CHAPTER ONE

Before the Inquiry

Shipman's Professional Career: Training

1.1 In September 1965, Harold Fredrick* Shipman entered the University of Leeds School of Medicine at the age of 19 years. He spent five years there, training for his future medical career. During that time, he married and the couple's first child was born. Shipman left Leeds in 1970, having gained the qualification MB ChB.

1.2 From Leeds, Shipman moved to Pontefract, where he was employed for 12 months as a pre-registration house officer at the Pontefract General Infirmary, before being fully registered with the General Medical Council (GMC) in August 1971. Thereafter, he continued to work at the same hospital as a senior house officer, gaining a diploma in child health (DCH) in 1972 and a diploma in obstetrics and gynaecology (DRCOG) in 1974.

The Move to Todmorden

1.3 In the early part of 1974, Shipman answered an advertisement in a medical publication and, after an interview, secured a position in a busy general practice operating from the Abraham Ormerod Medical Centre in Todmorden, a town in the Pennines on the Lancashire/Yorkshire border. After a short probationary period as an assistant general practitioner, Shipman became a junior partner in the practice, with a view to becoming an equal partner in due course.

1.4 Shipman impressed his partners with his competence, enthusiasm and capacity for hard work. He was popular with patients. He persuaded his partners to adopt a more modern system of categorising data contained in patient records and himself undertook much of the work required to change to the new system. Another task that he undertook was the disposal of a quantity of out-of-date controlled drugs which were stored in the surgery's controlled drugs cabinet. It also seems that he assumed responsibility for re-stocking the cabinet and, on occasion, for ordering stocks of controlled drugs for use by members of the practice.

Shipman's Abuse of Pethidine

1.5 By February 1975, the Home Office Drugs Inspectorate and the West Yorkshire Police Drugs Squad had become aware that Shipman was obtaining abnormally large quantities of pethidine from local pharmacies. Their discussions with the pharmacists concerned were reassuring; Shipman was held in high esteem by them and was described as ' very efficient and confident'. The police report written at the time concluded:

> **' It would seem from the enquiries made into this matter that there is no drug abuse by Dr Shipman.**

* Shipman himself uses the spelling ' Fredrick'; see, for example, page CO 76 04038 of the scanned documents.

A watch will be maintained and should anything further come to light then a further report will be submitted'.

1.6 In early June 1975, it was noticed that a local pharmaceutical company was regularly supplying to the pharmacy at Boots the Chemists in Todmorden abnormally large amounts of pethidine for injection. Those amounts were accounted for by Shipman's written orders on behalf of the practice and by prescriptions for the drug issued by him. As a consequence of this discovery, Shipman was interviewed by two Home Office drugs inspectors and a detective constable from the West Yorkshire Police. Shipman offered ready explanations for the amount of pethidine he had obtained and denied that he was abusing the drug. However, deficiencies were found in the controlled drugs documentation held by the practice; in particular, there was no register recording the supply of pethidine to patients from the surgery stocks, as required by law. It appeared to Shipman's interviewers that some of the ampoules of pethidine, which he had obtained on written requisition for the practice, were unaccounted for but, without a register of supplies, this could not be confirmed.

1.7 Because of the deficiencies in procedures which had been revealed at the interview, a Home Office drugs inspector, Mr Donald McIntosh, who has since died, visited the practice in early August 1975, saw all the partners, including Shipman, and advised them on the institution of a controlled drugs supply register and the correct procedure for destroying controlled drugs. No further action was taken at that stage, although Mr McIntosh expressed his intention of keeping the case under review. He requested from the police a further report in about six months' time, giving details of all controlled drugs obtained by Shipman over that period. In the event, that report was never prepared, having been overtaken by events.

1.8 Meanwhile, Shipman was experiencing problems with his health. In May 1975, one of his partners, Dr John Dacre, was called out by Mrs Primrose Shipman, after her husband had fallen in the bathroom and struck his head. Dr Dacre diagnosed concussion and referred Shipman to the casualty department of one of the local hospitals. Shipman's partners recall other occasions when he suffered ' blackouts' or ' seizures'; one occurred in the practice car park and another partner, Dr David Bunn, remembers assisting him on that occasion. Mrs Shipman gave evidence about an incident when her husband blacked out beside her while she was driving the family car with him as a passenger. According to another of his partners, Dr Michael Grieve, Shipman suffered several blackouts in front of patients in the surgery waiting room.

1.9 Because of his blackouts, Shipman was referred to Dr Philip Humberstone, a consultant physician at the Halifax Royal Infirmary. Shipman was seen there on 18th August 1975 and it seems that a diagnosis of idiopathic epilepsy (i.e. epilepsy of unidentified origin) was made.

1.10 At some time during 1975, Shipman was either advised, or himself decided, to stop driving and, from that time, he relied on his wife to drive him when he visited patients at their homes. It is not known precisely when this arrangement began. Mrs Shipman's recollection was that the blackouts began ' not many months' before they left Todmorden

in late 1975. She thought that she had been driving him around for only a matter of weeks before he ceased to practise in Todmorden.

Discovery

1.11 In late September 1975, Shipman's partners discovered that he was abusing pethidine and had been obtaining the drug illicitly to feed his habit. He had obtained large quantities of pethidine on written requisition, ostensibly for practice use; these quantities could not be accounted for and it was plain that Shipman had taken them for his own use. His partners confronted Shipman, who admitted that he was abusing pethidine and, after unsuccessfully trying to persuade his colleagues to assist him in continuing to obtain supplies of the drug illegally, tendered his resignation from the practice. Although he later withdrew that resignation, his partners took legal advice and eventually succeeded in dismissing him from the practice.

1.12 Shipman was immediately admitted to the Halifax Royal Infirmary under the care of Dr Humberstone, who quickly referred him to a consultant psychiatrist, Dr Hugo Milne. Dr Milne arranged for Shipman's voluntary admission to The Retreat, a private hospital in York, specialising in the treatment of psychiatric disorders. There, Shipman was placed under the care of Dr R W Bryson, consultant psychiatrist. Both psychiatrists later notified the Home Office that Shipman should be registered as a drug addict.

1.13 Shipman was successfully withdrawn from pethidine, following which he was diagnosed as suffering from a moderately severe depressive or melancholic state. He was treated with antidepressant medication, which appeared to effect a great improvement in his condition. He was discharged from The Retreat on 30th December 1975, with advice to continue under psychiatric supervision for several years.

Criminal Proceedings

1.14 Meanwhile, the latest developments had been immediately notified by Shipman's partners to the Home Office Drugs Inspectorate which, in turn, had informed the police. On 28th November 1975, Mr McIntosh, together with Detective Sergeant George McKeating, from the West Yorkshire Police Drugs Squad, interviewed Shipman at The Retreat. Initially, Shipman refused to speak to the police officer but quickly changed his mind and gave what his interviewers took to be a full account of his criminal activities. He admitted using a variety of deceptions to obtain pethidine for his own consumption which he claimed had risen, by the time of his discovery, to 600 to 700mg a day. He said that he had started taking pethidine about 18 months previously (that is in about May 1974) when he became depressed because he did not get on with his partners. It should be said that his partners do not agree that there was any friction within the practice; they were never asked for their response to Shipman's assertion and, indeed, say that they were unaware that he was to be prosecuted until they read about the court proceedings in the local newspaper.

1.15 Shipman then made a detailed written statement, setting out his account of what had occurred. In the course of that statement, he wrote:

‘ I have no future intention to return to General Practice or work in a situation where I could obtain supplies of pethidine’.

1.16 On 13th February 1976, Shipman appeared at the Halifax Magistrates’ Court, where he pleaded guilty to eight specimen charges: three offences of obtaining ten ampoules of 100mg pethidine by deception, three of unlawfully possessing pethidine and two of forging a prescription. He asked for 74 further offences to be taken into consideration. Unfortunately, no list of those further offences survives; the police and court files, which would have contained such a list, have now been destroyed. However, it is clear from contemporaneous press reports that 67 of the 74 offences concerned the obtaining of pethidine by deception. Shipman was fined £75 on each charge, £600 in all, and ordered to pay compensation of £58.78 to the NHS Family Practitioners Committee.

A New Job

1.17 By the time of his conviction, Shipman had already started a new job. On 2nd February 1976, he had commenced employment with the Durham Area Health Authority as a clinical medical officer at the Newton Aycliffe Health Centre. He told his prospective employers of his previous problem with drugs and of the fact that he was facing criminal proceedings and possible disciplinary action by the GMC. Having discussed his case with the psychiatrists who had been treating him, the Health Authority offered him the post on condition that he continue to have follow-up care from a psychiatrist. Shipman had no access to controlled drugs in the course of his new employment.

1.18 Meanwhile, Shipman’s health problems had resolved and he had ceased to suffer the blackouts or seizures which had affected him during his time in Todmorden. With hindsight, it is clear that those episodes were a product of his pethidine abuse, rather than a manifestation of epilepsy. His wife believes that he began to drive again in about March 1976. He was still under the care of Dr Milne in April 1976 but it is not known how much longer this psychiatric supervision continued, as Dr Milne’s records have not survived.

Possible Disciplinary Proceedings

1.19 Shipman’s convictions at the Magistrates’ Court were reported to the GMC, which then had to decide whether to take disciplinary action against him to remove or restrict his registration as a doctor. Following the procedure then in force, Shipman’s case was automatically referred to the Penal Cases Committee, whose task it was to decide, on the basis of written evidence and submissions, whether the case should be referred for inquiry to the GMC Disciplinary Committee.

1.20 Shipman’s case came before the Penal Cases Committee, which had before it reports from Dr Bryson and Dr Milne, the consultant psychiatrists who had treated Shipman. There was also a letter of support from Dr Michael O’Brien, Area Medical Officer of the Durham Area Health Authority; the letter stated that Shipman ‘ had settled well into his new employment’ and was ‘ well received by both patients and professional colleagues alike’, with no evidence to suggest any recurrence of ‘ his former difficulties’.

1.21 On 28th April 1976, the Penal Cases Committee of the GMC determined that no inquiry into Shipman's case should be held by the Disciplinary Committee and that the case could, therefore, be concluded. Subsequently, a letter was sent to Shipman, part of which reads as follows:

> **' The Committee instructed me to inform you that they take a grave view of offences arising out of an abuse of drugs and of offences involving dishonesty… You would therefore be wise to assume that, if information relating to any further conviction of a similar nature should be received by the Council, a charge would then be formulated against you on the basis of both the earlier and the later convictions and referred to the Disciplinary Committee of the Council for inquiry'**.

The GMC informed the Home Office of its decision by a letter dated 3rd May 1976.

1.22 Following Shipman's conviction for drugs offences under the Misuse of Drugs Act 1971, the Home Secretary had power under that Act to make a direction pursuant to section 12, prohibiting Shipman from having in his possession, prescribing, administering or otherwise dealing with such controlled drugs as were specified in the direction. In the event, the Home Office officials who dealt with the case decided that no such direction should be given. In reaching that decision, they appear to have been influenced by the view expressed by the police that there was no evidence that any of Shipman's patients had suffered as a result of his obtaining of pethidine and also by the decision of the GMC not to take disciplinary proceedings against Shipman.

The Move to Donneybrook

1.23 Shipman was, therefore, free to pursue his medical career when and where he chose. In 1977, he responded to an advertisement which had been placed in a medical publication by a seven doctor practice in Hyde, a former mill town which has, over the years, been subsumed into the Greater Manchester conurbation. The Donneybrook practice was seeking a new doctor to replace one who was leaving to work in industry. At interview, Shipman told members of the practice about his previous abuse of pethidine and his convictions. He referred them to one of the psychiatrists who had treated him and who would be able to give them details about his condition.

1.24 One of the doctors at the practice spoke to the psychiatrist named by Shipman (it is not clear whether this was Dr Milne or Dr Bryson, although it seems likely to have been the latter) and also to officials at the GMC and the Home Office. He was assured by the psychiatrist that Shipman was not, in his opinion, suffering from any mental health problems which would interfere with his work as a general practitioner and he was informed (correctly) by the GMC and the Home Office that there were no restrictions in force which would affect Shipman's use of controlled drugs. Once that information had been obtained, Shipman was invited to join the practice, starting on 1st October 1977.

1.25 Shipman stayed at the Donneybrook practice for over 14 years. He was hard-working, apparently dedicated and popular with his patients. He was active in introducing new ideas to the practice and also became involved in organisations outside the practice.

For several years, he was an area surgeon for the local St John Ambulance; he was a member of the (then) Family Practitioners Committee and, later, secretary of the Tameside Local Medical Committee.

1.26 In 1991, Shipman told his colleagues at Donneybrook that he was intending to leave the practice; the ostensible reasons for this were Shipman's dislike of the computer system, which had been introduced in 1989 to record patient details, and his disagreement with the proposed scheme of fundholding. With hindsight, these stated reasons for his departure make little sense since, once in his own practice, Shipman embraced enthusiastically the use of computers and became chairman of the local users' group for Micro-Doc, a software system developed especially for doctors. Moreover, in 1995, he joined the Tameside Consortium (South) for the specific purpose of fundholding. It seems that, even at the time, at least some members of the Donneybrook practice believed that he might have had other reasons for leaving. One describes Shipman as tending to be ' individualistic' in his approach and says that he ' could become irritated if confronted by any other of the doctors and other staff members'. According to him, the assumption at the time was that these features of his personality might have led Shipman to prefer single-handed practice. At his trial, Shipman claimed that he left because the other doctors were not as committed to fundholding as he was. It seems also that, towards the end of his time at the Donneybrook practice, Shipman's relationships with at least one member of the staff there had deteriorated badly.

The Market Street Surgery

1.27 Whatever the real reasons for his move, from 1st January 1992, Shipman ran a single-handed practice from within Donneybrook House until his new surgery was ready in August 1992. He then moved to premises at 21 Market Street, Hyde. He took with him several members of staff from the Donneybrook practice and, to the annoyance and financial detriment of his former partners, his patient list. The parting was acrimonious and was followed by lengthy negotiations between solicitors to settle the financial arrangements consequent upon Shipman's departure.

1.28 For the next six years, Shipman's practice appeared to flourish. He enjoyed a high reputation in Hyde as an attentive, caring doctor. A major reason for his popularity was his willingness to visit his elderly patients at home. One witness described his mother's delight at being accepted onto Shipman's patient list; it was, he said, ' as though she had won the lottery'. Many elderly people were persuaded to join Shipman's practice by friends or family members who were impressed by the quality of the care which they received from him. Shipman did not have space on his patient list to accommodate all those who wished to join it and, by the time of his arrest, he was actively attempting to recruit a partner to share his workload and enable the practice to take on more patients.

1.29 Shipman and his staff performed regular medical audits, which impressed the Health Authority's Audit Group, and the practice was generally regarded as being innovative and advanced. Some indication of the high esteem in which Shipman was held emerges from a Health Authority document dating from late December 1997. An issue had arisen about access to patient records and the Health Authority's solicitor had advised

Ms Andrea Horsfall, the deputy complaints manager, to contact a local general practitioner and ascertain whether he or she was aware of recent guidance issued by the British Medical Association. Ms Horsfall spoke to Dr Alan Banks, then Assistant Director of Primary Care and Medical Adviser to the Health Authority. Her note of that conversation records:

> **‘ Asked A. Banks which GP I should ring. He suggested Dr Shipman as he is apparantly** (*sic*) **very uptodate** (*sic*) **on all the latest information/ advice’**.

1.30 In addition, Shipman was active in local medical politics and an enthusiastic member, latterly treasurer, of the local branch of the Small Practices Association. Although there were people who regarded him as arrogant, sometimes overbearing, the majority of his patients, his staff and other professionals with whom he came into contact appear to have held him in high esteem and to have believed that the health and welfare of his patients were his main priority. When giving evidence to the Inquiry in May 2002, Mr Nigel Reynolds, widower of the late Dr Linda Reynolds, observed that, in 1998, Shipman was quite simply perceived as ‘ the best doctor in Hyde’.

The Police Investigation of March 1998

1.31 By March of that year, however, certain people in Hyde had begun to feel concern at the number of Shipman’s elderly patients who were dying in curiously similar circumstances. After discussion with her colleagues, Dr Reynolds, a partner in the nearby Brooke Practice, alerted the Coroner for the Greater Manchester South District (‘ the South Manchester Coroner’), Mr John Pollard, to the concerns felt by herself and others. Mr Pollard initiated a limited police investigation, during which the police sought the assistance of the West Pennine Health Authority. At the conclusion of that investigation, the police officer who conducted it, Detective Inspector David Smith, decided that there was no evidence to substantiate the concerns which had been expressed by Dr Reynolds to the Coroner. No further action was, therefore, taken.

1.32 The conduct of the March 1998 investigation and its outcome have been fully examined by the Inquiry in the course of oral hearings held between May and July 2002. The Inquiry’s findings as to the adequacy of the investigation will be published in due course.

The Death of Mrs Kathleen Grundy

1.33 Mrs Kathleen Grundy died on 24th June 1998. She was Shipman’s patient and he certified the cause of her death as ‘ old age’. Despite her 81 years, Mrs Grundy had enjoyed good health and her death was sudden and unexpected. She was buried at Hyde Chapel.

1.34 Mrs Grundy's daughter, Mrs Angela Woodruff, was a practising solicitor who, ever since she had qualified, had conducted any necessary legal work on her mother's behalf. In 1986, she had drawn up Mrs Grundy's will, by which Mrs Grundy had made her daughter the sole beneficiary to her substantial estate. Following Mrs Grundy's death, Mrs Woodruff became aware of the existence of what purported to be a new will; this was dated 9th June 1998 and had been sent, together with a covering letter apparently signed by Mrs Grundy, to a firm of Hyde solicitors very shortly before Mrs Grundy's death. Those same solicitors, to whom Mrs Grundy was not known, subsequently received a letter from a person signing himself or herself ' J. Smith' or ' S. Smith', informing them of Mrs Grundy's death. The new will left Mrs Grundy's entire estate to Shipman. A copy of the will and letters can be seen at the end of this Chapter.

Investigating Mrs Grundy's Death

1.35 Mrs Woodruff was immediately suspicious about the new will and her suspicions deepened after she had visited and spoken to the two patients of Shipman whose signatures appeared on the will as witnesses. On 24th July 1998, she reported her suspicions to the police in Warwickshire, where she lived. The matter was passed to the Greater Manchester Police for investigation and it was quickly realised that the doctor who was the beneficiary of Mrs Grundy's new will was the same doctor who had been the subject of a police investigation only a few months earlier.

1.36 A warrant for the exhumation of Mrs Grundy's body was obtained from the South Manchester Coroner and the exhumation took place on 1st August 1998. On the same day, the police executed warrants to search Shipman's surgery and home address. A typewriter and Mrs Grundy's medical records were seized from the surgery. On 3rd August 1998, Detective Chief Superintendent (then Detective Superintendent) Bernard Postles was appointed Senior Investigating Officer and a major incident investigation began.

1.37 A post-mortem examination of Mrs Grundy's body failed to establish the cause of her death and a decision was taken to carry out toxicological tests. On 14th August 1998, the police were told that initial tests carried out at the North West Forensic Science Laboratory had shown the presence of an opiate, possibly morphine, in Mrs Grundy's body. Further tests were to be carried out to confirm the type and levels of opiate present.

1.38 Also on 14th August 1998, an inspector from the Home Office Drugs Inspectorate, together with a chemist inspector from the Greater Manchester Police, visited Shipman at his surgery and interviewed him in connection with his use of controlled drugs. Prior to that visit, on 10th August, the Home Office inspector informed the police that Shipman had previous convictions. This was the first time that the Greater Manchester Police became aware that Shipman had a criminal record. Enquiries were then made and the nature of the previous convictions established.

1.39 Meanwhile, the police had decided to re-examine the 19 deaths certified by Shipman, of which they had become aware during the March 1998 investigation. They began to interview family members to ascertain whether they had any concerns about the

circumstances of the deaths. Later in August, the investigation was widened to include a further nine deaths.

1.40 On 26th August 1998, the police were informed of the opinion of Mr Michael Hall, a forensic document examiner, that the signatures on Mrs Grundy's new will had been forged and the will itself had probably been typed on the typewriter which had been seized from Shipman's surgery.

1.41 On 28th August 1998, Mrs Julie Evans, a forensic scientist, told the police that the levels of morphine present in Mrs Grundy's body were consistent with levels which had previously been known to have caused death by morphine overdose.

1.42 On 7th September 1998, Shipman was arrested on suspicion of the murder of Mrs Grundy, of attempting to obtain property by deception and of forgery. He was interviewed in connection with those offences and later charged. The following day, he appeared before Tameside Magistrates' Court, when he was remanded in custody. He has been in custody ever since.

Widening the Investigation

1.43 During September 1998, the bodies of Mrs Joan Melia, Mrs Winifred Mellor and Mrs Bianka Pomfret were exhumed. On 5th October 1998, Shipman was arrested on suspicion of their murders and was interviewed; however, the interview had to be discontinued because Shipman became distressed and confused. He was charged with the three murders on 7th October 1998.

1.44 In October 1998, the bodies of Mrs Marie Quinn and Mrs Ivy Lomas were exhumed. Shipman was arrested and interviewed in connection with those deaths on 11th November 1998 but made no comment during the interviews. He was charged with both murders the same day.

1.45 Exhumations of the bodies of Mrs Jean Lilley and Mrs Irene Turner followed in November 1998 and, following a further ' no comment' interview, Shipman was charged with their murders on 3rd December 1998.

1.46 On 22nd February 1999, Shipman was charged with the murder of Mrs Muriel Grimshaw, whose body had been exhumed in December 1998, together with the murders of Mrs Norah Nuttall, Mrs Kathleen Wagstaff, Miss Maureen Ward, Mrs Pamela Hillier, Mrs Maria West and Mrs Lizzie Adams, all of whom had been cremated.

Suspension from Practice

1.47 The police had been attempting for some time to prevent Shipman from continuing to practise. They had informed the GMC of the position in August 1998 but were told that the GMC could do nothing until Shipman had been convicted of an offence. On 18th August, the West Pennine Health Authority contacted the NHS Tribunal, which had power to suspend him, but a hearing by the Tribunal could not be arranged before 29th September. After that hearing, the Tribunal's decision to suspend Shipman from practice was not communicated to the Health Authority until 15th October. The Health

Authority was able to take control of the practice only after the expiration of the period for an appeal against that decision, on 29th October 1998.

The Criminal Trial

1.48 At Shipman's trial, which opened on 5th October 1999, he pleaded not guilty to the 15 counts of murder against him and to one count of forging Mrs Grundy's will. On 31st January 2000, Shipman was convicted on all counts. He was sentenced to 15 terms of life imprisonment and, for the forgery, a concurrent term of four years' imprisonment. When sentencing Shipman, the trial judge, Mr Justice Forbes, stated that his recommendation to the Home Secretary would be that Shipman should spend the remainder of his days in prison.

The End of Shipman's Professional Career

1.49 Following the trial, Shipman was suspended from practice by the GMC Preliminary Proceedings Committee and, on 11th February 2000, his name was erased from the medical register by the Professional Conduct Committee of the GMC.

The Inquests

1.50 In the course of the police investigations, bodies had been exhumed in three cases which did not form the subject of counts on the indictment at the criminal trial. Inquests into the deaths of Mrs Sarah Ashworth, Mrs Alice Kitchen and Mrs Elizabeth Mellor had been opened and adjourned by the South Manchester Coroner shortly after the exhumations; these inquests were concluded in August and September 2000; all three resulted in verdicts of unlawful killing.

1.51 By the time of the trial, the police had investigated a large number of deaths amongst Shipman's patients, in addition to the 15 deaths which were the subject of counts on the indictment and the additional three cases where bodies had been exhumed. Some of these investigations had been initiated by the police themselves; others had started as a result of communications from concerned relatives. As a result of their investigations, the police identified 23 further cases in which they believed that the evidence was strong enough to justify a prosecution for murder.

1.52 On 18th February 2000, the Director of Public Prosecutions announced that no further criminal proceedings would be instituted against Shipman because of the impossibility of his having a fair trial after the publicity surrounding his convictions in January 2000. A further factor was that, since it had been recommended that Shipman should spend the rest of his life in prison, no additional punishment would be imposed as a result of any future conviction.

1.53 In early 2001, the South Manchester Coroner sought and obtained from the Home Secretary a direction to open inquests into the 23 deaths identified by the police, together with a further death, that of Mr Charles Killan. The inquests were held between January and April 2001 and concerned the deaths of Mrs Dorothy Andrew, Mrs Irene

Berry, Mrs Edith Brady, Mrs Edith Brock, Mrs Elsie Cheetham, Mrs Erla Copeland, Mrs Lilian Cullen, Mrs Valerie Cuthbert, Mrs Elsie Dean, Mrs Joan Dean, Mrs Doris Earls, Mrs Elsie Hannible, Mrs Irene Heathcote, Mrs Hilda Hibbert, Mr Charles Killan, Mrs Bertha Moss, Mrs Nellie Mullen, Mrs Gladys Saunders, Miss Mabel Shawcross, Mrs Marjorie Waller, Mrs Mary Walls, Miss Ada Warburton, Mrs Amy Whitehead and Mrs Joyce Woodhead. All resulted in verdicts of unlawful killing, save for the inquests into the deaths of Mrs Joan Dean and Mrs Marjorie Waller, at the conclusion of which the Coroner returned open verdicts.

Further Police Investigations

1.54 The publicity surrounding Shipman's trial and convictions caused more people to contact the police, concerned about Shipman's possible involvement in the death of a family member. By the beginning of 2001, the Greater Manchester Police had investigated 192 deaths. Meanwhile, the West Yorkshire Police had carried out investigations into the deaths of Mr Edward Walker and Mrs Margaret Wilmore in Todmorden and an incident involving Professor Elaine Oswald, who had become concerned during the criminal trial that she may have been one of Shipman's intended victims.

1.55 On 5th January 2001, Professor Richard Baker's review of Shipman's practice, which had been commissioned by the Chief Medical Officer, was published. That review, which is discussed by Professor Baker in Appendix A to this Report, identified deaths which he considered suspicious, having examined the cremation forms and/or the medical records of the deceased. Approximately 60 of those deaths had not previously been investigated by the police; following publication of the review, the police proceeded to investigate them, together with others of which they had recently become aware.

1.56 Professor Baker discovered that Shipman had issued 22 Medical Certificates of Cause of Death (MCCDs) during his time in Todmorden, including the MCCD relating to the death of Mr Edward Walker. Following the publication of the review, the West Yorkshire Police investigated the other 21 deaths, as well as nine deaths (including that of Mrs Margaret Wilmore) which had been certified by the local coroner. They interviewed Shipman about the Todmorden deaths at Halifax Police Station on 30th April 2001. He refused to answer their questions.

1.57 All those investigations had been concluded by June 2001, at which time the incident room was closed and the police investigation scaled down.

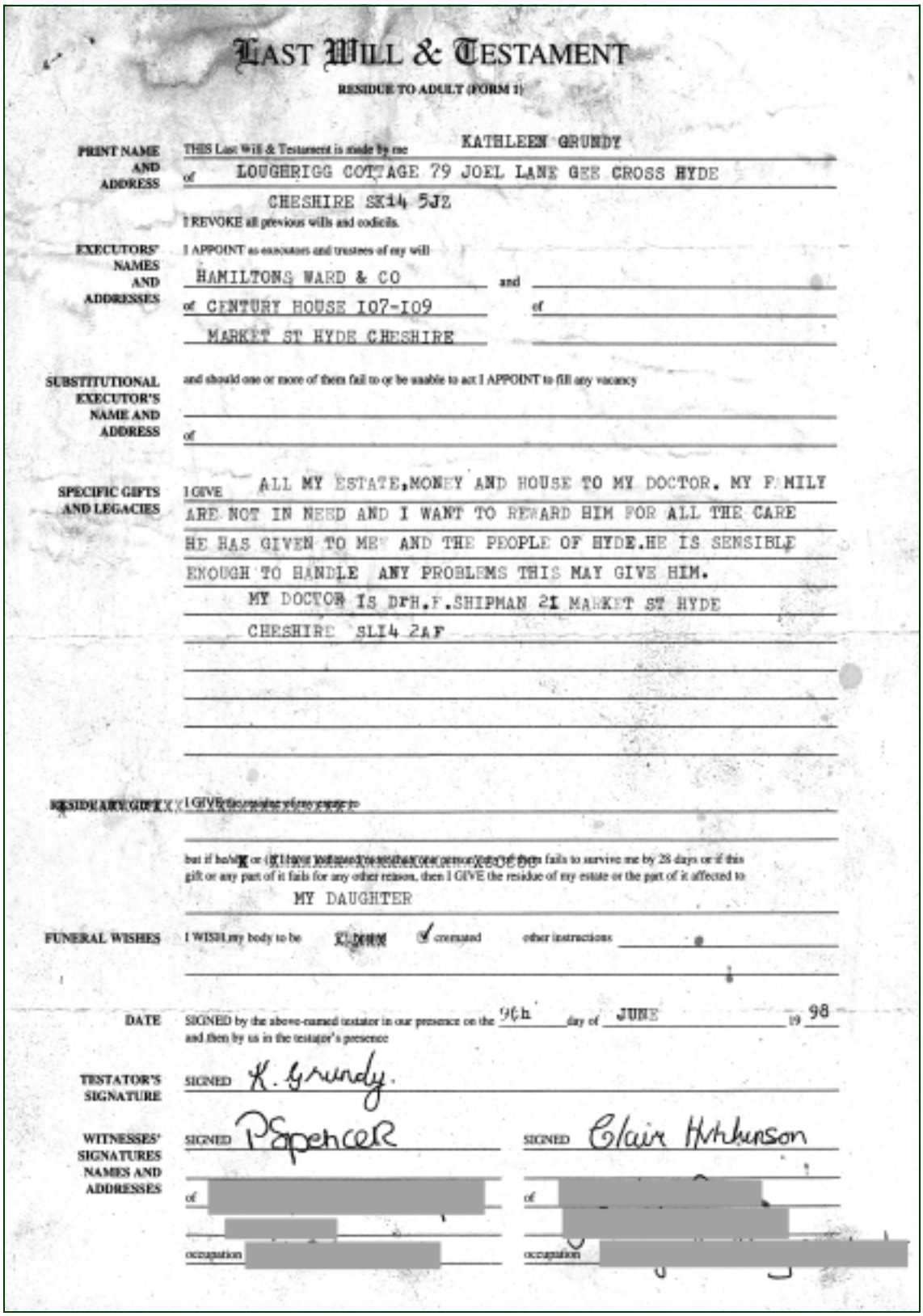
The Laming Inquiry

1.58 On 1st February 2000, the day after Shipman's convictions, the Secretary of State for Health, The Rt. Hon. Alan Milburn, MP, announced in the House of Commons the setting up of an inquiry under the provisions of section 2 of the National Health Service Act 1977, under the chairmanship of Lord Laming of Tewin.

1.59 The Laming Inquiry began its preliminary work but, when it was discovered that it was to be held in private, that members of the families of the deceased former patients of Shipman would not be permitted to hear or read the evidence given to the Inquiry by statutory and other bodies or individuals, and that families would not be permitted legal representation, there was widespread dissatisfaction about the form of the Inquiry. Representations were made to the Secretary of State on behalf of a number of relatives of Shipman's known or suspected victims, known collectively as the Tameside Families Support Group. The Secretary of State considered his decision afresh but declined to change it. He stated his reasons for maintaining his stance in a letter dated 12th April 2000, addressed to Ms Ann Alexander, the solicitor representing the Support Group. As a result, proceedings for judicial review were commenced by the Support Group and, subsequently, by nine media organisations.

1.60 On 20th July 2000, the Divisional Court set aside the Secretary of State's decision of 12th April and remitted the matter for re-determination by him.

1.61 On 21st September 2000, the Secretary of State announced that a public inquiry would be held into the issues surrounding the crimes committed by Shipman.



LAST WILL & TESTAMENT

RESIDUE TO ADULT (FORM 1)

PRINT NAME AND ADDRESS

THIS Last Will & Testament is made by me KATHLEEN GRUNDY

of LOUGHRIGG COTTAGE 79 JOEL LANE GEE CROSS HYDE

CHESHIRE SK14 5JZ

I REVOKE all previous wills and codicils.

EXECUTORS' NAMES AND ADDRESSES

I APPOINT as executors and trustees of my will

HAMILTONS WARD & CO and

of CENTURY HOUSE 107-109 of

MARKET ST HYDE CHESHIRE

SUBSTITUTIONAL EXECUTOR'S NAME AND ADDRESS

and should one or more of them fail to or be unable to act I APPOINT to fill any vacancy

of

SPECIFIC GIFTS AND LEGACIES

I GIVE ALL MY ESTATE,MONEY AND HOUSE TO MY DOCTOR. MY FAMILY ARE NOT IN NEED AND I WANT TO REWARD HIM FOR ALL THE CARE HE HAS GIVEN TO ME AND THE PEOPLE OF HYDE.HE IS SENSIBLE ENOUGH TO HANDLE ANY PROBLEMS THIS MAY GIVE HIM.

MY DOCTOR IS DR H.F.SHIPMAN 21 MARKET ST HYDE CHESHIRE SK14 2AF

RESIDUARY GIFT

I GIVE

but if he/she or (if more than one person) any of them fails to survive me by 28 days or if this gift or any part of it fails for any other reason, then I GIVE the residue of my estate or the part of it affected to

MY DAUGHTER

FUNERAL WISHES

I WISH my body to be buried ✓ cremated other instructions

DATE

SIGNED by the above-named testator in our presence on the 9th day of JUNE 19 98 and then by us in the testator's presence

TESTATOR'S SIGNATURE

SIGNED K. Grundy.

WITNESSES' SIGNATURES NAMES AND ADDRESSES

SIGNED P Spencer

of [redacted]

occupation [redacted]

SIGNED Clair Hutchinson

of [redacted]

occupation [redacted]

The forged will in the name of Mrs Kathleen Grundy, leaving her entire estate to Shipman

KATHLEEN GRUNDY
LOUGHRIGG COTTAGE
79 JOEL LANE
HYDE
CHESHIRE
SK14 5JZ

RECEIVED 24 JUN 1998

22.6.98

Dear Sir,

I enclose a copy of my will. I think it is clear in intent. I wish Dr. Shipman to benefit by having my estate but if he dies or cannot accept it ,then the estate goes to my daughter.

I would like you to be the executor of the will, I intend to make an appointment to discuss this and my will in the near future.

Yours sincerely

K. Grundy

Letter to a local firm of solicitors, purporting to be from Mrs Kathleen Grundy, sending them a copy of the forged will for safekeeping

RECEIVED 30 JUN 1998

28 JUNE 1998

Dear Sir,

I regret to inform you that Mrs K. Grundy, of 79 Joel Lane Hyde . died last week.

I understand that she lodged a will with you, as I as a friend typed it out for her.

Her daughter is at the address and you can contact her there.

Yours

J. Smith

Letter to the solicitors, purporting to be from a friend of Mrs Katheen Grundy called ‘ J. Smith’ or ‘ S. Smith’, informing them of Mrs Grundy’s death