SUMMARY

Introduction

1. On 31st January 2000, Harold Fredrick Shipman was convicted of the murder of 15 patients and of forging the will of one of them. His trial was the culmination of an investigation which began in July 1998 into the death of Mrs Kathleen Grundy.

2. Shipman had, however, been the subject of an earlier police investigation. On 24th March 1998, Dr Linda Reynolds, a principal of the Brooke Practice, which practised from premises opposite Shipman's surgery, reported to Mr John Pollard, HM Coroner for the Greater Manchester South District ('the Coroner'), her concerns, and those of her partners, about the number of Shipman's patients who were dying and the circumstances of their deaths. At the request of the Coroner, a confidential investigation was carried out by the Greater Manchester Police (GMP or 'the Force'). That investigation was conducted by Detective Inspector (DI) David Smith under the supervision of Chief Superintendent (CS) David Sykes.

3. DI Smith concluded that there was no substance in Dr Reynolds' concerns and his investigation ended on 17th April 1998. After that time, Shipman killed three more patients before his arrest. They were Mrs Winifred Mellor, Mrs Joan Melia and Mrs Grundy. After Shipman's trial, there were concerns about the thoroughness with which the first police investigation had been carried out and whether, if it had been conducted differently, Shipman's course of killing could have been stopped earlier and the lives of three of his victims saved.

4. In the course of hearings which took place between May and July 2002, the Inquiry conducted a detailed examination of the evidence relating to the March 1998 police investigation. This Second Report records my findings as to what occurred during this investigation and provides my opinion as to whether or not, in performing their duties, the conduct of the various public servants involved fell below the standard which the public is entitled to expect.

Dr Reynolds Makes her Report

5. When Dr Reynolds made her report to the Coroner, she mentioned two particular grounds for concern. First, she told him that she knew that Shipman, who was a single-handed practitioner, had signed 16 cremation Forms B in the previous three months, whereas the Brooke Practice, with a patient base of 9500, had had only 14 patient deaths during the same period. Shipman had a patient list which was approximately one-third the size of the Brooke Practice list. Moreover, the figure of 16 cremations within his practice would not include:

   - deaths which had occurred in hospital
   - deaths followed by burial
   - deaths certified by the coroner
   - deaths where Shipman had asked a doctor other than one from the Brooke Practice to complete Form C.

6. The effect of these factors was that, if Shipman's practice followed the usual pattern, those cremations which members of the Brooke Practice were aware of were likely to represent no more than about 21% at most of Shipman's total deaths during the relevant period. Given the fact that Shipman had a patient list which was approximately a third the size of that of the Brooke Practice, it is apparent that the disparity between the number of deaths of patients in Shipman's practice and in the Brooke Practice was potentially very large indeed. It was this disparity which concerned Dr Reynolds and the other members of the Brooke Practice.

7. The second cause of concern was the presence of features which appeared to characterise the deaths, namely that the deceased persons were elderly women who had been found dead at home, apparently alone, fully dressed. They did not appear to have been ill. Shipman often found them dead. These features were unusual. It is more common for deaths to be more or less equally distributed between men and women. Most deaths at home occur after a period of illness, with the patient confined to bed and relatives and friends in attendance. It is not common for a general practitioner to be present at the death of a patient or to find a patient dead. Mrs Deborah Bambroffe (nee Massey), a partner in the firm of Frank Massey and Son, Funeral Directors (Masseys), had expressed concern to Dr Reynolds about those features. Mrs Bambroffe did not want her name to be disclosed and Dr Reynolds informed the Coroner of this fact. She did not disclose the identity of Mrs Bambroffe to him.

8. Dr Reynolds also told Mr Pollard that she had signed a cremation Form C for one of Shipman's patients a few days before. Mr Pollard did not discover the identity of that patient, nor did he explore the possibility that the body might still be available for autopsy.

The Investigation Begins

9. The Coroner communicated Dr Reynolds' concerns to CS Sykes and DI Smith. He told them that Dr Reynolds had advanced two explanations, either of which might account for the factors giving rise to her concerns. The first was that Shipman was a caring doctor, who looked after his elderly and sick patients in their own homes, rather than having them admitted to hospital, and who visited them frequently when he knew them to be ill. The second was that he was killing his patients.

10. DI Smith began his investigation by interviewing Dr Reynolds. During the period of four years which elapsed between the investigation and the Inquiry hearings, he gave a number of accounts of that interview. I have found that, in his earlier accounts, DI Smith sought to diminish the seriousness and credibility of Dr Reynolds' concerns as explained to him; I have concluded that he did so in the hope of avoiding criticism in respect of his conduct of the investigation. In his oral evidence to the Inquiry, DI Smith abandoned his previous attempts to diminish Dr Reynolds' concerns. He admitted for the first time that Dr Reynolds had told him early in their meeting that she thought Shipman was killing his patients, either through lack of care or by murdering them and that, if he was murdering them, he was doing it by giving them some sort of drug.

11. DI Smith denied, however, that Dr Reynolds had told him that there were two bodies lying at the premises of funeral directors, which would be available for autopsy. As a result of

notes made in his own daybook (the book in which he made notes in connection with his work: see Appendix A) and other contemporaneous evidence, I have concluded that Dr Reynolds did indeed give DI Smith that information. The bodies were those of Mrs Lily Higgins and Miss Ada Warburton. I have previously found that Shipman killed both of them. However, DI Smith failed to pursue with the Coroner the possibility of autopsies on either or both of their bodies. I think it likely that, if asked, the Coroner would have agreed to that course. Had he been made aware, either by DI Smith or Dr Reynolds, of Dr Reynolds' belief that, if Shipman was killing his patients, he was doing it by administering a drug, the Coroner would have ordered an autopsy with toxicological examination. I think it likely that this would have happened. In that event, the presence of morphine in either or both of the bodies would have been detected. Mrs Higgins was cremated on 25th March 1998. Miss Warburton's body was available for autopsy until her cremation on 30th March 1998.

12. In the course of his interview with Dr Reynolds, DI Smith failed to ask many important questions. He did not discover the basis of her concerns about the disparity between the death rates of Shipman's practice and her own, nor did he ask to see the records from which the rates had been derived. He did not ask why the features of the deaths which Dr Reynolds had identified gave rise to concern. He did not seek to find out more about the circumstances of the individual deaths for which she had completed Forms C. He did not seek an explanation of the procedures for death and cremation certification. He did not ask to meet Dr Reynolds' partners. As a consequence of these failures, DI Smith left the interview, uncertain about the basis for Dr Reynolds' concerns and, in particular, with no understanding of the potential importance of the comparative death rates about which Dr Reynolds and her partners were so troubled.

The Tameside Register Office

13. DI Smith next went to the Tameside register office and requested Mr Frederick Loader, the Superintendent Registrar, to provide him with copies of all the entries in the registers of deaths relating to deaths certified by Shipman over the previous six months. During that period, Shipman had certified 31 deaths. On 26th March 1998, Mr Loader handed to DI Smith a bundle of copy death certificates. Mr Loader and his staff say that, since there had been 31 deaths in the relevant period, 31 certificates must have been handed over. DI Smith maintains that he was given significantly fewer certificates; he now says that the number was 20. If DI Smith is correct, the register office staff were at fault. If they are right and DI Smith was given all 31 certificates, he must have lost 11 or 12 of them almost immediately and failed to find them again at any time during the investigation.

14. I have concluded that it is more likely that there were errors in the register office, resulting in an incomplete bundle of certificates being given to DI Smith. If that conclusion is correct, it seems to me likely that Mr Loader was responsible for the errors. However, I do not think that a high degree of blame should attach to him.

15. Because DI Smith did not understand the significance of the number of deaths or the comparative death rates reported by Dr Reynolds, he did not recognise that the number of copy death certificates which he received from the register office (19 or 20, covering

a period of six months) was incompatible with the number of cremation forms signed for Shipman's patients by members of the Brooke Practice (16 in three months). It is because of that lack of understanding – and the fact that DI Smith attached no importance to the numbers or death rates – that I have concluded that the error made by the register office staff had no significant effect on DI Smith's conduct of the investigation.

Dr Alan Banks

16. DI Smith visited the Hyde office of the West Pennine Health Authority and sought access to the medical records of 17 of the 19 or 20 deceased persons for whom he had copy death certificates. Since he did not have the consent of the next of kin or personal representatives of the deceased, he was told he could not have access to the records. Instead, it was arranged that Dr Alan Banks, Assistant Director of Primary Care and Medical Adviser to the Health Authority, would examine the records; in the event, 14 of the 17 sets of records were available for examination. A 15th set became available at a later stage. I have concluded that the main task which Dr Banks believed he had to perform was to ascertain whether the medical records confirmed or denied the presence in all the deaths of the pattern of 'common features' reported by DI Smith to Mrs Janet Parkinson, the Consumer Liaison Manager for the Health Authority. These common features were that the deaths were of elderly females; all had been found at their homes by Shipman who had apparently called on them unannounced; all had been found during the day and in their day clothes and all had been certified as having died from stroke or heart disease. In addition, Dr Banks looked to see if the causes of death, as disclosed by the records, were generally compatible with the medical histories.

17. Dr Banks claimed that he did not realise that the concern being investigated by the police was that Shipman might be killing his patients. I do not accept that claim. I find that he must have known that the underlying concern was that Shipman was killing patients, either deliberately or by gross negligence. However, Dr Banks found the suggestion so incredible that it is doubtful that he contemplated it as a real possibility.

18. Dr Banks examined the medical records on 26th–27th March 1998 and compiled a chart (Appendix D) on which he sought to show the presence or absence of the common features which had been identified to him. On 1st April 1998, he met DI Smith to discuss the results of his examination. At that meeting, I am satisfied that Dr Banks told DI Smith that there were two or 'a few' deaths in which he considered there was insufficient information in the medical records to enable a proper diagnosis of the cause of death to be made. I am further satisfied that he said that he himself would have referred those deaths to the coroner. I do not accept that he said that such a referral would have been mandatory or that any reasonable doctor would have made the referral. Dr Banks suggested that the insufficiency of information might be caused by the limitations of the computerised records. The overall impression which he created was, I am confident, one of reassurance.

19. In my view, Dr Banks failed, when examining the medical records, to recognise features within them which tended to support the concerns which had been identified to him. He did not recognise as unusual the fact that 13 out of the 14 deaths for which he initially

examined records were of female patients. Although he noted on his chart that Shipman had been present around the time of death in ten out of the 14 cases, he did not draw that to DI Smith's attention. It does not appear that he noticed that Shipman had visited seven of the patients not long before the death was discovered. The medical records did not disclose any serious concern about the patients' condition yet, within a short time, the patients had been found dead. Dr Banks does not seem to have noticed that 12 out of the 14 deaths occurred at the patients' homes, with only two in residential or nursing homes.

20. I have concluded that Dr Banks' prior knowledge of, and respect for, Shipman made him an unsuitable person to carry out the task of examining the medical records. It is unfortunate that he did not recognise that fact. Because he approached the records on the basis that all would be normal, his search for the 'common features' was superficial. When he realised that not every feature of concern was present in the circumstances of all the deaths (an expectation which was illogical, had he paused to consider it), Dr Banks erroneously concluded that there was no 'pattern' to be found. He failed to see the unusual features which characterised many of the deaths. If he did notice anything which struck him as odd, he immediately found an innocent explanation for it. He approached his examination of the records in the belief that there would be no cause for concern and was simply unable to open his mind to the possibility that Shipman might have harmed a patient. He failed to appreciate the potential significance of the fact that Shipman was not referring deaths to the coroner which he himself believed should have been referred.

21. In mitigation of his failures, I accept that Dr Banks was not given all the information he could and should have been given. In particular, he was not told about the comparative death rates of the Brooke Practice and Shipman's practice. I think there is a real possibility that, if Dr Banks had been fully informed, his mind might have not been quite so tightly closed against the possibility of Shipman's guilt.

22. If DI Smith had received all 31 copy death certificates from the Tameside register office and Dr Banks had been made aware of most or all of them, the chance that he would have realised that the death rate among Shipman's patients was abnormal would have been increased. The additional records which would have been available for Dr Banks to examine contained a number of unusual features which tended to support the concerns that had been raised. However, I cannot say with confidence that Dr Banks would have realised the significance of this additional material even had he seen it. It is possible that he would have done so and would have expressed real concern to DI Smith but I cannot say that it is probable that this would have happened.

23. DI Smith was indeed reassured by what Dr Banks told him. I am satisfied that the receipt of Dr Banks' opinion effectively marked the end of this investigation.

The Dukinfield Crematorium

24. Nevertheless, later on 1st April 1998, DI Smith visited the Dukinfield crematorium. Whilst there, he asked no questions about the system of cremation certification. He failed to discover the fact that the crematorium held a bundle of certificates for each cremation which contained information supplied by the certifying (Form B) doctor about the circumstances of death. He did not look at the cremation register as he should have done.

Had he looked, he would have found that the name of the certifying doctor appeared in the record of each death. Had DI Smith looked back over the previous six months, he would have found entries for the 11 deaths of which he was at that time unaware. Also, because he asked no questions about cremation procedures, he remained unaware of the existence and role of the crematorium medical referee. He therefore lost the opportunity to interview Dr Betty Hinchliffe, Medical Referee at the crematorium. It is fair to say, however, that, if he had interviewed her, he would have received an assurance that Shipman always completed his Forms B satisfactorily and that his patients' deaths gave rise to no ground for suspicion.

Masseys

25. DI Smith also ascertained that nine of the funerals had been dealt with by Masseys; in discussion with Mr Michael Gurney, Senior Registrar at the crematorium, he came to the (correct) conclusion that the unidentified female undertaker of whom Dr Reynolds had spoken was Mrs Bambroffe, formerly Miss Deborah Massey.

26. On 2nd April 1998, Mrs Bambroffe's father, Mr Alan Massey, had been to see Shipman in his surgery. Initially, when Mrs Bambroffe and her husband, David, had voiced their concerns to Mr Massey, he did not share them. He was further reassured by a conversation which he had with Dr Alastair MacGillivray, of the Brooke Practice, which probably took place towards the end of February 1998. However, Mr Massey and his family have said that, by the end of March or the beginning of April, Mr Massey himself was concerned about the number of deaths among Shipman's patients and the circumstances surrounding those deaths. He wanted to seek an explanation from Shipman and therefore decided to make an appointment to see him.

27. At that time, Mrs Bambroffe was aware that her concerns and those of the Brooke Practice doctors had been reported to the Coroner. It is likely that she had been told that the police had been informed; certainly she would have known that, given the involvement of the Coroner, the police might well be involved also. I am satisfied that, by 2nd April, she had told her father of the report to the Coroner and that he too was probably aware that the police would also be involved.

28. In my judgement, Mr Massey went to see Shipman because he thought that, with the report to the Coroner, things had 'gone too far' and that Shipman should know what was being said about him. At the time he went, I have no doubt that Mr Massey was convinced that Shipman had done nothing wrong. I am satisfied that he did not intend to 'tip off' Shipman. Nor do I think that he went so far as to tell Shipman that there had been a report to the Coroner. I believe that he gave Shipman to understand that people were talking about the number of deaths among his patients and to make plain that he himself did not share the suspicions which were being voiced by others. Shipman's response was to produce his book of Medical Certificate of Cause of Death counterfoils and show Mr Massey various names and causes of death. He told Mr Massey that the book was available for inspection by 'anybody concerned'. He was relaxed, confident and apparently unconcerned by the deeply distressing (to an innocent person) gossip which was circulating about him. Mr Massey was entirely reassured by Shipman's response, although he had, of course, not received the explanation he claimed to have sought.

29. The effect of Mr Massey's visit was to alert Shipman to the fact that he was under suspicion, possibly even under investigation. I think the consequence was that Shipman stopped killing for a time before resuming and killing his last three victims on 11th May, 12th June and 24th June 1998. In my judgement, Mr Massey's action in speaking to Shipman did not lead to any loss of life and may indeed have saved lives. I am sure that he acted with good intentions when he went to see Shipman. His mistake was that he trusted, admired and respected Shipman and could not believe that the suspicions harboured by his daughter and the Brooke Practice doctors could have any foundation. I think he has found it very hard, indeed impossible, to accept that this was once his state of mind.

30. About two weeks after Mr Massey's visit to Shipman, probably on 15th April 1998, DI Smith met Mr and Mrs Bambroffe and Mr Massey. DI Smith confirmed that Mrs Bambroffe was the undertaker who had expressed concerns to the Brooke Practice doctors. He told Mrs Bambroffe of Dr Reynolds' concerns, as related to him, and of what he had done to investigate them. He asked Mrs Bambroffe if she had anything to add. His manner was reassuring and he gave the impression that he had made a thorough investigation and found nothing untoward. The family got the impression that the investigation was approaching its conclusion. DI Smith did not ask Mrs Bambroffe to elaborate upon her concerns, nor did he seek information about the deaths which she and other members of the family had attended. He did not seek access to the records kept by Masseys. Had he done all these things, he would have elicited a great deal of information, including the fact that there were five deaths dealt with by Masseys during the preceding six months, of which he was unaware. This meeting was not an evidence-gathering exercise; rather, the interview consisted of DI Smith imparting information. I can well understand, given the nature of the meeting and DI Smith's attitude, why Mrs Bambroffe did not feel able to repeat and expand upon the concerns which she had previously expressed. By the end of the meeting, DI Smith had learned nothing new.

The End of the Investigation

31. At about this time, DI Smith discussed the investigation with CS Sykes and it was agreed that it should be closed. There was no detailed discussion of the evidence collected by DI Smith and he submitted no written report. In effect, CS Sykes delegated the decision to close the investigation to DI Smith.

32. During the course of the investigation, DI Smith had made no check on the Police National Computer to ascertain whether or not Shipman had any previous convictions. He said that he forgot to do so. I doubt that he forgot and think it more likely that he thought his search of the Greater Manchester Police Integrated Computer System would be adequate, because a man like Shipman would not have any criminal convictions. Had he enquired, he would have discovered that Shipman had previous convictions for drug offences involving dishonesty, committed in the early 1970s. DI Smith claimed that, even had he known about Shipman's criminal record, it would not have affected his view of Shipman. I do not accept that assertion. Of course, the knowledge that Shipman had past drugs convictions would not immediately have led to the conclusion that he was killing his patients. However, when considered with Dr Reynolds' suggestion that Shipman might be

killing his patients by giving them some sort of drug, knowledge of his convictions would have raised the index of suspicion of any reasonable police officer.

33. On 16th April 1998, DI Smith visited Dr Reynolds and told her that he had found no evidence to confirm her suspicions. I am satisfied that he mentioned the apparent absence of motive; Dr Reynolds was disappointed at the emphasis on this aspect of the enquiry as she was concerned, not about motive, but about the disparity in death rates between the two practices. DI Smith gave no explanation for that disparity; he was not in a position to do so.

34. On 17th April 1998, DI Smith spoke to Mr Pollard by telephone. He mentioned the fact that he had had medical records examined; two sets had been 'questioned' but there had been nothing that 'gave any indication of any criminal acts'. He had 'inspected' the 'cremation records' of 20 people and seen the female undertaker of whom Mr Pollard had been told. He informed Mr Pollard that Shipman tried to get all his patients out of hospital and visited them without prior appointment. Mr Pollard accepted what was said and did not think deeply about it or question whether the proffered explanation could satisfactorily account for the startling disparity between the death rates. He did not take any steps to discover whether Dr Reynolds was satisfied with the result of the investigation. He accepted that the police enquiry had revealed nothing of concern and put the whole matter out of his mind. Thus ended the March 1998 police investigation.

Conclusions

Chief Superintendent David Sykes

35. The Inquiry was told that DI Smith, although an experienced detective, was not accustomed to working without direction and supervision. CS Sykes should have known that or, if he did not, he should have discovered it. He should have instructed a suitably experienced detective officer to undertake this unusual and potentially serious investigation. He should have realised also that he himself did not have the necessary experience to direct and supervise the investigation. He should have consulted Detective Superintendent Bernard Postles (now Detective Chief Superintendent Postles) who would have advised as to the appropriate level of seniority to which the concerns should be reported. I am satisfied that, had that been done, a properly directed investigation would have taken place.

36. Once the investigation was under way, CS Sykes failed to recognise that DI Smith was out of his depth. He failed to discuss the issues with DI Smith in any detail. If he had done so, he would have realised the extent of DI Smith's lack of understanding. He should not have left it to DI Smith to decide whether and 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, the outcome would have been different.

Detective Inspector David Smith

37. DI Smith himself made many mistakes in the course of the investigation. Some of those were the result of his lack of experience of criminal investigations of a non-routine nature.

He was wrong to continue with his investigation, pretending that he knew what he was doing when, as he admitted in evidence, he did not know 'where to go'. He should have sought the advice of a senior detective officer. As a consequence of his failure to seek advice, 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 and was allowed to close the investigation before it was complete. However, he should have had, without needing to ask for it, the benefit of supervision by a senior detective officer. In addition, he was not assisted by the poor advice which he received from Dr Banks, nor by the failure on the part of the Tameside register office to provide him with a complete bundle of copy death certificates.

38. Although I do not consider that DI Smith is primarily responsible for the failure of the investigation, in two respects his inaction contributed directly to the adverse result. The first was his failure to collect detailed information from Dr Reynolds and the second was his failure to report to the Coroner the fact that the bodies of Mrs Lily Higgins and Miss Ada Warburton were available for autopsy if the Coroner thought fit to order one.

39. In addition, DI Smith's lack of frankness about his part in the investigation merits strong criticism. In the various accounts of his investigation given to the police, he consistently sought to attribute its failure to the fault of others. He told lies in those accounts and repeated some of those lies in statements made to this Inquiry. In oral evidence, he told the truth about some matters, for which he deserves credit. However, he has continued to the end to lie about the circumstances in which he learned of the death of Miss Warburton. He did so in an attempt to evade responsibility for his failure to arrange an autopsy on her body.

Dr Alan Banks

40. In my judgement, Dr Banks must also 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. I have already referred to the inadequacies of his examination of the medical records and to the fact that he was unable to 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.

A Different Outcome?

41. Had CS Sykes put the investigation in the hands of a more senior detective officer, 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, in my view, have been very different. I think it likely that the opportunity would have been taken

to conduct an autopsy, with toxicological tests, on the body of Miss Warburton or of Mrs Martha Marley, of whose death on 24th March 1998 DI Smith remained ignorant throughout the investigation. Had that been done, 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.

42. Even if the opportunity for an autopsy had been lost then, I believe that, in due course, suspicions would have been such that the police would have applied for an exhumation and autopsy, with toxicological tests. It is probable that, by that time, concerns would have arisen about the death of Mrs Bianka Pomfret, and that her body would have been exhumed. Morphine would have been found. It would not have been long before Shipman became aware of the investigation and I do not think he would have killed again.

43. 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.

44. If CS Sykes had initially instructed DI Smith to carry out the investigation but had subsequently discovered that he was out of his depth, then it is more difficult to say what the probable outcome would have been. It would depend on how much time had elapsed before the discovery was made and the investigation was put into the hands of a more senior detective officer. Plainly, the later the change of officer in charge, the poorer the chance that Shipman would have been stopped before he killed again.

The Greater Manchester Police

45. At an early stage in the later police investigation into the death of Mrs Kathleen Grundy, it was discovered that there was no written report about the March 1998 investigation. Subsequently, DI Smith submitted two written reports, setting out details of the investigation. I have found that, in those reports, he sought to diminish the seriousness of Dr Reynolds' original concerns and to suggest that Dr Banks had raised no concerns whatever about the medical records. Clearly, DI Smith was seeking to deflect possible criticism of his conduct of the investigation. By the end of 1998, the GMP had good reason to suspect Shipman of being a serial killer, whom the first police investigation had failed to detect. The potential for criticism of the Force was recognised. Nevertheless, on the basis of DI Smith's reports alone, senior officers in the GMP concluded that the March 1998 investigation had been 'appropriate at that time'.

46. Immediately after Shipman's conviction, it was announced that there would be an Inquiry into the Shipman affair, including the first, failed police investigation. In preparation for the Inquiry, Detective Superintendent (Det Supt) Peter Ellis was instructed to prepare a 'comprehensive document' recording, as accurately as possible, a detailed account of the March 1998 investigation. The document was prepared following interviews with CS Sykes and DI Smith. The account given by DI Smith to Det Supt Ellis was different in a number of respects from his oral evidence to the Inquiry. Most notably, he told Det Supt Ellis that Dr Reynolds had at no time said that she suspected that Shipman was killing his patients. That was in contrast to his oral evidence to the Inquiry. In general, the account given to Det Supt Ellis, like DI Smith's previous reports, tended to minimise the

seriousness of the concerns being expressed and excused DI Smith's failure to find evidence to substantiate those concerns.

47. Having recorded DI Smith's account of the investigation, Det Supt Ellis then proceeded to make a series of 'observations', all of which had the effect of exculpating DI Smith. He excused DI Smith's failure to ascertain whether Shipman had previous convictions. He criticised Dr Reynolds and Mrs Bambroffe in a number of respects without querying the account he had been given. He emphasised the limitations placed on the investigations by the constraints of confidentiality. His conclusions echoed the view previously expressed by senior members of the Force that the investigation was 'appropriate at the time'. He pointed out the potential for criticism in DI Smith's failure to keep records of his enquiries but mitigated this by suggesting that written records might have been kept if any evidence supporting the suspicions had come to light.

48. Det Supt Ellis should not have been given the task of preparing the report, which should have been written by a more senior officer. He was not in a position to investigate the actions of CS Sykes, still less form a judgement about his supervision of the investigation. He was heavily influenced by the views of more senior officers, of which he was aware. Nevertheless, Det Supt Ellis' report was accepted by senior officers in the GMP, who maintained their view that DI Smith's investigation had been as thorough as possible. After the report had been submitted to this Inquiry, the witness statements submitted by officers of the GMP continued to reflect the same view.

49. On the first day of the Inquiry hearings of the evidence relating to the March 1998 police investigation, it was conceded on behalf of the GMP that the March investigation had been seriously flawed in a number of respects. That conclusion was prompted by a review of the investigation which was then being carried out by Detective Chief Superintendent (DCS) Peter Stelfox; that review constituted a careful, detailed and objective analysis of the evidence relating to the first investigation. 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.

50. In my view, the GMP should not have waited until 2002 to undertake a searching enquiry into the failure of the first investigation. It should have been carried out in late 1998 or early 1999. Instead, over a period of more than three years, they accepted DI Smith's own account and subjected it to no critical analysis whatsoever. 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. I am driven to the conclusion that, had it not been for the Shipman Inquiry, the GMP would never have made any more thorough enquiry into the matter than had been carried out by Det Supt Ellis. However, once DCS Stelfox had investigated, they accepted his conclusions without reservation. The gravity of their earlier failure to face up to the shortcomings of the first investigation is to some extent mitigated by that fact and by my recognition that the natural instinct of individuals and organisations is to seek to avoid criticism where possible.

Final Thoughts

51. I must and do feel sympathy for those few who have been found responsible for the failure of this investigation. They must live with that responsibility for the rest of their lives.

Although their predicament was of their own making, it should be recognised that it was their misfortune ever to be 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.

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