 16.14 These were important failures which, had they not occurred, might well have brought about a different result.

What Would the Outcome Have Been?

- 16.15 In my view, if CS Sykes had put the investigation in the hands of a more senior detective than DI Smith, one who had experience of devising and supervising a criminal investigation and, if that officer had acted with reasonable expedition, the whole course of the investigation would have been different.

- 16.16 A more senior and experienced officer would have recognised the potential significance of the disparity in the death rates between Shipman's practice and the Brooke Practice. He would have investigated that issue. I think it likely that an official approach for advice would have been made to the WPHA, at a higher level than was made, and this would have resulted in the realisation that the death rate was abnormal. Although detailed work on death rates might have taken several weeks, a provisional view could have been provided within a day or two. This would have been based on accurate figures as, if the register office had failed to produce a complete bundle of copy death certificates, comparison with the Brooke Practice records would have exposed the error.
- 16.17 A thorough exploration of Dr Reynolds' concerns would have been made within a day or two of her initial report. Almost certainly, Dr Reynolds would have persuaded Mrs Bambroffe to speak to the police. The police would then have had a proper understanding of the nature of, and reasons for, the concerns.
- 16.18 Had these interviews taken place within a few days, as they easily could have done, it would not then have been too late for an autopsy to take place on the body of Miss Ada Warburton or Mrs Martha Marley. As it would have been appreciated that, if Shipman had caused the death of either of these patients, he must have done so by means of a drug, toxicological tests would have been performed and morphine would have been found. An inquest would have been ordered and Shipman would have come to learn that he was under suspicion. I do not think he would have killed any more patients after that.
- 16.19 Even if the opportunity for an autopsy on the body of Miss Warburton or Mrs Marley had been lost, the police would have learned of the existence of cremation Forms B, which would have provided much information. The police would then have arranged for the medical records of the deceased patients to be examined by a suitable expert. I am confident that the WPHA would have agreed to access by an expert. Examination by someone such as Dr John Grenville or Dr Frances Cranfield would have revealed cause for grave concern. The expert would have found evidence of deaths which had not been reported to the coroner when they should have been, evidence of deaths which occurred or were discovered very shortly after a visit by Shipman and evidence of poor care in the period shortly before death. When considered in conjunction with advice from the Health Authority about death rates, I consider that the level of concern would have been such that the police would have begun to think about identifying a body for exhumation. They would also have examined the PNC and would have learned of Shipman's past convictions for drug abuse.
- 16.20 The medical expert would have been able to identify a death that gave rise to particular concerns, such as that of Mrs Bianka Pomfret, who had died on 10th December 1997, at the age of only 49, and whose body was available for exhumation. Shipman was convicted of killing Mrs Pomfret. Examination of her records would have given rise to real concern and I think she would have been the most probable choice. I think it likely that the Coroner, who would have been concerned to realise that deaths which should have been reported to him had not been reported, would have been willing to order exhumation, autopsy and toxicological tests. Morphine would have been found. It would not have been long before Shipman became aware of what had been going on and I do not think he would have killed

again. Of course, I accept that it is possible that the expert might have suggested the exhumation of a body, such as that of Mrs Winifred Healey, who, on my findings, died a natural death, in which case no morphine would have been found. Another possibility is that the Coroner might have refused to order exhumation. That would have left the police to seek an autopsy in the next suspicious death of which they became aware.

- 16.21 If the first opportunity to conduct autopsies had been lost, the steps I have outlined might well have taken several weeks. However, I think that the progress of the investigation would have given rise to an increasing sense of urgency. Although I cannot be certain of this, I think that, if the police and the Coroner had moved with reasonable expedition, the lives of Shipman's last three victims would probably have been saved.
- 16.22 I turn to consider the alternative set of circumstances which would have arisen if CS Sykes had instructed DI Smith to commence the investigation but had discovered at some stage that he was out of his depth. Plainly, any delay in the appointment of a competent and suitably experienced detective would have reduced the likelihood that Shipman would have been stopped before killing again. The possibilities are many. DI Smith might have admitted his difficulties at an early stage, in which case there might have been very little delay in appointing a more senior detective officer. If, on 1st April 1998, Dr Banks had told DI Smith that the records raised some concerns, this might have been the trigger for the appointment of a more senior and competent detective officer. Another possibility is that CS Sykes might have discovered the inadequacy of DI Smith's work if he had asked him to write a report at the end of the investigation. He would then have taken the advice of Mr Postles and the investigation would have been put onto the right track, albeit about four weeks late. Plainly, the later the change of officer in charge, the poorer the chance that Shipman would have been stopped before killing again.

The Greater Manchester Police Internal Investigation

- 16.23 I believe that the GMP know that their own internal enquiries into the failure of the March 1998 investigation were quite inadequate. It must be a matter of regret and criticism that there should have been so wide a chasm between the fine words and good intentions as expressed by Assistant Chief Constable Sweeney and the reality of the enquiry which followed.
- 16.24 It appears to me that the fault for this disparity lies with those senior officers who decided upon the scope of the enquiry and the personnel who were to undertake it. Det Supt Ellis was not a suitable choice. He was not sufficiently senior even to investigate the actions of CS Sykes, let alone form a judgement about him. Whoever was put in charge of these enquiries should have been required to cross-check the accounts given by the two officers under investigation against other information available to the police. When the factual enquiries were complete, the report should have been subjected to critical analysis by a senior officer, who should have been responsible for making a judgement about whether or not any officer appeared to be open to criticism and whether or not any lessons should be learned.
- 16.25 Two explanations were advanced for the failure of the police to conduct an adequate internal enquiry. First, it was said that the police could not interview witnesses from outside

the Force because an external inquiry was pending. That was so, but they could very well have looked into their management failures. They did not need to interview any witness other than CS Sykes to find out that he had retained control of the investigation and knew so little of criminal investigation procedures that he had not even required DI Smith to write a report. That excuse will not do. The second was that the police were hamstrung because they could not obtain any evidence from officers without warning them that they might face disciplinary proceedings and offering them all the safeguards provided by the disciplinary code. This cannot be so. If it is not possible to investigate conduct which might amount to a disciplinary offence, there could never be any disciplinary proceedings.

- 16.26 I do accept that the senior officers of the Force would be likely to set out on such an enquiry in the expectation that a detective inspector would, broadly speaking, tell the truth about what had happened. But, on discovering that DI Smith had not made any proper record of an investigation that was known to have failed, I do not think that continued unquestioning confidence in his veracity should have been maintained.

Recommendations to the Greater Manchester Police

- 16.27 Although senior officers of the GMP said in evidence that they hoped that I would make recommendations that might assist in improving their procedures, there is very little I wish to say.
- 16.28 The main reason why this investigation failed was that the wrong people were in charge of it. If officers with the requisite experience had been assigned to it, there would have been no difficulty in devising a proper plan of action. It would be to state the obvious if I were to say that the GMP ought to put in place procedures which would ensure that investigations were assigned to and supervised by officers with appropriate experience.
- 16.29 Nowadays, good police practice requires that there should be a protocol for the handling of many types of situation that occur on a regular basis. However, there will always be some sets of circumstances that are new and different from what has happened before. There cannot be a protocol for every eventuality. Some problems can be resolved only by the application of the minds of people with the necessary intelligence and experience. The investigation of Dr Reynolds' concerns was one such problem. The GMP know that as well as I do.
- 16.30 Although I have said that there cannot be a protocol for every eventuality, it does appear to me that some guidance should be issued to those detective officers who have to undertake investigations into allegations of wrongdoing by health professionals. Such investigations may take place in the context of a criminal investigation and, at the present time, the police are often involved in investigations on behalf of the coroner into allegations of mistreatment where the conduct alleged falls short of gross negligence. Since the hearings into the first police investigation were completed, the Inquiry has learned that a group led by Detective Chief Superintendent Steve Watts of the Hampshire Constabulary is working on guidance for officers involved in work of this kind. I have seen the first draft and it appears that the guidance will be very useful. One of the problems discussed is the identification of an appropriately qualified and independent expert to assess the evidence

gathered and to advise on the issues of culpability. At present, the draft guidance recognises the difficulties but makes no practical suggestions as to how they might be overcome. This is understandable; the solution is by no means straightforward. For reasons of confidentiality, the police must be extremely careful about whom they consult for advice. There are various published directories of experts. However, an officer cannot use a directory effectively if he does not know in which field of expertise he needs advice. In some cases, the police will readily recognise what sort of expert they need but not in all cases. Modern medicine is highly specialised. It seems to me that the police need an established route by which advice of this nature can be found. I make two suggestions. One is that, if and when the medical coroner service comes into being (as I will recommend in my Third Report), it would be appropriate for a medical coroner or a regional medical coroner to maintain a register of suitable experts and to provide confidential advice to the police. A second suggestion is that the police should invite the Crown Prosecution Service to provide access to an in-house solicitor with medico-legal experience. Such a solicitor should have available lists of suitable experts and of counsel with specialist medico-legal knowledge.

Final Thoughts

- 16.31 The hearing of this stage of the Inquiry has been a painful experience for many of those involved. For those who faced criticism, it must have been a very anxious time. Those few who have been found responsible must live with that responsibility for the rest of their lives. I must and do feel sympathy for them, even though their predicament was of their own making. It was a misfortune for CS Sykes, DI Smith and Dr Banks that they were ever caught up in the consequences of Shipman's criminality. There must be many others who would also have failed if put in the position in which these men found themselves.
- 16.32 My final word must be for the families of Shipman's last three victims. For them, these hearings and the reading of this Report must have been profoundly distressing. Once again, I can only offer them my deepest sympathy.

APPENDIX A

**Notes made by Detective Inspector Smith
in his daybook during the course of the
March 1998 investigation**

Massey 368 5645.

Dowse - Catterall 336 2947

Conrings 368 2319

Jordan + Robinson 368 2441.

Page referred to as 'left-hand page'

Jury bundle

Docs.
interview summaries
Photographs
Mortuary:
house.
Docs

368 4464

2-15pm

Janet Parkinson
Seiborn House
Union St.
Hyde.

24th March 1998.
Mr. Pottard

Mr. Hooper 330 1177.
Medical Defence Union

Dr. Linda Reynolds 2nd part 14/9500. patients
Thurs. Book Surgery. 20 Market St 368 3312
2nd part cremation certificate. No same period. 3 months.

Gina
Receptionist

Dr. Harold Shipman 1st part of cremation certificate
practises alone. 21 Market St ^{Hyde} 367 9777

Undertaker - elderly female
day clothes
details not known. friend & doctor.

i. Jowse Catherine
Lily Higgins. stroke
ii. Jordan & Robinson
Ada Warburton 87
stroke 368 2441

Registrar R - Mr. Hooper 330 1177.

iii. Amittages
iv. Massey

Registrar's General office 01704 569824.
General Section.

David Trenbath ~~4574~~
0151 471 4574

Police Liaison Clerk - Joyce Lawson
extension 4249
Isabelle McDonald - Jones.

Kenworthys, Gshwan	82253	f	Mavis Mary Pickup	26/9.
Masseys, Hyde	82560	f	PARR	8/11.
Masseys, Hyde burial Hyde	1/12/97.		Quinn x	
Masseys, Hyde	82723	f	Barnsby	19/12.
Masseys, Hyde burial Hyde	18/12/97.		Pomfret x	
Masseys	82846	M	King	6/1.
Revens, Straybridge	83041	f	Shawcross.	2/2.
Crimmages, Hyde	83045	f	Nurval	4/2.
Guis, Droylsey	83102	f	Harrison	10/2.
Masseys, Hyde	83104	f	Davies	10/2.
Worsley, Hockfield	83152	f	Hillier	17/2.
Heaviley Jackson, Shaw	83180	f	Bierley	20/2.
Masseys, Hyde	83215	f	Ward	26/2.
Ray, Massey, Duk. burial Dukinfield			Healey x	4/3.
Masseys, Hyde	83271	f	Dean	9/3.
Massey Robinson + Jordan, Hyde	83277	M	Edmeston	
Masseys, Hyde	83322	f	Walden	16/3
Robinson + Jordan, Hyde	83372	f	Long	23/3.
Bowse, Cartvill, Denton	83383	f	Higgins	25/3.
Robinson + Jordan, Hyde	83419	f	Warburton	30/3.

Jobbie Massey.

Edmeston, 9th March 98. 83277. died 4th March.

Manica Edmeston. - Coroner. died 28th Feb. - cremated with Mr. Edmeston. 83276.

Mike Gurney.

APPENDIX B

**Computer spreadsheet created by Detective Inspector Smith
in March/April 1998, setting out information obtained
from the copy death certificates and from
the Dukinfield crematorium**

	Name and Address	Age and Date of Birth	Sex	Date of Death	Found By	Funeral Directors
1	Mavis Mary PICKUP 9 Spring Avenue, Gee Cross	79 years 8.9.18.	Female	22.9.97.		Kenworthy's, Ashton
	Cause of Death Cerebrovascular Accident					Method of Interment Cremation
2	Bertha PARR 3 Booth Street, Hyde	77 years 6.2.20.	Female	11.11.97		Masseys, Hyde
	Cause of Death Natural Causes Old Age Hypertension Diabetes					Method of Interment Cremation
3	Marie QUINN 20 Peel Street, Hyde	67 years 10.8.30.	Female	24.11.97.		Masseys, Hyde
	Cause of Death Cerebrovascular Accident Arteriosclerosis Hypertension Scleroderma					Method of Interment Burial

	Name and Address	Age and Date of Birth	Sex	Date of Death	Found By	Funeral Directors
4	Elizabeth BATTERSBY 12 Norbury Avenue, Hyde	70 years 21.8.97.	Female	8.12.97.		
	Cause of Death Pulmonary Embolus Deep Venous Thrombosis Chronic leg ulcers				Method of Internment Cremation	Funeral Directors Masseys, Hyde
	Name and Address	Age and Date of Birth	Sex	Date of Death	Found By	
5	Bianca POMFRET 34 Fountain Street, Hyde	49 years 5.11.48.	Female	10.12.97.		
	Cause of Death Coronary Thrombosis Ischaemic Heart Disease Smoking, Chronic Depression				Method of Internment Burial	Funeral Directors Masseys, Hyde
	Name and Address	Age and Date of Birth	Sex	Date of Death	Found By	
6	James Joseph KING 32 Ogden Court, Hyde (daughters)	83 years 20.10.14.	Male	24.12.97.		
	Cause of Death Cerebrovascular Accident Hypertension				Method of Internment Cremation	Funeral Directors Masseys, Hyde

	Name and Address	Age and Date of Birth	Sex	Date of Death	Found By	Method of Internment	Funeral Directors
7	Mabel SHAWCROSS 105 Stockport Road, Hyde	79 years 15.12.18.	Female	22.1.98.		Cremation	Revells, Stalybridge
	Cause of Death Cerebrovascular Accident Hypertension Diabetes						
8	Norah NUTTALL 12 Baron Road, Gee Cross	64 years 6.12.33.	Female	26.1.98.		Cremation	Armitages of Hyde
	Cause of Death Left Ventricular failure Congestive Heart Disease Hypertension Obesity						
9	Muriel Eveline HARRISON Hyde Nursing Home, Grange Road South, Hyde	73 years 28.3.24	Female	2.2.98.		Cremation	Gills of Droylsden
	Cause of Death Cerebrovascular Accident Epilepsy						

	Name and Address	Age and Date of Birth	Sex	Date of Death	Found By	
10	Cissie DAVIES (alias Pat DAVIES) 59 Lodge Lane, Newton	74 years 14.5.24.	Female	3.2.98.		
	Cause of Death Broncopneumonia Diabetes					Method of Internment Cremation Funeral Directors Masseys, Hyde
	Name and Address	Age and Date of Birth	Sex	Date of Death	Found By	
11	Pamela Marguerite HILLIER 11 Stalybridge Road, Moltram	68 years 9.12.29.	Female	9.2.98.		
	Cause of Death Cerebrovascular Accioent Hypertension					Method of Internment Cremation Funeral Directors Worsleys of Hadfield
	Name and Address	Age and Date of Birth	Sex	Date of Death	Found By	
12	Edith BRIERLEY Hyde Nursing Home, Grange Road South, Hyde	90 years 31.8.07.	Female	11.2.98.		
	Cause of Death Cerebrovascular Accident Diabetes Alzeimers Dementia					Method of Internment Cremation Funeral Directors Heaviley, Jackson of Shaw

	Name and Address	Age and Date of Birth	Sex	Date of Death	Found By	
13	Maureen Alice WARD 41 Ogden Court, Frank Street, Hyde	57 years 14.8.40.	Female	18.2.98.		
	Cause of Death					Method of Internment Cremation
	Carcinomatosis (Secondary in brain) Carcinoma Breast					Funeral Directors Masseys, Hyde
	Name and Address	Age and Date of Birth	Sex	Date of Death	Found By	
14	Winifred HEALEY 80 Brunswick Street, Dukinfield	72 years 16.1.16.	Female	25.2.98.		
	Cause of Death					Method of Internment Burial
	Congestive Heart Failure Ischaemic Heart Disease					Funeral Directors R. Massey, Dukinfield
	Name and Address	Age and Date of Birth	Sex	Date of Death	Found By	
15	Joan Edwina DEAN 58 Joel Lane, Gee Cross	74 years 9.2.23.	Female	27.2.98.		
	Cause of Death					Method of Internment Cremation
	Coronary Thrombosis Ischaemic Heart Disease					Funeral Directors Masseys, Hyde

	Name and Address	Age and Date of Birth	Sex	Date of Death	Found By	
16	Harold EDDLESTON 25 Rufford Avenue, Hyde	77 years 5.3.20.	Male	4.3.98.		
	Cause of Death Carcinoma of Lung Atherosclerosis Hypertension				Method of Internment Cremation	Funeral Directors Robinson, Jordan of Hyde
	Name and Address	Age and Date of Birth	Sex	Date of Death	Found By	
17	Margaret Anne WALDRON 2 Woodend Lane, Gee Cross	65 years 20.4.32.	Female	6.3.98.		
	Cause of Death Coronary Thrombosis Ischaemic Heart Disease Hypercholesterolaemia				Method of Internment Cremation	Funeral Directors Masseys, Hyde
	Name and Address	Age and Date of Birth	Sex	Date of Death	Found By	
18	Dorothy LONG 10 Woodfield Avenue, Hyde	84 years 27.8.13.	Female	13.3.98.		
	Cause of Death Cerebrovascular Accident Hypertension				Method of Internment Cremation	Funeral Directors Robinson, Jordan of Hyde

	Name and Address	Age and Date of Birth	Sex	Date of Death	Found By		
19	Lily HIGGINS 352 Stochport Road, Hyde	83 years 21.2.15.	Female	17.3.98.			
	Cause of Death Cerebrovascular Accident Arteriosclerosis Old Age					Method of Internment Cremation	Funeral Directors Dowse, Catterall of Denton

APPENDIX C

**Notes made by Mrs Janet Parkinson, formerly Consumer
Liaison Manager of the West Pennine Health Authority,
in March and April 1998**

26.3.98.

Query received from DI. Dave Smith - 856 9343.

He had been contacted by the Coroner as a result of concern which had been expressed to him (the coroner) by a local GP. Apparently the local GP has been signing the second part of a cremation form for Dr Shipman and the local GP had expressed concern at the number of cremation forms being signed. In the last 3 mths 16 had been signed.

① The 16 cremations all had similar features/circumstances

- all elderly females
- all found at their home address by Dr Shipman who had apparently ~~been~~ called upon them ~~unannounced~~ unannounced.
- all had been found during the day and in their day clothes.
- all had been certified as having died from stroke / heart disease.

Also, Dr Shipman runs a scammer appeal and some of the 16 have made donations to that appeal either prior to death or in the will.

27.3.98.

Dr Banks has gone through the medical records and hasn't seen any evidence of anything odd. The majority of cases involve patients who had been treated for diabetes/high blood pressure. 2 found by ambulance men, 2 by deputation service, 1 by son.

NO 2 CASES ARE THE SAME.

Only concern is that in a couple of cases, Dr Banks felt insufficient history to make an accurate diagnosis.

Dr Banks available
to attend meeting
on Wed. at 10.30

Harold Eddleston
DOB 5.3.20
4.3.98

DI Smith not pursuing any
further.

Spoke with Dr Banks - he is
happy for matter to be closed.

2/15

Need to pass
on info to

DI Smith.

left message on
answerphone 2014.
left further message 1515.

- | | | |
|---|-----------|-----------------------|
| ① Mavis Mary Pickup
9 Spring Avenue
Gee Cross | 8.9.18 ✓ | ⑤ |
| ② Bertha Parr
3 Brook St
Hyde | 6.2.20 | ✓ 5 drawer |
| ③ Marie Quin
20 Peel St
Hyde | 10.8.30 | ✓ ⑤ |
| ④ Elizabeth Battersby
12 Norbury Ave
Hyde | 21.8.27 | ✓ ⑤ |
| ⑤ Bianca Pomfret
34 Fountain St
Godley | 5.11.48 | ✓ ⑤ |
| ⑥ James Joseph King
32 Ogden Court
Hyde | 20.9.14 | ✓ 5 |
| ⑦ Mabel Shawcross
105 Stockport Rd
Hyde | 15.12.18. | ✓ 5 |

- | | | |
|---|---------|------------------|
| ⑧ Nora Nuttall
12 Barren Road
Gree Cross | 6.12.33 | ✓ X |
| ⑨ Muriel E. Harrison
Hyde Nursing Home | 28.3.24 | ✓ X |
| ⑩ Sissy Davies (AKA Pat)
59 Lodge Lane
Newton | 14.5.24 | ✓ X |
| ⑪ Pamela M. Hillier
11 Stalybridge Road
Mothram | 9.12.29 | ✓ X |
| ⑫ Edith Brierley
Hyde Nursing Home | 31.8.07 | ✓ X |
| ⑬ Winifred Healy
80 Brunswick St
Dukinfield | 16.1.16 | * ✓ X |
| ⑭ Joan E. Dean
58 Joel Lane
Gree Cross | 9.2.23 | ✓ X |

(15) Margaret A. Waldren
2 Woodend Lane
Green Cross

20.4.32 ~~X~~ X
STILL ON ID.

(16) Dorothy Long
10 Woodfield Ave
Hyde

27.8.13 X
STILL ON ID

(17) Lilly Higgins
352 Stockport Rd
Hyde

21.2.15 X
STILL ON ID

APPENDIX D

**Chart compiled by Dr Alan Banks, Assistant Director of
Primary Care and Medical Adviser to the West Pennine
Health Authority, from information contained in 14 sets
of general practitioner records examined by him on
26th –27th March 1998**

<u>NAME & DOB</u>	<u>Date of Death</u>	<u>CAUSE</u>	<u>Where</u>	<u>Who Saw</u>
Winifred Healy 16/1/16	26/2/98	CHF (Congestive Heart Failure) IHD (Ischaemic Heart Disease) known ihd and on treatment for CCF	13/2/98 Viral Illness Died during afternoon nap	13/2/98 Dr Shipman Unclear who saw at time of death ? Deputy OOH
Cissie Davies 14/5/24	3/2/98	Bronchopneumonia Diabetes Mellitus Retinopathy	26/2/98 - cough 2/2/98 - urti 2/2/98 - ?flu	? Dr Shipman
Norah Nuttall 6/12/33		LVF (Left Ventricular Hypertrophy) CHP (?) Hypertension Obesity known Hypertension, CCF, IHD (95) Obesity BMI 50 (130Kg)	Son s/b Dr Shipman 26/1/98 Acute Wheezy Bronchitis	Dr Shipman
Muriel Harrison 28/3/24	2/2/98	CVA Mental subnormality, Blind, Epilepsy, COPD	Hyde Nursing Home S/B Dr Shipman 30/1/98	Dr Shipman
Bertha Parr Age 77	2/12/97	No Diagnosis (Sudden Collapse) Diabetes, Hypertension	Son Ambulance	Ambulance
James King 20/9/14	19/1/98	CVA Hypertension Intermittent Claudication, Depression, Prostatectomy	24/12/97 TIA > daughter died at home	Dr Shipman
Joan Dean 9/2/23	27/2/98	IHD	13/2/98 IHD Sudden Death Police in attendance	Deputising Doctor
Pamela Hillier 9/12/29	9/2/98	CVA Hypertension	9/2/98 Malaise for 1 week, raised Blood pressure	Neighbour Ambulance

<u>NAME & DOB</u>	<u>Date of Death</u>	<u>CAUSE</u>	<u>Where</u>	<u>Who Saw</u>
Edith Brierly 31/8/07	11/2/98 - 02:45	CVA Diabetes Alzheimers	Last seen 10/2/98 DOA	Deputising Doctor
Bianka Pomfret 5/11/48	10/12/97	CT (Coronary Thrombosis) IHD Smoker Manic Depression	V. thick notes 8/12/97 - IHD 10/12/97 - Angina s/b Dr Shipman	Social Worker D Shipman
Mabel Shawcross 15/12/18	22/1/98	CVA Hypertension Diabetes	Last seen 20/1/98 for BP check	?Dr Shipman
Elizabeth Battersby 21/8/27	8/12/97	Pulmonary Embolus DVT (Deep Vein Thrombosis)	Chronic Leg Ulcers and Varicose Veins 4/12/97 - DVT Rx Warfarin	Dr Shipman
Marie Quinn 10/8/30	24/11/97	CVA Arteriosclerosis Hypertension Scleroderma	Epilepsy Scleroderma 1985 S/B Nurse 11/11/97	Rang 17:45 Seen 18:15 Died 18:20 Dr Shipman
Mavis Pickup 8/9/18	22/9/97	CVA	PH Ca Uterus - TAH IBS (Irritable Bowel Syndrome) Parkinson's disease Brochiectasis 22/9/97 s/b Dr Shipman - ?TIA Pt refused Hosp Admission	Relatives Ambulance Dr Shipman

APPENDIX E

Participants in Stage One of Phase Two of the Inquiry and their Representatives

Counsel to the Inquiry

Miss Caroline Swift QC

Mr Christopher Melton QC

Mr Anthony Mazzag

Mr Michael Jones

instructed by Mr Henry Palin, Solicitor to the Inquiry

Participants

Representatives

Dr Alan Banks

Dr Kevin Naylor, instructed by Mr Nick Rawson, Radcliffes Le Brasseur Solicitors, Leeds, West Yorkshire

Mr John Pollard, HM Coroner, Greater Manchester South District

Miss Alison Hewitt, instructed by Mr Christopher Welton, Solicitor and Deputy Coroner, Greater Manchester South District

Doctors from the Brooke Practice

Mr Philip Gaisford, instructed by Ms Sarah Woodwark, Radcliffes Le Brasseur Solicitors, Leeds, West Yorkshire

Dr Ellis Friedman

Mr Peter Atherton, instructed by Mr Aidan Carr, Rowlands Solicitors, Manchester

Greater Manchester Police

Mr Michael Shorrock QC and Miss Kate Blackwell, instructed by Mrs Sandra Pope, Greater Manchester Police Force Solicitor

Mr Alan Massey

Miss Joanne Connolly, instructed by Mr Guy Rogers, Pluck Andrew Solicitors, Hyde, Cheshire

Detective Inspector David Smith

Mr Bruce Stuart, instructed by Mr Nick Holroyd, Russell Jones & Walker Solicitors, Manchester

Tameside Families Support Group

Mr Richard Lissack QC, Mr Paul Gilroy, Mr Andrew Spink and Miss Harriet Jerram, instructed by Ms Ann Alexander, Alexander Harris Solicitors, Altrincham, Cheshire

Staff employed at Tameside register office

Mr Geoffrey Tattersall QC, instructed by Ms Sylvia Roberts, Borough Solicitor, Tameside Borough Council

West Pennine Health Authority

Mr Gerard McDermott QC and Mr David Eccles, instructed by Mr Charles Howorth, George Davies Solicitors, Manchester



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