CHAPTER FOURTEEN

Internal Enquiries by the Greater Manchester Police

Chief Superintendent Sykes Speaks to Mr Postles

14.1 Chief Superintendent Sykes said that he discussed the closure of the investigation with Mr Postles. He said that it was not possible to discuss the issues in detail, as there were no written records and he was dependent on his recollection of what Detective Inspector Smith had told him. He said that Mr Postles was satisfied that the investigation had been properly conducted. Initially, CS Sykes appeared to suggest that this conversation took place before the decision to close the investigation was taken; however, in his oral evidence to the Inquiry, he seemed to accept Mr Postles' assertion that it took place some time after the decision had been taken.

14.2 Mr Postles told the Inquiry that he recalled a conversation with CS Sykes. He said that it had occurred 'some weeks' after he had first learned of the investigation, which was on 25th March 1998. He recalled that CS Sykes told him that the information elicited from various sources did not point to any wrongdoing by Shipman. In particular, he was told that, in the case of all the deaths that DI Smith had established had occurred within the last six months, the cause of death was, according to the Health Authority, consistent with the individual's medical condition.

14.3 In his Inquiry statement, Mr Postles also said that CS Sykes told him that DI Smith had established with the Health Authority that the number of deaths for which the register office had supplied details was not believed to be inordinately excessive. This is puzzling, as there is no evidence that Dr Banks and DI Smith discussed the death rate among Shipman's patients. There is, however, evidence that they discussed the size of Shipman's patient list and it is likely that Dr Banks expressed a view that the death rate did not seem inordinately high. CS Sykes does not remember saying anything of this nature to Mr Postles. In oral evidence, Mr Postles said that he was unsure about this aspect of his statement and thought he might have been referring to knowledge gained at a later time. I think that is probably the case.

14.4 I think the conversation between these two officers must have been of a fairly casual nature and I doubt whether CS Sykes was formally seeking Mr Postles' approval of his decision to close the investigation. Had that been the case, Mr Postles would have called for DI Smith's report and would have discovered that no such report existed. I am satisfied that Mr Postles did not realise until August 1998 that DI Smith had not written a report.

14.5 It is most unfortunate that CS Sykes did not call for a written report at the time of the closure of the investigation or soon afterwards. If DI Smith had written a report while events were still fresh in his mind and before he realised that he had reached the wrong conclusion, I am sure that the report would have been more detailed and accurate than the one written in August 1998. At that time, in April or May 1998, DI Smith would have had no motive (whether conscious or sub-conscious) to understate the seriousness of Dr Reynolds' concerns. It is likely that a report written at that time would have included reference to the comparative death rates provided by Dr Reynolds. These were not mentioned in

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

August 1998

14.6 No report of any kind had been written when, in August 1998, Mr Postles was put in charge of the investigation into the death of Mrs Kathleen Grundy. That investigation rapidly widened to include enquiries into the deaths of more of Shipman's former patients. Mr Postles wished to draw on the information uncovered in the first investigation. He then found that DI Smith had not kept any written records save for the scanty notes in his daybook and had not submitted a written report. He asked DI Smith to make good that omission. That is how the first of DI Smith's written accounts came into existence. The first report was dated 17th August 1998. DI Smith reported that:

(a) He had acted on a request from the Coroner who said that Dr Reynolds had raised concerns about deaths certified by Shipman. Since her arrival in Hyde in 1997 (in fact, she arrived in September 1996), there had been **'general banter'** amongst her practice partners that Shipman supplied them with **'pocket money'** by asking them to countersign his cremation certificates. In addition, there was concern about a number of **'alleged features'** of the deaths. These were that the persons were mainly female; they were found dead by Shipman; they were found wearing day clothes and the majority appeared to have been cremated.

(b) At interview, Dr Reynolds had repeated the information she had given to the Coroner. She had said that a local undertaker, who did not wish to be identified, had become aware of the circumstances of the deaths and it appeared that it was common gossip among doctors, nurses and undertakers that there were more deaths among Shipman's elderly female patients than in other practices. There was no evidence to support this rumour. Dr Reynolds did not wish her name to be made known during the investigation. She had made her report for peace of mind after consultation with her partners.

(c) DI Smith had later learned that Shipman had had a disagreement with his **'previous practice partner** [*sic*]**'** and was now a sole practitioner. This had created problems for Shipman, who now asked members of the Brooke Practice to countersign cremation certificates.

(d) Mr Loader had identified 19 deaths as the result of a search for all the deaths certified by Shipman during the previous six months.

(e) Enquiries at the crematorium had shown that, of those 19 deceased, 16 had been cremated and three buried. The usual proportion was 70% cremations. The funeral directors were various local firms.

(f) The undertaker mentioned by Dr Reynolds had been identified and interviewed but had said that she was only repeating **'general chit-chat and gossip that had been circulating for some time'**. This was supported by her father, who was present.

(g) An approach had been made to the **'Family Practitioners'** at Selbourne House, Hyde, with a view to examining patient records of the deceased persons. DI Smith had requested that each set of records be examined with a view to identifying whether the cause of death was consistent with the treatment being prescribed. There did not appear to be any cause for concern.

(h) DI Smith claimed that enquiries into the **'finding of the bodies'** were commenced but that, due to the limited sources of information available, it was difficult to identify all the circumstances. It was established that, at some of the deaths, other persons had been present such as the police, ambulance personnel and doctors from the emergency service. Some of the deceased had died in nursing homes.

(i) Shipman was regarded as being of the 'old school'. He made a lot of house calls and spent time with his patients. He would call unannounced. He was popular and there was a queue of people seeking acceptance onto his patient list.

(j) The investigation had not revealed any evidence to indicate that the deaths were anything but normal. Due to the requirements of confidentiality, it had not been possible to pursue all lines of enquiry (the nature of which were not specified) to a satisfactory conclusion.

(k) The findings were passed to Mr Pollard who was satisfied.

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

November 1998

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

(a) Mr Loader had provided 19 copy death certificates resulting from a search for all the deaths certified by Shipman over a six-month period.

(b) DI Smith had taken the certificates to **'the Family Practitioners'**, Hyde, and had asked that the medical records for each of the 19 persons be examined to establish whether the cause of death was consistent with the treatment and medication recorded within the records. He said that **'a couple'** of sets of records were not available, as they were still with Shipman's practice. Dr Banks had examined the records over a number of days.

(c) He had returned to see Dr Banks, who told him that there did not appear to be any discrepancies between the records and the causes of death and, although the causes of death given by Shipman were of a **'general nature'**, there did not appear to be cause for concern.

(d) He had told the Coroner of Dr Banks' findings and had given him four other items of information, namely: that the activities of Shipman were the subject of **'innuendo and gossip'**; that each of the cremation forms had been countersigned by a second doctor who had not raised any concerns about the deaths; that there was nothing to indicate foul play from what was known of the circumstances of the deaths or the discovery of the bodies, and that a variety of undertakers had been used.

(e) In view of the fact that **'the information appeared to be based on innuendo and gossip'**, he had not thought it appropriate to approach the families of the deceased persons, a decision with which the Coroner agreed.

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

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

December 1998

14.11 DCS Keegan passed the reports and enclosures to Assistant Chief Constable (ACC) David McCrone (now Deputy Chief Constable McCrone), who was then Head of Crime Operations. According to a memorandum dated 8th December 1998, from DCS Keegan to Mr Postles, ACC McCrone was satisfied that the actions of DI Smith were **'appropriate at that time'**. In view of the potential for criticism in the future, DCS Keegan suggested that Mr Postles should liaise with the Coroner with a view to establishing **'an agreed protocol/ press liaison strategy'** for use if necessary.

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

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

14.13 There matters rested until shortly after Shipman's conviction. On 1st February 2000, the Secretary of State for Health, The Rt. Hon. Alan Milburn, MP, announced that an Inquiry, chaired by Lord Laming of Tewin, would be held into the Shipman affair. It was clear from the announcement that the Terms of Reference of the Inquiry would include an examination of the first, failed police investigation.

14.14 Assistant Chief Constable (ACC) Vincent Sweeney, then Head of the Crime Operations Department, recognising that the conduct of the first investigation had not been properly recorded, issued a written instruction that a factual account should be prepared. In that

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

14.15 In his instruction, ACC Sweeney listed a number of points to be covered, based on allegations which had recently been aired in the media. They included the following issues:

(a) Whether or not Dr Reynolds had told DI Smith that she and her partners had calculated that the patients of Shipman were three times more likely to die than if they had been patients of the Brooke Practice.

(b) Whether or not Dr Reynolds had told DI Smith that she suspected that Shipman was killing his patients and whether or not she had said that the local undertaker could **'corroborate'** this suggestion.

(c) Whether or not, when DI Smith had visited Dr Reynolds to tell her the result of his investigation, she had **'made one last attempt to convince him'** by inviting him to go to the mortuary where two bodies of Shipman's patients lay.

(d) Whether or not DI Smith had asked Dr Reynolds if she had a problem working with male doctors.

(e) Whether or not Dr Reynolds had identified Masseys as the relevant firm of undertakers and, if not, how they had been identified.

(f) Which members of the Massey family had been spoken to and what had they said? Also, whether or not any statements had been taken from them or any other person and whether any documentation had been prepared.

(g) Whether or not Dr Reynolds or anyone else had identified any other potential witnesses.

(h) What enquiries had been made with reference to death certificates and in respect of cross-referencing of medical records? What were the agencies (presumably the register office and Health Authority) asked to do?

(i) What flaws were revealed during the second investigation in respect of information given during the first investigation and how were those flaws revealed?

(j) What background checks (criminal or professional) were made on Shipman during the first investigation?

(k) What was said at the conclusion of the investigation when DI Smith was briefing CS Sykes and the Coroner?

14.16 ACC Sweeney concluded by assuring those involved that the task was not to be a **'witch hunt'** but a **'collation of facts'** to enable the police to prepare for the questions they would be asked by the Laming Inquiry. The objective was **'to find the truth and not to criticise individuals'**. He concluded:

> **'If we have failed to do something then let us simply say that we have failed to do it and not cover anything up – we must be absolutely truthful in everything we say and only in this way can we learn from the findings of the Enquiry** [*sic*] **and play our role in ensuring that practices and procedures are changed so that the chances of such an occurrence happening again are minimised.'**

14.17 In oral evidence, ACC Sweeney said that his request for a report in **''story book' format'** was not intended to preclude observations by the writer on the adequacy of the first investigation. He wanted the Force to learn from any mistakes that had been made. He wanted officers (in particular, DI Smith) to be open about their involvement and not to feel inhibited by the fear of disciplinary proceedings. Police Regulations provide that, before any police officer is questioned about a matter that might lead to disciplinary proceedings, s/he must be warned that s/he need not answer the questions. ACC Sweeney said that the job of the officer assigned to the task of writing the report would have been impossible if senior officers had contemplated disciplinary proceedings against those involved. Although DI Smith had been given no categoric assurance that he would not be disciplined, there was at the time no suggestion that he had acted other than in good faith. There was therefore no immediate prospect of disciplinary action being taken against him. However, ACC Sweeney said that, if the investigation had found evidence of gross professional misconduct or wilful neglect, senior officers would have had to reconsider their views about the need for disciplinary proceedings.

14.18 There was to be a necessary limitation on the thoroughness of the exercise. ACC Sweeney directed that only police officers should be questioned. Any approach to a witness outside the Force might amount to an interference with the processes of the Laming Inquiry. I observe that this limitation would not have been necessary had the police carried out an investigation a year earlier.

14.19 The intention of ACC Sweeney, as expressed in this document, was entirely creditable. However, by this time, the GMP knew that their first investigation had failed to detect a serial killer and they were aware, from the media, of allegations that DI Smith had failed to follow up leads and information given to him in March 1998. Although I accept that senior officers would not normally suspect that an officer's report on an investigation would be seriously inaccurate, allegations were being made in the media which were implicitly inconsistent with DI Smith's account. The Force was on notice that DI Smith's account might not be true. It was known that DI Smith had not made any notes of what he had done

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

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

The Ellis Report

14.21 On 21st February 2000, Det Supt Ellis received instructions to prepare a written narrative of the first investigation. He understood that his task was to prepare an account of the facts, to assist the future independent Inquiry. He told this Inquiry that he 'was not to comment or criticise in any way, shape or form' DI Smith's investigation but was rather to present to the Laming Inquiry DI Smith's viewpoint of that investigation. Det Supt Ellis was aware of ACC Sweeney's memorandum, in which he spoke of his wish for openness and the need for the Force to learn from mistakes. However, he was also aware that senior officers in the Force had already reached the conclusion that DI Smith's investigation had been properly conducted. This was to influence his approach to his task. For, as we shall see, Det Supt Ellis did not confine himself to telling the story of the first investigation; he was to write a justification of it. In a structured organisation such as a police force, it is asking a great deal of a middle-ranking officer to take an independent approach to any issue on which he already knows the views of those senior to him.

14.22 On 4th April, Det Supt Ellis interviewed CS Sykes; he made no notes of the interview, because, he said, CS Sykes said 'very little'. On 5th April, he interviewed DI Smith; the interview was noted in longhand but not recorded. He had prepared a checklist of issues to be covered. He invited DI Smith to give his own account of what he had done. When that was complete, Det Supt Ellis went through the checklist to ensure that all topics had been covered. He did not challenge or probe DI Smith's account in any way.

14.23 I have already said that the oral evidence which DI Smith gave to the Inquiry was different in some important respects from accounts given by him on earlier occasions, including that given to Det Supt Ellis. There are also some important differences between what DI Smith had said in his reports of August and November 1998 and what he told Det Supt Ellis. I do not propose to set out every detail of what DI Smith told Det Supt Ellis. The most significant features were as follows:

(a) DI Smith told Det Supt Ellis that the Coroner had told him and CS Sykes that Dr Reynolds had explained that the patient base of the Brooke Practice was 9500 and there had been 14 deaths in the practice during the previous three months. In that period, Shipman had had 16 deaths in his practice. However, DI Smith maintained that at no time had Dr Reynolds suggested that she and her partners had

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

(b) DI Smith went on to tell Det Supt Ellis that, when he saw Dr Reynolds, she told him that she did not know whether she was doing the right thing. Since her arrival in Hyde, there had been banter within the practice about Shipman providing pocket money by asking for signatures on cremation certificates. Det Supt Ellis noted that the suggestion that the issue of cremation certificates had been the subject of a joke was contrary to what one of Dr Reynolds' former colleagues, Dr Patel, was reported in the media to have said, namely that doctors from the Brooke Practice were concerned about Shipman's activities. DI Smith told Det Supt Ellis that it was clear to him that Dr Reynolds was acting alone in making a report to the Coroner and did not have the support of her colleagues. He reported that, so far as he was aware, those colleagues were still signing cremation certificates for Shipman. When asked whether he had requested to speak directly to any of Dr Reynolds' colleagues, DI Smith replied that he had not but added that she had not offered to make them available. She had not mentioned them by name.

(c) DI Smith also told Det Supt Ellis that Dr Reynolds' concerns related to **'alleged features'** of the deaths of some of Shipman's patients who were mainly female, were discovered dead by Shipman and were wearing day clothes when found. There was no discussion between Det Supt Ellis and DI Smith about the significance or unusual nature of these features. The majority of the deceased appeared to have been cremated. DI Smith went on to say that Dr Reynolds had consulted the Coroner, after speaking to an undertaker who had similar concerns. She refused to identify the undertaker; this latter observation appears in Det Supt Ellis' report in capital letters, as if to give it particular significance.

(d) Dr Reynolds had not produced any documentary evidence. It does not appear that DI Smith was asked what documentary evidence she might have had, nor whether he had asked her to provide such evidence.

(e) When asked directly by Det Supt Ellis, DI Smith stated that Dr Reynolds had at no time said that she suspected that Shipman was killing his patients. This was, of course, in contrast to his oral evidence to the Inquiry.

(f) DI Smith said that, after seeing Dr Reynolds, he sought production of the death certificates of Shipman's patients who had died in the previous six months. Two days later, he was given **'ten to twelve'** certificates and, a few days later, Mr Loader produced several more, making 19 in all. He made a chart on the computer from information contained within the certificates. With the certificates, he went to the crematorium and found out which patients had been buried and which cremated.

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

(g) DI Smith said that he searched the GMPICS 'Incident Handling' to establish whether there had been any police involvement in the deaths that he was investigating. He had found three entries but these were not helpful. He was not asked whether he had done a check on the computer archive or whether he had spoken to the officers who attended the scenes of death.

(h) DI Smith said that he had checked the GMPICS Operational Information System but had found no relevant information about Shipman. He had not made any other check to discover whether Shipman had previous convictions. He was not asked why he had not checked the PNC.

(i) DI Smith said that he attended at the WPHA premises and asked Dr Banks and Mrs Parkinson for access to the records of the patients whose death certificates he had. He claimed that, for reasons of confidentiality, he had not told them anything of the nature of his enquiries, not even, in the first instance, that they involved Shipman. (This was not so, as Mrs Parkinson's note later revealed.) He told Det Supt Ellis that they agreed to research his request and contact him.

(j) DI Smith related how, on his return to the Health Authority premises a few days later, it emerged that Dr Banks and Mrs Parkinson had realised that all the records related to patients of Shipman and there was then a discussion about Shipman's style of practice; he was said to be an old-fashioned doctor who would visit patients unannounced. At this meeting, DI Smith also learned for the first time, he said, about the scanner appeal. (This was quite wrong, as the Coroner's note of 25th March has revealed.) On this second visit, some of the medical records were now available. DI Smith claimed that, there and then, he asked Dr Banks to examine the records and to tell him what the patients were being treated for, whether the treatment was appropriate and whether the cause of death on the certificate was consistent with the complaint. Most remarkably, DI Smith told Det Supt Ellis that Dr Banks had already made this examination and was ready to state his findings. (It does not appear that Det Supt Ellis ever wondered how Dr Banks could have undertaken this task if all he had known, until that moment, was that DI Smith wanted to see the records of a list of deceased patients. If he did, it does not seem that he asked DI Smith how he thought Dr Banks had been able to do the job.) DI Smith told Det Supt Ellis that Dr Banks had found that all the causes of death were associated with old age and that he was happy with the records; nothing stood out as untoward. Dr Banks commented that Shipman's use of drugs was **'on high side'** but nothing gave him concern. He did not mention that Dr Banks had said that he would have reported two of the deaths to the Coroner.

(k) DI Smith claimed that he had returned to the Health Authority on a further occasion about a week later, when more records had been found and examined. This time he

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

(l) Meanwhile, DI Smith had discovered from Police Constable Napier the identity of the unknown undertaker. He said that he went to see **'Debbie Massey'**. Her husband and father were present. The handwritten note prepared at the interview records that DI Smith claimed that, when confronted by him, Mrs Bambroffe and her father said that the concerns she had expressed were 'just gossip'. They had laughed and joked about it. It was coincidence. DI Smith maintained that, despite being **'pushed'** by him, Mrs Bambroffe had produced nothing of evidential value. (I observe that this account was a travesty of the truth, although Det Supt Ellis was not to know that.)

(m) DI Smith said that he had briefed Mr Pollard fully about his enquiries. He suggested to the Coroner that they might wait until another body was available and **'secure'** it for pathology, or that they might approach the families of deceased persons but, he said, the Coroner did not want that. (I have already found that DI Smith did not make such a suggestion.)

(n) DI Smith said that he revisited Dr Reynolds and briefed her fully. He suggested that nothing further could be done other than intervention at the **'next death'**. She seemed disappointed.

(o) In response to a specific question from Det Supt Ellis, DI Smith said that Dr Reynolds had not at any time invited him to examine bodies available at the mortuary. This was a reference to the allegation, which had appeared in the press, that Dr Reynolds had told DI Smith that there were two bodies available for autopsy. (In fact, as I have found, Dr Reynolds did tell DI Smith, on 24th March 1998, that there were two bodies available for examination. They were those of Mrs Lily Higgins and Miss Ada Warburton. The bodies were not at the mortuary, but at the premises of funeral directors.) Det Supt Ellis added that subsequent investigation had demonstrated that there was never a time when two bodies of Shipman's former patients had been at the mortuary at the same time. This is the only occasion on which it appears that any attempt was made to cross-check what DI Smith had said.

(p) DI Smith had not made any record of his investigation, other than the notes in his daybook and the information entered on the spreadsheet. Nor had he prepared a written report. CS Sykes had not asked him to do so and Mr Pollard had been content with an oral report. Indeed the suggestion seemed to be that CS Sykes believed that the requirement for a report would in some way breach the confidentiality of the investigation.

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

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

14.25 However, Det Supt Ellis did not stop there. He embarked upon a series of **'OBSERVATIONS'**. First, he noted what he called the **'unique'** nature of this **'highly sensitive'** investigation. He observed that the police investigation had been handicapped by Dr Reynolds' insistence on anonymity and by the Coroner's insistence that Shipman should not become aware of it. He remarked that the handicap was exacerbated by Dr Reynolds' refusal or conscious decision not to identify potential witnesses. That comment was not justified on the evidence before him. The only witness whom Dr Reynolds had declined to identify (at her specific request) was Mrs Bambroffe. DI Smith had discovered Mrs Bambroffe's identity, but had failed to ask her any relevant questions. He had also failed to ask if he could speak to Dr Reynolds' partners. I cannot think of any other witness whom Det Supt Ellis might have had in mind.

14.26 Det Supt Ellis then went on to pose the question **'whether the initial police investigation was as thorough as possible'**. He had not been asked to deal with this issue, although ACC Sweeney said that he did not intend him to be precluded from doing so. However, if the issue was to be addressed, it should have been dealt with fairly and objectively. It was not.

14.27 Det Supt Ellis first excused DI Smith's failure to check the PNC and discover Shipman's previous convictions. He said that this was excusable because, at the time, it was unthinkable that a doctor might deliberately kill his patients. No other officer in the GMP sought to support that view. CS Sykes was reluctant to criticise DI Smith in this respect but eventually agreed that the check should have been made. The flaw in Det Supt Ellis' reasoning is so obvious, that I find it amazing that the report was not sent back for amendment, as soon as it had been seen by a senior officer. The reasoning seems to be that DI Smith was investigating an allegation that could not be true; therefore there was no need to do it thoroughly. If the police are asked to investigate an excess of deaths in unusual circumstances among the patients of a particular doctor, it must be because it is suspected that he might be harming them. The fact that the allegation is most unusual cannot be an excuse for not carrying out a routine (and important) part of any criminal investigation. I note, also, that Det Supt Ellis had not established why DI Smith had not checked for previous convictions. He told the Inquiry that he had forgotten to do so. It appears that Det Supt Ellis understood that DI Smith had consciously decided not to do so.

14.28 Det Supt Ellis then embarked upon an indictment of Dr Reynolds. He catalogued her supposed failures. She had not told DI Smith about the comparative death rates. (This was a manifestly unjustified accusation because DI Smith certainly knew of the figures; they were in his daybook.) She had not said that she thought he might be murdering his patients. (She had.) She had not identified the female undertaker. Her claim (as reported in the media) that she had told DI Smith of two bodies available for autopsy was untrue. She had given him no documentary evidence and had identified no potential witnesses. Her bona fides were questioned; it had been claimed in the media that she and her

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

14.29 Det Supt Ellis observed that the Masseys had offered nothing to progress the enquiry. Indeed they had not; they had had little opportunity to do so. However, Det Supt Ellis accepted, without question, DI Smith's claim that Mrs Bambroffe had said it was all gossip and a joke, which was, as I have said, a travesty of the truth.

14.30 Det Supt Ellis observed that the register office had failed to provide a complete bundle of death certificates for the six-month period. However, he did not suggest that this failure had had an adverse effect on the investigation. He said only that it was difficult to see how the true figure could have influenced the officer, given the constraints of the investigation. In oral evidence, he said that it appeared to him that DI Smith had not understood or explored the significance of the number of deaths; therefore, it would not have made any difference to his investigation even if he had discovered the true number of deaths. If that was his reasoning, which I doubt, it is surprising that he did not explain it in his report. It would have been in sharp contrast to his otherwise bland acceptance that DI Smith had done a perfectly acceptable job. I think it far more likely that he meant that, as DI Smith could not interview the relatives of the 19 deceased patients of whom he knew, it would not have helped to know that there were in fact 31 patients of Shipman who had died in the previous six months. He still would not have been able to interview the relatives.

14.31 Without further comment or justification, Det Supt Ellis observed that DI Smith could have acted in no other way than to accept the findings of Dr Banks. In oral evidence, he accepted that he did not have the necessary information to advance an opinion in those strong terms. He also agreed that he had reached conclusions without making any critical analysis of the information he had received. In his report, he concluded that the investigation conducted by DI Smith was **'appropriate at the time'**. (I note that this was precisely the expression used in DCS Keegan's memorandum of 8th December 1998, a document which Det Supt Ellis had seen. Det Supt Ellis agreed that he was heavily influenced by the views expressed earlier by senior officers.) He went on to say that **'criticism could be levelled'** at the organisation in respect of DI Smith's failure to keep records and observed that this might give rise to difficulties at the forthcoming Inquiry. This was similar to the observation made in December 1998 in the correspondence between DCS Keegan and Mr Postles. He moderated his criticism of DI Smith's failure to keep records by suggesting that written records might have been kept if any evidence supporting the suspicions had come to light.

14.32 This report was accepted without criticism by senior officers in the GMP. ACC Sweeney told the Inquiry that it was 'reassuring' in that it contained no surprises. It remained the

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

14.33 The need for confidentiality imposed on the investigating officer limitations that would not usually apply in a murder investigation. DI Smith could not, as would be usual practice, interview and take statements from the relatives and neighbours of the people whose deaths had given rise to concern. But that was known from the start and, as has now been recognised, there were many lines of enquiry that could have been pursued, with success and without loss of confidentiality, if only the officers involved had thought of them. Even those enquiries that DI Smith did think of, he did not pursue thoroughly.

14.34 By 'the credibility gap', the officers of the GMP meant the difficulty that they had in accepting that it was possible that a doctor, particularly one as well-respected as Shipman, might deliberately kill his patients. I accept the general proposition. For a person, such as Mr Alan Massey, with no professional responsibility to investigate any suspicions brought to his attention, I accept that the difficulty would be very great indeed. Mrs Angela Woodruff spoke of the same difficulty; I quoted from her views in Chapter One of this Report. However, a police officer charged with an investigation cannot perform his professional duty unless he is able to set aside these difficulties and open his mind to the possibility that the incredible allegation might be true. Mr Postles spoke of his own difficulty in believing that Shipman might have killed a large number of patients. He said that he remained in doubt even until the trial began. That may be so, but his incredulity did not prevent him from conducting a thorough and searching investigation.

14.35 I accept that the police will sometimes be faced by allegations of an incredible nature from a source in which they do not have much confidence. That is bound to affect the vigour with which any investigation is conducted. The Inquiry was always anxious to discover whether DI Smith or CS Sykes had ever regarded Dr Reynolds as an unreliable source. They denied it. If those denials are true, then the fact that she was raising concerns of a very serious nature imposed on them a duty to investigate thoroughly and with an open mind. If, on the other hand, they thought she was unreliable or malicious or had 'a bee in her bonnet', then it would be understandable if they failed to open their minds to the idea that Shipman might be a serial killer. But, in my view, the police cannot, at the same time, claim that they regarded Dr Reynolds as a sensible professional woman with genuine concerns and rely on the 'credibility gap' to excuse the inadequacy of their work.

14.36 It appeared to be the intention of the Force that the Ellis report would form the basis of the GMP's case to the Laming Inquiry. ACC Sweeney told the Inquiry that the police saw the Ellis report as 'the beginning of a process of gathering information', a process which foundered with the end of the Laming Inquiry. Whatever the earlier intentions, no further investigative work was done.

The Evidence Initially Submitted to the Shipman Inquiry

14.37 The Shipman Inquiry was set up in January 2001, following judicial review proceedings of the Secretary of State's decision to convene the Laming Inquiry, which was to sit in private. On 6th February 2001, in response to a request from Mr Campbell Kennedy, then the Solicitor to the Inquiry, the GMP provided copies of various documents including the Ellis report. In May 2001, I announced that the Inquiry would be conducted in phases, the first of which would be devoted to an investigation into which and how many patients Shipman had killed and that the first police investigation would be examined as part of Phase Two. In December 2001, I announced that I hoped that the hearings relating to the first police investigation would begin in May 2002. During the second half of 2001, the GMP and DI Smith submitted witness statements, the thrust of which was that DI Smith's investigation had been thorough, given the information available at the time, but had been hampered by the need for confidentiality. The Inquiry received no indication that the Ellis report did not represent the views of senior officers in the Force.

14.38 In March 2002, the Inquiry released to participants the CD-ROM containing the statements and documentary evidence to be relied on during the hearings in relation to the first police investigation. Meanwhile, the GMP had submitted to the Inquiry a witness statement, dated 19th February 2002, from Detective Chief Superintendent Stelfox. This dealt specifically with a series of questions posed in a letter from Miss Ita Langan, Deputy Solicitor to the Inquiry; those questions were designed to discover the rules of best practice in respect of note taking and record keeping in the course of a police investigation. DCS Stelfox provided a helpful account with references to the Code of Practice made under Section 23 of the Criminal Procedure and Investigations Act 1996, which came into force on 1st April 1997. DCS Stelfox later submitted a second statement to the Inquiry, dated 26th April 2002, in which he accepted that the Code applied to the March 1998 investigation and that the failure of DI Smith to keep adequate records amounted to a breach of the Code. He also expressed the view that the preparation of a written report at the conclusion of the investigation, although not required under the Code, would have been good practice. He pointed out that responsibility for setting the requirement for a final report, and for specifying the form in which it should be provided, had lain with CS Sykes.

The Stelfox Report

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

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

14.40 I thanked Mr Shorrock and the GMP for the openness of those admissions, which had come as a complete surprise to me and the Inquiry team. I observed that it appeared that there must be some documents which had not yet been disclosed to the Inquiry. When DCS Stelfox's report became available (it is dated 15th May and was submitted to the Inquiry soon afterwards), it was found to be a careful, detailed, objective analysis of the evidence then available in respect of the first investigation. The report recognised that there were some issues on which the position would remain incomplete until oral evidence was heard. On the basis of the evidence already available, DCS Stelfox was deeply critical of DI Smith for his conduct of the investigation and of CS Sykes for his failure properly to direct and supervise it.

14.41 DCS Stelfox followed the evidence given at the Inquiry and, when he came to give oral evidence on 11th June, he said that his views had changed very little. He remained deeply critical of the first investigation.

14.42 I do not propose to set out DCS Stelfox's conclusions. They are broadly compatible with my own conclusions, save in one respect. DCS Stelfox was of the view that there had been confusion about whether the investigation was a police investigation or was being conducted on behalf of the Coroner. He thought that this had led to uncertainty about who was in charge and was responsible for making decisions. I do not agree that there was any such confusion or uncertainty. CS Sykes, DI Smith and Mr Pollard all thought this was a police investigation. In my view, it clearly was. I do not think there was any doubt that the police were in charge. CS Sykes was responsible for decisions but he delegated that responsibility to DI Smith. CS Sykes should not have taken charge because he did not have the experience or expertise required for the task. Once in charge, he should not have delegated responsibility for taking the decision to close the investigation.

14.43 The question arose as to why the police had waited until the eleventh hour before undertaking the objective review eventually conducted by DCS Stelfox. It was claimed on their behalf that they were unable to do so until they received the CD-ROM containing the Inquiry's evidence. It was argued that they could not embark on a thorough investigation without having access to the evidence of witnesses. It would not have been proper, it was

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

Findings

14.44 In my view, the GMP ought to have undertaken a searching enquiry into why their investigation had failed. They well knew that three lives might have been lost as the result of that failure.

14.45 I regret to say that I have been driven to the conclusion that, had it not been for the Shipman Inquiry, the GMP would never have made any more thorough enquiry into this matter than had been carried out by Det Supt Ellis. They submitted his report to this Inquiry without expressing any reservations about its conclusions. Until a very late stage, their stance was that DI Smith's investigation had been as thorough as was possible in the circumstances. I fear that the truth might not have emerged at all if the Shipman Inquiry had not been set up. The Laming Inquiry did not have the extensive investigative resources that enabled this Inquiry to uncover the evidence that has revealed the untruthfulness of DI Smith's account.

14.46 That said, once DCS Stelfox had investigated, the GMP accepted his conclusion without reservation. The conduct of the hearings on their behalf was entirely proper and at no stage did they seek to defend that which had occurred. They raised points in mitigation of their failures but only to a realistic extent.

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