CHAPTER TWO

The Coroner Becomes Involved

Dr Reynolds Informs the Coroner

2.1 Dr Reynolds telephoned the Coroner's office early in the morning of Tuesday, 24th March, before Mr Pollard had arrived at work. Mrs Mary Evans, the first coroner's officer, realised that Dr Reynolds was very concerned about something. Dr Reynolds telephoned the office again at about 10.25am. She told Mrs Margaret Blake, the member of staff to whom she spoke on that occasion, that it was important that she spoke directly to Mr Pollard and was put through. Mr Pollard made a contemporaneous note of what Dr Reynolds told him. This note is consistent with his recollection that Dr Reynolds told him that she and her partners were concerned about the number of deaths among Shipman's patients. She told him that she herself had signed a cremation Form C on the previous Thursday. He said that she also reported that one of the local undertakers was concerned about the deaths of some elderly female patients who appeared to have been found dead by Shipman. Mr Pollard noted the figures that Dr Reynolds gave him. He recorded that the Brooke Practice, with 9500 patients, had had 14 patient deaths in three months but that Shipman, who was a sole practitioner, had signed 16 cremation forms (i.e. Forms B) in the same period. That this was the first time Dr Reynolds is recorded as having mentioned the comparative numbers confirms my view that they had only recently come into her possession.

2.2 Mr Pollard said that he understood that Dr Reynolds was concerned about the number of deaths and also because the patients were found dead at home during the day and Shipman was often present at the time. Dr Reynolds made it plain to Mr Pollard that she was concerned that Shipman might be killing his patients. She thought that there were two possibilities: either Shipman was a very caring doctor (who visited so frequently that he happened to be with the patient at or shortly before the time of death) or he was killing his patients. Dr Reynolds wanted the Coroner to investigate her concerns but she asked him not to disclose her name as the source of the information. She was anxious that the investigation should be discreet because, if her concerns were unfounded, there would be an obvious risk to her professional relationship with Shipman should it become known that she had expressed concerns of such a serious nature about him.

2.3 Mr Pollard told the Inquiry that he understood the nature of Dr Reynolds' concerns about the differing death rates. He realised that Shipman's practice would have had no more than about 3000 patients. He also understood that Dr Reynolds was drawing a distinction between cremations and deaths, so that the 16 cremation certificates from Shipman's practice would not include those deaths where the bodies had been buried. He seems to have realised that the 16 cremations would not include any patient of Shipman who had died in hospital, although I do not think he realised the full potential impact of that factor. He told the Inquiry that he thought he had appreciated that there might be other deaths among Shipman's patients for which the cremation Form C had been signed by a doctor from a practice other than the Brooke Practice. He did not realise that the 14 deaths from the Brooke Practice were the total deaths among their 9500 patients, not just the ones for whom they had signed the MCCD. In fact, they had signed only three MCCDs during the

previous three months. In short, Mr Pollard appreciated the fact that there was a disparity between the numbers for the two practices, but I am not sure that he really understood its significance. He realised that it appeared that Shipman's practice had a death rate at least three times higher than that of the Brooke Practice. He recognised that these concerns merited prompt action and decided to report them to the police.

2.4 Mr Pollard did not suggest a face to face meeting with Dr Reynolds. On the telephone, he did not discuss with her the possibility that the cremation of the deceased person for whom she had completed Form C the previous week might be halted and an autopsy carried out. He said that Dr Reynolds did not give him the names of either Mrs Lily Higgins or Miss Ada Warburton, who had very recently died and whose bodies had not yet been cremated. Certainly he did not note them. He did not ask Dr Reynolds about any specific deaths. Mr Pollard said that he did not consider that a specific death was being reported to him and he did not explain to Dr Reynolds that he was not able to initiate an investigation into a death unless it was formally reported to him and the body was lying within the district over which he had jurisdiction. He assumed, without asking, that the body of the deceased person mentioned by Dr Reynolds had already been cremated. He said that, if Dr Reynolds had mentioned Mrs Higgins by name and had said that she was worried that the cause of death as certified might not be correct and that the body had not been cremated, he would have been prepared to order an autopsy. He pointed out, however, that, had this been done, Shipman would have had to be informed and might well have realised the source of the report.

2.5 Mr Pollard also said that he assumed that the death mentioned by Dr Reynolds must have been natural because two doctors had certified the death. This demonstrates that he had only a superficial understanding of Dr Reynolds' concerns. If, as Dr Reynolds suspected, Shipman was killing his patients, one would not have expected that Shipman would certify that the death had been anything but natural, either on the MCCD or on cremation Form B. Here was the doctor who had herself signed Form C, saying that she was worried that Shipman might be killing his patients. It should have been apparent to Mr Pollard that, in the case of the death for which Dr Reynolds had recently signed Form C, she was expressing (or at least implying) concern that the cremation certification procedure might not have provided any protection against concealed homicide. Mr Pollard did not suggest that, if Dr Reynolds or her partners had any concerns about future requests from Shipman to sign a Form C, they might wish to contact him.

2.6 Immediately after receiving the telephone call from Dr Reynolds, Mr Pollard went into the general office and informed his staff (Mrs Evans, Mrs Blake and the second coroner's officer at the time, Mrs Joan Collins) what Dr Reynolds had told him and of his intention to ask the police to investigate. He did not instigate any other enquiry of his own. It did not occur to him to look in the records held by his own office to see whether they revealed anything unusual about Shipman. He did not, for example, look to see when Shipman had last reported a death to him. He agreed that, had he done so, he would have found that no death had been reported formally within the previous six months. That would have been unusual. Mr Pollard said that, since his appointment in 1995, about 3000 deaths had been reported to him each year out of a total of about 8000 deaths that occurred in his district.

So, if Shipman had signed 16 MCCDs and cremation certificates within three months and had not reported any deaths to the Coroner, that fact would have been worthy of note.

The Coroner Informs the Police

2.7 Shortly after speaking to Dr Reynolds, Mr Pollard telephoned Chief Superintendent Sykes, Commander of the Tameside Division of the GMP. The two men knew each other personally and were on first name terms. Mr Pollard and CS Sykes disagree about how much detail was given by Mr Pollard during their telephone conversation but it is clear that they agreed to meet at Divisional Police Headquarters, Ashton-under-Lyne ('Ashton'), a short time later. It seems likely that Mr Pollard gave CS Sykes some indication of the nature of the matter he wished to discuss, as CS Sykes asked Detective Inspector Smith to attend the meeting.

2.8 CS Sykes says that Mr Pollard told him in some detail about the nature of the concerns expressed. He wished to take advice from Detective Superintendent (Det Supt) Bernard Postles, who was the senior divisional detective and acted as CS Sykes' crime adviser. However, he discovered that Det Supt Postles was on leave that day, so he decided to instruct DI Smith, the senior sub-divisional detective, to attend the meeting, with a view to him conducting the investigation that he understood would be required. CS Sykes said that he chose DI Smith because he was the only detective officer of the rank of inspector available to him. However, he regarded him as suitable for the work. He believed him to be a very good operational detective. He regarded him as calm and level-headed. He thought that DI Smith could undertake this investigation effectively. If he had not thought so, he could and would have requested a suitably qualified officer from another part of the Force.

The Meeting Between the Coroner and the Police

2.9 In evidence, Mr Pollard said that, when the three men met, he related to the police officers all that Dr Reynolds had told him of her concerns. He told them that Dr Reynolds was worried about the number of cremation certificates she and her partners had been asked to sign for Shipman's patients. He said that Dr Reynolds had signed a cremation certificate for one of Shipman's patients on the previous Thursday. He told the police the comparative numbers of deaths and cremations for the two practices and he believes that he explained the significance of the comparative numbers, although he doubts that he explained the difference between a 'death' and a 'cremation'. He told the police that the Brooke Practice had 9500 patients and said that Shipman was a sole practitioner but does not believe that he discussed the possible size of Shipman's practice. He thinks that he told the police that Dr Reynolds' partners shared her concerns. He said that he told the police that an undertaker (who was not identified, at Dr Reynolds' insistence) was also concerned about deaths among Shipman's patients, who were elderly females, were found in their day clothes and were found dead by the doctor. Mr Pollard cannot now recall whether or not he mentioned that Shipman was sometimes present at the death. He did not explain why Dr Reynolds regarded these features as unusual or worrying. Indeed, I am not sure that Mr Pollard himself understood why Dr Reynolds and the undertaker were worried about

these features. In view of these uncertainties in Mr Pollard's mind, it is perhaps not surprising that, at the end of the meeting, DI Smith did not have a completely clear idea of the nature of Dr Reynolds' concerns.

2.10 Mr Pollard said that he made plain to the police officers that any investigation should be conducted with the utmost discretion and that, in particular, Shipman must not know anything about it. The undertaker was not willing to disclose her name. He said that Dr Reynolds was concerned that Shipman might be killing his patients but recognised that it was possible that there was nothing amiss and that Shipman was a good and caring doctor. Mr Pollard said that there was no discussion at this meeting about the possibility of holding an autopsy on any body that was then available. Nor was any consideration given to what might be done about arranging an autopsy in the event of another death occurring that gave rise to any concern.

2.11 In evidence, DI Smith agreed that Mr Pollard told him about the number of cremation certificates that the Brooke Practice doctors had signed for Shipman and the number for the Brooke Practice itself but said that he had not understood the distinction between deaths and cremations. He thought he was being asked to compare like with like and that the figures given were the numbers of cremations within the last three months in each practice. He did not know the size of Shipman's patient list but he did realise that Shipman was a sole practitioner and would have a much smaller list than the Brooke Practice. He did not understand the significance of the common features noted by the undertaker. Like Mr Pollard, he said that there was no discussion about the possibility of an autopsy. He accepted that it was made plain to him that the concern was that Shipman might be killing his patients, although it was said that he might just be a very caring doctor. DI Smith did not recall that the Coroner told him that Dr Reynolds' partners shared her concern. He said that the Coroner suggested that he might begin his enquiries by obtaining the death certificates of Shipman's recently deceased patients. Mr Pollard did not think that he had made any such suggestion. Wherever it came from, the suggestion was plainly a good one.

2.12 CS Sykes had very little recollection of this meeting but what he recalled was broadly in line with the recollections of Mr Pollard and DI Smith. He understood that Dr Reynolds had two distinct concerns. One was that the death rate among Shipman's patients appeared to be far higher than that at the Brooke Practice. He did not appreciate that there was a distinction between the number of deaths and the number of cremations. He, like DI Smith, thought that the figures represented a comparison between like and like. However, he knew that Shipman was a sole practitioner. He would have realised that, if Dr Reynolds had even only one partner, it would suggest that Shipman's death rate might be double that of the Brooke Practice. CS Sykes said that he did not understand why some of the features of the deaths gave rise to concern. He did not recall any discussion about the bodies being fully dressed in day clothes. He realised that Dr Reynolds' concern was that Shipman might be killing his patients but he knew also that she had told the Coroner that there might be another explanation for the high number of deaths. This was that Shipman, being a very caring doctor, liked to keep his elderly patients at home rather than have them die in hospital.

2.13 CS Sykes did not recall any discussion about the signing of Forms C. He frankly admitted that, at that time, he knew nothing about death or cremation certification. He thought that two doctors certified all deaths. He said that he understood that Dr Reynolds had recently been involved in some way in helping to certify the death of one of Shipman's patients and that this would have raised the possibility that there might still be a body available for autopsy. However, there was no discussion about the availability of a body or bodies. He said that it would have been helpful if he had been told that the most recent patients to die had not yet been cremated.

2.14 The only contemporaneous note of this important meeting is to be found in DI Smith's daybook, the hard-backed A4 book in which he made notes in connection with his work. Mr Pollard, who was imparting the information, understandably did not take a further note, but referred to the note he had made during his telephone conversation with Dr Reynolds. CS Sykes did not make any record. A facsimile of the relevant pages of DI Smith's daybook, as they appeared at the end of the investigation, appears at Appendix A to this Report. It can be seen that the information recorded in the middle and to the left of the right-hand page (page 143) relates to what Mr Pollard says he told the police. There is other information, mainly names and telephone numbers, on the right and towards the bottom of the page. When asked to look at DI Smith's daybook, Mr Pollard said that he had not given DI Smith these names and telephone numbers. He had not mentioned Mrs Janet Parkinson (then Consumer Liaison Manager for the WPHA), Gill (a receptionist at the Brooke Practice), Mr Frederick Loader (the Superintendent Registrar at the Tameside register office) or the personnel at the General Register Office (referred to in the note as the **'Registrar General Office'**). He said he did not mention Dowse Catterall, Jordan and Robinson, Armitages or Masseys, all of which are firms of funeral directors in the Hyde area. Nor had he mentioned the names **'Lily Higgins'** and **'Ada Warburton'**, which appear on the right of the page. I am satisfied that only part of the information recorded on that page was written at the meeting between the police and the Coroner on 24th March. Some of it was written later that day and the rest on the following day or days.

The Arrangements for the Investigation

2.15 Following the meeting with Mr Pollard, CS Sykes confirmed his instructions to DI Smith that he was to investigate Dr Reynolds' concerns. He also resolved to supervise DI Smith's work on this project himself. CS Sykes had been a uniformed officer for 30 years. As Divisional Commander, he was responsible for determining the strategy for the division on such topics as budget, resources and policy. He did not have extensive experience of crime detection or criminal investigation. He said that if, in the course of his duties, he needed advice on a criminal matter, he would turn to Det Supt Postles.

2.16 CS Sykes accepted that he shouldered overall responsibility for this investigation. He said he was nominally responsible for all investigations in his division. However, he said the number of ongoing criminal investigations and the nature of his other duties meant that he could not usually take direct responsibility for supervision; that would be taken by a Criminal Investigation Department (CID) officer. CS Sykes explained that his personal duties would not allow time for him to read the files and keep up sufficiently with the detail of what was happening. Sometimes, he would attend a briefing session in a criminal

investigation, but this was to keep himself generally informed, rather than to enable him to undertake any active supervisory role. However, he decided not to instruct any other CID officer to supervise DI Smith's work on this investigation. Mr Pollard had spoken directly to him and, having been present at the initial meeting with him, he knew more details about the matter than he usually would. Whilst he retained overall responsibility for supervision, CS Sykes did not give DI Smith any instructions or advice as to how he was to go about the task of investigation. He did not see that as part of his function. He left him to his own devices. He realised that DI Smith would have to undertake a 'learning exercise' but, if he was in doubt or difficulty, there were many people to whom he could turn for advice. He told DI Smith to keep him and the Coroner informed of progress.

2.17 Detective Chief Superintendent (DCS) Peter Stelfox explained to the Inquiry how a criminal investigation should be supervised. He said that, in an investigation such as this one, which was not of a routine nature, the supervising officer should give the officer undertaking the investigation specific instructions as to whom s/he should interview and what information should be sought. The supervising officer should ensure that the investigating officer understands the purpose of what s/he is asked to do. At frequent intervals, the supervising officer should find out what the investigating officer has discovered. Usually, the investigating officer would submit a written report of what he had done and found out, which the supervising officer would discuss with him.

2.18 It is most unfortunate that DI Smith did not have the advantage of an experienced detective supervising his work. It is now clear that, although DI Smith was accustomed to working as part of a team in major criminal investigations, his work had always been supervised by a senior detective officer and he had never before been left to devise the way in which an investigation should be carried out. Also, it is now clear that he did not fully understand the nature and significance of Dr Reynolds' concerns. He did not appreciate the significance of the apparent disparity in the death rates within the two practices. Nor did he understand why the common features mentioned by the undertaker gave rise to concern. He told the Inquiry that he thought that what the Coroner had related was 'a bit wishy-washy'. This was, of course, a very different type of investigation from that which DI Smith was accustomed to undertake. There was no definite reported 'crime'. The task was to investigate whether or not a crime or crimes might have been committed. A different technique was required from that which he was accustomed to deploy.

2.19 DI Smith decided to undertake the investigation alone. He told the Inquiry that he thought that, if he involved any other officer, there would be a danger that the nature of the investigation might leak out. This, he said, had to be avoided because of the requirements of strict confidentiality imposed by the Coroner and Dr Reynolds.

2.20 Accordingly, DI Smith embarked on this investigation with a poor understanding of the issues and without the benefit of direct supervision by a more experienced senior detective officer. Nor did he have the advantage of a colleague with whom to discuss the conduct of the investigation.