CHAPTER TWO

The Inquiry

The Setting Up of the Inquiry

2.1 On 31st January 2001, exactly a year after Shipman's convictions and following resolutions in both Houses of Parliament, the Secretary of State for Health issued the instrument of appointment, establishing The Shipman Inquiry, giving it the powers conferred by the Tribunals of Inquiry (Evidence) Act 1921 and appointing me as Chairman of the Inquiry.

Terms of Reference

2.2 The Terms of Reference of the Inquiry are as follows:

' (a) after receiving the existing evidence and hearing such further evidence as necessary, to consider the extent of Harold Shipman's unlawful activities;

(b) to enquire into the actions of the statutory bodies, authorities, other organisations and responsible individuals concerned in the procedures and investigations which followed the deaths of those of Harold Shipman's patients who died in unlawful or suspicious circumstances;

(c) by reference to the case of Harold Shipman to enquire into the performance of the functions of those statutory bodies, authorities, other organisations and individuals with responsibility for monitoring primary care provision and the use of controlled drugs; and

(d) following those enquiries, to recommend what steps, if any, should be taken to protect patients in the future, and to report its findings to the Secretary of State for the Home Department and to the Secretary of State for Health'.

Independence

2.3 Although the Inquiry was set up by Parliament at the invitation of the Secretary of State for Health and is funded from the budget of the Department of Health, it is wholly independent of Government.

Starting Work

2.4 The Inquiry was able to take over the offices at Gateway House, Manchester which had previously been occupied by the Laming Inquiry. Work began immediately on the collection and assessment of the available evidence; the legal team at first consisted only of Leading Counsel to the Inquiry, Miss Caroline Swift QC, and the Inquiry's then Solicitor, Mr Campbell Kennedy, but they were soon joined by Senior Counsel, Mr Christopher Melton (who was appointed Queen's Counsel in April 2001) and Junior Counsel, Mr Anthony Mazzag and Mr Michael Jones, and by the Deputy Solicitor to the Inquiry, Miss Ita Langan. In March 2001, Mr Kennedy was replaced as Solicitor to the

Inquiry by Mr Henry Palin. The Secretary to the Inquiry, Mr Andrew Griffiths, established the administrative team.

2.5 I appointed Dr Aneez Esmail, LRCP MRCS MFPHM PhD to be my Medical Advisor. At the time of his appointment, Dr Esmail was Head of the School of Primary Care at the University of Manchester; he is a practising general practitioner and has also trained in public health. He has, therefore, been able to advise me on matters relating to the organisation of general practice and on medical issues relating to some of the individual deaths which I have had to consider.

Deciding How to Proceed

2.6 The first of the Inquiry's Terms of Reference required it to consider the extent of Shipman's unlawful activities. It seemed to me that this could be done in two ways. The first possible approach was for me to look at the totality of the evidence relating to the deaths which Shipman was known to have caused or was suspected of causing, and take a broad and general view of his criminality. Alternatively, I could instruct the legal team to investigate every suspicious or potentially suspicious death in which Shipman may have been involved as thoroughly as possible and then, on the basis of the evidence collected, reach a decision in the case of each individual death as to whether or not Shipman was responsible for it.

2.7 Having considered the matter carefully and discussed it with the legal team, I decided on the latter course. My reasons for doing so were these:

- There were hundreds of people who were in a state of uncertainty and distress, not knowing whether their relatives had died a natural death or been killed by Shipman; there was a strong feeling that it was only by knowing the truth that they would be able to begin to come to terms with their shock and grief.
- Whilst it was anticipated that some of the deaths would be the subject of coroner's inquests in the future, not all those deaths had been fully investigated by the police, and, if the Inquiry did not undertake further investigations, the evidence relating to those deaths would remain incomplete. Also, it was unlikely that inquests would be held into all the deaths which the Inquiry would investigate.
- It seemed to me essential that, before I went on to consider whether, and, if so, in what respects, there had been failures in systems or on the part of individuals or statutory or other bodies, which had allowed Shipman to commit murder unchecked, I had to be able to form an accurate and authoritative view as to the number of people he had killed and the period over which – and the circumstances in which – the killings were perpetrated. Only by making decisions about Shipman's responsibility for individual deaths would I be able to form such a view.

2.8 In deciding that individual deaths should be investigated, I did, of course, anticipate that a great deal of work would be involved in the collection and analysis of evidence relating to the individual deaths and, indeed, in the decision-making process itself. In the event, the Inquiry's decision to investigate a large number of deaths which had not

previously been investigated by the police has made the task an even more formidable one than I had anticipated. However, the reaction of many of the family members concerned, and their evident relief at being made aware for the first time of the full circumstances surrounding their relatives' deaths, has persuaded me that my decision was the right one.

The First Report

2.9 It was plainly logical that the determination of Shipman's guilt in respect of individual deaths should be the subject of the first phase of the Inquiry. Thus, when the Inquiry published its List of Issues in March 2001, the issues to be considered in Phase One were identified as:

> **' ..how many patients Shipman killed, the means employed and the period over which the killings took place'**.

2.10 Because of my desire to bring to an end, wherever possible, the uncertainty of many family members as to whether or not Shipman killed their relatives, I decided that the Inquiry should publish a First Report, setting out my findings as to Shipman's guilt in respect of all those deaths which the Inquiry legal team placed before me for decision. Those findings can be found in Volumes Two to Six of this Report.

The Application of the Coroners Act 1988

2.11 In February 2000, the South Manchester Coroner sought a direction from the then Home Secretary, The Rt. Hon. Mr Jack Straw, MP, to open inquests into all the deaths (not previously the subject of the criminal trial or past or planned inquests) which had been reported to him by the police. Such a direction was required because the bodies had been cremated.

2.12 The Inquiry legal team was concerned that, if the Coroner were to proceed to hold full inquests into those deaths, this would involve a duplication of the work of the Inquiry in investigating and making decisions in respect of those deaths. There was also the risk of inconsistency as between the Coroner's verdicts and my own findings.

2.13 Accordingly, I invited the Lord Chancellor to exercise his powers under the provisions of Section 17A of the Coroners Act 1988 and to require that the inquests, when opened, should be adjourned pending publication of the findings of the Inquiry.

2.14 On 30th April 2001, the Home Secretary directed the Coroner to open inquests into 262 deaths and, on 4th May 2001, the Lord Chancellor wrote to Mr Pollard, requiring that those inquests, once opened, should be immediately adjourned in the absence of any exceptional reason why this should not be done.

2.15 On 18th May 2001, the Coroner opened inquests into 232 deaths, which inquests were then adjourned. The disparity in the numbers of inquests (i.e. between 262 and 232) was caused, according to the Coroner, by the fact that the original list included a number of deaths which had already been the subject of criminal convictions or inquests.

2.16 Following publication of this First Report, my findings in the 232 cases will be communicated to the Coroner; he will then forward certificates to the register office, with a view to re-registration of the deaths with causes of death consistent with my findings, without the need for the inquests to be resumed. In those cases where no inquest has yet been opened but where it appears that, on the basis of my findings, re-registration of the death is appropriate, I anticipate that inquests will be opened and adjourned under the provisions of Section 17A of the 1988 Act and that my findings will be forwarded to the register office in the same way.

Identifying the Deaths to be Investigated

2.17 The first task confronting the legal team was to identify all those deaths which should be examined by the Inquiry. A database was created, on which details of every death known to the Inquiry were recorded.

HOLMES

2.18 The starting point was the huge amount of information which had already been collected by the police. The Greater Manchester Police gave the Inquiry immediate access to their database, the Home Office Large Major Enquiry System (' HOLMES'), on which appeared details of, and evidence relating to, all the deaths which had been investigated by them and by the West Yorkshire Police, together with details of some deaths which had not been investigated. The information contained on HOLMES was updated from time to time until the police incident room was closed, and the investigation scaled down, in June 2001.

Professor Baker's Audit

2.19 In the course of the research involved in his review, Professor Baker had identified virtually every death in Todmorden and Hyde for which Shipman had signed the MCCD. Inevitably, a small number of such deaths were missed, either because they were registered outside the district or by reason of human error. However, the Inquiry has been able to identify most, if not all, of the ' missed' deaths by checking through Shipman's books of used MCCDs, in which the counterfoils remain. Professor Baker provided to the Inquiry a list of every death which he had identified; many of them also appeared on HOLMES but the remainder were added to the Inquiry's database, for scrutiny by the Inquiry team. Those additional deaths which the Inquiry had identified from the MCCD counterfoils were also put on the database.

Expressions of Concern

2.20 Any death in respect of which a relative, friend or other member of the public expressed concern to the Inquiry was considered by the legal team. Sometimes, there was no known connection between the death and Shipman, and the caller just wanted to exclude the possibility that he might have been involved; in that event, the legal team was able to reassure him or her and close the case immediately. In other cases, however, the circumstances gave rise to a possibility that Shipman may have been responsible for the death and, in such cases, a full investigation was undertaken.

Coroner's Cases

2.21 There is a perception among the public that all deaths automatically come to the attention of the local coroner. In fact, that is not the case – the coroner only becomes aware of deaths which are specifically referred to him, or about which his advice is sought. The majority of deaths proceed to registration, and thereafter to burial or cremation of the body, without the intervention of the coroner, the cause of death having been certified by the deceased's general practitioner or a hospital doctor. Initially, therefore, the police investigation centred on deaths which had been certified by Shipman, rather than those which had been referred to the coroner.

2.22 Following publication of Professor Baker's review, however, there was considerable concern in Todmorden about Shipman's possible involvement, not only in deaths which had been certified by him, but also in deaths which had been referred to and certified by the coroner. In response to that concern, the West Yorkshire Police considered 81 deaths which had been referred to the Coroner during Shipman's time in Todmorden and carried out detailed investigations into nine of those deaths where there was thought to be a real possibility of involvement by Shipman.

2.23 The Inquiry has examined the Coroner's files for the 81 deaths considered by the police. The files contained post-mortem examination reports and factual summaries provided to the Coroner by the police at the time of the death. The Inquiry legal team confirmed that there was evidence of involvement by Shipman only in the nine cases already identified by the police. One additional file was opened but was closed when the hospital records of the deceased person in question revealed that Shipman was not involved in the death. One of the nine cases involved the death of a newborn child. There is no question of deliberate killing in that case, although it has been suggested that Shipman may have provided inadequate medical care. As such, that death falls outside the Inquiry's Terms of Reference for Phase One. I have given decisions in the remaining eight cases and am satisfied, on the basis of the available evidence (including expert forensic pathological evidence), that six were natural deaths. In the seventh, there was inadequate evidence to enable me to reach a decision and the eighth I regarded as suspicious, without being able to come to any positive conclusion about Shipman's guilt.

2.24 The legal team considered for some time whether or not it should perform a similar exercise in relation to the deaths which had been referred to the South Manchester Coroner during Shipman's time in Hyde. It was recognised that this would be a far bigger task than in Todmorden, involving as it would the examination of an estimated 52,500 files, covering a period of 21 years. It was also recognised that the Inquiry had to balance the need to obtain the fullest possible information about deaths occurring during Shipman's professional life against the time and resources which a full review of the South Manchester Coroner's files would take. With those considerations in mind, I decided that, in the interests of completeness, a search of the Coroner's files should be undertaken, with a view to identifying those deaths which were or might be connected with Shipman.

2.25 As a result of the search which ensued, 136 deaths in which Shipman had some involvement, usually as the deceased's general practitioner, were identified. The

majority of the deaths raised no suspicion, once the circumstances were examined, and those cases were closed. A number of the deaths identified from the Coroner's files had come to the Inquiry's attention by other means and were already the subject of investigation. However, a small proportion were deaths of which the Inquiry had no previous knowledge and these were made the subject of further investigation by the legal team.

2.26 In the event, I have found that Shipman was responsible for only three deaths which had been referred to the Coroner immediately after the death (other than by means of an informal telephone query such as that made in the case of Mrs Kathleen Grundy); in one of those cases (that of Mr Charles Barlow), there was a post-mortem examination which revealed an apparently natural cause of death. In another (that of Mr John Stone), the Coroner issued a Form 100A, indicating that there had been no post-mortem examination and that he did not consider it necessary to hold an inquest. The third patient, Mrs Renate Overton, died on 21st April 1995. She had remained in a persistent vegetative state for 14 months, following an injection administered by Shipman in February 1994. After a post-mortem examination without inquest, Mr Peter Revington, who was then the South Manchester Coroner, certified that Mrs Overton had died as a result of natural causes. I have found that Shipman unlawfully killed Mrs Overton.

2.27 It is plain that Shipman made every effort to ensure that deaths for which he was responsible did not come to the coroner's attention and, as is evident from my decisions, he developed many techniques by which he was able to prevent them from doing so.

The Deaths Investigated

2.28 In all, the Inquiry has investigated 887 deaths which were, initially at least, believed to have some connection with Shipman. I have given written decisions in respect of 493 of these deaths and one incident involving a living person; the remaining 394 cases have been closed without a decision having been made. It is necessary to explain why.

2.29 As soon as the legal team began to consider the deaths which had been recorded on the Inquiry database, it was evident that some were completely unconnected with Shipman. A number of people, listed on HOLMES as ' deceased', proved to be potential witnesses who had died, or were deceased relatives of persons whose deaths were being investigated, but who had not themselves had any dealings with Shipman. There was obviously no point in considering those deaths further and the files relating to them were closed.

2.30 Similarly, there were a number of deceased patients of Shipman whose medical records had been found at his home and whose details appeared on HOLMES. The Inquiry team at first suspected that the mere fact that records relating to a particular patient were found at Shipman's home might mean that the death of that patient should automatically be regarded as sinister. However, after the legal team had spent some time looking specifically at such cases, it became clear that no particular significance could be attached to the fact that a patient's records had been found at Shipman's home. Consequently, while some of the deaths merited further investigation, there were many

others where no cause for suspicion arose. Some of the patients concerned had died in hospital after a significant period of in-patient treatment, others had died abroad or suffered an accident. Again, those cases could be closed, in the knowledge that Shipman was not responsible for the deaths.

2.31 Sometimes, it was only when further evidence was obtained – evidence from a family witness, for example, to the effect that the deceased person had remained conscious and apparently well for several hours after Shipman's most recent visit – that it became plain that Shipman could not have caused the death. Such cases were, therefore, closed at that stage.

2.32 The preliminary view of the Inquiry legal team was that I should give a written decision:

- in the case of all deaths where the Inquiry's investigations revealed real suspicion as to whether Shipman was responsible for the death;
- in all cases where a family, friend or other member of the public had expressed a real concern about the circumstances of the death and where that concern related to potentially unlawful activity and was, therefore, within the Inquiry's Terms of Reference; this excluded allegations of incompetence, poor service or clinical negligence;
- in the case of all deaths which had been assessed by Professor Baker as moderately or highly suspicious on the basis of medical records or cremation documentation; and
- in the case of all the Todmorden deaths investigated by the police (save for the one which fell outside the Inquiry's Terms of Reference for Phase One).

2.33 The effect of applying these criteria was to leave unallocated, either to the ' closed' or ' decision' categories, a significant number of cases where no concern had been expressed by relatives and which Professor Baker had assessed as non-suspicious or had not been able to assess at all because of the absence of medical records or cremation forms. These were mainly cases from the late 1970s and early 1980s and, in many (152 at the time of the Opening Meeting of the Inquiry in May 2001), the only information which the Inquiry had in its possession was a copy of the entry in the register of deaths. The amount of information available in these cases increased as more relatives were traced by means of enquiry agents and advertisements in the press, and as additional documents – Shipman's visits books from the Donneybrook years, books of MCCD counterfoils and daily report diaries from a residential care home, Charnley House – came into the Inquiry's possession, but the evidence still remained very limited in some cases.

2.34 In the first instance, the legal team had intended that, of those cases with very little available evidence, only those where there was some positive evidence that Shipman had been, or might have been, involved in the death would be investigated and put before me for decision; it was proposed that the remainder should be closed. As matters progressed, however, it became clear that, for the early years, this was going to mean that there would be few decisions and, moreover, no means by which the public would be able to see the reasoning which had led to large numbers of cases being

closed. There was also the risk that this approach would mean that some cases where Shipman had killed would be missed.

2.35 It was decided, therefore, to change the approach. Instead of requiring **positive** evidence of Shipman's involvement, the legal team would investigate as fully as possible those cases where there was little information available and refer them to me for decision, in the absence of compelling evidence that Shipman had **not** been involved in the death.

2.36 From the first, the legal team had taken the view that the fact that family members had no concerns about the death, or were positively opposed to the death being investigated, would not prevent the Inquiry from investigating in a case where there was real cause for suspicion. However, where there were no overtly suspicious circumstances and the family, on being contacted, had declared that they had no concerns about the death, it was initially thought appropriate to close the case.

2.37 Once the decision was taken to lower the threshold for determining which cases would be placed before me for decision, it was recognised that the Inquiry's stance in relation to families expressing ' no concerns' would also have to be changed. After all, the relative of a deceased person may have ' no concerns' about Shipman's involvement in the death because he or she was with that person continuously during the days before death and knows that Shipman never visited; equally, he or she may have ' no concerns' because, having being abroad at the time of the death, he or she knows nothing about the circumstances of the death but has no positive reason to suspect Shipman's involvement. In the first case, Shipman was obviously not implicated in the death; in the second, it is impossible to know one way or another. In order to find out the true state of affairs, it was necessary to approach families to ascertain precisely what they knew about the circumstances of their relatives' deaths. When this was done, it was discovered that, in some cases where families had reported ' no concerns', further enquiries revealed that the circumstances of the death were such as to arouse considerable suspicion about Shipman's possible involvement.

2.38 Naturally, the Inquiry has been reluctant to take any step which might disturb or upset families who have, hitherto, had no worries about their relative's death, or who had been unwilling to voice any concerns which they may have had. It has, however, been impossible to avoid approaching such families in some cases. I hope that those who have been contacted by the Inquiry, in circumstances when they would have preferred that this was not done, will understand that it was necessary in order to discharge the Inquiry's duty to obtain the fullest possible information about deaths occurring during Shipman's professional career. The vast majority of people from whom the Inquiry has sought information have responded courteously and patiently and I am most grateful to them for their co-operation.