CHAPTER EIGHT

Raising Concerns about Shipman

Introduction

8.1 The scale of Shipman's crimes and the long period over which they were perpetrated suggest, at first sight, that his behaviour must inevitably have raised concerns and suspicions among those who worked closely with him. Surely such people as medical colleagues, other healthcare professionals and members of his practice staff must have realised that something was wrong and reported it? What about those lay people – friends, families and neighbours – who had been involved in the aftermath of the deaths? Previous inquiries that have investigated criminal or other wrongful conduct by an individual or organisation have often heard evidence about complaints which had been made or concerns which had been expressed over the years and had gone unheeded, as a result of which the offending conduct was permitted to continue without check.

8.2 Surprisingly, however, this Inquiry's investigations revealed no long history of complaints or concerns in Shipman's case. That they did not is an indication both of the high regard in which Shipman was generally held and of his extraordinary ability to lie his way convincingly out of the most compromising situations.

8.3 In this Chapter, I shall consider the position of Shipman's colleagues at the Donneybrook practice and examine whether they had any reason to suspect Shipman. The Inquiry has of course heard that, in 1998, a member of another practice, the late Dr Linda Reynolds, became suspicious about the number of deaths among Shipman's patients. She and her colleagues at the Brooke Practice in Hyde decided that she should report their concerns to the Coroner. That report initiated the abortive police investigation of March 1998 which I examined in my Second Report. There were a few other people who also had their suspicions about Shipman. In this Chapter, I shall describe how those suspicions developed and what, if anything, those who had concerns felt able to do about them. I shall deal separately with the position of the practice staff and health professionals who worked with Shipman at the Market Street Surgery in Chapter 9.

The Doctors at the Donneybrook Practice

8.4 I have already described, in Chapter 3, the circumstances in which Shipman came to join the Donneybrook practice in 1977. I have found that no criticism can be levelled against the members of the practice who appointed him, whether in relation to their initial decision to appoint or to the fact that, having been appointed, Shipman was not made the subject of any special supervision.

8.5 Nevertheless, Shipman was a member of the Donneybrook practice for almost 15 years. I have found that, during that time, he killed at least 71 patients. The question must arise as to whether his colleagues should have been alerted to the number and circumstances of the deaths of Shipman's patients or to any other unusual features of his practice.

8.6 The Inquiry heard evidence from Dr John Smith, Dr Geoffrey Bills, Dr Geoffrey Roberts, Dr Ian Napier and Dr Jeffery Moysey. Dr Derek Carroll and Dr William Bennett provided statements.

8.7 The way in which the Donneybrook practice was arranged, with each doctor (save for Dr Bills and Dr Carroll) operating a single list, meant that patients of one doctor would rarely be seen by the other doctors in the practice. It would happen only if the patient's usual doctor was on holiday, if the patient required treatment out of hours, if a consultation was required on the doctor's half day off or at times of illness and in other exceptional circumstances. Therefore, in general, members of the practice neither got to know patients registered with their colleagues, nor their medical histories. When a colleague's patient died, this would not have had the same impact on other members of the practice as if the care of that patient had been shared.

8.8 Moreover, there were no formal means by which members of the practice were informed about the deaths of patients registered with other members. They would have no involvement in the certification of the cause of death or the certification for the purposes of cremation. Each member had his own book of Medical Certificates of Cause of Death (MCCDs), so would not see how many MCCDs Shipman had issued. In general, other members of the practice would become aware of the death of one of Shipman's patients only if the practice staff talked about it or if Shipman specifically mentioned it.

8.9 Nor would members of the practice have any information about the total number of deaths among Shipman's patients or in the practice as a whole. I have found that the annual number of killings during Shipman's period at the Donneybrook practice was variable. I found that, in 1989, he killed 12 patients; in some years (1977, 1980, 1982 and 1991), he may not have killed at all. Certainly he was not killing with the same frequency as in his last years at the Market Street Surgery. Even if they had been aware that a death had occurred, Shipman's colleagues would not have known anything about the circumstances of the death (e.g. whether Shipman had been present or had visited shortly before) unless Shipman had volunteered this information. During Shipman's time at the practice, there was no process of reviewing deaths. An examination of Shipman's killings by the Inquiry revealed that few of the deaths were likely to have come to the attention of his colleagues. None of those cases would have given real cause for concern. None of the doctors remembered the death of Mrs Mary Hamer, which occurred in the surgery of the Donneybrook practice. I found that Shipman killed her. In the past, there had been other deaths at the surgery with which Shipman had not been involved. There was, therefore, no reason for Mrs Hamer's death to be regarded with particular suspicion.

8.10 None of Shipman's former colleagues at the Donneybrook practice had any concerns about the number or circumstances of deaths among Shipman's patients. No such concerns had been expressed to them by others. Dr Roberts, who covered Shipman's patients on his half days, said that he saw nothing odd in Shipman's medical records or his pattern of visiting. He was not aware that a number of patients had died in Shipman's presence. He said that, if he had known that, he would have been surprised. Dr Moysey, who covered Shipman's half days after Dr Roberts left the practice, saw nothing unusual in Shipman's records or prescribed treatments.

8.11 Dr Roberts regarded Shipman as hardworking and observed that he appeared to get on well with patients, colleagues and staff. He exhibited no unusual behaviour. Dr Smith recalled that Shipman had a good medical knowledge and always kept himself up to date.

Dr Napier observed that there were no concerns about Shipman's honesty or competence. He was well regarded by clinicians and proactive in disease prevention. His professional conduct 'seemed exemplary'. None of the doctors felt that Shipman had an especially isolated personality when at the Donneybrook practice.

8.12 There were a few negative comments about Shipman. Dr Moysey and Dr Napier observed that he was 'mercurial'. Dr Smith recalled that he sometimes fell out with the practice staff. Dr Bills felt that he was theatrical, as if always presenting an image. He felt that Shipman exaggerated the seriousness of his patients' illnesses so as to make more of an impression when he was able to 'cure' them. Dr Carroll agreed with this view. Dr Bills also noticed that Shipman was somewhat insensitive when speaking of patients who were terminally ill. He also said that Shipman impressed patients, who 'thought he was marvellous'. He commented that the social workers and health visitors with whom Shipman came into contact were more impressed with his prowess than were the district nurses who worked with him.

8.13 None of the doctors observed any sign of relapse by Shipman into his previous drug taking habits. Nor did they have any recollection of problems with Shipman's prescribing during his time at Donneybrook. In 1989, one of Shipman's colleagues, Dr William Bennett, suffered a coronary thrombosis in the surgery. Shipman administered an injection which Dr Bennett believed to contain 10mg morphine. Dr Bennett did not question where the morphine came from, nor did Dr Napier, who was told about the incident afterwards. They were just grateful that Shipman had taken the correct action. By then, it was 12 years or so since Shipman had joined the practice. It seems there had been no further discussion about the keeping of controlled drugs. If Dr Bennett and Dr Napier had thought about where Shipman had got the morphine for the injection (which they did not), they would no doubt have assumed that he was now keeping a small quantity of controlled drugs for emergencies. Those members of the practice who kept a stock of controlled drugs maintained their own controlled drugs registers (CDRs). There was no shared CDR and there would have been no reason for one member of the practice to inspect another member's CDR.

8.14 Most of his colleagues were surprised when Shipman announced his impending departure from the Donneybrook practice. Dr Napier believed that Shipman was frustrated at the slow pace of change within the practice. He took Shipman aside and pointed out the disadvantages of moving to single-handed practice.

Conclusions

8.15 It is not in my view surprising that Shipman's colleagues at the Donneybrook practice were unaware of his criminal activities and had no reason to suspect that his practice was in any way unusual. The structure of the practice meant that they knew little of each other's clinical activities. No concerns had been expressed to them about Shipman. There were no unusual features to attract their attention. Indeed, the information which they received about Shipman's practice was generally favourable. It is clear in my view that they had no suspicions at the time and I am satisfied that they cannot be criticised for that.

8.16 Dr Napier told the Inquiry that arrangements within the practice which had been introduced since Shipman's departure would make it more likely that behaviour such as his would be detected. The doctors now have shared lists. The fact that the care of patients is shared leads to discussion between the doctors about diagnosis and treatment. They are more likely to notice if a patient dies unexpectedly. They share one book of MCCDs, which is open to inspection by all. The medical records are computerised and of better quality. Members of the practice have meetings at which they review significant events (including deaths) and perform risk assessments. Similar developments have taken place in many other practices over the same period. Later in this Report, I shall discuss the effect of such changes.

The Concerns of Mrs Christine Simpson

8.17 Mrs Christine Simpson was the resident manager of Ogden Court from about 1987 until 2002. Her husband, Mr Alan (sometimes known as Sam) Simpson worked as a gardener and cleaner at Ogden Court and at other similar properties in the area.

Ogden Court

8.18 Ogden Court was one of a large number of properties owned by the Manchester and District Housing Association (the Housing Association). Ogden Court was a sheltered housing development (or sheltered housing 'scheme'), providing 42 flats for rent, together with various communal facilities for the use of residents. Most of the residents of Ogden Court were elderly. Some were entirely independent, while others received a high level of care provided by Social Services or members of their family. All residents had access to a 24 hour emergency call facility.

Mrs Simpson's Duties

8.19 Mrs Simpson lived in a flat on the ground floor of the main building at Ogden Court. Her role was that of a 'good neighbour' to the residents of Ogden Court. She was required to make a daily check on their welfare and to liaise with the Housing Association in order to ensure that any necessary works of maintenance, repair and adaptation were carried out. She was also responsible for facilitating the residents' access to professional care from agencies such as Social Services, for ensuring that the premises were kept safe and for organising regular social activities for the residents. Her husband told the Inquiry that she formed close relationships with the residents, who were happy to confide their problems and worries to her.

The Management of Ogden Court

8.20 The primary function of the Housing Association in relation to Ogden Court was as landlord with responsibility for the allocation and letting of the flats, the collection of rents, the arranging of necessary works of maintenance, repair and adaptation, the resolution of disputes between tenants and other matters of that kind.

8.21 From 1985 until her retirement in March 2003, Mrs Janet Schofield worked for the Housing Association as a housing officer. Until 1993, she was employed full-time; thereafter she worked part-time only. She had responsibility for Ogden Court for various periods between 1987 and 2001. She could not remember precisely when those periods were, as her duties changed frequently. For part of this time, she had a job share arrangement so that responsibility for Ogden Court was shared between herself and another member of staff. For a period from April 1996, Mrs Schofield alone assumed responsibility for dealing with Ogden Court. Documents in the possession of the Inquiry would suggest that Mrs Schofield's active involvement with Ogden Court may have ceased in late 1998/early 1999.

8.22 Mrs Schofield managed about 800–1000 residential units on behalf of the Housing Association. She held monthly liaison meetings with the resident managers of all the sheltered housing schemes for which she had responsibility. Discussions at her meetings with Mrs Simpson centred on issues relating to the fabric of the premises at Ogden Court and to Mrs Simpson's employment. In addition, there would be discussions about the dependency levels of individual residents and the extent to which they might require additional care from Social Services or transfer to alternative accommodation such as a residential care home. Recent deaths were noted, and forthcoming and existing vacancies ('voids') discussed. Minutes of liaison meetings were kept by Mrs Schofield and forwarded to Mrs Simpson. The Inquiry has seen the minutes of meetings between Mrs Schofield and Mrs Simpson which took place between December 1996 and May 1998. The minutes of earlier meetings are no longer available. In addition to visiting Ogden Court for meetings, Mrs Schofield would visit two or three times a month in order to see residents.

8.23 Between meetings, there was frequent telephone contact between Mrs Simpson, Mrs Schofield and other staff at the Housing Association, in the course of which Mrs Simpson would report day-to-day problems as they arose. She would report the deaths of residents as they occurred, since these would give rise to voids.

Deaths at Ogden Court

8.24 The Inquiry has found that nine residents of Ogden Court were killed by Shipman. They were:

Mrs Alice Prestwich, who died, aged 69, on 20th October 1988
Mr John Charlton, who died, aged 81, on 16th October 1989
Mrs Alice Kennedy, who died, aged 88, on 9th January 1995
Mrs Muriel Ward, who died, aged 87, on 24th October 1995
Mrs Gladys Saunders, who died, aged 82, on 17th June 1996
Mr Samuel Mills, who died, aged 89, on 23rd November 1996
Mrs Betty Royston, who died, aged 70, on 4th February 1997
Mr James King, who died, aged 83, on 24th December 1997
Miss Maureen Ward, who died, aged 57, on 18th February 1998.

8.25 Mrs Simpson co-operated fully with Phase One of the Inquiry, providing a number of statements in connection with the various deaths. She has been unwell for some time and

retired from work in 2002 on health grounds. After she was requested to give evidence in Phase Two, the Inquiry received medical evidence to the effect that attendance at the Inquiry would be detrimental to her health. In those circumstances, she was not required to attend to give evidence. She did provide a detailed witness statement, however, setting out her recollection of the events surrounding the deaths and her developing suspicions of Shipman's involvement in them.

Mrs Alice Prestwich

8.26 The first death, that of Mrs Prestwich, occurred on 20th October 1988. Mrs Prestwich had requested a visit from Shipman because her legs (Mrs Simpson recalled it was her knees) were swollen and painful. Shipman summoned Mrs Simpson and told her that Mrs Prestwich had died a few minutes earlier, while he was examining her. Despite the suddenness of the death, Mrs Simpson said she had no suspicions about it. She did, however, regard Shipman's attitude to the death as flippant, casual and inappropriate to the circumstances.

Mr John Charlton

8.27 Mr Charlton's death occurred a year later on 16th October 1989. Shipman, who had visited Mr Charlton unannounced (probably in response to an informal request for a visit made by his family through the Donneybrook practice nurse), called at Mrs Simpson's flat and said he needed to telephone for an ambulance to take Mr Charlton, who was very ill, to hospital. Shipman asked Mrs Simpson to go to Mr Charlton's flat. There, she found Mr Charlton lying flat on his back on his bed. He was dead. Mrs Simpson said she found it strange that Mr Charlton should have died in that position. He had been experiencing breathing problems and had taken to sleeping in a reclining chair rather than in bed. She was not convinced that Mr Charlton had died a natural death and wondered whether Shipman might have assisted in it in some way, by arrangement with Mr Charlton.

Mrs Alice Kennedy

8.28 More than five years then passed before the death of Mrs Kennedy on 9th January 1995. Shipman called on her, apparently unannounced. He later telephoned Mrs Kennedy's daughter, Mrs Patricia Higgins, to express concern that Mrs Kennedy did not seem well. When Mrs Higgins visited her mother later in the day, she found Mrs Kennedy dead in her chair. Mrs Kennedy had suffered from Parkinson's disease and was quite frail. Mrs Simpson said that she did not find the fact of the death suspicious in itself. It was the knowledge that Shipman had been present shortly before the death was discovered which made her suspect that he might have been responsible for it.

8.29 Mrs Simpson said that, by this time, it had also become clear to her that the deaths of Shipman's patients followed a different pattern from those of other residents at Ogden Court. Usually, deaths were preceded by a period of decline, with a gradual loss of independence and a need for a greater degree of care from Social Services and/or family members. In most cases, death would occur in hospital. On those occasions when a resident died at Ogden Court, it would be known beforehand that death was imminent. By

contrast, Shipman's patients died suddenly and at a time when he was, or had recently been, in physical proximity to them.

Mrs Muriel Ward

8.30 Mrs Ward died on 24th October 1995. She had fallen and fractured her hip two months previously and had suffered a deep vein thrombosis while recovering in hospital. At the time of her death, she was back at home and making good progress. Shipman visited her to take a blood sample just as her daughter, Miss Maureen Ward, was leaving for the shops. When she returned about half an hour later, she found her mother dead in her chair. Mrs Simpson said that it was once again the fact that Shipman had visited Mrs Ward so recently before the discovery of her death that caused her to suspect that the death had not been natural.

Mrs Gladys Saunders

8.31 Mrs Saunders died about eight months later on 17th June 1996. She had been discharged from hospital ten days before she died, following an episode of diverticular disease. She appeared to Mrs Simpson to be in good health and spirits, although she had complained to others about weakness and 'flutters' in her heart. She had asked Shipman to make a home visit. He did so and later called on Mrs Simpson and informed her that Mrs Saunders was dying. Mrs Simpson accompanied Shipman to Mrs Saunders' flat. She believed that Mrs Saunders took her last breath just as they arrived. Mrs Simpson said that she was convinced at the time that Shipman had killed Mrs Saunders.

Mr Samuel Mills

8.32 On 23rd November 1996, Mr Mills died. Mrs Simpson was not at Ogden Court at the time. Mr Mills was suffering from cancer of the prostate and had become very frail. On the morning of his death (a Saturday), he felt unwell and asked Mr Simpson (in Mrs Simpson's absence) to request a visit from Shipman. Shipman duly visited and, while with Mr Mills, he summoned the mobile warden service used by Ogden Court when Mrs Simpson was unavailable, saying that Mr Mills was dying. The warden arrived to find Mr Mills lying on the floor, obviously dying. Shortly afterwards, Shipman appeared and pronounced him dead. Mrs Simpson arrived back a little later and made contact with members of Mr Mills' family. She said that the position in which Mr Mills was lying did not appear natural, causing her to believe that Shipman was once again responsible for the death.

Mrs Betty Royston

8.33 The circumstances in which the death of Mrs Royston was discovered, on 5th February 1997, caused Mrs Simpson's suspicions to be aroused yet again. She discovered Mrs Royston dead that morning. Mrs Royston was lying neatly on the floor. Her spectacles (which she always wore) were on the back of the settee. Shipman had, at the request of Mrs Royston's son, Mr Alan Royston, visited Mrs Royston the day before. On discovering the death, Mrs Simpson telephoned Shipman's surgery. Shipman was not immediately available so Mrs Simpson left a message with a receptionist. She then telephoned the

police to report the death. This was the usual policy when a death was sudden and the deceased person's general practitioner (GP) was not available. Police records show that the call was made at 8.39am. The message received was:

> **'MRS BETTY ROYSTON, HAS BEEN FOUND ON THE LIVING ROOM FLOOR BY WARDEN. APPEARS TO HAVE BEEN THERE ALL NIGHT. PLEASE ATTEND WARDEN'S OFFICE.'**

Mrs Simpson said she thought the police would investigate the death and Shipman would finally be caught out.

8.34 However, before the police arrived, Shipman appeared. He was cross when Mrs Simpson told him that she had summoned the police. He went with her to see Mrs Royston, felt for Mrs Royston's pulse, confirmed that she was dead and told Mrs Simpson that he would be able to issue a death certificate as he had seen Mrs Royston the previous evening. He then left, having been present for only a short time. In her statement to the Inquiry, Mrs Simpson said that the police never came. She believed that Shipman must have telephoned them and told them that their attendance was not necessary. She said that she did not feel able to contact the police again and tell them that she disagreed with Shipman.

8.35 In fact, Mrs Simpson's recollection was at fault there. Police records show that Police Constable (PC) Donna Jones attended Ogden Court with a colleague, arriving at 8.58am. In a statement made in January 1999, PC Jones said that she spoke to Mrs Simpson. At 9am she sent a message to the police Area Operations Room, saying that it would appear that Mrs Royston's GP, Shipman, would issue a death certificate. That information must have come from Mrs Simpson, who had only just received it from Shipman himself. The police then attempted to contact Shipman at his surgery. He was with a patient at the time but subsequently a receptionist confirmed that he would be issuing a death certificate. The police left Ogden Court shortly afterwards.

8.36 It seems that, on this occasion, Mrs Simpson was presented with an opportunity to voice her concerns about Mrs Royston's death to the police in Shipman's absence. It may be that she lacked the confidence to do so in the face of Shipman's assertion that he would sign a death certificate. She may have been taken aback by the police's ready acceptance that a death certificate was to be issued and that no investigation was therefore necessary.

8.37 Another possible explanation for Mrs Simpson's failure to voice her concerns to the police on this occasion would be that those concerns were not as great as she now believes them to have been. However, a conversation which she had with Mrs Royston's son supports her assertion that she was indeed suspicious of Shipman at the time. Mrs Simpson said that when Mr Royston arrived at his mother's flat, he was immediately suspicious and expressed the view that there was **'something not right'** about the death. She described how she did not disagree with his suggestion. She believed that he was going to tackle Shipman. She felt it appropriate that, as Mrs Royston's son, he should be the one to take the matter further.

8.38 Mr Royston has given two statements to the Inquiry. His wife has also provided a statement. Mr Royston confirmed that a number of features about the death – including his

mother's position and that of her spectacles – struck him as odd. He began to wonder if Mrs Royston had died in Shipman's presence and if Shipman had left her because he did not want to deal with the aftermath of the death. Mr Royston recalled having a conversation with Mrs Simpson. He believed that this took place some days after his mother's death rather than on the day itself, as Mrs Simpson suggests. He asked Mrs Simpson (in what he called a **'tongue and cheek way'**) whether Shipman could have **'bumped off'** his mother and whether Mrs Simpson thought Shipman might be a **'serial granny killer'**. He said that Mrs Simpson's face changed and she told him that several people had died after Shipman had been to visit them. She also said that she had discussed the matter with her husband but felt that no one would believe her if she said anything to anyone else. Her remarks caused Mr Royston to wonder whether Shipman had killed Mrs Royston. He talked the matter over with work colleagues and members of his family. They could not believe that Shipman had killed Mrs Royston. Although Mr Royston continued to have lingering concerns about the circumstances of the death, he did not seriously consider telling anyone in authority about those concerns until he heard that Shipman was under investigation. He contacted the police shortly afterwards, on 21st August 1998.

Mr James King

8.39 Mr King died on Christmas Eve 1997. Mrs Simpson said that, despite his age, he was in good general health. On the day of his death, however, he had complained of feeling **'woozy'**, by which she understood that he was experiencing dizzy spells. She did not think anything was seriously wrong. Mr King told her that he had asked Shipman to visit. This was very unusual for him. Shipman visited in response to Mr King's request. Shortly afterwards, Mr King's daughter found him dead in his chair. The suddenness of Mr King's death, and the fact that it occurred so soon after a visit from Shipman, caused Mrs Simpson to believe that Shipman had killed again.

Miss Maureen Ward

8.40 On 18th February 1998, Shipman called at Mrs Simpson's flat and told her that he had found Miss Maureen Ward (the daughter of Mrs Muriel Ward) dead. Miss Ward was only 57 years old and had stayed on at Ogden Court after her mother's death. She had previously undergone treatment for cancer but, immediately before her death, had appeared well. She was planning a holiday and looking forward to moving house in the near future. It was evident to Mrs Simpson, when she accompanied Shipman to Miss Ward's flat, that Miss Ward had been engaged upon her usual daily activities until something had interrupted her. Mrs Simpson was shocked at Miss Ward's death and told Shipman so. He informed her that Miss Ward had been suffering from a brain tumour which had caused her death. Mrs Simpson could not believe that Miss Ward would have been planning so enthusiastically for the future if she had believed that she did not have long to live. Once again, she believed that Shipman was responsible for the death.

Mr Simpson's Evidence

8.41 Mr Simpson gave oral evidence to the Inquiry. He confirmed that his wife had come to believe that Shipman was killing his patients. At first, she had discussed with him the

possibility that Shipman might have an arrangement with his patients to assist them to die when their quality of life became poor. At some time, however, she had ceased to believe that the patients had acquiesced in their deaths. Mr Simpson could not remember when this change of mind occurred. He did recall that, when Mrs Saunders died in June 1996, Mrs Simpson could not believe that she would have wanted to take her own life. Mr Simpson himself recognised the close association between Shipman's visits and the deaths. He believed that they might have occurred with the patients' consent. He told the Inquiry that he just could not accept that Shipman could be killing his patients without their consent, as there appeared to be no reason for him to do so. He was unsuccessful in persuading Mrs Simpson to share his view. Gradually, over a period of time, she became depressed. At the time, she blamed other problems for her depression. In retrospect, however, Mr Simpson believes that her concerns about the deaths of Shipman's patients were a significant factor.

The Communication of Concerns to Third Parties

8.42 Mrs Simpson and her husband described two occasions (in addition to the conversation with Mr Royston which I have already described) when she voiced her concerns to persons outside her immediate family. On one such occasion, she spoke of her suspicions to a respected friend of many years' standing. The friend worked in a medical practice and was a patient of Shipman. She advised Mrs Simpson to say nothing about her suspicions because people would say she **'was mad'**.

8.43 The other person in whom Mrs Simpson claimed to have confided was Mrs Schofield. She says that she raised her concerns at the end of one of her regular liaison meetings with Mrs Schofield. Mr Simpson remembered it being decided that his wife should tell 'management' of her concerns about the deaths. He did not recall when this was. Mrs Simpson herself believed that she spoke to Mrs Schofield after the death of Mrs Ward, i.e. some time after 24th October 1995. That would have been about three years before Shipman's eventual arrest. Mr Simpson thought that the timing sounded about right. He did not know precisely what was said but would have expected Mrs Simpson to give a clear account of her suspicions and of the events that had given rise to them.

8.44 In her witness statement, Mrs Simpson related how she could not bring herself to say that she suspected that Shipman was murdering people. She thought that she mentioned Shipman by name and told Mrs Schofield that:

> **'... there had been a number of deaths where the circumstances of the deaths had been odd and I was suspicious and concerned. I expressed my concern in general rather than specific terms. I said that patients were dying after visits from the doctor and that other people had started to talk about it as well.'**

According to her husband, Mrs Simpson was hoping to obtain some guidance as to what to do or an assurance that Mrs Schofield would assume responsibility for taking her concerns forward. Instead, Mrs Schofield gave no reaction and asked no questions. She made no suggestion as to what Mrs Simpson could or should do. Mrs Simpson had the impression that Mrs Schofield was not taking her seriously. In a sense, she appears to

have found Mrs Schofield's lack of response reassuring, at least in the short term. However, she said that, when Mrs Saunders died the following June, she ceased to feel reassured and felt that she had been right to be suspicious.

8.45 Mrs Simpson recalled that Mrs Schofield made some notes about her concerns but that, when she received the minutes of the relevant meeting, she does not remember seeing any reference to them. As I have already said, minutes of meetings from this period are no longer available. Even if they were, I would not find it surprising that such a sensitive matter was not recorded. I can also understand why Mrs Simpson would not necessarily have pressed for them to be recorded subsequently. She would not have wanted her concerns to be seen by others at the Housing Association, particularly if, by then, she had been to some extent reassured by Mrs Schofield's attitude and believed that her suspicions might be unfounded.

8.46 Mrs Simpson said that she did not think that she mentioned her concerns again to Mrs Schofield. Mrs Schofield never referred to the topic. Mrs Simpson did not know what else to do. She considered consulting a solicitor but did not think she would be taken seriously since she had no direct evidence to support such a serious allegation. So far as she was aware, no one shared her concerns. She was worried about being proved wrong. She was of course aware of the good reputation that Shipman enjoyed among his patients and the wider community.

8.47 On 14th October 1998, Mrs Simpson gave a statement to the police about the death of Mrs Royston. She told the interviewing officer that Shipman had been involved in nine deaths at Ogden Court and supplied details. On 21st October 1998, she was interviewed in connection with those deaths and described to the police her developing suspicions.

Mrs Schofield's Evidence

8.48 Mrs Schofield gave oral evidence. She denied that Mrs Simpson expressed concerns to her at any stage about the deaths of Shipman's patients. She told the Inquiry that, if Mrs Simpson had done so, she would have reported the matter to her superiors. She thought that, if Mrs Simpson had had concerns, she would have expressed them clearly and directly and that, if those concerns had not been acted on, she would have pursued them. Mrs Schofield was adamant that this was never done. She had no recollection of any concern being raised about the death of Mrs Ward. She says she would have remembered this, because she had had previous dealings with the Wards and knew them.

8.49 Mrs Schofield gave three statements to the Inquiry. In the first two, she said that she did recall Mrs Simpson referring to Shipman as 'Dr Death' on a few occasions over the years she had worked with her. She said that, on at least some of those occasions, Mrs Simpson had linked the mention of a visit from 'Dr Death' with the occurrence of a void. The implication was that a void had been or would be caused by a death following a visit from Shipman. Mrs Schofield said that she did not take these comments seriously. She just thought that deaths were inevitable among elderly people.

8.50 When making her third statement, signed only three days before she attended to give evidence, Mrs Schofield changed her evidence somewhat. She said that the phrase

'Dr Death' was not used by Mrs Simpson to describe any specific individual. Mrs Schofield suggested that the term was used generally when speaking of a void caused by a death. She said that she had heard other people speak about Shipman as 'Dr Death', but only after Shipman was known to be under investigation, i.e. after mid-August 1998.

8.51 Mrs Schofield's oral evidence about these references was very confused. At times, she suggested that she did recall Mrs Simpson using the name 'Dr Death' in connection with Shipman. However, she said that she believed this was after Shipman came under investigation in 1998. It is not clear when this would have been, as Mrs Simpson stopped working some time before July 1998 and does not appear to have returned until about October. (Her precise dates of absence cannot be ascertained.) At other times, Mrs Schofield suggested that Mrs Simpson might have used the name 'Dr Death' just to indicate that a death had occurred. She made the point that the words which she was trying to recall were spoken several years ago so her recollection was hazy.

8.52 In the course of her oral evidence, Mrs Schofield said that, after Shipman's arrest, the police had telephoned her to ask whether it was true that people used to call Shipman 'Dr Death'. She said that she had told them, 'That's true, they did.' She explained that she thought she said this because, by that time, the name 'Dr Death' was being used to describe Shipman by people in Hyde and by the newspapers. That explanation was, of course, unsatisfactory since the purpose of the police enquiry would plainly have been to find out what was being said before the investigations into Shipman started, not afterwards.

8.53 In the event, however, the purpose and nature of the police enquiry were quite different from that suggested by Mrs Schofield. After she had given evidence, the Inquiry obtained the police record of a telephone conversation which took place on 15th February 1999. A police officer had been tasked to contact Mrs Schofield in order to investigate Mrs Simpson's assertion, made in a police statement dated 21st October 1998, that she had spoken to Mrs Schofield about her suspicions at about the time of Mrs Ward's death. The record states:

> **'... ON MONDAY 15TH FEBRUARY 1999 AT 3PM I SPOKE TO JANET SCHOFIELD WHO IS A HOUSING OFFICER WITH MANCHESTER AND DISTRICT HOUSING OFFICE ... MRS SCHOFIELD STATED THAT SHE DID NOT FEEL CONFIDENT ENOUGH TO MAKE A STATEMENT IN REGARDS TO ANY CONVERSATION THAT SHE HAD HAD WITH N762 SIMPSON RE THE DEATH OF MURIAL** (*sic*) **WARD AS SHE COULD NOT REMEMBER IF ONE ACTUALLY TOOK PLACE, SHE DOES HOWEVER STATE THAT ON SEVERAL OCCASIONS COMMENTS WERE MADE BY CHRISTINE SIMPSON IN REGARDS TO THE NUMBER OF DEATHS THAT WERE OCCURRING AT OGDEN COURT WHILST DR SHIPMAN WAS PRESENT. MRS SCHOFIELD CANNOT BE ANYMORE SPECIFIC IN REGARDS TO THE CONTENTS OF THESE COMMENTS OR THE TIMES AND DATES THEY WERE MADE, THUS A STATEMENT HAS NOT BEEN TAKEN FROM HER AT THIS TIME.'**

Mrs Schofield was offered an opportunity to comment on the record but chose not to do so. The contents of this record make it clear that Mrs Simpson did make comments linking Shipman's presence at Ogden Court with deaths that had occurred there. It also makes clear that those comments were made, not once, but on several occasions.

Conclusions

8.54 Mrs Schofield was an experienced housing officer and I have no reason to doubt that she fulfilled her duties in a conscientious and professional manner. She acknowledged that she was not a curious or enquiring person. Indeed, she came across as a somewhat detached and distant character. It was perhaps significant that, despite her close connections with Ogden Court over a period of years, she had never sought to find out how many residents there were killed by Shipman, and took no interest in Shipman's trial. One of the counts of which Shipman was convicted related to Miss Ward, who was known to Mrs Schofield. In oral evidence, she observed, 'quite honestly, it wasn't of ... interest to me'.

8.55 Although I have not seen Mrs Simpson, it is plain from the evidence I have heard and read that she was a very different character. Mrs Schofield herself acknowledged that Mrs Simpson made an excellent job of managing Ogden Court. She was competent, capable, professional and committed to the welfare of 'her' residents. Her determination to achieve the best for them led on occasion to tension between herself and her employers.

8.56 Mrs Schofield's perception was that Mrs Simpson was a somewhat difficult personality, with a negative attitude to authority in general and to her employers in particular. This view was plainly shared by another officer of the Housing Association, who referred in his report of an appraisal conducted in December 1994 to Mrs Simpson's **'confrontational approach'**. Other documents record her feelings of isolation and her complaint that she did not receive adequate support from the Housing Association, together with her belief that her employers regarded their sheltered housing schemes **'more or less just as other properties and tenants'**. It is also clear that she became frustrated at the lack of continuity in the housing officers with whom she had to deal. These factors no doubt presented greater challenges to Mrs Schofield when dealing with Mrs Simpson than she encountered in her dealings with other resident managers.

8.57 In addition, it seems that Mrs Simpson exhibited signs of stress and anxiety, certainly in the years leading up to 1998, when she suffered a 'breakdown' and was off work for several months. She had a number of problems, some of which she discussed with Mrs Schofield at their monthly meetings. One was the fact that she lived on site at Ogden Court, with a consequent lack of privacy and constant responsibility for the residents. She and Mrs Schofield discussed the possibility of her acquiring a property elsewhere to which she could escape at weekends. They also discussed practical ways of combating her feelings of isolation.

8.58 In evidence, Mrs Schofield described Mrs Simpson in somewhat unsympathetic terms. She said she was a 'complex personality' with a 'strange way of looking at things'. She was 'obsessed with death' – her own and those of residents. She was said to be 'preoccupied with death ... it almost became a fixation with her'. In short, Mrs Schofield believed

Mrs Simpson to be a difficult and somewhat hysterical personality. I am satisfied that that belief (whether justified or not) would have coloured Mrs Schofield's view of anything Mrs Simpson reported to her. Indeed, in her second statement to the Inquiry, Mrs Schofield herself observed:

> **'... I think it is fair to say that because Christine was so negative and could get a bee in her bonnet about lots of things, I did often take what she told me with a grain of sand. Christine's negativity appeared to be often directed at authority figures and I think I would have regarded her comments about Shipman with that in mind.'**

8.59 I am entirely satisfied that, despite the inaccuracy of her recollection of the circumstances surrounding Mrs Royston's death, the essential features of Mrs Simpson's evidence are both true and accurate. I accept that she did develop suspicions about Shipman and that, on at least one occasion, she voiced them to Mrs Schofield. Whether she did so as early as October 1995 is, in my view, less certain. It may be that it was after the death of Mrs Saunders that Mrs Simpson became really concerned about the possibility of murder. It may have been then that she decided to speak to Mrs Schofield. In any event, I am satisfied that they first spoke about the matter in 1995 or 1996.

8.60 Both Mrs Schofield and Mr Simpson expressed the view in evidence that, if Mrs Simpson had voiced concerns to Mrs Schofield, she would have been likely to do so in a clear and direct manner. That would have been typical of her usual approach. However, Mrs Simpson herself said that she could not bring herself to do so. She said that she expressed her concerns in general, rather than specific, terms. I am satisfied, however, that, when speaking to Mrs Schofield, she linked the deaths with visits by Shipman and that she gave what she believed to be a clear indication of her concern that all was not as it should be.

8.61 In my view, Mrs Simpson's uncharacteristically oblique approach was not recognised by Mrs Schofield as a concern upon which she was expected to act. I say this for two reasons. First, I am satisfied that it would have required a clear and unequivocal statement that Shipman might have harmed a specific resident before Mrs Schofield would have recognised that she had a duty to act. If more general concerns were expressed, I do not think that she would have encouraged Mrs Simpson to elaborate further. She would not have questioned Mrs Simpson as to what might lie behind a more oblique statement and have attempted to draw from her the real cause of her concerns. Such an approach would not have accorded with Mrs Schofield's personality. Second, I am confident that Mrs Schofield would have dismissed Mrs Simpson's concerns, if expressed generally, as part of the latter's morbid fixation with death. It may, of course, be that Mrs Simpson's fears about the deaths of Shipman's patients lay at the root of her expressions of concern about death generally, but Mrs Schofield would not have realised that. She would no doubt have dismissed Mrs Simpson's concerns as another of her 'strange' ideas. Even if Mrs Simpson had stated her fears directly and clearly, it is possible that Mrs Schofield would have dismissed them as a manifestation of Mrs Simpson's personality. However, if they had been voiced obliquely, it would have been far easier for her to do so.

8.62 While Mrs Simpson did not bring up her concerns again in any 'formal' manner, I am satisfied that she referred to them in conversation with Mrs Schofield by means of comments linking Shipman's name with deaths at Ogden Court. She probably used the name 'Dr Death' to describe Shipman on occasion. Again, given her views about Mrs Simpson and the fact that the latter had other concerns and problems of which she also spoke, it is not in my view surprising that Mrs Schofield did not regard these continuing references as being significant. Nevertheless, I am satisfied that they were made and that they indicated a continuing and growing concern on Mrs Simpson's part.

8.63 Mrs Schofield pointed to a number of routes within the Housing Association and the local authority by which Mrs Simpson might have taken her concerns further if she had been dissatisfied that no action had been taken by Mrs Schofield herself. I can well understand why Mrs Simpson would have regarded it as inappropriate to raise such serious concerns in any of these ways. It is in my view natural that she should have preferred to mention the topic to her line manager, whom she had known for some time, in a 'low key' way at the end of an informal meeting. I think she was in effect 'testing the water' to see what reaction she got. She was also no doubt hoping that Mrs Schofield would enquire further into her concerns and pass them on for investigation. When she met with no discernible reaction, she lost confidence and felt unable to mention them again, other than by oblique references. The fact that Mrs Simpson did not pursue her concerns by any of the routes suggested by Mrs Schofield does not, to my mind, in any way suggest that she did not express her concerns to Mrs Schofield in the first place. I am satisfied that she did and also that, in view of Mrs Schofield's reaction, her actions were entirely understandable. Mrs Simpson cannot be blamed for not having taken her concerns any further.

8.64 Should Mrs Schofield be criticised for her failure to recognise that Mrs Simpson was trying to convey to her a real concern that Shipman might be killing his patients? In order to judge this fairly, I must put from my mind the unattractive features of Mrs Schofield's evidence to the Inquiry. It is unfortunate, in my view, that Mrs Schofield sought to deny that Mrs Simpson had ever raised concerns about Shipman and particularly unattractive that, in oral evidence, she should seek to put a different construction on words she had used quite unequivocally in her written statements. However, her lack of frankness to the Inquiry, unattractive though it is, must not affect my judgement as to her failure to respond to Mrs Simpson's concerns at the time.

8.65 In my view, a manager in Mrs Schofield's position should have been alert to the kind of oblique message of concern that Mrs Simpson tried to convey to her and should have taken any such concerns seriously. If, after discussion, it appeared that there was any possibility that the concerns might be well founded, the manager should have taken them forward.

8.66 Mrs Schofield did not realise that Mrs Simpson was trying to raise a concern with her. I have said that Mrs Schofield is not a very curious person. I think also that she did not particularly like Mrs Simpson. She found her difficult to deal with and did not fully recognise her undoubted commitment to the welfare of the elderly people for whom she had some responsibility. I think Mrs Schofield's attitude towards Mrs Simpson inhibited her willingness or ability to listen carefully to what Mrs Simpson was telling her and to think

about its implications. I think Mrs Schofield was dismissive of Mrs Simpson's 'message' and attributed it to an obsession with death. However, the concerns which Mrs Simpson was trying to raise were quite extraordinary and would probably have seemed to many to be preposterous. The friend to whom Mrs Simpson voiced her concerns advised her not to mention them to anyone else because people would say she was 'mad'. The friend was perceptive; Mrs Schofield attributed Mrs Simpson's concerns to an obsession with death. Today, we know that Shipman was a killer and that concerns about him were well founded; before his crimes were uncovered, any suspicion of him was, to many, virtually unthinkable.

8.67 My criticism of Mrs Schofield is muted. She did not listen carefully to Mrs Simpson's attempts to raise her concerns. That was due in part to her own personality and her attitude towards Mrs Simpson. But I think also that her attitude was understandably affected by the belief that any suggestion that a doctor might be harming his patients was unthinkable.

The Concerns of Mr John Shaw

8.68 Mr John Shaw was a self-employed taxi driver in Hyde for about ten years beginning in 1988. Most of his working life had been spent in engineering, although, as a young man, he had served for two short periods in the police force. Mr Shaw gave oral evidence to the Inquiry.

8.69 In August 1998, following press coverage of the fact that Shipman was under investigation by the police for forgery of a patient's will, Mr Shaw contacted the police and expressed concern about the deaths of 21 people (most of them former customers of his) whom he believed to have been patients of Shipman. I have found that Shipman killed 19 of the 21 people identified by Mr Shaw, namely:

Mrs Rene Sparkes, who died, aged 72, on 7th October 1992
Miss Joan Harding, who died, aged 82, on 4th January 1994
Mrs Maria West, who died, aged 81, on 6th March 1995
Mrs Netta Ashcroft, who died, aged 71, on 7th March 1995
Mrs Ada Hilton, who died, aged 88, on 12th July 1995
Mrs Muriel Ward, who died, aged 87, on 24th October 1995
Mr Sidney Smith, who died, aged 76, on 30th August 1996
Mrs Millicent Garside, who died, aged 76, on 23rd October 1996
Mr Thomas Cheetham, who died, aged 78, on 4th December 1996
Mr Kenneth Smith, who died, aged 73, on 17th December 1996
Mrs Irene Brooder, who died, aged 76, on 20th January 1997
Mrs Lizzie Adams, who died, aged 77, on 28th February 1997
Mrs Elsie Cheetham, who died, aged 76, on 25th April 1997
Miss Lena Slater, who died, aged 68, on 2nd May 1997
Mrs Florence Lewis, who died, aged 79, on 10th November 1997
Mrs Norah Nuttall, who died, aged 64, on 26th January 1998
Miss Maureen Ward, who died, aged 57, on 18th February 1998
Mrs Margaret Waldron, who died, aged 65, on 6th March 1998
Miss Ada Warburton, who died, aged 77, on 20th March 1998.

The other two persons identified by Mr Shaw were not, in fact, patients of Shipman and he was not implicated in their deaths.

8.70 Many of Mr Shaw's customers were elderly people who had regular bookings with him. Some travelled with him so frequently that they became personal friends of his. When one of his customers died, Mr Shaw would usually hear about the death from a relative of the customer, who would telephone and tell him why he need not pick up the customer any more. Often, he would be told something about the circumstances of the death. As time went on, he began to notice that a pattern was developing. The common factor in each case was that Shipman had been the dead person's GP. Mr Shaw told the Inquiry:

> **'I couldn't believe what my suspicions were. My suspicions were so fantastic that I just couldn't ... I couldn't grasp what was going on in my own mind.'**

He began to make a point, when he was told about a death, of asking who the deceased's GP had been. He had a card index system of customers and, in it, he began to note down details of the deaths about which he had suspicions.

8.71 Mr Shaw said that the suspicions of which he spoke arose first following the death of Mrs Ashcroft in March 1995. By that time, four of his customers who had been patients of Shipman had died and he had begun to suspect that Shipman might have killed them. In October 1996, another of his customers, Mrs Garside, died. A relative told Mr Shaw that Shipman had given her an injection before her death. By this time, Mr Shaw's concerns were so great that he wanted to inform Mrs Garside's relatives, whom he knew, of his belief that Shipman had murdered her. However, he felt unable to say anything.

8.72 Mr Shaw explained that he did not say anything about his concerns because he was beginning to question his own mental state. He felt that, if he did speak, nobody would believe him and others might also question his mental state. He feared being wrong and that this could lead to him being sued for libel and losing everything he had. His wife too was fearful of the consequences if he spoke out and were proved wrong.

8.73 Another factor was the respect in which Shipman was held in the local community, and his popularity. On one occasion, Mr Shaw warned a customer who was planning to visit Shipman not to go alone. He told the Inquiry that he received a sharp rebuff and was told he was 'paranoid'. The customer concerned dropped him 'like a hot potato' and did not book him again. Such was Shipman's popularity that patients were clamouring to get onto his list. Mr Shaw also pointed out that other people who knew about the deaths did not appear to share his suspicions.

8.74 Mr Shaw felt unable to go to the police with his concerns because he had no direct evidence about the deaths, only hearsay accounts. Moreover, these were often not even firsthand hearsay accounts, but secondhand or even thirdhand. He considered going to the General Medical Council whom he understood to have some responsibility for doctors. However, he had no confidence that his concerns would be taken seriously. He did not know of any other organisation which had responsibility for monitoring or controlling GPs. Even if he had known of the role of the Health Authority, he would not have felt able to approach it as he would have assumed that (like other professions) the medical profession

would have 'closed ranks' in the face of a complaint from outside. Mr Shaw felt he had nowhere to go with his concerns.

8.75 When asked what might have persuaded him to come forward, Mr Shaw said that he would have felt able to report his concerns only to an unbiased and independent organisation that had no connection with the medical profession and dealt with reports from people with concerns and with matters relating to sudden, unexplained deaths. He said that he would have felt able to approach an organisation for advice about how to go about reporting his concerns, provided that the organisation had been well publicised and that it operated on a national – not a local – basis. He would have felt uncomfortable about reporting his concern or requesting advice locally, because Shipman was so well known and highly regarded. He therefore believed it to be of vital importance that any organisation for the use of people like himself should be geographically remote and independent.

8.76 Mr Shaw was a member of the public with no obligation to bring his concerns to the attention of the authorities. Yet he had valuable information to give – information which, if properly considered and investigated, could have led to Shipman's earlier detection. It is important that persons such as Mr Shaw should feel able to bring forward any genuine and serious concerns which they may have, secure in the knowledge that those concerns will be objectively and independently examined and that persons airing the concerns will not be penalised as a result of their action in voicing them.

The Concerns of Mrs Dorothy Foley and Mrs Elizabeth Shawcross

8.77 Mrs Dorothy Foley and Mrs Elizabeth Shawcross were employed as home helps by Tameside Social Services. Mrs Foley worked as a home help from 1985 until she became a resident warden of sheltered accommodation in 1992. Mrs Foley and Mrs Shawcross were home helps for Miss Mona White, Mrs Mary Tomlin and Mr George Vizor. The Inquiry has found that Shipman killed all three of them. Both Mrs Foley and Mrs Shawcross gave written statements to the Inquiry about the deaths. In addition, Mrs Foley gave oral evidence.

The Death of Miss Mona White

8.78 Miss White died on 15th September 1986. Mrs Foley and Mrs Shawcross saw her standing at her front door at about midday on the day of her death. She said that she was waiting for Shipman to visit and was concerned because he had not arrived. They assured her that he would arrive soon and went on their way. They both recalled that Miss White did not look ill. Had she seemed ill, the home helps would not have left her alone to wait. A short time later, Mrs Shawcross saw Shipman near to Miss White's flat. She asked him whether Miss White's problem was with her heart. Shipman replied that it was and that he had given her an injection for her pain. Mrs Shawcross returned to see Miss White about 20 minutes later. She found the door unlocked. She went inside and found Miss White sitting upright in her usual chair. She looked as though she was sleeping. Mrs Shawcross was unable to wake Miss White and realised that she had died. Mrs Shawcross ran to Mrs Foley's house, which was nearby, and together they returned to Miss White's flat. By that time, Shipman had returned. Shipman made no attempt at resuscitation. This was the first death that

Mrs Foley had encountered in the course of her work as a home help. She said that she did not have any particular concerns about the death although she did think that it was very sudden.

The Death of Mrs Mary Tomlin

8.79 Mrs Tomlin died just over three weeks later, on 7th October 1986. Mrs Foley and Mrs Shawcross had visited Mrs Tomlin on the day of her death. They arrived at her flat just before lunchtime and found her unwell. She was sitting up in bed. When asked by the police, in the course of their investigations after Shipman's arrest, neither Mrs Foley nor Mrs Shawcross was able to remember what exactly had been wrong with her. Mrs Tomlin told them that she was expecting a visit from Shipman. Mrs Shawcross and Mrs Foley stayed for a while and chatted. Mrs Tomlin seemed quite cheerful and was looking forward to Shipman's visit. After a short time, the home helps left to continue with their rounds. Shortly afterwards, Mrs Foley saw Shipman go into Mrs Tomlin's flat. About ten minutes later, she made her way to the flat and was met by Shipman. He said to her, 'Go and put the kettle on, we'll ring the family, she's going.' Mrs Foley asked Shipman what he meant, to which he replied, 'She's going, I'll just go and have a look at her.' Shipman then went into the bedroom and Mrs Foley went into the living room. Shortly afterwards, Shipman came through into the living room and told Mrs Foley that Mrs Tomlin was dead. Shipman said that Mrs Tomlin had been a very poorly and lonely lady and that every day had been a 'bonus'. He did not summon an ambulance. Nor did he make any attempt at resuscitation.

8.80 Mrs Foley said that, after Mrs Tomlin's death, she had a strong feeling that 'something was not right' about her death and that of Miss White. Mrs Shawcross shared her views. Mrs Foley believed that Shipman was a good doctor so did not think that medical incompetence was the explanation. It crossed her mind that Shipman was trying to give his patients 'a perfect death'. However, she was aware that neither Miss White nor Mrs Tomlin had been suffering from any terminal illness.

The Death of Mr George Vizor

8.81 Three years then passed before the death of Mr Vizor on 18th October 1989. Mrs Shawcross visited him at home on the day of his death. She thought that he did not look well and requested a visit from Shipman. When Mrs Shawcross had done her jobs for Mr Vizor, she left him alone as usual. She did not think he was so unwell that he needed someone to stay with him. At about midday, Mrs Shawcross and Mrs Foley were visiting another client near to Mr Vizor's home and Mrs Shawcross told Mrs Foley that Shipman was due to visit Mr Vizor. They agreed to call in on Mr Vizor later.

8.82 Some time later, Mrs Shawcross saw Shipman getting into his car, which was parked outside Mr Vizor's flat, and driving away. About 15 to 20 minutes after that, Mrs Shawcross and Mrs Foley went to Mr Vizor's flat. The door was locked but, through the glass panel, Mrs Shawcross could see the lower half of Mr Vizor's body on the floor in the doorway between the living room and the hallway. At the time, she thought that he must have got up to see the doctor out and then collapsed on his way back into the living room.

Mrs Shawcross summoned the warden and the three ladies went into the flat. They examined Mr Vizor's body and concluded that he was dead.

8.83 During the time between Mrs Tomlin's death and that of Mr Vizor, Mrs Foley became aware of the deaths of other patients of Shipman. Other home helps would remark that one of their clients had died and Mrs Foley said that she would 'automatically' ask whether Shipman had been there. Sometimes, a home help would remark that Shipman had given her client an injection before the death. Mrs Foley would speculate with her colleagues about whether Shipman was causing the deaths.

8.84 After Mr Vizor's death, Mrs Foley's suspicions were heightened once again. She and Mrs Shawcross talked about their concerns. However, she does not recall that they had any specific discussion regarding what they might do about those concerns. Mrs Foley explained that, if home helps had concerns about their clients, they were instructed to report them to their line manager. However, she had never felt that she could use this channel to voice her concerns about Shipman. She would not have expected her word to be believed against that of a doctor.

8.85 Mrs Foley said that, if the same thing happened now, she would voice her concerns. This is partly because of her previous experience and partly because she is now more confident. She would raise her concerns with her line manager. If there were an organisation to which she could voice her concerns in private, she would use that. She mentioned an existing organisation which staff can telephone if they believe an elderly person may be the subject of abuse. The organisation ensures that there is someone who will listen and will look into the concerns, whether the caller is right or wrong. She said that employees are now trained to bring forward any concerns that they have. Outside the employment structure, Mrs Foley said she would like to see an independent body which she could telephone and which would investigate her concerns on a confidential basis. She emphasised that such a body should be entirely independent and remote from the locality in which the concerns arose.

The Concerns of Mrs Shirley Harrison

8.86 Mrs Shirley Harrison is the niece of Mrs Erla Copeland. She was also a neighbour of Mrs Mavis Pickup. I found that Shipman killed both Mrs Copeland and Mrs Pickup. Mrs Harrison gave oral evidence to the Inquiry.

The Death of Mrs Erla Copeland

8.87 Mrs Copeland died on 11th January 1996. Mrs Harrison's mother, Mrs Dorothy Proctor, found Mrs Copeland dead, sitting in her usual armchair. Shipman was known to have visited shortly before her death. He came to the house after the death and said that he had not been expecting Mrs Copeland to die. He then proceeded to certify the death as being due to **'natural causes'**.

8.88 Mrs Harrison explained that, in the months leading up to Mrs Copeland's death, Shipman had led the family to believe that she was terminally ill, although they now realise that this was not the case. Following the death, Mrs Harrison and other members of her family

thought that Shipman might have helped Mrs Copeland to die in view of the circumstances in which her body was found. However, they believed that Shipman had saved Mrs Copeland from a lot of suffering and so came to terms with her death and with Shipman's possible involvement in it. Mrs Harrison said that she had spoken to a friend about her belief that Shipman had been involved in the death but the friend warned her to be very careful about what she was suggesting because Shipman was a well-respected GP.

The Death of Mrs Mavis Pickup

8.89 On 22nd September 1997, Mrs Pickup died. A neighbour had discovered the death several hours after a visit from Shipman. The neighbour alerted Mrs Harrison to the death and she went into Mrs Pickup's house. She saw Mrs Pickup lying on her back on the kitchen floor, dead. Following that death, Mrs Harrison became very troubled. She realised that the circumstances surrounding the death of Mrs Pickup were very similar to those of her aunt's death. She believed that Shipman had killed Mrs Pickup. She told the Inquiry that she was 'in turmoil' because, although she had real concerns, she also felt she was reading too much into everything. She spoke to members of her family who continued to believe that the death of Mrs Copeland had been a 'mercy killing'. They pointed out that they were not in a position to know what Mrs Pickup's state of health had been before her death. Mrs Harrison did not mention her concerns to anyone else. Following Shipman's conviction for murder, she said she was 'riddled with guilt' at not having come forward with her concerns sooner.

8.90 Mrs Harrison did not know who was responsible for managing or monitoring GPs. The only people to whom it had occurred to her to talk were her vicar and her doctor. However, she was afraid of being wrong and did not approach either. She said that she would have been reluctant to approach her doctor, as criticising one doctor to another doctor would not have been 'ideal'. She felt that someone outside the profession was necessary.

8.91 Mrs Harrison felt that, if a well-publicised independent advice service had existed, to which she could have expressed her concerns, it would have been easier for her to come forward. She would not, however, have felt able to report Shipman within the Tameside area and it would have been necessary for the service to be outside the immediate locality, e.g. covering the whole of Manchester. She thought it possible that she would have reported her concerns about Mrs Pickup's death if the public were encouraged to take their concerns to the Coroner Service. However, she felt that it would have taken her time to make the decision to do so.

8.92 Like Mr Shaw, Mrs Harrison had been concerned that, if she voiced her suspicions and they proved to be wrong, she would be in serious trouble. In order for her to come forward, she would have needed to be confident that, provided that her concerns were genuine, she would not be penalised for raising them, even if they proved to be unfounded. Like Mr Shaw, she identified the necessary characteristics of an organisation set up to receive concerns, or to give advice about the voicing of concerns, as being independence, distance from the immediate locality and a high profile with the public.

The Concerns of Mr David and Mrs Deborah Bambroffe

8.93 Mr David and Mrs Deborah Bambroffe are funeral directors who work in the family business, Frank Massey & Son, Funeral Directors (Masseys). Mrs Bambroffe's father, Mr Alan Massey, also works in the business although he handed over day-to-day control to his daughter and son-in-law in about 1996.

8.94 In the course of their work, Mr and Mrs Bambroffe dealt with the deaths of many people who had been Shipman's patients. Over time, they developed a growing awareness that there were odd features about some of those deaths. Mr Bambroffe, who joined the business in 1996, soon began to notice that Shipman's patients often died alone while sitting up, dressed in their day clothes and showing no sign of having been ill. This was not the normal pattern. Usually, death occurred in bed with the patient surrounded by his/her family and the paraphernalia of illness. Mr and Mrs Bambroffe discussed these matters and began to notice other strange features. They realised, for example, that Shipman often seemed to be present at or about the time of the death. In a witness statement, Mrs Bambroffe told the Inquiry that she never really formed a firm view about the reason for the different circumstances of the deaths of Shipman's patients. She just knew that something was 'not right'. On the other hand, she was aware that Shipman was widely respected as a good doctor. He was her own GP and she had faith and confidence in him. In late 1997 or early 1998, Mr and Mrs Bambroffe mentioned their concerns to Mrs Bambroffe's parents. Mr Massey, who had known Shipman for years, did not share their anxiety.

8.95 Mr and Mrs Bambroffe were very concerned about making an accusation against Shipman. They were afraid of being wrong. They thought they might not be taken seriously. They thought that people might think they were mad. Mrs Bambroffe was also aware that, if they raised a concern about a death, post-mortem examinations might be carried out. She did not wish to cause unnecessary distress to families, should her concerns turn out to be wrong.

8.96 In February 1998, however, Mrs Bambroffe mentioned her concerns to Dr Susan Booth, a member of the Brooke Practice. Members of the Brooke Practice, including Dr Booth, often signed Form C cremation certificates for Shipman. The full sequence of events thereafter is set out in my Second Report. Suffice it to say here that Mrs Bambroffe's action in speaking to Dr Booth was an important factor in the subsequent decision by Dr Reynolds to report her concerns about Shipman to Mr John Pollard, HM Coroner for the Greater Manchester South District. That in turn led to the first police investigation into Shipman, which failed to detect his criminal activity.

8.97 Mr and Mrs Bambroffe said they would have been more confident in reporting their concerns if there had been an organisation which they could have approached on a confidential basis and which they knew would have taken them seriously.

The Concerns of Dr Linda Reynolds

8.98 Mr Nigel Reynolds, the widower of the late Dr Reynolds, gave oral evidence during the Stage One hearings and afterwards provided further written evidence. He explained that

his wife's greatest fear in reporting her concerns was fear of the consequences of making an unfounded accusation. In particular, she had discussed with him the possibility of a libel action being brought, which would have ruined them financially. He felt that help and advice should be made available to a person in his wife's position. Mr Reynolds also considered that there might be a need for a central body to whom doctors could report any concerns about their colleagues. That central body could then make a judgement about the legitimacy of those fears and decide whether the matter should be taken forward.

The Concerns of Bereaved Families and Friends

8.99 The vast majority of the bereaved relatives and friends of Shipman's victims had no suspicions whatever about the deaths at the time. They were frequently surprised at the suddenness with which the death had occurred but, in general, accepted Shipman's explanation without question. There were, however, those who did have concerns. These misgivings rarely related to the possibility of *criminal* behaviour; more usually, the concerns were that Shipman might have given substandard care – perhaps by failing to attempt resuscitation or to summon an ambulance or by leaving a dying patient alone. Sometimes, the concerns amounted only to a general feeling of unease that there was something 'not quite right' about a death. A few individuals sought an interview with Shipman to discuss their worries. But, until Shipman was under investigation for Mrs Kathleen Grundy's death, none of the bereaved relatives and friends reported their concerns to the authorities. Some were intimidated at the prospect of questioning the actions of a doctor; others were persuaded by members of their families that their worries were unfounded. Several have told the Inquiry that they did not know to whom they should take their concerns.

Conclusions

8.100 As I have said, remarkably few people had any concerns about Shipman and the circumstances in which his patients died. In this Chapter, I have described the difficulties faced by those who did have such concerns and the conditions that they believe might have made it easier for them to report those concerns. There must be not a word of criticism of these people for what, on the face of it, appears to be failure to raise serious concerns in the appropriate quarter. These people did not fail to act because they were irresponsible; they did not act because they felt 'disempowered'. The culture of the time was such that they feared that their concerns would not be taken seriously but would be dismissed as irrational. Some of them feared that they might be wrong to harbour suspicions about Shipman, and that, if they did, the consequences for them would be serious. Some of them had no one to whom they could turn for independent and confidential advice. In Chapter 11, I shall consider what steps might be taken to assist people who have genuine concerns about health professionals to bring those concerns forward for investigation by the appropriate authorities.