CHAPTER EIGHT

Further Enquiries

What Detective Inspector Smith Probably Did from 27th to 31st March

8.1 There is no clear evidence that Detective Inspector Smith was actively engaged on his investigation into Dr Reynolds' concerns on Friday, 27th, Monday, 30th or Tuesday, 31st March 1998. No telephone calls relevant to this investigation are recorded, save for the brief call to Mrs Parkinson on 30th March. DI Smith might have been engaged on a different enquiry, although he did not think that he was. He might have worked on other police duties of a routine nature. However, at some stage, DI Smith undertook some further enquiries into Shipman and it seems likely that they were made during this period.

8.2 DI Smith said that he asked the Charities Commission whether a scanner appeal run by Shipman was registered as a charity. He found that it was not. The Charities Commission has no record of his enquiry.

8.3 DI Smith also recounted how he attempted to discover whether the police had attended any of the deaths of which he was aware. When a sudden death occurs, the police are frequently called. If necessary, they will trace and notify the deceased's next of kin. Provided that there are no obviously suspicious circumstances surrounding the death, they will also try to contact the deceased person's general practitioner to see if s/he is prepared to issue an MCCD. If the doctor agrees to do so, then police involvement comes to an end. However, an incident log recording the attendance of the police is made and retained. For the first 28 days after the death, the log is readily available on the police computer. After 28 days, the log is archived and the process of recovery is more time-consuming. In the archive, each topic has a code reference; the code for sudden death reports was, at the time, 84.

8.4 DI Smith said that he retrieved two or three incident logs relating to deaths of Shipman's patients which had occurred within the previous 28 days but found no evidence of suspicious circumstances. DI Smith seems to have thought that this showed that the deaths were not in fact suspicious. However, given the nature of the suspicion against Shipman, that he might be killing his patients by giving them a drug of some kind, one would not expect to find overt evidence of suspicious circumstances in a sudden death report. The potential value of these reports to DI Smith's investigation into Shipman was that they identified the police officer who had attended the scene of the death. That officer would have seen the body and might have had the opportunity to speak to a relative or neighbour who knew something of the circumstances surrounding the death. As DI Smith needed information about the individual deaths but could not approach relatives, he should have recognised the potential benefit of contacting the officers who had attended the deaths. Some of them might well have remembered information which was not recorded in the incident log.

8.5 DI Smith did not speak to the police officers who had completed the incident logs he retrieved. Moreover, he chose not to attempt to recover the archived logs. He said he regarded the coding system as unreliable. That it may have been, and it is possible that

an archive search would not have produced all the relevant incident logs. However, it would have produced some. The Inquiry caused a search of the archive for the six-month period in which DI Smith was interested. Incident logs were found for seven of the 20 deaths of which DI Smith became aware. Examination of the documents themselves would have revealed that all the deceased patients were women. One was said to have been found sitting in a chair. Others were said to have been on the floor. In six of the seven cases, it was apparent that the doctor (Shipman) had been willing to issue an MCCD. In other words, it was clear that none of those six deaths was referred to the coroner.

8.6 If DI Smith had bothered to find these reports and to speak to the officers who had attended the scenes of the deaths, he would have obtained a wealth of useful information. He would have learned of the position of the deceased, whether they were in day clothes and whether they were showing signs of illness before death. He might well have discovered whether relatives and friends regarded the death as sudden and unexpected. In my view, the unreliability of the coding system was not a valid reason for DI Smith's decision not to make the attempt. This was an important opportunity to obtain evidence about the deaths without breaching the requirement of confidentiality imposed by the Coroner at his original meeting with Chief Superintendent Sykes and DI Smith.

8.7 DI Smith also checked the Greater Manchester Police Integrated Computer System (GMPICS) to see whether there was any intelligence known about Shipman. He found that there was not. However, he did not access the Police National Computer (PNC) to ascertain whether Shipman had any previous convictions. He said that he forgot to do so. He also remarked that a check of the PNC was less convenient than one on the local system. However, he well knew that GMPICS would cover only intelligence and information about matters that had occurred in the Manchester area. I doubt that he forgot to search the PNC and think it more likely that he thought his search of GMPICS would be adequate, because a man like Shipman would not have any criminal convictions. This is borne out by a short passage in the Ellis report, to which I shall refer later, from which I infer that DI Smith told Detective Superintendent Ellis that he had made a conscious decision not to search the PNC. Had DI Smith searched the PNC, he would have discovered that Shipman had previous convictions for drugs offences involving dishonesty, committed in the early 1970s.

8.8 DI Smith claimed that knowledge of these convictions would not have affected his view of Shipman; the offences were a very long time ago and, he said, it is not uncommon to find doctors who have stolen drugs. I cannot accept that evidence. Shipman had a very high reputation and, in my view, the discovery that he had previous convictions would have come as a great surprise to anyone, including DI Smith. Examination of the record would have revealed that the offences had taken place over a considerable period of time and involved acts of dishonesty. Of course, the knowledge that Shipman had past drugs convictions would not immediately lead to the conclusion that he was killing his patients. However, it would have meant that his reputation was called into question. When considered together with the suspicion that he might be killing his patients by giving them some sort of drug, as Dr Reynolds had suggested, knowledge of these convictions would have raised the index of suspicion of any reasonable police officer.

8.9 DI Smith said that he did not contact the General Medical Council (GMC) in connection with his enquiries into Shipman. At one stage, the Inquiry considered that he might have done, as a telephone call was made to the GMC from Ashton police station at 9.09am on 14th April. It lasted only 52 seconds. However, DI Smith said that he did not make this call in connection with Shipman. The call might have been made by him or by another officer in connection with another case. The GMC has no record of the call, which, they say, must, from its length, have been a routine enquiry. DI Smith ought to have asked the GMC whether Shipman had been the subject of disciplinary proceedings. This enquiry should be made as a matter of routine in any criminal investigation into the conduct of a doctor. Had he made a proper formal enquiry and had the GMC been prepared to assist, it may be that DI Smith would have found out about Shipman's convictions through that route.

What Detective Inspector Smith Did Not Do During the Same Period

8.10 During this period at the end of March, DI Smith did not attempt to locate or interview the unknown female undertaker. She was plainly an important potential witness, provided that she was willing to speak to him. He had no reason to suppose that she would not; he knew only that she did not wish her identity to be disclosed. It is hard to understand why DI Smith did not request Dr Reynolds to ask 'the unknown undertaker' whether she would speak to him in confidence. He said that he asked Police Constable (PC) Peter Napier, a coroner's liaison officer, if he knew of any female undertakers. PC Napier gave him two or three names, including that of 'Debbie Massey' (now Mrs Bambroffe). However, PC Napier said that he did not provide Mrs Bambroffe's name. PC Napier said that, on 24th March (which was the first day of the investigation), he had passed DI Smith in the corridor at Ashton police station. DI Smith had asked him if he knew of any female undertakers in Hyde. PC Napier said that he gave DI Smith one name, but not that of Mrs Bambroffe because he thought, erroneously, that she was only an employee, and not a principal, of the firm of Masseys. However, there is no evidence that DI Smith contacted any of the female undertakers named by PC Napier.

Reporting and Supervision

8.11 CS Sykes said that it was usual practice for DI Smith to come to his room each morning to discuss current matters. These morning meetings occurred during this period but were not specifically related to the Shipman investigation, which would be mentioned briefly. CS Sykes remembered hearing that DI Smith had obtained some documents, probably the copy death certificates, but said he did not know about his attempts to obtain the medical records. It appears that there was never any in-depth discussion of the issues between the two men. CS Sykes said that it did not occur to him to question DI Smith about what he was doing in this investigation. It certainly did not occur to him to ask whether DI Smith had checked to see if Shipman had any criminal convictions. He gained the impression that matters were being dealt with properly but that nothing had emerged from the investigation such as to give rise to any concern.

The Lost Chance for an Autopsy

8.12 I noted earlier that, on 30th March, Dr Reynolds telephoned Dr Gough to give a report on progress. Dr Gough recorded that Dr Reynolds thought that an autopsy was to take place

on one of the bodies she had identified to the investigating police officer. Mrs Lily Higgins had been cremated on Wednesday, 25th March and Miss Ada Warburton was cremated on 30th March. The opportunities for autopsy had gone. The body of Mrs Martha Marley was cremated on 31st March. Her body had also been available for examination but DI Smith had never become aware of her death.

8.13 In short, no progress had been made in the investigation between 27th and 31st March.