CHAPTER SIXTEEN

Conclusions

16.1 In the previous Chapters, I have set out my findings as to the conduct of each stage and aspect of the investigation. It will be apparent that I consider that the conduct of Chief Superintendent Sykes, Detective Inspector Smith and Dr Banks fell below the standard which the community is entitled to expect of public servants in their respective positions. In this final Chapter, I shall summarise the reasons for the failure of the investigation and shall attempt broadly to apportion the responsibility for that failure among those involved in the investigation. I shall also consider, so far as I am able, what would probably have happened if the investigation had been conducted with a reasonable degree of diligence and competence.

Who Was to Blame?

Chief Superintendent Sykes

16.2 In my view, the primary reasons why this investigation failed were that CS Sykes instructed DI Smith to undertake the investigation and kept to himself the responsibility for supervision. He was culpably wrong in both respects. He realised that the concerns raised were unusual and potentially serious. He should have realised that the investigation would not be of a routine nature. He should have discovered (if he did not already know) that DI Smith was not accustomed to working without direction and supervision. He should have realised that he himself did not have the experience to direct or supervise the investigation. His decision to retain responsibility himself was not merely a poor decision within the band of decisions open to him; it was fundamentally wrong. CS Sykes should have discussed the matter with Mr Postles, who was the divisional adviser on criminal matters. Mr Postles would have advised as to the appropriate level of seniority within the GMP to which the concerns should be reported. I am satisfied that, had that been done, a properly directed investigation would have taken place.

16.3 I am critical of CS Sykes in other respects also. Once the investigation was under way, he failed to realise that DI Smith was out of his depth. If he had discussed the issues in any detail, in the way in which Detective Chief Superintendent Stelfox said he would have discussed them, he would have realised the extent of DI Smith's lack of understanding. His failure was partly due to his own lack of experience of criminal investigation. However, even lacking such experience, I consider that he should have realised that DI Smith had not satisfied himself that the death rate among Shipman's patients was not abnormally high. CS Sykes should not have left it to DI Smith to decide when the investigation was to be closed. If, even at that stage, he had asked a senior detective officer to scrutinise the information that DI Smith had gathered, its inadequacy would have been discovered and a proper investigation could have taken place, albeit after some delay.

16.4 I have been unable to reach any firm conclusion about why CS Sykes resolved to retain control of this investigation. I suspect that he decided to retain control because he did not wish it to appear to the Coroner that he did not have the experience to control the investigation personally. In mitigation of CS Sykes' failures, I believe that he recognised

that he had made errors and that the apology that he offered to the bereaved families at the conclusion of his oral evidence to the Inquiry was genuine and deeply felt.

Detective Inspector Smith

16.5 I have been very critical of DI Smith in respect of many aspects of the conduct of the investigation. I recognise that many of the mistakes he made were the result of his lack of experience of criminal investigations of a non-routine nature. I can summarise my criticism of him by saying that he was wrong to continue with his investigation without seeking the advice of a senior and more experienced detective officer. He soldiered on alone, pretending to all involved that he knew what he was doing, when, as he admitted in evidence, he did not know 'where to go'. He should have acknowledged at the time that he was in difficulty. The result of his failure to seek advice was that he never understood the issues, never had a plan of action, had no one to help him analyse the information he received, had no one to make suggestions as to the information he should seek from the available witnesses (Dr Reynolds and Mrs Bambroffe) and was allowed to close the investigation before it was complete.

16.6 In mitigation of this fault, I believe that he should, without having to ask for it, have had the benefit of supervision by a senior detective officer. Also, he received poor advice from Dr Banks. The idea of seeking the medical records was a good one. His decision to allow Dr Banks to review the records without having any very clear idea of the purpose behind the review was unfortunate but resulted from his lack of 'direction'.

16.7 DI Smith was not assisted by the failure of the staff at the Tameside register office to provide him with a complete bundle of copy death certificates. However, I do not consider that this failure had any material effect on the course of the investigation.

16.8 I accept that DI Smith found it difficult to believe that Shipman might have murdered his patients. Many witnesses spoke of this difficulty; it became known as the 'credibility gap'. I must give this factor due weight if I am to avoid the danger of judging with the benefit of hindsight. However, I cannot accept that this difficulty can provide an excuse for the particular shortcomings I have identified above. I observe that Dr Reynolds had surmounted this difficulty and had made her complaint.

16.9 I do not consider that DI Smith is primarily responsible for the failure of the investigation. He was not a suitable person to be put in charge of it. However, in two respects, his inaction contributed directly to the adverse result. One was his failure to collect detailed information from Dr Reynolds. Any detective, however unaccustomed to self-direction, should have known he must do that. The second (and more crucial) was his failure to report to the Coroner the fact that the bodies of Miss Ada Warburton and Mrs Lily Higgins were available for an autopsy if the Coroner thought fit to order one.

16.10 Although DI Smith's conduct since April 1998 has had no effect on the course of the investigation of Shipman's crimes, I must comment upon it. His lack of frankness merits strong criticism. In the several accounts of his investigation given to the police, he consistently sought to attribute its failure to the fault of others. I well understand the natural human reaction by which we all seek to interpret events so as to absolve ourselves from

blame, but the line must be drawn when it comes to telling lies. DI Smith told lies in his report of August 1998 and when speaking to Detective Superintendent Ellis. He repeated some of those lies in statements made to this Inquiry. In oral evidence, he told the truth about some matters, thereby correcting his earlier accounts. For that he deserves credit. However, he has continued to the end to lie about the circumstances in which he learned of the death of Miss Ada Warburton. He did so in an attempt to evade responsibility for his failure to arrange an autopsy on her body.

Dr Banks

16.11 In my judgement, Dr Banks must bear some responsibility for the failure of the investigation, although I consider that his contribution is substantially less than that of CS Sykes and DI Smith.

16.12 He failed to notice the causes for concern that were there to be seen in the medical records he examined. He failed to realise that the records suggested that Shipman had repeatedly failed to report to the coroner deaths that any reasonable doctor would have reported. He failed to notice that many of the deaths contained some of the very features that had been mentioned as having given rise to concern. He failed in these respects, not because he was lazy or incompetent or because the task of reviewing the records was beyond him, but because he could not open his mind to the possibility that Shipman might have killed his patients or even that he might have given them substandard care. That mindset would have been excusable if he had not known that the reason why the police were making enquiries was because a concern had arisen that Shipman might be killing his patients. I accept that Dr Banks' knowledge of, and respect for, Shipman made it even more difficult for him to have an open mind. The 'credibility gap' amounts to mitigation for Dr Banks' failures, but cannot provide an excuse in the case of a professional man asked for his professional opinion.

16.13 Because he knew the nature of the underlying concern, Dr Banks ought also to have given more careful consideration to the numbers of deaths among Shipman's patients. I find it surprising that a doctor of his experience should not know the annual crude death rate for patients in UK general practice. It is ten deaths per year per thousand of the population, a very easy number to remember. If he did not know it, he should have found it out and should have alerted DI Smith to the fact that, for a single-handed practitioner, 16 deaths (and, even more so, 16 cremations) in three months seemed rather high. Instead, it is likely that he gave DI Smith the impression that the numbers did not strike him as particularly high.

16.14 These were important failures which, had they not occurred, might well have brought about a different result.

What Would the Outcome Have Been?

16.15 In my view, if CS Sykes had put the investigation in the hands of a more senior detective than DI Smith, one who had experience of devising and supervising a criminal investigation and, if that officer had acted with reasonable expedition, the whole course of the investigation would have been different.

16.16 A more senior and experienced officer would have recognised the potential significance of the disparity in the death rates between Shipman's practice and the Brooke Practice. He would have investigated that issue. I think it likely that an official approach for advice would have been made to the WPHA, at a higher level than was made, and this would have resulted in the realisation that the death rate was abnormal. Although detailed work on death rates might have taken several weeks, a provisional view could have been provided within a day or two. This would have been based on accurate figures as, if the register office had failed to produce a complete bundle of copy death certificates, comparison with the Brooke Practice records would have exposed the error.

16.17 A thorough exploration of Dr Reynolds' concerns would have been made within a day or two of her initial report. Almost certainly, Dr Reynolds would have persuaded Mrs Bambroffe to speak to the police. The police would then have had a proper understanding of the nature of, and reasons for, the concerns.

16.18 Had these interviews taken place within a few days, as they easily could have done, it would not then have been too late for an autopsy to take place on the body of Miss Ada Warburton or Mrs Martha Marley. As it would have been appreciated that, if Shipman had caused the death of either of these patients, he must have done so by means of a drug, toxicological tests would have been performed and morphine would have been found. An inquest would have been ordered and Shipman would have come to learn that he was under suspicion. I do not think he would have killed any more patients after that.

16.19 Even if the opportunity for an autopsy on the body of Miss Warburton or Mrs Marley had been lost, the police would have learned of the existence of cremation Forms B, which would have provided much information. The police would then have arranged for the medical records of the deceased patients to be examined by a suitable expert. I am confident that the WPHA would have agreed to access by an expert. Examination by someone such as Dr John Grenville or Dr Frances Cranfield would have revealed cause for grave concern. The expert would have found evidence of deaths which had not been reported to the coroner when they should have been, evidence of deaths which occurred or were discovered very shortly after a visit by Shipman and evidence of poor care in the period shortly before death. When considered in conjunction with advice from the Health Authority about death rates, I consider that the level of concern would have been such that the police would have begun to think about identifying a body for exhumation. They would also have examined the PNC and would have learned of Shipman's past convictions for drug abuse.

16.20 The medical expert would have been able to identify a death that gave rise to particular concerns, such as that of Mrs Bianka Pomfret, who had died on 10th December 1997, at the age of only 49, and whose body was available for exhumation. Shipman was convicted of killing Mrs Pomfret. Examination of her records would have given rise to real concern and I think she would have been the most probable choice. I think it likely that the Coroner, who would have been concerned to realise that deaths which should have been reported to him had not been reported, would have been willing to order exhumation, autopsy and toxicological tests. Morphine would have been found. It would not have been long before Shipman became aware of what had been going on and I do not think he would have killed

again. Of course, I accept that it is possible that the expert might have suggested the exhumation of a body, such as that of Mrs Winifred Healey, who, on my findings, died a natural death, in which case no morphine would have been found. Another possibility is that the Coroner might have refused to order exhumation. That would have left the police to seek an autopsy in the next suspicious death of which they became aware.

16.21 If the first opportunity to conduct autopsies had been lost, the steps I have outlined might well have taken several weeks. However, I think that the progress of the investigation would have given rise to an increasing sense of urgency. Although I cannot be certain of this, I think that, if the police and the Coroner had moved with reasonable expedition, the lives of Shipman's last three victims would probably have been saved.

16.22 I turn to consider the alternative set of circumstances which would have arisen if CS Sykes had instructed DI Smith to commence the investigation but had discovered at some stage that he was out of his depth. Plainly, any delay in the appointment of a competent and suitably experienced detective would have reduced the likelihood that Shipman would have been stopped before killing again. The possibilities are many. DI Smith might have admitted his difficulties at an early stage, in which case there might have been very little delay in appointing a more senior detective officer. If, on 1st April 1998, Dr Banks had told DI Smith that the records raised some concerns, this might have been the trigger for the appointment of a more senior and competent detective officer. Another possibility is that CS Sykes might have discovered the inadequacy of DI Smith's work if he had asked him to write a report at the end of the investigation. He would then have taken the advice of Mr Postles and the investigation would have been put onto the right track, albeit about four weeks late. Plainly, the later the change of officer in charge, the poorer the chance that Shipman would have been stopped before killing again.

The Greater Manchester Police Internal Investigation

16.23 I believe that the GMP know that their own internal enquiries into the failure of the March 1998 investigation were quite inadequate. It must be a matter of regret and criticism that there should have been so wide a chasm between the fine words and good intentions as expressed by Assistant Chief Constable Sweeney and the reality of the enquiry which followed.

16.24 It appears to me that the fault for this disparity lies with those senior officers who decided upon the scope of the enquiry and the personnel who were to undertake it. Det Supt Ellis was not a suitable choice. He was not sufficiently senior even to investigate the actions of CS Sykes, let alone form a judgement about him. Whoever was put in charge of these enquiries should have been required to cross-check the accounts given by the two officers under investigation against other information available to the police. When the factual enquiries were complete, the report should have been subjected to critical analysis by a senior officer, who should have been responsible for making a judgement about whether or not any officer appeared to be open to criticism and whether or not any lessons should be learned.

16.25 Two explanations were advanced for the failure of the police to conduct an adequate internal enquiry. First, it was said that the police could not interview witnesses from outside

the Force because an external inquiry was pending. That was so, but they could very well have looked into their management failures. They did not need to interview any witness other than CS Sykes to find out that he had retained control of the investigation and knew so little of criminal investigation procedures that he had not even required DI Smith to write a report. That excuse will not do. The second was that the police were hamstrung because they could not obtain any evidence from officers without warning them that they might face disciplinary proceedings and offering them all the safeguards provided by the disciplinary code. This cannot be so. If it is not possible to investigate conduct which might amount to a disciplinary offence, there could never be any disciplinary proceedings.

16.26 I do accept that the senior officers of the Force would be likely to set out on such an enquiry in the expectation that a detective inspector would, broadly speaking, tell the truth about what had happened. But, on discovering that DI Smith had not made any proper record of an investigation that was known to have failed, I do not think that continued unquestioning confidence in his veracity should have been maintained.

Recommendations to the Greater Manchester Police

16.27 Although senior officers of the GMP said in evidence that they hoped that I would make recommendations that might assist in improving their procedures, there is very little I wish to say.

16.28 The main reason why this investigation failed was that the wrong people were in charge of it. If officers with the requisite experience had been assigned to it, there would have been no difficulty in devising a proper plan of action. It would be to state the obvious if I were to say that the GMP ought to put in place procedures which would ensure that investigations were assigned to and supervised by officers with appropriate experience.

16.29 Nowadays, good police practice requires that there should be a protocol for the handling of many types of situation that occur on a regular basis. However, there will always be some sets of circumstances that are new and different from what has happened before. There cannot be a protocol for every eventuality. Some problems can be resolved only by the application of the minds of people with the necessary intelligence and experience. The investigation of Dr Reynolds' concerns was one such problem. The GMP know that as well as I do.

16.30 Although I have said that there cannot be a protocol for every eventuality, it does appear to me that some guidance should be issued to those detective officers who have to undertake investigations into allegations of wrongdoing by health professionals. Such investigations may take place in the context of a criminal investigation and, at the present time, the police are often involved in investigations on behalf of the coroner into allegations of mistreatment where the conduct alleged falls short of gross negligence. Since the hearings into the first police investigation were completed, the Inquiry has learned that a group led by Detective Chief Superintendent Steve Watts of the Hampshire Constabulary is working on guidance for officers involved in work of this kind. I have seen the first draft and it appears that the guidance will be very useful. One of the problems discussed is the identification of an appropriately qualified and independent expert to assess the evidence

gathered and to advise on the issues of culpability. At present, the draft guidance recognises the difficulties but makes no practical suggestions as to how they might be overcome. This is understandable; the solution is by no means straightforward. For reasons of confidentiality, the police must be extremely careful about whom they consult for advice. There are various published directories of experts. However, an officer cannot use a directory effectively if he does not know in which field of expertise he needs advice. In some cases, the police will readily recognise what sort of expert they need but not in all cases. Modern medicine is highly specialised. It seems to me that the police need an established route by which advice of this nature can be found. I make two suggestions. One is that, if and when the medical coroner service comes into being (as I will recommend in my Third Report), it would be appropriate for a medical coroner or a regional medical coroner to maintain a register of suitable experts and to provide confidential advice to the police. A second suggestion is that the police should invite the Crown Prosecution Service to provide access to an in-house solicitor with medico-legal experience. Such a solicitor should have available lists of suitable experts and of counsel with specialist medico-legal knowledge.

Final Thoughts

16.31 The hearing of this stage of the Inquiry has been a painful experience for many of those involved. For those who faced criticism, it must have been a very anxious time. Those few who have been found responsible must live with that responsibility for the rest of their lives. I must and do feel sympathy for them, even though their predicament was of their own making. It was a misfortune for CS Sykes, DI Smith and Dr Banks that they were ever caught up in the consequences of Shipman's criminality. There must be many others who would also have failed if put in the position in which these men found themselves.

16.32 My final word must be for the families of Shipman's last three victims. For them, these hearings and the reading of this Report must have been profoundly distressing. Once again, I can only offer them my deepest sympathy.