CHAPTER ELEVEN

Shipman's Unlawful Activities: The Donneybrook Years

11.1 Shipman began to practise at the Donneybrook Medical Centre, Clarendon Street, Hyde on 1st October 1977. In Chapter Four, I have described the arrangements and working practices in operation there. In this Chapter, I shall deal with the results of the Inquiry's investigations into Shipman's crimes during the Donneybrook years.

11.2 The extent to which Shipman was able to and did kill patients is inextricably connected with his ability to obtain supplies of the strong opioid drugs which he undoubtedly used. In Chapter Eight, I mentioned that there was no longer any documentary evidence from the late 1970s and 1980s from which Shipman's access to controlled drugs could be established. Such evidence is available from his usual source of supply, the Norwest Co-op Pharmacy, from 1991 onwards. One of his favoured methods of obtaining pethidine in Todmorden was to prescribe larger than necessary quantities for patients, many of whom were terminally ill and had a genuine need for the drug, and to take the excess for himself. I consider it likely that he adopted a similar technique after his arrival in Hyde. It is possible that he also used other methods during the Donneybrook years, such as are demonstrated by the controlled drugs register for 1993. During that year, Shipman obtained fourteen single 30mg ampoules of diamorphine by prescribing them in the name of patients who did not need them and, sometimes, in the name of a patient who had recently died.

11.3 I think, however, that he would probably have been very cautious about the ways in which he obtained controlled drugs when he first arrived in Hyde. He had been caught out in Todmorden and must have realised that he had been lucky not to be disciplined by the GMC in 1976. He had had to admit to the members of his new practice that he had been convicted of drugs offences. He told them that he did not intend to keep a personal controlled drugs register. That would mean that he was not allowed to carry controlled drugs in his medical bag. He would not have wished to do anything to arouse their suspicion, in the early days, until he had established a degree of trust and confidence. I think it unlikely therefore that he would have risked signing orders for controlled drugs at the pharmacies or prescribing for patients who were dead. It seems to me that, when Shipman wanted illicit supplies of controlled drugs, he would, at first, choose the method least vulnerable to detection, namely to take possession of the drugs left over after a cancer death. It would be easy for him to say to the family, and possibly to the district nurses, that he was taking the drugs away for destruction.

11.4 Once the decisions in the individual cases were complete, I was able to identify the deaths of patients with terminal cancer who had been cared for by Shipman and for whom it was known or might reasonably be supposed that he was prescribing opiates. I found a remarkably close correlation between opportunities to obtain drugs prescribed for the terminally ill and deaths that I have attributed to him. The following account will demonstrate a link between the cancer deaths which could have provided supplies of opiate and the deaths he caused. This correlation is not always precise but I believe it is close enough to be significant.

11.5 I do not propose to give a full account of the circumstances of every death that Shipman caused during his years at the Donneybrook Medical Centre. A chronological list of decided cases appears at Appendix F and the decision for each case is to be found in Volumes Three to Six. Instead, I shall seek to describe the pattern of Shipman's criminality and to draw attention to the development of his *modus operandi*. I described in Chapter Nine some of the features that became apparent during Shipman's trial as typical of his methods. Other features, which had not arisen in the 15 conviction cases, emerged as typical from my examination of the other cases where I have found that Shipman had killed. Many of these features first appeared in the Donneybrook years.

The Period from 1977 to 1983

1977

11.6 Shipman did not begin to kill patients as soon as he arrived in Hyde. He certified the causes of only four deaths during the three month period between October and December 1977. I have found that two of the deaths were probably natural. In the third, I am unable to reach any decision, as almost nothing is known of the circumstances. The investigation into the fourth death was closed. In none of the four deaths was the cause related to cancer. Nor was there any reason to suppose that opiate drugs might have been prescribed.

1978

11.7 I have found that Shipman killed four patients in 1978. He attributed each death to coronary thrombosis. He probably obtained opiates following the deaths of two patients who died of cancer in late July. Those drugs were almost certainly used to kill Mrs Sarah Marsland on 7th August and Mrs Mary Jordan on 30th August. Further cancer deaths occurred on 25th September and 5th December. In both of those cases, the patient was receiving opiates for pain relief and I suspect that Shipman might have hastened the death by giving an overdose. In either case, he might well have retained excess drugs. On 7th December, Shipman killed Mr Harold Bramwell, who was suffering from cancer and had been prescribed opiates. From some or all of these deaths Shipman could have retained excess drugs and would then have had a supply with which to kill Mrs Annie Campbell on 20th December.

11.8 Mrs Marsland's death is an early example of what was to become a typical Shipman killing. Shipman was in the habit of making unsolicited visits; his elderly patients appreciated it. I think this was normal practice for many general practitioners in the 1970s and 1980s, although it no longer is. Mrs Marsland was a widow who lived alone. She was 86 but was in quite good health for her age and was still mobile and independent. She had recently suffered a bereavement; one of her daughters, Cicely, had died and she was rather depressed. On the day of the death, her daughter, Mrs Irene Chapman (who was herself later to become one of Shipman's victims) arrived at her mother's house to find her mother lying on the bed with Shipman leaning over her. Shipman said that he had found Mrs Marsland sitting in her chair; she had told him that she ' got an awful pain' when she thought of Cicely. Shipman said he had moved her onto the bed. She had collapsed and died. He said that he had tried unsuccessfully to

resuscitate her. That was plainly not true; for one thing he had not moved her onto a hard surface. However, it was the extraordinary coincidence that Mrs Marsland should die just at the time of Shipman's unsolicited visit which persuaded me that he had probably killed her. This case illustrates Shipman's ability to make up a story as an explanation for what had occurred and the willingness of shocked and grieving relatives to accept a most implausible account of the death.

1979–1980

11.9 I have found that Shipman did not kill any patients in the early part of 1979. On 18th July, Mrs Lavinia Wharmby died of cancer. I suspect that Shipman might have hastened her death and I also suspect that he acquired a supply of opioid drugs at the time of her death. There was another cancer death on 2nd August. On 4th and 5th August, there were two deaths about which I have strong suspicions but cannot reach positive conclusions.

11.10 On 9th August 1979, Shipman gave Mrs Alice Gorton a large dose of opiate, from which she died the following day. Mrs Gorton was 76 and suffered from very severe psoriasis. Her general health was reasonable, although she probably had angina. Mrs Gorton's daughter, Mrs O'Neill, lived nearby and saw her every day. She spent the morning of 9th August with her mother, who seemed in normal health. Shipman was due to make a routine visit to provide supplies of creams and dressings needed for her chronic condition. When Mrs O'Neill went home for lunch, Shipman had not yet arrived. About half an hour after she had reached home, Shipman came to Mrs O'Neill's house. He told her that her mother had been taken ill and she must come with him immediately. Shipman left and Mrs O'Neill followed. When she arrived, a few minutes later, Shipman was in her mother's front room. He told her that there would be no need for a post-mortem examination. The import of this was just dawning on Mrs O'Neill when she heard a loud groan coming from the bedroom. She rushed in to find her mother lying unconscious on the bed, fully clothed. Mrs Gorton lay in a coma until she died the following afternoon. She was not admitted to hospital. Shipman certified that the death was due to a coronary thrombosis. The death was not referred to the coroner.

11.11 On hearing the evidence, I strongly suspected that Mrs Gorton's sudden collapse into unconsciousness had occurred in Shipman's presence and had been caused by him. The coincidence that she should have been taken ill in the short interval between Mrs O'Neill's departure and Shipman's arrival was too great to accept. I was puzzled because, in the other killings that I had by this time considered, the deaths had all occurred very quickly. I had not come across a lingering death about which there was suspicion or concern. However, Dr Grenville explained that it was possible that Shipman had given a ' sub-lethal' dose of opiate, which was not quite enough to kill Mrs Gorton outright. The opiate could have depressed her respiration to such an extent that she had suffered permanent brain damage due to lack of oxygen. She could have then lingered until she died, either as the result of the brain damage or from bronchopneumonia (to which she would be vulnerable while lying unconscious) or possibly from a combination of the two. I concluded that that is what had happened. I infer that, for some reason, Shipman underestimated the amount of opiate needed.

11.12 Three months later, Shipman killed Mr Jack Leslie Shelmerdine. Mr Shelmerdine had chronic bronchitis and, in the few days before his death, was suffering from an episode of heart failure. Shipman was called out late one evening when Mr Shelmerdine was very breathless. He gave him an intramuscular injection of opiate. Mr Shelmerdine went into a deep sleep from which he never awoke. He died from bronchopneumonia about 30 hours after the injection. It is known that Shipman gave an injection of opiate because he said so in a letter written in response to a complaint made by Mr Shelmerdine's son to the Regional Health Authority. The complaint arose because Shipman had promised to arrange a domiciliary visit by a geriatrician. The geriatrician did not attend when expected. As a result, Mr Shelmerdine was moved to hospital and died not long after arrival. Shipman admitted that he had given 10mg morphine at his late night visit, although I suspect that he gave more. Even 10mg would have been excessive for a patient in Mr Shelmerdine's condition and Shipman must have known that the likely effect would be to send the patient into a deep sleep and to depress his respiration. I think it likely that Shipman intended that Mr Shelmerdine would die of respiratory failure during the hour following the injection. Shipman must also have known that, if Mr Shelmerdine were to survive the night but remain unconscious, he could well die of bronchopneumonia within the next day or so. I do not think Shipman was ignorant of the effects of opiate drugs. I think he knew of the special risk of giving opiates to patients with impaired respiratory function.

11.13 I strongly suspect that Shipman gave Mr Shelmerdine more than 10mg morphine. I suspect that he intended to kill him outright but, as with Mrs Gorton, he underestimated the dose. I think Shipman must have been unnerved by his failure to kill these two victims as quickly and efficiently as he had intended. He was probably very worried by the complaint to the Regional Health Authority, even though he himself was not the subject of the complaint. It appears likely that he did not kill again until April 1981, well over a year later. In the intervening period, there is a suspicion that he might have killed Miss Bethel Evans on 3rd January 1980. There are also several deaths during this period about which I have been unable to reach any conclusion due to the insufficiency of evidence.

1981

11.14 On 7th January and 2nd March 1981, Shipman attended at two cancer deaths, either or both of which could have provided him with a supply of opiates. On Saturday, 18th April, he killed Mrs May Slater. This death is an early example of the way in which Shipman involved and made use of other people in the events surrounding the death. He often involved the wardens of sheltered accommodation. Wardens are in a position of responsibility towards their residents and their involvement would allay any suspicion which might otherwise arise. On occasions, Shipman would leave the warden to deal with the deceased's relatives.

11.15 Mrs Slater was 84 and lived in sheltered accommodation at Bradley Green Old People's Centre, Hough Lane, Hyde, which was supervised by a warden, Mrs Doreen Laithwaite. On the Saturday afternoon, Mrs Slater's son, Mr James Slater, and his wife received a telephone call from Mrs Laithwaite, to say that Mrs Slater had been taken ill and the

doctor had been called. Shipman attended. Mrs Laithwaite says that it would be her usual practice to accompany a doctor who called to see one of her residents and to stay during the consultation. However, it appears that, on this occasion, Shipman must have instructed her to meet the family and prevent them from coming to Mrs Slater's bungalow. He was then alone with Mrs Slater and had the opportunity to kill her, which I believe he took. When Mr and Mrs James Slater arrived, they were prevented from going straight into Mrs Slater's bungalow. They cannot now recall why this happened but they recall meeting Mrs Laithwaite and being taken to her flat. A while later, Shipman came out of Mrs Slater's bungalow and told Mrs Laithwaite that Mrs Slater had died. He did not speak to the family. Shipman later certified that the death was due to congestive heart failure. The medical records have not survived and I cannot tell whether Mrs Slater had been suffering from that condition. I assume that she had been, at least to some extent. I also assume that Mrs Slater was quite unwell that afternoon as the doctor was called out on a Saturday afternoon. It is possible that Mrs Slater died a natural death. However, as Shipman obviously contrived to be alone with Mrs Slater, I think it likely that he killed her. Even if Mrs Slater was suffering from the effects of heart failure, it is typical that Shipman would take the opportunity to ensure that she did not survive.

11.16 In August 1981, there is a very close temporal relationship between the natural death of Mrs Emma Smith from cancer on 25th August and the killing of Mrs Elizabeth Ashworth on the following day. Mrs Ashworth's death was in many respects a typical Shipman killing. She was living independently at home and was in reasonable health. She had been gardening on the day of her death. She was taken ill and Shipman was called. He gave her an injection and she died not long afterwards.

11.17 In September and October 1981, there were three deaths about which I entertain some suspicion but the evidence is not sufficiently strong for me to reach a positive conclusion. Two of them raise the possibility that Shipman might have killed using Largactil (the proprietary name for chlorpromazine) rather than an opiate drug. On 8th September 1981, Mrs Ann Coulthard died. She had had a stroke, or possibly two. She was plainly declining and, during her last few days, she seemed restless and possibly in pain. Shipman attended on 7th September and gave an injection in the buttock, after which Mrs Coulthard was very sleepy. The injection might have been a sub-lethal dose of an opiate but might well have been Largactil, or some other sedative. Largactil is not a controlled drug. The following morning, Shipman informed the family that Mrs Coulthard would die that day. It is not clear whether or not he gave another injection during that visit. However, he came again in the early evening and gave an injection. Mrs Coulthard died about an hour afterwards, although the time estimate is very uncertain. It is possible that this death was entirely natural but other possibilities do arise. Shipman might have given a lethal dose of opiate on the evening of the death. He might have given a further dose of a sedative, such as Largactil. In other words, it is possible that he kept Mrs Coulthard very deeply sedated for something over 24 hours.

11.18 Miss Elsie Scott died on 6th October 1981. There is evidence that Shipman gave her a very large dose of Largactil on the day before her death. The dose appears to have been 100mg. Dr Grenville says that an appropriate dose for Miss Scott would have been of the order of 25mg. The evidence of Miss Scott's underlying state of health is unclear.

Here again, the suspicion arises that Shipman might have deliberately over-sedated this elderly patient in the 18 hour period before her death.

11.19 Elderly patients who are over-sedated are at increased risk of developing bronchopneumonia, a common mechanism of death in the elderly. It is possible that Shipman deliberately over-sedated Mrs Coulthard and Miss Scott to ensure that they would not regain consciousness. There are other cases where a similar suspicion arises. Even where the factual evidence is clear (and in some cases it is not) I do not feel able to reach a positive decision. It is quite possible that Shipman gave the sedative for proper therapeutic reasons. He might have given the drug as the best way to keep the patient comfortable. However, because I know that Shipman killed his patients, I naturally suspect his motives. If Shipman wanted to kill, to inject Largactil (or indeed any other sedative) would be a very uncertain method to choose. More than one ampoule would be necessary to produce very deep sedation. Patient responses are very variable and the patient might not die. However, it is possible that Shipman used Largactil, intending to kill, despite the disadvantage of uncertainty. Largactil would have some advantages. It would be less likely to excite the suspicion of the care staff in a residential home than would an opiate, which, if given in a lethal dose, would cause death within the hour. Largactil is not a controlled drug and Shipman would have been entitled, quite properly, to have a supply in his medical bag. Shipman might at times have been short of illicit supplies of opiate. In the light of these uncertainties, I cannot say whether Shipman ever deliberately killed a patient by over-sedation. I suspect that he might have done.

1982–1983

11.20 With the possible exception of the two suspicious deaths mentioned above and four other suspicious deaths in 1982, I have not made any finding that Shipman killed between August 1981, when he killed Mrs Elizabeth Ashworth, and January 1983, when he hastened the death of Mr Percy Ward, who was terminally ill. Part of this interval might be explained by the lack of a ready supply of opiates. However, that does not seem to have been the only reason, as there were two cancer deaths in March 1982 and no death which arouses more than suspicion occurred for a further ten months.

11.21 Mr Ward was 90 and was very ill indeed. He had had a burst duodenal ulcer; he was having great difficulty in breathing and his death was expected. Shipman gave him an injection after which he soon died. I observe that the risk to Shipman when killing a patient who was terminally ill was very much less than the risk he ran when killing a patient who was in reasonable health and living independently and whose death was therefore sudden and unexpected.

11.22 After killing Mrs Ashworth in August 1981, Shipman did not kill a ' healthy' patient until 28th June 1983, when he killed Miss Moira Fox. Not long before Miss Fox's death, Mr Charles MacConnell died of lung cancer on 24th May 1983. I suspect that Shipman might have hastened his death by giving an overdose of opiate. I think it likely that he prescribed more opiate than was needed and kept the excess.

11.23 Miss Fox's death was entirely typical of a Shipman killing; it bears his hallmark. Miss Fox was 77 and lived in sheltered accommodation at Chartist House, Hyde. She was well known to the caretaker, Mr Ralph Unsworth, and his wife, who was the warden. Miss Fox talked a great deal about her ailments but Mr Unsworth was of the view that she was in quite good condition for her age. She had changed doctors more than once and it is likely that she was quite a demanding patient. I am afraid that that would have made her particularly vulnerable to Shipman. On 28th June, Shipman found Mr Unsworth and asked him to come to Miss Fox's flat. He said that Miss Fox had telephoned earlier to ask him to visit, as she was not feeling well. When he arrived, he said, he had found her door ajar and could see Miss Fox lying on the floor behind the door, preventing him from opening it. He had forced his way in, pushing her to one side. He had examined her and found that she was dead. When Mr Unsworth and Shipman reached the flat, Miss Fox was lying on her back on the bed, looking as though she had been laid out by an undertaker. Mr Unsworth was puzzled that Miss Fox's clothes did not appear at all disturbed. Shipman then behaved rather strangely, as I have described fully in the decision, requiring Mr Unsworth to examine the body to ensure that Miss Fox was indeed dead and addressing her as a ' rum old devil' who had led people on a ' merry dance'. Shipman certified that the cause of death was a coronary thrombosis. What convinced me that Shipman had killed Miss Fox was an entry in his own visits book for 27th June, the day before the death. It says: **' Miss Fox 104 Chartist House blood tomorrow'**. On 28th June the visits book says: **' Miss Fox – bloods – dead'**. It is clear that Shipman went to see Miss Fox on 28th June, not because she had summoned him on account of feeling unwell, but because he had said that he wanted to take a blood sample. That Miss Fox should happen to collapse and die on the morning when Shipman was due to visit to take a blood sample is too much of a coincidence. I am satisfied that what really happened is that she let him in and he suggested that she should lie on the bed while he took the blood sample. That is why she did not look at all disturbed, as might have been expected if Shipman had had to pick her up off the floor and put her on the bed. This is the first case in time in which I have found that Shipman used the excuse of taking a blood sample as an opportunity to give an intravenous injection and kill the patient. This was to become a frequent practice. Many patients do not watch their doctor when a blood sample is being taken. Shipman played on this and may even have suggested that the patient should turn his or her head away. I am satisfied that many patients were killed in this way and did not realise that, instead of taking blood from them, Shipman was in fact administering an injection.

The Period from 1984 to 1989

11.24 During the period that I have just reviewed, Shipman killed occasionally and sporadically. In the period to which I now come, Shipman killed quite regularly, between eight and twelve times a year and, at least until 1988, there were no long intervals between the deaths.

1984

11.25 After the death of Miss Fox, Shipman did not kill again until Saturday, 7th January 1984. This victim, Mrs Dorothy Tucker, was only 51, but she was overweight and suffered from

leg ulcers. She could hardly walk and used a wheelchair out of doors. She is another example of a patient who was probably rather demanding of Shipman's attention. She might well have been at risk of a heart attack on account of her obesity alone. Mrs Tucker's cousin, Mrs Mary Bennett, spoke to Mrs Tucker at about 2pm on 7th January. Mrs Tucker said that she had called the doctor, as she had not been feeling well. He had given her an injection and told her that she would ' feel better in a bit'. She said that she intended to have a sleep. No one saw or spoke to Mrs Tucker again and she was found dead in the early evening. The lights were off; the gas fire was on high and the room was very hot. Mrs Tucker was slumped in the corner of the settee, looking as if she were asleep. Shipman was called to see the body. He observed that it was probably ' for the best' that Mrs Tucker should have died rather than continue to suffer. He certified that the death was due to coronary thrombosis. Although the death was obviously sudden and had apparently occurred while Mrs Tucker was alone, it was not referred to the coroner. On the MCCD counterfoil, Shipman said that he had last seen Mrs Tucker alive the day before the death.

11.26 Apart from Mrs Bennett's account that at 2pm Mrs Tucker said that the doctor had just been, there was no evidence that Shipman saw Mrs Tucker on 7th January. As it appeared that Mrs Tucker had been able to speak to Mrs Bennett after the doctor had given her an injection, it seemed that Shipman could not have been responsible for the death, at least not by using what was certainly to become his preferred method of killing, the intravenous injection of opiate. Dr Grenville and Professor McQuay say that the effect of the drug, given intravenously, is so rapid that the patient would not be able to have a conversation on the telephone after it had been administered. However, it can be very difficult to find a vein in a very obese patient and Shipman might have decided to give an intramuscular injection. Alternatively, it is possible that he tried to give an intravenous injection but the needle slipped out of the vein and the drug entered Mrs Tucker's system subcutaneously. In either of those situations, the drug would act much more slowly and it would be quite feasible to suppose that, if Mrs Bennett had telephoned within about 15 minutes after the injection, Mrs Tucker would have been able to answer the telephone and speak sensibly. She might well have begun to feel a little sleepy, to plan a rest and then to settle on the settee. This is one of only a very few cases where I have found that Shipman killed an active patient by means of a slower-acting intramuscular or subcutaneous injection. I think he often used the intramuscular route with patients who were ill in bed. No risk would arise from doing so. The patients would not go anywhere; no one would feel alarmed if they complained of feeling sick; no one would summon an ambulance if they fell deeply asleep. The period of time which would elapse before death would also have the advantage of distancing Shipman from the death. For the patient who was not confined to bed, the slow-acting methods of killing carried the risk that a friend or relative might arrive, feel alarmed and summon help in time. The patient might survive and live to tell the tale. However, I think that Shipman may well have taken that risk in Mrs Tucker's case.

11.27 This is the first case in time in which witnesses remarked on the high temperature in the room where the body was found. The gas fire was turned up high. This puzzled me but I found that this feature was present in such a number of Shipman killings that

I concluded that it must be of some significance. Shipman must sometimes have wanted the body to lie in a warm room. A high ambient temperature would result in the more rapid onset of rigor mortis but a slower rate of drop in body temperature. These are the two features on which a pathologist might rely if asked to estimate the time of death. Shipman might wish that the pathologist would not be able to make a reliable estimate. All I can think is that Shipman hoped to ' muddy the water' for the pathologist, in the event that a post-mortem examination followed.

11.28 Not long after Mrs Tucker's death, there were two cancer deaths. The first occurred in a residential home from which it would have been difficult for Shipman to take away any excess drugs, but the second, which took place on 30th January 1984, seems likely to have been a source of opiates. Just over a week later, on Wednesday, 8th February, Shipman killed Mrs Gladys Roberts. This case is an early example of what became a very common ploy for Shipman. He would claim that he had called an ambulance or was arranging admission to hospital but the patient had died and the arrangement had been cancelled.

11.29 Mrs Roberts was 78 and lived alone. She had a leg ulcer, which was dressed regularly by the district nurse. On the morning of 8th February, the nurse suggested that the doctor should examine her leg. At about 12.40pm, Mrs Roberts telephoned her daughter-in-law, Mrs Enid Roberts, and mentioned that she was expecting the doctor to look at her leg. She seemed quite well in herself. She promised to telephone again when the doctor had been. By 3.40pm, she had not done so, so Mrs Enid Roberts telephoned her. Shipman answered and told her that Mrs Roberts had died. He said he had been with her and was telephoning the hospital when Mrs Roberts gave one cough. He had turned round and saw that she had died. He said she had had a pulmonary embolism. Because this death occurred so long ago, it has not been possible to check whether Shipman did telephone the hospital. For more recent deaths in which Shipman made this claim, it has been possible to check whether he had made the telephone call. He hardly ever had. In one later case, that of Mrs Hilda Hibbert, he called an ambulance but not as an emergency. He asked that it should arrive in an hour, by which time Mrs Hibbert had died. In other cases, such as those of Mrs Lizzie Adams and Mrs Kathleen Wagstaff, of whose murders Shipman was convicted, he told the relatives that he had telephoned for an ambulance. The records showed that he had not. Accordingly, I strongly suspect that, in cases such as that of Mrs Roberts, Shipman claimed falsely to have summoned an ambulance as part of his attempt to create the impression that he had taken appropriate steps to prevent the death. Although I accept that it is possible that Mrs Roberts might have developed a deep vein thrombosis, it is too much of a coincidence that she should die suddenly during Shipman's visit.

11.30 Two months later, on Sunday, 15th April 1984, Shipman killed Mr Joseph Bardsley. He was a widower, aged 83, and lived alone in sheltered accommodation supervised by the same warden, Mrs Laithwaite, who had been present on the day of Mrs May Slater's death in 1981. Mrs Laithwaite knew Mr Bardsley well and saw him every day. She says that he was in good health on the day of his death. In fact, Mr Bardsley suffered from anaemia and was supposed to have vitamin B12 injections but he did not like them and had decided that he would not have any more. On that Sunday, Mr Bardsley's cousin

called on him after church and brought him some lunch. She stayed for about an hour. He was well when she left. At about 3pm, Shipman called on Mrs Laithwaite to say that he could not gain access to Mr Bardsley. He could see him through the window but could not attract his attention. Mrs Laithwaite, who knew that Mr Bardsley had not asked for the doctor to visit, asked Shipman why he had called on Mr Bardsley. Shipman told her that he had been ' in the area' and wanted to take a blood sample. Mrs Laithwaite took her key and let herself and Shipman into Mr Bardsley's bungalow. He was dead, sitting upright in his usual place on the settee. Shipman did not examine Mr Bardsley; he just asked Mrs Laithwaite to inform the next of kin. Shipman certified that the death was due to old age. This is not an appropriate cause of death for someone who has been up and about in reasonable health shortly before the death. He also claimed that he had seen Mr Bardsley 12 days before his death. I doubt that he had done and suspect that he was seeking to create the impression that he had treated Mr Bardsley during his ' last illness' and was therefore qualified to certify the cause of death. If Mr Bardsley had died naturally that afternoon, it was a sudden death for which the cause was not known. Any honest doctor would have referred the death to the coroner. I have no doubt that Shipman called on Mr Bardsley that afternoon, that Mr Bardsley let him in and that Shipman persuaded him either to let him take a blood sample or to give him an injection. I am satisfied that he killed him, by giving a lethal injection of opiate. He left, closing the door behind him. He then pretended to Mrs Laithwaite that he had been unable to gain access.

11.31 On the afternoon that Shipman killed Mr Bardsley, he had been called out to see a patient of Dr Bills named Mrs Jessie Wagstaff. After Shipman had visited Mrs Wagstaff, he chose to visit and kill Mr Bardsley that Sunday afternoon, rather than return home to continue his leisure activities.

11.32 Shipman killed Mrs Winifred Arrowsmith on Tuesday, 24th April 1984. She was a widow, aged 70, and lived alone in a flat in Chartist House, the sheltered accommodation where Mrs Jennifer Unsworth was the warden. Mrs Arrowsmith had a number of medical problems, including severe arthritis in the knees, which greatly restricted her mobility. She was mentally very alert and always cheerful. Mrs Arrowsmith was expecting Shipman to visit on 24th April. She usually left her door on the latch if she was expecting a visitor, as she was slow on her feet. Between 1.30pm and 2pm, Shipman telephoned the home of Mrs Valerie Lomax, Mrs Arrowsmith's daughter, to tell the family that Mrs Arrowsmith was dead. His account was that he had called on Mrs Arrowsmith, but had been unable to get any reply at the door. He had gone down to ask the warden whether Mrs Arrowsmith might have gone out. Mrs Unsworth took her passkey and went up to the flat with Shipman. They found Mrs Arrowsmith sitting on her sofa, fully dressed, looking as though she was asleep. She was dead. When the family visited the flat the following day, they found signs that Mrs Arrowsmith had done all her usual chores and had eaten lunch on the day of her death. Shipman certified the death as due to coronary thrombosis. In the absence of the medical records, I could not assess the likelihood that Mrs Arrowsmith might indeed have died a sudden cardiac death. However, it would have been something of a coincidence if she had had a sudden fatal heart attack between eating her lunch and Shipman's arrival, which must have been

before 1.30pm. The close temporal association between Shipman's visit and the death gave rise to a strong suspicion that he had killed her. My conclusion was that Shipman had visited Mrs Arrowsmith and had gained access in the usual way. He had given her a lethal injection, probably after asking her to let him take a blood sample. He had then left the flat, closing the door behind him so as to give the impression that he had been unable to get in. He then went for Mrs Unsworth and together they ' discovered' the death. This is exactly the same method he had used with Mr Bardsley, only nine days earlier.

11.33 On 7th August 1984, Mrs Mary Haslam died of cancer. It is likely that Shipman replenished his stock of opiate at the time of her death. He killed Mrs Mary Winterbottom on 21st September. Mrs Winterbottom was a widow and lived alone. She was 76 but was in good general health and was independent. A few days before her death, she was unwell with what appeared to be influenza or a chest infection. She did not appear to be seriously ill. On the day of her death, she spoke to her daughter at about 3pm to 3.30pm. She said that she was feeling better and was still waiting for the doctor to arrive. Soon after 3.30pm, Mrs Norma Miles, Mrs Winterbottom's niece (who lived nearby) learned that Shipman was at Mrs Winterbottom's flat. She went there and met Shipman, who told her that Mrs Winterbottom had died. He asked her if she would like to see her aunt and then told her that he had taken Mrs Winterbottom's dentures out. Indeed he had. Mrs Winterbottom's body was lying on the bed, dressed in day clothes. Shipman gave the family the impression that he had found Mrs Winterbottom dead when he arrived. In due course, Shipman certified the cause of death as coronary thrombosis. On cremation Form B he said that he had last seen Mrs Winterbottom alive two days before her death. He claimed that he had found her collapsed on the bed and had unsuccessfully tried to resuscitate her. He said she had been suffering from ischaemic heart disease. That is quite possible. Even so, it would be a quite remarkable coincidence if Mrs Winterbottom had had a sudden fatal heart attack in the few minutes which elapsed after speaking to her daughter on the telephone and just as Shipman was about to arrive to see her about an entirely different medical condition. I concluded that Shipman killed Mrs Winterbottom.

11.34 Two aspects of this case should be highlighted. Mrs Winterbottom's death was one of many in which Shipman claimed to have attempted unsuccessfully to resuscitate a patient who was having a heart attack. Yet he did not summon an ambulance or move the patient onto a hard surface. The proper procedure is to summon an ambulance; then to put the patient on a hard surface (usually the floor) and continue with resuscitation measures until the ambulance arrives. If the ambulance is carrying a defibrillator, it might then be possible to restore the heart to its normal rhythm. If not, cardiopulmonary resuscitation should be continued until the patient reaches hospital. The second matter of interest relates to Mrs Winterbottom's dentures. I have come across quite a number of cases in which Shipman took the dentures out of the mouth of a patient who had died. It does not appear that he did this to all patients who wore dentures. I do not think there is a single report of a case in which he removed the dentures of a patient who had died naturally. It seems that he sometimes removed the dentures of a patient whom he had killed. I found this puzzling, but Dr Grenville

suggested a possible explanation. When a patient has been given a lethal dose of opiate and falls into a very deep sleep, the relaxation of the muscles might allow the dentures to become dislodged. If a denture were to slip into the throat, it might cause the patient to gag and begin to gasp and struggle. This might interfere with the smooth progress towards death that Shipman intended. He might, Dr Grenville suggests, have had a bad experience at some time, after which he thought it prudent to remove the dentures as the patient was falling asleep, if he thought there was a risk of them slipping into the throat.

11.35 Shipman killed Mrs Ada Ashworth on 27th November 1984. She was a widow who lived alone and was 87. Her death was a typical Shipman killing. She was well at about 1pm. A short time later, Shipman went to her neighbours' home, claiming that he had arrived to visit Mrs Ashworth and had found her dead. When the neighbours went in with him, they saw Mrs Ashworth sitting upright in her chair. Her appearance was typical of that of many of Shipman's victims. Shipman ascribed her death to ' old age', which was quite inappropriate, as Mrs Ashworth had been up and about that morning.

11.36 Shipman killed three patients in the Christmas period of 1984. Mr Joseph Everall died on 17th December, Mrs Edith Wibberley on 18th December and Mrs Eileen Cox on 24th December. All three deaths were typical illustrations of the way in which Shipman killed. Mr Everall was suffering from cancer but had not yet reached the terminal phase of his illness. He had recently undergone surgery but appeared to be recovering. He was found dead in the afternoon of 17th December, not long after Shipman had visited. Shipman certified that the death was due to cerebro-arteriosclerosis, which, if present, would pre-dispose the patient to suffering a stroke. Mr Everall was found lying on his bed and showed no sign of having suffered a stroke. Nor was his family aware of any symptoms indicative of severe arteriosclerosis. Members of the family were very shocked by the death but Shipman assured them that there was no need for a post-mortem examination and that he would ' square it' with the coroner. In many ways, Mr Everall was a typical victim. He lived alone, was not in good health and would have required a good deal of medical and nursing support had he lived longer.

11.37 Mrs Wibberley was a widow who lived alone. She was 76 and was in poor health. She had had a fall and had broken her hip. She had had a series of transient ischaemic attacks. She was very dependent on the support of her daughter-in-law and her home care worker, Mrs Shirley Pleva. On the day before her death, she had another stroke but appeared stable. Shipman called and told her that he would return the next day to take a blood sample. The following morning, Mrs Wibberley appeared to Mrs Pleva to be in reasonable health. When Mrs Pleva returned after lunch, she found Shipman kneeling on Mrs Wibberley's bed with her head on his knees and his hand on her neck, as if feeling for a pulse. Shipman announced that Mrs Wibberley had had ' a massive stroke'. Mrs Pleva said she would call an ambulance, but Shipman told her that it would be a waste of time. He told her to put the kettle on, to contact the relatives and to tell them to hurry up or Mrs Wibberley would be dead before they arrived. A few minutes later, he declared her dead. This appears to be another case in which Shipman gave a lethal injection under the pretext of taking a blood sample.

11.38 Mrs Cox was only 72 when she died. She was a widow and lived alone. She was active and independent but suffered from angina and bronchitis. Her daughter says that she was a hypochondriac and used to call Shipman out rather frequently. On 24th December, Mrs Cox telephoned her daughter, Mrs Susan Davies, to say that she was not feeling well; she thought she had bronchitis and had called the doctor, whom she was expecting at about midday. Shortly after noon, Mrs Davies telephoned her mother; but there was no reply, so she went round. She found her mother in bed with the clothes tucked tightly round her chest in a manner which she could not have managed for herself. She looked as if she were peacefully asleep. She was dead. Shipman was informed and arrived in due course. After seeing the body, he observed that Mrs Cox was in exactly the position in which he had left her. He suggested that she must have died only seconds after he had left. He certified that she had died of a coronary thrombosis. On cremation Form B, he said that the death had occurred at about 2pm and that he had seen Mrs Cox two hours before her death, at which time she had complained of chest pain. He said that she was known to suffer from angina. Shipman's account of this death is incredible. First, no doctor would leave a patient who had a history of angina alone while suffering from chest pain. Shipman did not call an ambulance or telephone Mrs Davies. In any event, it is clear that Mrs Cox had not had chest pain; she would have told her daughter if she had. The notion that Mrs Cox could have died suddenly a few seconds after Shipman had departed is fanciful. Nor do patients die of heart attacks lying in bed, looking peaceful and with their arms tucked inside the covers. It is plain that Shipman killed Mrs Cox. It is also plain that he was becoming quite confident in giving an explanation which, on rational consideration, can be seen to be quite implausible. Shipman seems to have realised that even a highly improbable explanation would not be questioned.

1985

11.39 Shipman killed eleven patients during 1985. On 2nd January 1985, Shipman hastened the death of Mr Peter Lewis, who was dying of cancer. He removed the remaining drugs from Mr Lewis' home after the death. Mr Frederick Dentith died naturally of cancer on 25th January and I think it is likely that Shipman obtained further supplies of opiate at that time. Not long after these two cancer deaths, there was a spate of killings.

11.40 Mrs May Brookes was killed on 1st February 1985. She was 74, a widow and lived alone. She was in reasonable health and spoke to at least two people on the morning of the day she died, one of them very shortly before Shipman arrived for a routine visit at about 1pm. Within half an hour, Shipman telephoned Mrs Brookes' daughter to tell her that her mother was dead. Mrs Brookes was found sitting in her chair, looking quite unruffled. Later, Shipman claimed that he had found Mrs Brookes collapsed on the floor when he arrived. He said that she was dying. He had lifted her onto her chair. As she weighed over 13 stone, that seems very unlikely. He certified that the death was due to a cerebrovascular accident. On Form B he lied, saying that a neighbour had been present at the moment of death. Shipman had almost certainly told Mrs Brookes that he wanted a blood sample and injected her with an opiate.

11.41 Shipman killed Mrs Ellen Higson on 4th February 1985. She was 84 and a widow living alone. She may not have been in good health. Shipman was present at her death, which seems to have been sudden and unexpected. Shipman certified that the cause was renal failure, which is not usually a cause of sudden death. It appears that Mrs Higson's home help was present at the death and may even have been present when Shipman administered the lethal injection.

11.42 Mrs Margaret Conway was killed on 15th February. She was 69 and a widow living alone. She had had a stroke some time before and had been left with some residual disabilities. On the day of her death, she spoke to one of her daughters, Mrs Joan Duncan, at about 2.15pm. She was expecting Shipman to visit that day. When another daughter, Mrs Patricia Whittle, arrived at her mother's house at about 4.15pm, she found Mrs Conway dead in her chair. Shipman later certified that the death was due to a stroke. He gave the family to understand that Mrs Conway had not been ill when he visited earlier in the afternoon. On cremation Form B, he told lies about the time of his visit and stated that Mrs Conway had spoken to one of her daughters after his visit. These lies were designed to distance his visit from the death and to demonstrate that Mrs Conway was still alive some time after his departure, which I am quite sure she was not.

11.43 On 22nd February 1985, Shipman killed Miss Kathleen McDonald. She was 73 and lived alone. She was in good physical health and was quite active. She lived in Carter Place, Hyde, where Shipman had several patients. Shipman made an unsolicited visit to Miss McDonald during the afternoon of 22nd February. He was later to tell her neighbour, Mrs Lucy Virgin (who in 1995 was herself to be one of Shipman's victims) that it was fortunate that he had called, as he had found Miss McDonald dying. He said that she had ' died in his arms'. He certified that her death was due to a cerebrovascular accident.

11.44 Four months later, on 26th June 1985, Shipman killed two patients on the same day, Mr Thomas Moult and Mrs Mildred Robinson. The evidence in respect of Mr Moult's death is very limited. However, I drew the inference that Shipman killed him because the documentary evidence indicated that Shipman was probably present at the death. As Mr Moult was only 70 and was not expected to die, I felt that Shipman's presence at the death was sufficient to draw me to my conclusion. The evidence in Mrs Mildred Robinson's case is complex and cannot be conveniently summarised. I concluded that Shipman was present at the death and had probably caused it. Shipman certified that both deaths were due to coronary thrombosis and that chronic bronchitis was said to have been a contributory cause in each case.

11.45 On 23rd August 1985, Shipman killed Miss Frances Turner. She was 85 and was quite frail following a fall in which she had fractured her hip. She did not wish to go into residential care and had recently been assessed for the provision of support at home. I think her insistence on retaining her independence would have made her a likely target for Shipman. Shipman's visits book suggests that he was to make a routine visit on the day of her death. There is nothing to indicate that Miss Turner was suffering a life-threatening illness. It is clear from cremation Form B that Shipman was present at the

death. Shipman certified that the death was due to old age, although this was quite inappropriate. Miss Turner had not been confined to bed before her death and was still living alone.

11.46 Shipman killed three patients during the Christmas period of 1985. These were Mrs Selina Mackenzie who died on 17th December, Miss Vera Bramwell, who died on 20th December, and Mr Fred Kellett, who died on 31st December. It is not clear from where Shipman had obtained his supply of opiates, although he had been briefly involved in the care of one of Dr Moysey's patients, Mrs Mary Ogden, who had died a natural death of cancer on 17th October. It is quite possible that he had obtained opiates in connection with her death. In any event, I think it likely that, by 1985, Shipman was more confident about his ability to obtain and conceal illicit supplies of opiate. I think, by this time, he had probably turned to other means of obtaining his supplies than simply taking excess supplies from patients who had died of cancer. It is quite possible that he had begun to prescribe opiates for patients who did not need the drugs and never received them.

11.47 Mrs Mackenzie was a widow who lived alone. She was 77, had had two strokes and was quite disabled. However, she was determined to remain in her own home and was receiving considerable support from social services and from her family. Patients requiring this level of support appear to have been particularly at risk from Shipman. On 17th December, Shipman visited, ostensibly for the purpose of checking that Mrs Mackenzie was well enough to travel to her daughter's home in Nottingham for Christmas. He was seen arriving at her home at about 3pm. She was found dead at about 3.45pm, sitting in her chair. No one had seen her or spoken to her since Shipman's visit. Shipman claimed that she had died at about 4pm and certified the cause of death as a cerebrovascular accident. He offered to arrange a post-mortem examination if the relatives wished, but then pointed out the disadvantages. As I have previously observed, this was one of Shipman's common ploys.

11.48 Miss Bramwell was 79 and lived alone in sheltered accommodation. She had been in good health and went shopping on the morning of the day of her death. It appears likely that Shipman was asked to visit her, although it is possible that he made an unsolicited visit. In any event, he told the warden that, when he arrived, he found Miss Bramwell dead in her chair. Inconsistently with that, on cremation Form B, he admitted that he had been present at the death, which he attributed to a coronary thrombosis. This was yet another coronary thrombosis which happened to occur in Shipman's presence. Yet he did not call an ambulance. He claimed that the warden of the sheltered accommodation was present at the death, when the other evidence suggests that she was not. It appears likely that Shipman was alone with Miss Bramwell when she died.

11.49 Mr Kellett was 79 when he died. His wife was living in a nursing home in Denton. He was in quite good health and visited her regularly. On the day of his death, his niece, Mrs Valerie Wood, had asked Shipman to visit him, as she was concerned that he had a cough. She was speaking to her uncle on the telephone at about 11am, when he told her that Shipman had just arrived. About 45 minutes later, Shipman telephoned Mrs Wood to tell her that her uncle had died. His explanation was that Mr Kellett ' had

just sat down in his chair and died'. Later, Mr Kellett was seen sitting in his chair; he looked very peaceful. Shipman certified that the death was due to coronary thrombosis.

1986

11.50 In 1986, Shipman killed eight patients. The first was Mrs Deborah Middleton on 7th January. Mrs Middleton was 81 and lived with her daughter, Mrs Barbara Taylor. She suffered from bronchitis in the winter but was still very active. She looked after her great-grandchildren every afternoon when they came out of school. On the day of Mrs Middleton's death, her daughter telephoned the surgery to ask Shipman to visit her mother, who had been complaining of feeling tired. She did not seem to be seriously ill and Mrs Taylor went to work as usual. Shipman visited in the afternoon, probably at about 3pm. No one saw Mrs Middleton alive after his visit. She was found dead at about 4.15pm. She was sitting in her chair looking peaceful. She had made all her usual preparations for the children's arrival from school. Shipman's explanation was that she had died of cardiac failure after his visit. On Form B, he said that the death had occurred at 5pm, which was clearly an attempt to distance the death from his visit. He lied on Form B, saying that Mrs Middleton's granddaughter, Mrs Jacqueline Slaney, had been present at the moment of death. She was not.

11.51 The death of Mrs Dorothy Fletcher on 23rd April 1986 was not typical of Shipman's pattern of killing. Mrs Fletcher lived in Charnley House, a residential home for the elderly. She was only 74 but suffered from dementia. The daily diary of Charnley House shows that, for a week or two before her death, she had had a chest infection and was treated with an antibiotic. There were also some signs that she had heart failure. Her condition deteriorated gradually and it seemed that her death was imminent. On the morning of 23rd April, she was still poorly and Shipman was sent for. It is not clear whether or not he came at his usual time, which was about lunchtime. In any event, Mrs Fletcher rallied, seemed much better and ate a ' full lunch'. There is then no further account until the daily diary records that she died at 6.30pm. The diary suggests that Shipman did not come to the home until after the death, but the time of his visit appears to have been left blank and completed later. On Form B, Shipman said that he saw Mrs Fletcher at 6pm and she died at 6.20pm. I concluded that Shipman had been present at the death, a situation I had come to regard as suspicious. The full reasoning appears in the decision. I think it likely that everyone had thought Mrs Fletcher's death was imminent but that she then confounded them by making a recovery. I think Shipman would not have wished her to recover and probably ensured that she died that evening by giving her an injection of opiate.

11.52 On 6th June 1986, Shipman killed Mr Thomas Fowden. He was 81 and lived alone. He was quite independent and ran his house with the assistance of a home help, Mrs Joan Ralphs, whose mother, Mrs Lily Higgins, and mother-in-law, Mrs Anne Ralphs, were later to be victims of Shipman. On 6th June, Mrs Ralphs found Mr Fowden unwell and went to call the doctor and to telephone Mr Fowden's nephew, Mr Edwin Fowden. She was only away a few minutes but, when she returned, Shipman was there, standing over Mr Fowden, who by that time was either dead or unconscious. Soon afterwards, Mr Edwin Fowden arrived. Shipman told him that he had given his uncle an injection ' to

help his breathing' but that Mr Fowden was ' practically gone'. A short while later, Shipman pronounced Mr Fowden dead.

11.53 In September and October 1986, Shipman killed two patients in remarkably similar circumstances. Both lived on Thorpe Hall Grove, Newton. On 15th September, Shipman killed Miss Mona White. She was only 63 and was quite well, although she suffered from arthritis and angina. She lived alone and had the assistance of a home help once or twice a week. On 15th September, she was expecting Shipman; it is not clear why. However, when Mrs Elizabeth Shawcross and Mrs Dorothy Foley (the two home helps who worked in that area) passed by her house at about noon, they saw and spoke to her, as she was at her door. She was looking out for Shipman and did not seem to be very ill. A short time later, Mrs Shawcross spoke to Shipman, who was at his car, outside Miss White's house. He told her that he had given Miss White a ' little injection for her pain'. About twenty minutes later, Mrs Shawcross called on Miss White to see if she was all right. She found her sitting in her chair, dead. Shipman was not there. Mrs Shawcross ran to fetch Mrs Foley and, by the time they arrived back at Miss White's, Shipman had reappeared. He told them Miss White was dead. He had put the kettle on and was making himself a cup of tea. He asked the home helps to telephone Miss White's sister, Mrs Alison Forder. She and her husband arrived at 12.55pm. Shipman told Mrs Forder that when he arrived to see Miss White, she was having a massive heart attack and he knew she was going to die. He had sat with her until she died. It would have been no use calling an ambulance. There was no need for a post-mortem examination. Shipman certified the death as due to a coronary thrombosis.

11.54 Only three weeks later, Mrs Mary Tomlin, another client of Mrs Shawcross and Mrs Foley, was killed. The two home helps had visited Mrs Tomlin at lunchtime. They found her in bed. She said she was not well and was expecting Shipman to visit. They left to continue work, promising to return to fetch her prescription. About an hour afterwards, Mrs Foley saw Shipman go into Mrs Tomlin's flat. About ten minutes later she went to the flat and met Shipman, who told her that Mrs Tomlin was ' going' and instructed her to put the kettle on. A few minutes later, Shipman joined Mrs Foley in the living room and told her that Mrs Tomlin was dead. Mrs Tomlin was only 73. Shipman attributed her death to a coronary thrombosis. It is clear that he had killed her.

11.55 On 17th November 1986, Shipman killed Mrs Beatrice Toft. She was only 59 but she suffered from emphysema and chronic obstructive airways disease and had an oxygen cylinder by her bed. She could not do a great deal for herself and was very dependent on her family. On the day of her death, the meals on wheels service delivered her lunch and she ate it. Shipman visited at some time in the afternoon. Mrs Toft was found dead by one of her daughters at about 4.20pm. She was lying flat on her back in bed, a position which would have been most uncomfortable for her in life; she usually lay propped against pillows to ease her breathing. Her dentures were not in her mouth. An ambulance was summoned; Shipman also arrived. He told the paramedics that he had seen Mrs Toft at 2.30pm that day and that there was no need for them to stay. The practice is that if a doctor is in attendance at a sudden death and indicates that he is prepared to certify the cause of death, the ambulance personnel (and police if present) take no further steps in connection with the death. One of Mrs Toft's daughters asked

Shipman what could have happened to Mrs Toft's dentures. Shipman suggested that she might have swallowed them. No one saw Mrs Toft alive after Shipman's visit and in my view it is clear that he had killed her. I think he must also have removed her dentures.

11.56 There were two killings just before Christmas 1986: Mrs Lily Broadbent on 16th December and Mr James Wood on 23rd December. Both died in circumstances entirely typical of a Shipman killing. Mrs Broadbent's death was attributed to a coronary thrombosis, which Shipman claimed had occurred shortly after he had visited her. She was found with the gas fire on very high. Mr Wood's death was attributed to old age, although he was up and about on the day of his death. He was not seen alive after Shipman visited that day.

1987

11.57 In 1987, Shipman killed eight patients. On 30th March, he killed Mr Frank Halliday. Mr Halliday was 76 and in poor health. His sister lived with him but, at the time of his death, she was spending a week or two in Scotland. On the day of his death, a neighbour asked Shipman to visit Mr Halliday, as he was not well. Mr Halliday died in the course of that visit. Shipman's entry in the medical records suggests that Mr Halliday had been complaining of chest pain for two days. On examination, he was showing signs from which Shipman diagnosed a coronary thrombosis. Shipman supposedly gave an intravenous injection of 10mg morphine. There is no further description of the manner in which this was given. The note then says that the neighbour was called. An ambulance was called and cancelled, as Mr Halliday had died. On cremation Form B, Shipman said that he had been with Mr Halliday for an hour during his last illness and that Mr Halliday had been in a coma for 30 minutes before death. Shipman's account is obviously false. First, if Mr Halliday had had chest pain for two days, his sister would have been told and she would have returned from Scotland. Second, Shipman frequently claimed that he had called an ambulance but had cancelled it because the patient died before it arrived. In this case, putting the medical record together with Form B, it appears that Shipman had almost an hour in which to call an ambulance before Mr Halliday died.

11.58 This is the first case I have considered in which the general practitioner records have survived. These records are also the first of several which contain a note in which Shipman claimed to have given a small dose of morphine to relieve the pain of a coronary thrombosis. Dr Grenville says that it is good practice to give a small dose of opiate to a patient who is in severe pain during a heart attack. However, the dose should be given very slowly, titrating the amount given against the effect on the patient's pain, so that the injection can be stopped as soon as the pain is adequately relieved. The doctor's note should say how much was given and over what period. In all the cases in which Shipman has claimed to have given morphine for the pain of a heart attack, I have never seen any suggestion that anything less than the full dose has been given and I have never seen an estimate of the time over which it was given. Shipman almost always claimed to give either 10mg morphine, as here, or 5mg diamorphine, which is the equivalent. I have seen such entries on several occasions, and in each case, the patient has died. I believe that Shipman gave a much larger dose than 10mg morphine.

I do not know whether Mr Halliday was having a heart attack when Shipman arrived. He might have been and it may be that it would have been fatal. On the other hand, Mr Halliday might not have been having a heart attack at all. Whatever was the matter with him, I think it likely that Shipman gave him a lethal dose of opiate. The entry Shipman made in the medical records is typical of many I have seen in other cases where he has killed the patient. This type of record is one of the hallmarks of a Shipman killing.

11.59 Only two days later, on 1st April 1987, Shipman killed Mr Albert Cheetham, probably during the early evening, when he was on out of hours duty. He left the body overnight, with the gas fire on full. Shipman was unable to lock the door behind him. The next morning he went back to ' discover' the body. He gave a false explanation about the circumstances of the death. He said that he had called, as he ' happened to be in the area' and had found Mr Cheetham in a ' nervy' state. He had promised to return the next day to give him a prescription. Why he could not have done that on the first day is hard to understand. Shipman suggested that Mr Cheetham must have sat down to watch ' Coronation Street' and died.

11.60 On 16th April 1987, Shipman killed Mrs Alice Thomas. She was 83 and in poor health. She had had a number of strokes. She died during a routine visit by Shipman.

11.61 On 8th May, Shipman killed Mrs Jane Rostron. She was 78. On the day of her death, it appears that a neighbour requested that Shipman should visit because Mrs Rostron was not feeling well. He clearly did visit, probably at about lunchtime. Mrs Rostron's daughter found her dead when she visited her mother in the mid-afternoon. Shipman's explanation was that, when he called on her, he found that she had suffered a ' slight stroke'. He had urged her to be admitted to hospital but she had refused. Mrs Rostron's daughter found that quite credible. Shipman suggested that, if Mrs Rostron had taken his advice, she might still be alive. For reasons fully set out in the decision, I found that Shipman had killed Mrs Rostron. This is an early example of what was to become one of Shipman's favourite ploys; he blamed the death on the patient's refusal to go to hospital.

11.62 Mrs Nancy Brassington was Shipman's next victim. She was 71 and had had a stroke, from which she was said to have made a full recovery. At about lunchtime on 14th September 1987, a neighbour saw Shipman's car outside Mrs Brassington's house. A while later, she noticed Shipman leave the house but Mrs Brassington did not see him off, which she thought was strange. As soon as Shipman had gone, she and her husband went across and found Mrs Brassington sitting in her chair, dead. This was a classic Shipman killing.

11.63 Once again, there was a cluster of killings around Christmas. On 11th December, Shipman killed Mrs Margaret Townsend. She was 80 and had a complicated medical history. She was, I think, a rather demanding patient and might at times have exaggerated her symptoms. She had been extensively investigated at hospital on account of abdominal pain but no cause had been found. She died during a home visit by Shipman. He attributed her death to carcinomatosis due to carcinoma of the stomach. Whatever had been the cause of Mrs Townsend's pain, it was not due to carcinoma of the stomach, which had been ruled out during investigations.

11.64 On 29th December 1987, Shipman killed Mrs Nellie Bardsley. She was only 69. On the morning of the day she died, she told her daughter that she felt unwell and wanted the doctor to call. Shipman visited later in the day. Mrs Bardsley's medical records are available and it can be seen that the circumstances of her death are very similar to those of Mr Frank Halliday. Shipman claimed that he found her having a coronary thrombosis and gave her 10mg morphine. Later, he told Mrs Bardsley's daughter, Mrs Carol Chapman, that he had called an ambulance but had cancelled it, as Mrs Bardsley had died before it arrived. This last assertion cannot be checked, as the ambulance records are no longer available.

11.65 On the following day, 30th December 1987, Shipman killed Mrs Elizabeth Rogers. She was 74 and lived alone in a flat in Chartist House. She was very independent. On 30th December, it appears that she telephoned Shipman to ask him to visit; it is not clear why, but his visits book does not indicate that it was a matter of urgency. He visited her and killed her. He then went downstairs to see Mrs Unsworth, told her that he was admitting Mrs Rogers to hospital and asked her to come upstairs with him to help Mrs Rogers to pack her necessary things. When they reached the flat Mrs Rogers was, of course, dead. Shipman used this kind of ruse, or variants upon it, many times. He liked to have someone with him when the death was discovered.

1988

11.66 In the New Year of 1988, Shipman killed Mrs Elizabeth Fletcher on 5th January and Mrs Alice Mary Jones on 15th January. Mrs Fletcher was 90 but very active. She looked after her granddaughter, who had learning difficulties. Shipman called on her ' as he was passing'. He claimed that he found her dying and sat with her until it was over. That was a lie, as was his claim on cremation Form B that Mrs Fletcher's sister-in-law had been present at the death.

11.67 Mrs Jones had very poor eyesight. Shortly before her death, she had had an ailment for which Shipman had visited several times. She was reasonably well on the morning of her death, but when her sister-in-law arrived between noon and 1pm, she found Mrs Jones dead in her chair. The torch and magnifying glass she used for reading were in her hands. An ambulance was called and the paramedics said that the police and coroner must be informed, but then Shipman arrived and said that that would not be necessary. He said he had seen Mrs Jones at 11am. He certified the death as due to a stroke. On cremation Form B, he said that the death had occurred at noon and he had seen Mrs Jones at 10.30am. He was distancing his visit from the death.

11.68 A short time after these two deaths, there was a spate of killings within a week in February 1988. Mrs Dorothea Renwick was killed on 9th February, Miss Ann Cooper (who was 93 and Shipman's oldest victim) and Mrs Jane Jones on 15th February, and Mrs Lavinia Robinson on the following day, 16th February. Mrs Renwick was 90 and had had a stroke but was well and was eating her lunch when her daughter left her on the day of her death. Shipman visited soon afterwards to provide repeat prescriptions. Mrs Renwick was found dead in the early evening. The gas fire was on high. The next day, Shipman suggested that the death was ' a good thing', as Mrs Renwick's daughter would now be able to look after herself.

11.69 Miss Cooper was 93 but was in good health and lived independently. Her niece asked Shipman to call as she thought Miss Cooper was becoming confused. He visited that afternoon and found Miss Cooper doing some washing. He later claimed that he had advised her to see a specialist and that she had been well when he left. Miss Cooper was found dead not long after he left. It is clear he had killed her.

11.70 On 15th February 1988, Mrs Jones called Shipman out, as she wanted an antibiotic for her cold and bad chest. When her niece, Mrs Vera Panther, called on her at about 10.30am, she did not appear to be seriously ill. At about 12.30pm, Shipman arrived at Mrs Panther's home to say that he had found Mrs Jones in a state of collapse. He had given her an injection to ' help her breathing'. She was now very poorly and he asked Mrs Panther to come to her aunt's home. When they arrived, she was dead.

11.71 Mrs Robinson's death was extremely sudden. She was 83 but was fit and active. She lived in Chartist House. On 16th February 1988, her son called on her in the early afternoon. When he left at 2.15pm, she was well. At about 3pm, he received a message that his mother had died. Shipman had called.

11.72 After this spate of four killings within a week, there was an interval of seven months. There is no clear evidence as to why Shipman stopped killing for so long. However, it is quite possible that the occurrence of four sudden deaths within the week had caused comment, possibly from a doctor or member of staff at the Donneybrook practice. I think it likely that there was some such explanation for this temporary cessation. When Shipman killed again, on 18th September 1988, his victim, Mrs Rose Adshead, was very ill, suffering from cancer and was in great pain. Shipman hastened her death. I have already observed that the killing of a terminally ill patient entails much less risk of discovery than the killing of a healthy patient. The following month, Shipman resumed the killing of patients who were not terminally ill. He killed Mrs Alice Prestwich on 20th October and Mr Walter Tingle on 6th November.

11.73 Mrs Prestwich's death exemplifies several features typical of a Shipman killing. She was 69 and awaiting an eye operation. I believe that Shipman took the view that it was not ' worth' spending the resources of the health service on patients who were old, would not live long and, in his view, would not enjoy a good quality of life. I think he probably thought that of Mrs Prestwich. He called on her in her flat in Ogden Court, at the request of the warden, Mrs Christine Simpson, who had noticed that morning that Mrs Prestwich's legs were swollen. Shipman killed Mrs Prestwich while he was alone with her; then he went to fetch Mrs Simpson. He told Mrs Simpson the implausible tale that Mrs Prestwich had ' died while I was examining her'. As they were leaving the flat together, Mrs Simpson expressed incredulity that Mrs Prestwich could have died so suddenly. Shipman replied ' We'll go back and check her if you like. I wouldn't want her waking up in the Chapel of Rest'.

11.74 Mr Walter Tingle was another typical Shipman victim. He lived in sheltered accommodation. He was 85 and in poor health. He was also depressed about his health. He sometimes said that he ' had had enough'. On the morning of 6th November 1988, Shipman was called and when he arrived a warden was present. Mr Tingle almost certainly told Shipman that he ' had had enough'. Shipman may have contrived to

send the warden away. He gave Mr Tingle an injection. Within a few minutes, Mr Tingle was dying.

11.75 Shipman killed two patients just before Christmas, making a total of 11 killings in 1988. Both patients were due to spend Christmas with their families. At about 9.30am on Saturday, 17th December, Mr Harry Stafford telephoned his daughter-in-law to say that he had a cold and had called the doctor. At about 10.30am, Mrs Brenda McEvilly, one of Mr Stafford's neighbours, saw Shipman arrive at Mr Stafford's house. A while later, she saw Shipman leave the house and knock at the doors of three neighbouring houses, with no apparent response. He then came to her house. He told her that Mr Stafford had called him out and had said that he would leave the door unlocked. Shipman said that Mr Stafford was very unwell and asked Mrs McEvilly to go with him to Mr Stafford's house. When they arrived, Mr Stafford was sitting up in his armchair. He was dead. Shipman apologised to Mrs McEvilly that he had not told her the truth when he had said that Mr Stafford was very unwell. Soon afterwards, Shipman telephoned Mr Stafford's daughter-in-law to tell her of the death. He said that, soon after he had arrived at the house, Mr Stafford had collapsed and died. Shipman fabricated an entry in the medical records to suggest that, when he had arrived, Mr Stafford had given a history of chest pain and breathlessness for two days. On examination, Shipman had found signs from which he diagnosed a coronary thrombosis with left ventricular failure. Mr Stafford had died. Shipman claimed he had given intravenous injections of Cyclimorph (injectable morphine; the dose was not stated) and 80mg Lasix, a strong diuretic. Shipman told the family that he arrived to find Mr Stafford having a ' massive' heart attack and there was nothing he could do.

11.76 Two days later, the nephew of Miss Ethel Bennett called on her between 11am and noon. She told him she was expecting Shipman to call. At about 2.45pm, Shipman went to the home of Mrs Susan Cropper, Miss Bennett's great-niece, to visit her son, Daniel, who was unwell. He told Mrs Cropper that Miss Bennett was unwell, had pleurisy and ought to be in hospital but she had refused to go. He asked Mrs Cropper to go round to persuade her. When Shipman had gone, Mrs Cropper tried to telephone her great-aunt but there was no reply. She could not leave her son, so asked her father, Mr Alan Bennett, to go round. He went to Miss Bennett's home at about 6pm and found her dead. The gas fire was on full. When Shipman arrived, Mr Bennett suggested that the police should be called. Shipman said that this was not necessary and there was no need for a post-mortem examination. He repeated that Miss Bennett had refused to go to hospital. He fabricated an entry in the medical records, which suggested that Miss Bennett had had left-sided chest pain for seven days. He claimed that, after examining Miss Bennett, he had diagnosed pleurisy and advised hospital admission but she had refused. He claimed that he had prescribed an antibiotic. Miss Bennett had been found dead later in the day and the cause of death was bronchopneumonia. Shipman lied on Form B. He said that he had visited at 1pm and that the death occurred at 4pm. If the death were natural, he could not have known the time at which it occurred. He was seeking to distance the death from his visit. He claimed that a neighbour had heard Miss Bennett moving about at 3pm. That was a lie, designed to show that Miss Bennett was alive some time after his visit. In fact, it was an implausible lie as, if

Miss Bennett had died of bronchopneumonia at 4pm, she was unlikely to have been moving about an hour earlier.

1989

11.77 From this time onwards, medical records have in some cases, although not all, been available to the Inquiry.

11.78 In 1989, Shipman killed 12 patients. The first killing of the year took place on 31st January, when he killed Mr Wilfred Leigh. On 8th March 1989, for the first time, Shipman killed a patient in the surgery. This was Mrs Mary Hamer. She was 81 and in good health. She had an appointment during the morning. It is not known for what reason. However, she looked quite ' normal' when she went into the consulting room. A few minutes later, Shipman told the receptionist to send the next patient in, as Mrs Hamer was undressing in the examination room and would be some time. He finished his list of two or three more patients before telling the receptionist that he thought Mrs Hamer had died. The receptionist went into the examination room and saw Mrs Hamer on the bed, fully dressed. She was dead. Later, Shipman told Mrs Hamer's family that, when she came into the consulting room, she told him she had chest pain. He examined her and thought she was having a coronary thrombosis. He advised that she should be taken to hospital and she agreed. He gave her a small dose of morphine to relieve her pain and went to telephone the hospital. When he returned, she had died. He said that he had not attempted to resuscitate her, as he thought she had suffered brain damage. He certified the cause of her death and said that a post-mortem examination was not necessary.

11.79 Mrs Josephine Hall, who died on 5th June, had a long psychiatric history. She suffered from agoraphobia, insomnia, depression and anxiety. Shipman was intolerant of what he seems to have seen as her weakness. He once said that he would like to treat her agoraphobia by taking her into Hyde and leaving her there, so that she would have to make her own way home. Mrs Hall made quite frequent demands on Shipman's time. I fear that this would have made her a preferred target for Shipman. In April 1988, following a psychiatric referral at which the consultant reported that Mrs Hall was **' fed up with life'**, Shipman noted in her records: **' No use, what do we do?'** Mrs Hall also took medication to control her blood pressure. Shipman killed her during a routine visit. In the fabricated medical record, he claimed that he had found her with symptoms of a stroke or transient ischaemic attack. He claimed that her blood pressure was very high, which he attributed to her failure to take her medication. He claimed that he was considering a domiciliary visit by a consultant and that he would review her the next day. Mrs Hall was found dead later that afternoon. Shipman certified that the cause of death was a cerebrovascular accident. It is typical of Shipman that he would, where possible, choose to attribute the death to a cause that had some basis in the past medical history.

11.80 On 12th May 1989, Miss Beatrice Clee was killed. She was frail and had poor eyesight but lived independently. She was well at about 10am on 12th May. She was found dead at about 3pm, sitting upright in her armchair, apparently asleep. Shipman had been there in the interim. He made a medical record suggesting that he had visited on

account of Miss Clee's leg ulcer, which was satisfactory. He then fabricated entries to suggest that Miss Clee had complained of symptoms of heart trouble. It is clear that these were designed to provide a plausible explanation for her sudden death.

11.81 On 6th July 1989, Shipman killed Mrs Hilda Fitton during an unsolicited visit. She had seen him in his surgery the day before on account of a chest condition, for which Shipman did not think treatment was necessary. The following day, Shipman called on Mrs Fitton and killed her. He fabricated a note in her medical records to suggest that she had woken in the night with palpitations, chest pain and breathlessness. He claimed that she was very worried but on examination there was little abnormality. He thought she might be having a heart attack and suggested hospital but Mrs Fitton did not wish to be admitted. He wrote the letters **' TLUK'**, which meant ' to let us know', and noted that he would visit her the following day. This false account was intended to create the impression that Shipman had taken proper care of the patient but that the death, when discovered, was explicable. Shipman often used this type of ploy, particularly with the letters ' TLUK'. However, the ploy was not a very convincing one as, if Mrs Fitton had really described palpitations, chest pain and breathlessness, good medical practice would have required that some arrangement be made for her care, either by calling a relative or arranging the attendance of the district nurse. No doctor would leave a patient alone suffering from the symptoms that Mrs Fitton supposedly described. In those circumstances, no doctor would leave the onus on the patient to let him know if she needed attention.

11.82 On 14th August, Shipman killed Mrs Marion Carradice. On 22nd September, he killed Mrs Elsie Harrop and, only four days later, on 26th September, Mrs Elizabeth Burke. There were then three killings within three days in October 1989. These were Mrs Sarah Jane Williamson on 15th October, Mr John Charlton on 16th October and Mr George Vizor on 18th October. Shipman was called out to Mrs Williamson on a Sunday afternoon. She was very poorly and might well have been having a heart attack. However, it appears that, instead of treating Mrs Williamson in the way that most doctors would have done, Shipman gave her a dose of opiate which ensured that she died.

11.83 Finally, for that year, on 6th November 1989, Shipman killed Mr Joseph Wilcockson. He was 85 and a widower. He lived alone although he was very close to his granddaughter, Miss Lisa Wilcockson, who saw him every day and often went out with him in the evenings. His general health was quite good, although he had a painful varicose ulcer on his leg, which was dressed periodically by the district nurse. The leg ulcer did not prevent him from enjoying an active social life. For many years, he had been involved in the organisation of local working men's clubs. He greatly enjoyed visiting the clubs in the Hyde area, where he was well known. He and Miss Wilcockson had been to two or three clubs the night before he died. On the day of his death, his home help called in between 9am and 10am. She found him a little subdued. She did not know but, that morning, he had contacted the local newspaper to place an entry in the ' In Memoriam' column to commemorate the anniversary of his wife's death. At about noon, the district nurse arrived to dress Mr Wilcockson's leg. She found him sitting in his usual chair, dead. He was still warm and the bandage on his leg had been disturbed. She telephoned the surgery and Shipman attended. The district nurse told him what she had

found. Shipman did not tell her that he had visited Mr Wilcockson that morning. In fact, he had visited, as he was later to tell Miss Wilcockson. He told her that he had found her grandfather in reasonable health. Shipman certified that Mr Wilcockson had died as the result of a coronary thrombosis. He said that a post-mortem examination was not necessary. On cremation Form B, he gave the time of death as 12.30pm and said that he had seen Mr Wilcockson alive at 10.30am. Both of those times were probably inaccurate. The death must have occurred before 12.30pm and Shipman's visit almost certainly took place after 10.30am. Shipman probably gave false times in order to distance the death from his visit. I suspect that, on this occasion, Shipman only narrowly avoided being caught red-handed by the district nurse. He did not tell her that he had been at Mr Wilcockson's flat that morning, in circumstances where it would have been the natural reaction to do so. It is quite likely that, because of the district nurse's involvement, this death might have been the subject of comment amongst the surgery staff. I think the death of Mr Wilcockson probably gave Shipman a bad scare. He did not kill again for ten months.

The Years 1990 and 1991

11.84 As on the previous occasion when Shipman had ceased killing for several months, his first victim, on resumption, was terminally ill with cancer. On 18th September 1990, Shipman hastened the death of Mrs Dorothy Rowarth. There would have been very little risk that he would be detected in such a killing. I have the impression that Shipman was regaining his confidence. The next ' healthy' victim was killed on 30th December 1990. Mrs Mary Dudley was only 69 but she had a history of heart trouble. On Christmas Day, her close companion, a man, died quite suddenly. She spent Christmas with her family and returned to her own home on Saturday, 29th December. The following morning, 30th December, she was not feeling well and called Shipman. She was not seriously ill and still intended to go to her son's house for lunch. In the late morning, she called on her neighbour, Mrs Ivy Murphy, as usual, for a chat. A while later, Mrs Murphy saw Shipman arrive at Mrs Dudley's flat. After about 15 minutes, Mrs Murphy went to Mrs Dudley's flat and found the door ajar. She went in and met Shipman in the hall. He told her that Mrs Dudley was dead and Mrs Murphy saw that that was so. She heard Shipman speak on the telephone to a relative and say that Mrs Dudley would not live long. Later, he was to tell Mrs Dudley's sons that he had found Mrs Dudley having a heart attack. He said that he had given her some morphine for the pain, but she had died. He created a false medical record, suggesting that Mrs Dudley had been suffering from chest pain for two weeks.

11.85 Mrs Dudley was the last patient whom Shipman killed while working at the Donneybrook Surgery. It appears that it was at about this time that he began to plan his departure from Donneybrook. A year later, on 1st January 1992, he set up as a sole practitioner, from rooms within Donneybrook House, where he remained until his new premises at Market Street were ready. During the Donneybrook years, Shipman had killed 71 patients. The circumstances of a further 30 deaths give rise to suspicion.

CHAPTER TWELVE

Shipman's Unlawful Activities: The Market Street Years

12.1 In this Chapter, I shall give a chronological account of Shipman's years as a sole practitioner between January 1992 and his arrest in September 1998. Shipman moved to new premises at Market Street, Hyde on 24th August 1992. Between then and his arrest, Shipman killed 143 patients. It is plainly not practicable for me to summarise the facts of each of these cases in this narrative. I shall do so only where the circumstances mark a turning point in Shipman's conduct or are in some other way unusual. For the majority of cases, the reader must refer to the individual decisions in Volumes Three to Six.

12.2 In Chapter Eleven, I sought to illustrate the development of Shipman's criminal behaviour during the Donneybrook years and the various methods he used to cover up his conduct. These methods were to be repeated time and time again during his time at Market Street. There are many cases in which Shipman made false entries in the medical records, told lies on cremation forms, lied to relatives, claimed to have arrived to find patients dead when they were not, claimed to find patients ' breathing their last' when they were not, claimed that patients had refused to be admitted to hospital when they had not and claimed to have summoned an ambulance when he had not. In this Chapter, I shall explain how Shipman obtained large quantities of diamorphine and demonstrate the relationship between his drug supplies and the pattern of killings. I shall also refer to particular groups of deaths and point to some trends in Shipman's methods of concealing his crimes.

1992

12.3 From 1st January 1992, Shipman was a sole practitioner working from rooms within Donneybrook House. He remained there until his new premises in Market Street were ready in August 1992. Although I suspect that he might have been responsible for the death of Mrs Annie Powers on 10th January 1992, I have not found that he killed any other patient during this period of almost eight months. However, it does appear that he obtained some diamorphine by illicit means. The only transaction involving Shipman recorded in the Norwest Co-op Pharmacy controlled drugs register during this period was the dispensing of two 30mg ampoules of diamorphine on 16th March 1992. These were prescribed in the name of a male patient who subsequently transferred to another doctor and has since died. The Inquiry has not investigated his death, which was plainly unconnected with Shipman. However, the patient's medical records have been obtained and reveal no record that he was prescribed diamorphine in March 1992, nor any condition which would have justified such a prescription. It seems therefore that Shipman obtained the drugs for his own purposes.

12.4 Shipman's new premises at 21 Market Street were immediately adjacent to the Norwest Co-op Pharmacy. There was a ceremonial opening of the surgery with a good deal of publicity. Only a few weeks later, on 7th October, Shipman killed Mrs Monica Sparkes. Mrs Sparkes was 72 and lived alone. For some weeks before her death she had been ' bad on her feet' and had had a number of falls. As a result, her daughter-in-law,

Mrs Avril Sparkes, asked Shipman to visit and, on 21st September, he directed an increased dose of Stemetil, which Mrs Sparkes took for vertigo. On 6th October, Mrs Sparkes was well and, when her son visited, was ironing in preparation for a holiday in the Lake District. She was expecting Shipman to call the following day. At about lunchtime on 7th October, Mr Phyllis Holt, Mrs Sparkes' sister-in-law, telephoned her but the call was answered by Shipman, who told her that Mrs Sparkes had had a slight stroke. He said he had called for an ambulance but, as there was an emergency at Manchester Airport, there were no ambulances available. Indeed, there had been an incident at the airport that day although the Inquiry's investigations suggest that this would not have resulted in there being no ambulances to deal with other emergencies. Whether Shipman knew of the airport incident because he had requested an ambulance for Mrs Sparkes or for some other reason is not clear. Shipman also told Mrs Sparkes' sister-in-law that he had told Mrs Sparkes to lie on the bed and await his return. He said he had to go to the surgery. Members of Mrs Sparkes' family then tried to contact her by telephone but there was no reply. It is clear that Shipman had killed Mrs Sparkes during his visit to her home. Shipman returned to Mrs Sparkes' home at about 3.30pm and then telephoned her sister-in-law, Mrs Dorothy Sparkes, to say that he had found her dead. He certified that the death was due to a stroke. In the medical record, Shipman said only that Mrs Sparkes had had a stroke and that he had called an ambulance to take her to Tameside General Hospital. In short, Shipman had resumed killing in much the same way as he had killed before.

1993

12.5 Shipman resumed a regular pattern of killing in February 1993 and it is hard to resist the inference that there must have been a connection between this resumption and what he perceived to be the constraints imposed by practice at the Donneybrook Surgery. For several months in this year, Shipman's pattern of killing can be closely related to his supply of diamorphine. Between February and August, he issued fourteen prescriptions for a single 30mg ampoule of diamorphine, a most unusual amount to be prescribed for therapeutic purposes, but a dose that would be lethal for an opiate-naï ve patient. Six of the prescriptions were dispensed within a few days after the death of the patient in whose name they were issued and four on the day of the death itself. The two live patients in whose names prescriptions were dispensed say that they never received them. None of the medical notes of the patients concerned record the administration of diamorphine, although three (those of Miss Mary Andrew, Mrs Edna Llewellyn and Mrs Amy Whitehead) refer to the intravenous administration of 10mg morphine sulphate or morphine on the day of death. Those cases will be discussed further below.

12.6 It is now clear that, during 1993, Shipman was using 30mg ampoules of diamorphine to kill and was replenishing his stock as and when necessary. On 22nd February 1993, for example, he obtained two ampoules of diamorphine in the names of Mr Harold Freeman who died on 20th February and Mrs Louisa Radford who died a natural death on 22nd February. Two days after obtaining those ampoules, on 24th February, Shipman killed Mrs Olive Heginbotham and Mrs Hilda Couzens.

12.7 His actions in respect of these two patients were very similar. He visited both during the afternoon and killed them. On his return to the surgery, he gave instructions to the receptionist to make arrangements for each to be visited at home by a consultant geriatrician from Tameside General Hospital. Both appointments must have been later cancelled. Mrs Couzens' body was found during the evening of 24th February. By about noon the next day, 25th February, Mrs Heginbotham's death had not been discovered. Shipman went to the house, knocked at a neighbour's door and asked for a key. The neighbour did not have a key but accompanied Shipman to Mrs Heginbotham's house, where, by looking through a window, Shipman claimed to be able to tell that she had died. Shipman then departed, leaving the neighbour to deal with the situation. Shipman later claimed that Mrs Heginbotham had died during the early hours of the morning but the evidence shows that she had died before dark on the previous day. Shipman replaced his stock of diamorphine by obtaining a 30mg ampoule in the name of Mrs Heginbotham on 25th February and a further ampoule on 26th February in the name of a patient who is still alive.

12.8 On 22nd March 1993, Shipman killed Mrs Amy Whitehead and obtained a 30mg ampoule of diamorphine in her name. On 8th April, he killed Miss Mary Andrew and obtained a further ampoule of diamorphine in her name four days later. On 17th April, he obtained an ampoule in the name of Mrs Sarah Ashworth and killed her. It is not clear whether the killing occurred before or after the obtaining of the drug. On 26th April, he killed Mrs Fanny Nichols and, on 27th April, he killed Mrs Marjorie Parker. On that day, 27th April, he obtained an ampoule in the name of each of those two women. He killed Mrs Nellie Mullen on 2nd May and Mrs Edna Llewellyn on 4th May. On 5th May, he obtained an ampoule in the name of each of those two women. On 12th May, he killed Mrs Emily Morgan, and on 13th May he killed Mrs Violet Bird. On 20th May, he obtained an ampoule in the name of Mr Ernest Ralphs. He killed Mrs Jose Richards on 22nd July. On 14th August, he obtained another ampoule in the name of Mr Ralphs and killed Mrs Edith Calverley three days later on 17th August. On 27th August, he obtained another ampoule in the name of a patient who is still alive.

12.9 With the 14 ampoules he obtained between February and August 1993, Shipman killed 13 patients during the same period. I think it possible that the fourteenth ampoule was used in an attempt to kill Mrs Mary Smith on 31st August 1993. If that was an attempt, it failed. Shipman was disturbed while visiting Mrs Smith at home. Her step-daughters arrived unexpectedly at her flat. Shipman was leaning over Mrs Smith, who was unconscious. Mrs Smith slept deeply until the following morning, when she awoke, with no apparent ill effects. I felt unable to reach a definite conclusion about what had happened. It is possible that Shipman was injecting her and intended to kill her but had to stop the process before completion, as the step-daughters arrived, with the result that Mrs Smith did not receive a lethal dose. It may well be that this incident gave him rather a fright, as he did not kill again until December 1993.

12.10 In some of the 1993 cases, Shipman admitted, either in the medical records or orally to relatives, that he had given the deceased a small dose of morphine or diamorphine. In the case of Mrs Amy Whitehead, Shipman was asked to visit on the morning of 22nd March, as Mrs Whitehead had stomach trouble and had started to suffer from

diarrhoea in the night. She cannot have been very ill, as she did all her usual household tasks including putting the washing on the line. She also made some lunch. Shipman arrived in the late morning and killed Mrs Whitehead. Shortly before 1pm, he telephoned the home of Mrs Whitehead's son and spoke to his wife. He told her that he had visited Mrs Whitehead and had found her in heart failure. He had given her an injection. He suggested that the son and daughter-in-law should come over but said that they should not rush as, by the time they arrived, Mrs Whitehead would be dead. The daughter-in-law said that they would come immediately but Shipman said that he could not stay; he had to look after the living and not the dead. He agreed a time at which he would meet them at Mrs Whitehead's house. In the medical records, Shipman fabricated an entry to suggest that he found Mrs Whitehead suffering from a coronary thrombosis. He claimed that he had given her an intravenous injection of 10mg morphine sulphate. If Mrs Whitehead had been suffering the severe pain of a heart attack, a modest dose of morphine would have been appropriate, although 10mg would probably be rather a large dose. The injection should be given slowly and stopped when the pain is relieved. Shipman did not say that he had done that. In any event, 10mg morphine would not have killed Mrs Whitehead.

12.11 At some time that day, Shipman obtained 30mg diamorphine in Mrs Whitehead's name. It is not possible to discover whether he obtained the diamorphine before he went to Mrs Whitehead's home or afterwards. Shipman was not supposed to carry controlled drugs in his medical bag, as he did not maintain a controlled drugs register. He could legitimately have a controlled drug in his possession which had been prescribed for a particular patient and which he was about to administer. Any controlled drug not administered to the patient should have been destroyed. If Shipman had collected 30mg diamorphine for Mrs Whitehead before he visited her, it would have been very suspicious indeed, as he thought she had only a stomach upset. If he prescribed and collected 30mg diamorphine after he visited her, that too would be suspicious, as he had noted in the medical record that he had administered 10mg morphine sulphate, a dose which would be about one sixth of the amount of opiate which he later collected from the pharmacy. It is clear that Shipman gave Mrs Whitehead much more than 10mg morphine and he almost certainly gave her 30mg diamorphine, which would be a lethal dose.

12.12 I mention this case for two reasons. First, it is an example of how startlingly callous Shipman could be when breaking the news of a death. His attitude during the telephone call to Mrs Whitehead's daughter-in-law was shocking. Second, it illustrates why the admission in the notes that Shipman had given a modest dose of opiate should be treated with suspicion. He almost certainly gave much more. The advantage to him of saying that he had given some morphine or diamorphine would be that, if a post-mortem examination were to be called for and if toxicological tests were to be ordered, he would have a ready explanation for the finding of morphine in the body. Also, if the mark of an injection was evident, Shipman would have been able to explain it.

12.13 The death of Miss Mary Andrew on 8th April 1993 is strikingly similar to that of Mrs Amy Whitehead. In the morning, she telephoned Shipman's surgery to ask for a visit; she had back pain. During the morning, she was not seriously ill. She was visited by two

neighbours, Mrs Judith Page and, later, Mrs Martha Marley, who herself was killed by Shipman in March 1998. Mrs Marley left when Shipman arrived. Not long afterwards, Shipman telephoned Miss Andrew's brother and told him that his sister had died. He said he had given her an injection of morphine and had gone to ask Mrs Page to look after her but he had found that Mrs Page was not at home. He said that, when he returned, Miss Andrew was dead. In the medical records, Shipman claimed that he had found Miss Andrew suffering from a coronary thrombosis and congestive heart failure. He had given her 10mg morphine but she had died. We know from the controlled drugs register at the Norwest Co-op Pharmacy that Shipman obtained 30mg diamorphine in Miss Andrew's name four days after her death. It is clear that he was replacing the 30mg ampoule that he had used on Miss Andrew.

12.14 The death of Mrs Edna Llewellyn a month later, on 4th May 1993, is a variation on the same theme. She suffered from heart disease and, on the morning of 4th May, she had an attack of angina. Shipman was called but, by the time he arrived, Mrs Llewellyn was much better. Shipman went into the bedroom and was alone with Mrs Llewellyn. Her daughter-in-law and a friend, who were also in the house, stayed in the living room. After a few minutes, Shipman went to collect something from his car and returned to the bedroom. A few minutes after that, he emerged from the bedroom and announced that Mrs Llewellyn had died of a ' massive' heart attack. In my judgement, he had killed her. In the medical records, Shipman claimed that he had given 10mg morphine intravenously, ostensibly to relieve pain. The following day, he obtained 30mg diamorphine from the Norwest Co-op Pharmacy. Once again, it is apparent that Shipman was carrying opiates in his medical bag. Once again, Shipman replenished his stock by collecting about six times as much drug as that which he claimed to have administered.

12.15 Mrs Violet Bird was only 60 at the time of her death on 13th May 1993. The circumstances of her death are similar, although not identical, to those I have just described. Once again, Shipman attributed the death to a heart attack. Once again, he claimed to have given an intravenous injection of opiate, this time 10mg diamorphine, which is twice what he claimed to have given in the other cases. Once again, he obtained 30mg diamorphine shortly after her death. In fact, he did not obtain this until 20th May and he obtained it in the name of Mr Ernest Ralphs, who was still alive. Nonetheless, it is hard to resist the inference that he was replacing the ampoule of diamorphine that he had used to kill Mrs Bird.

12.16 The death of Mrs Jose Richards on 22nd July 1993 is also similar to the others. Mrs Richards was 74. She suffered from chronic obstructive airways disease. However, she had no history of heart trouble. Her state of health immediately before the death is not clear, as a crucial date in the medical records has been overwritten and is virtually illegible. It may be that Mrs Richards had suffered an episode of congestive heart failure on the day before her death. On the other hand, Shipman might have fabricated an entry to suggest that. Whatever happened on the day before the death, Shipman visited of his own volition on 22nd July. Mrs Richards spoke to a friend at about 12.15pm and seemed perfectly well. When the friend called at her house at about 1.45pm, she found Shipman there. He announced that Mrs Richards had ' just gone', meaning that she was

dead. He told the friend that he had given Mrs Richards an injection for her pain and that the injection had killed her; he had not realised how frail she had become. He was very matter of fact. He had made himself a cup of tea. Mrs Richards was sitting in her chair. Her dentures had been removed. In the medical records Shipman claimed that he had found Mrs Richards suffering from a heart attack. He had given her an intravenous injection of 10mg diamorphine. Mrs Richards had died half an hour later. Three weeks later, Shipman obtained another 30mg diamorphine in the name of Mr Ernest Ralphs.

12.17 According to the available records, after August 1993, Shipman never again prescribed single 30mg ampoules. Whether he changed his method because he was fearful that the unusual pattern of prescribing might be noticed, or whether he simply found a better way of obtaining diamorphine, I do not know. However, in November 1993, Shipman took advantage, for the first time, of a new and more prolific source of diamorphine. Mr Raymond Jones, who was suffering from terminal cancer, began to require large amounts of diamorphine. He was provided with a syringe driver, a device which feeds a regular supply to the patient by means of subcutaneous injection. So far as I have been able to discover, Mr Jones was the first of Shipman's patients to be provided with a syringe driver. There were to be more in the future, as this had become the preferred method of administering analgesics to patients suffering from protracted pain who were unable to take oral medication. Following Mr Jones' death, on 27th November 1993, Shipman took possession of two or three boxes, each containing ten 100mg ampoules of diamorphine. He did not return them to the pharmacy for destruction. I am satisfied that he kept them for his own purposes. From this time onwards, I think that Shipman always had a plentiful supply of diamorphine and it appears that the frequency with which he killed patients increased accordingly. He killed three patients in December 1993, making a total for that year of 16.

1994

12.18 Shipman killed two patients in January 1994, one of whom, Miss Joan Harding, died in his surgery. Miss Harding had some history of anxiety and depression. She was a regular attender at Shipman's surgery and it is quite likely that he regarded her as a nuisance. When she went in for her appointment in January 1994, she was complaining of pains in her elbow and back. Shipman noted this and then examined her. According to his note, which is clearly false, he observed signs that Miss Harding had had a heart attack. He claimed to have ordered an ambulance and then he recorded that the patient had collapsed and he had been unable to resuscitate her. He claimed that he and Sister Morgan, the practice nurse, had been present at the death. In fact, Shipman had injected Miss Harding with a lethal dose of opiate. When she was unconscious, he went to fetch Sister Morgan and asked her to help with resuscitation. So far as Sister Morgan was concerned, these were genuine attempts but I am quite sure that, for Shipman, they were a charade. An ambulance was summoned, but not until after Miss Harding was dead. It was cancelled soon after it was ordered.

12.19 On 9th February 1994, Shipman killed Mrs Elsie Platt. Later that month, Shipman had a scare. He injected Mrs Renate Overton with diamorphine, intending to kill her. However, she was kept alive by the intervention of a team of paramedics and remained

unconscious until her death 14 months later. This incident could easily have led to an inquiry into his treatment of Mrs Overton but, in the event, did not. During the evening of 18th February 1994, Shipman was called out to see Mrs Overton, who was suffering from an asthma attack. She was a rather demanding patient and Shipman might well have regarded her as a nuisance. Mrs Overton's daughter was in the house but, when she was satisfied that her mother's asthma attack had been successfully treated, she went upstairs to her room, leaving Shipman alone with her mother in the living room. Shipman then injected Mrs Overton with diamorphine. After a short time, he called Mrs Overton's daughter downstairs and staged an emergency. Mrs Overton was unconscious on the floor. Shipman said that Mrs Overton had had a heart attack and had gone into cardiac arrest. The daughter called an ambulance and was then asked to assist in resuscitation. Before long, the ambulance arrived and the paramedics succeeded in starting Mrs Overton's heart. They took her to Tameside General Hospital. She was deeply unconscious and had suffered irreversible brain damage. She lived in a persistent vegetative state for 14 months.

12.20 I am quite sure Shipman intended to kill Mrs Overton on 18th February 1994. Whether he underestimated the dose which would be needed to kill her, or whether the vigour of the resuscitation procedures prevented her death, or whether the ambulance paramedics arrived as she was on the point of death and prevented her death by the use of their defibrillator, I do not know. At the time of admission, Shipman told the paramedics and the hospital staff that Mrs Overton had suffered a heart attack at home and that he had given 10mg diamorphine to relieve her pain. In normal circumstances, that might be a reasonable thing to do, although the dose was on the high side. However, these were not normal circumstances, as Mrs Overton was known to be asthmatic and had just had an asthma attack. Staff at the hospital realised that Shipman had given far more opiate than he should have done. Why there was no formal complaint or report is to be investigated in Phase Two of the Inquiry. However, I think Shipman must have felt extremely vulnerable in the days and weeks following this incident. If his apparent negligence were investigated, there must have been a danger that his possession of illicit supplies of opiate and his more sinister intentions would be uncovered. Shipman did not kill for three months after the episode involving Mrs Overton. It may be that he destroyed his cache of diamorphine, as he did not kill again until the day on which he next obtained a supply.

12.21 On 17th May, Shipman killed Mrs Mary Smith. She was the patient whom he might have killed in August 1993 had he not been disturbed. By May 1994, Mrs Smith was suffering from lung cancer but she had not yet reached the terminal phase. On 17th May, Shipman obtained a supply of 1000mg diamorphine in Mrs Smith's name, almost certainly on the pretext that she was to be issued with a syringe driver. She did not have a syringe driver; indeed she did not need one, as she was not in severe pain before her death. Shipman must have used a small proportion of the diamorphine to kill Mrs Smith and kept the rest.

12.22 Shipman killed again on 26th May, 15th June, 17th June and 27th July 1994. He obtained 500mg diamorphine in September 1994 and killed again on 25th and 30th November

1994. On 3rd December, he procured a further 1000mg diamorphine and killed again on 29th December 1994. In all, he had killed 11 patients in that year.

1995

12.23 In January 1995, Shipman killed one patient. In late February and in mid-March, he obtained further supplies of diamorphine, prescribed in the name of Mr Frank Crompton. It has not been possible to discover how much of the drug was administered to Mr Crompton and how much was kept by Shipman. Shipman killed no fewer than nine patients in the month of March and three more in April, one of whom was Mrs Clara Hackney, who had cancer. On 13th April 1995, Shipman obtained 1000mg diamorphine in Mrs Hackney's name. On the following day, Shipman hastened her death and almost certainly kept the unused diamorphine.

12.24 In addition to the three patients killed in April 1995, Mrs Renate Overton died on 21st April, as the result of the injection that Shipman had given her in February 1994. Following her death, Shipman was questioned on behalf of the then South Manchester Coroner about the circumstances in which Mrs Overton had become unconscious 14 months earlier. Shipman explained that he had been called out to see Mrs Overton, who was having an asthma attack. He claimed that he had stabilised her and had then gone upstairs to tell her daughter that Mrs Overton would probably need some hydrocortisone. When he came down, he found Mrs Overton ' flat on the floor'. He commenced resuscitation and an ambulance was called. He said that he was just about to give up his attempt to revive Mrs Overton when the ambulance arrived and the ambulance men ' found a bleep on the machine'. They managed to restore a heartbeat but, in Shipman's view, Mrs Overton was already brain dead. She had been in a coma ever since. He said nothing about the administration of morphine or diamorphine. Had there been an inquest and had anyone looked carefully at the hospital records, Shipman would have been required to explain his administration of diamorphine to Mrs Overton the previous February. In the event, the coroner decided not to hold an inquest and, on 26th April, issued a certificate for cremation, which permitted disposal of the body.

12.25 I am quite satisfied that Shipman killed Mrs Overton and intended to do so. If he had stood trial in 1995, following her death, he could not have been convicted of murder (although he could have been convicted of attempted murder), as the law then provided that the prosecution must prove that the death had occurred within a year and a day of the act causing death. This was an old rule, doubtless intended to avoid the danger that a defendant might be convicted of an offence where the causal link between the act and the death would be uncertain. The law was changed by the Law Reform (Year and a Day Rule) Act 1996, because, nowadays, it is not at all uncommon for a victim to live for many months or even years on a life support system after the act which caused the eventual death. Mrs Overton's case was one such.

12.26 Shipman killed four patients in June 1995. One of these was Mrs Bertha Moss, who died in Shipman's surgery. In all, six of Shipman's patients were killed on surgery premises. The first of these deaths, that of Mrs Mary Hamer, occurred at the Donneybrook Surgery in March 1989. I have described the circumstances in Chapter Eleven. Miss Joan Harding was killed at the Market Street Surgery in January 1994. There were two surgery

deaths in 1995, those of Mrs Moss and Mrs Dora Ashton, who died on 26th September 1995. Mrs Edith Brady was killed at the surgery on 13th May 1996 and Mrs Ivy Lomas, of whose murder Shipman was convicted, died at the surgery on 29th May 1997. All six of these deaths are remarkably similar.

12.27 Dr Grenville says that it is most unusual for a patient to die in a general practitioner's surgery. The reasons are obvious. If the patient is very ill, he or she will not have been well enough to travel to the surgery. If a sudden untoward event, such as respiratory or cardiac arrest, occurs, as occasionally does happen, expert medical help is on hand immediately and the patient can be transferred to hospital by ambulance with the minimum delay. Occasionally, a patient will die on surgery premises. However, the evidence suggests that, when this happens, it has followed an emergency in which virtually everyone on the premises has been called upon to help. That this is the common experience of other doctors makes the circumstances of the six deaths in Shipman's surgeries the more unusual. In each case, the death occurred while Shipman was alone with the patient behind closed doors, although, on two occasions, he involved members of his staff in ostensible attempts at resuscitation.

12.28 As I have said, a death in a surgery is a most unusual event. Six of Shipman's patients died in his surgery in just over eight years. Yet no questions were asked. The coroner was never informed and no real suspicion was aroused.

12.29 Mrs Bertha Moss was only 68 when she died. She had high blood pressure and late-onset diabetes. She had suffered a deep vein thrombosis in the past. She was a smoker and was at high risk of suffering a heart attack. However, she was very active and independent. On the day of her death, before her appointment at Shipman's surgery, she did her shopping in Hyde. While waiting in the reception area, Mrs Moss chatted with an old friend, Mrs Jessie Morley. Mrs Moss seemed perfectly well. Mrs Morley saw the doctor and, as she was leaving, said goodbye to Mrs Moss, who still seemed perfectly well. A short time after Mrs Moss went into Shipman's consulting room, he came to the reception desk and asked the receptionist, Mrs Jane Kenyon, to find the telephone number of Mrs Moss' next of kin. He telephoned Mrs Brenda Hurst, one of Mrs Moss' daughters, and told her that her mother had had a heart attack. He asked her to come to the surgery. Mrs Hurst telephoned two of her sisters, Mrs Betty Clayton and Mrs Jayne Gaskell. They all agreed to go to the surgery. They did not know that their mother was dead. When Mrs Gaskell arrived, Shipman told her that Mrs Moss had come into the surgery and then said that there was ' nothing he could do'. Mrs Gaskell then began to realise that her mother had died. When the other daughters had arrived, Shipman gave a fuller explanation of what had supposedly occurred. He said that Mrs Moss had had a heart attack. He had taken an electrocardiograph (ECG) and, whilst he was putting the equipment away, Mrs Moss had had a ' funny do'. He had done his best to revive her but had been unable to do so. He said that the ECG trace showed that she had had a slight heart attack. All this was untrue. Shipman then said that there was no need for a post-mortem examination, as he had been present at the death. He said that the family would not want to have her body ' cut up'. Later, in conversation with another daughter, Shipman suggested that it was all for the best that Mrs Moss had died when she did, as she would have had to have her legs ' chopped off' on account of her

diabetes and she would not have wanted to spend the rest of her life in a wheelchair and to be a burden to her family. Shipman's medical record of this incident shows that Mrs Moss came in for a routine check but it then goes on to record that she was complaining of a vague chest pain extending into the left arm. Shipman claimed to have taken an ECG, which supposedly showed that Mrs Moss had had a heart attack. He had not done so. He claimed that Mrs Moss had then collapsed, had ' no output', no blood pressure and no respiration. He gave artificial respiration with a bag and external cardiac massage but there was no response and, 15 minutes later, he declared her dead. He had not, of course, summoned an ambulance or sought the assistance of the receptionist. The whole account was obviously false.

12.30 On 12th July, Shipman killed Mrs Ada Hilton. Later in the month, he obtained some diamorphine from the home of Mr James Arrandale, who died a natural death on 28th July 1995. Shipman probably took more than 1000mg diamorphine from the house after the death, under the pretext that he intended to destroy the drugs. He plainly did not, as some of that stock was found at Shipman's home at the time of his arrest in 1998. Shipman killed again on 31st July, 29th August and 14th September 1995. In late September 1995, he obtained a further supply of diamorphine in the name of Mr Peter Neal, who was dying of cancer and had a syringe driver. Shipman probably diverted about 1000mg by prescribing it for Mr Neal, collecting it from the pharmacy and keeping it for himself instead of delivering it to Mr Neal's home. Mr Neal died a natural death on 23rd September 1995.

12.31 Shipman killed again on 26th September. Mrs Dora Ashton walked from her home to the surgery for her appointment that day. She walked unaided into the surgery, showing no sign of serious illness. A short time later, Shipman called the receptionist into his consulting room and told her that Mrs Ashton was unwell. He said that he wanted her to go to hospital, but she would not agree. He said she was in the adjacent examination room, ' having a lie down'. He asked the receptionist to telephone her son to ask him to come to the surgery. When the receptionist had done so, she went (as she thought) to tell Mrs Ashton that her son was coming. She found Mrs Ashton dead on the couch. There was no attempt at resuscitation and an ambulance was not called. Later, Shipman told Mrs Ashton's son that his mother had fallen to the floor as she was walking into his consulting room, having suffered a minor stroke. He had managed to sit her down, but she had had a ' second stroke' and had died.

12.32 Shipman killed patients on 24th October, 8th November, 22nd November and 25th November 1995. On 14th December 1995, Shipman visited Mr Kenneth Woodhead, who was terminally ill with cancer and using a syringe driver. Shipman gave Mr Woodhead an overdose of diamorphine that hastened his death. He then took the remaining stock of diamorphine (probably five ampoules each containing 100mg), pretending that he would destroy it. On the same day, he killed Mrs Elizabeth Sigley. In all, he had killed 30 patients in 1995.

1996

12.33 In 1996, Shipman again killed 30 patients, including two in January, two in February, one in March, two in April and four in May, two of whom died on consecutive days.

12.34 Mrs Edith Brady was 72 when she died in the surgery on 13th May 1996. She led an active life but was somewhat preoccupied with her health and was a very frequent visitor to Shipman's surgery. There is some evidence that he thought she was a nuisance. On the day of her death, she had an appointment for a vitamin injection. She drove into Hyde by car, parked it behind the surgery and went to have a look round the flea market before going to the surgery. Soon after Mrs Brady had gone into Shipman's consulting room, he came out into the corridor and met Mrs Alison Massey, the practice manager. He told her that he wanted her. He went out to fetch a bag from his car and then went into the examination room. Mrs Massey followed. There, she saw Mrs Brady lying on the couch, fully clothed but unconscious and probably dead. Shipman then carried out external cardiac massage for a short time before taking a torch from the bag he had fetched from the car and shining it in Mrs Brady's eyes. He then felt at the back of her head, telling Mrs Massey that he was checking the brain stem. That was nonsense. He said there was ' nothing there; that is it'. He asked Mrs Massey to contact Mrs Brady's relatives. When Mrs Brady's son-in-law, Mr Rodney Turner, a police officer, telephoned in response to a message, Shipman told him that Mrs Brady had collapsed in the surgery. Mr Turner asked how serious it was. Shipman replied, ' How serious do you want it to be? The only way she's going to leave here is with the help of Robinson and Jordan'. They are a firm of undertakers. Later, Shipman told the family that Mrs Brady had been breathless when she arrived in his room and he found that her pulse was very fast. He told her to go into the examination room and lie on the bed. He said he would come and take an ECG after he had signed a sick note for the next patient. By the time he reached her, she had ' more or less gone'. He claimed that vigorous attempts had been made at resuscitation but that Mrs Brady had been ' brain dead'. He told the family that a post-mortem examination would not be necessary. He gave the cause of death as coronary thrombosis. Neither the police nor an ambulance had been called. Shipman simply signed the MCCD and the body was taken away.

12.35 On 6th June 1996, Shipman obtained an enormous haul of diamorphine, no less than 12,000mg. Mr Keith Harrison, who died a natural death on that day, had been suffering from cancer and had been using a syringe driver. The district nurses were responsible for filling the driver and keeping a record of the drugs used. Their drug record card tallies with the amounts prescribed by Shipman in Mr Harrison's name until the day of the death. It appears that, after hearing of Mr Harrison's death, Shipman prescribed 12,000mg diamorphine in Mr Harrison's name, collected it from the pharmacy and kept it. This would have been enough to kill about 360 healthy average-sized morphine-naï ve adults. This acquisition was followed by a marked increase in the frequency with which Shipman killed. He killed 11 patients during the next two months. The last died on 29th July. Shipman took a holiday from 3rd to 19th August and a locum took his place at the surgery. Soon after his return to work, Shipman resumed killing. There were deaths on 30th August, 12th September, 20th September, 23rd October, 20th November, 23rd November, 4th December and 17th December.

12.36 At about this time, Shipman's techniques of concealment became noticeably more sophisticated. He had always told demonstrable lies on cremation Forms B but, as time went by, these became more elaborate. For example, in cases where he was obliged to

admit that he had been present at the death, he began to claim that others had been present with him, when the truth was that he had been alone with the patient at the time. One such case was that of Mrs Edith Brady, who died in the surgery. Shipman claimed that **' self and staff'** had been present at the death. In fact, Mrs Massey, the practice manager, had been summoned to watch him go through a charade of cardiac massage, when he knew that Mrs Brady was already dead. Shipman claimed that a neighbour had been present at the death of Mrs Margaret Vickers on 25th June 1996. In fact, Shipman killed Mrs Vickers before going to fetch the neighbour, telling her that Mrs Vickers had had a stroke and that he had called an ambulance to take her to hospital. When he and the neighbour went back to the house, Mrs Vickers was dead.

12.37 In cases where Shipman was not obliged to admit that he was present at the death but had to admit that he had visited earlier on the day of the death, he began more frequently to claim that someone had seen the deceased alive between the time of his visit and the discovery of the body. This would demonstrate to anyone who thought about the matter that he could not possibly have been responsible for the death. He adopted this technique on one or two occasions in 1994 and 1995 but, in 1996 and 1997, he used this ruse more frequently and more inventively. Shipman visited Mrs Marjorie Waller on 18th April 1996. He killed her and left her on her bed. Later, when he completed Form B, he claimed that, after his visit, neighbours had taken Mrs Waller's prescription to the chemist and, on their return, had found her dead. In other words, she had been seen alive after his departure. This was untrue. Mrs Nellie Bennett was killed on 25th June 1996 but her body was not found until the following day. Shipman was called and certified the cause of death. On Form B, he said that the death had occurred at 8am on 26th June and stated that a neighbour had seen Mrs Bennett alive during the evening of 25th June, which was untrue. Mrs Elsie Barker was killed on 29th July 1996. On Form B, Shipman claimed that her nephew had spoken to her on the telephone after the time at which he had in fact visited and killed her. He also tried to conceal the fact that he had visited her on 29th July and stated on Form B that he had not seen her since 24th July. However, somewhat inconsistently, he made entries in the medical records showing that he did visit on the day of her death.

12.38 Associated with these more elaborate lies on Forms B were increasingly elaborate pretences that Shipman could estimate the time of death with accuracy. In many cases in which the death was discovered some time after his visit, Shipman would state the time of death on Form B with some precision. Even some quite early Forms B show such estimates. Dr Grenville has said that it is impossible for a general practitioner to make such an estimate. It is usually undertaken only by a pathologist and requires, as a starting point, an internal body temperature, usually taken rectally. An estimate of the ambient temperature of the room in which the body has lain is also needed. The calculation is quite complex. Shipman often claimed that he could estimate the time of death from body temperature. This was pure charlatanism. His motive for doing so must have been that he wished to create the impression that the death had taken place several hours after his visit.

12.39 On 20th November 1996, Shipman visited Mrs Irene Heathcote, probably at about 4pm, and killed her. Friends tried to visit her in the evening but there was no reply at the door.

Her body was not found until the following morning. The gas fire was on very high in the room. When Shipman was called, he placed a thermometer under her armpit and then announced that she had died the previous evening. In the medical records, he noted that her body temperature indicated that she had died at 8pm and he gave 8pm as the time of death on cremation Form B. It was absurd to claim that he could estimate the time of death in this way. He also claimed, falsely, that Mrs Heathcote had been seen alive by neighbours at 7.45pm. That would, of course, be well after his own visit.

12.40 Another case in which Shipman's estimate of the time of death was absurd was that of Mr Thomas Cheetham. He had cancer but was not yet at the terminal stage. In the early afternoon of 4th December 1996, Mrs Cheetham went shopping while her husband was watching the racing on television at his neighbour's house. He was keeping a look-out for Shipman, whom he was expecting. When Shipman arrived, Mr Cheetham went back to his own house. Shipman gave him a lethal injection. Shipman was about to leave when he must have noticed Mrs Cheetham returning from town. He waited outside the door, pretending that he had not been inside. She went inside and found her husband dead, sitting in his usual chair. Shipman followed her in. Shipman pretended that he could estimate the time of Mr Cheetham's death, which he said had taken place between one and two hours earlier. He also pretended that he had not seen Mr Cheetham alive for twelve days before his death.

12.41 On many occasions, particularly in the early years, Shipman admitted to relatives, on Forms B and in medical records that he had been present at the death or had seen the deceased on the day of the death, some time before the death was discovered. In the later years, there were more occasions when he avoided making that admission if he could. It may be that he would always have preferred to avoid making that admission. On many occasions, he had no option. If he was at the house when a relative or neighbour arrived or telephoned, there could be no avoiding it. On other occasions, I think it likely that he was unsure whether or not he had been seen at the deceased's house and felt it prudent to say from the outset that he had been there. It seems that this would not give rise to surprise, as he had created for himself a reputation of being an old-fashioned doctor who often called on his patients unannounced. In 1994 and 1995, there were one or two cases in which he avoided admitting that he had seen the patient on the day of death. Whether by chance or design, there were more such cases in 1996. In some cases, I can see why he would be particularly anxious to avoid admitting that he had visited the patient on the day of the death. When Shipman was called to the death of Mrs Leah Fogg, whose body was found in the early evening of 10th June 1996, he did not admit that he had visited Mrs Fogg that afternoon, despite the fact that, on the previous Friday, her daughter had asked him to visit, as she thought her mother, a widow, might benefit from bereavement counselling. Mrs Fogg had been in good physical health, although she was 82. Shipman had not seen her for some weeks. In fact, on 10th June, Shipman had visited her and killed her and had left without being noticed. Mrs Fogg lived on a busy road in an area where Shipman had few patients and no doubt he thought, rightly, that he had not been noticed. I think Shipman recognised that Mrs Fogg was in such robust health that, if she were to be found dead within a short time of his visit, some suspicion might be aroused.

12.42 In 1996 and 1997, Shipman killed four patients who were immediate neighbours and good friends. Mr Thomas Cheetham and his wife Elsie lived at 17 Garden Street. Two brothers, Mr Sidney Smith and Mr Kenneth Smith, both bachelors, lived at number 15. On 30th August 1996, Shipman killed Mr Sidney Smith in the living room of his house while his brother waited in the kitchen. I have already described the circumstances of the death of Mr Thomas Cheetham on 4th December 1996. Only two weeks later, on 17th December, Shipman killed Mr Kenneth Smith. Since the death of his brother, he had decided that he wished to remain in his own home, although Shipman had suggested that he should go into a residential home. Shipman killed him during a routine visit. Finally, Shipman killed Mrs Cheetham on 25th April 1997.

1997

12.43 In 1997, Shipman killed 37 patients. On 2nd January, he killed Mrs Eileen Crompton, who lived at Charnley House, a residential home for the elderly. Mrs Crompton was one of only three of Shipman's victims who lived in a nursing or residential home. She was 75 and had quite severe Parkinson's disease. She deteriorated during the last few weeks of her life and no longer recognised her sons. However, there was no particular concern about her physical condition and she continued to eat quite well. On 2nd January 1997, she seemed very **' flushed'** in the morning and was kept in bed. Her mouth was congested with mucus. The doctor was sent for. Shipman arrived at about lunchtime. Without examining her, Shipman announced that Mrs Crompton was in heart failure and that, unless he gave her an injection immediately, he was ' going to lose her'. He told the deputy manager of the home, Mrs Patricia Heyl, that the drug he was going to use was very powerful. Its purpose was to ' kick-start' the heart. He went out to his car and came back with a syringe and ampoule. He injected Mrs Crompton in the back of the hand. Within a minute, she was dead and Shipman said, ' Oh dear, this is what I feared would happen'. In the medical records, Shipman recorded a history of influenza with bronchopneumonia and claimed that he had examined Mrs Crompton and had treated her with benzylpenicillin, an antibiotic, which would have been appropriate treatment if Mrs Crompton had had a very severe chest infection. It could not ' kick-start' the heart and would not have caused the patient's sudden death. Shipman certified that the cause of death was bronchopneumonia. I am satisfied that Shipman administered a strong opiate and not an antibiotic.

12.44 Shipman killed again on the following day, 3rd January, and on seven further occasions before the end of February. On 20th March, he almost certainly replenished his drug supplies by obtaining about 1000mg diamorphine following the natural death of Mr Squire Barber. Two days later, on 22nd March, he killed Mrs Rose Garlick and, on 27th March, he killed Mrs May Lowe. At the end of April, there were three killings, one on 21st April and two on 25th April. On that day, Shipman killed Mrs Jean Lilley at lunchtime and Mrs Elsie Cheetham in the early afternoon. They lived only about a mile apart.

12.45 Shipman killed four patients in May 1997, one of whom was Mrs Ivy Lomas, the last of Shipman's victims to die in the surgery. Mrs Lomas had heart disease and suffered from anxiety and depression. She was a very regular attender at Shipman's surgery. On 29th May 1997, Mrs Lomas took a bus into Hyde for her appointment at the surgery. She

walked unaided into the consulting room. A minute or so later, Shipman took her into the examination room. About ten minutes later, Shipman came into the reception area and apologised for keeping his patients waiting. He said that he had had a problem with the ECG machine. He dealt with two or three more patients before returning to the examination room. He then called the receptionist, Mrs Carol Chapman, and told her that he had tried to take an ECG on Mrs Lomas but could not get a trace. At first, he had thought that the machine was broken, but then he realised that she had died. He asked Mrs Chapman to contact Mrs Lomas' son. Mrs Chapman was unable to contact him and she telephoned the police. A police officer attended and looked at the body but, as Shipman said that he could certify the cause of death, the officer took no action. Later that day, Shipman told Mrs Lomas' daughter that her mother had come into the surgery looking unwell. That was probably true. He said that he had taken her through to the treatment room while he saw another patient. When he returned, she was dead. She had had a ' massive heart attack'. He had tried to revive her but had failed. Shipman gave a different account in evidence at his trial and claimed that Mrs Lomas had collapsed as she climbed onto the couch in the examination room. He had done all he could to revive her. He claimed that he had not called an ambulance because he himself was skilled in resuscitation techniques. Mrs Lomas was buried. In 1998, her body was exhumed and morphine was found in the tissues.

12.46 Mrs Vera Whittingslow suffered from syringomyelia, a rare neurological disorder which had resulted in loss of mobility. She used a wheelchair. She had hypertension and, at times, her blood pressure was very high. On 24th June 1997, Shipman made a routine visit to her home. He took Mrs Whittingslow's blood pressure and told her husband that it was very high, too high for her to be moved to hospital. He sent Mr Whittingslow to the chemist to fetch a prescription, as a matter of urgency. While Mr Whittingslow was away, Shipman killed his wife. When Mr Whittingslow returned, Shipman was taking his bag back to his car. He told Mr Whittingslow that his wife was fine and they had been having a chat. When Mr Whittingslow went inside, he found his wife apparently unconscious; in fact she was dead. Shipman returned to the house; he pretended to be surprised and said that Mrs Whittingslow was ' dying'. He said that he would wait in the living room while Mr Whittingslow ' said goodbye' to his wife.

12.47 In early July, Shipman acquired more diamorphine, probably 800mg, from Mrs Maureen Jackson. She had cancer and was using a syringe driver. The district nurses were responsible for the drug record card. Their record tallies with the amounts prescribed until 3rd July, when Shipman prescribed 2300mg but delivered only 1500mg to Mrs Jackson's home. On 7th July, Shipman gave Mrs Jackson an overdose of diamorphine and hastened her death. Shipman was present with the district nurse when the remaining stock held at the house was destroyed.

12.48 By the end of July, Shipman had killed three more patients and there was another killing on 10th August, shortly before he went on holiday. He returned to work on 26th August and killed four patients in September. On 1st November 1997, Shipman obtained 1000mg diamorphine, which he prescribed in the name of Mr Lionel Hutchinson who did not receive it. There were four killings in November and five more in December, one of which was on Christmas Eve.

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12.49 On 7th January 1998, Shipman obtained a further 1000mg diamorphine, again prescribed in the name of Mr Lionel Hutchinson, to whom it was not administered. Shipman killed patients on 22nd and 26th January, 2nd February, 9th February, 13th February, 15th February, 18th February and 27th February. On 4th March 1998, he killed Mr Harold Eddleston, who had been his patient for only about a week and whose wife had died of a heart attack on 28th February. Mr Eddleston had cancer but had not yet reached the terminal stage of his illness and was not in severe pain. He was using a fentanyl patch for pain relief but there had been no question of him needing a syringe driver. On 3rd March, Shipman prescribed ten 100mg ampoules of diamorphine in Mr Eddleston's name and collected them from the pharmacy. That size of ampoule is for use in a syringe driver. None of the drug was delivered to Mr Eddleston. Shipman killed him the next day. He then killed on 6th, 7th, 13th, 17th, 20th and 24th March. Within the first three months of 1998, Shipman had killed 15 patients. Three patients had died natural deaths during that time. Of the 18, all but one had been cremated.

12.50 Since 1993, when the doctors from the Clarendon Practice moved to premises on Market Street, just opposite Shipman's surgery, Shipman had had an informal arrangement whereby those doctors (by then known as the Brooke Practice) would sign cremation Forms C for his patients. One of those doctors, Dr Rajesh Patel, told the Inquiry that Shipman often used to come across to the Brooke surgery premises to make the request personally, bringing with him the patient's medical records. He would give a very full explanation of the medical history leading to the death. It was always very plausible. Shipman never actually showed the records to the Brooke Practice doctor but the presence of the records in his hand added authority to his words of explanation. It appears that the doctors of the Brooke Practice became accustomed to the large number of deaths among Shipman's patients and attributed it to their perception that Shipman had a large patient list with a high proportion of very elderly people whom he would strive to keep at home, rather than having them admitted to hospital.

12.51 However, during March 1998, one of the Brooke Practice doctors, Dr Linda Reynolds, became concerned about the number of Forms C the practice was being asked to complete. On 24th March, she raised her concerns with the South Manchester Coroner, Mr Pollard. She told him that, during the previous three months, she and her colleagues had signed 16 cremation Forms C for Shipman, who was a sole practitioner. The Brooke Practice, with 9500 patients, had had only 14 deaths within the same period. On the same day, the Greater Manchester Police initiated a confidential investigation into Dr Reynolds' concerns. I think it likely that Shipman learned of that investigation in early April. However, that issue has been the subject of evidence during Stage One of Phase Two of the Inquiry and I have not yet reached a definite conclusion on the point. My provisional view is that he became aware of it in early April and it is likely that he knew that the source of the report about him was the Brooke Practice doctors who signed his cremation Forms C.

12.52 Quite apart from the evidence, which I have heard in Phase Two Stage One, there is evidence from Phase One from which I infer that Shipman knew of the suspicions of the

Brooke Practice doctors. First, after killing Mrs Martha Marley on 24th March, Shipman did not kill again for seven weeks. During the next few months, Shipman presented only two Forms C to the doctors of the Brooke Practice. They related to patients who had died naturally. This is very unlikely to have been coincidence. It seems to me that Shipman knew he was under suspicion and was probably expecting that any death which came to the attention of the Brooke Practice doctors would be referred to the Coroner. When Shipman killed again, on 11th May, his victim was Mrs Winifred Mellor, who was a Roman Catholic. Mrs Mellor's daughter, Mrs Susan Duggan, has told the Inquiry that cremation would be contrary to her mother's religious beliefs. She thinks it more than likely that her mother, who confided in Shipman, made him aware of her beliefs and of her wish to be buried after her death. Thereafter, he did not kill again until 12th June. As it happens, his victim on that occasion, Mrs Joan Melia, was also buried, although there is no evidence that Shipman would have known in advance what arrangements would be made after her death. His last victim, Mrs Kathleen Grundy, was also buried after her death on 24th June.

12.53 Second, in July 1998, Shipman was visited by Dr Alan Banks, a medical adviser employed by the West Pennine Health Authority, for the purpose of a routine discussion about Shipman's prescribing practices. Shipman took the opportunity to volunteer to Dr Banks the information that there had been an unusually high number of deaths amongst his elderly patients during the first three months of the year. He said that he and his staff had carried out an audit of the deaths and had found that there was no cause for concern. In fact there was no such audit. Moreover, Shipman's death rates were not significantly higher during the first three months of 1998 than in the last three months of 1997. The numbers of deaths during both periods were abnormally high, as Shipman had killed a substantial number of patients. The reference to the first three months of 1998 suggests that he knew that that was the period about which concern had been expressed.

12.54 It may be that Shipman intended to resume killing, as he had done on previous occasions, when he felt that suspicions had died down. On 6th July 1998, he obtained 100mg diamorphine from a patient who had cancer. He did not use it to kill but the fact that he obtained it suggests that he intended to do so when the opportunity arose. Very soon after that, on 9th July, Mrs Woodruff, the daughter of Mrs Grundy, visited Mrs Claire Hutchinson, one of the witnesses who had apparently signed Mrs Grundy's will. Mrs Hutchinson later told Shipman that Mrs Woodruff was making inquiries about her mother's will. Shipman must then have realised that Mrs Woodruff was likely to report her concerns to the police. He had not killed again by the time of his arrest on 7th September 1998. Thus Shipman's career of killing was brought to an end.

CHAPTER THIRTEEN

Shipman's Character and Motivation

Introduction

13.1 The Inquiry's Terms of Reference require me to consider the extent of Shipman's unlawful activities. They do not expressly require me to consider the motives behind Shipman's crimes or the psychological factors that underlay them. However, I decided that I ought to consider and report on those matters, as well as I am able. I consider that some understanding of Shipman's character will be of assistance in Phase Two, particularly when the Inquiry comes to consider improved systems of death certification and the issues surrounding the monitoring and supervision of doctors. For this reason, I considered that an investigation into Shipman's psyche fell within the Inquiry's Terms of Reference. I also think the relatives of the victims and the public will wish to understand why Shipman committed so many murders. For the relatives, some understanding of Shipman's motives, or lack of them, might assist them in coming to terms with what has happened.

13.2 In seeking to reach an understanding of why Shipman murdered so many of his patients, I would naturally have wished to obtain thorough psychological and psychiatric assessments. Shipman has refused to take part in the Inquiry proceedings and has continued to deny responsibility for the deaths of his patients, in the face of overwhelming evidence of guilt. It seemed, therefore, that he would be most unlikely to agree to such assessments. For the reasons I outlined in Chapter Three, it is plainly impracticable to force him to undergo any examination or assessment. In any event, without genuine cooperation on his part, the interviews which would necessarily form part of any assessment would not be fruitful. I have, therefore, had to make do with such materials as are available without Shipman's cooperation.

13.3 In order to assist my understanding, I decided to seek the advice of a team of experienced forensic psychiatrists. I did not want to limit myself to the opinion of a single expert. I wanted the psychiatrists to discuss the issues and to reach a consensus if they could; if not, I wanted them to express their differing views. I consulted a team from the Institute of Psychiatry, King's College, London. The team comprised:

Professor John Gunn, Professor of Forensic Psychiatry;
Professor Pamela Taylor, Professor of Special Hospital Psychiatry;
Dr Clive Meux, Honorary Senior Lecturer in Forensic Psychiatry;
Dr Alec Buchanan, Clinical Senior Lecturer in Forensic Psychiatry.

13.4 The psychiatrists did not think it appropriate to provide formal reports because they were unable to carry out the examinations that would normally precede the preparation of a full psychiatric assessment. It was agreed that they would read the relevant material assembled by the Inquiry team and would then meet me, Counsel to the Inquiry and Dr Esmail, the Inquiry's Medical Advisor, for a full discussion of the issues. That discussion took place in private because some of the material, which I felt it right to allow the psychiatrists to see, will not go into the public domain.

13.5 At an early stage, the Inquiry had obtained some confidential documents relating to Shipman, mainly his medical and prison records. It was necessary for the legal team to consider whether they contained material of direct relevance to the crimes themselves. They might for example have contained admissions. The documents were obtained, on summons, from the relevant authorities. With the exception of three pages of records dating from 1975, they did not contain anything of direct relevance and they were therefore put aside. However, when the Inquiry came to consider issues of Shipman's character and possible motive, I had to consider whether or not the documents should be disclosed to the psychiatric team. Shipman was entitled to refuse permission for such disclosure. I was entitled to override that refusal, but would only do so to the extent that I considered it necessary for the proper purposes of the Inquiry. I hoped and believed that the documents would assist the team to gain insight into Shipman's personality. I recognised that such disclosure would be an infringement of Shipman's right to privacy and confidentiality. I specifically considered Article 8 of the European Convention on Human Rights. My decision was that the limited disclosure I had in mind was necessary in order to assist in achieving the objects of the Inquiry. Those objects are designed to contribute to the prevention of crime, to secure the future health and welfare of citizens and to protect their future rights and freedoms. I considered that the Inquiry's need to inform itself properly on these matters (and the public interest in the Inquiry's proper conduct of its investigation) outweighed Shipman's right of complete confidentiality.

13.6 This confidential material has not been put into the public domain. Nor will it be. The psychiatrists have received it in confidence. This Report contains no direct reference to it. It has been used only to inform the opinions of the psychiatrists, who in turn have given me advice and guidance. As I shall explain below, the main source of information on which my opinions and conclusions will rest is the evidence about Shipman's crimes, which is now in the public domain. All I say about the private material is that there is nothing within it that is inconsistent with the conclusions I have expressed.

13.7 In the event, the confidential material has not enabled the psychiatrists to gain any real insight into Shipman's character as they and I had hoped. The psychiatrists have also been hampered by the very limited nature of the information available to the Inquiry about Shipman's family background and relationships. I decided, at an early stage, that it would be inappropriate to intrude upon the privacy of his children. They have enough to cope with. For similar reasons, I also decided that Mrs Shipman should not be asked about her personal relationship with her husband. When she gave evidence, counsel were permitted to ask her about factual matters relating to his practice and the various specific events on which she might be able to shed light. I did not think it reasonable to intrude on her privacy by allowing questions about her relationship with her husband. In any event, I am quite sure that he kept aspects of his character secret from his family. These decisions leave gaps in our knowledge of Shipman but I think they were correct.

13.8 The psychiatrists would have wished to have an understanding of Shipman's motivation in becoming a doctor. It is not known when he first developed the ambition to practise medicine. It is possible that this was related to the suffering and death of his mother when he was in late adolescence. It is not known what hopes and ambitions he

entertained for his medical career. It may be that he felt fulfilled by his career or he may have been disappointed and dissatisfied that he became a general practitioner in a small town rather than, say, an eminent surgeon or a member of the influential elite of the medical profession.

13.9 The psychiatrists stressed to me that the ideas we discussed could not be regarded as authoritative opinions. They did their best to consider possible explanations for Shipman's conduct but, with the materials available, were unable to reach any conclusions. I am grateful for the assistance they have given me but, in the end, I have been unable to attempt any detailed explanation of the psychological factors underlying Shipman's conduct. All I can do is to draw attention to features of his behaviour which might throw some light on his personality and motivation. The views I express in this Chapter are not those of the psychiatrists, but are my own, and have been reached by the usual judicial process of drawing common sense inferences from evidence.

13.10 As I have described in the previous three Chapters, I am satisfied that Shipman killed more than 200 patients over a period of 23 years. After some possible early experimentation, his usual method of killing was to give an intravenous injection of a lethal dose of diamorphine, which led to death within a few minutes. With a few victims, mainly patients who were terminally ill, he sometimes gave an intramuscular injection, which would take effect and result in death within the hour. There is a suspicion that he sometimes gave large doses of sedatives, such as Largactil, to elderly patients with reduced respiratory function, so as to induce deep prolonged sleep and to make the patient vulnerable to death by bronchopneumonia.

Motive

13.11 Save for the case of Mrs Kathleen Grundy, which I will discuss in greater detail below, I have found no evidence that Shipman was motivated by monetary gain. Very few of his patients left him any money. Those who did, such as Mrs Mavis Pickup, left relatively modest tokens of appreciation for his services and, as they saw it, his friendship. Shipman was, however, acquisitive. There were occasions when he asked for an item of property belonging to a patient he had just killed. In 1985, he asked the family of Mrs Margaret Conway if he could have her budgerigar for his aunt; his request was not granted. In 1997, he asked the brother of Miss Lena Slater for her sewing machine, which he was allowed to have. He asked Mrs Joan Sellars, the niece of Miss Mabel Shawcross, for her antique bench, saying that it had been Miss Shawcross' intention that he should have it after her death. Mrs Sellars did not agree. Shipman ran a patient fund for the provision of equipment for the surgery and encouraged donations and bequests. Although this fund was not registered as a charity, there is no reason to think that the money was used for anything other than proper purposes. It was administered by a patient, a retired police officer. There is much suspicion that Shipman pilfered money and items of property from the homes of his victims, although the evidence is not sufficiently clear for me to reach any positive conclusions in individual cases. I am quite satisfied that any such acquisitions, whether with or without permission, did not supply a motive for murder.

13.12 Mrs Grundy's murder on 24th June 1998 was, on the face of it, motivated by monetary gain. She was one of his wealthiest patients. She had a comfortable detached cottage in an attractive area of Hyde. She owned a second property and some investments. Her estate was worth about £386,000. I have already outlined the way in which Shipman forged a will in her name, using his own typewriter. The forgery of her signature and of those of the ' witnesses' was very poor. Shipman sent the will to Hamilton Ward, a firm of solicitors in Hyde, with a forged covering letter, ostensibly from Mrs Grundy. Mr Burgess of that firm was puzzled to receive it, as Mrs Grundy was not a client of his firm and the firm had had nothing to do with drafting the will. It was not addressed to anyone in particular at the firm. He put it to one side.

13.13 In the will, Mrs Grundy had left all her property to Shipman and nothing to her dearly loved daughter and grandchildren. The will said that she wished to give all her estate to her doctor to reward him for **' all the care he has given to me and the people of Hyde'**. She added that he was **' sensible enough to handle any problems this may give him'**. I will return in due course to what the wording of the will reveals of Shipman. For the moment, I consider only whether Shipman really was motivated by money in killing Mrs Grundy. Soon after he had killed her on 24th June, Shipman wrote, on 28th June, to Hamilton Ward. He typed the letter on his own portable typewriter, the same one he had used to forge the will. He introduced himself as a friend of Mrs Grundy who had helped her to make her will, and informed the solicitor of her death. He signed it **' J. Smith'** or possibly **' S. Smith'**. The police were later to find that Mrs Grundy knew no one with either of those names. Copies of the will and the forged letters are to be found at the end of Chapter One.

13.14 Mrs Grundy's daughter, Mrs Angela Woodruff, is a solicitor in practice in Warwickshire. In 1986, Mrs Grundy had made a will in favour of her daughter and this was held in safe custody at Mrs Woodruff's office. Shipman knew Mrs Grundy quite well. Not only had she been a patient of his for many years, they were both involved in local affairs. Mrs Grundy was very proud of her daughter and grandchildren and Shipman must have known that Mrs Woodruff was a solicitor.

13.15 The forging of Mrs Grundy's will led directly to Shipman's downfall. I have little doubt that his killing of her would not have been detected but for his forgery of her will. However, the will was so obvious a forgery and so entirely uncharacteristic of Mrs Grundy that Mrs Woodruff was bound to investigate it. In fact, she reported her suspicions about the will to the police. The forgery was soon uncovered and the rest is history.

13.16 It seems to me that Shipman could not rationally have thought that he would get away with Mrs Grundy's estate. The whole venture was grossly incompetent. Discovery was inevitable. I will return later in this Chapter to discuss what might have been Shipman's state of mind at the time he forged this will and killed Mrs Grundy. It does appear that Shipman planned the forgery of the will well in advance of the killing, which suggests that money was his motivation. However, I am not convinced that Shipman decided to kill Mrs Grundy because he wanted her money. I think his thought processes must have been much more complex than that.

13.17 There is no suggestion that Shipman interfered in any way with the bodies of the patients he had killed. He might on occasions have ' arranged' them, for example by putting a book or newspaper on the victim's knee to create the impression that he or she was reading just before death. In 1988, when killing Mrs Alice Jones, whose sight was poor, he put her magnifying glass and torch in her hands after she had lapsed into unconsciousness. But these minor arrangements seem much more likely to be related to a desire to create unsuspicious circumstances than to any underlying motive for the crime. There does not appear to have been any overtly sadistic or erotic motivation for his crimes. The psychiatrists say that they cannot speculate on whether there might have been some underlying sexual or necrophiliac element within his motivation. However, there is no evidence from which I could infer that there was.

13.18 In short, if one defines motive as a rational or conscious explanation for the decision to commit a crime, I think Shipman's crimes were without motive. The psychiatrists warn me that it is possible that, in Shipman's own mind, there was a conscious motivation. All I can say is that there is no evidence of any of the features that I have observed, in my experience as a judge, that commonly motivate murderers.

Other Explanations

13.19 If I am to find any explanation for Shipman's crimes, it seems to me that I must look, so far as I can, within his personality. What kind of a man works hard to become a doctor, takes the Hippocratic oath and, within only a few years, embarks on a career of killing his patients?

13.20 Our personalities are governed by a mixture of genetic factors and the effects of our experiences. Very little is known about Shipman's family or early years. His mother died of cancer when he was in late adolescence. The psychiatrists think it possible that the fact and circumstances of her death might have had a profound effect upon his psyche. The only evidence on this subject available to the Inquiry is that of Mrs Florence Bateson, for many years a patient of Shipman, who said (in a statement made in connection with the death of her father, Mr George Charnock) that Shipman used often to speak to her about his mother and had said to her husband, Mr Norman Bateson, that he had seen her suffer from cancer when he was 17. I cannot assess the impact of his mother's death or indeed any other potentially formative experiences. In seeking to describe Shipman's personality, I am dependent upon what he has revealed of himself through his actions and the descriptions of people who have known him and have described him and his behaviour to the Inquiry.

Professional Reputation

13.21 Shipman had the reputation in Hyde of being a good and caring doctor. He was held in very high regard by the overwhelming majority of his patients. He was also respected by fellow professionals. His patients appear to have regarded him as the best doctor in Hyde. His register was full and there always seems to have been a waiting list. Patients liked him for a variety of reasons. Many would say that he ' always had time' for them. His surgeries overran but no one minded because they understood his wish to take

whatever time was necessary for each patient. He never hurried them out. He always had time for a few words of a personal nature. Elderly patients and their families were particularly grateful for his willingness to visit at home. Other doctors might be reluctant to visit and might try to insist that a patient be brought to the surgery. Shipman never did that. With the benefit of hindsight, one can see that this willingness to make home visits created many opportunities for killing. At the time, it seemed to his patients only to show that he was considerate of their welfare. There must, in fact, have been many occasions when the consideration he showed for his patients was not simply a cover for criminal actions.

13.22 There is, however, a deeply sinister aspect to the way in which Shipman created for himself the reputation of being a very caring doctor. He encouraged people to regard him as an ' old-fashioned family doctor' who would willingly visit his patients at home and made a habit of calling on them when he was in their area. I am sure he promoted this view of himself quite deliberately. Dr Patel, of the Brooke Practice, told the Inquiry of an occasion when Shipman had asked him to sign a cremation Form C for one of his patients. On reading the Form B, Dr Patel noticed that Shipman had been present at the death. He observed that this was rather unusual. In what might now be seen as an example of attack being the best form of defence, Shipman responded rather aggressively, putting the young Dr Patel firmly in his place. He asserted that young doctors nowadays do not visit their patients as he and his generation did. The implication was that they were not as caring as he. He also let it be known that he thought it preferable that elderly patients should be allowed to die at home ' with dignity' instead of being subject to the ' hustle and bustle' of a hospital ward. It may be that many of his patients agreed. Certainly, there would be more work for the general practitioner in caring for an elderly patient at home. However, it is hard to resist the conclusion that these habits created many opportunities to kill which would not otherwise arise and that his reputation in respect of these matters was a useful ' cover' for his killings.

13.23 There is no doubt that Shipman was also industrious. When he took his first post in general practice at the Abraham Ormerod Medical Centre, Todmorden, his partners found him keen and hardworking. He was always willing to take on more than his fair share of out of hours work. He volunteered to do the donkey-work involved in the introduction of a new method of filing. In 1998, he had a list of almost 3100 patients. That represented a very large caseload, substantially greater than the average list of single-handed general practitioners in Tameside, which was under 2500. He worked long hours. There was never any delay in arranging an appointment and it appears that there were very few occasions when he failed to visit a patient on the day of request. He was a regular attender at continuing education sessions at Manchester and Liverpool Universities and at Tameside General Hospital. In general, he seems to have been a good administrator and appears to have maintained the loyalty of his staff. He had a poor relationship with one member of the practice staff at the Donneybrook Surgery, whom he regarded as incompetent. The other doctors did not share that view and it may be that there was a personality clash. Several members of the Donneybrook staff chose to leave their employment with that practice in 1992 and move with him to his new premises at Market Street.

13.24 His Achilles' heel as an administrator appears to have been his keeping of medical records. He was a poor record-keeper. His notes were usually scanty and often incomplete in important respects. That criticism does not only apply to the entries associated with a killing. Why his record-keeping was so poor, I cannot say. He might not have thought the records very important and so gave them a low priority, but on other occasions there were without doubt more sinister reasons for this failure, as I have explained in previous Chapters.

Personal Relationships

13.25 Shipman does not appear to have had many friends. His professional associates never became friends. Dr Doreen Belk was a fellow student of Shipman at medical school in Leeds and also went to Pontefract to work as a house officer. She and her husband lived in hospital accommodation very close to Shipman and his wife. Yet they never became friends. Dr Belk found Shipman cold, aloof and unapproachable. He appeared to have ' a chip on his shoulder' and a grudge against life. When he had settled in Todmorden and later in Hyde, he involved himself in many local activities. In Hyde, he worked with the St John Ambulance Brigade. He was active in medical politics; for a time he was secretary of the Local Medical Committee. He was a school governor. At least one of his sons was keen on rugby and played for the Ashton-under-Lyne Rugby Union team. Shipman and his wife were regular supporters of the club. All these were activities that would usually result in the acquisition of a large circle of friends. Yet the evidence is that Shipman had very few.

13.26 Many patients describe Shipman as having a wonderful bedside manner, especially with the elderly. He would make much of them and would sometimes tease them gently. They liked it. He made many of them feel that he was a real friend as well as their doctor. Yet he would kill them. Perhaps the most poignant example of this is the case of Mrs Mavis Pickup. In August 1997, Mrs Pickup's husband, Kenneth, died of a heart attack. They had been happily married for nearly fifty years and she was devastated, of course. Soon after the death her son, Mr James Pickup, went to see Shipman to thank him for the care he had given his father over the many years he had suffered from heart disease. Shipman was curiously brisk about Mr Pickup's death but showed great concern about his widow. He asked after her in a most sympathetic way and told her son that, if there was anything he could do, if she needed any kind of help, not limited to medical matters, he ' would always be there for her'. He killed her three weeks later after she had telephoned the surgery, upset because children had been knocking on her door and running away.

13.27 Shipman had a reputation for ' calling a spade a spade' but many of his patients seemed to like him for that. Some of his remarks were quite inappropriate but people seemed to accept them as being typical of the man. For example, when Mr Stephen Dickson asked Shipman on 28th February 1998 how long his father-in-law, Mr Harold Eddleston, who had cancer, was likely to live, Shipman replied ' I wouldn't buy him any Easter eggs'. Mr Dickson did not take offence because he thought this kind of remark was typical of Shipman's style. Shipman killed Mr Eddleston four days later.

13.28 Many of the families of Shipman's victims report that his usually kind and sympathetic attitude disappeared when their relative had died. They would naturally be very distressed. He would be curt and dismissive and would sometimes say the most inappropriate and hurtful things. When he had just killed Mrs Mary Coutts in April 1997, and her son and daughter-in-law, who were in a state of grief and shock at the suddenness of her death, were asking him about the circumstances, Shipman said, ' Well, I don't believe in keeping them going'. After the death of Mrs Margaret Conway in 1985, he took it upon himself to inform her 14 year old granddaughter (who happened to have an appointment that afternoon at the surgery) that her grandmother had died, despite her mother having contacted the surgery to say that he should not do so. The girl was shocked and distressed.

13.29 It seems that Shipman's attitude towards his patients was quite unpredictable. At times he was encouraging and sympathetic but at times he was cold, brusque and offhand. Often, he seemed unable to empathise with the bereaved.

Aggression, Conceit and Contempt

13.30 Other well-marked traits of Shipman's personality were aggression, conceit, arrogance and contempt for those whom he considered to be his intellectual inferiors. Perhaps the most striking illustration of his conceit is what he wrote about himself in Mrs Grundy's forged will, to which I have already referred. He wrote (as if the words were Mrs Grundy's) that he was to be rewarded for all the care he had given her and the people of Hyde. I think he enjoyed referring to himself in the third person in this flattering way.

13.31 Another example of his conceit may be seen in a letter he wrote in August 1998 to the NHS Appeals Tribunal in connection with a decision of the local Health Authority about funding of his practice staff, in which Shipman felt able to claim:

> **' We are a proactive practice, we have the highest level of screening for cholesterol, blood pressure, diabetes and asthma in the West Pennine Health Authority. We are a flagship – the Health Authority can always compare the quality of this practice to any other and ask why the other practice is underperforming'**.

13.32 It may be that Shipman was ahead of his time in the practice of preventive medicine. He had clinics for the monitoring of diabetes, congestive heart failure and high blood pressure. He had begun to call patients in for regular health checks at a time when many doctors had not yet begun to do so. Yet his boasting was a most unattractive trait.

13.33 Although Shipman was generally admired, there were quite a large number of people in Hyde who disliked him. Their usual criticism was that he was arrogant. He appeared arrogant and conceited, even during his trial. When he gave evidence, he boasted about his achievements at the practice. He was asked about a patient's blood pressure, which on a particular occasion was 140/80. Counsel suggested to him that that was a perfectly acceptable level. Shipman replied that it might be for many doctors but he aimed for ' perfection'.

13.34 He plainly thought he was by far the best doctor in Hyde. His patients seemed to agree. Dr Patel, who worked for him as a locum in the early 1990s, said that patients would often refuse to be seen by him and would prefer to wait until Shipman had returned to work. Shipman would not allow a locum to immunise his child patients. He had to do it himself.

13.35 Dr Bills, who worked with Shipman during the Donneybrook years, says that Shipman often described a patient's condition to his colleagues in very florid terms, for example, saying that the patient had pneumonia, when in truth he or she had only a moderate chest infection. Then, when the patient recovered, Shipman would claim credit for the cure. One of his more frequent boasts was about his success in treating heart disease. He prescribed medication very freely and liked to impress upon his colleagues how successful his treatment was. This was strange because, if anyone had examined the number of deaths from coronary heart disease among his patients, it would have been found to be quite high. That was not because a large number of his patients died of that disease but because coronary thrombosis was his favourite ' cause of death' for a patient he had killed.

13.36 To some extent, one can see why Shipman became conceited. He obviously relished his good reputation in Hyde and the adulation accorded to him by so many of his patients. He seems to have enjoyed almost celebrity status among his patients. One of his victims, Mrs Florence Lewis, was delighted when she was taken on to his list. Her son said that it was almost as if she had won the lottery.

13.37 Another manifestation of Shipman's conceit was the delight he took in ' taking on' and getting the better of officials and those in authority. He conducted a long-running battle with the Health Authority about his expensive prescribing habits and funding for his practice. There might be many doctors whose sympathies would lie with Shipman on these issues, but the point is that he seemed to revel in this kind of dispute and the language in which he addressed the officials was at times unpleasant, aggressive and conceited.

13.38 Another unattractive trait was Shipman's habit of humiliating people whom he felt were not doing their jobs properly. One example concerned a young female sales representative from a drug company, who attended a meeting of the Donneybrook doctors. She was nervous and inexperienced and perhaps not quite as knowledgeable about her products as she should have been. Shipman was quite ruthless in his criticism of her and seemed to enjoy the fact that he had reduced her to tears.

13.39 Dr Hardman, a medical referee, recalls attending a lecture at which Shipman was in the audience. He kept interrupting and disagreeing with the visiting lecturer in a very pompous way. His behaviour became an embarrassment to those who knew him.

13.40 I have been able to form my own view of Shipman's arrogance by listening to tapes of the police interviews of September and October 1998. He was interviewed on 7th September and on 5th October. On each occasion, he began confidently and treated the police officers in a patronising and arrogant way. They continued steadily and, as the evidence was put to him, his attitude gradually changed until, at the end of

5th October, when it was clear that the police knew that he had falsified medical records on his computer, he broke down and was unable to continue with the interview.

Dishonesty

13.41 An important trait in Shipman's personality is that he is profoundly dishonest. His dishonesty was first revealed in 1975 when it was found that he had dishonestly obtained large quantities of pethidine by deception and kept them for his own use. I have described these offences in Chapter One. Shipman pleaded guilty to offences of dishonesty – in effect, forgery and theft – which had taken place over a prolonged period.

13.42 Shipman regularly obtained large quantities of diamorphine by similar dishonest means during the 1990s. As I have explained earlier in this Report, I have every reason to believe that he employed the same methods in the 1980s, although the records, which would prove the point beyond doubt, have been destroyed.

13.43 Obtaining drugs was not Shipman's only dishonesty. He was an accomplished and inventive liar. He could lie spontaneously to get himself out of a difficult situation and did so on countless occasions. Even at a very early stage in his career, in July 1975, when the Home Office Drugs Inspectorate and West Yorkshire Police Drugs Squad first suspected him of stealing pethidine, he so impressed them in interview that they took matters no further, at least for the time being. He had told them a pack of lies.

13.44 Sometimes, when he had killed a patient, Shipman was caught almost red-handed. Yet, he was able to invent an explanation for the death without showing any noticeable discomfiture. This arose in the case of Mrs Maria West. Mrs West was entertaining her friend, Mrs Marian Hadfield, during the afternoon of 6th March 1995. The two women were sitting in Mrs West's front room when Mrs Hadfield wanted to use the bathroom. The bathroom was upstairs and the staircase led out of the kitchen. While she was upstairs, Shipman arrived, to find Mrs West apparently alone. When Mrs Hadfield came downstairs, she could hear voices in the front room, realised the doctor had arrived and stayed in the kitchen. Within a few minutes of his arrival, Shipman killed Mrs West. Mrs Hadfield realised that the conversation had stopped. A few moments later, Shipman came into the kitchen. One would have thought that he would have been completely thrown off balance by the realisation that Mrs Hadfield had been only a few feet away while he was killing Mrs West. He looked a little surprised to see her but confidently explained that Mrs West had collapsed and died. He had come into the kitchen to look for her son, so he said.

13.45 There are many other examples of the confidence with which he would tell lies and act them out. He would quite often tell a relative (untruthfully) that he had summoned an ambulance on finding the patient in a serious condition. He would then say that the patient had died, so he had cancelled the ambulance. On some occasions, he would actually go through the charade of picking up the telephone, dialling a number and pretending to speak to the ambulance control centre to make the cancellation.

13.46 His dishonesty is well illustrated by the way in which he fabricated medical records to invent plausible explanations for deaths that he had caused. He also made countless false entries on MCCDs and cremation certificates. Indeed, in respect of his duties of certification, he was frequently dishonest, even in cases where he had not killed the patient and had no need to invent a cover story. He was, in short, a consummate and inveterate liar.

Addiction

13.47 There is evidence that Shipman was addicted to pethidine in the 1970s. He claimed that he was addicted to it and it seems likely that he was. He certainly obtained large quantities and injected himself (the marks were seen by Detective Sergeant McKeating at the time) and it is clear that he suffered a number of blackouts. It is possible that he was already abusing that drug while working as a house officer in the Department of Obstetrics and Gynaecology at Pontefract General Hospital, where pethidine would have been in regular use. There is no evidence that Shipman ever resumed any personal abuse of controlled drugs after his rehabilitation in late 1975 and early 1976.

13.48 When challenged about his drug taking in 1975, Shipman claimed that he had taken to it because he had become depressed and unhappy about his work and his relationships with his partners. His partners were unaware of any signs of depression and did not think there were difficulties within the practice. The psychiatrists say that the reason why many people become addicted to drugs is that they are depressed or anxious or deeply unhappy. There is no obvious reason why Shipman should have been depressed, anxious or deeply unhappy in the 1970s. He had achieved his ambition to become a doctor, which, at that time, was a considerable achievement for someone from his background. He was married and had a young family. Although the marriage had not taken place under ideal circumstances (Shipman was a student and Mrs Shipman was pregnant) it does not appear to have been unhappy. It has certainly stood the test of time. However, the psychiatrists stress (and I accept) that Shipman might have had all manner of underlying problems. We simply do not know. It seems to me that whatever problem it was that drove him to pethidine addiction in the 1970s was almost certainly never resolved and probably became a permanent part of his make-up.

13.49 The psychiatrists say that a person who has one addiction is quite likely to be subject to other forms of addiction. I think it likely that whatever it was that caused Shipman to become addicted to pethidine also led to other forms of addictive behaviour. It is possible that he was addicted to killing.

What Does This Constellation of Traits Reveal?

13.50 This is not an attractive constellation of traits. However, it is by no means unique or even particularly uncommon. I have talked to the psychiatrists about Shipman's characteristics. They have made some tentative suggestions about his underlying personality but stress that these are only theories and cannot be demonstrated without formal assessment. They suggest that Shipman may have a rigid and obsessive personality. They think he may be isolated and may have difficulty in expressing

emotions. They suggest that his arrogance and over-confidence are almost certainly a mask for poor self-esteem. They think that, for most of his adult life, he was probably angry, deeply unhappy and chronically depressed. They suggest that he has a deep-seated need to control people and events. Once he fears that he cannot control events, he feels threatened and reacts so as to take or regain control.

13.51 It is clear that these traits are not in themselves enough to explain why Shipman became a serial killer. On the evidence available, the psychiatrists cannot explain how this melange of characteristics could lead to such extreme conduct. Even if Shipman also has unresolved feelings of grief about the loss of his mother at an impressionable age, there is still not enough to explain his later conduct. There must be something else, much more significant. The psychiatrists say that they cannot discover this without many hours of discussion with him. They postulate the theory that he could be psychotic, although they stress there is no evidence that he is. They think that his actions must be the product of a diseased mind but are unable to shed any light on the nature of that disease. They suggest the possibility that Shipman might have developed a fear of death and a need to control death. It is possible that he has a morbid interest in death. It is possible that he might have experienced a ' buzz' of pleasure from association with death. It is also possible that death might have given him a sense of relief from some intolerable pressure or anxiety. In short, Shipman may have had a need to kill. Any of these attitudes towards death, present in conjunction with an addictive personality, prone to obsessive and repetitive behaviour, might go some way towards providing an explanation.

13.52 There is not a great deal of evidence that Shipman had a morbid interest in death or derived pleasure from killing or from the circumstances of death. There is some, however. Mrs Judith Page, a patient of Shipman who worked as a home help, reported that one morning, during a consultation in his surgery, Shipman remarked to her that in the course of her work, he supposed she must sometimes find a client dead. She agreed that this had happened on one or two occasions and added that she had found it very upsetting, as she had become fond of her elderly clients. Shipman's response was to ask her whether she did not find that it gave her ' a buzz'.

13.53 Some evidence that Shipman had a morbid interest in death may be seen on the occasion of Mrs Mavis Pickup's death, when Shipman came to the house to examine Mrs Pickup's body and to certify the cause of death. Shipman's young son, who was then aged about 11 or 12, was with him, sitting outside in the car. While Shipman was waiting for the arrival of the funeral director, he went outside to bring his son in to see the body. The boy declined to come.

13.54 There are some circumstances from which I think it is reasonable to infer that Shipman either enjoyed killing or felt compelled to go in search of a victim. On 15th April 1984, a Sunday, he was on out of hours duty. In the afternoon, he was called out to see a patient (who died later that day). He dealt with her and was then free to return home. Whereas most doctors would be only too pleased to return home and resume their leisure activities, Shipman preferred to make an unsolicited visit to Mr Joseph Bardsley and,

under the pretext that he needed to take a blood sample, injected Mr Bardsley and killed him.

13.55 The case of Mrs Leah Fogg, who died on Monday, 10th June 1996, shows Shipman's urge to kill as soon as he became aware of an available victim. On Friday, 7th June 1996, Mrs Fogg's daughter, Mrs Marjorie Stafford, visited Shipman because she was concerned that her mother was depressed and not coping with the loss of her husband some years before. Mrs Stafford had noticed a sign in Shipman's waiting room that said that counselling services were available at the surgery. Mrs Stafford hoped that Shipman would arrange for her mother to receive bereavement counselling. However, she was concerned that her mother should not know that she had been to see Shipman, as it was ' behind her back'. Shipman promised to call on Mrs Fogg and said that he would do so unannounced. He did so three days after their talk, and killed Mrs Fogg. It would have been far less risky to wait a few weeks before killing her.

13.56 Usually, when Shipman had killed, he did not linger at the scene. This may have been because he was very busy and was due back at the surgery. However, I have the impression that after a death, when the relatives had assembled, he would enjoy acting as ' master of ceremonies'. He would be the centre of attention and would take control. He would present himself as omniscient. He would give instructions about the removal of the body. He would give his explanation for the death, often saying that, although it might have been a surprise to the relatives, it had been no surprise to him. He might add remarks such as ' she was riddled with cancer', as he said of Miss Lena Slater. Relatives would often be grateful to him and pleased that he had been present at the death.

13.57 The evidence that Shipman was fascinated by death is slight but not negligible. There is no evidence from which I could directly infer that he had a fear of death or a need to control it. There is some evidence that he is an addictive personality and it is possible that killing was a form of addiction. I do not think he can have had any concept of the value or sanctity of human life. I regret to say that I can shed very little light on why Shipman killed his patients. I do, however, think that it is possible to gain some insight into his thinking from an examination of which patients he chose to kill.

The Selection of Patients

13.58 Statistically, it is clear that Shipman killed mainly elderly women living alone. He also killed some men and they too were usually elderly and living alone. In general, he killed people who were in poor health. Some of the earliest killings were of patients who were terminally ill or very unwell. Many of his victims were frail and in poor general health. I have already referred to what Shipman said about the elderly to the family of Mrs Mary Coutts after her death, namely, that he did not believe in ' keeping them going'. Mrs Kathlyn Kaye, the daughter of Mrs Annie Powers, told the Inquiry that Shipman told her elderly parents that, if they were animals, he would have them put down. He may have regarded this as a joke but Mr and Mrs Powers did not. Nor did Mrs Kaye, when Shipman repeated the remark to her. I think this remark reveals something of Shipman's attitude to elderly people.

13.59 Shipman seemed to think that he knew when a patient ought to die. He quite often said that it was ' for the best' that the patient should have died when he or she did. It was better that ' she should not suffer'. The patient would not have wanted to ' live in a wheelchair', or ' be a vegetable', or have to stay in hospital ' with wires coming out of her', or ' be a burden to her family'. Of course, some people make this kind of remark following a death in the belief that they are comforting the bereaved. In Shipman's case, when he had just killed a patient, it may be that he persuaded himself that what he had done was in some way justifiable. The fact that most of the early killings were of people who were either close to death or very ill lends support to that view.

13.60 I think there was probably another reason why most of Shipman's early victims were terminally ill or in very poor health. For a doctor to give an overdose of opiate to a patient whose death is expected would give rise to very little risk of suspicion or detection. I think Shipman's earliest victims were those whose deaths presented the least danger of discovery. The killings of such people might also have seemed to him to be the least morally culpable. He might have persuaded himself that he was doing his patients and their relatives a favour. The psychiatrists say that these apparently logical explanations for the early killings are not inconsistent with the theory that Shipman killed in response to a need within himself. It seems to me likely that Shipman killed primarily in response to his own needs or wishes but, initially at least, selected victims whose deaths would not greatly threaten his own security and could perhaps be justified to himself in some way.

13.61 Shipman continued to kill terminally ill patients over the years and also killed patients who were suffering from acute life-threatening conditions. If Shipman was called to a patient who was having a stroke or a heart attack, he would be more likely to give a lethal injection so as to ensure that the patient died there and then, rather than attempt to treat the condition and give the patient a chance of life. The killings of Mrs Sarah Williamson and Mrs Laura Linn are examples of this. These deaths would be easily explained and would give rise to a very low risk of detection. Shipman might even have justified such killings to himself on the basis that the patients' quality of life after the acute event would be poor.

13.62 Shipman might also have felt justified in killing those patients who told him that they ' felt unable to go on', implying that they were ready to die. Whether such sentiments were the product of a settled wish to die or of a passing episode of unhappiness is not for me to consider. The law is clear. A doctor is not permitted to end life in response to a request and Shipman well knew that.

13.63 Shipman seems to have been particularly willing to kill the bereaved. Mr Harold Eddleston was killed only a few days after his wife died and Mrs Mavis Pickup lived for less than four weeks after her husband's death. I have already referred to the case of Mrs Leah Fogg, which illustrates the same point.

13.64 Shipman often killed patients who had a chronic condition which required a great deal of medical attention. For example, Mrs Alice Gorton, whom he killed in 1979, had terrible psoriasis. Shipman visited her very frequently to give her the supplies of the ointments and dressings she required. Mr Joseph Wilcockson, who was killed on 6th November

1989, had a painful ulcer on his leg, which was probably never going to heal. The district nurse attended regularly to dress it. Mrs Beatrice Toft had severe lung disease and used an oxygen cylinder. She had been into hospital on a number of occasions in the past and would plainly have needed a great deal of care had she lived out the terminal stage of her illness. None of these patients was close to death, however, and the suddenness of their deaths might have aroused suspicion. I suspect that Shipman selected patients such as these, who were or were about to be very demanding of his time and the resources of the practice. That he was concerned about resources is apparent from a remark he made about Mrs Edith Calverley, who had severe respiratory problems and was taking several different types of medication. After her death, Shipman remarked to the district nurse, ' That's one off my drugs bill'.

13.65 There are some patients whom I think Shipman regarded as a nuisance. Most of Shipman's younger victims had chronic conditions, often associated with psychiatric problems. Mrs Bianka Pomfret was only 49 when she was killed. She had a long history of psychiatric illness. Mr Ronnie Devenport was only 57. He was a very demanding patient and was probably a hypochondriac. Miss Joan Harding and Mrs Ivy Lomas, both of whom were killed in the surgery, suffered from anxiety and depression and consulted Shipman regularly. After Shipman had killed Mrs Lomas, he ' joked' to Police Sergeant (then Police Constable) Phillip Reade that Mrs Lomas had been such a nuisance that he had considered having a seat in his waiting area set aside for her, and having a plaque mounted which said ' Seat permanently reserved for Ivy Lomas'.

13.66 Shipman seems also to have chosen to kill patients who annoyed him for some reason. Mr Joseph Bardsley had refused to have the injections Shipman had prescribed for his pernicious anaemia. Shipman seems to have been particularly vindictive against patients who would not accept his advice about a move into residential care. Mr John Greenhalgh agreed to such a move and then changed his mind. He was dead within a few days. Mrs Lily Taylor was in good health and looked after her husband, who had Alzheimer's disease. She resisted Shipman's pressure to put her husband in residential care. In July 1997, Shipman killed Mrs Taylor and Mr Taylor then had to go into residential care. On this theme, I have found several further examples of Shipman killing the fitter partner of a couple, with the result that the surviving partner would have to go into residential care. For example, Mrs Doris Earls was a very fit 79 year old and looked after her husband, who had Alzheimer's disease. Shipman killed her and her husband had to move into a residential home.

13.67 I stress that, in drawing attention to the circumstances in which Shipman appears to have selected patients to kill, I am not suggesting that these considerations provide a motive for killing. They do not explain why he killed those particular patients, only why he selected some victims rather than others.

The Interludes When Shipman Did Not Kill

13.68 Shipman's killings gradually increased in frequency. However, that trend was interrupted from time to time. The evidence suggests that these interruptions were dictated by his fear of detection and his desire for self-preservation.

13.69 In the early days, I believe that Shipman did not kill very frequently. I have found only one patient whom he killed in Todmorden. She was Mrs Eva Lyons, who had terminal cancer. There are others about whom I am suspicious. After Shipman moved to Hyde, he killed his first victim in August 1978 and had then killed six others by the end of November 1979. After he had killed Mrs Alice Gorton in August 1979 and Mr Jack Leslie Shelmerdine in November 1979, I have concluded that he killed his next victim in April 1981. I think this interval probably occurred because Shipman had a scare. First, he failed to kill Mrs Gorton as efficiently as he had intended. He thought she was dead and was telling her daughter that it would not be necessary to have a post-mortem examination when Mrs Gorton groaned: she was still alive. She lay unconscious for about 24 hours before dying. Shipman must have been afraid that she might recover and recount what had occurred. Second, I think Shipman was probably very anxious indeed in the aftermath of the killing of Mr Shelmerdine, whose son made a complaint, which was not about Shipman, but was about the failure of the Geriatric Department of Tameside General Hospital to send out a doctor on a domiciliary visit. Shipman might well have feared that Mr Shelmerdine's death would be investigated and that there would be a post-mortem examination. In the event, there was not.

13.70 I have made only two findings of unlawful killing in 1981 and none at all in 1982. The first killing after this second interval was of Mr Percy Ward in January 1983. Mr Ward had terminal cancer and would have been a ' low risk' death. The only other patient whom I have found that Shipman killed that year was Miss Moira Fox. From 1984, Shipman killed more frequently and without any long intervals until the death of Mr Joseph Wilcockson in November 1989. Here, again, it appears that Shipman might well have been concerned that he had almost been detected. It appears that the district nurse who visited Mr Wilcockson must have arrived very shortly after Shipman left Mr Wilcockson's flat, having killed him. Following that death, there was another quite long interval. Shipman did not kill for ten months. His next victim was Mrs Dorothy Rowarth, who died in September 1990. She had terminal cancer and was another ' low risk' death. In December 1990, Shipman killed Mrs Mary Dudley. She was not in poor health, although she had recently been bereaved.

13.71 I have found that Shipman next killed after he had moved to his new premises at Market Street. Shipman gave various excuses and explanations for his decision to leave Donneybrook. He claimed that he disagreed with his partners about computerisation of records and about fundholding. I think it unlikely that either of those excuses was the true reason for his wish to be a sole practitioner. It may well be that he thought he would prefer single-handed practice for a variety of reasons, but I think that a major factor must have been a wish to be free of the constraints unwittingly imposed by the Donneybrook doctors. It is not unreasonable to postulate that he had become alarmed that one or more of the doctors or staff might be suspicious of him. In fact, they say that they had no suspicions but that does not mean that Shipman did not fear that they had.

13.72 Once established at Market Street, Shipman resumed killing within weeks and was soon killing more frequently. There were no more long interludes. There were occasional short periods when he did not kill for a few months. One such occurred between February and May 1994. On 18th February 1994, Shipman gave Mrs Renate Overton an overdose

of opiate, almost certainly diamorphine. He intended to kill her but the ambulance arrived before she died and the paramedics resuscitated her and took her to hospital. She was deeply unconscious and had suffered irreversible brain damage. She lived, in a persistent vegetative state, for 14 months. I explained in Chapter Twelve why Shipman must have been very anxious following that episode. Shipman did not kill for three months after 18th February. When he killed again, his victim had cancer, although she had not yet reached the terminal phase. He told his victim, Mrs Mary Smith, that he was arranging for her to go into a hospice for terminal care. In this way he created the impression that her death was imminent.

13.73 I think these interludes suggest that Shipman was able to restrain himself from killing. If he was addicted to killing, it does not seem to me that his addiction was so great that it could not be controlled if the need were great enough. However, the psychiatrists warn that there may be other explanations for these temporary halts, possibly associated with Shipman's mental health. I heed that warning, but it seems to me that the temporal associations I have described provide compelling evidence of cause and effect. I think it likely that Shipman stopped killing from time to time because he feared that he might be under suspicion. When he resumed killing, he did so gradually, sometimes beginning with a terminally ill patient. It was as if he were entering the pool at the shallow end to see if he could still swim.

13.74 After 1994, Shipman's rate of killing gradually increased until it reached its highest levels in 1997 and early 1998. I do not know whether this increase was related only to the ease with which he was able to acquire diamorphine during this period. However, I think the pace is also consistent with the hypothesis that he had become addicted to killing and needed to kill more frequently. It seems that during this period he was less worried by narrow escapes. He became more confident and self-assured, always able to talk himself out of a difficult situation. During this period, Shipman killed male and female, the healthy and the sick, the elderly and the not so elderly. Mrs Lily Higgins and Mrs Enid Otter enjoyed excellent health. Mrs Maureen Jackson and Mr Harold Eddleston had cancer. At the time of their deaths, Mrs Bianka Pomfret was 49 years of age, Miss Maureen Ward was 57 and Mrs Jean Lilley was 58. Mrs Margaret Waldron was 65 and lively and active. Mr Charles Killan was 90 and Mrs Martha Marley was 88. Opportunity seems to have been all that was required. It may be that, during these later years, Shipman was virtually out of control. It is typical of addictive behaviour that the subject needs more and more opportunities to feed the addiction. He does seem, however, to have exercised some control after the end of March 1998.

Shipman's Downfall

13.75 I have described in Chapters One and Twelve how, in March 1998, Dr Linda Reynolds became concerned about the number of cremation certificates Shipman was asking her and her colleagues to sign. She reported her concerns to the South Manchester Coroner. He instigated a police investigation, which concluded that there need be no concern about Shipman's practice. Soon afterwards, it is likely that Shipman learned that he was under suspicion or investigation. I think he knew that concerns had been expressed about the number of his patients who had died. He probably realised that the

doctors of the Brooke Practice were the source of the concerns. After killing Mrs Martha Marley on 24th March, he stopped killing for several weeks. He killed again on 11th May and 12th June. By 12th June, he had begun the arrangements for forging Mrs Grundy's will. On 9th June, he had obtained sample signatures from Mrs Grundy and two potential ' witnesses'.

13.76 Shipman's forgery of Mrs Grundy's will was hopelessly incompetent and the arrangements he made for its delivery were bound to excite suspicion. The psychiatrists find it hard to believe that Shipman really thought he could get away with forging the will and killing the testator. I agree. If he did, he had lost touch with reality. It is possible that he had begun to think he was untouchable. He had got away with so many killings and was still idolised by many of his patients. By June, it must have appeared to him that any suspicions entertained in March had been allayed.

13.77 The psychiatrists say that it is not uncommon for serial killers to be detected because they draw attention to themselves in an obvious way. They believe that this occurs because the pressure on the killer becomes too great and he or she has to find some way of bringing his or her crimes to a halt or of relieving his or her guilt. This is probably not a conscious process but is more likely to be subconscious. The psychiatrists say that the fact that Shipman did not confess after drawing attention to himself is not inconsistent with the theory that he had a subconscious desire to be stopped from killing. Other serial killers have behaved in this way.

13.78 The psychiatrists suggest that Shipman might have had mixed subconscious motivations in forging the will before killing Mrs Grundy. He might have felt an overwhelming need to stop killing. He might have been, as it were, ' throwing himself to the gods'. Either his plan would succeed and he would leave Hyde and run away with the money, or he would be caught. Either way, the killing would be stopped. However, the psychiatrists stress that this is only one of several possible theories that might explain Shipman's actions at this stage. So little is known of his psyche that they cannot even postulate what other thought processes or motivations might have been at work.

13.79 It seems to me that, in forging Mrs Grundy's will and killing her, Shipman must have been raising a flag to draw attention to what he had been doing. I think it likely that the conflict between whatever drove him to kill and his fear of detection, which I think was revived in early April 1998, must have driven him to the edge of breakdown. I think perhaps that, when he knew he was being talked about around that time, he might have tried to stop himself from killing. He failed, and killed Mrs Winifred Mellor on 11th May. No longer in touch with reality, I think he might then have devised a fantasy plan, by which he could obtain Mrs Grundy's money, run away and stop being a doctor. The killings would cease. This plan, rationally considered, was bound to fail, but it would offer him a fantasy future and a way to stop himself from killing. Whether he needed to end the killings only because he feared detection or whether there were other psychological needs, I do not know. But I think that the intolerable tension between his drive to kill and his need to stop lay at the root of this fantasy. That is the best explanation I can offer for the final event.

After Mrs Grundy's death

13.80 That Shipman did not kill again after 24th June must, I think, show that he still hoped and believed that his plan would succeed. He wrote to Hamilton Ward to tell them that Mrs Grundy had died and to remind them that they had her will. He suggested that they should contact Mrs Woodruff. He could not take matters forward. It is remarkable that in this situation, which most people would find intolerable, he continued to operate as a doctor in his usual way. It may be of significance that, on 6th July, he obtained a modest quantity (100mg) of diamorphine. This would tend to suggest that he was at least contemplating the possibility of killing again. When Mrs Claire Hutchinson came to see him to tell him that Mrs Woodruff had been to enquire whether she had witnessed Mrs Grundy's will, he said that he was very sorry that she had been bothered at home and that he would never again ask anybody to witness anything in the surgery. In late July, he had the confidence to tell Dr Banks that he and his staff had carried out an audit of the patient deaths which had occurred in the first three months of the year and he was satisfied that there was no cause for concern. Even when the news of the police investigation broke on 18th August 1998, and the media were full of the story, Shipman continued to work normally at the surgery. He dealt with the journalists. He received many expressions of support from patients who were not prepared to entertain the possibility that the allegations might be true.

13.81 When the arrest came, Shipman retained his composure. In interview, he was, for the most part, confident and asserted his supposed superiority. At times, he treated the police with contempt. I notice that he never expressed any sense of regret or sympathy for the relatives of his victims. He gave clear and apparently rational answers to the police questions. I say ' apparently rational' because his explanation for the finding of morphine in Mrs Grundy's body was not really rational. He told the police that she must have taken heroin and claimed that he had for some time suspected her of being a drug addict. Knowing what he knew of Mrs Grundy's character and background, this must have been an answer given in desperation. He did not offer any explanation for the finding of morphine in the bodies of Mrs Winifred Mellor and Mrs Marie Quinn. Shipman continued to deal with the questions until the interviews of 5th October reached the stage at which the police made it clear that examination of the surgery computer had revealed clear evidence that he had made backdated entries in the medical records of Mrs Mellor, that were plainly designed to provide a plausible explanation for her death. At that stage, he was clearly at breaking point. The interview was stopped at the request of his solicitor and was not resumed for over a month. When the interviews were resumed, he answered ' no comment' to every question. He remained in control of himself and, to some extent, of the situation.

13.82 At the trial, Shipman played a full and active part. He made copious notes and frequently gave instructions to his counsel. He gave detailed evidence. He never lost control of himself. His defence was that he had not killed any of the 15 patients; their deaths had been natural. At the trial he had an explanation for much of what was alleged but could not explain the presence of morphine in the bodies. With the exception of Mrs Grundy, he never sought to do so. He advanced explanations for the backdating of entries on the computer records, but they were clearly implausible. The

evidence of guilt was overwhelming. Yet he did not confess, and he maintains to this day that all he had ever done was to give appropriate treatment to his patients. It may be that he has convinced himself that he is innocent. The psychiatrists say that such a degree of self-deception, which involves compartmentalisation of ideas and dissociation of thought processes, is not uncommon following the commission of very serious crimes. It is a mental mechanism by which the criminal defends himself from the overwhelming anxiety which facing reality would cause.

13.83 I cannot say whether Shipman has genuinely convinced himself of his innocence. If he has, he is plainly out of touch with reality. It may be that he knows what he has done and that it was wrong but chooses, possibly as a form of self-protection, to maintain a complete denial. I doubt that we will ever know.

CHAPTER FOURTEEN

Conclusions

The Numbers

14.1 In Phase One of the Inquiry, I set the Inquiry team the task of uncovering all Shipman's unlawful killings. As there was uncertainty about whether he had killed a large number of patients, I decided that the only way the task could be achieved was to consider the evidence available in relation to every patient of Shipman who died while he was in practice. Shipman's guilt in 15 cases was determined by the jury. In all, the Inquiry considered 887 deaths. In 394 cases, there was compelling evidence that the patient had died a natural death. Those cases were closed without further investigation. The Inquiry legal team has investigated the circumstances of the remaining 493 deaths and I have written a decision in each. I have also written a decision in relation to one incident in which Shipman acted unlawfully but which did not result in the patient's death.

14.2 I have found that Shipman committed serious criminal offences throughout his professional career. From 1974, he regularly obtained controlled drugs by illicit means. In August 1974, he unlawfully administered an opiate, probably pethidine, to Mrs Elaine Oswald, causing her to suffer respiratory arrest and putting her life at risk. He first killed a patient, Mrs Eva Lyons, in March 1975. She was suffering from cancer and was terminally ill. Shipman gave her a lethal overdose and hastened her death. In the 24 years during which Shipman worked as a doctor, I have found that, in addition to the 15 patients of whose murder he was convicted, he killed 200 patients. In a further 45 cases, there is real cause to suspect that Shipman might have killed the patient. In 38 cases, I have been unable to reach a conclusion of any kind due to the insufficiency of evidence. These deaths occurred mainly in the early years of Shipman's career, for which there are few written records. I regret that the families of these patients will be left in a state of uncertainty. Shipman's last victim was Mrs Kathleen Grundy, who died on 24th June 1998. In 210 of the cases in which I have written a decision, I have found that the death was certainly or probably natural.

The Typical Shipman Killing

14.3 The following picture of a typical Shipman murder emerged. Shipman would visit an elderly patient, usually one who lived alone. Sometimes, the visit would be at the patient's request, on account of an ailment of some kind; sometimes, Shipman would make a routine visit, for example to take a blood sample or to provide repeat prescriptions; sometimes he would make an unsolicited call. During the visit, Shipman would kill the patient. Afterwards, he behaved in a variety of ways and had a variety of typical explanations for what had happened. Sometimes, he would claim that he had found the patient dead when he arrived. If asked how he had gained entrance, he would say that the patient had been expecting him and had left the door ' on the latch'. Sometimes, he would stay at the premises and telephone relatives or call upon neighbours and reveal the death to them. He might say that he had found the patient close to death or he would sometimes claim that the patient had died quite suddenly in

his presence. Sometimes, he would leave the premises after killing the patient, closing (and thereby locking) the door behind him. Either then or later, he would go in search of a neighbour who held a key, or to the warden if the patient lived in sheltered accommodation, and together they would go to the premises and ' discover' the body. On other occasions, he would leave the body unattended and would wait for a relative or friend to discover the death.

14.4 Shipman's usual method of killing was by intravenous injection of a lethal dose of strong opiate. Sometimes, mainly if the patient was ill in bed, he killed by giving an intramuscular injection of a similar drug. I suspect that, on occasions, he also gave overdoses of other drugs, such as Largactil, with the intention of putting a patient into a deep sleep from which he or she would be unlikely to awake. There is no reliable evidence that he killed other than by the administration of a drug.

14.5 In addition to these serious offences against the person, Shipman must have committed drugs offences virtually every day he was in general practice, in that he was almost always in possession of controlled drugs without lawful authority. He obtained large quantities of pethidine and diamorphine by illegal, dishonest means, using deception and forgery.

The Report of Professor Richard Baker: Compatibility of Results

14.6 Professor Richard Baker's review of Shipman's clinical practice was published in January 2001, shortly before the Inquiry was set up. When my own decisions were complete, I invited Professor Baker to analyse and relate them to his findings. His analysis is at Appendix A of this Report.

14.7 In his review, Professor Baker considered the 521 deaths of which, according to his researches, Shipman had certified the cause. He compared the death rates among Shipman's patients with those of the patients of other comparable general practitioners. His best estimate was that an excess of 236 deaths was ' most likely to reflect the true number of deaths about which there should be concern'. Within a 95 per cent confidence interval, he estimated that the excess deaths (which represented the number of patients Shipman had probably killed) lay between 198 and 277 patients. Including the closed cases, the Inquiry has considered a larger number of deaths than did Professor Baker, as we have considered many deaths of Shipman's patients which were not certified by him. Nonetheless, my own decisions have produced results quite remarkably similar to his. My conclusion that Shipman killed 215 patients falls well within Professor Baker's confidence interval. I think it likely that at least some of the 45 deaths that I have designated as ' suspicious' were ones for which Shipman was responsible. If 50 per cent of the suspicious deaths were in fact killings, my conclusions would match Professor Baker's best estimate very closely indeed.

14.8 The similarity between our conclusions is particularly remarkable because the processes by which we reached them were completely different. Professor Baker compared Shipman's death rates with those of other general practitioners working in the same localities. I did not have regard to any statistical information, but considered only the material available in respect of the individual deaths. The overall similarity between

our conclusions gives rise to a high degree of confidence in their accuracy. It would seem to follow that a statistical comparison of the death rates of a general practitioner with those of other practitioners in a similar position could be used as a method of detecting a doctor who was killing his patients. Such a method would not, of course, detect an occasional killing.

14.9 Professor Baker has demonstrated a very close correlation between the deaths which I have found were unlawful killings and those which he designated as highly suspicious after considering the cremation Forms B, where available. There was also a good correlation between the deaths that I found were natural and those which he regarded as not suspicious. That would suggest that the kind of information which is presently contained in cremation Form B should be provided under any new form of death certification. Scrutiny of such material would be useful when unexplained deaths are investigated and might well be of value if a system were to be instituted for the random monitoring of the certification of individual deaths.

14.10 Similarly, Professor Baker has found a close correlation between those deaths for which I have found Shipman responsible and those which he himself regarded as suspicious after considering the clinical records. There is also quite a good correlation between those cases which I am satisfied were natural deaths and those which Professor Baker considered were not suspicious, on the basis of the clinical records. This would suggest that the examination of clinical records would be useful in the investigation of unexplained deaths.

Deaths in Nursing and Residential Homes

14.11 For the 24 year period under review, the Inquiry has investigated 124 deaths in nursing and residential homes. I have found that only three of those patients were unlawfully killed by Shipman. They were Mrs Dorothy Fletcher who died in Charnley House on 23rd April 1986, Mr Clifford Heapey who died in Hyde Nursing Home on 2nd June 1995, and Mrs Eileen Crompton who died in Charnley House on 2nd January 1997. There is some suspicion surrounding the deaths of a further eight patients. All of Shipman's other victims were given a lethal injection in their own home or in Shipman's surgery. I infer from those figures that patients living in nursing and residential homes were to a very large extent protected from Shipman by the presence of staff.

14.12 In his review, Professor Baker found that, over the 24 year period, Shipman had 61 more patient deaths in institutions than did comparable doctors working in the same areas. Because he found little cause for suspicion in the cremation documents or medical records relating to the deaths, Professor Baker did not think that the excess was due to Shipman killing his patients. He could not identify the reason for it. I am confident that the reason for this excess cannot be that Shipman was killing his patients. Although I do not rule out the possibility that I might have been given untruthful evidence in a few cases, I am quite sure that I have not been misled into believing that a large number of deaths in institutions were natural, when they were in fact killings. The Inquiry has obtained evidence from many members of staff who worked in nursing and residential homes in Hyde. If Shipman had regularly killed patients in these homes, I am sure that

the staff would have been aware of it and would have expressed their concerns to the Inquiry.

14.13 Other evidence has emerged during the Inquiry which, at least to some extent, explains the excess. It occurred mainly during the years 1978 to 1984 and 1993 to 1998. The excess during the first period is easily explained. It appears that Shipman almost certainly had more patients in institutions than the doctors with whom he has been compared. He was new to Hyde in 1977 and was building up his practice list. The evidence shows that he was popular with the residents of Charnley House and was well respected by its owner. All new residents who were not already on the list of a general practitioner in the area were registered on Shipman's list. During this period, he had a large number of Charnley House patients and it is, therefore, reasonable to assume that he would have had a large number of deaths. Shipman stopped accepting all new residents of Charnley House onto his patient list in the late 1980s and the number of his patients living there must have gradually declined. That would account for the fact that there were no or very few excess deaths between 1985 and 1992. Examination of the Charnley House admissions register shows that Shipman's patients lived approximately the same length of time after admission as the patients of other doctors. There is, therefore, no reason to suspect that he was killing his Charnley House patients during this period.

14.14 The excess in the second period 1993 to 1998 is not so obviously explained, although it appears that Shipman might well have had more patients in institutions than did the other comparable general practitioners. At least two explanations occur to me. One is that, for financial reasons, Shipman might have been anxious to increase his patient list after leaving the Donneybrook practice. Another, more sinister, explanation is that he might have been particularly willing to accept patients in nursing and residential homes onto his register in order to ensure that his percentage of elderly patients remained within the normal parameters.

Systems Failures and Tasks for Phase Two

14.15 It is deeply disturbing that Shipman's killing of his patients did not arouse suspicion for so many years. The systems which should have safeguarded his patients against his misconduct, or at least detected misconduct when it occurred, failed to operate satisfactorily. The esteem in which Shipman was held ensured that very few relatives felt any real sense of disquiet about the circumstances of the victims' deaths. Those who did harbour private suspicions felt unable to report their concerns. It was not until March 1998 that any fellow professional felt sufficiently concerned to make a report to the coroner. Unfortunately, Dr Linda Reynolds' report of 24th March 1998 came to nought. Had it not been for Shipman's grossly incompetent forgery of Mrs Grundy's will, it is by no means clear that his crimes would ever have been detected.

14.16 All but three of the deaths for which I have found that Shipman was responsible were entered in the register of deaths in reliance on MCCDs completed by Shipman. The majority of those deaths were followed by cremation. Before a cremation can be authorised, a second doctor must confirm the cause of death and the cremation

documentation must be checked by a third doctor employed at the crematorium. These procedures are intended to provide a safeguard for the public against concealment of homicide. Yet, even with these procedures in place, Shipman was able to kill 215 people without detection. It is clear that the procedures provided no safeguard at all. In Phase Two, the Inquiry will consider why the procedures failed and what should be done to devise a system which will afford the public a proper degree of protection.

14.17 Shipman's patients frequently died suddenly at home, without any previous history of terminal or life-threatening illness. Such deaths should be reported to the coroner. Yet, when he had killed a patient, Shipman managed to avoid a referral to the coroner in all but a very few cases. He did this by claiming to be able to diagnose the cause of death and to be able to certify its cause. He persuaded relatives that there was no need for a post-mortem examination. There was in place no system which detected that Shipman was not reporting to the coroner deaths which ought to have been reported. In Phase Two, the Inquiry will consider how to ensure that unexpected or unexplained deaths are reported and their causes properly investigated.

14.18 After Shipman's convictions for drugs offences in 1976, he declared his intention never to carry controlled drugs again. Accordingly, he was not obliged to keep a controlled drugs register. Yet he was able, by a number of different methods, to obtain and stockpile large quantities of controlled drugs. Despite the fact that the possession and supply of such drugs are said to be ' controlled', the controls clearly failed to work. In Phase Two, the Inquiry will consider why that was so and what measures should be taken to strengthen and improve the systems of control.

14.19 Professor Baker has observed that an effective system of monitoring the death rates of general practitioners would have detected the excess number of deaths among Shipman's patients. No such system was in place during Shipman's years in general practice. In Phase Two, the Inquiry will seek to identify effective systems for monitoring death rates, will consider other possible improvements to the arrangements for the monitoring of general practitioners and will examine ways of encouraging those genuinely concerned about possible misconduct by doctors to express their concerns to those in a position properly to investigate and evaluate them.

14.20 By the end of the Inquiry, I hope to be able to make recommendations which will seek not only to ensure that a doctor like Shipman would never again be able to evade detection for so long, but also to provide systems which the public will understand and in which they will have well-founded confidence.

The Betrayal of Trust

14.21 Deeply shocking though it is, the bare statement that Shipman has killed over 200 patients does not fully reflect the enormity of his crimes. As a general practitioner, Shipman was trusted implicitly by his patients and their families. He betrayed their trust in a way and to an extent that I believe is unparalleled in history. We are all accustomed to hearing of violent deaths, both in the media and in fiction. In some ways, Shipman's ' non-violent' killing seems almost more incredible than the violent deaths of which we

hear. The way in which Shipman could kill, face the relatives and walk away unsuspected would be dismissed as fanciful if described in a work of fiction.

14.22 Although I have identified 215 victims of Shipman, the true number is far greater and cannot be counted. I include the thousands of relatives, friends and neighbours who have lost a loved one or a friend before his or her time, in circumstances which will leave their mark for ever. Although the responsibility for what happened was Shipman's, there are many who will never cease to regret that they had not done something differently: to wish that they had not encouraged their parents to register on Shipman's list or that, on the day of the death, they had done something which would have deprived Shipman of his opportunity to kill. Those people are not, of course, in any sense, responsible for what occurred (and, rationally, they know it), but it is human nature that some will harbour the thought that, if only they had acted differently, their loved one would still be alive today. There are also the hundreds of patients of Shipman who have been deeply disturbed by the realisation that Shipman was not the kind, caring and sympathetic man they took him for. They too must feel betrayed.

14.23 Shipman has also damaged the good name of the medical profession and has caused many patients to doubt whether they can trust their own family doctor. This trust forms the basis of the relationship between doctor and patient. Although I believe that the overwhelming majority of patients will, on reflection, realise that they can indeed trust their doctor as they always have done, there will be some who will remain uncertain.

14.24 I would like to express my deepest sympathy and that of the Inquiry team to all those who have been bereaved or distressed by Shipman's actions. The process of the Inquiry has been welcomed by some but not by all. For many, this Report will provide the answers they have expected or feared; for many others, it will provide reassurance. I regret that there are some who must remain in uncertainty. I wish to express my gratitude to all the witnesses who have assisted the Inquiry by providing statements and giving evidence. For some, I believe the experience has been cathartic and beneficial. For many, it was deeply distressing. I am grateful to them all.

APPENDIX A

The Relationship between the Findings of the Review of Shipman's Clinical Practice and the Inquiry's Determinations

Richard Baker

Clinical Governance Research and Development Unit
Department of General Practice and Primary Health Care
University of Leicester
17 June 2002

Introduction

In this Appendix, the findings with regard to excess numbers of deaths and deaths giving cause for concern reported in the review of Shipman's clinical practice[1] published in January 2001 are compared with the determinations of the Inquiry. The purpose is to identify any general discrepancies between the two investigations and, if discrepancies are identified, to attempt to explain them. It is important to note that this Appendix is primarily concerned with those cases for which Shipman issued the Medical Certificate of Cause of Death (MCCD). It does not deal with the large number of other deaths that have also been investigated by the Inquiry, these cases being considered in the main body of the Inquiry's Report.

The Appendix contains the following sections:

1 The findings of the review are outlined.

2 The numbers of determinations of cases in different categories are compared with the excess numbers of deaths estimated in the review.

3 The degree of agreement between the determinations of cases by the Inquiry and the levels of suspicion attached to cases in the review is assessed.

4 An analysis is presented of cases according to the determination category in order to identify the occurrence of features typical of the convictions in each category.

5 The excess of deaths among patients in residential or nursing homes is considered.

6 A summary is included of deaths in Todmorden.

7 A summary is included of findings about the frequency of different categories of case throughout Shipman's career as a general practitioner.

8 Summary and conclusions.

Section 1. The Review

In January 2000, following the trial, the Secretary of State for Health asked the Chief Medical Officer to commission a review of Shipman's clinical practice. The review considered several aspects of Shipman's clinical activities during his career as a general practitioner from 1974, but concentrated in particular on the patterns of deaths among his patients. The investigation of

deaths was undertaken to identify any excess in the numbers of deaths, the time and place of deaths, and the relationship between certified cause of death and clinical history. Three principal sources of information were used – surviving clinical records, surviving cremation certificates, and data obtained from the registration of deaths.

Clinical records

Prior to July 1994, the clinical records of deceased patients were retained by the National Health Service for a period of three years, although retention for ten years is now mandatory.[2] In addition, Shipman chose to store some records beyond the required period and, in consequence, 282 records of deceased patients were available for review. Fifteen of these records were those of the patients of whom Shipman had been convicted of murdering, and these were reviewed to identify features that could be classed as typical of the murders. These features were found to include:

- All were older females.
- Shipman was present at, or shortly before, the death of the patient.
- Death occurred suddenly at home and, in 14 of the 15 cases, in the afternoon.
- There was only a weak association between the clinical history and the cause of death as certified by Shipman.

Of the remaining 267 records, 87 involved deaths that had occurred in hospital and had been certified by hospital doctors, and 180 involved cases in which Shipman had himself issued the MCCD. To seek evidence of features typical of the convictions, a review was undertaken of the 180 records of those cases in which Shipman had issued the MCCD. Of these, it was possible to classify 179 according to the degree of suspicion about the true cause of death. One hundred and two (57.0%) were classified as highly suspicious, 39 (21.8%) as moderately suspicious, and 38 (21.2%) as not suspicious.

Cremation forms

Specific information must be provided in order to obtain consent to dispose of a body by cremation. In addition to information provided by the deceased's relative or executor, the doctor who attended the patient during the last illness must complete a form (Form B), and a second doctor must complete another form (Form C) to confirm that there is no need for further investigation of the cause of death. The information provided by the doctor who attended the patient in the final illness includes details of persons present at death, and the mode, duration and time of death. Cremation forms are retained for 15 years and, therefore, most forms completed by Shipman from 1985 onwards were traced.

In my review, information provided by Shipman on cremation forms was compared with the information provided by a sample of six local general practitioners who were selected because they had cared for similar patients and had been in practice for approximately the same period as Shipman. A total of 767 cremation certificates were available for review, 292 having been completed by Shipman and 475 by the comparison general practitioners.

The key findings were that Shipman's patients were more likely to be reported as having died:

- In the afternoon (55% between 13.00 and 19.00 in comparison with 25% for the other general practitioners).
- With the general practitioner present (19.5% in the case of Shipman, 0.8% in the case of the comparison practitioners) or with no one present (40.4% vs 19.0%), and relatives or carers less likely to be present (40.1% vs 80.2%).
- In a short time – 60.4% of Shipman's patients were said by him to have died in 29 minutes or less, in comparison with 22.7% of the patients of the other general practitioners.

Death registrations

All deaths must be notified by an informant to the registrar of the district in which the death takes place. The informant provides background information about the deceased (date and place of birth, occupation, usual address) in addition to the information contained on the MCCD. The data recorded by registrars are collated by the Office of National Statistics, and are stored as part of the National Deaths Register. For the review, the Office of National Statistics provided information about the notifications of deaths it had received in which the MCCD had been completed by Shipman or one of the matched sample of six Hyde general practitioners for the period 1977–1998, or four comparison practitioners in Todmorden for 1973–1976.

The data were used to identify any differences between the observed numbers of deaths among Shipman's patients and the numbers expected if their rate of deaths had been the same as that of the patients of the comparison practitioners. The estimated excess of deaths 1974–1998 among patients dying at home or on practice premises was 236 (95% confidence interval 198 to 277). There were six deaths on practice premises.

The excess number of deaths among all patients for whom Shipman had issued an MCCD was also estimated. In this analysis, deaths at home, in the practice, and in residential and nursing homes were all included. Deaths occurring in hospitals were also included if the MCCD had been issued by the general practitioner. The comparison group in this analysis consisted of the equivalent patients of the matched local general practitioners. In this analysis, the excess was 297 (95% confidence interval 254 to 345).

A third and different analysis restricted to deaths from 1987 to 1998 was also undertaken. In this analysis, all deaths among Shipman's registered patients were included, irrespective of where the death occurred or who had completed the MCCDs. If Shipman had cared for a greater proportion of his seriously ill patients at home than other doctors, the total number of deaths among his patients would not have been excessive, even though he had issued more MCCDs himself. Therefore, an analysis that included all deaths was necessary.

The comparison groups chosen to estimate the numbers of deaths that would have been expected were those represented by the national death rate in England and Wales, by the rate in districts classified as manufacturing, and by the rate in the local health district of Tameside. Using this approach in an updated analysis, the excess in comparison with England and Wales was 197 (including an excess among females of 162), in comparison with other manufacturing

districts it was 176 (153 among females), and in comparison with Tameside it was 152 (141 among females). Note that these figures relate to only 12 of Shipman's 23 years in general practice.

In taking account of the findings of these three analyses, and the findings from examination of records and cremation forms, I concluded that the excess of 236 identified in the analysis limited to deaths certified by Shipman and occurring at home or in the practice only was ' most likely to reflect the true number of deaths about which there should be concern'.

Section 2. The Determinations

The review considered 521 deaths in which the MCCD was issued by Shipman. The Inquiry identified a small number of additional cases in which he had certified the cause of death, bringing the total of deaths in which Shipman had issued the certificate to 526. All the additional cases involved deaths occurring before 1988 and it is probable that the relevant certificates were overlooked during the hand search of the National Deaths Register. The Register has been held on a computer database from 1993, and searches of this database are almost certainly less subject to error than hand searches of the earlier paper records. The detailed and arduous process undertaken by the Inquiry to reach a judgement in each of these cases is described elsewhere.

In addition to these 526 cases, the Inquiry has considered a large number of other cases not included in the review. These are: (a) 42 cases certified either by the coroner or by a doctor other than Shipman and in which determinations have been made; (b) other cases that had been investigated by the coroner but were established by the Inquiry as not suspicious and were closed; and (c) many other cases that came to the Inquiry's attention through various routes, and which were also closed because there was compelling evidence that death was natural. These three groups of cases are not considered in this Appendix.

The determinations have been grouped by the Inquiry into the following categories:

A: Sure the patient was unlawfully killed (includes the 15 convictions);

B: Satisfied the patient was probably unlawfully killed;

C: A real suspicion of unlawful killing, falling short of probability;

D: Satisfied that death was probably natural;

E: Sure the death was natural;

Z: Insufficient evidence upon which to reach a conclusion;

Closed: Compelling evidence that the death was natural, precluding the need for further investigations.

The numbers determined to be unlawfully killed in comparison with the estimated excess

The numbers of cases in each category are shown in Table 1. Two hundred and twelve cases were classified as either A or B (the 15 convictions are included as A cases). The number classified as either A, B or C was 255.

Table 1: The numbers of determinations in different categories (all deaths)

Determination	N	%
A	165	31.4
B	47	8.9
A + B	212	40.3
C	43	8.2
A + B + C	255	48.5
Z	37	7.0
Closed	60	11.4
D	54	10.3
E	120	22.8
Total	526	100

In Table 2, the same data are presented, but in relation only to those deaths that occurred in the patient's home or on practice premises. The total number classified as A or B was 209 (a little more than 50% of all deaths), and the total for A, B and C was 244.

Table 2: The numbers of determinations in different categories (deaths at home or in the practice only)

Determination	N	%
A	164	40.7
B	45	11.2
A + B	209	51.9
C	35	8.7
A + B + C	244	60.6
Z	27	6.7
Closed	59	14.6
D	27	6.7
E	46	11.4
Total	403	100

Although both the review of Shipman's clinical practice and the Inquiry have investigated the deaths of his patients, they had different aims and used different methods. In comparison with the Inquiry's investigation, the review had very much less information available. This was restricted to the numbers of deaths, the information contained on death notifications held by the Office of National Statistics, and surviving cremation forms and clinical records. The conclusions of the statistical analyses undertaken depended on choice of comparison groups. Although the findings were similar when a matched group of local general practitioners and national and district mortality rates were used in different analyses, the estimates of the excess should not be regarded as completely exact.

In addition to the information used in the review, the Inquiry has been able to call on the evidence of the relatives and friends of the people who died, and health professionals who were involved in, or were able to provide expert opinions about, the care provided to the deceased. Furthermore, painstaking investigations, supported by the statutory powers of the Inquiry, have led to the discovery of large amounts of supplementary documentary evidence, including the counterfoils of the MCCDs issued by Shipman, practice visits books and appointments sheets, and other materials.

It should not be surprising, therefore, if the review's statistical analyses and assessments of a comparatively limited number of documents should produce a conclusion different to that arising from the Inquiry's exhaustive case by case investigation. In the event, however, the two

approaches lead to very similar conclusions. If only A and B cases are taken into account, Table 2 indicates a slightly lower Inquiry figure of 209 in comparison with the review's 236 (95% confidence interval 198 to 277) for the number of cases about which there should be concern. If A, B and C cases are included (in which there was at least ' a real suspicion of unlawful killing, falling short of probability'), the Inquiry's figure rises to 244 cases. It should also be noted that 27 cases were placed in the Z category by the Inquiry (' insufficient evidence upon which to reach a conclusion'). Thus, as far as excess numbers of deaths at home or in the practice are concerned, the findings of the review and the Inquiry are more or less the same.

In the review, the excess of deaths was 297 (95% confidence interval 254 to 345) when deaths in residential or nursing homes certified by Shipman had been included. This figure was regarded as unlikely to reflect the true number of deaths about which there should be concern. In the course of the review, only one death in an institution was classified as highly suspicious on the basis of information in the cremation form, and one on the basis of review of medical records. Ten deaths in institutions were classified following review of records as moderately suspicious, and six as moderately suspicious on review of cremation forms. Consequently, it was concluded that the excess of deaths among residents of residential or nursing homes was unlikely to have been due to unlawful killings. The Inquiry classified only three cases involving deaths in residential or nursing homes as either A or B, and a further eight as C, and the findings of the review are compatible with this conclusion. It should be noted that ten deaths in institutions were classified as Z. Almost all the excess of deaths in institutions cannot, therefore, be explained by unlawful killings, and alternative explanations are considered in Section 5 of this Appendix.

The fact that the review and the Inquiry have reached similar conclusions has two principal implications. First, it is possible to have confidence in the general conclusion that Shipman, during his working life, unlawfully killed in the region of 220–240 people. Second, a system for monitoring the mortality rates of people registered with individual general practitioners should have detected this excess. The methods used in the review to estimate the excess relied on the retrospective identification of deaths and the reconstruction of Shipman's practice register, but a specifically designed and prospective system would not have to overcome these difficulties. Therefore, plans to introduce a monitoring system should be encouraged.

Section 3. The Association between Determinations and Levels of Suspicion

The Inquiry has made a determination in each case it considered. In my review, cases in which some documentary evidence (clinical records or cremation forms) could be identified were classified as not, moderately or highly suspicious. Tables 3 and 4 show the relationship between the classification of cases by the Inquiry and in the review on the basis of cremation

forms and clinical records respectively. The convictions are excluded from these analyses since verdicts were reached before I undertook the review of cremation forms and records.

Table 3: Relationship between determinations and classification of cases from review of cremation forms (convictions excluded)

Level of suspicion	**Determinations**							**Total**
	A	B	C	D	E	Z	Closed	
none	2	5	8	17	44	8	30	114
moderate	16	7	6	1	10	1		41
high	108	17	3	1	1			130
Total	126	29	17	19	55	9	30	285

Table 4: Relationship between determinations and classification of cases from review of clinical records (convictions excluded)

Level of suspicion	**Determinations**							**Total**
	A	B	C	D	E	Z	Closed	
none	2		1	5	20	1	9	38
moderate	15	6	2	1	14	1		39
high	80	12	4	2	4			102
Total	97	18	7	8	38	2	9	179

Despite the different nature of the evidence available to the review and the Inquiry, the classification of cases is similar. In the comparison of level of suspicion assessed on the basis of cremation forms with the determinations of the Inquiry, 108 (85.7%) of the 126 in the A category had been classed as highly suspicious, and 16 (12.7%) as moderately suspicious. Forty-four (80.0%) of the 55 cases in the E category were classed as not suspicious, and ten (18.2%) as moderately suspicious. All 30 of the closed cases were classed as not suspicious. Of the 17 cases in category C, nine (52.9%) were classed as moderately or highly suspicious.

The relationship between level of suspicion based on clinical records and the Inquiry's determinations is similar. Of the 97 cases in category A, 80 (82.5%) had been classed as highly suspicious and 15 (15.3%) as moderately suspicious. Of the 38 cases in category E, 20 (52.6%) were classed as not suspicious and 14 (36.8%) as moderately suspicious. All of the nine closed cases were classed as not suspicious. Of the seven cases in category C, four (57.1%) were classed as highly suspicious.

In general, these findings indicate that the review and the Inquiry have reached similar conclusions. Some differences would be expected, since the Inquiry has been able to take account of much new evidence, but the degree of consistency should provide reassurance about the general conclusions of both the Inquiry and the review.

Section 4. Identification of Features Typical of the Convictions

Certain features could be identified as typical among the murders of which Shipman was convicted (sudden death at home, on weekday afternoons, of older females, with a weak association between clinical history and certified cause of death, and Shipman having been present at or having attended the patient shortly before death). These features would not necessarily all be present in a single case; for example, the deaths of some male patients have been categorised as A, as has one death in a residential home. In general, however, these features may be used to explore the likelihood of unlawful killing among groups of patients. Thus, if these features were to be found among a high proportion of cases categorised as D, E, Z or closed, the possibility should be considered that some deaths in these categories were in fact unlawful killings.

In the review, evidence of the presence of features typical of the convictions was obtained from clinical records and cremation forms, most of which had been completed by Shipman himself. The Inquiry has collected a large quantity of evidence from sources independent of Shipman, and, since these sources are more reliable, the data collected by the Inquiry have generally been employed in the analyses that follow. Five features are considered: time of death, gender of deceased, age of deceased, certified cause of death, and day of week of death. The convictions have again been included in category A.

Time of death

The time of death was one feature typical of the murders. In 451 cases, the Inquiry has established the time of death from independent sources (usually witness statements), and the findings related to each category of case are shown in Table 5. In 412 cases, the time of death could be identified with confidence as occurring in one of four six-hour periods (24.01– 6.00, 6.01–12.00, 12.01–18.00, 18.01–24.00). In 39 cases, the time of death could not be firmly established, and in these cases, the evidence was restricted to broad periods such as the night, during the day, the afternoon or evening, or some time in a two day period.

Of the cases in which the time of death could be identified to a particular six hour period, 152 were in category A, and of these 124 (81.6%) occurred in the 12.01–18.00 period. Comparison of the Inquiry's findings in the A category cases with the information obtained during the review from cremation forms completed by the other general practitioners indicates a marked difference. Of the 464 cases of the comparison practitioners, 105 (22.6%) occurred 24.01–6.00, 134 (28.9%) 6.01–12.00, 114 (24.6%) 12.01–18.00, and 111 (23.9%) 18.01–24.00.

The proportions of deaths occurring 12.01–18.00 for the other determination categories are shown in Table 5. The findings in relation to the closed and E cases are similar to those relating

to the other general practitioners. Caution should be used in drawing conclusions about cases in categories C, D and Z since the numbers in each category are relatively small.

Table 5: The time of day of death as concluded by the Inquiry, for each category of case determination (n=451; in 74 cases the likely time of death could not be established)

Time of day (hours)	**Determinations**							**Total**
	A	**B**	**C**	**D**	**E**	**Z**	**closed**	
1. Cases identified to one of four six-hour periods								
0-6		1	2	7	26	2	10	**48**
6.01-12 & morning	27	3	3	9	41	7	6	**96**
12.01-18 & afternoon	124	31	14	14	17	6	6	**212**
18.01-24 & evening	1	6	12	4	22	2	9	**56**
Subtotal	152	41	31	34	106	17	31	**412**
% in afternoon	81.6	75.6	45.2	41.2	16.0	35.3	19.4	
2. Cases for which the time of death could not be firmly established								
during the night				6	7		3	**16**
6.01-18.00	10	3			2	2		**17**
past 1-2 days	2		3					**5**
12.01-24.59		1						**1**
Total	**164**	**45**	**34**	**40**	**115**	**19**	**34**	**451**

Figure 1 displays the proportion of deaths occurring in the four six-hour quarters of the day for the 412 cases in which this could be confidently established, and the same information relating to the patients of the comparison general practitioners taken from cremation forms. The times of death of Shipman's patients are those established by the Inquiry, and are grouped into cases categorised as either A, B or C combined, or D and E combined, or Z cases. Those in the A, B or C group have a distinctly different distribution in comparison with patients of the other general practitioners. The D and E group is similar to the comparison general practitioners. The same data are shown in Figure 2 relating only to deaths occurring at home.

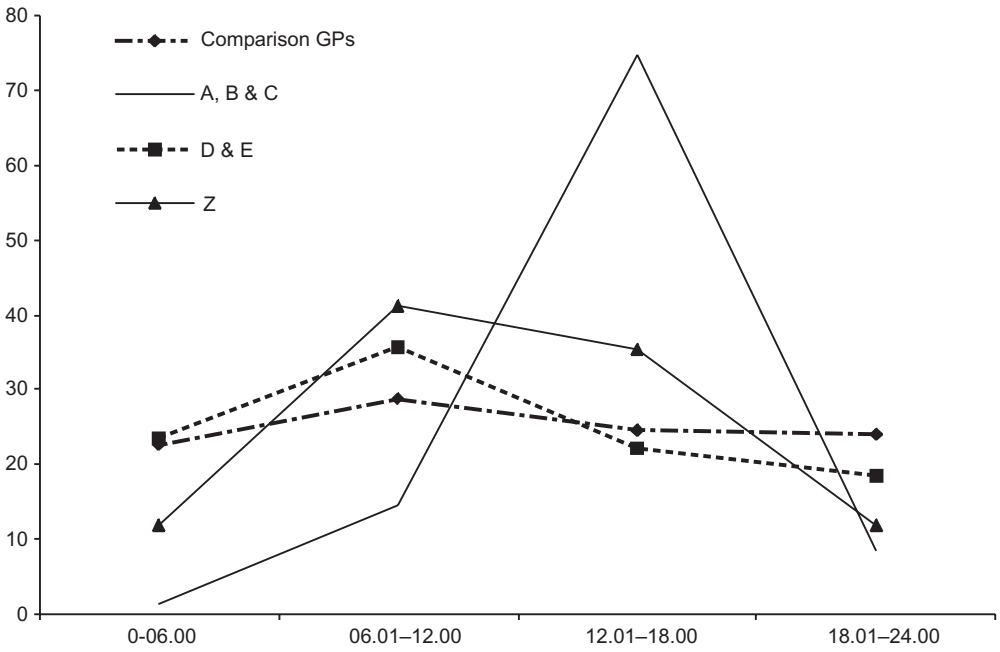

Figure 1: Percentage of deaths occurring at home or institutions in each six hour period of the day (0.0–06.00, 06.01–12.00, 12.01–18.00, 18.01–24.00), comparing deaths of patients of the comparison general practitioners (data taken from cremation forms) with category A, B or C, D and E, and Z cases (times established by the Inquiry). N=412.

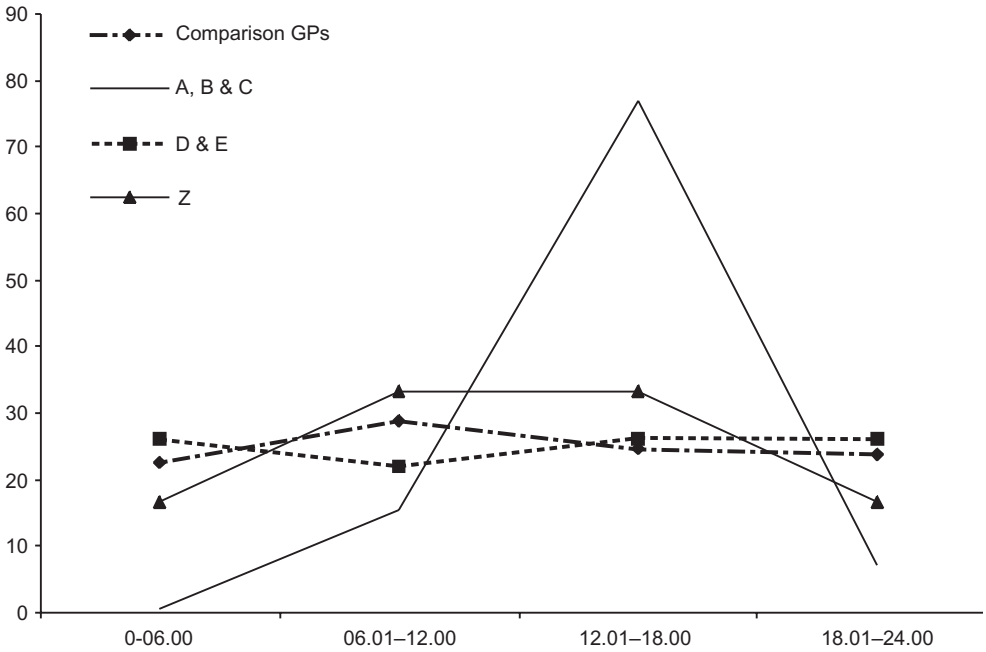

Figure 2: Percentage of deaths occurring at home only in each six hour period of the day (0.0–06.00, 06.01–12.00, 12.01–18.00, 18.01–24.00), comparing deaths of patients of the comparison general practitioners (data taken from cremation forms) with category A, B or C, D and E, and Z cases (times established by the Inquiry). N=307.

Gender and age

The review reported that, in comparison with the deaths certified by the other general practitioners, a greater proportion of deaths certified by Shipman were of females. Table 6 displays information about the gender of patients according to category of case. The proportion of cases that were female exceeded the proportion for the comparison practitioners for all categories other than the closed cases.

Table 6: Gender of patients according to determination categories. N=526. *from review, page 64

Determinations		Gender		Total
		male	female	
A	N	31	134	165
	%	18.8	81.2	
B	N	11	36	47
	%	23.4	76.6	
C	N	17	26	43
	%	39.5	60.5	
Z	N	17	20	37
	%	45.9	54.1	
D	N	16	38	54
	%	29.6	70.4	
E	N	36	84	120
	%	30.0	70.0	
Closed	N	30	30	60
	%	50.0	50.0	
Total	N	157	369	526
	%	29.8	70.2	
Comparison GPs, all deaths*	N	528	608	1136
	%	46.5	53.5	
Comparison GPs, deaths at home*	N	440	360	800
	%	55.0	45.0	

In general, a high proportion of people in nursing and residential homes are women, and, therefore, a difference between Shipman and the comparison practitioners in the numbers of deaths among females could be accounted for if a large number of Shipman's cases involved deaths in institutions. Therefore, in investigating gender, deaths that occurred at home were

also considered separately. Among deaths at home in the D category, the proportion that were female was higher than expected in comparison with the other general practitioners – of 27 D cases 11 (40.7%) were males and 16 (59.3%) females. Among E cases 25 (54.3%) were males, and 21 (45.7%) females, and among Z cases, there were 15 (55.6%) males and 12 (44.4%) females.

There were no differences in age between different categories of cases (Table 7).

Table 7: Mean age of patients according to case determination category (N=526)

Determinations	N	Mean	95% Confidence Interval for Mean	
			Lower	Upper
A	165	76.8	75.4	78.2
B	47	76.5	73.2	79.8
C	43	77.7	75.0	80.3
Z	37	79.8	76.7	82.8
D	54	80.3	76.9	83.6
E	120	79.9	77.7	82.1
Closed	60	72.1	69.1	75.2
Total	**526**	**77.6**	**76.6**	**78.5**
Comparison GPs	1136	76.4	75.7	77.2

Cause of death

In comparison with the other general practitioners, Shipman certified a greater proportion of deaths among his patients as due to heart conditions or stroke (Table 8.27 of the review). It should be remembered, of course, that the causes of death are those given by Shipman. Therefore, they should be regarded as being causes that could be associated with the circumstances of death and could be used by Shipman in explanation of what had happened; for example, heart conditions or stroke might be used as explanations in cases of sudden death due to unlawful killing. In many cases, they are plausible fabrications rather than truthful statements.

Table 8 shows the proportion of cases in each category that Shipman certified as due to causes belonging to one of five groups: heart conditions (heart attacks, heart failure), stroke, cancer, old age (including senility), and other causes (for example, bronchopneumonia, renal disease). A high proportion of cases categorised A, B or C were certified as due to heart conditions or stroke, but the proportions for cases in categories D or E were relatively similar to the pattern found among the comparison practitioners.

Among deaths at home in the cases categorised D, E or Z, the proportions of cases certified by Shipman as due to old age were lower (although still higher than the comparison practitioners), indicating that he used this cause of death more commonly among people who died in

residential or nursing homes. Since there are only small numbers of cases in the C, D and Z groups, caution is required in drawing conclusions.

Table 8: Cause of death as certified by Shipman according to the case determination categories (N=526)

Determinations	**Cause of death category**						**Total**
		cardiac	stroke	cancer	old age etc	other	
A	N	75	52	8	11	19	165
	%	45.5	31.5	4.8	6.7	11.5	
B	N	24	8	7	5	3	47
	%	51.1	17.0	14.9	10.6	6.4	
C	N	20	3	7	6	7	43
	%	46.5	7.0	16.3	14.0	16.3	
D	N	8	7	11	17	11	54
	%	14.8	13.0	20.4	31.5	20.4	
E	N	31	15	20	39	15	120
	%	25.8	12.5	16.7	32.5	12.5	
Z	N	10	3	11	8	5	37
	%	27.0	8.1	29.7	21.6	13.5	
Closed	N	10	6	29	2	13	60
	%	16.7	10.0	48.3	3.3	21.7	
Total	N	178	94	93	88	73	526
	%	33.8	17.9	17.7	16.7	13.9	
Comparison GPs	N	319	130	337	50	300	1136
	%	28.1	11.4	29.7	4.4	26.4	

Table 9: Cause of death as certified by Shipman according to the case determination categories. Deaths at home only (N=403)

Determinations	Cause of death category						Total
		cardiac	stroke	cancer	old age etc	other	
A	N	75	52	8	11	18	164
	%	45.7	31.7	4.9	6.7	11.0	
B	N	23	8	7	5	2	45
	%	51.1	17.8	15.6	11.1	4.4	
C	N	16	3	7	3	6	35
	%	45.7	8.6	20.0	8.6	17.1	
D	N	6	3	8	5	5	27
	%	22.2	11.1	29.6	18.5	18.5	
E	N	23	4	11	4	4	46
	%	50.0	8.7	23.9	8.7	8.7	
Z	N	8	2	8	5	4	27
	%	29.6	7.4	29.6	18.5	14.8	
Closed	N	9	6	29	2	13	59
	%	15.3	10.2	49.2	3.4	22.0	
Total	N	160	78	78	35	52	403
	%	39.7	19.4	19.4	8.7	12.9	
Comparison GPs (deaths at home)	N	239	88	295	12	166	800
	%	29.9	11.0	36.9	1.5	20.8	

Day of death

In comparison with the other general practitioners, a lower proportion of deaths certified by Shipman occurred on Saturday or Sunday (see Table 8.28 of the review). The numbers of deaths on different days of the week by category of case are shown in Table 10. The findings indicate that, for those cases in which the day of death could be confirmed, a higher proportion of deaths in categories A and B occurred on weekdays, but this pattern was not evident for cases in categories D, E or Z.

Table 10: Day of week of death according to category of determination. N=520.

Determinations	Day of week of death								Total
		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday	
A	N	39	37	28	22	25	7	7	165
	%	23.6	22.4	17.0	13.3	15.2	4.2	4.2	
B	N	3	8	9	6	13	3	4	46
	%	6.5	17.4	19.6	13.0	28.3	6.5	8.7	
C	N	9	10	5	4	7	6	2	43
	%	20.9	23.3	11.6	9.3	16.3	14.0	4.7	
Z	N	8	3	4	5	5	4	6	35
	%	22.9	8.6	11.4	14.3	14.3	11.4	17.1	
D	N	5	12	5	8	8	11	5	54
	%	9.3	22.2	9.3	14.8	14.8	20.4	9.3	
E	N	19	18	16	25	13	13	16	120
	%	15.8	15.0	13.3	20.8	10.8	10.8	13.3	
Closed	N	4	7	4	9	13	14	6	57
	%	7.0	12.3	7.0	15.8	22.8	24.6	10.5	
Total	N	87	95	70	80	84	58	46	520
	%	16.7	18.3	13.5	15.4	16.2	11.2	8.8	
Comparison GPs	N	152	167	184	178	150	167	138	1136
	%	13.4	14.7	16.2	15.7	13.2	14.7	12.1	

Summary and conclusion

Five features typical of the convictions were investigated in order to determine whether they were confined to cases categorised as A, B or C, or were also found in other categories. Some caution is required in drawing conclusions relating to categories that include relatively small numbers of cases, notably, categories C and Z. Nevertheless, some findings are clear:

- Categories A and B are distinctly different to the other categories in three respects: death is more likely to have occurred on a weekday; it is more likely to have occurred in the afternoon; and the causes of death as certified by Shipman were more likely to be heart conditions or stroke, causes that could be used as plausible fabrications when death had been sudden.
- Among cases classified as C, high proportions involved females, deaths in the afternoon and on Mondays and Tuesdays, and were certified as due to heart conditions.

- The features typical of the convictions were not found in excess among closed and E cases. Deaths were not more likely to occur in the afternoon or on weekdays in comparison with the patients of other general practitioners, and the causes of death did not indicate an excess of heart conditions or strokes.
- Among Z cases, ' old age' was a frequently certified cause of death, and there was a slightly higher proportion of females, but other features typical of the convictions were not found.
- Cases categorised as D included more deaths occurring between 12.01 and 18.00 than occurred in E or closed cases, or among patients of the comparison practitioners. Since the number of cases is small, care should be exercised in drawing conclusions from this finding. Furthermore, in the case of a death occurring in the afternoon but otherwise regarded as natural, the fact of death in the afternoon would have been taken into account in the Inquiry's decision to allocate the case to the D rather than the E category.
- D cases also included high proportions of females and deaths certified as due to ' old age'. This finding was made even among deaths at home. However, there was no pattern of decreased numbers of deaths at weekends among D cases.
- In comparison with the other general practitioners, a greater proportion of Shipman's cases were female, other than the closed group. With regard to the E category, this was largely accounted for by deaths in residential or nursing homes.
- There were no differences between the categories with regard to mean age at death.

In view of these findings, it is reasonable to conclude that the closed and E categories are highly unlikely to include unlawful killings. The possibility of a few unlawful killings among D cases is unlikely, but cannot be completely excluded.

Section 5. Deaths in Residential and Nursing Homes

The review identified a greater excess of deaths among Shipman's patients when those that occurred in residential and nursing homes (institutions) were included (297 versus 236, a difference of 61 extra deaths). Since only a very small number of deaths in institutions were regarded as suspicious in the review, the explanation for the excess was unclear. Of the 123 deaths in institutions, only 11 (8.9%) have been categorised as A, B or C (Table 11). Apparently, therefore, the excess number of deaths in institutions cannot be adequately accounted for by unlawful killings. In this section, additional evidence collected by the Inquiry is used to help explain the observed excess number of deaths in institutions.

Table 11: The numbers of deaths certified by Shipman occurring in institutions (residential or nursing homes and hospitals) or the patient's own home (includes Shipman's practice)

Determinations	Place of death		Total
	Institution	Own home or the practice	
A	1	164	165
B	2	45	47
C	8	35	43
Z	10	27	37
D	27	27	54
E	74	46	120
Closed	1	59	60
Total	**123**	**403**	**526**

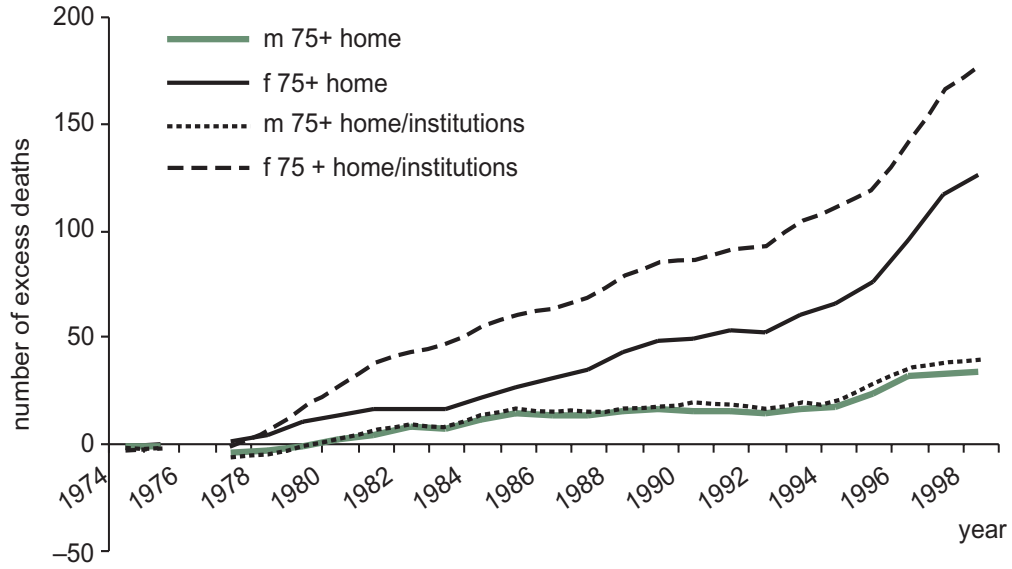

Figure 3: The cumulative excess of deaths, males and females aged 75 or above, including those occurring in the patient's own home and those occurring in either institutions or the patient's own home (all deaths)

Figure 3 shows the cumulative excess of deaths certified by Shipman with and without the inclusion of deaths in institutions. Only the aged 75 and above age groups are shown, since the addition of deaths in institutions to the age groups 0–64 and 65–74 does not alter the trend. Only among females in the age group 75 or above does a difference emerge. In comparison with the trend for deaths at home only, the addition of deaths in institutions is associated with a steep increase in the years 1978 to 1984.

Table 12: Annual excess number of deaths in institutions, 1974–1998. *From Tables 8.15–8.26 of the review

Year of death	Number of deaths in institutions	Expected number of deaths*	Excess of deaths
1974	2	1.42	.58
1975	1	1.97	-.97
1977	1	1.55	-.55
1978	8	2.52	5.48
1979	8	2.45	5.55
1980	8	2.35	5.65
1981	12	1.32	10.68
1982	7	1.63	5.37
1983	7	5.62	1.38
1984	8	3.45	4.55
1985	3	3.89	-.89
1986	2	2.29	-.29
1987	5	3.49	1.51
1988	4	2.94	1.06
1989	2	2.00	0
1990	2	1.69	.31
1991	4	2.55	1.45
1992	4	2.70	1.30
1993	8	4.14	3.86
1994	4	3.27	0.73
1995	5	2.36	2.64
1996	7	3.58	3.42
1997	8	2.70	5.30
1998	3	0.81	2.19
Total	123	62.69	60.36

Table 12 shows the excess numbers of deaths in institutions in each year, 1974–1998. The total excess in this period was 60.4. The excess that accumulated between 1978–1984 was 38.7 deaths, with an additional excess of 18.1 deaths occurring 1993–1998. These two periods account for 56.8 of the 60.4 excess deaths.

Deaths among people in institutions that were categorised A, B or C are shown by year in Table 13. Only four deaths in the 1978–1984 period were C category cases, which is only 10.3% of the excess deaths in this period, and none was A or B. However, in the 1993–1998 period, one case was categorised B, one A and two C (22.1% of the excess deaths in the period).

Table 13: The determinations of the deaths in institutions in A, B and C categories, 1974–1998 (years with no deaths in these categories not shown)			
Year	**Determinations**		
	A	B	C
1979			1
1980			1
1981			1
1982			1
1986		1	
1987			1
1992			1
1993			1
1994			1
1995		1	
1997	1		

Table 14 shows background information about the deaths in institutions 1978–1984, and Table 15 the same information for the period 1993–1998. In the second period, a greater proportion of deaths were of males, old age was less commonly given as the cause of death, and the proportion of those aged over 85 was lower.

Table 14: Age groups, gender, year of death and cause of death of deaths in institutions, 1978–1984 (N=58)			
		N	**%**
Age group	65–74	2	3.4
	75–84	25	43.1
	85 or above	31	53.4
Gender	male	7	12.1
	female	51	87.9
Cause of death	Heart conditions	8	13.8
	Stroke	6	10.3
	Cancer	4	6.9
	Old age	30	51.7
	Other	10	17.2

Table 15: Age groups, gender, year of death and cause of death of deaths in institutions, 1993–1998 (N=35)			
		N	**%**
Age group	<65	2	5.7
	65–74	5	14.3
	75–84	12	34.3
	85 or above	16	45.7
Gender	male	11	31.4
	female	24	68.6
Cause of death	Heart conditions	7	20.0
	Stroke	7	20.0
	Cancer	5	14.3
	Old age	11	31.4
	Other	5	14.3

Table 16 presents information about the day and time of death, and likelihood that Shipman had been present near the time of death for deaths 1978–1984, and Table 17 presents the same information for 1993-1998. In the later period, fewer deaths occurred during weekends and Shipman was more likely to be identified as attending the patient around the time of death, although there was no difference in the proportions dying at different times of the day. The usual caution about drawing conclusions from small numbers should be borne in mind.

Table 16: Day of death, evidence of attendance on day of death from MCCD counterfoils or other sources of evidence, and time of death for deaths in institutions, 1978–1984 (N=58). *Information obtained by the Inquiry.

		N	%
Day of death	Monday	7	12.1
	Tuesday	6	10.3
	Wednesday	6	10.3
	Thursday	13	22.4
	Friday	7	12.1
	Saturday	10	17.2
	Sunday	9	15.5
MCCD counterfoil records attended on day of death*	no	45	77.6
	yes	13	22.4
Other evidence indicates Shipman attended on day of death (2 cases no information available)*	No or probably no	33	58.9
	Yes	23	41.1
Time of death (data not available for 11 cases)*	0–6.00	9	19.1
	6.01–12.00	20	42.6
	12.01–18.00	9	19.1
	18.00–24.00	9	19.1

Table 17: Day of death, evidence of attendance on day of death from MCCD counterfoils or other sources of evidence, and time of death for deaths in institutions, 1993–1998 (N=35). *Information obtained by the Inquiry.

		N	%
Day of death	Monday	6	17.1
	Tuesday	6	17.1
	Wednesday	3	8.6
	Thursday	9	25.7
	Friday	6	17.1
	Saturday	3	8.6
	Sunday	2	5.7
MCCD counterfoil records attended on day of death*	no	24	68.6
	yes	11	31.4
Other evidence indicates Shipman attended on day of death*	No or probably no	14	40.0
	Yes	21	60.0
Time of death (data not available for 1 case)*	0–6.00	9	26.5
	6.01–12.00	14	41.2
	12.01–18.00	7	20.6
	18.00–24.00	4	11.8

Table 18: Numbers of deaths in each year in each residential or nursing home, 1978–1998 (excludes deaths in Todmorden). *Nursing home.

	Rest/nursing home												**Total**
Year of death	Charnley House	Sycamores	Hyde Nursing Home*	Laurel Bank	Charlotte House	Tameside General Hospital	Norbury House	Pole Bank Hall	Yew Trees	Bowlacre	The Lakes	Hazledene	
1978	6	1										1	**8**
1979	6	1								1			**8**
1980	7									1			**8**
1981	7	1						1	1	2			**12**
1982	6	1											**7**
1983	5	1						1					**7**
1984	4	1						1		2			**8**
1985	2							1					**3**
1986	2												**2**
1987	3	1						1					**5**
1988							2	2					**4**
1989					1		1						**2**
1990							1				1		**2**
1991		1	1							2			**4**
1992	1						2		1				**4**
1993	1	3	1		1		1	1					**8**
1994	1		3										**4**
1995			3	1									**4**
1996		2	1	3		1							**7**
1997	1		4	2	1								**8**
1998		1	2										**3**
total	52	14	15	6	3	1	7	8	2	8	1	1	**118**
A, B or C cases	4		1										**5**
N female	52	11	7	4	3	0	7	8	2	3	1	1	**99**
% female	100	78.6	46.7	66.7	100	0	100	100	100	37.5	100	100	**83.8**
Mean age (yrs)	85.0	86.2	78.7	93.6	88.2	54.0	85.2	88.8	82.1	86.5	75.5	81.9	**84.8**

In Table 18, the number of deaths in each institution in each year are shown, together with the percentage of cases that were females and the mean age of the deceased. In the early years, most deaths occurred in one residential home, Charnley House, but, from 1987 onwards, deaths were more common in other institutions. The Inquiry has obtained a witness statement from the director of Charnley House, Mrs Lynn Lanceley. Her evidence confirms a policy operated at Charnley House in which Shipman would be asked to take on the care of newly admitted residents. From the late 1980s, this policy was discontinued, since Shipman became less willing to accept residents of the home as patients. The witness also indicated that Charnley House had been one of only a few residential homes in Hyde throughout the 1970s and early 1980s but, from the mid-1980s, a growing number of residential homes were opened in the area. This evidence explains the decline in the number of Shipman's patients who died in Charnley House from 1984.

Table 18 also suggests an increase in the numbers of people who died in nursing homes. Nursing homes accommodate people who require at least some nursing care, and who are more likely, therefore, to suffer from disabilities and illnesses than people in residential homes. Consequently, it is probable that the characteristics of the patients who died during the second period of excess deaths, 1993–1998, are explained by their greater need for nursing care in comparison with the 1978–1984 period.

Fifty-six (45.5%) of the 123 patients of Shipman who died in institutions were residents of Charnley House. Shipman issued the MCCD in 52 of these cases, the other four being investigated by the coroner. The admissions register of this home contains both the date of admission and the date of death, and it was possible, therefore, to calculate the length of time all 56 patients lived in the home before death. The mean age at death of Shipman's patients was 84.8 years, the other patients having a mean age of 84.7 years. The mean number of days between admission to Charnley House and death (if death occurred in Charnley House) was 682 days for Shipman's patients and 619 days for the patients of other doctors. Among Shipman's patients, 27.3% survived 100 days or less, in comparison with 21.2% for the other patients. Also, 8.9% of Shipman's patients survived 2000 days or longer, in comparison with 5.1% among the other patients.

In summary, the new information obtained by the Inquiry generally supports the view that the excess of deaths in institutions has a natural explanation:

- The excess of deaths in institutions occurred 1978–84 and 1993–1998.
- The excess was confined to older females.
- Only 11 deaths in institutions were categorised as A, B or C.
- The excess 1978–1984 is explained by the policy at that time of one residential home (Charnley House) to register newly admitted patients with Shipman. After admission to the home, Shipman's patients generally lived as long or longer than the patients of other doctors.
- The excess 1993–1998 is associated with a high proportion of deaths in nursing homes. The reason why Shipman would have a high number of such patients is not clear, although nursing home care replaced much long-term hospital care during the 1990s.

Section 6. Deaths in Todmorden

Confident conclusions about the deaths that occurred in Todmorden 1974–1975 are difficult because only a limited amount of evidence remains available. Furthermore, the findings of any statistical analysis must be treated with considerable caution because of the small number of deaths involved. The tentative conclusion of the review was that there were reasons for concern about some of the deaths, but that more evidence was needed. Some additional evidence is now available from the investigations of the Inquiry. This is summarised in Table 19.

Table 19: **Deaths in Todmorden certified by Shipman, showing date, day of week, age and gender, cause, time of death, whether Shipman had been present, and case category (N=22)**

	Date of death	Day of week of death	Age	Gender	Cause of death	Time of death	Shipman present	Category
1	10.05.1974	Friday	72	female	other			D
2	23.07.1974	Tuesday	26	male	cancer			D
3	09.12.1974	Monday	18	male	other	0-6		E
4	16.12.1974	Monday	26	female	other			E
5	29.12.1974	Sunday	86	female	cardiac			Z
6	21.01.1975	Tuesday	62	male	other	12.01-18	Yes	C
7	21.01.1975	Tuesday	73	female	cancer	18.01-24	Yes	C
8	21.01.1975	Tuesday	84	female	cva	12.01-18	Yes	C
9	25.01.1975	Saturday	70	male	cardiac	6.01-12		Z
10	15.02.1975	Saturday	80	female	cardiac			C
11	11.03.1975	Tuesday	72	female	cancer			E
12	11.03.1975	Tuesday	65	male	cardiac	18.01-24		E
13	17.03.1975	Monday	70	female	cancer	18.01-24	Yes	B
14	21.03.1975	Friday	67	female	cardiac	During last 1-2 days		C
15	01.04.1975	Tuesday	87	male	cardiac	12.01-18		Z
16	06.04.1975	Sunday	77	male	other	12.01-18		D
17	7.04.1975	Monday	67	female	cancer	12.01-18		Z
18	08.04.1975	Tuesday	86	female	cardiac	12.01-18	Yes	E
19	26.05.1975	Monday	59	female	cancer	0-6	Yes	D
20	04.08.1975	Monday	77	female	cardiac		No	E
21	09.08.1975	Saturday	88	male	cardiac			D
22	01.09.1975	Monday	70	female	cardiac	18.01-24		E

Of the 13 cases in which the time of death could be established, six occurred 12.01–18.00. It was also established that Shipman had been present at about the time of death in six cases, three of which involved deaths occurring 12.01–18.00. The numbers of cases are too few to enable meaningful conclusions to be reached about the causes of death, age and gender, or days of the week of death.

In coming to a conclusion about the likelihood that Shipman unlawfully killed some patients in Todmorden, the most significant information in Table 19 is the determination in each case; of the 22 cases, one case was classified as B, five as C and four as Z. All the others were classified as D or E.

Deaths 6, 7 and 8 in Table 19 occurred on the same date. In addition, two other deaths (11 and 12) also occurred on the same date. From time to time, two or more patients of a general practitioner will die on the same day, and, therefore, care should be taken in ascribing these clusters of deaths to murders. Some assistance in estimating the frequency with which a general practitioner will certify more than one death on the same day can be obtained from the deaths certified by the ten comparison practitioners (four in Todmorden, six in Hyde) (see Table 20). Of the deaths certified by Shipman, 62 (11.8%) are accounted for by deaths that occurred on the same day as another death. Of the 1136 deaths certified by the comparison practitioners, 22 (1.9%) occurred on the same day as another death certified by the same practitioner. Shipman certified three deaths on the same day on two occasions, 21 January 1975 and 26 March 1984. No other doctor certified three deaths on the same day. Consequently, concern about the true cause of one or more of the three deaths that occurred in Todmorden on 21 January 1975 would be justified. The concern about the explanation for three deaths that occurred in Todmorden on the same day is reflected by the Inquiry's determinations in these cases, all having been categorised as C.

Table 20: **The number of occasions on which Shipman and ten other general practitioners certified more than one death on the same day**

Doctor	Years included	Total deaths certified	Number of occurrences of more than one death on same day	Total number of patients involved
Shipman	1974-1998	526	30	62
1	1973-1976	65	0	
2	1973-1976	21	0	
3	1973-1976	43	1	2
4	1973-1976	47	0	
5	1977-1996	193	2	4
6	1977-1998	210	2	4
7	1977-1997	145	0	
8	1983-1998	135	3	6
9	1977-1998	178	3	6
10	1982-1998	99	0	
Total		**1662**	**39**	**84**

Section 7. An Analysis of Patterns from 1974

The determinations made by the Inquiry enable an exploration of the emergence of Shipman's criminal behaviour. The numbers of determinations in each category are shown in Table 21. These data are displayed in Figures 4 and 5, which show the numbers of cases in each category for each year from 1974 to 1998. The percentages of deaths for each year in categories A or B and C are shown in Figure 6, and Figure 7 shows the cumulative number of A or B and C cases. Category A includes the convictions.

Table 21: The annual number and percentage of cases in different categories, 1974–1998. (N=526)

Year		Determinations							Total
		A	B	C	D	E	Z	Closed	
1974	N				2	2	1		5
	%				40.0	40.0	20.0		
1975	N		1	5	3	5	3		17
	%		5.9	29.4	17.6	29.4	17.6		
1977	N				2		1	1	4
	%				50.0		25.0	25.0	
1978	N	2	2	5	4	8	2	5	28
	%	7.1	7.1	17.9	14.3	28.6	7.1	17.9	
1979	N		1	5	6	11	3	3	29
	%		3.4	17.2	20.7	37.9	10.3	10.3	
1980	N			1	5	6	5	6	23
	%			4.3	21.7	26.1	21.7	26.1	
1981	N		2	4	3	10	6	3	28
	%		7.1	14.3	10.7	35.7	21.4	10.7	
1982	N			4	2	8	2	5	21
	%			19.0	9.5	38.1	9.5	23.8	
1983	N	1	1	1	3	5		4	15
	%	6.7	6.7	6.7	20.0	33.3		26.7	
1984	N	7	2	4	3	7	6	3	32
	%	21.9	6.3	12.5	9.4	21.9	18.8	9.4	
1985	N	6	5	2	4	3	2	4	26
	%	23.1	19.2	7.7	15.4	11.5	7.7	15.4	
1986	N	6	2	2	1	2	1	1	15
	%	40.0	13.3	13.3	6.7	13.3	6.7	6.7	

Table 21: The annual number and percentage of cases in different categories, 1974–1998. (N=526) (Continued)

Year		Determinations							Total
		A	B	C	D	E	Z	Closed	
1987	N	6	2	1	2	4	2	2	19
	%	31.6	10.5	5.3	10.5	21.1	10.5	10.5	
1988	N	10	1		2	2	1	4	20
	%	50.0	5.0		10.0	10.0	5.0	20.0	
1989	N	8	4		1	2		2	17
	%	47.1	23.5		5.9	11.8		11.8	
1990	N	1	1			4		3	9
	%	11.1	11.1			44.4		33.3	
1991	N				4	6	1	1	12
	%				33.3	50.0	8.3	8.3	
1992	N	1		1		4		1	7
	%	14.3		14.3		57.1		14.3	
1993	N	13	3	2	1	8		2	29
	%	44.8	10.3	6.9	3.4	27.6		6.9	
1994	N	8	3	2	1	2		1	17
	%	47.1	17.6	11.8	5.9	11.8		5.9	
1995	N	22	6	1		6	1	3	39
	%	56.4	15.4	2.6		15.4	2.6	7.7	
1996	N	27	3	1	2	7		3	43
	%	62.8	7.0	2.3	4.7	16.3		7.0	
1997	N	34	3	2	2	5		1	47
	%	72.3	6.4	4.3	4.3	10.6		2.1	
1998	N	13	5		1	3		2	24
	%	54.2	20.8		4.2	12.5		8.3	
Total	N	165	47	43	54	120	37	60	526
	%	31.4	8.9	8.2	10.3	22.8	7.0	11.4	

The data reveal a distinct pattern. Only a small number of cases in the A, B or C categories occur until 1984, and the majority of these are C cases. Beginning in 1984, there is a marked increase in cases in the A or B categories, more than 40% of the total annual deaths being in these categories in the four years 1986–1989. Between 1990 and 1992, only two cases were categorised as A and one as B. Thereafter, a second peak in the numbers of unlawful killings occurred during the six years 1993–1998. In these six years, more than half the deaths for which Shipman had issued an MCCD were categorised either A or B, or were convictions. The possible reasons for these patterns are discussed in the main body of the Report.

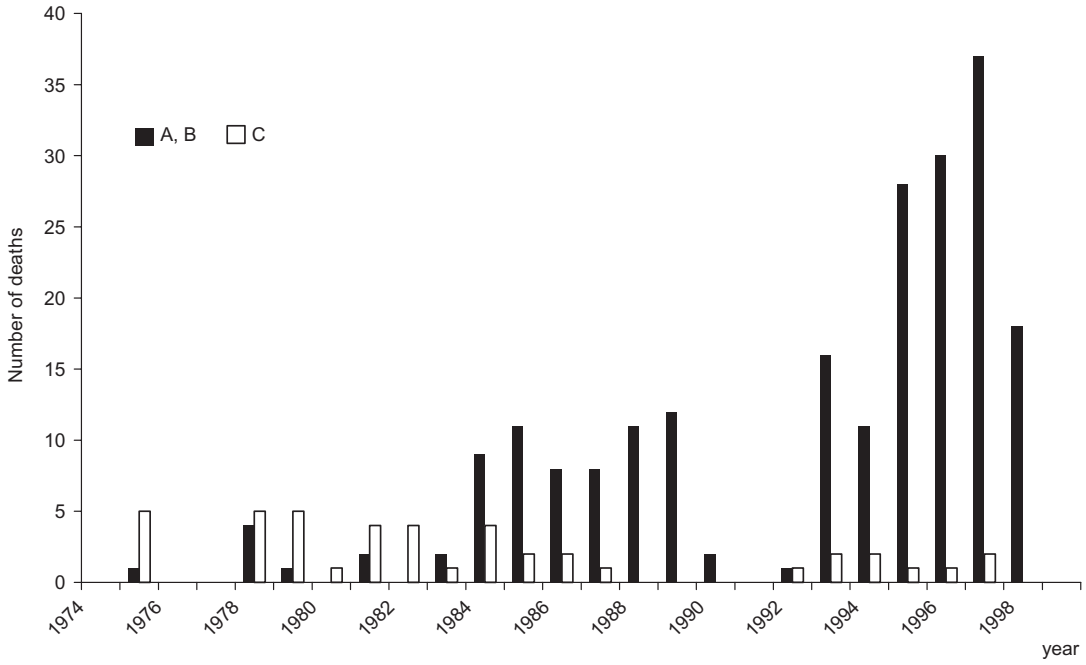

Figure 4: Annual number of deaths in categories A or B, and C, 1974–1998

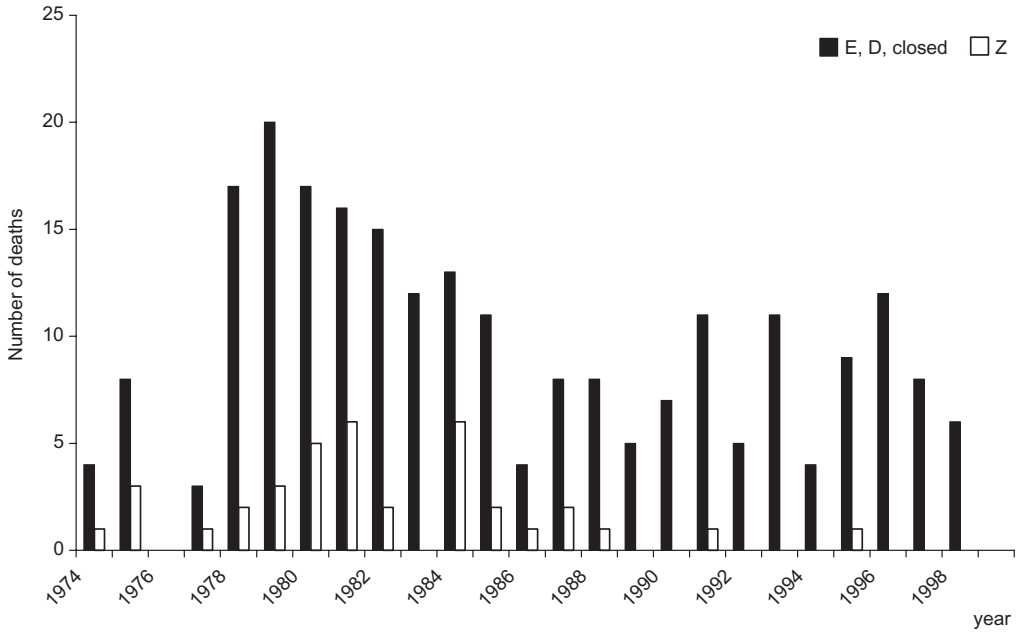

Figure 5: Annual number of deaths in categories E, D or closed, and Z, 1974–1998

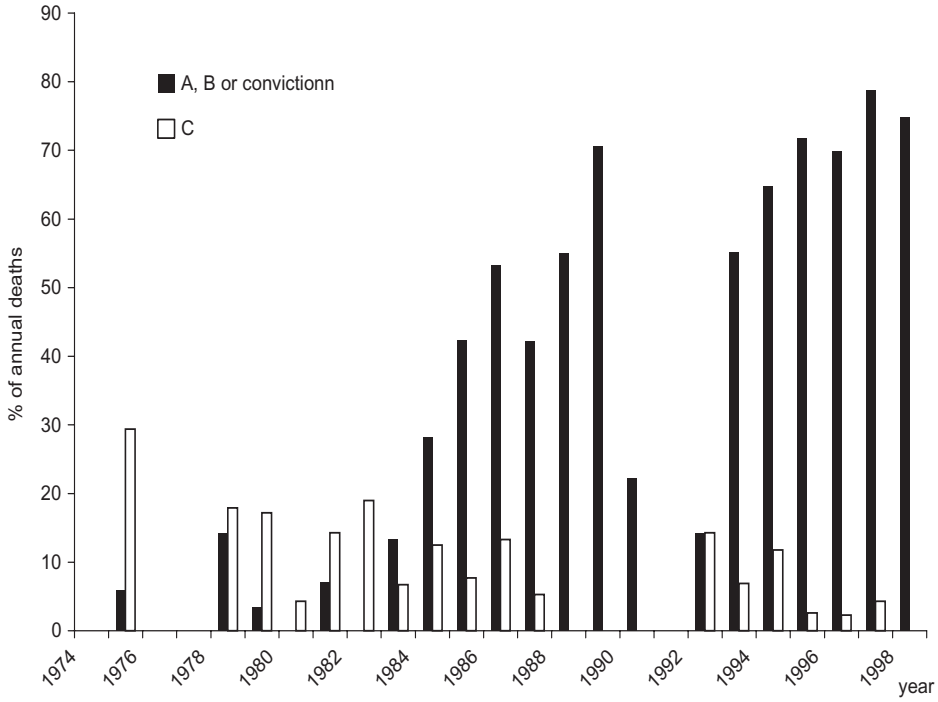

Figure 6: The percentage of deaths certified by Shipman categorised A or B, and C 1974–1998

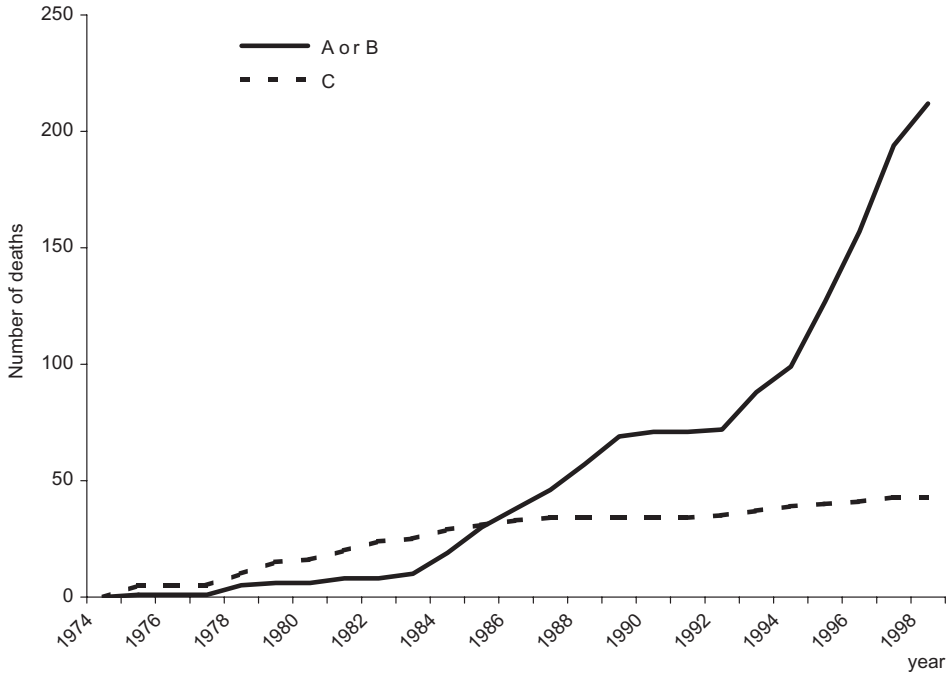

Figure 7: The cumulative number of deaths in A, B or C categories, 1974–1998

Section 8. Summary and Conclusions

This Appendix has compared the findings from the 2001 review of Shipman's clinical practice and the determinations of the Inquiry. The relationship between the numbers of cases in each category and the features typical of the convictions has been investigated, and additional analyses undertaken to explore the excess numbers of deaths in institutions. Finally, the pattern of cases in different categories emerging during Shipman's career as a general practitioner has been outlined.

The findings indicate that the review and the Inquiry have reached similar conclusions about the total numbers of unlawful killings. The Inquiry had very much more information available, and its exhaustive case by case investigation supports the view that the excess of deaths is in the region of 220–240. One implication is that a system to monitor the death rates of patients of general practitioners would have detected the excess.

The review relied on the documentary evidence contained in clinical records and cremation forms to assess the level of suspicion in each case. There was a reasonable level of consistency between these assessments of suspicion and the definitive determinations of the Inquiry. However, caution should be taken in assuming on this basis that review of records would be sufficient to detect cases of murder by health professionals. Prior to the review, the key features of murder had been established during the trial, and were used to inform the review. Furthermore, there were some cases in which the evidence obtained by the Inquiry led to a classification different to that following review of records and cremation forms only.

The cases in A and B categories differ substantially from those in the other categories. In the A and B cases, Shipman is more likely to have attended the patient on the day of death, to be recorded as being present at death, and death was more likely in the afternoon, to have occurred in less than 30 minutes, to be certified as due to heart conditions or strokes, and less likely to occur at weekends. This distinctive pattern is not found among the closed or E category cases, and is much less common among D cases. Nevertheless, from this limited evidence, it is not possible to entirely rule out the possibility that a few D cases were in fact unlawful killings.

The excess of deaths in institutions is not due to a large number of unlawful killings. Although a small number of deaths in institutions were categorised A or B, the findings indicate that the most likely explanation is that, between 1978 and 1984, Shipman was the preferred general practitioner for people in one residential home in particular. From 1993, there was a second peak in excess deaths among people in institutions, and this was associated with deaths in a nursing home. It is likely that this finding is largely a consequence of an increased use of nursing homes during these years.

The emergence of Shipman's activities during his career can be traced through the variations in the annual numbers of cases categorised as A, B or C. In the early years, the number of C category cases steadily accumulates. From the mid–1980s, the numbers of A and B cases rise steeply, to be followed by a period of few deaths (1990–1992). In the 1990s, the numbers of A and B cases rise again and, in the final six years, consistently more than half of all deaths certified by Shipman fall into these categories; in one year (1997), the proportion exceeds three-quarters.

References

[1] Baker R. Harold Shipman's clinical practice 1974–1998. London: The Stationery Office, 2001.

[2] NHS Executive. Guidance for general medical practices and Family Health Service Authorities on preservation, retention, and destruction of GP general medical records relating to patients. Appendix to FHSL (94)30. Leeds: NHS Executive, 1994.

APPENDIX B

Participants in Phase One 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
HM Coroner, Greater Manchester South	Mrs Jennifer Leeming, Solicitor and Deputy Coroner, Greater Manchester South
The General Medical Council	Mr Matthew Lohn, Field Fisher Waterhouse Solicitors, London
Greater Manchester Police	Mr Michael Shorrock QC and Miss Kate Blackwell, instructed by Mrs Sandra Pope, Greater Manchester Police Force Solicitor
Medical Protection Society	Dr Albert Day, Medico-Legal Adviser, Medical Protection Society, Leeds, West Yorkshire
Gillian Morgan	Mr Kevin McNerney, Royal College of Nursing Legal Department, Leeds, West Yorkshire
Mrs Primrose Shipman	Mr Jim Sturman, instructed by Mr Paul Taylor, Pannone & Partners Solicitors, Manchester
Detective Inspector David Smith	Mr Nick Holroyd, Russell Jones & Walker Solicitors, Manchester
Surgery staff at 21 Market Street, Hyde	Miss Ruth Stockley, instructed by Mrs Kate Oldfield, Davis Blank Furniss 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
West Pennine Health Authority	Mr Gerard McDermott QC and Mr David Eccles, instructed by Mr Charles Howorth, George Davies Solicitors, Manchester
Mrs Christine Whitworth	Ms Julie Lever, Bhailock & Fielding Solicitors, Preston, Lancashire

APPENDIX C

Specimen Medical Certificate of Cause of Death, with counterfoil

MED A 22 000000

COUNTERFOIL

BIRTHS AND DEATHS REGISTRATION ACT 1953

MEDICAL CERTIFICATE OF CAUSE OF DEATH

MED A 22 000000

MED A 22 000000

NOTICE TO INFORMANT

DUTIES OF INFORMANT

CANCELLED

PERSONS QUALIFIED AND LIABLE TO ACT AS INFORMANTS

The following persons are designated by the Births and Deaths Registration Act 1953 as qualified to give information concerning a death; in order of preference they are:

DEATHS IN HOUSES AND PUBLIC INSTITUTIONS

(1) A relative of the deceased, present at the death.

(2) A relative of the deceased, in attendance during the last illness.

(3) A relative of the deceased, residing or being in the sub-district where the death occurred.

(4) A person present at the death.

(5) The occupier* if he knew of the happening of the death.

(6) Any inmate if he knew of the happening of the death.

(7) The person causing the disposal of the body.

DEATHS NOT IN HOUSES OR DEAD BODIES FOUND

(1) Any relative of the deceased having knowledge of any of the particulars required to be registered.

(2) Any person present at the death.

(3) Any person who found the body.

(4) Any person in charge of the body.

(5) The person causing the disposal of the body.

*"Occupier" in relation to a public institution includes the governor, keeper, master, matron, superintendent or officer, but not resident officers.

Complete where applicable

A	B
I have reported this death to the Coroner for further action.	I may be in a position later to give, on application by the Registrar General, additional information as to the cause of death for the purpose of more precise statistical classification.
Initials of certifying medical practitioner.	Initials of certifying medical practitioner.

The death should be referred to the coroner if:

- the cause of death is unknown
- the deceased was not seen by the certifying doctor either after death or within the 14 days before death
- the death was violent or unnatural or was suspicious
- the death may be due to an accident (whenever it occurred)
- the death may be due to self-neglect or neglect by others
- the death may be due to an industrial disease or related to the deceased's employment
- the death may be due to an abortion
- the death occurred during an operation or before recovery from the effects of an anaesthetic
- the death may be a suicide
- the death occurred during or shortly after detention in police or prison custody

LIST OF SOME OF THE CATEGORIES OF DEATH WHICH MAY BE OF INDUSTRIAL ORIGIN

MALIGNANT DISEASES	Causes include
(a) Skin	– radiation and sunlight – pitch or tar – mineral oils
(b) Nasal	– wood or leather work – nickel
(c) Lung	– asbestos – chromates – nickel – radiation
(d) Pleura and peritoneum	– asbestos
(e) Urinary tract	– benzidine – dyestuff manufacture – rubber manufacture
(f) Liver	– PVC manufacture
(g) Bone	– radiation
(h) Lymphatics and haematopoietic	– radiation – benzene

POISONING	
(a) Metals	e.g. arsenic, cadmium, lead
(b) Chemicals	e.g. chlorates, benzene
(c) Solvents	e.g. trichloroethylene

INFECTIOUS DISEASES	Causes include
(a) Anthrax	– imported hides, horsehair, hide or fur
(b) Brucellosis	– farming or veterinary
(c) Tuberculosis	– contact at work
(d) Leptospirosis	– farming, sewer or under-ground workers
(e) Tetanus	– farming or gardening
(f) Rabies	– animal handling
(g) Viral hepatitis	– contact at work

CHRONIC LUNG DISEASES	
(a) Occupational asthma	– sensitising agent at work
(b) Allergic alveolitis	– farming
(c) Pneumoconiosis	– mining and quarrying – pottteries – asbestos
(d) Chronic bronchitis and emphysema	– underground coal mining

NOTE:—The Practitioner, on signing the certificate, should complete, sign and date the Notice to the Informant, which should be detached and handed to the informant. Where the informant intends giving information for the registration outside of the area where the death occurred, the notice may be handed to the informant's agent. The Practitioner should then, without delay, deliver the certificate itself to the Registrar of Births and Deaths for the sub-district in which the death occurred. Envelopes for enclosing the certificates are supplied by the Registrar.

APPENDIX D — Specimen Cremation Form A

DUKINFIELD CREMATORIUM
HALL GREEN ROAD, DUKINFIELD SK16 4EP
Telephone : Registrar & Superintendent 0161 330 1901

Form A

CREMATION ACTS, 1902 AND 1952

APPLICATION FOR CREMATION

PURSUANT TO THE REGULATIONS MADE BY THE SECRETARY OF STATE FOR THE HOME DEPARTMENT

This application should be made by an executor wherever possible.

I (name of applicant) .....
(Christian Names must be stated in full)

(Address) .....

(Occupation or Description) .....

apply to the Tameside Metropolitan Borough Council to undertake the Cremation of the remains of:

(Name of Deceased) .....
(Christian Names must be stated in full)

(Address) .....

(Occupation) .....
(If retired please state previous occupation)

(Age) ..... *(Sex)* ..... *Whether married, widow, widower, or unmarried* .....

The true answers to the questions set out below are as follows:

ALL THE QUESTIONS should be carefully read and answered.

1. Are you an executor or the nearest surviving relative of the deceased? (Answer "Executor" or "Nearest surviving relative" if either).	
2. If not, state - (a) Your relationship to the deceased... (b) The reason why the application is made by you and not by an executor or any nearer relative.....	(a) (b)
3. Have the near relatives (1) of the deceased been informed of the proposed cremation?	
4. Has any near relative of the deceased expressed any objection to the proposed cremation? If so, on what grounds?...	
5. What was the date and hour of the death of the deceased?.....	
6. What was the place where the deceased died?..... *(Give the address and say whether own residence, lodgings, hotel, hospital, nursing home, etc.)*	
7. Do you know, or have you any reason to suspect, that the death of the deceased was due, directly or indirectly, to (a) violence; (b) poison; (c) privation or neglect?.....	(a) (b) (c)
8. Do you know any reason whatever for supposing that an examination of the remains of the deceased may be desirable?	
9. Give name and address of the ordinary medical attendant of the deceased.	
10. Give names and addresses of the medical practitioners who attended deceased during his or her last illness.	

(1) The term "near relative" as here used includes widow or widower, parents, children above the age of 16, and any other relative usually residing with the deceased.

(2) Exempt from Statutory Instruments, 1965 No. 2146. The application shall be verified by being countersigned by a HOUSEHOLDER to whom the applicant is known who shall certify that the applicant is known to him or her and that he or she has no reason to doubt the truth of any of the information furnished by the applicant.

I Declare that to the best of my knowledge and belief the information give in this application is correct and not material particular has been omitted.
Date..... Signature .....

The applicant is known to me and I have no reason to doubt the truth of any of the information furnished by the applicant.
Date..... Signature .....
(Capacity in which signatory has signed).....
(Must be a householder confirming with marginal Note 2) Address.....

This form when complete should be forwarded with the Certificate for Disposal (after Registry) to The Registrar & Superintendent, Dukinfield Crematorium, Hall Green Road, Dukinfield, SK16 4EP.

Specimen Cremation Form B

This form is issued by
DUKINFIELD CREMATORIUM
Telephone: 061-330 1901.

Forms B C & F

CREMATION ACTS, 1902 and 1952.

Statutory Rules and Orders, 1930 and 1952.

These Forms are Statutory. All the questions must be answered therefore, to make the Certificate effective for the purpose of Cremation.

These medical certificates are regarded as strictly confidential. The right to inspect them is confined to the Secretary of State, the Ministry of Health and the Chief Officer of a Police Force.

Form B

CERTIFICATE OF MEDICAL ATTENDANT.

(1) This form is not to be used in the case of a Coroner's Inquest.

I am informed that application is about to be made for the cremation of the remains of:–

(Name of Deceased) .....

(Address) .....

(Occupation or Description) ..... (Age) .....

(2) NOTE – The answers to the questions should be as concise as possible. Figures may be used instead of words.
ALL the questions must be answered.

Having attended the Deceased before death, and **seen and identified the body after death,** I give the following answers to the questions set out below:–

1. On what date and at what hour, did he or she die?	
2. What was the place where the deceased died? (Give address and say whether own residence, lodging, hotel, hospital, nursing home, etc.)	
3. Are you a relative of the deceased? If so, state the relationship.	
4. Have you, so far as you are aware any pecuniary interest in the death of the deceased?	
5. (a) Were you the ordinary medical attendant of the deceased?	(a) .....
(b) If so, for how long?	(b) .....
6. (a) Did you attend the deceased during his or her last illness?	(a) .....
(b) If so, for how long?	(b) .....
7. When did you last see the deceased alive? (Say how many days or hours before death).	
8. (a) How soon after death did you see the body?	*(The doctor must see the body after death).* (a) .....
(b) What examination of it did you make?	(b) .....
8A. If the deceased died in a hospital* at which he was an in-patient, has a post-mortem examination been made by a registered medical practitioner of not less than five years' standing who is neither a relative of the deceased nor a relative or partner of yours and are the results of that examination known to you?	

SEE NOTE OVERLEAF.

(3) If the death has been reported to Coroner for any reason, this should be stated in answer to question 18.

9. What was the cause of death?

I

Immediate cause. (a) .....

Morbid conditions, if any, giving rise to immediate cause (stated in order proceeding backwards from immediate cause). due to (b) ..... due to (c) .....

II

Other morbid conditions (if important) contributing to death but not related to immediate cause. .....

.....

CPU/1967/3/85/5m

(OVER

10. (a) What was the mode of death? (Say whether syncope, coma, exhaustion, convulsions, etc.) (b) What was its duration in days hours, or minutes?	(a) ..... (b) .....
11. State how far the answers to the last two questions are the result of your own observations, or are based on statements made by others. If on statements made by others, say by whom.	
12. (a) Did the deceased undergo any operation during the final illness or within a year before death? (b) If so, what was its nature and who performed it?	(a) ..... (b) .....
13. By whom was the deceased nursed during his or her last illness? (Give names and say whether professional nurse, relative, etc. If the illness was a long one this question should be answered with reference to the period of four weeks before the death).	
14. Who were the persons (if any) present at the moment of death?	
15. In view of the knowledge of the deceased's habits and constitution, do you feel any doubt whatever as to the character of the disease or the cause of death?	
16. Have you any reason to suspect, that the death of the deceased was due, directly or indirectly, to (a) Violence ... ... (b) Poison ... ... (c) Privation or neglect	*Death due directly or indirectly to alcohol has now to be reported to the Coroner.*
17. Have you any reason whatever to suppose a further examination of the body to be desirable?	
18. Have you given the certificate required for registration of death? If not who has?	
19. Has the Coroner been notified? if so please give **FULL DETAILS**	

(4) When the certificate for registration has been given by authority of the Coroner, this fact should be stated.

I Hereby Certify that the answers given above are true and accurate to the best of my knowledge and belief, and that I know of no reasonable cause to suspect that the deceased died either 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.

(Signature) .....

NAME IN BLOCK CAPITALS PLEASE

..... *(Address)* .....

Registered Qualifications .....

(Date) ..... *(Tel.)* .....

NOTE — This certificate must be handed or sent in a closed envelope by the medical practitioner, who signs it, to the medical practitioner who is to give the confirmatory certificate below, "except in a case where question 8A overleaf is answered in the affirmative, in which case the certificate must be so handed or sent to the Medical Referee".

**"The term "hospital" as used here means any institution for the reception and treatment of persons suffering from illness or mental disorder, any maternity home, and any institution for the reception and treatment of persons during convalescence".*

Additional information regarding either of the Certificates may be given here if necessary

Has a pacemaker or any radio active material been inserted in the deceased? (YES or NO) .....

If so, has it been removed? (YES or NO) .....

CREMATION CANNOT TAKE PLACE UNTIL IT HAS BEEN REMOVED.

Forms B and C must be delivered to the Crematorium not later than 11 a.m. on the day (exclusive of Sunday) before the Cremation. Any delay in the delivery of these forms may lead to a postponement of the Cremation.

Specimen Cremation Form C

Form C

CONFIRMATORY MEDICAL CERTIFICATE

Pursuant to No. 9 of the Cremation Regulations, 1930 and 1952.

The Confirmatory medical certificate in Form C, if not given by the Medical Referee must be given by a medical practitioner who has been registered in this country for not less than 5 years and who is not a relative of the deceased or a relative or partner of the doctor who has given the certificate in Form B.

I, being neither a relative of the deceased, nor a relative or partner of the medical practitioner who has given the foregoing medical certificate, have examined it and have made personal inquiry as stated in my answers to the questions below:—

(5) Each question must be answered. The answers to Nos. (1), (2) & (4) should invariably be in the affirmative.

See note above

	The doctor must see the body of the deceased.
1. Have you seen the body of the deceased?	
2. Have you carefully examined the body externally?	
3. Have you made a post mortem examination?	
4. Have you seen and questioned the medical practioner who gave the above certificate?	
5. (a) Have you seen and questioned any other medical practioner who attended the deceased?	(a) .....
(b) (Give names and addresses of persons seen and say whether you saw them alone.)	(b) .....
6. (a) Have you seen and questioned any person who nursed the deceased during his or her last illness, or who was present at the death?	(a) .....
(b) (Give names and addresses of persons seen and say whether you saw them alone).	(b) .....
7. (a) Have you seen and questioned any of the relatives of the deceased?	(a) .....
(b) (Give names and addresses of persons seen and say whether you saw them alone).	(b) .....
8. (a) Have you seen and questioned any other person?	(a) .....
(b) (Give names and addresses of persons seen and say whether you saw them alone).	(b) .....

I am satisfied that the cause of death was .....

Here insert cause of death.

.....

and I 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.

(Signature) .....

NAME IN BLOCK CAPITALS PLEASE ..... *(Address)* .....

.....

(Date) ..... *(Tel.)* .....

Registered Qualifications ..... *Year*.....
(One of which must be of 5 years standing as above).

Appointment held .....

NOTE— These Certificates, after being signed by both medical men, must be handed or sent in a closed envelope to the **Registrar and Superintendent, Dukinfield Crematorium, Hall Green Road, Dukinfield,** by one or other of the Medical Practitioners by whom the Certificates are given. (Telephone: 061-330 1901).

Forms B & C must be delivered to the Crematorium not later than 11-0 a.m. on the day (exclusive of Sunday) before the Cremation. Any delay in the delivery of these forms may lead to a postponement of the Cremation.

Specimen Cremation Form F

CREMATION ACT, 1902 & 1952

Form F

Required by the Regulations made by the Secretary of State for the Home Department, 1930 & 1952.

TO BE LEFT BLANK. THIS CERTIFICATE WILL BE OBTAINED BY THE CREMATION AUTHORITY

Authority to Cremate

Whereas application has been made for the Cremation of the remains of

† Name .....

Address .....

.....

Occupation .....

And whereas I have satisfied myself that all the requirements of the Cremation Acts, 1902 and 1952, and of the regulations made in pursuance of these Acts have been complied with, that the cause of death has been definitely ascertained and that there exists no reason for any further inquiry or examination: –

I hereby authorise the Superintendent of the Crematorium at Dukinfield to cremate the said remains.

(Signature) .....
Medical Referee to the Dukinfield Crematorium

(Date) .....

†In the case of a stillborn child, in place of the name, address and occupation, insert a description sufficient to identify the body, and in place of the words "that the cause of death has been definitely ascertained" insert the words "that the child was stillborn."

No. ..... Name ..... Cremated .....

APPENDIX E

Summaries of Conviction Cases

Lizzie Adams

Introduction

Mrs Lizzie Adams died on 28th February 1997 at the age of 77. She was a widow and lived alone.

Personal Background

She had been a professional ballroom dancer and was still keen on dancing. For her age, she was physically very fit. On 26th February, she had returned from a holiday in Malta with a group of friends, including her dancing partner. She had a cold and a cough. On 27th February, she spent the day shopping in Stockport with her daughter, Mrs Doreen Thorley. By the end of the day, she was tired and a little troubled by her cough. At 4pm, Mrs Thorley collected a prescription for an antibiotic (Ceporex) from Shipman's surgery, had it dispensed and took it to her mother.

The Circumstances of the Death

The following morning, Friday, 28th February, Mrs Adams told Mrs Thorley that the antibiotic had ' nearly blown her head off'. On her daughter's advice, at 12.10pm, Mrs Adams telephoned the surgery. A note made by the receptionist on the visits request form recorded that Mrs Adams felt dizzy, sick and wobbly and wanted a visit. During that morning, Mrs Adams washed some clothes by hand and hung them out on the washing line. She also partly cooked her evening meal. When Shipman arrived at the house, in the early afternoon, the ironing board and iron were set up in the kitchen ready for use.

In the mid-afternoon, Mr William Catlow, a friend of Mrs Adams, arrived at the house. He found the door unlocked and Shipman in the front room looking into a china cabinet. Shipman told him that Mrs Adams was ill and he was sending her to hospital. When Mr Catlow reached her, he found Mrs Adams apparently asleep in her chair. He took her hand, which felt warm. He said to Shipman, ' I think she's fainted'. Shipman came over and said, ' She's gone'. He said he would cancel the ambulance. There was no medical examination.

Shipman telephoned the Thorley home and, according to Mr Thorley, said that he had ordered an ambulance to take Mrs Adams to hospital. Shipman then telephoned Mrs Thorley at work and said her mother had to go to hospital. He did not say she was dead. Mrs Thorley went quickly to her mother's home where she found her mother in her chair, with her legs crossed in a comfortable way. Shipman told her that her mother had died of pneumonia. He was very abrupt with her. He told her there was no need for a post-mortem examination, as he had been present at the death.

The Defence Case

Shipman's account, which the jury must have rejected, was that, when he arrived in the early afternoon, Mrs Adams was obviously poorly. She came to the door slowly to let him in. She led him back into the living room at the rear of the house. She said that she was breathless, she felt unwell and had a cough. On examination he found that her heart was racing. She was clammy to touch and looked pale. On listening to her chest, he heard fine crackles. Her lips were slightly blue. He thought she had bronchopneumonia in both lungs. He told her she should be

in hospital. She said she had been just as ill as this on other occasions and had stayed at home. At her suggestion, he went into the front room to find a telephone to speak to Mrs Thorley. While he was there, Mr Catlow arrived. Shipman explained the situation and said that he was about to telephone the daughter, as Mrs Adams ought to be admitted to hospital. After a few seconds, Mr Catlow called him into the living room and said that Mrs Adams was not very well. He carried out a full external examination and concluded that she had died. He thought the cause was bronchopneumonia. He explained to Mr Catlow that he could not resuscitate her on account of the infection. He summoned Mrs Thorley and, when she arrived, he gave her a full explanation of what had happened and asked her if she wanted a post-mortem examination. She did not.

The following day, Mrs Sonja Jones, Mrs Adams' other daughter, went to see Shipman. He gave her an account which tallied with his evidence to the court save that she claimed that he told her he had telephoned for an ambulance and had cancelled it later after Mrs Adams had died. It was admitted at trial that no call was made from the house to the ambulance service. Shipman denied ever having said he had called for or cancelled an ambulance. Mrs Jones also claimed that she asked Shipman whether there should be a post-mortem examination in view of the suddenness of the death but he said it was not necessary. That was also disputed.

Certification

Shipman signed the Medical Certificate of Cause of Death (MCCD), saying that the cause of death was bronchopneumonia of 12 to 24 hours' duration. He completed cremation Form B saying that death had occurred at 14.50, some 50 minutes after his arrival. He said that a neighbour (Mr Catlow) was present at the death. He certified that he carried out a complete external examination. In evidence, he claimed that he undertook a modified external examination, which included looking at the pupils, the retina and listening to the heart through Mrs Adams' clothing. Mr Catlow said that no examination at all was carried out at that time.

The Expert Evidence

Dr John Grenville examined the medical records. On the visits request form, Shipman had written:

> **' Chest infection green phlegm 120pm irregular chest pains central L shoulder. feels ill bronchopneumonia'**.

There was no reference to any proposed treatment or to calling an ambulance or to the death. The computerised records contained entries made on the day after the death. They said:

> **' Bronchopneumonia due to unspecified organism.**
>
> **very poorly arrange to admit 1430 hrs'**.
>
> **' O/E – dead**
>
> **friend present daughter telephoned 1450 hrs'**.

Mrs Adams' Lloyd George records were found in Shipman's garage after his arrest. They showed that Mrs Adams had suffered from a number of chronic conditions, none of which was related to the death.

Dr Grenville said that the antibiotic, Ceporex, could cause stomach upset, dizziness and nausea. In his view, Mrs Adams' deterioration on the morning of her death was probably due to an adverse reaction to the antibiotic. It was possible that her chest infection had worsened but, as she did not complain to the receptionist of breathlessness or deterioration in her cough when she telephoned the surgery, that was unlikely. He said that Shipman's note of the consultation on the visits request form was consistent with a severe chest infection but he thought it very strange that the fatal outcome had not been recorded. He said that, if Mrs Adams had been as ill as Shipman claimed she was when he arrived, he should have sat her down in the front room and examined her there. If, as he claimed, he was out of the room when Mrs Adams ' fainted', he should have summoned an ambulance and tried to resuscitate her. Her chest infection would have been treatable. This was a sudden and unexpected death which should have been reported to the coroner.

Comment

The following significant points arise in this case:

- The death took place in Mrs Adams' home and in Shipman's presence. This is a factor which gives rise to a high degree of suspicion. A natural death at home during a doctor's visit is an extremely rare event in the experience of most general practitioners. If Shipman were to be believed, natural deaths occurred frequently during his home visits.
- The death was extremely sudden. As Dr Grenville has explained, death from bronchopneumonia is not as sudden as this. The patient is very ill for at least a few hours before death. Mrs Adams had been out shopping the previous day. That morning she had done her usual household jobs.
- Shipman's treatment of the condition he claimed to have found was inappropriate, according to Dr Grenville. If Mrs Adams had been truly as ill as Shipman later claimed, he should have summoned an ambulance immediately. If she had been unwilling to go to hospital, he should have spoken to Mrs Thorley. If Mrs Adams really had collapsed, he should have tried to resuscitate her. As it was obvious that he had not made any attempt to do so, he made an untenable attempt to justify his decision. He should have made a complete and thorough note of the consultation, Mrs Adams' reluctance to go to hospital, the steps he had taken in the face of that reluctance and the events leading to the death. He did not.
- Mrs Adams was found sitting in a chair as though asleep. This position and appearance are not typical of a death following bronchopneumonia but are entirely typical of those observed at the deaths of many of Shipman's victims.
- Shipman told others that the patient had been advised she needed hospital admission but that she was reluctant to agree. This is an explanation Shipman was to give on many other occasions.
- Shipman told others he had called an ambulance and cancelled it but no such call was made. At trial, he denied having said this.

- A witness says that Shipman did not carry out any examination to diagnose death whereas Shipman claimed he did. This is a feature common to many cases.
- Shipman's claim on cremation Form B that Mr Catlow was present at the death is misleading.
- Shipman claimed that he suggested a post-mortem examination but the witnesses said that Shipman told them this was not necessary. The death was not reported to the coroner although, as Dr Grenville said, such a report was plainly called for.

Muriel Grimshaw

Introduction

Mrs Muriel Grimshaw died on 14th July 1997 at the age of 76. She was in very good general health. The medical records show regular prescriptions for medication to control her blood pressure and occasional episodes of lumbago. She attended the surgery periodically for routine checks but had not consulted her doctor since May 1997, when she had suffered an episode of back pain. She had recovered from this after buying a new bed. In the weeks before her death, she had been well and had led a full and active life. After exhumation of her body, morphine was found in the tissues consistent with the administration of a lethal dose.

Personal Background

Mrs Grimshaw's daughter, Mrs Ann Brown, used to see her mother regularly on Sundays and Thursdays. They spoke by telephone on most days. On Sunday 13th July, Mrs Grimshaw and Mrs Brown went to church together. After church, they had a cup of coffee and a chat at Mrs Grimshaw's house. They agreed to have lunch together on the coming Wednesday. Mrs Grimshaw was in good health and spirits on that day.

The Circumstances of the Death

Each Tuesday, Mrs Grimshaw went shopping with her friend, Mrs Ryan. Early on the morning of Tuesday 15th July 1997, Mrs Barbara Ryan called to collect her. There was no answer when she rang the doorbell, so she contacted Mrs Brown. They entered the house and found Mrs Grimshaw, lying dead on her bed, fully dressed in day clothes. The television had been left on and the curtains were open. It would have been most unusual for Mrs Grimshaw to leave the television on when she went to bed; she always unplugged it at night. Mrs Brown telephoned for Shipman. On arrival, he looked at the body but did not touch it. He announced that Mrs Grimshaw had died at about 5.30pm the previous day. He said that it had been a nice way to go. There would be no need to inform the coroner. He did not say anything about the cause of death.

Later he signed a Medical Certificate of Cause of Death (MCCD), stating that death had been due to a cerebrovascular accident with hypertension as an underlying condition. He stated that he had last seen Mrs Grimshaw alive on 2nd July. However, Mrs Grimshaw's medical records did not contain any reference to a consultation on that day and Mrs Brown said that her mother had not seen Shipman since May.

The Defence Case

Shipman's account in evidence, which the jury must have rejected, was that Mrs Grimshaw suffered from hypertension and rheumatoid arthritis. He claimed that he had decided to call on her on 2nd July because he had noticed that the previous day she had asked for a repeat prescription for her medication. It was true that she had asked for repeat prescriptions; they were recorded on the computer. He said that he recalled that the last time he had seen her, which was when she had lumbago in May, she had not been entirely well. When he visited on 2nd July, he found her well, although her back was still a little troublesome. Mrs Brown said that, to her knowledge, he had not called and her mother's back was not troubling her in July.

Shipman said that he called to see Mrs Grimshaw again at about 1pm on 14th July. He found her having a cup of tea. She said her back was giving no trouble. He went back to the surgery and made an entry timed at 2.06pm in which he recorded that visit. An entry was indeed made at that time; it said only that Shipman had seen the patient in her own home. He said that the next thing he knew about Mrs Grimshaw was that he was called to her house the next day as her body had been found. He said that he examined the body and found that rigor mortis was setting in. From a discussion with Mrs Brown about her mother's habits, he had been able to estimate the time of death at 6pm. Mrs Brown denied that any such discussion had taken place. Shipman said that he had diagnosed the death as being due to a stroke associated with hypertension. He considered that Mrs Grimshaw had not had a heart attack. The onset of her symptoms had been slow enough to allow her to lie down, whereas, if she had had a heart attack, she would have fallen where she was. At the time, it did not occur to him to think that a post-mortem was necessary. He had offered one to Mrs Brown but she had declined.

The Expert Evidence

Post-mortem examination showed no significant abnormality apart from the presence of morphine in the tissues. There was some atherosclerosis in the coronary arteries but this was not of such severity as to be likely to cause a heart attack in the absence of stress on the heart due to physiological trauma. There was no bleeding into the brain and no sign of either a haemorrhagic or occlusive stroke. Although Dr Rutherford could not rule out the possibility that Mrs Grimshaw had had a stroke, there was nothing to suggest that she had and the presence of morphine in the body tissues drove him to the conclusion that she had died as the result of morphine toxicity. Shipman had no explanation for the presence of the morphine.

The medical records showed that Mrs Grimshaw had had hypertension since 1989 but this was well controlled with medication. Dr John Grenville said that it would not have been possible for any doctor to diagnose the cause of death on the information available and the death should have been reported to the coroner.

Comment

This is a clear case of murder in which morphine was found in the body. Shipman must have made a completely unsolicited visit on 14th July to a patient whom he had not seen since May and who was in completely normal health. He must have found some pretext for giving her an injection. The significant features are:

- The sudden death of this healthy woman was discovered very soon after a visit at which Shipman saw her alone.
- When Shipman was summoned, Mrs Brown said that he did not even examine the body sufficiently to establish that Mrs Grimshaw was dead. This is an observation made by many relatives in cases in which Shipman has killed. The inference to be drawn is that he already knew that the patient was dead.
- There was no feasible natural explanation for the sudden death and Shipman was not in a position to certify the cause of death. Shipman should have refused to certify the cause of death and the death would then have had to be reported to the coroner. Shipman claimed

that Mrs Brown had refused his suggestion that there should be a post-mortem examination. Shipman often said that relatives had refused or had ‘ not wanted’ a post-mortem examination. It is not a matter for the relatives to decide. It is for the doctor to decide whether he or she is in a position to issue the MCCD. In any event, Mrs Brown says that Shipman made no such suggestion.

Kathleen Grundy

Introduction

Mrs Kathleen Grundy died on 24th June 1998 at the age of 81. Shipman certified her death as having been due to old age but scientific analysis of body tissues following exhumation of her body in August 1998 showed that she had died of morphine poisoning.

Personal Background

Mrs Grundy was a widow and lived alone. She was in remarkably good health for her age. She led a busy social life and worked for many charitable organisations, including Age Concern and Werneth House, a day centre for the elderly. She spent the evening before her death with a friend and was in normal health when she went home.

The Circumstances of the Death

In the few days before her death, Shipman had inveigled Mrs Grundy into agreeing to take part in a research project into the ageing process, supposedly to be conducted by Manchester University. This was a ruse by which means he obtained a sample of her signature (which he used in an attempt to forge a will) and also created an excuse to visit her at home. She visited him on 23rd June, to have her ears syringed, and he told her that he needed a blood sample, for the research project, which must be taken early in the morning. He arranged to visit her at about 8.30am the next morning.

The next day, she was due to attend Werneth House but she did not arrive. Friends and colleagues there became concerned and two of them, Mr John Green and Mr Ronald Pickford, went to her house at about midday. They found her, lying on the sofa, fully dressed. She was dead and her body was cold. The door to the house was unlocked. They summoned Shipman to the house. Following a perfunctory examination of the body, he said ' cardiac arrest'. He had a brief discussion with someone in the coroner's office, in which it was agreed that a certificate, which stated the cause of death to be ' old age', would be acceptable. No record was kept of the conversation with the coroner's office.

When Shipman had left the house, Mr Green informed the police, as he was unable to contact Mrs Grundy's daughter, Mrs Angela Woodruff. The officers concerned (PCs John Fitzgerald and Neil Phillips) spoke to Shipman later. Shipman told them he had called on Mrs Grundy earlier that day because she had been unwell. He did not say he had called to take a blood sample. He said he had spoken with the coroner's office and he was going to issue a certificate stating that Mrs Grundy had died of natural causes. The police officers took a quick look at the body and, on seeing nothing suspicious, took no further action.

The day after the death, Shipman spoke to Mrs Woodruff. He told her that he had seen Mrs Grundy on the day before her death, just for ' a routine thing'. He was vague and mentioned chest pain, possibly due to indigestion. He said he had arranged to collect a blood sample the next morning. When he arrived, she was not yet dressed. He then said that some old people complain of feeling unwell a few days before they die and then just die. He implied that this had happened to Mrs Grundy. He handed Mrs Woodruff the Medical Certificate of Cause of Death (MCCD) and said that he had certified the death as being due to old age.

The Defence Case

Shipman's account of this death, which the jury must have rejected, was that for some time he had suspected that Mrs Grundy might be abusing drugs. He claimed that he had become concerned about her general health. He decided he would like to take a blood sample in order to check for diabetes and anaemia and suchlike. When she came into the surgery on 23rd June, he thought she looked in poor health and he decided to do extensive tests. He arranged to visit her the next morning to take a blood sample. This had to be available for collection before 11am, so he visited at 8.30am. She was dressed in her housecoat. She looked old and moved slowly. He took the sample and left. That morning he was so busy he forgot to send the sample for testing. He threw it away, thinking that he would have to obtain another. (It should be noted that in interview with the police he claimed that he had sent the sample to the laboratory but they had lost it.) Soon after midday, he was summoned to Mrs Grundy's house, where he did a full examination of the body and found she was dead. She was wearing different clothes from when he had seen her earlier, implying that she must have dressed herself after he left. He thought she had been dead since about 10am. When confronted with the results of the forensic tests following the post-mortem examination, Shipman suggested that Mrs Grundy must have administered the morphine to herself.

Neighbours and relatives gave evidence that Mrs Grundy would never have left the door unlocked. She was very conscious of the need for security. If she had not left the door unlocked herself after letting Shipman out, the inference was that Shipman must have let himself out of the house after killing her and had been unable to lock the door behind him.

There was no record of a blood sample being received at the pathology laboratory.

The Expert Evidence

Dr Rutherford, the pathologist who conducted the post-mortem examination, found no natural explanation for Mrs Grundy's death. She had been in good health. Scientific analysis of the body tissues revealed levels of morphine consistent with the administration of a fatal dose.

Dr John Grenville said that there were a number of false entries in the medical records. These had been created after the death to give credence to Shipman's stories first that Mrs Grundy was under the weather when he saw her on 23rd June and second that Mrs Grundy had been abusing drugs and might have administered the morphine herself. These false records comprised veiled expressions of his supposed suspicion that Mrs Grundy was taking drugs and of his supposed decision not to confront her with his suspicions.

The Forging of the Will

Shipman's attempt at forging Mrs Grundy's will was crude and hopelessly incompetent.

First, he sought to obtain the whole of Mrs Grundy's substantial estate, leaving nothing to her well-loved daughter and grandchildren. Second, he chose to forge the will of a woman whose daughter was a solicitor, who might therefore be expected to know something about her mother's previous testamentary arrangements. Third, he drafted the will using his own old-fashioned Brother portable typewriter. When the police came to Shipman's premises and took

possession of the typewriter, the will was immediately linked to him. The product looked thoroughly unprofessional and it was wholly foreseeable that it would arouse suspicion.

Fourth, Shipman forged Mrs Grundy's signature and dated the will 9th June 1998. On that day, he staged a ' signing and witnessing' event in his consulting room. He must have prepared a document for Mrs Grundy to sign, which purported to provide for her consent to take part in some medical research supposedly to be conducted by Manchester University. This document required that Mrs Grundy's signature should be witnessed by two others, who also had to sign and provide their names, addresses and occupations. While Mrs Grundy was at Shipman's surgery on 9th June, Shipman appears to have obtained her signature on this document and then called two patients from his waiting room into the consulting room where they completed and signed the witnesses' part of the document. Shipman must then have copied the three signatures as well as he could. The forgeries were obviously poor and would have aroused suspicion even from a non-expert. Expert evidence soon proved them to be forgeries.

Fifth, Shipman delivered the forged will with a covering letter to a firm of solicitors in Hyde with whom Mrs Grundy had had no previous dealings. The solicitor who opened the letter was very puzzled and put it to one side. He had received it on 24th June 1998. Only six days later he received another letter, apparently signed by someone called Smith, who did not exist. This had been written by Shipman on his own typewriter. It informed the solicitor of Mrs Grundy's death and advised him that her daughter could be contacted at Mrs Grundy's house. The solicitor contracted Mrs Woodruff and sent her the will. She was immediately suspicious and set in train the investigations which led to the detection of Shipman's crimes.

Comment

This was a clear case of morphine poisoning, proved by the post-mortem results. Even leaving that evidence out of account, there are a number of noteworthy features:

- This was a very sudden death of an elderly person in good health. It was discovered shortly after a visit from Shipman during which he was alone with her.
- Shipman claimed or implied that Mrs Grundy must have left the door unlocked after letting him out. This is a feature of other cases where Shipman has been unable to leave the security system in the condition in which relatives would have expected.
- The medical records had been falsified to show that Mrs Grundy was unwell just before her death and that Shipman had suspected her of drug abuse. Even so, they still showed that Mrs Grundy had been in good general health and had no potentially fatal conditions or increased risk factors.
- The cause of death, ' old age', was quite inappropriate for a person who had been in such good health.

Pamela Marguerite Hillier

Introduction

Mrs Pamela Marguerite Hillier died on 9th February 1998 at the age of 68. She was a widow and lived alone. She lived a busy, physically active life. She kept a dog, which she walked regularly. She took medication for hypertension.

The Circumstances of the Death

About a week before her death, Mrs Hillier fell and hurt her knee. The injury was not such as to interfere with her usual activities but, on Sunday 8th February, she found her knee was painful while driving the car. Early the next day, she telephoned Shipman's surgery and asked him to visit. The receptionist's note of the conversation mentioned the painful knee and nothing else. When Mrs Jacqueline Gee, Mrs Hillier's daughter, left shortly before lunch, after spending the morning with her, Mrs Hillier was very well. Mrs Hillier intended to sort out her accounts. The two women spoke by telephone at 1.07pm. Shipman must have visited shortly afterwards. At about 2pm, Mrs Gee telephoned her mother but there was no reply. Later in the afternoon, Mrs Gee made several more attempts to speak to her mother and became worried when there was still no reply. She contacted Mr Peter Ellwood, a neighbour, who went in and found Mrs Hillier. She was flat on her back on the bedroom floor. He arranged for an ambulance to be called and gave mouth-to-mouth resuscitation but to no avail. When the paramedics arrived, they said that Mrs Hillier was dead. Mrs Gee arrived soon afterwards. She found the papers relating to her mother's accounts on the table and her lunch in the microwave oven.

Later, Shipman attended. One of the paramedics said that he would have to inform the police, as this was a sudden death at home. Shipman said that would not be necessary. Mrs Hillier had had a stroke. Mr Gee asked if there would be a post-mortem but Shipman said this would not be necessary as he knew Mrs Hillier had had a stroke on account of the way in which she had been lying. If she had had a heart attack, she would have been holding her chest or reaching for something. One witness said that Shipman said, ' Let's put it down to a stroke'. Shipman said he had seen Mrs Hillier earlier and had found her blood pressure rather high. He had told her to take another tablet. He had not increased the dose earlier as she had not complained. Shipman was variously described as abrupt, unfriendly, detached and unsympathetic.

The Day after Death

The following day Mrs Gee and her brother, Mr Keith Hillier, spoke to Shipman about the death. Shipman said that Mrs Hillier had died because of her high blood pressure. Mr Hillier asked why, if the blood pressure had been too high, it had not been possible to increase the medication. Shipman said it was necessary to have three raised readings before the medication could be increased. Mr Hillier again raised the question of a post-mortem. Shipman said it was not necessary. He was sure of the cause of death. It would be an unpleasant thing to do, to put Mrs Hillier through a post-mortem. The death had been instantaneous and painless. He could tell from her position that she had not suffered. If she had been in pain she would have doubled up forwards.

Certification

Shipman signed a Medical Certificate of Cause of Death (MCCD), giving cerebrovascular accident of a few minutes' duration as the immediate cause of death. Hypertension of six years' duration was the underlying cause. As Mrs Hillier was to be cremated, he completed Form B. He stated that the death had occurred at about 2pm, about 30 minutes after he had seen Mrs Hillier. He said he had attended her for 24 hours during her last illness. He said that no one had been present at the death. She had been found by a neighbour, collapsed and dead. He said that the mode of death had been syncope of only seconds' duration. This must have been an assumption on his part.

Dr Richard Fitton signed Form C. He said that Shipman told him about the case. He carried out an external examination but did not expect to see any external signs. He was satisfied that the cause of death was cerebrovascular accident.

The Medical Records

The computerised medical records contained a number of backdated entries, made after the death, designed to give the appearance of a developing problem with high blood pressure and some concern over whether Mrs Hillier was taking her medication as prescribed. Shipman invented a consultation on 5th February (which Mrs Gee said did not take place) at which Mrs Hillier is said to have complained of osteoarthritis, worse in the left knee than the right, and her blood pressure was found to be raised at 150/100. Shipman noted that the patient said she was off colour and one leg was weak. He purported to wonder whether this was due to the knee. He noted that there was no sign of a cerebrovascular accident but the blood pressure was definitely raised. He had had a chat with the patient about her diet and exercise. He wondered whether to increase her tablets, presumably meaning the blood pressure tablets.

Shipman also created a false entry for the day of the death. For the visit to her home when she was alive, he noted that she complained of malaise. Her blood pressure was high at 170/106. He advised her to increase her medication. She was ' to let us know' – about what is not clear. She was to come to the surgery on the Friday. The second entry for that day records that she had been found by a neighbour and an ambulance had been called. She was dead. He stated the time as 14.00 hours. She had collapsed on the bedroom floor and it looked like a cerebrovascular accident.

The Defence Case

Shipman's account in evidence, which the jury must have rejected, was that he had visited Mrs Hillier at 1.30pm. She told him her knees were no better and that the Co-codamol tablets which he claimed he had prescribed for her on 5th February were not working. He took her blood pressure and found it to be 170/80, which was worryingly high. He said he would have to increase the dosage of her medication. She should take a tablet immediately and then lie down for a couple of hours. She should see him on Friday. Until then, she should take things quietly. For the knee, he would refer her to a consultant orthopaedic surgeon. She then told him that there had been two other occasions (6th January and 5th February) on which Mrs Gillian Morgan, the surgery nurse, had taken her blood pressure and found it to be high. Nurse Morgan had told Mrs Hillier to tell Shipman when she saw him but she had not done so as, on

the first occasion, she had missed taking a couple of her tablets and the second time she thought the rise was a temporary matter associated with the anniversary of her husband's death. Shipman asked Mrs Hillier if she had other symptoms of raised blood pressure and she admitted that she felt tired and her injured leg felt weak. On his return to the surgery after the visit of 9th February, he had entered the information she had given him at the dates on which she had said the readings were taken. He said this was not done with an intention to deceive, although the entries were plainly misleading. He said he had intended to ask Nurse Morgan about the raised blood pressure readings but had not done so. He was critical of her for not having told him of the readings. However, none of these matters were put to Nurse Morgan when she gave evidence. This tale was of recent invention.

Comment

The jury convicted although there was no direct evidence of morphine poisoning. The case contains a number of features typical of a Shipman killing:

- The deceased was in apparently good health and death was very sudden and wholly unexpected.
- The death was discovered shortly after a visit during which Shipman was alone with the patient. No one saw Mrs Hillier alive or spoke to her after Shipman's visit.
- Shipman deterred the family from seeking a post-mortem examination (by applying some emotional pressure). He also dissuaded the paramedics from making a report to the police.
- He falsified the records to lend credibility to his claimed cause of death. This is one of the cases where the audit trail enabled the prosecution to prove that there had been an elaborate falsification. Mrs Hillier was not suffering from any potentially fatal condition and Shipman found it necessary to create evidence that she was.

Jean Lilley

Introduction

Mrs Jean Lilley died on 25th April 1997 at the age of 58. She was a married woman. At the time of her death, she was not in good health. She suffered from heart disease, hypertension and respiratory problems. She used a wheelchair when out of the house. These illnesses might well have accounted for her sudden death. However, following exhumation of her body, morphine was found in the tissues and at the trial it was accepted that she had died as the result of morphine toxicity. The jury must have found that Shipman had injected her with morphine or diamorphine.

The Circumstances of the Death

Mr Albert Lilley, Mrs Lilley's husband, worked as a long-distance driver. He carried a mobile telephone with him, which was always switched on. For about two days before her death, Mrs Lilley had had a cold and cough. At about 11am on the day of his wife's death, Mr Lilley telephoned his wife from his vehicle to see how she was. She told him she had telephoned to ask the doctor to visit on account of her cold. She was awaiting his visit.

Mrs Elizabeth Hunter, a neighbour, visited Mrs Lilley for a chat and a cup of tea in the middle of the morning. Mrs Lilley said she was not feeling well and was waiting for the doctor to visit. From her own home, Mrs Hunter saw Shipman arrive at about noon. She was about to go round 45 minutes later, when she saw Shipman leave. Shortly afterwards, she went into Mrs Lilley's flat and found her on the sofa, apparently asleep. She felt her hand and found it cold. She ran out to try to stop Shipman but he had just gone. She went back inside and tried to resuscitate Mrs Lilley but there was no response and she noticed that her lips were blue. Mrs Hunter telephoned the surgery and was advised to call an ambulance, which she did. This was at 1.19pm. The paramedics arrived at 1.29pm and pronounced Mrs Lilley dead. They removed her body into the bedroom. Then Shipman arrived. He was quite brusque with Mrs Hunter, who was crying. He told her that Mrs Lilley had had a bad heart and her death had been expected. He said that, when he had visited earlier, he had tried to persuade her to go to hospital but she had refused. He did not examine the body or even go into the bedroom. He told the paramedics that he would sign a Medical Certificate of Cause of Death (MCCD). He told them that Mrs Lilley had had a long medical history and her death was not unexpected.

Early in the afternoon, Shipman spoke to Mr Lilley and told him that he had tried to persuade Mrs Lilley to go to hospital but she would not agree to do so. Mr Lilley found that hard to believe, as his wife respected Shipman and had previously accepted his advice on such matters without question. Shipman said that he had been waiting until Mr Lilley came home and could persuade her to go to hospital but it was now ' too late'. Her heart had failed. Mr Lilley wondered why his wife had not telephoned him if she had wanted to discuss admission to hospital.

The Defence Case

Shipman's account, which the jury must have rejected, was that he had called upon Mrs Lilley at about 1pm at her request. He found her dressed. She said she was not breathing well and had pains in the chest and was producing phlegm. He checked her pulse, took her blood

pressure and listened to her chest where he heard fine crackles, which convinced him that Mrs Lilley should be admitted to hospital. When told of this opinion, Mrs Lilley was reluctant to agree and asked him to give her an antibiotic. He tried to persuade her to go to hospital and suggested that she should telephone her husband or a member of her family. He then left, saying that if, when she had spoken to her husband, she would agree to be admitted, he would come back and arrange it. Otherwise he would come back that evening. He was with her for about 20 to 25 minutes. About 20 minutes after leaving, he was paged by the surgery and was told that Mrs Lilley had collapsed. He returned to the flat and found the paramedics in attendance. Mrs Lilley was on the bed. He did not examine her as the paramedics had done so. He made appropriate arrangements to tell members of the family of the death. The following day, he asked Mr Lilley if he wanted a post-mortem examination but Mr Lilley did not think it necessary.

Certification

Shipman completed the MCCD, saying that Mrs Lilley had died of heart failure due to ischaemic heart disease and hypertension. He stated she had also suffered from fibrosing alveolitis and hypercholesterolaemia.

The Expert Evidence

Dr John Grenville examined the medical records and accepted that past entries showed that Mrs Lilley had chronic ill health with angina due to narrowing of the arteries and apparent alveolitis. The cholesterol levels were raised. Hypertension had been treated. The entry for the day of the death, made by Shipman after the death, created an impression of a very poor state of health, entirely consistent with heart failure. There were references to basal crepitations and a rapid irregular heartbeat. The liver was said to be enlarged, a sign of heart failure. The Crown's case was that this entry had been fabricated to give credibility to Shipman's account of the death.

Dr Grenville made two points. First, if Shipman's account were true, he had found Mrs Lilley in urgent need of medical treatment. She should have been admitted to hospital as an emergency. Had she refused, Shipman should have contacted relatives who could have tried to persuade her. On no account should he have left her. Second, if Mrs Hunter's evidence was right, Shipman left Mrs Lilley when she was either in extremis or just dead. The cyanosis observed by Mrs Hunter would have taken two to three minutes to develop after the heart had stopped. Mrs Lilley must at least have been in cardiac arrest when Shipman left.

After exhumation, a post-mortem examination was performed and samples taken for scientific examination. Morphine was found in the tissues at a level consistent with the administration of a fatal dose. Shipman could offer no explanation for its presence.

Dr John Rutherford, the pathologist, said that Mrs Lilley had only mild to moderate atherosclerosis. There was no sign of alveolitis. There were no blood clots. In short, there was no clear cause for her sudden death, other than the finding of morphine. He pointed out that to give morphine to someone suffering from a chest infection, with impaired respiratory function, would be disastrous. Even a therapeutic dose might kill.

Comment

The following significant points arise from this case:

- Because Mrs Lilley was in poor health, her sudden death would readily have been passed off as due to heart failure, had it not been for the finding of morphine in the body tissues. When Shipman had killed a patient, he usually attributed the death to a cause for which some foundation could be found in the medical records.
- This was a sudden death which occurred in the patient's home, either while Shipman was present or very shortly indeed after he had been with her. If, as Mrs Hunter said, the body was cold by the time she found it, then Shipman had been present at the death. For a patient to die in the presence of his or her general practitioner during a home visit is a very rare event in the experience of most doctors.
- Mrs Lilley was found sitting in a chair as though asleep. This appearance is typical of many of Shipman's victims who have been killed by diamorphine injection. This appearance would not be typical of a death from heart failure.
- Shipman's explanation of events was not credible. It would have been most unlikely that Mrs Lilley would have rejected his advice to go into hospital. She would have contacted her husband on his mobile telephone to discuss the situation.
- Shipman's account of his actions fell well below acceptable standards of medical practice. He claimed that Mrs Lilley rejected his advice to be admitted to hospital. If she were so ill as to require admission as an emergency, he should not have left her without making some efforts to find a relative who might persuade her to be sensible or without making some arrangements for her care.

Ivy Lomas

Introduction

Mrs Ivy Lomas died on 29th May 1997 at the age of 63. The death occurred in Shipman's surgery. He certified the death as being due to coronary thrombosis. Post-mortem examination, after exhumation of the body, showed a level of morphine in the tissues consistent with the administration of a fatal dose.

Personal Background

Mrs Lomas was not in good health just before her death. Her medical records show that she suffered from chronic obstructive airways disease and quite frequent upper and lower respiratory tract infections. She had been a heavy smoker and smoked 40 cigarettes per day. She could not walk far or lift anything heavy. She also suffered from depression and anxiety and was a very frequent visitor at Shipman's surgery. Her adult son suffered a psychiatric illness and this caused Mrs Lomas a great deal of worry. On account of her restricted tolerance of exercise, one of her neighbours took her dog for a walk each day.

The Circumstances of the Death

Two neighbours saw Mrs Lomas on the day of her death. To one, she mentioned that she had pains in her chest and arms. However, she was able to go out in the morning to make arrangements for the care of her son, who was ill. In the afternoon, she took a bus into Hyde in order to attend a 4pm appointment with Shipman. She arrived early and was seen to be looking a little pale. She walked into the consulting room unaided.

After a very short time, Shipman took Mrs Lomas from his consulting room to the treatment room. After about ten minutes, Shipman came to the reception area. According to the receptionist, he looked flushed and apologised for keeping his patients waiting. He said he had had a problem with the electrocardiograph (ECG) machine. He dealt with two or three more patients in his consulting room before returning to the treatment room. He then called the receptionist, Mrs Carol Chapman, into the treatment room and told her that he had tried to take an ECG reading on Mrs Lomas but could not get a trace. He said that he had first thought the machine was broken but then realised that Mrs Lomas had died. He said he had tried to resuscitate her but could not do so. He told Mrs Chapman to contact Mrs Lomas' son, Jack. He saw some more patients. Mrs Chapman could not contact Mr Lomas, so she rang the police.

When PC Reade attended, he was shown the fully clothed body of Mrs Lomas in the treatment room. Shipman told him that he would be able to certify death as due to natural causes. PC Reade was curious (although apparently not suspicious) and asked Shipman what had happened. Shipman said that Mrs Lomas had come in to consult him about bronchial problems. After treating her for that, he had shown her into the treatment room to rest. He had carried on seeing other patients. About 15 minutes later, he had gone back to Mrs Lomas and had found her dead. He did not mention an ECG to PC Reade. He said he had not tried resuscitation because Mrs Lomas had been quite beyond that. Nor had he called an ambulance. PC Reade claims that he was amazed. Shipman made a joke in very bad taste about Mrs Lomas having been so frequent a visitor to the surgery that he had thought of having a seat reserved for her, with a plaque.

Mrs Lomas' daughter, Mrs Carol Dalpiaz, saw Shipman that evening. He told her that Mrs Lomas had come into the surgery looking unwell. He said he had taken her to the treatment room, as he had to see another patient in his consulting room. He did not say that he had wanted to do an ECG. He said that, when he had seen the other patient, he went back to see Mrs Lomas and found her dead. She had gone blue round the mouth. She had had a massive heart attack and had died. He had tried to revive her but failed. He said nothing about a post-mortem examination.

The Defence Case

Shipman's account in evidence, which the jury must have rejected, was that, when she arrived for the consultation, Mrs Lomas said she had had chest pain for four hours that day. She looked sweaty and had an irregular pulse. He thought she might be having a coronary thrombosis. He decided to do an ECG so he took her to the treatment room. As she was getting onto the bed, she collapsed. He turned her onto her back and saw that she was unconscious. He tried resuscitation. He hit her hard twice on the chest. He put a tube down her throat to keep the tongue out of the way. He did external cardiac massage and mouth-to-mouth resuscitation. She did not respond. He checked her eyes and heart and found she was dead. He had not called for assistance, as he was skilled in first aid. He had not thought it appropriate to call for an ambulance with paramedics. He then went to see Mrs Chapman and told her he had a problem with the ECG machine and would see the next patient. He did not tell her Mrs Lomas was dead, as that would have meant taking her off her duties. So he saw three patients, then told Mrs Chapman of the death and asked her to contact Mr Lomas. He had certified the death as due to a coronary thrombosis.

The Medical Records

The medical records were voluminous but contained only one reference to heart disease. This was on the handwritten summary card; the last entry, dated 1991, said **' IHD'**, which means ischaemic heart disease. The computerised records contained no reference to heart disease of any kind and Mrs Lomas was not receiving any medication for a cardiac condition. The Crown suggested that the reference to ischaemic heart disease in the summary card was false and had been made in order to lend plausibility to Mrs Lomas' death supposedly from a heart attack.

Shipman's record of the final consultation said that Mrs Lomas had been suffering from pain in the centre of the chest radiating to the arms for four to five hours that day. It was now continuous and she felt sick and dizzy. Blood pressure was recorded as 100/70, which is low. The pulse was said to be 64 beats per minute but irregular. She was said to look grey. Shipman claimed to have diagnosed a coronary thrombosis on the basis of these clinical signs. The record continues:

> **' 1445 Died family informed'**.

The causes of death are set out.

The Expert Evidence

Dr John Rutherford, the pathologist, conducted the post-mortem examination and found some signs of emphysema. There was also a moderate degree of atherosclerosis, sufficient to give rise to a coronary thrombosis. So, in fact, Mrs Lomas was suffering from heart disease. However, it appears that, until that day, she had not complained of any symptoms relating to her heart. Dr Rutherford also took samples for scientific analysis and, in the light of the amount of morphine found in the tissues, he expressed the opinion that death was due to morphine poisoning. Had there not been so much morphine in the body tissues, he would have been prepared to say that the death was due to coronary thrombosis.

Dr John Grenville expressed the view that, if Shipman's claim (that Mrs Lomas collapsed as she was mounting the bed) was true, Shipman should have reacted very promptly by summoning help with resuscitation and calling an ambulance. On no account should he have left Mrs Lomas alone.

Comment

This was a clear case of murder, as the jury found, but it was clear only because of the morphine level found in the body tissues. Were it not for that evidence, this death might well have been passed off as natural, even at a post-mortem examination. The noteworthy features are:

- This was a sudden death behind closed doors in Shipman's surgery. This is a very rare event in the experience of other doctors. Such an event gives rise to a high degree of suspicion. If a patient collapses at a surgery, the doctor should call for assistance and ask for an ambulance to be summoned. Shipman did not call an ambulance or request the assistance of the staff in his claimed attempt to resuscitate Mrs Lomas. In fact, there is little doubt that no such attempt was made.
- Shipman chose an explanation for the death which was plausible in that Mrs Lomas had been complaining of chest pain and pain in the arm on the day of her death. It rather looks as though Shipman realised that this was pain of cardiac origin and took the opportunity to kill Mrs Lomas.
- Shipman gave inconsistent accounts of events to others. To Mrs Dalpiaz, he had said he had tried resuscitation. To PC Reade, he said he had not. To Mrs Chapman, he did not say that he had. To Mrs Chapman, he said that Mrs Lomas had died in his presence, as he was trying to use the ECG machine. To PC Reade and Mrs Dalpiaz, he said Mrs Lomas had died while he was attending to another patient in another room.

Joan May Melia

Introduction

Mrs Joan May Melia died on 12th June 1998 at the age of 73. Shipman certified her death as being due to lobar pneumonia. Post-mortem examination after exhumation of her body showed a level of morphine in the tissues consistent with the administration of a lethal dose.

The Circumstances of the Death

Mrs Melia was in good general health in the months before her death. She attended Shipman's surgery infrequently. On 11th June 1998, she was feeling tired and under the weather. The following morning, her companion, Mr Derek Steele, took her to Shipman's surgery. Shipman prescribed an antibiotic. Mrs Melia collected her prescription and bought some throat pastilles. She told Mr Steele that the doctor had said that she had pleurisy and pneumonia. In fact, in her medical records, he had noted only that she had a chest infection, the nature of which was not otherwise specified, that air entry was reduced and he could hear rhonchi in the chest. Mr Steele was surprised at the reference to pleurisy and pneumonia, as Mrs Melia did not seem to be seriously ill. He thought that, if she were suffering from these conditions, she would have been admitted to hospital. He took her home. She seemed tired, so he suggested that she should have a rest. He left her and went to his own home nearby. In the late afternoon, he telephoned her but there was no reply. He went round and found Mrs Melia sitting in a chair with her glasses on and a crossword puzzle on her knee. She was dead and her body already felt cold. There were signs that she had had something to eat since Mr Steele had left her.

At 5.54pm, Mr Steele sent for Shipman. On arrival, Shipman looked at Mrs Melia and said that the tablets had not had time to work. He did not touch her. He said he would make out a death certificate. He was in the house only five minutes. He completed a Medical Certificate of Cause of Death (MCCD), saying that the cause of death was lobar pneumonia of two to three days' duration with emphysema as an unrelated contributory condition.

The following day, Shipman told Mrs Melia's niece that her aunt had been very poorly when he saw her in the surgery the previous morning. He had told her to go home to bed. There was no point in taking her to hospital, as she might have died on the way there. He had done what he thought right at the time. He said nothing about a post-mortem examination.

The Defence Case

Shipman's account in evidence, which the jury must have rejected, was that, on the morning of the day of her death, Mrs Melia had complained of a cough with green sputum and of feeling generally unwell. She had no pleuritic pain. Shipman told her to let him know if she had any pain and promised her that he would visit her the following day. Shipman warned her that, if she were no better, she would have to go to hospital. He advised her to go home, take the antibiotic and plenty of liquid and keep warm. Mr Steele summoned him that evening. Shipman examined Mrs Melia's eyes and pulse but she was clearly dead. She was cold. He thought she had died of lobar pneumonia. He had diagnosed that condition that morning but did not think it appropriate to send her to hospital. If all patients who had that condition were to be admitted, the hospitals would be overrun. Only five per cent of sufferers died of it. It was sensible to send her home. He had not mentioned a post-mortem examination to Mr Steele because he had not

realised he was closely connected with Mrs Melia. He had no explanation for the morphine in her body.

The Expert Evidence

Post-mortem examination by Dr John Rutherford, the pathologist, showed slight emphysema and moderate narrowing of the arteries. Mrs Melia had not had lobar pneumonia. He found nothing to account for her death. There were food remains in the stomach, showing that Mrs Melia had eaten a meal not long before death. The scientific analysis of the body tissues showed the presence of morphine and Dr Rutherford said that the cause of death was morphine toxicity. This was not challenged by Shipman. Dr Rutherford made the point that a death from lobar pneumonia can be very rapid but, if this occurs, the patient is extremely ill at the end. He also said that it would appear that Mrs Melia had a chest infection on the day of her death. The administration of morphine while lung function was impaired would have a disastrous effect. In other words, even a dose that was normally safe might be fatal.

Dr John Grenville said that the medical records showed that Mrs Melia had been in good general health. A chest x-ray taken in February 1998 showed only minor changes. The record of the morning visit and the prescription of an antibiotic connoted a chest infection of moderate severity but not one from which the patient might die so quickly. The fact that Mrs Melia had had something to eat after Mr Steele left showed she had not been very ill. This was a sudden death for which the cause was unknown and the coroner should have been informed.

Comment

Had it not been for the finding of morphine in the body tissues, there would have been very little evidence of Shipman's involvement in the death:

- First, there is no direct evidence of a visit by Shipman during the afternoon of 12th June. No one saw Shipman arrive or leave; no one saw his car outside. There is no record of a visit in the surgery documents or on the computer. However, the jury must have been prepared to infer that Shipman had visited Mrs Melia and had administered a fatal dose, almost certainly of diamorphine.
- Second, there are no false, exaggerated or backdated entries in the medical records. The record of the consultation of the morning of 12th June appears to be a genuine one, properly reflecting the moderately severe chest infection from which Mrs Melia was actually suffering. Shipman does not appear to have created any false records to lend credibility to the cause of death he was to certify.
- Third, Shipman did not spin any elaborate tale of Mrs Melia having refused treatment or hospital admission.
- The only suspicious factors (apart from the finding of morphine) were that Shipman exaggerated the seriousness of her chest infection when speaking to Mrs Melia and certified a cause of death which was incompatible with her ability to walk about and eat a meal only a short time before death. If Mrs Melia had been cremated, there would have been no prospect of Shipman being convicted of her killing.

Winifred Mellor

Introduction

Mrs Winifred Mellor died on 11th May 1998 at the age of 73. She had lived alone since the death of her husband in 1989. She had been a patient of Shipman since 1977 and held him in very high regard.

Following exhumation of her body in September 1998, scientific analysis showed that she had morphine in the body tissues consistent with the administration of a fatal dose.

Personal Background

Mrs Mellor had been in good health until her death and, although she was a smoker, she did not smoke heavily. She lived a busy life and was described as being young for her age. She still played football with her grandchildren. She was active in her church and in the community. She had recently booked a holiday in the Holy Land. She frequently walked into Hyde to shop, which took ten to fifteen minutes. She developed a cold a few days before her death but did not appear to her daughter, Miss Sheila Mellor, to be seriously ill on the day before she died, when the two had lunch together.

The Circumstances of the Death

On the morning of her death, Mrs Mellor telephoned the school, where she helped the children with reading, to say that she would not come in that day as she had a cold and a bad chest. She said she was going to see the doctor. She cannot have been very ill, as she did not mention any illness to her friends, Mrs Josephine Barnes and Mrs Mary Ball, both of whom spoke to her on the telephone that morning. Also, she went shopping to Hyde Market in the early afternoon. Her friend, Mrs Margaret Nickson, chatted to her and thought she seemed her usual cheerful self. It is not clear whether she contacted Shipman that day and, if so, how. The records show that she did not telephone the surgery, nor did she attend for an appointment. After her death, Shipman told members of the family that he had called on her during the afternoon at her request and indeed Mrs Gloria Ellis, a neighbour, saw his maroon car outside her house from about 3pm until about 3.20pm. At the trial, Shipman denied that he had visited Mrs Mellor that day, until summoned after her death. It must be assumed that the jury was sure that he had visited her during the day while she was still alive.

At about 6.30pm, Shipman called at the house of Mr and Mrs Ellis and asked them to let him into Mrs Mellor's house. He said he could see that Mrs Mellor was not well. When Mr and Mrs Ellis let Shipman into the house, they found Mrs Mellor sitting in her usual chair. Her head was to one side and she looked as though she had fallen asleep. Shipman picked up her hand, then flicked up her eyes and announced that she was dead. Mrs Ellis was very distressed and Shipman was extremely brusque with her.

Shipman's first detailed account of events was given to Mrs Mellor's daughter, Mrs Kathleen Adamski, in a telephone call from Mrs Mellor's home soon after the body was found. He told her that Mrs Mellor had had heart problems since 1997 but that she had refused treatment. He said that she had called at the surgery earlier in the day and he arranged to visit her at 3pm. When he arrived, he had found her quite poorly, complaining of heart or chest problems. She had refused treatment. He did not say why he had left her. He said she had telephoned the

surgery at about 5.30pm and he had gone to her flat again as soon as he could. He had seen her through the window but could not gain access so he had gone to a neighbour for a key. Mrs Adamski, who at this stage had not realised that her mother was dead, asked whether he was going to send Mrs Mellor to hospital but he said it was too late. She then realised that her mother was dead.

Shipman repeated this account later that evening in the presence of all three of Mrs Mellor's daughters and the priest, Father Dennis Maher, who had called to give the last rites. Shipman said that Mrs Mellor had telephoned him at the surgery at about 2.30pm complaining of chest pains. He said he had visited at about 3pm and had offered Mrs Mellor a spray to put under her tongue. He also offered to admit her to hospital but she had refused and tried to pass the pain off as indigestion. He then said that she had been suffering from angina since about August 1997. On several occasions, she had refused treatment and did not want to go to hospital. He said that Mrs Mellor had telephoned the surgery again at about 5.30pm to say that her pain was increasing. Shipman had promised to come up as soon as he could. When he arrived, he could see through the window that Mrs Mellor was sitting in her chair. When he knocked, she did not respond. He went to find a neighbour who could let him in. When he had examined her, he found that Mrs Mellor was dead. He said that the cause of death was coronary thrombosis and asked the daughters if they agreed that he should put that on the death certificate. He said nothing about a post-mortem examination.

The daughters found the account very strange. First, they were unaware that their mother had angina and found it hard to believe that she had not told them about it. They were a close family. They also found it hard to believe that their mother would have refused medical treatment. She had a very high opinion of Shipman. Finally, they thought she would have telephoned one of them had she felt ill during the day. There was every sign that Mrs Mellor had been quite well during the day. She was sitting in her usual chair, with a cup of coffee at her side. Her shopping remained unpacked in the kitchen. It may be that her sleeve was rolled up and her arm bruised. That is what the family now recalls, but it should be noted that not all these matters were mentioned to the police when they first took statements.

The three daughters and Mr and Mrs Ellis, the neighbours who gave Shipman access to the house after the death, were shocked at his abrupt and unsympathetic attitude.

Certification

Shipman signed the Medical Certificate of Cause of Death (MCCD), giving coronary thrombosis as the cause. He stated that he had last seen Mrs Mellor alive on the day of her death.

The Defence Case

Shipman's account at trial, which the jury must have rejected, was that Mrs Mellor had called into the surgery without appointment at about 4pm on the day of her death. She had given him an account of having suffered chest pain over a period of several months. He advised her that she should have an electrocardiogram and see a cardiologist but she was reluctant and went away, saying that she would think about it. She was to ring him at 5.30pm. As she failed to do so, he went to see her on his way home and found her dead. He claimed to have carried out a

full examination to establish death. He accepted the evidence that morphine had been found in the body tissues and could offer no explanation as to how it came to be there.

The Medical Records

By the time of trial, it had been established that Mrs Mellor's records had been altered at about 4pm on the day of the death. New, backdated entries had been created to give the impression that Mrs Mellor had been suffering from chest pain over a period of several months and had refused the treatment suggested by the doctor. At trial, Shipman claimed that he had made those backdated entries to reflect what Mrs Mellor had told him when she called into the surgery on 11th May. He said they were not intended to mislead (although they clearly did). The entries contained information which could not have been recalled so long after the date of the supposed consultation and could not have been honestly made so as to reflect information provided on the day of the death. Moreover, in interview, before it had been established that the records had been backdated, Shipman claimed that the entries were contemporaneous records of Mrs Mellor's complaints of chest pain.

The medical records also contained two entries made early in the morning of the day after the death, both of which related to the day of the death. The first described an attack of angina pectoris with no signs of congestive heart failure. It was said that Mrs Mellor had refused treatment. There is no reference to a refusal to go to hospital. The second entry deals with Shipman's visit at which he declared that Mrs Mellor was dead. The cause of death was given as coronary thrombosis. The record noted that her daughter and a neighbour were present. Although the record does not explicitly say so, it gives the misleading impression that the daughter and neighbour were present at the time of death.

If the falsified records are taken out of account, there is nothing in Mrs Mellor's medical history to suggest that she was suffering from any serious or potentially fatal condition.

The Post-Mortem Examination

Post-mortem examination revealed no natural cause of death. There was no significant abnormality of the heart or blood vessels. There was no intracranial bleeding and no blood clots were seen in the lung. There was some narrowing of the arteries but not such as would account for sudden death, save under physical stress.

Comment

This was a clear case of morphine poisoning as the post-mortem results showed. Apart from that evidence, the case contains a number of features worthy of note:

- This was a sudden death of a woman who lived alone and which was discovered shortly after a visit from Shipman, at a time when she was alone. No one saw Mrs Mellor alive or spoke to her after Shipman had visited.
- Shipman altered medical records to create a history of angina, which was supportive of his diagnosis of the cause of death, namely coronary thrombosis.

- There are important conflicts between the accounts Shipman gave at the time of the death and the evidence given at trial. Shipman told the family that he had visited Mrs Mellor at home at about 3pm. He told them that Mrs Mellor had been suffering from angina for about a year. At the trial, he said that Mrs Mellor saw him at the surgery in the afternoon and told him for the first time about the angina symptoms she had supposedly been suffering. This was a complete volte-face, rendered necessary by the realisation that the police had been able to trace and time the false records.
- Shipman claimed that the patient had refused treatment shortly before death. This is one of his regular excuses for leaving a supposedly sick patient alone when the truth was that the patient had not been ill and had not required treatment but had been killed by Shipman. He would then have an explanation for the death when it was discovered.
- Shipman was ready to give the impression that a daughter and neighbour had been present at the time of death, when they had not.

Norah Nuttall

Introduction

Mrs Norah Nuttall died on 26th January 1998 at the age of 64. She lived with her son, Mr John Anthony Nuttall. She was a patient of Shipman and thought well of him.

Personal Background

According to her son, Mrs Nuttall was in good general health before her death. She was very independent and often went into Hyde to shop and see friends. Her medical records show that she was obese and suffered from a number of chronic conditions. Dr John Grenville said that there was a history of rheumatic fever, which predisposed her to valvular disease of the heart. There were some references to ischaemic heart disease. The records mentioned breathlessness on exertion and oedema of the legs. The most frequently recurring entries related to nosebleeds. Dr Grenville considered that Mrs Nuttall appeared to have quite severe heart disease and had been appropriately treated, although not well investigated.

The Circumstances of the Death

Shortly before her death, Mrs Nuttall developed a cough. This did not keep her indoors and, on the morning of the day of her death, she went into Hyde to see Shipman. She met some friends who later said that she appeared to be her usual self. When Mr Nuttall came home from work at 2pm, his mother told him that Shipman had given her some medicine and advised her to stay indoors for a couple of days. She did not say that she was expecting Shipman to call. Mr Nuttall was not concerned for his mother's health. Shortly before 3pm, he went out to attend to his ponies.

When Mr Nuttall returned, about 40 minutes later, he saw Shipman's car outside. Shipman was leaving the house. He asked Shipman what was wrong. Shipman told him that his mother was not well and he had rung for an ambulance to take her to hospital. In fact he had not. Mr Nuttall ran into the house and found his mother slumped in a chair, apparently asleep. When he spoke to her, there was no response. Shipman came in behind him and said that it looked as though his mother had taken a turn for the worse. Shipman touched her neck and said, ' She's gone.' He looked in her eye. When Mr Nuttall asked if anything could be done, Shipman said that she had gone and there was nothing he could do. He pretended to cancel the ambulance.

Shipman told Mr Nuttall that he had been visiting nearby when he had received a call asking him to visit Mrs Nuttall and he had come at once. That was not true and, in evidence, Shipman admitted that he had just decided to call on her. He claimed that Mrs Nuttall had told him that she had chest pains. He said that the death had been due to the failure of the left ventricle of the heart. He told Mr Nuttall that, in such a case, a patient would become unconscious and die within about 20 minutes and that, even if the paramedics had come, they would not have been able to save Mrs Nuttall. He did not mention a post-mortem examination. He said that the funeral directors could take the body away.

Shipman telephoned Mrs Oldham, Mrs Nuttall's sister, and told her that he had received a call asking him to visit Mrs Nuttall. He said that, when he arrived, he had found Mrs Nuttall was poorly. She had taken a turn for the worse and died.

The Day after Death

The following day, when Mr Nuttall and Mrs Oldham went to the surgery to collect the Medical Certificate of Cause of Death (MCCD), Shipman purported to demonstrate from the records that Mrs Nuttall had been suffering from breathlessness and high blood pressure.

The Defence Case

The medical record for the day of death shows that Mrs Nuttall attended the surgery complaining of wheezy bronchitis and was given a decongestant. She was also seen in her own home, when she was dead on examination.

Shipman's account in evidence, which the jury must have rejected, was that, when Mrs Nuttall came into the surgery on the morning of 26th January, he diagnosed her as suffering from wheezy bronchitis. She seemed to be all right. He gave her a bottle of cough medicine. At some time between 3pm and 4pm he decided to call on her. He gave a variety of reasons for this visit, such as wishing to see how she was managing in her ' new' house, in which she had then been living for about eight years. His reasons were not credible. He said that Mrs Nuttall had been surprised to see him. As she sat down, she said she was glad he had called, as she was worse than she had been in the morning. She was very breathless, she felt ill and her ankles had swelled up. She had not wanted to bother him by telephoning the surgery. He examined her and found her ankles were swollen and her pulse was ' thready'. On listening to her chest, it was clear she had fluid in the lungs. She was very breathless, cold and slightly blue round the lips. He made a provisional diagnosis of left ventricular failure. He decided to give her an injection of Lasix, a rapid-effect diuretic, so he went out to the car to collect it. As he was going out, Mrs Nuttall's son arrived. Shipman explained that he had just called to see Mrs Nuttall and that she was seriously ill. He was fetching a drug from his car and would then call an ambulance. Shipman followed Mr Nuttall into the house and was preparing the syringe, when he realised that Mrs Nuttall had stopped breathing. He felt her pulse, looked at her pupils and listened to her heart and chest. She was dead. He decided not to attempt resuscitation, as it would not succeed and would be distressing for her son. He explained to Mr Nuttall what had happened. He did not suggest a post-mortem examination, as he felt confident of his diagnosis of left ventricular failure. When he spoke to Mrs Oldham, he advised that a post-mortem was not necessary. Later Mr Nuttall said he did not want a post-mortem. Shipman had not called an ambulance and had not said that he had done so.

Certification

On the MCCD, Shipman stated that the cause of death was left ventricular failure of 15 minutes' duration. This was due to congestive heart failure of three years' duration. Hypertension for four years and obesity for 20 years had also contributed. As Mrs Nuttall was to be cremated, Shipman completed Form B, stating that he had seen Mrs Nuttall immediately before death. The mode of death was syncope of ten minutes' duration. Shipman claimed to have carried out a full external examination after death. He stated that Mr Nuttall was present at the death.

Dr Jeremy Dirckze signed Form C, confirming the cause of death as left ventricular failure. He said he would have relied entirely on what Shipman had told him. He had no recollection of the

case. Shipman claimed that he had shown Dr Dirckze the medical records but Dr Dirckze did not confirm this.

The Expert Evidence

Dr Grenville said that Shipman's claim to have found Mrs Nuttall in a poorly state did not tally with her son's description of her condition only a short time before. Shipman's description of the death was not typical of ventricular heart failure, in which the patient would be gasping for breath and usually producing froth at the mouth and nose. If, as Shipman suggested, Mrs Nuttall appeared simply to have stopped breathing, she should have been resuscitated, especially as she was only 64.

Comment

This was a cremation case in which there were no remains to be examined. Nonetheless, the jury convicted Shipman of murder. The case bore a number of the hallmarks of a Shipman killing:

- Shipman had no proper reason for his decision to call upon the patient. He lied in claiming that the patient had requested a visit. He knew that she was not well because she had called at the surgery that morning. In describing her condition just before death, he exaggerated it, claiming that she was seriously ill when she was not.
- The death was extremely sudden and quite unexpected. It occurred while the patient was alone with Shipman. That is an extremely rare event in the experience of most general practitioners.
- Shipman chose a cause of death which was plausible, in that Mrs Nuttall had been suffering from heart disease for some time.
- Shipman's description of the manner of death was not typical of a death from the cause he diagnosed. Nor was the appearance of the body (sitting in a chair as if asleep) such as would have been expected after a death from heart failure. It was what would be expected from a death from diamorphine.
- Shipman did not attempt resuscitation in circumstances in which that would have been the appropriate course if Mrs Nuttall really had gone into acute heart failure.
- Shipman lied when he claimed to have rung for an ambulance and pretended to cancel it. This is a feature that occurs in other cases.
- Shipman's examination of the body was perfunctory. It was not sufficient to have diagnosed the fact of death. It was as if he already knew that Mrs Nuttall was dead.

Bianka Pomfret

Introduction

Mrs Bianka Pomfret died on 10th December 1997 at the age of 49. At post-mortem examination after exhumation of her body in 1998, the morphine levels in her tissues were consistent with the administration of a fatal dose.

The Circumstances of the Death

Mrs Pomfret was a divorcee and suffered from a depressive illness. Those who saw her in the few days before her death were aware that she was chesty and was expecting a visit from the doctor. During the morning of 10th December 1997, her neighbour, Mr Paul Graham, saw her looking out of her lounge window. At about 5pm that day, Mrs Susan Adshead, a community mental health support worker, called to visit Mrs Pomfret but there was no reply to her knock. On looking through the window, she could see Mrs Pomfret on the sofa. When Mrs Pomfret's son, William, was brought, he found his mother was dead. She was fully clothed and looked relaxed. A half-drunk cup of coffee and a burned out cigarette were on the table beside her. Mr Pomfret called an ambulance. The paramedics summoned Shipman.

Mr Pomfret said that, when Shipman arrived, he said that he had visited Mrs Pomfret at about 12.30pm that day, because she had telephoned to say that she was unwell. She had told him she was suffering from chest pains. He did not mention any treatment. He said he had told her to make an appointment to see him again if need be. He now thought she had had a heart attack later in the day. He told Mr Pomfret and his wife that Mrs Bianka Pomfret had been suffering from angina for about ten months. They were very surprised at that. Shipman said that Mrs Pomfret's depression, medication and smoking habit had all played a part in her death.

The Defence Case

Shipman's account, which the jury must have rejected, was that Mrs Pomfret had requested a visit on 10th December. On his arrival, she told him that she had had chest pain on several occasions and gave him details of three such episodes which had occurred in the past. It sounded to him as though she had angina so he offered her glycerine trinitrate to see if it afforded her any relief. She refused it, saying that she already took too many tablets. He told her that she ought to be referred to a cardiologist but she refused. He advised her to make an appointment for an electrocardiogram (ECG) and left. She came to the door to wave him off.

Shipman went back to the surgery and made several entries in the records. One was for that day's visit but others were backdated entries. He said that his intention was to reflect the history of the previous episodes of chest pain about which Mrs Pomfret had told him. He said that he had no intention to create a misleading impression. In fact, he made three misleading entries in the records spread over a period of nine months. These were false and were designed to lend credence to his contention that Mrs Pomfret had been suffering from heart disease over that period. Some entries contained blood pressure readings, which he could not possibly have recalled so long after the event. Also, some contained comments (such as ' seems better') which were designed to give the flavour of contemporaneity. By the time he came to give evidence, it had been discovered that these entries had been backdated.

In evidence, Shipman said that, when summoned to the house later that day, he had seen the body and an ECG trace taken by the paramedics, which showed that Mrs Pomfret was dead. He thought she must have had a coronary thrombosis. He offered the family a post-mortem examination but they refused.

The Aftermath

Shipman completed the Medical Certificate of Cause of Death (MCCD), stating that death was due to coronary thrombosis with ischaemic heart disease as an underlying cause. He said that smoking and depressive illness had contributed to the death but were not related to the immediate cause of death.

The following day, Shipman spoke to Dr Tait, the consultant psychiatrist responsible for Mrs Pomfret's care. Dr Alan Tait made a written note of the conversation at the time. Shipman told him that he had seen Mrs Pomfret on 8th December and that she had complained of chest pains which could have been angina. He arranged an ECG but the results were not significant. He had seen her the next day and she had been cheerful. On 10th December, he had found her collapsed with a ' thready' pulse and she had proceeded to ' asystole'. She had been resuscitated and defibrillated but had died. He said that this was a natural death and there was no reason for a post-mortem examination. In effect, Shipman gave Dr Tait a completely different account of events from that which he had given to Mr Pomfret and which he later gave to the jury.

The Expert Evidence

At post-mortem examination, Dr Rutherford found no natural cause of death. There was no significant narrowing of the arteries, nor any heart disease nor any sign of intracranial bleeding. In evidence, he said that the morphine found in the body tissues must have been administered while Mrs Pomfret was alive. In his opinion, the cause of death was morphine poisoning and this was not challenged.

Dr John Grenville said that, when the false backdated records were taken out of account, there was nothing in the records to explain Mrs Pomfret's sudden death. This death should have been reported to the coroner.

Comment

The death is a clear case of morphine poisoning but, even if the evidence of morphine in the body is taken out of account, there remain a number of significant factors:

- This was a sudden death, which was discovered shortly after a visit from Shipman at which he saw the patient alone. No one saw or spoke to Mrs Pomfret after Shipman's visit.
- Shipman told the family that Mrs Pomfret had refused treatment that he had advised. Shipman often said this of patients whom he had killed.
- Shipman gave a quite different account to Dr Tait from that which he had given to the family.

- Mrs Pomfret's position and peaceful appearance in death were not typical of those seen in a patient who has suffered a heart attack. They were entirely typical of those seen in many of Shipman's victims who had been killed by diamorphine injection.
- When the falsified entries were excluded, the medical records did not support Shipman's stated opinion of the medical cause of death.
- The family says that Shipman did not offer a post-mortem but Shipman said that he had offered the family a post-mortem but they had refused it. This particular conflict of evidence is found again and again in cases where Shipman is suspected of killing a patient. In any event, it was not for Shipman to offer the family a post-mortem examination. It was his duty to decline to sign the MCCD if he was not sufficiently confident that he knew the cause of death. On his story, he could not have been sufficiently sure that Mrs Pomfret had had a heart attack and the death should have been reported to the coroner.

Marie Quinn

Introduction

Mrs Marie Quinn died on 24th November 1997 at the age of 67. Following exhumation of her body in September 1998, it was found that she had morphine in the tissues consistent with the administration of a lethal dose.

The Circumstances of the Death

Mrs Quinn was divorced and lived alone. Her only son, Mr John Quinn, worked in Japan; he kept in frequent contact with her. On the morning of the day of her death, Mrs Quinn attended a funeral in Hyde. She appeared to friends to be in normal health. At about 2.30pm, she telephoned her son in Japan for a chat. She said nothing that caused him to be concerned for her health. A close friend, Mrs Ellen Hanratty, who also saw Mrs Quinn regularly, said she seemed in normal health.

Shipman's account of the events of the day was that Mrs Quinn telephoned the surgery at about 5.45pm, asking for a visit as she had noticed some weakness on the left side. Records showed that no telephone call was made from her home to the surgery that day. Shipman claimed he had taken it himself, as he happened to be standing in the reception area, preparing to leave for the day. He claimed that Mrs Quinn told him that she had noticed a weakness down the left side, over the last hour. He told her he would come; she should leave the door on the latch and he would let himself in. Shipman was lying. She did not telephone him and it must have been his own idea to visit Mrs Quinn.

Nobody saw Shipman arrive, so the time of the visit is not known. He claimed that it had taken him about 25 minutes to reach the house, due to rush-hour traffic and he had arrived at about 6.15pm. However, that too was a lie as the computerised records of other patients showed that he was still seeing patients in the surgery at 6.16pm.

In evidence, Shipman claimed that, when he let himself in, he found Mrs Quinn on the kitchen floor, close to death. He examined her and found a slight carotid pulse and some reaction of the pupils to light. She was not breathing but he said that she responded abnormally to the Babinski test. That is a test in which the doctor strokes the underside of the foot. Normally the big toe reacts by going down. If there is cerebral irritation, such as occurs in a stroke, the big toe will go up. Shipman considered that Mrs Quinn was still alive but deeply unconscious. He decided not to attempt resuscitation as he thought she had had a severe stroke and would be irreparably brain damaged if revived. He waited for two minutes. Had she stirred, he would have called an ambulance but she did not. He then checked and found that she was dead. He believed she had had a stroke. In fact he must have given her a dose of morphine and she must have died very quickly as, at 6.32pm, he telephoned Mrs Hanratty, who was named as the contact on Mrs Quinn's records.

Shipman gave an account of what had happened to Mrs Hanratty, Mr Quinn and Mrs Cecilia Adshead, a friend. In essence, he said that Mrs Quinn had telephoned the surgery saying that she seemed to be having a stroke and was paralysed down one side of her body. He told her he would come and she should leave the door on the latch. When he arrived he had found her on the floor, breathing her last, and it had been too late to admit her to hospital. He said she had had a massive stroke.

Shipman signed a Medical Certificate of Cause of Death (MCCD), giving the immediate cause as cardiovascular accident of 20 minutes' duration. This was due to arteriosclerosis, which was said to have been present for five years, and hypertension, said to have been present for three years.

The Medical Records

Mrs Quinn's medical records showed that she appeared to suffer from systemic sclerosis, which causes fibrosis of the skin and other tissues. In Mrs Quinn, it affected her oesophagus and the small blood vessels in the fingers and toes. There was a single entry in the summary card dated 1992, suggesting that she suffered from arteriosclerosis, and another, dated 1994, for hypertension. However, there was no other reference to arteriosclerosis and the prosecution suggested that the summary card had been falsified in order to provide some support for Shipman's diagnosis of the causes of death. The evidence of hypertension was not clear from the records. The only high blood pressure reading was 170/100 on a day in October 1997. However, it appears that Mrs Quinn had been taking Nifedipine since 1993. Shipman said that this had been prescribed for hypertension, so it may be that her blood pressure had been well controlled.

There was an entry in the records made on the morning after Mrs Quinn's death, saying:

> **' rang 1745 weak larm leg visit 1815 dying cert 1820 cva arteriosclerosisi** (*sic*) **hypertension and sclerodema'**.

The Expert Evidence

Post-mortem examination showed that there were no blood clots in the brain. The vessels in the brain stem appeared normal. There was a minimal degree of fatty deposit in the carotid arteries. The cardiovascular and respiratory systems were in good condition. There was no obvious sclerosis. Dr John Rutherford was able to rule out cerebral haemorrhage, as there was no blood clot in the brain. He could not positively rule out occlusion of a blood vessel, as this was difficult to confirm at autopsy. However, an occlusive stroke does not usually cause sudden death but rather paralysis and loss of function on one side after which the patient might recover but, if deterioration continues, death might follow within a period or two to three days. Dr Rutherford expressed the view that the cause of death was morphine toxicity and this diagnosis was not challenged on Shipman's behalf at trial. Nor did he advance any explanation as to how the morphine had come to be in Mrs Quinn's body.

Shipman had given the immediate cause of death as cerebrovascular accident. Dr Rutherford said that neither the pathological findings nor the clinical circumstances fitted that diagnosis. Shipman had given arteriosclerosis and hypertension as underlying causes. Dr Rutherford said there was no evidence of cardiovascular disease. There could have been some hypertension. In other words, Shipman's diagnoses of the causes of death could not be justified on the medical history.

Comment

The evidence in this case is overwhelming, as with all the cases where morphine was found in the body. Even without that evidence the case would have been strong and there are a number of noteworthy features:

- This was a sudden death, wholly unexpected to those who knew Mrs Quinn.
- The death was closely associated in time with Shipman's presence. He claimed to have found Mrs Quinn on the verge of death. There are a number of other cases where Shipman has claimed to have found a patient already dead or dying, when the truth is that they were alive when he arrived but dead when he left.
- Shipman claimed that the patient had telephoned, requesting a visit. This was a proven lie as no call had been made from Mrs Quinn's house to the surgery. Shipman sometimes said this to the families of victims as an excuse for a visit, when the truth was that he had made his own decision to call.
- Shipman also claimed that he had told Mrs Quinn to leave the door on the latch. He sometimes said this to families of victims when he needed an explanation for his means of entry, when he was claiming that on arrival he found the patient already dead.
- Despite his attempts at falsification, the cause of death given by Shipman was not borne out by examination of the records.

Irene Turner

Introduction

Mrs Irene Turner died on 11th July 1996 at the age of 67. Her body was exhumed in 1998 and the levels of morphine found in her body tissues were consistent with the administration of a fatal dose.

Personal Background

For some years before her death, Mrs Turner suffered from non-insulin dependent diabetes and arterial disease. She had had breast cancer and had suffered a heart attack in 1994. Notwithstanding that, she led a full and active life and appeared to friends and family to be generally quite well. She had been to Torquay for a week's holiday just before her death. On her return, she developed a cold and was bringing up phlegm, which had caused her to vomit. Her daughter and son-in-law, Mrs Carol and Mr Michael Woodruff, advised her to call the doctor.

The Circumstances of the Death

On 11th July, Mrs Turner rang Shipman's surgery to ask for a visit. She stayed in bed. She asked Mr Woodruff to bring a meat and potato pie in for her lunch. When he arrived, she said she would eat it when the doctor had been. At 2.15pm, Mrs Turner telephoned Mr Woodruff and said that the doctor had not yet been. She must have been in the living room at that time to use the telephone. That was her last communication.

Mrs Sheila Ward, a neighbour, said that, at about 3.25pm, she saw Shipman in his car in the road. He asked her to go into Mrs Turner's house. He told her to wait for about five minutes before going in. He gave no reason why she should delay. When she went in, she found Mrs Turner dead in bed. She was lying on the bed, with her head on the pillows and her arms outside the bedclothes, which came up to her chest. Shipman arrived and told her that Mrs Turner had died of diabetes. It was all through her body and it had been too late to send her to hospital.

Shipman told Mr Woodruff that there was no need for a post-mortem examination. He had told Mrs Turner that she should go to hospital but she had not liked the idea. He was cold and matter of fact.

Shipman told Mr Alfred Isherwood, another son-in-law, that Mrs Turner had not looked after her diabetes. He said she had died of ischaemic heart disease. He gave a very complicated explanation of her supposed condition. He said Mrs Turner would not have suffered any pain; she would just have gone to sleep. He was cold and businesslike. He said Mrs Turner had not wished to go to hospital. Mr Isherwood thought that was strange as Mrs Turner held Shipman in high regard and would always accept his advice. Shipman blamed Mrs Turner for leaving it until so late before she called the doctor. He said she would have survived if she had called him earlier.

The Defence Case

Shipman's account, which must have been disbelieved by the jury, was that, when he arrived, Mrs Turner was very poorly. She told him that she had been vomiting for five to six days and may have vomited her diabetes tablets. He thought her diabetes was out of control and that she was dehydrated. He told her she ought to go to hospital but she would not agree. She told him that, in the past, she had been worse than she then was and she had recovered without telling him. Eventually, she agreed to go into hospital if her urine showed both blood and protein, so he took a sample and left. He was confident that the results would show a serious situation, so he told her to get ready for hospital and suggested that he should ask her neighbour, Mrs Ward, to come in. He left and saw Mrs Ward outside. He asked her go to Mrs Turner in a few minutes, by which time Mrs Turner would have been to the lavatory. He told her he would be back shortly. He went to the surgery and did the test, which was positive, so he went straight back to the house. He was away only ten minutes. He found Mrs Turner unconscious. He felt for a pulse, examined her eyes and concluded that she was dead. He considered that the cause of death was failure of the peripheral circulation.

Certification

Shipman signed the Medical Certificate of Cause of Death (MCCD), giving the date of death as 10th July and purporting to sign it on 10th June 1996. He gave the cause as circulatory failure, with ischaemic heart disease and diabetes mellitus as underlying conditions. Hypertension was a contributory factor.

The Expert Evidence

The post-mortem examination revealed signs of diabetes, coronary artery disease and past heart attacks. These conditions were severe enough to account for a sudden death. However, the morphine levels found in the tissue samples were consistent with a fatal dose and, in Dr John Rutherford's view, morphine was the cause of death. From the post-mortem examination findings and a perusal of the medical records, it appeared to him that both the diabetes and hypertension were well controlled.

The Medical Records

The medical records revealed a complicated medical history, which it is not necessary to record. With reference to the death, Shipman had made a handwritten account of his final visit, although it was mistakenly dated 10th June 1996. This account was plainly designed to lend plausibility to the cause of death he had given. The note suggested that he had found Mrs Turner to be very ill. She had been vomiting for four days. She had a fever, dysuria and was dehydrated. He thought she was in circulatory collapse. There was tenderness over the kidneys. She was acidotic. He had prescribed amoxycillin, an antibiotic. He had taken a urine sample and had left. On his return, he had found her dead from the causes which appeared on the MCCD.

Dr John Grenville did not think this note made medical sense. He said that, if the note were accurate, it showed a woman in urgent need of hospital admission for intravenous rehydration and control of the diabetes. She was a medical emergency. There should have been no delay.

It was inappropriate to prescribe amoxycillin or to take away a urine sample for testing. The doctor should have called an ambulance. If the patient had refused to go to hospital, he should have warned her of the risk of imminent death and should have summoned a relative who could persuade her. Failing all else, he should have asked her to confirm her objection in writing. Dr Grenville doubted the feasibility of obtaining a urine sample from Mrs Turner if she was as dehydrated as the note suggested. He observed that the urine test was not recorded in the notes. Dr Grenville doubted that Mrs Turner was as ill as Shipman claimed. She would have looked very ill and would not have been interested in food. Shipman's case did not add up.

Shipman claimed that the handwritten record was made while he was at Mrs Turner's house. The computerised records, which Shipman claimed he had made on his return to the surgery that evening or the next morning, were different in many respects from the written record. For 11th July, there are several separate entries which say:

> **' Had a chat to patient**
>
> **very ill not happy re hosp'**.
>
> **' Had a chat to patient**
>
> **circulatory failure bs 20** (*blood sugar 20, which is very high. Shipman claimed that Mrs Turner had taken this reading herself on her glucometer*)**'**.
>
> **' Examination of patient**
>
> **100/60 cold? uti tluk** (*to let us know*)**'**.
>
> **' O/E – dead**
>
> **1540 circ fail dm ihd//hyperte** (*on examination dead; circulatory failure, diabetes mellitus ischaemic heart disease//hyptertension*)**'**.
>
> **' Seen in own home**
>
> **Dr H.F.Shipman'**.

Shipman was quite unable to explain the many inconsistencies between the handwritten and computerised records. It was not possible to establish from objective evidence when either record was made.

Comment

This was a proven case of morphine poisoning. However, if one takes that factor out of the equation, there remain several factors which are common to other cases:

- This was a very sudden death of a patient who did not appear to others to be seriously ill on the day of death. However, she had underlying conditions which could have resulted in her sudden death at any time. Shipman's victims often had potentially fatal conditions, which he relied on as a plausible cause of death.
- Shipman claimed that he found Mrs Turner to be seriously ill and that she refused admission to hospital. This is a common feature in many Shipman killings. Shipman left her alone, supposedly in a serious condition. She was found dead very shortly afterwards. It would

have been a remarkable coincidence if she had died naturally during the few intervening minutes.

- Shipman's account of his treatment of Mrs Turner was inappropriate. In order to explain the course of events, he was driven to give an account of his actions which, if true, would have shown him to be seriously incompetent. This is a common feature of Shipman killings.
- Shipman's two sets of records of the events preceding the death were woefully inadequate and were mutually inconsistent. It was accepted that Shipman was a poor record keeper and this is amply demonstrated in very many cases.
- The body gave the appearance of having been ' laid out'. So neat and tidy an appearance is not typical of an unattended death from natural causes. Other examples of this feature have emerged from the Inquiry's investigations.

Laura Kathleen Wagstaff

Introduction

Mrs Laura Kathleen Wagstaff died on 9th December 1997, the day before Mrs Bianka Pomfret. She was aged 81. She was a patient of Shipman and thought highly of him.

The Circumstances of the Death

Mrs Wagstaff was in good general health at the time of her death. On the day on which she died, she went shopping in Hyde at about lunchtime. At about 1.45pm, Shipman left the surgery without saying where he was going. A neighbour saw Mrs Wagstaff letting him into her flat, some time between 2pm and 3pm. She seemed pleased and surprised to see him. Another neighbour saw him arrive and saw him again in the car park after about 20 to 30 minutes.

In the mid-afternoon, Shipman went to a neighbour and told him that Mrs Wagstaff had died. He said he would inform the relatives and left. Shipman erroneously informed Mrs Wagstaff's daughter-in-law that her mother had died. He discovered his mistake when he spoke to Mrs Carol Chapman, a receptionist at the surgery. Then, Mrs Wagstaff's son, Peter, was informed and went to the house. He found his mother slumped in her chair. She had been slightly sick.

Shipman told Mr Wagstaff that his mother had telephoned the surgery, asking for a visit. That was a lie. No call had been made from Mrs Wagstaff's house to the surgery. Shipman claimed that the surgery staff had paged him and, as he was close by, he had visited her. On arrival he had found Mrs Wagstaff looking ill, very grey, sweating and blue round the mouth. He had helped her upstairs and settled her in her chair. He said that he had found her pulse was ' thready' so he telephoned for an ambulance. That was a proven lie. He said he went to fetch his bag from the car and when he returned he found that Mrs Wagstaff had slumped over and died. He had checked her pulse. He had cancelled the ambulance. That was also a proven lie. He said nothing about an attempt at resuscitation. He said she had had a heart attack and had not suffered. She had had heart disease of a kind that could ' carry you off' quite quickly. Mr Wagstaff was surprised, as he was unaware that his mother had heart problems. In fact she had not.

The Defence Case

In evidence, Shipman's account, which the jury rejected, was that he had been in the reception area of the surgery at about 3pm when he had taken a call from Mrs Wagstaff. That was a lie. He claimed that she said she had chest pain and did not feel well. She had not had it before. She needed him to visit. He took out her notes and went straight there. She let him in and went slowly upstairs to her flat where she sat in her chair in the corner. He had his bag and notes with him. She looked grey and cyanosed. Her pulse was fast, over 100 beats per minute. The blood pressure and heart sounds were normal. There was no sign of a chest infection. He listened to her heart and thought she might be having a coronary thrombosis. He told her she ought to be in hospital to confirm the diagnosis. He said he would write up the notes and then ring for an ambulance. He claimed to have written up the notes but subsequent examination of the notes revealed no entry in them. He said that he had then realised that her mouth was open. She had died. He attempted resuscitation but she was too big to move. He tried mouth-

to-mouth resuscitation and external cardiac massage while she was still in the chair. He did not call for help from the paramedics as he was doing everything that could be done for her. After ten minutes, he knew he could not revive her so he set about informing the relatives of the death.

Certification

Shipman completed the Medical Certificate of Cause of Death (MCCD) saying that the cause of death was coronary thrombosis, which had begun 30 minutes before death. An underlying condition was ischaemic heart disease of eight to ten years' onset. As Mrs Wagstaff was to be cremated, he completed Form B of the cremation certificate. He said that he had seen Mrs Wagstaff on the day of her death. He claimed that a neighbour had been present at the death, which was untrue.

Dr Alastair MacGillivray from the Brooke Surgery signed Form C, confirming that he was satisfied that the death was due to coronary thrombosis. He said he relied totally on the account given him by Shipman. He would not expect any external signs if Mrs Wagstaff had died of coronary thrombosis.

The Expert Evidence

Dr John Grenville said that Mrs Wagstaff's records showed that she had been very healthy for her age. There was no sign of heart disease. There were two entries showing raised blood pressure but no real hypertension. The entry describing the death was very brief. It said:

> **' call 1500 arrive 1515 def ct collapse died 1520'**.

Dr Grenville said that, if Mrs Wagstaff had collapsed in the way Shipman claimed, the doctor should have called an ambulance immediately, as every effort should have been made to resuscitate her. She was a very fit woman for her age. Resuscitation needs more than one person.

Comment

This was a cremation case so there was no direct evidence that the cause of death was morphine poisoning. Nonetheless, the jury convicted. The salient features of this case are:

- Mrs Wagstaff was in good health and her death was wholly unexpected.
- Shipman made an unsolicited visit to Mrs Wagstaff. His claim that she had summoned him was a lie. He must have made his mind up in advance that he was going to call on her and kill her.
- The death took place in Shipman's presence. Most doctors say that it is extremely unusual for a patient to die suddenly during a home visit.
- On Shipman's account of the sudden collapse, there was no excuse not to call an ambulance and to make a proper attempt to resuscitate. No doctor would behave as he did in the circumstances he described.

- His two differing accounts both contained proven lies. In particular he had not telephoned the ambulance station.
- Shipman chose to say that Mrs Wagstaff had died after a coronary thrombosis. However, her medical records showed that she was not likely to suffer such a death. Shipman usually chose a cause of death which would be plausible in the light of the medical history. However, Mrs Wagstaff was not suffering from any potentially fatal condition.

Maureen Alice Ward

Introduction

Miss Maureen Alice Ward died on 18th February 1998 at the age of 57. Some time before her death, she had suffered from cancer but she had been successfully treated. She had other medical problems and was seeking early retirement on medical grounds.

Personal Background

At the time of her death, Miss Ward appeared to her friends to be in good health. For several years, she had lived with her mother at Ogden Court, sheltered accommodation in Hyde, and had stayed on after her mother's death. She was about to leave Hyde and was looking forward to moving to Southport. Most of her belongings were packed. In addition, she had booked a Caribbean holiday, starting on 1st March. In the afternoon of the day before the day of her death, Miss Ward attended Shipman's surgery to discuss her continuing need to take tamoxifen, an anti-cancer drug. Mrs Carol Chapman, the receptionist, chatted with her. Miss Ward appeared to be in good health and spirits.

The Circumstances of the Death

On the morning of her death, Miss Ward helped an elderly resident by carrying a heavy bag of bedding across to the laundry. Then she went shopping in Hyde to buy a new dress for her holiday. The residents of Ogden Court were astonished to learn that Miss Ward had died later that day. They would have been even more astonished had they known that Shipman was to certify her death as due to carcinomatosis, which is the expression used to describe cancer which has become so generalised that it is not possible to specify which organs are affected. Patients with carcinomatosis do not usually die suddenly.

At about 3.30pm on 18th February 1998, Shipman called upon Mrs Christine Simpson, the warden of Ogden Court, and asked her to come to Miss Ward's flat. He said he had just found her dead. When Mrs Simpson expressed surprise, Shipman said, ' Well she did have a brain tumour you know'. Knowing that Miss Ward was very strict about security, Mrs Simpson asked Shipman how he had gained entry to Miss Ward's flat. He said that Miss Ward had been expecting him and she had left the lock ' on the snip'. He said he was bringing her an appointment letter for her to go to Stepping Hill Hospital. When Mrs Simpson reached the flat, she found Miss Ward lying on her bed, fully dressed in day clothes. Her eyes were closed and she looked ' completely straight and tidy'. In the kitchen there were signs that Miss Ward had been interrupted while spooning some cat food onto the cat's dish.

At about 4pm, Shipman returned to the surgery and told Mrs Chapman that Miss Ward was dead. He told her that he had been passing the corner of the street and had seen an ambulance outside Ogden Court. He had called in and the paramedics had told him that Miss Ward was dead. The following day, Mrs Chapman heard Shipman tell other members of staff that he had called at Miss Ward's home to give her an appointment. She claims to have observed out loud that that was not what he had told her the day before.

The Defence Case

Shipman's account in evidence, which was rejected by the jury, was that he had seen Miss Ward twice on the day before her death, not once as the records showed. At lunchtime, he had noticed her in the reception area and she had asked to have a word with him. He took her to his room and she told him she had been having some ' funny do's' with headaches and blurred vision. These had settled and she had not gone to the optician. About a week earlier, she had found herself on the floor. She had wet herself. Shipman thought it sounded as if she might have had an epileptic fit, which can be a sign of a brain tumour. He had been unaware of these symptoms until 17th February. When he learned of them, he inserted them into the records at the dates at which Miss Ward said these events had occurred. He thought this was a proper way to amend the records and he had not intended that the records should be misleading. They plainly were. When she told him of these events, he advised her that she must see her consultant at Stepping Hill Hospital, Mr Peter England, as a matter of urgency. That afternoon and the next morning he had made considerable efforts to get Miss Ward an early appointment but had been unable to get through to the hospital. So he had written her a letter of referral which she could take with her. He went round to give her this letter and to advise her to attend the next clinic, but found her already dead.

Certification

Shipman signed a Medical Certificate of Cause of Death (MCCD), giving the cause of death as carcinomatosis of eight weeks' duration (with a secondary tumour in the brain). He said that breast cancer had been an underlying condition. He stated that he had seen Miss Ward alive on the day of her death. As Miss Ward was to be cremated, he completed a Form B repeating that diagnosis but stating that he had last seen Miss Ward alive 24 hours before her death. He said that the mode of death was collapse of ' minutes' duration. That information was based on information from the warden who had found Miss Ward in a collapsed state. The warden had been present at the moment of death. These statements were untrue.

Dr Susan Booth signed Form C, saying she too was satisfied that death was due to carcinomatosis. Any enquiry of anyone who knew Miss Ward (such as the warden) would have shown this to be false and would have revealed the falsity of the claim on Form B.

The Medical Records

Examination of the medical records showed that several false entries had been made on the day of the death. Some had been made before the body was discovered, some afterwards. Some entries were designed to show that, during the previous two months, Miss Ward had exhibited signs of a brain tumour. On 17th February, a genuine contemporaneous record was made of the consultation about the long-term need to take tamoxifen. At about 2.45pm, on 18th February, a series of three backdated entries was made, purporting to have been made on 17th December 1997 and 6th and 17th February 1998. These entries included references to headaches and blurred vision. The headaches had been accompanied by nausea and unsteadiness in the legs. On 17th February, examination had supposedly shown raised intracranial pressure. Another entry, made at about 5.45pm on 18th February, suggests that Miss Ward had told Shipman that, about six days earlier, she had found herself on the floor and

she had wet herself. Shipman wondered whether she had had an epileptic fit. These entries were clearly designed to lend credibility to Shipman's explanation for Miss Ward's death. Dr John Grenville said that, without the false entries, there was nothing to support the diagnosis of carcinomatosis or brain tumour. In any case, a death from those causes is a slow process in which the patient develops neurological signs and suffers a gradual reduction in consciousness.

The remaining entries made on 18th February were all made at about 5.45pm, that is after Miss Ward was known to be dead. One says that Miss Ward was dead on examination. Another says that she had been referred for further care and was to have an urgent appointment with Mr England. She had been seen in her own home. These entries were designed to support Shipman's account of his reason for visiting Miss Ward at home on the occasion when he supposedly found her dead.

The doctors responsible for her supervision at Stepping Hill Hospital reported that Miss Ward had attended for periodic review and had made no complaint of any symptom referable to a brain tumour.

Comment

Although this was a cremation case, with no direct evidence of morphine poisoning, it was a very clear case of murder:

- This was a sudden death discovered very shortly after Shipman had had access to Miss Ward alone and the opportunity to inject diamorphine.
- The cause of death was not plausible given the past medical history. Miss Ward was not terminally ill. Even with heavily altered records, Shipman's explanation for the death did not make medical sense.
- Shipman gave a false account of events on Form B where his entries were plainly designed to distance him from the death.
- Miss Ward's appearance was not what one would expect if Miss Ward had had a sudden collapse. On the other hand her appearance was consistent with her having been given an injection of diamorphine.

Maria West

Introduction

Mrs Maria West (also known as Marie) died on 6th March 1995 at the age of 81. She was a widow who usually lived alone. At the time of her death, her son had been staying with her for a few days. He said she seemed in reasonably good health and was fairly fit for her age. In recent weeks, she had begun to suffer pain from arthritis in her legs, hips and back, for which she took anti-inflammatory drugs. She also had poor circulation in the legs. She had recently started to use an inhaler for asthma. Despite these problems, she was still leading a busy social life and was about to book a Butlins holiday. She had not complained to her son of blurred vision or dizziness or numbness of the hand.

The Circumstances of the Death

On 27th February and 2nd March 1995, Mrs West had consulted Shipman about her arthritis. He had prescribed pethidine tablets but these had not agreed with her and she had asked him to visit her on 6th March. Her good friend, Mrs Marion Hadfield, visited her on that day. Mrs West made cups of tea and carried them into the living room. Then the two women chatted, watched television together and waited for the doctor to arrive. Mrs Hadfield said that Mrs West was quite well during this time. She did not have any trouble with blurred vision and she did not complain of dizziness or numbness of the hand.

Shipman arrived while Mrs Hadfield was upstairs using the bathroom. When she came down, she could hear voices coming from the living room, so she remained in the kitchen so as not to intrude. After a while, the voices ceased. Then Shipman came into the kitchen. He seemed surprised to see her and said he was going to see if Mrs West's son was upstairs as Mrs West had ' collapsed' on him. Mrs Hadfield asked if he could do anything for her. He said it was too late; she had ' gone'. Mrs Hadfield went into the living room and found Mrs West sitting in the chair exactly where she had been before. Shipman did not attempt resuscitation. He just raised Mrs West's eyelid and said there was no sign of life. He told Mrs Hadfield that he had just turned away to pack his bag and, when he turned round, he found that Mrs West had collapsed.

Shipman telephoned Mrs West's son, Christopher, and told him that he had taken his mother's blood pressure and had gone out to put the machine in the car. When he came back in, he found her dead. When Mr West arrived, Shipman told him that his mother had had a massive stroke. Shipman said that he had expected her to die as she had hardening of the arteries but had not expected it to happen so soon. He had not tried to resuscitate her, as she would have been a vegetable if she had been brought round. He did not suggest a post-mortem examination.

The Defence Case

Shipman's account, the essential aspects of which the jury must have rejected, was that he had visited Mrs West on 6th March to see how her back pain had been since she had been taking pethidine. If the pain were not resolving, she would have to be referred to a consultant. Mrs West told Shipman that the back pain had improved but she now had another problem. She had noticed altered vision and weakness in the arm and leg, lasting for an hour or so at a

time. Shipman turned away to reach into his bag for his stethoscope and blood pressure machine. He spoke to her but there was no response. When he looked at her, she was slumped in her chair. He examined her and found that she was dead. He did not attempt resuscitation as in his opinion, if revived, she would have been severely disabled. He found the son's telephone number and went into the kitchen to look for the telephone. (In fact the telephone was in the living room.) In the kitchen, he found Mrs Hadfield and told her that Mrs West had collapsed and died. When Mrs Hadfield asked if he was sure that Mrs West was dead, he tested the carotid pulse again and proved the point by showing Mrs Hadfield the dilated pupils. He telephoned Mr West and told him of the death. He did not say that Mrs West had collapsed while he was outside collecting his bag. When Mr West arrived, he explained to him how the death had occurred. He mentioned the possibility of a post-mortem examination but Mr West did not want one.

After the death, Shipman made an entry in the medical records in which he stated that Mrs West had complained of blurring of vision and weakness in the arm. Strangely, he did not mention that she had died in the middle of the examination. The Crown suggested that this record was a fabrication, designed to add plausibility to his false account of her death. As the jury convicted, one must infer that they found that Shipman must have given Mrs West an injection of diamorphine soon after his arrival.

Certification

Shipman completed the Medical Certificate of Cause of Death (MCCD), saying that the cause of death was a cerebrovascular accident of only a few minutes' duration. A contributory cause was arteriosclerosis of 18 years' duration.

When completing cremation Form B, Shipman said that he had been present at the death with a neighbour. He said he had carried out a complete external examination. He felt no doubt as to the cause of death and there was no reason for further examination of the body.

The Expert Evidence

Dr John Grenville, who had examined the records, said that for many years Mrs West had been at risk of having a stroke. She had had high blood pressure on two occasions in 1990 but this had been well controlled since then. She had also had a suspicion of carotid bruit and a fleeting episode of blindness. The records also revealed chronic bronchitis and asthma but these were not relevant to the death. The records for the week before her death showed that Mrs West was prescribed pethidine for hip pain. The only possible reference to a vascular problem was an entry for 4th March which said:

> **' pethidine for pain, TCI'**,

which could have meant ' to come in' or, as Shipman claimed in evidence, ' transitory cerebral ischaemia'.

Dr Grenville said that Shipman's account of Mrs West's sudden transition from life to death did not ring true. Death did not occur in that way. If Shipman's account of the collapse were true, he should have attempted resuscitation and called an ambulance. Anything less was not acceptable as Mrs West was not terminally ill. Further, he said that the history recorded by

Shipman of a complaint of blurred vision and weakness in the arm sounded more like the symptoms of a mild evolving stroke than the kind of severe stroke that can cause a sudden cerebrovascular death. The cause of death given on the MCCD could not be justified and the case should have been reported to the coroner.

Comment

This was a cremation case with no direct evidence of morphine in the body tissues. There are a number of significant features about this case, all of which are common to other cases:

- The death took place in Mrs West's home and while Shipman was alone with her. This is a highly suspicious factor, as other general practitioners say that this is an extremely rare event.
- Death was extremely sudden, so sudden that it could not have happened as Shipman claimed.
- Shipman made no attempt to resuscitate the patient and justified his decision by claiming that she would have been severely disabled if revived.
- Mrs West's appearance in death, sitting peacefully in a chair as though asleep, was similar to the appearance of many of Shipman's other victims.
- Shipman gave inconsistent accounts of the circumstances to different people. However, it must be borne in mind that the accounts of friends and relatives may not be wholly reliable due to the passage of time and the effect of shock and distress.
- There was a dispute as to whether Shipman mentioned the possibility of a post-mortem examination. The relative said he did not. Shipman made no report to the coroner in a case in which such a report was plainly called for, as the death was sudden and unexplained.
- To explain Mrs West's death, Shipman selected a moderately plausible cause, in that there were features of her medical history which put her at risk of a stroke.
- Shipman wrote on cremation Form B that a neighbour was present at the death. Although she was in the house, Mrs Hadfield was not in the room at the moment of death and the statement that she was present is misleading. This is a typical example of the way in which Shipman would make false statements, seeking to distance himself from the death or to make it appear he had not been alone with the patient at the time of death.

APPENDIX F

Chronological List of Decided Cases

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
1974				
10/5/74	Ruth Highley	72	Own home	Natural death
22/6/74	Edith Annie Bill	67	Own home	Natural death
23/7/74	Colin Whitham	26	Own home	Natural death
2/8/74	Stanley Uttley	58	Surgery	Natural death
9/10/74	Hena Cheetham	77	Ambulance	Natural death
10/11/74	Harold Edward Jackman	78	Hospital	Natural death
9/12/74	Sean Stuart Callaghan	18	Hospital	Natural death
16/12/74	Moira Kelly	26	Hospital	Natural death
29/12/74	Sarah Ann Thomas	86	Own home	Insufficient evidence for decision
There is also a decision in respect of Frances Elaine Oswald, relating to an incident which took place on 21/08/74				
1975				
21/1/75	Lily Crossley	73	Own home	Suspicion of unlawful killing
21/1/75	Robert Henry Lingard	62	Own home	Suspicion of unlawful killing
21/1/75	Elizabeth Pearce	84	Own home	Suspicion of unlawful killing
25/1/75	Edward Walker	70	Residential home	Insufficient evidence for decision
15/2/75	Jane Isabella Rowland	80	Own home	Suspicion of unlawful killing
11/3/75	Alice Brown	72	Own home	Natural death
11/3/75	Jack Wills	65	Own home	Natural death
17/3/75	Eva Lyons	70	Own home	Unlawful killing
21/3/75	Edith Roberts	67	Own home	Suspicion of unlawful killing
1/4/75	Wilbert Mitchell	87	Own home	Insufficient evidence for decision
6/4/75	Joe Ainscow Stansfield	77	Own home	Natural death
7/4/75	Winifred Isabel Smith	67	Own home	Insufficient evidence for decision

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
8/4/75	Jane Ellen Lord	86	Own home	Natural death
28/4/75	Michael Connors	64	Own home	Insufficient evidence for decision
26/5/75	Phyllis Oxley	59	Own home	Natural death
27/7/75	Lilian Shaw	54	Own home	Natural death
4/8/75	Leah Pickering	86	Own home	Natural death
5/8/75	Albert Redvers Williams	75	Own home	Suspicion of unlawful killing
9/8/75	William Earnshaw	88	Daughter's home	Natural death
1/9/75	Mary Ann Tempest	70	Own home	Natural death
27/9/75	Margaret Wilmore	38	Own home	Natural death
1977				
8/10/77	Josephine May Carroll	81	Residential home	Natural death
21/11/77	Eveline Robinson	77	Own home	Insufficient evidence for decision
15/12/77	Wilfred Chadwick	81	Own home	Natural death
1978				
9/1/78	Eric Wardle	60	Own home	Suspicion of unlawful killing
24/2/78	Lily Shore	87	Residential home	Natural death
24/2/78	William Henry Brown	74	Residential home	Natural death
26/2/78	Alice Dixon	88	Residential home	Natural death
7/6/78	James Ashworth	81	Own home	Insufficient evidence for decision
22/7/78	Esther Lowe	73	Residential home	Natural death
29/7/78	Reginald Potts	83	Own home	Insufficient evidence for decision
2/8/78	Clifford Gess	65	Friend's home	Natural death
7/8/78	Sarah Hannah Marsland	86	Own home	Unlawful killing
10/8/78	Ellen Ashton	81	Residential home	Natural death
30/8/78	Mary Ellen Jordan	73	Own home	Unlawful killing
6/9/78	Hervey Nuttall	74	Own home	Natural death
6/9/78	Thomas Alfred Longmate	69	Own home	Suspicion of unlawful killing

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
17/9/78	Christina Harrison	96	Residential home	Natural death
25/9/78	Emily Williams	75	Daughter's home	Suspicion of unlawful killing
7/11/78	Winifred Amy Tuffin	86	Residential home	Natural death
12/11/78	Ada Heywood	78	Own home	Natural death
22/11/78	Mary Jane Hett	77	Own home	Natural death
23/11/78	Elsie Royles	70	Own home	Suspicion of unlawful killing
2/12/78	Ruth Strickland	84	Residential home	Natural death
5/12/78	Robert Hickson	76	Own home	Suspicion of unlawful killing
7/12/78	Harold Bramwell	73	Own home	Unlawful killing
9/12/78	Ellen Kelly	82	Residential home	Natural death
20/12/78	Annie Campbell	88	Own home	Unlawful killing
20/12/78	Esther Hannah Roberts	89	Own home	Natural death
1979				
11/1/79	Albert Slater	79	Own home	Insufficient evidence for decision
11/1/79	Annie Wilkinson	81	Own home	Natural death
22/1/79	Harriet Harris	77	Own home	Natural death
11/3/79	Ernest Shawcross	74	Own home	Natural death
20/3/79	Agnes Edge	87	Residential home	Natural death
14/4/79	Stanley Riley	77	Own home	Natural death
1/5/79	Mary Alice Garratt	86	Residential home	Natural death
2/5/79	Sydney Walton	57	Own home	Insufficient evidence for decision
3/5/79	Richard Johnson	89	Own home	Natural death
10/5/79	Gertrude McLoughlin	83	Own home	Natural death
17/5/79	William Hill Wareing	61	Own home	Natural death
30/5/79	Florence Leach	92	Residential home	Natural death
5/7/79	Arthur Floyd	97	Residential home	Natural death
18/7/79	Lavinia Wharmby	88	Own home	Suspicion of unlawful killing

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
29/7/79	Elsie King	84	Residential home	Natural death
2/8/79	Sarah Adkinson	76	Own home	Natural death
4/8/79	Fanny Dawson	68	Own home	Suspicion of unlawful killing
5/8/79	Hannah Helena Mottram	69	Own home	Suspicion of unlawful killing
8/8/79	Maud Matley	88	Residential home	Natural death
10/8/79	Alice Maude Gorton	76	Own home	Unlawful killing
13/8/79	Frederick Vickers	66	Own home	Suspicion of unlawful killing
18/8/79	Edith Graham	72	Own home	Insufficient evidence for decision
25/8/79	Dora Elizabeth Smith	83	Residential home	Natural death
25/8/79	Leonora Hamblett	78	Own home	Natural death
30/9/79	Mary Kingsley	91	Residential home	Natural death
9/10/79	Ada Marjorie Preston	68	Own home	Natural death
11/11/79	Leah Johnston	80	Residential home	Suspicion of unlawful killing
28/11/79	Jack Leslie Shelmerdine	77	Hospital	Unlawful killing
5/12/79	Norman Adshead	84	Residential home	Natural death
23/12/79	Alice Chappell	85	Own home	Natural death
1980				
3/1/80	Bethel Anne Evans	92	Residential home	Suspicion of unlawful killing
2/2/80	Charles Henry Wood	83	Own home	Natural death
7/2/80	Edgar Dobb	79	Own home	Natural death
10/2/80	Frederick Coomber	81	Residential home	Insufficient evidence for decision
12/2/80	Norman John Bell	72	Own home	Natural death
14/3/80	Fanny Wood	89	Residential home	Natural death
22/3/80	Miriam Davies	66	Own home	Natural death
3/4/80	Miriam Rose Emily Mycock	91	Residential home	Insufficient evidence for decision
6/4/80	Nellie Gee	79	Own home	Natural death
12/4/80	Clara Ethel Aveyard	90	Residential home	Natural death

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
1/5/80	Hannah Cartwright	83	Residential home	Natural death
23/6/80	Mary Ann Mansfield	84	Own home	Insufficient evidence for decision
23/7/80	Sarah Hawkins	77	Residential home	Natural death
29/9/80	Robert Swann	92	Own home	Insufficient evidence for decision
30/10/80	Sarah Tideswell	85	Residential home	Natural death
2/11/80	Hannah Everall	78	Own home	Natural death
17/11/80	Bertha Bagshaw	88	Own home	Insufficient evidence for decision
24/12/80	Lily Acton	91	Own home	Natural death
1981				
7/1/81	Leonard Shaw	85	Own home	Insufficient evidence for decision
18/1/81	Caroline Veronica Hammond	70	Own home	Natural death
2/3/81	Samuel Oldham	69	Own home	Natural death
5/3/81	Mary Elizabeth Firman	87	Residential home	Natural death
18/4/81	May Slater	84	Own home	Unlawful killing
20/4/81	Emmeline Swindells	86	Residential home	Natural death
28/4/81	William James McLaren	86	Residential home	Natural death
4/5/81	Cyril Mitchell	60	Own home	Insufficient evidence for decision
12/5/81	Albert Arrandale	77	Own home	Natural death
16/5/81	Alice Bolland	80	Residential home	Natural death
27/5/81	Frances Bennett	82	Residential home	Natural death
2/6/81	Rosetta Pedley	67	Own home	Natural death
23/6/81	Violet Mary Whittaker	59	Own home	Natural death
27/6/81	Florence Taylor	93	Own home	Suspicion of unlawful killing
29/6/81	Florence Sidebotham	83	Residential home	Insufficient evidence for decision
5/7/81	Ellen Frances Wharam	91	Residential home	Insufficient evidence for decision
16/7/81	Elsie Lewis	88	Residential home	Natural death
18/7/81	Ethel Doris Holgate	91	Residential home	Natural death

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
3/8/81	Alline Devolle Holland	84	Residential home	Insufficient evidence for decision
25/8/81	Emma Smith	85	Own home	Natural death
26/8/81	Elizabeth Ashworth	81	Own home	Unlawful killing
8/9/81	Annie Coulthard	75	Own home	Suspicion of unlawful killing
28/9/81	William Givens	77	Own home	Suspicion of unlawful killing
6/10/81	Elsie Scott	86	Residential home	Suspicion of unlawful killing
6/10/81	Mark Wimpeney	86	Own home	Insufficient evidence for decision
10/11/81	Mary Elizabeth Bowers	86	Residential home	Natural death
1982				
9/1/82	Samuel Harrison	87	Own home	Suspicion of unlawful killing
21/1/82	Alice Squirrell	81	Residential home	Natural death
6/2/82	Florence Slater	88	Own home	Natural death
18/2/82	William Henry Leech	84	Own home	Natural death
23/2/82	Alice Holt	75	Own home	Suspicion of unlawful killing
4/3/82	William Baxter	70	Own home	Insufficient evidence for decision
8/3/82	Edith Leech	83	Residential home	Insufficient evidence for decision
16/3/82	Fred Davies	76	Own home	Natural death
26/3/82	George Charnock	81	Own home	Natural death
29/3/82	Louisa Stocks	80	Residential home	Suspicion of unlawful killing
1/5/82	Annie Rowbottom	91	Residential home	Natural death
5/6/82	Annie Parkes	94	Residential home	Natural death
30/6/82	Wilfred Leigh	74	Own home	Suspicion of unlawful killing
8/7/82	Norah Johnson	76	Own home	Natural death
8/7/82	Emma Hirst	86	Residential home	Natural death
11/8/82	Alice Smith	74	Own home	Natural death
10/9/82	Ivy Elizabeth Challinor	83	Residential home	Natural death
15/12/82	May Vizor	57	Own home	Natural death

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
1983				
4/1/83	Percy Ward	90	Own home	Unlawful killing
7/1/83	Fanny Clayton	87	Residential home	Natural death
15/3/83	Hannah Moss	82	Residential home	Natural death
13/5/83	Margaret Metcalfe	84	Residential home	Natural death
15/5/83	Mary Alice Brown	85	Residential home	Natural death
24/5/83	Charles MacConnell	72	Own home	Suspicion of unlawful killing
28/6/83	Moira Ashton Fox	77	Own home	Unlawful killing
12/7/83	Violet Nicholls	83	Residential home	Natural death
13/7/83	George Winston	80	Own home	Natural death
29/9/83	Ethel Buckley	89	Residential home	Natural death
12/10/83	Olive Winston	93	Residential home	Natural death
28/11/83	Mary Taylor	78	Own home	Natural death
1984				
7/1/84	Dorothy Tucker	51	Own home	Unlawful killing
13/1/84	Miriam Bradshaw	88	Residential home	Insufficient evidence for decision
27/1/84	Gladys Heapey	69	Own home	Insufficient evidence for decision
30/1/84	Norah Cheetham	83	Own home	Natural death
8/2/84	Gladys Roberts	78	Own home	Unlawful killing
26/3/84	Annie Wood	82	Residential home	Insufficient evidence for decision
26/3/84	Doris Bridge	83	Own home	Suspicion of unlawful killing
26/3/84	Christopher Denham	97	Residential home	Natural death
30/3/84	Walter Mansfield	83	Daughter's home	Suspicion of unlawful killing
15/4/84	Joseph Bardsley	83	Own home	Unlawful killing
15/4/84	Jessie Irene Wagstaff	70	Own home	Insufficient evidence for decision
24/4/84	Winifred Arrowsmith	70	Own home	Unlawful killing
6/5/84	Annie Grimshaw	88	Residential home	Natural death

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
6/5/84	Thomas Condon	73	Own home	Insufficient evidence for decision
13/5/84	Caroline Mary Taylor	84	Residential home	Natural death
3/6/84	Mary Ivy Birchall	63	Own home	Natural death
22/7/84	May Warren	72	Own home	Natural death
2/8/84	Laura Victoria Parkin	81	Residential home	Natural death
7/8/84	Mary Elizabeth Haslam	77	Own home	Natural death
8/9/84	Donald Anthony Grundy	75	Own home	Natural death
21/9/84	Mary Winterbottom	76	Own home	Unlawful killing
26/9/84	Lily Nichols	80	Residential home	Natural death
17/10/84	Beatrice Lowe	88	Own home	Suspicion of unlawful killing
13/11/84	Oscar Meredith	78	Own home	Insufficient evidence for decision
15/11/84	William Hague	89	Residential home	Natural death
23/11/84	Charles Harris	70	Own home	Suspicion of unlawful killing
27/11/84	Ada Ashworth	87	Own home	Unlawful killing
17/12/84	Joseph Vincent Everall	80	Own home	Unlawful killing
18/12/84	Edith Wibberley	76	Own home	Unlawful killing
24/12/84	Eileen Theresa Cox	72	Own home	Unlawful killing
1985				
1/1/85	John Howcroft	77	Own home	Suspicion of unlawful killing
1/1/85	Edwin Foulkes	88	Own home	Suspicion of unlawful killing
2/1/85	Peter Lewis	41	Own home	Unlawful killing
8/1/85	Edna Shawcross	66	Own home	Natural death
25/1/85	Frederick Dentith	60	Friend's home	Natural death
1/2/85	May Brookes	74	Own home	Unlawful killing
1/2/85	Christina McCulloch Mackie	83	Residential home	Natural death
2/2/85	Jesse Hampson	92	Own home	Natural death
4/2/85	Ellen Higson	84	Own home	Unlawful killing

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
15/2/85	Margaret Ann Conway	69	Own home	Unlawful killing
15/2/85	Albert Brierley	91	Own home	Insufficient evidence for decision
22/2/85	Kathleen McDonald	73	Own home	Unlawful killing
17/3/85	Olive Lees	81	Residential home	Natural death
24/5/85	Violet Hadfield	74	Own home	Suspicion of unlawful killing
26/6/85	Mildred Robinson	84	Own home	Unlawful killing
26/6/85	Thomas Moult	70	Own home	Unlawful killing
10/7/85	Hannah Jones	84	Own home	Insufficient evidence for decision
23/8/85	Frances Elizabeth Turner	85	Own home	Unlawful killing
17/10/85	Mary Ogden	58	Own home	Natural death
29/10/85	Tom Redfern	76	Own home	Natural death
17/12/85	Selina Mackenzie	77	Own home	Unlawful killing
20/12/85	Vera Bramwell	79	Own home	Unlawful killing
28/12/85	Edith Goddard	82	Residential home	Natural death
31/12/85	Fred Kellett	79	Own home	Unlawful killing
1986				
4/1/86	Jane Bridge	80	Own home	Insufficient evidence for decision
7/1/86	Deborah Middleton	81	Own home	Unlawful killing
28/1/86	Vara Penney	86	Own home	Natural death
1/4/86	May Hurd	78	Residential Home	Natural death
23/4/86	Dorothy Fletcher	74	Residential Home	Unlawful killing
7/5/86	Charles Geoffrey Brassington	69	Own home	Natural death
16/5/86	Jozef Iwanina	63	Own home	Suspicion of unlawful killing
27/5/86	Neville Shaw	57	Hospital	Natural death
6/6/86	Thomas Fowden	81	Own home	Unlawful killing
15/9/86	Mona Ashton White	63	Own home	Unlawful killing
7/10/86	Mary Tomlin	73	Own home	Unlawful killing

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
17/11/86	Beatrice Toft	59	Own home	Unlawful killing
17/11/86	Annie Watkins	81	Own home	Suspicion of unlawful killing
16/12/86	Lily Broadbent	75	Own home	Unlawful killing
23/12/86	James Wood	82	Own home	Unlawful killing
1987				
7/3/87	George Eric Higginbottom	66	Own home	Insufficient evidence for decision
12/3/87	Alice Hilda Connaughton	77	Residential home	Suspicion of unlawful killing
27/3/87	Hilda Hulme	78	Residential home	Natural death
30/3/87	Frank Halliday	76	Own home	Unlawful killing
1/4/87	Albert Cheetham	85	Own home	Unlawful killing
6/4/87	Robert Edward Jones	81	Own home	Natural death
8/4/87	Violet Garlick	86	Residential home	Natural death
16/4/87	Alice Thomas	83	Own home	Unlawful killing
17/4/87	Ethel Dolan	82	Residential home	Natural death
17/4/87	Kenneth Harry Simpson	61	Own home	Natural death
8/5/87	Jane Frances Rostron	78	Own home	Unlawful killing
26/7/87	Mary Gaunt	76	Daughter's home	Insufficient evidence for decision
14/9/87	Nancy Anne Brassington	71	Own home	Unlawful killing
21/9/87	Susan Eveline Shaw	81	Residential home	Natural death
11/12/87	Margaret Townsend	80	Own home	Unlawful killing
29/12/87	Nellie Bardsley	69	Own home	Unlawful killing
30/12/87	Elizabeth Ann Rogers	74	Own home	Unlawful killing
1988				
5/1/88	Elizabeth Fletcher	90	Own home	Unlawful killing
15/1/88	Alice Mary Jones	83	Own home	Unlawful killing
5/2/88	Constance Anne Couldwell	88	Residential home	Insufficient evidence for decision
9/2/88	Dorothea Hill Renwick	90	Own home	Unlawful killing

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
15/2/88	Ann Cooper	93	Own home	Unlawful killing
15/2/88	Jane Jones	83	Own home	Unlawful killing
16/2/88	Lavinia Robinson	84	Own home	Unlawful killing
17/2/88	Kate Elizabeth Stafford	93	Residential home	Natural death
18/9/88	Rose Ann Adshead	80	Own home	Unlawful killing
5/10/88	Alice Rawling	100	Residential home	Natural death
20/10/88	Alice Prestwich	69	Own home	Unlawful killing
25/10/88	Harry Waller	69	Own home	Natural death
2/11/88	Amy Chidlow	85	Residential home	Natural death
6/11/88	Walter Tingle	85	Own home	Unlawful killing
1/12/88	Ellen Hennefer	91	Residential home	Natural death
17/12/88	Harry Stafford	87	Own home	Unlawful killing
19/12/88	Ethel Bennett	80	Own home	Unlawful killing
1989				
31/1/89	Wilfred Chappell	80	Own home	Unlawful killing
8/3/89	Mary Emma Hamer	81	Shipman's surgery	Unlawful killing
21/3/89	Margaret Smith	90	Residential home	Natural death
12/5/89	Beatrice Helen Clee	78	Own home	Unlawful killing
18/5/89	Edith Pitman	86	Residential home	Natural death
5/6/89	Josephine Hall	69	Own home	Unlawful killing
6/7/89	Hilda Fitton	75	Own home	Unlawful killing
14/8/89	Marion Carradice	80	Own home	Unlawful killing
22/9/89	Elsie Harrop	82	Own home	Unlawful killing
26/9/89	Elizabeth Mary Burke	82	Own home	Unlawful killing
15/10/89	Sarah Jane Williamson	82	Own home	Unlawful killing
16/10/89	John Charlton	81	Own home	Unlawful killing
18/10/89	George Edgar Vizor	67	Own home	Unlawful killing

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
6/11/89	Joseph Frank Wilcockson	85	Own home	Unlawful killing
15/11/89	Samuel Mellor	73	Own home	Natural death
1990				
28/5/90	Annie Elizabeth Golds	83	Own home	Natural death
10/7/90	Genevieve Challoner	69	Own home	Natural death
18/9/90	Dorothy Rowarth	56	Own home	Unlawful killing
21/9/90	Clara Hackney	84	Own home	Natural death
31/10/90	Marion Harrison	68	Residential home	Natural death
4/11/90	Winifred Mary Walker	75	Residential home	Natural death
30/12/90	Mary Rose Dudley	69	Own home	Unlawful killing
1991				
21/2/91	Ronald Jameson	48	Own home	Natural death
2/3/91	Ellen Walker	88	Residential home	Natural death
21/3/91	Alfred Cheetham	73	Own home	Insufficient evidence for decision
3/5/91	Mary Middleton	81	Own home	Natural death
5/5/91	Barry Higgins	58	Own home	Natural death
5/8/91	Phyllis Farrell	79	Own home	Natural death
26/8/91	Ethel May Proud	94	Own home	Natural death
3/10/91	Margaret Ousey	33	Own home	Natural death
11/10/91	Nora Grundy	77	Residential home	Natural death
21/10/91	Elsie Clayton	82	Residential home	Natural death
27/10/91	Alice Richardson	82	Own home	Natural death
17/11/91	Joseph Andrew	84	Nursing home	Natural death
1992				
10/1/92	Annie Alexandra Powers	89	Residential home	Suspicion of unlawful killing
28/4/92	Joseph Drummond	85	Own home	Natural death

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
2/7/92	Muriel Elsie Wilson	87	Residential home	Natural death
7/7/92	Alice Drinkwater	79	Residential home	Natural death
7/10/92	Monica Rene Sparkes	72	Own home	Unlawful killing
7/11/92	Hannah Frith	79	Own home	Natural death
14/12/92	Thomas O'Sullivan	67	Own home	Natural death
20/12/92	Harriet Stopford	80	Residential home	Natural death
1993				
12/2/93	Edith Whittle	84	Residential home	Natural death
20/2/93	Harold Freeman	83	Residential home	Suspicion of unlawful killing
24/2/93	Hilda Mary Couzens	92	Own home	Unlawful killing
24/2/93	Olive Heginbotham	86	Own home	Unlawful killing
16/3/93	Winifred Freeman	75	Residential home	Natural death
22/3/93	Amy Whitehead	82	Own home	Unlawful killing
8/4/93	Mary Emma Andrew	86	Own home	Unlawful killing
16/4/93	Lydia Edith Butcher	94	Residential home	Natural death
17/4/93	Sarah Ashworth	74	Own home	Unlawful killing
26/4/93	Fanny Nichols	84	Own home	Unlawful killing
27/4/93	Edna Mary Taylor	90	Residential home	Natural death
27/4/93	Marjorie Parker	74	Own home	Unlawful killing
2/5/93	Nellie Mullen	77	Own home	Unlawful killing
4/5/93	Edna May Llewellyn	68	Own home	Unlawful killing
5/5/93	Rebecca Gray	84	Own home	Natural death
12/5/93	Emily Morgan	84	Own home	Unlawful killing
13/5/93	Violet May Bird	60	Own home	Unlawful killing
22/7/93	Jose Kathleen Diana Richards	74	Own home	Unlawful killing
29/7/93	George Lawton Wagstaff	77	Own home	Natural death
16/8/93	Edith Calverley	77	Own home	Unlawful killing

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
23/9/93	Ernest Colin Ralphs	69	Own home	Natural death
29/10/93	James Edward Barnes	65	Nursing home	Natural death
1/11/93	Margaret Sankey	90	Residential home	Natural death
16/12/93	Joseph Leigh	78	Own home	Unlawful killing
22/12/93	Eileen Robinson	54	Own home	Unlawful killing
22/12/93	David Jones	73	Own home	Suspicion of unlawful killing
23/12/93	Marion Platt	78	Residential home	Natural death
31/12/93	Charles Edward Brocklehurst	90	Own home	Unlawful killing
1994				
4/1/94	Joan Milray Harding	82	Shipman's surgery	Unlawful killing
13/1/94	Christine Hancock	53	Own home	Unlawful killing
9/2/94	Elsie Platt	73	Own home	Unlawful killing
17/5/94	Mary Alice Smith	84	Own home	Unlawful killing
25/5/94	Ronnie Devenport	57	Own home	Unlawful killing
15/6/94	Cicely Sharples	87	Own home	Unlawful killing
17/6/94	Alice Christine Kitchen	70	Own home	Unlawful killing
27/7/94	Maria Thornton	78	Own home	Unlawful killing
8/9/94	Eric Davies	72	Nursing home	Natural death
7/10/94	Audrey Reade	58	Hospital	Natural death
4/11/94	John Hilton	64	Own home	Suspicion of unlawful killing
10/11/94	Florence Heywood	91	Nursing home	Suspicion of unlawful killing
25/11/94	Henrietta Walker	87	Own home	Unlawful killing
30/11/94	Elizabeth Ellen Mellor	75	Own home	Unlawful killing
4/12/94	Beatrice Jeffries	81	Nursing home	Natural death
20/12/94	Janet Hallsworth	90	Residential home	Natural death
29/12/94	John Bennett Molesdale	81	Own home	Unlawful killing

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
1995				
6/1/95	Sarah Ann Hill	74	Daughter's home	Natural death
9/1/95	Alice Kennedy	88	Own home	Unlawful killing
17/1/95	Lily Brookes	80	Nursing home	Natural death
23/1/95	Sydney Hoskins Copeland	80	Own home	Natural death
1/3/95	Lucy Virgin	70	Own home	Unlawful killing
3/3/95	Joseph Shaw	88	Own home	Unlawful killing
6/3/95	Maria West	81	Own home	Conviction
7/3/95	Netta Ashcroft	71	Own home	Unlawful killing
7/3/95	Lily Bardsley	88	Own home	Unlawful killing
13/3/95	Marie Antoinette Fernley	53	Own home	Unlawful killing
17/3/95	Ida Cains	84	Own home	Insufficient evidence for decision
21/3/95	John Crompton	82	Own home	Unlawful killing
26/3/95	Frank Crompton	86	Own home	Unlawful killing
31/3/95	Vera Brocklehurst	70	Own home	Unlawful killing
10/4/95	Angela Philomena Tierney	71	Own home	Unlawful killing
13/4/95	Edith Scott	85	Own home	Unlawful killing
14/4/95	Clara Hackney	84	Own home	Unlawful killing
21/4/95	Renate Eldtraude Overton	47	Hospital	Unlawful killing
3/5/95	Maud Wilkinson	82	Residential home	Natural death
4/5/95	Kate Maud Sellors	75	Own home	Unlawful killing
22/5/95	Arthur Bent	90	Own home	Suspicion of unlawful killing
2/6/95	Clifford Barnes Heapey	85	Nursing home	Unlawful killing
11/6/95	James Clough	71	Own home	Natural death
13/6/95	Bertha Moss	68	Shipman's surgery	Unlawful killing
17/6/95	Brenda Ashworth	63	Own home	Unlawful killing
29/6/95	Ernest Rudol	82	Own home	Unlawful killing

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
4/7/95	Alice Carrington	75	Hospital	Natural death
12/7/95	Ada Matley Hilton	88	Own home	Unlawful killing
31/7/95	Irene Aitken	65	Own home	Unlawful killing
23/8/95	Ivy Jones	64	Hospital	Natural death
25/8/95	John France	84	Nursing home	Natural death
29/8/95	Arthur Henderson Stopford	82	Own home	Unlawful killing
14/9/95	Geoffrey Bogle	72	Own home	Unlawful killing
26/9/95	Dora Elizabeth Ashton	87	Shipman's surgery	Unlawful killing
24/10/95	Muriel Margaret Ward	87	Own home	Unlawful killing
2/11/95	Kathleen May Wass	87	Residential home	Natural death
8/11/95	Edith Brock	74	Own home	Unlawful killing
22/11/95	Charles Henry Barlow	88	Own home	Unlawful killing
25/11/95	Konrad Peter Ovcar-Robinson	43	Own home	Unlawful killing
14/12/95	Elizabeth Teresa Sigley	67	Own home	Unlawful killing
14/12/95	Kenneth Wharmby Woodhead	75	Own home	Unlawful killing
17/12/95	Kathleen May Boardman	72	Own home	Natural death
1996				
2/1/96	Hilda Mary Hibbert	81	Own home	Unlawful killing
11/1/96	Erla Copeland	79	Own home	Unlawful killing
19/1/96	Peter Higginbottom	42	Hospital	Natural death
26/1/96	Nora Needham	76	Own home	Natural death
8/2/96	Edward Buckland	84	Residential home	Natural death
19/2/96	George Henry Mottram	91	Residential home	Natural death
21/2/96	Jane Elizabeth Shelmerdine	80	Own home	Unlawful killing
27/2/96	John Sheard Greenhalgh	88	Own home	Unlawful killing
12/3/96	Minnie Doris Irene Galpin	71	Own home	Unlawful killing
12/4/96	Joseph Beech	80	Own home	Natural death

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
18/4/96	Marjorie Hope Waller	79	Own home	Unlawful killing
18/4/96	Minnie Ward	104	Residential home	Natural death
22/4/96	Frances Potts	85	Residential home	Natural death
24/4/96	John Stone	77	Own home	Unlawful killing
7/5/96	Elsie Godfrey	85	Own home	Unlawful killing
13/5/96	Edith Brady	72	Shipman's surgery	Unlawful killing
18/5/96	Fanny Clarke	82	Own home	Suspicion of unlawful killing
29/5/96	Valerie Cuthbert	54	Own home	Unlawful killing
30/5/96	Lilian Cullen	77	Own home	Unlawful killing
6/6/96	Renee Lacey	63	Own home	Unlawful killing
8/6/96	John Baddeley	80	Own home	Natural death
10/6/96	Leah Fogg	82	Own home	Unlawful killing
17/6/96	Gladys Saunders	82	Own home	Unlawful killing
25/6/96	Margaret Mary Vickers	81	Own home	Unlawful killing
25/6/96	Nellie Bennett	86	Own home	Unlawful killing
2/7/96	Tom Balfour Russell	77	Own home	Unlawful killing
11/7/96	Irene Turner	67	Own home	Conviction
16/7/96	Carrie Leigh	81	Own home	Unlawful killing
19/7/96	Marion Elizabeth Higham	84	Own home	Unlawful killing
22/7/96	Pamela Grace Mottram	57	Own home	Natural death
24/7/96	Elsie Hannible	85	Own home	Unlawful killing
29/7/96	Elsie Barker	84	Own home	Unlawful killing
30/8/96	Sidney Arthur Smith	76	Own home	Unlawful killing
12/9/96	Dorothy Mary Andrew	85	Own home	Unlawful killing
20/9/96	Anne Lilian Ralphs	75	Own home	Unlawful killing
23/10/96	Millicent Garside	76	Own home	Unlawful killing
12/11/96	Grace Sumner	60	Hospital	Natural death

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
18/11/96	Agnes Oldham	95	Residential home	Natural death
20/11/96	Irene Heathcote	76	Own home	Unlawful killing
23/11/96	Samuel Mills	89	Own home	Unlawful killing
29/11/96	Marion Gaskell	77	Hospital	Natural death
4/12/96	Thomas Cheetham	78	Own home	Unlawful killing
16/12/96	Maureen Whittaker	62	Nursing home	Natural death
17/12/96	Kenneth Ernest Smith	73	Own home	Unlawful killing
1997				
2/1/97	Eileen Daphne Crompton	75	Residential home	Unlawful killing
3/1/97	David Alan Harrison	47	Own home	Unlawful killing
8/1/97	Elsie Lorna Dean	69	Own home	Unlawful killing
9/1/97	Albert Edward Saunders	81	Nursing home	Natural death
11/1/97	Mary Louisa Boardman	95	Residential home	Natural death
20/1/97	Irene Brooder	76	Own home	Unlawful killing
27/1/97	Charlotte Bennison	89	Own home	Unlawful killing
3/2/97	Charles Henry Killan	90	Own home	Unlawful killing
4/2/97	Betty Royston	70	Own home	Unlawful killing
23/2/97	Joyce Woodhead	74	Own home	Unlawful killing
28/2/97	Lizzie Adams	77	Own home	Conviction
20/3/97	Squire Barber	69	Nursing home	Natural death
22/3/97	Rose Garlick	76	Own home	Unlawful killing
27/3/97	May Lowe	84	Own home	Unlawful killing
29/3/97	Hilda Fish	97	Residential home	Natural death
11/4/97	Elaine Dutton	73	Nursing home	Natural death
21/4/97	Mary Coutts	80	Own home	Unlawful killing
21/4/97	Mary Tuff	76	Own home	Suspicion of unlawful killing
25/4/97	Elsie Cheetham	76	Own home	Unlawful killing

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
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2/5/97	Lena Norah Slater	68	Own home	Unlawful killing
12/5/97	Ethel May Kellett	74	Own home	Unlawful killing
21/5/97	Doris Earls	79	Own home	Unlawful killing
25/5/97	Bessie Delaney	87	Residential home	Natural death
29/5/97	Ivy Lomas	63	Shipman's surgery	Conviction
24/6/97	Vera Whittingslow	69	Own home	Unlawful killing
7/7/97	Maureen Lamonnier Jackson	51	Own home	Unlawful killing
14/7/97	Muriel Grimshaw	76	Own home	Conviction
25/7/97	John Louden Livesey	69	Own home	Unlawful killing
28/7/97	Lily Newby Taylor	86	Own home	Unlawful killing
10/8/97	Dorothy Doretta Hopkins	72	Own home	Unlawful killing
13/8/97	Harry Lomas	82	Nursing home	Natural death
27/8/97	Kenneth Pickup	77	Country park footpath	Natural death
1/9/97	Nancy Jackson	81	Own home	Unlawful killing
22/9/97	Mavis Mary Pickup	79	Own home	Unlawful killing
26/9/97	Bessie Swann	79	Own home	Unlawful killing
29/9/97	Enid Otter	77	Own home	Unlawful killing
10/11/97	Florence Lewis	79	Own home	Unlawful killing
11/11/97	Bertha Parr	77	Own home	Suspicion of unlawful killing
14/11/97	Mary Walls	78	Own home	Unlawful killing
21/11/97	Elizabeth Mary Baddeley	83	Own home	Unlawful killing
24/11/97	Marie Quinn	67	Own home	Conviction
8/12/97	Elizabeth Battersby	70	Own home	Unlawful killing
9/12/97	Laura Kathleen Wagstaff	81	Own home	Conviction
10/12/97	Bianka Pomfret	49	Own home	Conviction

Date of Death	Name of Deceased	Age of Deceased	Place of Death	Decision
18/12/97	Alice Black	73	Own home	Unlawful killing
24/12/97	James Joseph King	83	Own home	Unlawful killing
1998				
22/1/98	Mabel Shawcross	79	Own home	Unlawful killing
26/1/98	Norah Nuttall	64	Own home	Conviction
2/2/98	Muriel Eveline Harrison	73	Nursing home	Natural death
2/2/98	Cissie Davies	73	Own home	Unlawful killing
9/2/98	Pamela Marguerite Hillier	68	Own home	Conviction
11/2/98	Edith Brierley	90	Nursing home	Natural death
13/2/98	Laura Frances Linn	83	Own home	Unlawful killing
15/2/98	Irene Berry	74	Own home	Unlawful killing
18/2/98	Maureen Alice Ward	57	Own home	Conviction
25/2/98	Winifred Healey	82	Own home	Natural death
27/2/98	Joan Edwina Dean	75	Own home	Unlawful killing
28/2/98	Monica Eddleston	75	Hospital	Natural death
4/3/98	Harold Eddleston	77	Own home	Unlawful killing
6/3/98	Margaret Anne Waldron	65	Own home	Unlawful killing
7/3/98	Irene Chapman	74	Own home	Unlawful killing
13/3/98	Dorothy Long	84	Own home	Unlawful killing
17/3/98	Lily Higgins	83	Own home	Unlawful killing
20/3/98	Ada Warburton	77	Own home	Unlawful killing
24/3/98	Martha Marley	88	Own home	Unlawful killing
28/4/98	Mary Keating	95	Residential home	Natural death
11/5/98	Winifred Mellor	73	Own home	Conviction
12/6/98	Joan May Melia	73	Own home	Conviction
24/6/98	Kathleen Grundy	81	Own home	Conviction

APPENDIX G

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