CHAPTER NINE

The Decision-Making Process

9.1 Before I began to write the decisions in the individual cases, I had read the transcript of Shipman's trial and the generic evidence of Dr Grenville and Professor McQuay, which I have summarised in Chapters Six and Seven. I had informed myself of the systems in use at the various practices in which Shipman had worked, which are summarised in Chapter Four and I had also familiarised myself with the law and practice relating to death registration and cremation certification, which are summarised in Chapter Five.

The Evidence in Individual Cases

9.2 The vast majority of case files contain witness statements taken by the Inquiry team, death registration documents and at least some surgery records. Many files contain witness statements taken during the police investigation, cremation certificates, medical records and expert evidence. Some contain a variety of miscellaneous documents such as nursing home records, telephone billing records, police and ambulance logs and district nursing records. Very few medical records survive for the years before 1992 but many were available after that date. A few files, in which the coroner's office was involved, contain the coroner's papers. In general, the older the case, the fewer the documents and the less detailed the recollection of the witnesses. In some cases I had the benefit of oral evidence. In most, I based my decision on written statements and documentary evidence.

Similar Fact Evidence

9.3 It was clear from an early stage that there would be very few cases in which physical evidence would be available to show whether Shipman killed the patient in question. Besides the cases in which Shipman was convicted, the police investigation had found three deaths where traces of morphine were found in body tissues. There would be no more cases with morphine in the body tissues. It was also clear that there would be no evidence from Shipman himself. My decisions would be very largely based on inferences from circumstantial evidence. My confidence in drawing such inferences would be greatly increased if I found that patients had died in circumstances strikingly similar to those in which the jury had found that Shipman had murdered his patients.

9.4 In a criminal trial, the jury is not usually permitted to draw the inference that the defendant is guilty of the crime with which he is charged from evidence that he has done something of a similar nature in the past. The jury is allowed to take past conduct into account only if the similarity between the past conduct and the present allegation is so great or so striking that it would be an affront to common sense not to do so. However, it is universally recognised that people do tend to repeat their patterns of conduct, good, bad and indifferent. We all have propensities to behave in certain ways, just as we have traits of personality. In a civil action, a judge is allowed to take a person's propensities into account rather more freely than is permitted in a criminal trial. A public inquiry is neither a criminal trial nor a civil action. My task in this Phase of the

Inquiry has been to find out what Shipman has done. I felt free to consider all Shipman's conduct, throughout the whole of his professional career and to assemble as complete a picture as possible of the ways in which he conducted himself. If I formed the view that he carried out a killing in a particular way on one occasion, I felt free to infer that he might have done something similar on other occasions, either before or after that occasion. I began by analysing the circumstances of the 15 cases in which Shipman had been convicted of murder.

The Fifteen Convictions

9.5 The cases are summarised at Appendix E.

9.6 Murder is the unlawful killing of a person carried out with the intention to kill or to cause really serious harm. At Shipman's trial, the jury found that Shipman had given a large injection of opiate to each victim. The giving of the injection, which was not for therapeutic purposes, was plainly an unlawful act. As Shipman was a doctor, the jury must have been satisfied that he knew what the effect of the drug would be in the dose that he gave. As the dose killed the patient, the jury must have inferred that Shipman had intended to kill the patient. It appeared to me that, if I concluded that Shipman had given an opiate injection, which had caused the death of a patient whose death did not otherwise appear to have been imminent, I could properly infer that Shipman had intended to kill that patient.

9.7 In nine of the 15 conviction cases, the bodies of the deceased had been exhumed and morphine had been found in the remains. In each of those cases, there was strong medical evidence that the true cause of death was morphine poisoning. In one case, Shipman sought to advance an explanation for the presence of the drug in the body tissues. He suggested that Mrs Kathleen Grundy might have been a drug addict. This explanation was obviously rejected by the jury. In the other cases, Shipman offered no explanation for the presence of morphine in the bodies. The finding of morphine coupled, in eight of the nine cases, with evidence of Shipman's presence with his patient at the death or shortly before the discovery of the body (in circumstances which had afforded him an opportunity to administer an injection), provided a devastating evidential nexus. In those eight cases, it is hard to imagine what conclusion the jury could have reached other than that Shipman had murdered his patient by injecting morphine or diamorphine. In the remaining case in which morphine was found in the body, that of Mrs Joan Melia, the prosecution could not demonstrate that Shipman had been present at the death or present at the house shortly before the death was discovered. However, the jury must have inferred that he had.

9.8 In the other six cases, the bodies had been cremated and there were no remains to be examined. The lack of physical evidence of morphine poisoning meant that there was, in those cases, less evidence of Shipman's guilt. However, the circumstances of each case and Shipman's conduct in the cremation and non-cremation cases were so similar that, when all the cases were considered together, the evidence in the cremation cases became compelling. The jury drew the inference that Shipman had injected all 15 victims with morphine or diamorphine. No doubt the 15 cases for which Shipman was

prosecuted were chosen because the evidence was strong. As it happens, they also provided a good range of examples of Shipman's methods.

9.9 The most striking feature in 14 of the conviction cases was the temporal association between Shipman's contact with the victim and the victim's death. Only in the case of Mrs Joan Melia was the Crown unable to show this close temporal association. Of those victims with morphine in the body, Shipman admitted that he had been with two at the moment of death. They were Mrs Ivy Lomas, who died in the surgery, and Mrs Marie Quinn. Mrs Irene Turner and Mrs Jean Lilley were found dead minutes after Shipman had been present in their homes. Mrs Kathleen Grundy and Mrs Bianka Pomfret were found dead not long after Shipman's departure from their homes. Shipman was seen outside Mrs Winifred Mellor's house shortly before her death was discovered, although he later denied having visited her that day. Mrs Muriel Grimshaw's death was discovered at home the day after Shipman's last visit, but no one had seen her or spoken to her since he had been there. In each of those eight cases, Shipman had been alone with the patient.

9.10 Of the six cremation cases, where there could be no physical evidence of the presence of morphine, Shipman admitted that he had been present at the death of four: Mrs Kathleen Wagstaff, Mrs Lizzie Adams, Mrs Norah Nuttall and Mrs Maria West. Of the other two deaths, that of Mrs Pamela Hillier was discovered only about half an hour after Shipman had visited; in the case of Miss Maureen Ward, Shipman claimed that he had found Miss Ward dead when he arrived at her flat. The jury plainly disbelieved him.

9.11 A second feature common to many of the conviction cases was that the patient was found sitting peacefully in a chair or on a sofa, as if asleep. Mrs West, Mrs Adams, Mrs Lilley, Mrs Wagstaff, Mrs Pomfret, Mrs Nuttall, Mrs Mellor and Mrs Melia were all found sitting in their chairs or sofas. Mrs Turner, Mrs Grimshaw and Miss Ward were lying on their beds. Mrs Grundy was lying on the sofa.

9.12 A third feature of the conviction cases was the fact that none of the patients was terminally ill and in no case did it appear that Shipman had been sent for on account of a sudden and serious deterioration in the health of his patient. The deaths were sudden and not expected by the family or friends of the deceased.

9.13 In summary, the striking features of the circumstances surrounding the conviction cases were Shipman's proximity (temporal and physical) to the death, the appearance in death of the victims and the sudden and unexpected nature of the deaths.

The Significance of the Features Emerging from the Conviction Cases

Presence at Death

9.14 Expert evidence and common sense suggest that it is very rare indeed for a patient to die during a general practitioner's visit, unless the patient is terminally ill or the doctor has been sent for as a matter of urgency on account of symptoms of sudden and life-threatening illness. None of the six victims in the conviction cases who died in Shipman's presence was terminally ill. Not one of them had called Shipman out or attended his surgery as an emergency. The deaths were all sudden and unexpected.

As a sudden and unexpected natural death in the course of a general practitioner's routine consultation is a very unusual event, for Shipman to have been present at no less than six sudden, unexpected and supposedly natural deaths during a period of three years would have represented a quite remarkable series of coincidences. Clearly, the jury thought that these were not coincidences. The explanation was that Shipman had killed the patients.

9.15 I have found a large number of sudden and unexpected deaths at which Shipman was present. I regard his presence at such a death as highly suspicious and think that it is reasonable to infer that Shipman probably killed the patient, unless there is other evidence that suggests the contrary.

Discovery of Death Shortly after Shipman's Departure

9.16 If it is most unusual for a patient who is not terminally ill to die in the course of a routine visit by the doctor, it must also be unusual for such a patient to be found dead shortly after a doctor's visit. (The reason is obvious; the doctor would be expected to make arrangements for the patient's admission to hospital if he or she was concerned that the patient's death might be imminent). If this happened occasionally, it might not be suspicious. But with Shipman, it happened frequently. It happened in seven of the conviction cases. The jury must have thought that was too much to be due to coincidence. I have found many more cases in which a patient has been found dead shortly after Shipman's departure. If it appears that no one saw the patient alive or spoke to him or her after Shipman's departure, I consider the circumstances to be highly suspicious and I have inferred that Shipman probably killed the patient. If the patient failed to answer the telephone soon after Shipman's departure and was later found dead, the same inference can be drawn. If the patient was found dead some hours after Shipman's departure, the inference cannot be so readily drawn. The possibility of a natural death having occurred in the mean time increases with the passage of time but, if no one spoke to the patient or saw him or her alive, an inference of guilt may still be drawn, but not so readily or conclusively.

Discovering a Death

9.17 It is quite unusual for a doctor to discover a patient dead at home although, of course, this might happen occasionally to any doctor. If Shipman were to be believed, it happened to him quite frequently. In one of the conviction cases, Shipman claimed that he had found Miss Maureen Ward dead when he went to her home, supposedly to give her some information about a hospital appointment. The jury must have accepted the Crown's case that Shipman had made an unsolicited visit to Miss Ward's flat and had killed her; that he had then gone to find the warden of the sheltered accommodation where she lived and asked her to come back to see the body. Shipman told the warden that Miss Ward had left the door open for him, as she was expecting him. I have found several cases in which Shipman has claimed to find one of his patients dead. Sometimes, he would claim (as with Miss Ward) that the door had been left open or unlocked for him. At other times, he would claim that he had called on a patient and had been unable to gain access. He would then go to find a neighbour, who had a key, or the warden, if the patient lived in sheltered accommodation. He would ask the

neighbour or warden to return with him to the patient's home. Together they would ' discover' the body. As I have said, such an event might happen occasionally in the life of any general practitioner. With Shipman, such events happened too frequently for the explanation to be chance. I regard such circumstances as highly suspicious.

Appearance in Death

9.18 As I have mentioned previously, the appearance in death of many of Shipman's victims is not typical of what is seen following death from most of the common causes of sudden death, such as heart attack, pulmonary embolism or stroke. Dr Grenville said that these positions were what one might expect if someone had been given a lethal dose of strong opiate, injected intravenously so that it took effect very quickly. In cases which I had to consider, I regarded the evidence of these typical positions as indicative, but not strongly probative, of guilt.

Shipman's Behaviour in the Aftermath of a Killing

9.19 Shipman became a plausible and accomplished liar. He lied about the circumstances both of his attendance at deaths and of visits that he made to patients shortly before their deaths.

9.20 In a small number of cases, Shipman was observed in the victim's house at the time of or immediately after the death. In other cases, Shipman openly accepted that the patient had been alive when he arrived and had died while he was there. In reality, he would have given a lethal injection during the visit and, typically, he would then have waited with the patient until he or she was dead, which was usually only a matter of minutes. He had a range of explanations for his presence that he would offer to relatives and neighbours. He would often say that he had arrived to find the patient ' breathing her last' or suffering a ' massive heart attack'. He would say that it was too late to do anything, but he had stayed with the patient to comfort her. Sometimes, he would say that he had given a small dose of morphine to ease her pain. At other times, he would say that the patient had not been seriously ill when he arrived but had ' taken a turn for the worse' while he was there and died. Some of his descriptions of sudden death are breathtaking: ' I turned round to get my stethoscope out of my bag and she just collapsed and died'; ' I was telephoning for an ambulance and she gave one cough. When I turned round I could see that she had died'; ' She just died while I was examining her'. Sometimes, he would say that, when he arrived, he had realised immediately that the patient was very ill, had called an ambulance and had begun to arrange admission to hospital. Unfortunately the patient had died suddenly, so he had cancelled the arrangements. In the later cases, where telephone records were available, it was possible to check whether or not he had made the telephone calls as claimed. He hardly ever had. On other occasions, he would say that the patient had rejected his advice to be admitted to hospital and there was nothing more he could do. In those cases, he would sometimes blame the patient's death on the refusal to be admitted. Examples of these ploys are to be found in the conviction cases and I have found many more.

9.21 When Shipman had killed and nobody had arrived at the house while he was there, he would often leave and go about his business. Sometimes, a neighbour would see him depart and would go to see how the patient was. The neighbour would then find the patient dead, within minutes of Shipman's departure. Shipman would be called back. One might think this would be a difficult situation for him. But he would have a ready explanation. He might say that he had been on his way to fetch something from the surgery and had intended to return immediately. Or he might simply say that the patient had been all right when he left and must have died since he left. His explanations were sometimes implausible but were nevertheless accepted.

9.22 If Shipman was able to leave the body and go about his business, as he often did, quite a long time might elapse before the body was found. It then became much easier for him to explain the death. Often, he would admit that he had seen the patient earlier in the day. He might say that the patient had been perfectly well when he left and that he was surprised by the death. However, he would never be so surprised as to be unable to certify the cause of death. On other occasions, instead of saying that the patient had been well earlier in the day, he would quite often say that the patient had been ill, so ill in fact that he had advised admission to hospital. However, the patient had refused. The death was really the patient's own fault. If Shipman's advice had been accepted, the patient might still have been alive.

9.23 Sometimes, when a body was found by a neighbour or member of the family, for example, the police or an ambulance would be called. Usually, in that situation, the police or paramedics would telephone the surgery and Shipman would come round quickly. He would then tell the police and paramedics that he was able to certify the cause of death. Since there were no obviously suspicious circumstances, the police and paramedics would depart and the death would not be referred to the coroner. Shipman would certify the cause of death and complete a cremation Form B if necessary. Sometimes, if a body was not found quite soon after Shipman had left it, he would return to the house and ' discover' it himself. I suspect that he did this in order to avoid the danger that he might not be available when the body was found; if he were not, there would then be a risk that the death might be referred to the coroner.

9.24 Each of the conviction cases, except that of Mrs Melia, involved one or more of the circumstances I have just described.

Lies told by Shipman on Cremation Form B

9.25 Shipman must have recognised that his presence alone at the death of so many of his patients might seem suspicious. For this reason, one of his most common lies on cremation forms was to suggest that someone had been present at the moment of death, either in addition to or instead of himself. In the case of Mrs West, he claimed on Form B that her neighbour, Mrs Marian Hadfield, had been present at the death, when the truth was that she had been in the kitchen, while Shipman was killing Mrs West in the living room. In the case of Mrs Adams, Shipman's claim that ' a neighbour' (Mr William Catlow) was present at the death was a lie. Mr Catlow, who was in fact Mrs Adams' lodger, arrived at the house shortly after Shipman had killed Mrs Adams. In the case of Mrs Nuttall, Shipman claimed that her son, Mr John Nuttall, was present at the death. He

was not; he arrived home shortly after the death. In the case of Miss Ward, Shipman claimed that the warden was present at the death. She was not. Shipman himself fetched her afterwards. This type of lie had a purpose. Shipman clearly wished to create the impression that he had not been alone with the patient at the moment of death, when in fact he had. I have found many other cases in which Shipman has told this type of lie. There are some cases where he did not suggest that he had been present but did suggest, falsely, that a neighbour or relative had been. I regard this feature as suspicious.

9.26 As a variation on this theme, Shipman would sometimes say on Form B that people who had supposedly been present at the death (but who had not been) had provided him with information which he was supplying on the form. He did this in the case of Miss Ward, where he claimed that the warden had told him that she had found Miss Ward in a collapsed state and that she had died only minutes later. That was untrue. The purpose of the lie was to divert attention away from himself by suggesting that others had been involved around the time of the death, and thereby to paint a picture which would not arouse suspicion in the minds of medical colleagues concerned in the certification process.

9.27 I have also found many other types of lie on Forms B. As I described in Chapter Five, Shipman sometimes told lies about the time of the death and the time of his last visit, in order to distance himself from the death. I regard that kind of lie (if a proven lie and not a mere inaccuracy) as highly suspicious and probative of guilt. I regard some of Shipman's spurious claims that he could estimate the time of death from body temperature as highly suspicious. Sometimes, particularly in the mid-1990s, Shipman would claim that somebody (usually a relative or neighbour) had seen the deceased person alive at a specific time, after Shipman's own visit and before the death. If true, Shipman could not have killed the patient during his visit. If the statement was shown to be a lie, I regarded it as highly suspicious.

9.28 I must make it plain that I have found a great number of inaccuracies in both Forms B and MCCDs, which cannot be proved to be deliberate lies and which may well be the result of carelessness. Indeed, I have seen many errors and internal inconsistencies within the certification documents in cases where it is quite clear that Shipman has not killed the patient. Before drawing any inference of guilt from an inaccurate statement on a Form B or MCCD, I have always considered whether it is a proven lie or possibly only a mistake and I have always asked myself whether I could perceive a purpose behind the telling of the lie. Only if I believe the statement to be a deliberate lie and if I can perceive an ulterior motive for the lie have I regarded it as probative.

Avoiding Referrals to the Coroner

9.29 There are some types of lie that occur so frequently, sometimes in cases which look suspicious and sometimes in cases which do not, that I can attach very little weight to the fact that the lie has been told. The most obvious example is the ' 14 day lie' to which I have already referred at paragraph 5.27.

9.30 Shipman frequently claimed that he had seen a patient within 14 days before the death when the other evidence strongly suggests that he had not. The obvious reason for telling this lie is that it would avoid the possibility that the registrar would or might question Shipman's qualification to certify the cause of death. The result of that might be a referral to the coroner. If Shipman had killed a patient, he would naturally wish to avoid such a referral. A post-mortem examination might well follow a referral, with the possibility (no more) that toxicological tests might be carried out. Shipman avoided a coroner's referral in all the conviction cases, although he had an informal chat with a member of the South Manchester Coroner's staff following Mrs Grundy's death. The surprising thing was that Shipman sometimes told the ' 14 day lie' in cases where he had plainly not killed the patient. I think that sometimes he must have wished to avoid a referral to the coroner for reasons other than the avoidance of the risk of detection of unlawful conduct. Possibly, he might have wished to save the family the additional distress of a post-mortem examination and the inevitable delay in the making of funeral arrangements. I think he might not, at times, have wanted to involve himself in the ' bother' of a referral. Possibly, he simply liked to keep his patients' deaths completely under his own control, because he thought he knew best. Whatever his motives, I cannot attach great probative weight to the ' 14 day lie'. Where, however, it fits in with other signs that the death is suspicious, I do consider that it adds a little weight to the evidence.

9.31 Shipman had other means of avoiding referring deaths to the coroner. Sometimes, when a death had occurred very suddenly and the relatives were puzzled, they would ask about a post-mortem examination. Shipman had a number of ploys by which he would discourage this. He would suggest to the relatives that a post-mortem examination would serve no useful purpose; he knew the cause of death and a post-mortem could not bring the loved one back. He would point out that the funeral would be delayed. Often he would add that a post-mortem examination was ' not a very nice thing to do to your mother'. Sometimes he would suggest that the family had enough to cope with at the present time without the additional burden and worry of a post-mortem examination. Often, he managed to leave the relatives with the impression that he had been willing to refer the case to the coroner but that they had taken the decision that he should not do so. Sometimes, relatives were left with the feeling that they had been manoeuvred into agreement. Often, one member of the family would go along with Shipman, whilst others agreed to do so with reluctance. In effect, Shipman avoided a post-mortem examination by manipulating the family's feelings in circumstances where the law and common sense demanded that there should be one.

Falsifying a Patient's Medical History

9.32 The vast majority of Shipman's victims' deaths were sudden and unexpected. Shipman recognised that it would help to avert suspicion if he lied about his patients' state of health in such a way that might explain their sudden deaths.

9.33 A common feature of real significance and probative value was the falsification of medical records. In October 1996, Shipman's surgery computer was modified and an audit trail facility was installed. When the police came to investigate Shipman, they

found that they could establish the exact time at which any post-October 1996 record had been entered on the computer. They could also discover when a record had been deleted. When the Inquiry began its own investigations, the same facility was available. In four of the conviction cases, those of Mrs Mellor, Miss Ward, Mrs Hillier and Mrs Pomfret, Shipman was found to have altered the records on the computer after the death to create a more plausible explanation for a supposedly natural death.

9.34 I have found several other cases where Shipman has made backdated entries on the computer and I regard this feature as highly probative of guilt. For example, in the case of Mrs Joan Dean, who died on Friday, 27th February 1998, there would have been insufficient evidence to connect Shipman with the death had it not been for the false backdated entries on the computer. Mrs Dean had been seen alive and well at about midday on the day of her death. She failed to attend a hair appointment at 4pm and was found dead at 7pm by friends who had called to take her to the theatre. She was lying across the bed in her spare bedroom. An ambulance was called and, some time later, a doctor from the deputising service arrived and confirmed that Mrs Dean was dead. From the circumstances, it would appear that she had probably died before 4pm. There was no eyewitness evidence that Shipman had visited her that afternoon, and no record in the surgery visits book to suggest that he intended to visit. He was out on his rounds as usual that afternoon and would have had the opportunity to visit Mrs Dean had he wished to do so.

9.35 The evidence that enabled me to conclude that Shipman had visited Mrs Dean and had killed her comprised several entries on the surgery computer, which had been made after her death. At about 8.30am on the Saturday, the day after her death, Shipman concocted three entries in the medical records on the computer, which were designed to show that Mrs Dean had consulted him on 6th January, 30th January and 13th February and had on each occasion reported an episode that sounded like a minor stroke. These were elaborate fabrications and I did not think they could have been made for no purpose. They appear to be designed to support the proposition that, if Mrs Dean died, her death could be attributed to a cerebrovascular accident. Strangely, by the following Monday, when he came to sign the MCCD, Shipman seems to have become confused or forgotten about these entries; he certified that her death was due to a heart attack. He also told a number of lies on that form and on cremation Form B, in particular suggesting that the death had taken place at 7.25pm, in the presence of friends and paramedics.

9.36 As it was clear that Shipman had falsified some computer records, the handwritten records had to be scrutinised with a sceptical eye. It was found at the trial that there were signs that some of the handwritten records of Mrs Grundy and Mrs Quinn had been altered in an attempt to create a history that might explain the death. I came to recognise many fabricated records, some of which may well have been made contemporaneously, rather than after the event. Sometimes the entry is false from the beginning. It might, for example, set out a history of recent chest pain. Shipman would recount how, on examination, he had found signs from which he had diagnosed a heart attack. He had given a small injection of morphine to relieve the chest pain; he had summoned an ambulance; the patient had collapsed; he had attempted resuscitation

but the patient had died and the ambulance had been cancelled. Initially, I might have accepted such a record as genuine unless there was evidence from witnesses to show that the patient had not complained of chest pain on the day in question. I quickly came to suspect such entries, simply from the familiarity of the pattern.

9.37 There is another type of entry that I came to recognise as false. A typical example is seen in the case of Miss Joan Harding, whom Shipman killed in 1994. She visited Shipman in his surgery on account of pain in her elbow and upper back. She went into the consulting room unaided. Shipman noted her complaints and her responses to his enquiries about her symptoms. Then, suddenly, the note switched to a description of a heart attack which, within minutes, had apparently resulted in her death. The suggestion was that, although Miss Harding had come to see Shipman on account of her elbow and back pain, she had suddenly and coincidentally suffered a coronary thrombosis in his presence and had died. I have found several entries where this kind of ' hybrid' record has been made. The circumstances vary but the underlying theme is the same. The patient begins to recount one type of concern; then, suddenly, some much more serious condition becomes evident and this second condition leads to death. I regard entries of that kind as highly suspicious.

9.38 Besides the entries that I was able to identify as false, there were also a large number of entries of doubtful genuineness. Sometimes, I could only assess the genuineness of the record by comparing it with what the eyewitnesses said about the condition of the patient at the time of the consultation. I had to bear in mind that the witnesses were speaking of events that had occurred a long time ago. Their recollections might have been influenced by what they have heard and read of Shipman. I have, therefore, been careful not to assume that a record is false just because it does not accord with the recollection of a witness. Even so, I have found many entries in the medical records that have plainly been fabricated. I regard a fabricated medical record as strongly indicative of guilt.

No Evidence of Presence before Death

9.39 There are a number of cases in which there is no direct evidence that Shipman was at the patient's house at a time when he could have had the opportunity to kill. By that I mean that there was no eyewitness evidence of his presence, no report that he was expected to visit, no entry in the visits book or medical records and no admission of presence on the MCCD or cremation Form B. There was one case of this kind, that of Mrs Melia, among the 15 of which Shipman was convicted. However, in her case, morphine was found in the body tissues after exhumation and the jury convicted. I have had to consider many cases in which there has been no evidence of presence and, of course, no evidence of morphine in the tissues. In some of those cases, I have felt able to say that Shipman killed the patient. In certain cases, of which the death of Mrs Joan Dean is again an example, there were such remarkable alterations to the medical records or such obvious lies told on cremation Form B that I felt able to reach that decision. In other cases of this kind, I have decided that the circumstances surrounding the death raise a real suspicion that Shipman might have killed but have been unable to reach a positive conclusion that he did.

Standard of Proof

9.40 In a criminal trial, the members of the jury are directed that, before they can convict the defendant, the prosecution must make them sure of guilt. This is a very high standard of proof. It used to be said that the jury must be satisfied beyond reasonable doubt. That is the same as saying that they must be sure. This high standard of proof is required because the convicted defendant faces punishment by the court, acting on behalf of the state and in the name of society. It has been accepted for hundreds of years that a high standard of proof is appropriate.

9.41 In a civil case, the usual rule is that the claimant must prove the case on the balance of probabilities. In other words, the judge decides what probably happened. Theoretically, the balance of probabilities means that the judge is 51 per cent satisfied in respect of the crucial facts, even though 49 per cent of the evidence might point to the opposite conclusion. In practice, evidence cannot be so finely assessed and judges do not usually have to make such fine calculations. Occasionally, in a civil case, the judge will find the evidence finely balanced but, of course, still has to reach a conclusion. If the weight of the evidence tips in favour of the claimant, he or she will succeed. If it favours the defendant or is evenly balanced, the claimant will fail, as he or she has not discharged the onus of proving the case.

9.42 Where a civil case concerns an allegation of serious misconduct, such as fraud or the deliberate causing of death or serious injury, the burden on the claimant making the allegation is rather higher than the bare balance of probabilities. Where the allegation is grave, the evidence must prove it with an appropriate degree of cogency. The courts have not attempted to specify the standard of proof required, although it is clear that the standard is not as high as the criminal standard. It is usually referred to as the higher civil standard. The degree of proof required is a matter of judgment for the judge. The judge must remind himself or herself that, as the allegation is very serious and the consequences for the defendant of an adverse finding may be very serious indeed, he or she will wish to feel a greater degree of confidence that the allegation has been proved than on the mere balance of probabilities.

9.43 In an inquiry such as this, there is no required standard of proof and no onus of proof. My objective in reaching decisions in the individual cases has been to provide an answer for the people who fear or suspect that Shipman might have killed their friend or relative. I have also sought to lay the foundation for Phase Two of the Inquiry. My decisions do not carry any sanctions. Shipman has been convicted of 15 cases of murder and sentenced appropriately. He will not be tried or punished in respect of any other deaths. Nor will my decisions result in the payment of compensation by Shipman. It is possible that relatives might recover damages from Shipman if they can show that Shipman has killed their loved one, but my decision that he has done so will not automatically result in an award of compensation against him. Accordingly, I have not felt constrained to reach my decisions in the individual cases by reference to any one standard of proof.

Findings of Unlawful Killing

9.44 I have written decisions in almost 500 cases. The quality of the evidence in some, particularly the more recent ones, is very high and it has been possible to reach a clear conclusion. In some cases, I have felt sure that Shipman has killed the patient. Where I have felt sure, I have said so. In some cases, I have concluded that Shipman has killed the patient but I have not been able to say that I am sure of it. In those cases, I have said that Shipman probably killed the patient. The evidence in those cases is not finely balanced; it is clearly weighted on the side of guilt and I have reached a positive conclusion. If it seemed to me that the evidence was too finely balanced, I have not reached a positive conclusion.

9.45 Many relatives of Shipman's victims have made a claim from the Criminal Injuries Compensation Authority. Some have already received their compensation; others await a decision from the Authority. The Authority reaches its decisions on the balance of probabilities. I understand that it intends to rely on my decisions. The success of an individual claim will not depend on whether I have declared myself sure that Shipman killed the deceased or decided that he probably did.

Decisions that the Death was Natural

9.46 There are many cases in which I have been able to say that I am sure the death was natural and that Shipman was not in any way involved. There are also some in which I think it likely, or even very likely, that the death was natural and that Shipman was not involved. I have drawn the distinction between being sure and being not quite sure usually where there is some uncertainty in the evidence, which leaves open the *possibility* that Shipman was involved, even though my conclusion is that he was probably or almost certainly not. These cases, where there is a little uncertainty in my mind, are mainly deaths from the earlier period of Shipman's professional career, where the Inquiry has not been able to recover the medical records or where a witness with knowledge of some important circumstance has died. I hope that the families of these former patients will not feel undue concern simply because I have not been able to say that I am sure that the death was natural.

Cases where no Decision has been Possible

9.47 It was inevitable that there would be some cases in which I would not be able to reach a positive conclusion one way or the other. There are a number of cases where real suspicion arises that Shipman might have killed the patient and yet the evidence is not sufficiently clear for me to say that he probably did. In those cases, which I call ' suspicious cases', I have explained why my suspicions are aroused but I cannot give a positive decision either way. I regret that the families of such patients are left in a state of uncertainty.

9.48 There are also a number of cases in which there was insufficient evidence or evidence of such poor quality that I have been unable to form any view at all. I have not said that the death was natural or probably natural unless there was a proper evidential basis for

that conclusion. In general, if there were no reason to think that a death is unnatural, one would assume it was natural. Unfortunately, where Shipman was involved, there is always a possibility that the death might have been unnatural. Where, for example, all that is known is that Shipman certified the cause of death and indicated that he had seen the patient shortly before the death, I do not feel able to say that the death was probably natural. It might or might not have been.

Shipman's Terminally Ill Victims

9.49 A number of the suspicious cases concern terminally ill patients who were receiving injections of morphine or diamorphine for pain relief. Suspicion arises if the death occurred within a short time of Shipman having given a pain-relieving injection. Dr Grenville and Professor McQuay agree that, if a lethal injection of opiate is given intravenously, it will kill within a few minutes; if given intramuscularly, it will kill within the hour. If a patient's death occurred within these time limits, a suspicion arises that Shipman deliberately gave a lethal dose instead of that which was necessary for pain relief. Suspicion would be heightened if the family had had the impression that the death was not imminent. Where I was suspicious that Shipman had hastened the death of such a patient, the question of what he had intended was not straightforward.

9.50 I do not intend to discuss issues relating to euthanasia or assisted suicide. These issues fall outside the scope of the Inquiry's Terms of Reference. The present law is clear. If a person gives a drug with the intention of killing the recipient and it does kill the recipient that is unlawful. Usually, it will be murder. The law for doctors is the same as for others. However, doctors may lawfully give a drug which is primarily intended to have a therapeutic effect but which might, in the event, have the effect of shortening life.

9.51 Dr Grenville says that it can be very difficult for a doctor to assess the right amount of opiate to give a patient with intractable pain. If the doctor errs on the low side, the pain might persist and the patient will suffer. Death might be accelerated by the distress. If the doctor errs on the high side, the drug might hasten the death. In this type of case, even though I might infer that the drug injected had caused the death, I could not infer that Shipman had intended to cause it. The injection might have been given in good faith for therapeutic reasons and yet have been the immediate cause of the death. With most doctors, one would naturally assume that the dose had been given for therapeutic purposes. With Shipman, in such circumstances, I am bound to suspect that he might have intended to kill. However, I could not infer *an intent to kill* merely from the fact that he caused the death. I have not found that he intended to kill unless there was other evidence from which I could properly draw the inference that that was indeed his intention. If there was no evidence from which his intention could be inferred, I have not made a positive decision but have said that I suspect that Shipman might have hastened the patient's death. I hope that it is some consolation to the families of these patients to know that, if Shipman did hasten the death, he did not do so by very long.

9.52 I have found that other suspicious circumstances arose in connection with very elderly patients in poor health. In a few cases, there is evidence that Shipman gave a drug which did not kill outright but which sedated the patient very heavily, with the result that

he or she slept deeply for many hours. In a few cases, Shipman sedated patients heavily with chlorpromazine (Largactil). Chlorpromazine would not kill save in an enormous dose and it is unlikely that Shipman would have chosen chlorpromazine if he intended to kill. Chlorpromazine was commonly used in the 1980s for the treatment of distress and confusion in the elderly. Some doctors also used it for the relief of pain. If an elderly patient with impaired respiratory function were to be deeply sedated over a substantial period, he or she would be more vulnerable to bronchopneumonia, which is a common cause or mechanism of death in the elderly. The patient's cough reflex is suppressed and there is a risk of inhaling foreign matter. In a debilitated patient, bronchopneumonia can be fatal within hours and certainly within a day or two. A doctor acting in good faith for the patient's welfare might think it necessary to give periodic injections of sedative in order to keep the patient comfortable. He might recognise the risk of bronchopneumonia but decide that the risk must be taken. With most doctors, I would assume that the drug had been given for proper therapeutic reasons. With Shipman, the suspicion arises that he over-sedated the patient with the intention that he or she should die within the next few days. Where these difficult issues have arisen, I have usually concluded that Shipman's actions give rise to suspicion, rather than proof, of unlawful conduct.

Re-registration of Deaths

9.53 The South Manchester Coroner has already conducted some inquests into the deaths of Shipman's victims and these have resulted in re-registration of the relevant deaths. In May 2001, he opened more inquests. These presently stand adjourned under section 17A of the Coroners Act 1988. When the Coroner receives my findings in these cases, he will forward a certificate to the Registrar with a view to the re-registration of each death with a cause of death consistent with my findings. In those cases for which an inquest has not yet been opened but in which it appears that it would be appropriate that the death be re-registered, I anticipate that inquests will be opened and adjourned and my findings will be sent to the register office following the same procedure.

Allegations of Theft

9.54 A number of relatives of patients who have been killed by Shipman made complaints, both to the police and to the Inquiry, that money and other property, particularly jewellery, was missing from the patient's home after the death. Suspicion arises that Shipman might have stolen these items. The police made extensive enquiries about these possible thefts. They seized a quantity of jewellery from Shipman's home and interviewed a number of jewellers with whom Shipman had dealt. In the event, no witness was able to identify any individual piece of jewellery found in Shipman's possession as having come from his or her relative's home. I decided at an early stage that it would not be appropriate to expend the resources of the Inquiry on further investigations into allegations of theft. Although the Terms of Reference require me to consider the extent of Shipman's unlawful activities, I believe that it was the intention of Parliament that I should focus on the taking of life, not property. Accordingly, the evidence is such that I have been unable to reach any firm conclusions in respect of

individual allegations of theft. Property has disappeared in circumstances where Shipman had the opportunity to take it. He is a dishonest man. Yet I am conscious of other possible explanations for the disappearance of the property. Elderly people sometimes dispose of property without telling their families. A house which has been left insecure at the time of the death (as the houses sometimes were) is vulnerable to a sneak thief. I recognise that there are a few cases in which the suspicion against Shipman is strong. I also realise that in some cases the loss of family possessions has caused great distress. I do not underestimate those feelings. However, there is no sufficiently clear evidence of theft in any single case and I cannot infer that Shipman has stolen merely from the evidence of opportunity.

Professor Richard Baker's Review

9.55 Shortly before the Inquiry began its work, the review of Professor Richard Baker was published. He had carried out a statistical analysis of the difference in the death rates between Shipman's practice and the comparable practices of other general practitioners. He had also examined the available medical records and cremation Forms B of Shipman's deceased former patients. His work suggested that Shipman might have killed well over 200 patients. I was, of course, aware of his findings and knew which individual deaths he regarded as suspicious, either on account of the contents of the medical records or cremation Form B, or both. I treated his views, based as they were on very limited information, as an item of expert evidence. In a large number of cases, I had much more detailed expert evidence from Dr Grenville. I soon learned to recognise for myself the suspicious features of cremation Forms B and the signs of a fabricated medical record. I did not in any way seek to reach findings that coincided with Professor Baker's conclusions. In some cases, particularly where evidence has been available to the Inquiry which was not before Professor Baker, I have differed from his view.

9.56 Professor Baker discovered several statistical anomalies in the deaths of Shipman's patients. For example, he found an excess of deaths among women over the age of 75 and an excess of deaths occurring in the afternoon. In my view, these features, which are undoubtedly typical of a Shipman murder, are not necessarily evidentially probative. I do not, for example, think there is any probative significance in the fact that the deceased was a woman rather than a man. It is true that Shipman killed more women than men and that his typical victim was an elderly woman living alone. However, he also killed men. It should be noted that, in general, women live longer than men and so there are, living alone, more elderly women than elderly men. So there are more potential typical female victims than male. In an individual case, the fact that the deceased person is female cannot increase or decrease the likelihood that the patient was killed by Shipman.

9.57 Similarly, Professor Baker found that there was an excess number of deaths that occurred in the afternoon. Yet, we know that sometimes Shipman killed in the morning. The explanation for the excess is that Shipman worked in his surgery for most of the morning and went out on his rounds between about noon and 3.30pm. That was when he had the greatest opportunity to kill so that is when most deaths occurred. However,

the probative weight of the fact that death occurred in the afternoon is very slight. Evidence of Shipman's presence at or just before the death is highly significant, whatever the time of day. If there is no evidence of Shipman's presence but the death is otherwise typical of a killing, the fact that the death appears to have occurred in the afternoon (rather than in the late evening or early hours of the morning), when there is a greater chance that Shipman visited, is of some probative value. However, the mere fact that the death occurred in the afternoon is not, of itself, probative.

9.58 I must acknowledge that Professor Baker's overall conclusion about the number of deaths attributable to Shipman gave me some reassurance, as I found more and more cases of murder. Had it not been for his statistical analysis, I might have doubted the validity of my own conclusions. They might have seemed unthinkable. As it has turned out, our conclusions are broadly compatible, despite the fact that the processes by which we reached our conclusions were very different.