TRANSCRIPT OF PROCEEDINGS

MEDICO-LEGAL SOCIETY OF VICTORIA

THE MELBOURNE CLUB

MELBOURNE

FRIDAY 12 OCTOBER 2012

Dr Harold Shipman - Britain's Most Prolific Serial Killer

PRESENTED BY: DR John Rutherford

MERRILL CORPORATION
4/190 Queen Street, Melbourne. Telephone: 8628 5555
Facsimile: 9642 5185

MR REGOS: In January 2000 Harold Shipman was convicted of killing 15 of his patients. A subsequent public enquiry indicated that he may have killed as many as 265.

This presentation is the story of the work behind the convictions as viewed from the perspective of a pathologist who conducted autopsies on the 12 victims whose bodies were available for exhumation. The presentation will conclude with a brief consideration of the repercussions for the medico-legal system.

Dr Rutherford is based in Wellington and is a regional forensic pathologist in the National Forensic Pathology Service of New Zealand, a post he has held since 2006. He also holds the office of Senior Lecturer in Forensic Medicine at Otago University. Before that he was a Home Office pathologist in the U.K. and has worked as a consultant diagnostic pathologist in the U.K. National Health Service, a registrar in internal medicine and a general practitioner. He has conducted around 6,500 autopsies, has been engaged in a number of high-profile cases and has been involved in body recovery and identification assignments in Kuwait, Iraq and Egypt.

If all that sounds too serious he does have a quirky side. He hates writing papers, public speaking terrifies him, he has done the hippy trail to India, he captained the university judo team, he enters poetry competitions and he climbed Mount Kilimanjaro nearly to the top. I am not sure which one of these personalities we are going to get tonight, but please welcome Dr Rutherford.

DR RUTHERFORD: Mr President, Ladies and Gentlemen, thank you for that kind introduction. As you can tell I am very nervous of speaking so I have written everything down -

just kidding.

What I am going to talk to you about tonight is Dr Harold Shipman, Britain's most prolific serial killer. So:

It is an Ancient Mariner,
And he stoppeth one of three.
'By thy long grey beard and glittering eye,
Now wherefore stopp'st thou me?

The Bridegroom's doors are opened wide,
And I am next of kin;
The guests are met, the feast is set:
Mayst hear the merry din.'

He holds him with his skinny hand,
'There was a ship,' quoth he.
'Hold off! unhand me, grey-beard loon!'
Eftsoons his hand dropped he.

He holds him with his glittering eye -
The Wedding-Guest stood still,
And listens like a three years' child:
The Mariner hath his will.

What a wonderful phrase, "grey-beard loon". I should perhaps explain, so you don't totally mistake me for a grey-beard loon, why I introduce this presentation from Samuel Taylor Coleridge's very famous narrative poem. The answer is it tells the story of a man to whom something happened. It happens that the ancient mariner shot down a bird which is a bad thing to do, an albatross,

and it brought bad luck upon the ship thereafter and he had a really bad time of it. The crux of the story is that every time he reaches a peak of internal turmoil he has to tell the story, and after he has told the story he feels an awful lot better.

The psychotherapists who may be here will be able to tell you that is part of a method of psychotherapy called a narrative therapy where you tell the story and you feel better afterwards. It does not happen to everybody but it sort of happened with me with the Shipman case. It took a couple of years out of my life basically and every time I get the urge I have to tell the story, and I guess you are the lucky people this evening. So here we go.

This presentation is going to cover the background to Dr Shipman. It is going to cover the police investigation, it is going to cover the autopsies, it is going to cover the toxicology and the complications therefrom. I am going to say a little bit about the Court and I am going to talk about the aftermath.

There is a health warning. I am a pathologist, I cannot do presentations without showing pictures. It is a medico-legal society. They may be offensive to some people. I am going to try and keep the language in order, but the pictures might not be acceptable to all people. They will be anonymised so nobody knows who is who when we show them, and I have taken some not from the Shipman series and mixed them in so that I cannot be accused of identifying any particular person.

The situation before Shipman, this is before the shooting down of the albatross, was that I was working in Manchester. There is a Royal mailbox in red there. It is

Royal mail, reminding you that I am one of Her Majesty's subjects and if I am a bad boy I will be detained at Her Majesty's pleasure and placed in one of Her Majesty's institutions, either a mental institution or a prison depending on the nature of the crime.

I was enjoying my life in the sunshine in Manchester hearing the roar from the Manchester United football ground at Old Trafford, and of course on Sunday morning picking up the bits and pieces from all the pub fights et cetera that went on after the match on the Saturday night, and Wednesday nights sometimes as well.

Then came Dr Shipman. The first thing I knew about it was a call from a police officer who said, "Well, Doc, we think we have got a doctor who has been killing a patient." I said, "Okay, yeah right" sort of thing, because we were always getting calls like that from the police and it is usually some surgeon who has operated on someone who has been in a moribund condition and they have been dealing with poor tissues and the sutures have torn through and the person has bled to death on the table or afterwards; and the family are not very happy about this and they accuse the doctor of killing their loved-one. Once the autopsy is done and it is all explained everybody is happy.

I thought it was something like that but they said instead of inviting me down to the local mortuary, to the local police station and they showed me some documents and I thought, "Oh dear, here we go."

In order to understand all this you need to understand the system which I think is pretty much the same in Australia. We have the health service, National

Health Service, where you have a primary care physician or a family doctor or a GP; you have specialist care which is a hospital consultant and the GP refers cases to the hospital consultant; and running parallel with that you have the private health care system.

In fact, if you have anything really bad, like needing an emergency triple coronary artery bypass surgery or anything you probably get just as good if not better treatment in the health service. It is just that when you have routine things like hernias the private health care system is pretty good because you do not have to wait for your bed and you get nice, pretty nurses at the private health system.

Anyway, what you must understand is that all this depends upon trust. You have to trust that the doctor makes the right diagnosis and then prescribes the right sort of pills or does the right sort of operation, and you have to trust that he is not going to kill you about all this.

The next thing is the coroner. You have to understand the coroner's jurisdiction. The coroner cannot just move in and take jurisdiction of anything. Something has to be reported to him. Certainly in New Zealand only about 20 per cent of cases are reported to the coroner. The remaining 80 per cent he has no jurisdiction over, and the doctors are the gatekeepers of what goes on.

Shipman himself qualified in medicine in 1970. He was married with children. My daughter wagged it off school and went and watched me give evidence at the trial and actually sat next to Shipman's son and had a chat, and he seemed a very nice guy and all the rest of it. She did

not marry him in the end, she married an American but that is a different story.

He was a family doctor, a general practitioner or primary care physician. He was well-respected. His patients loved him. He used to go around and see them, talk to them. He was a brusque sort of man from Nottingham and they were a brusque northern people, so he fitted in quite well.

What they did not know, his patients where he finally ended up, was that he had a past medical history. The past medical history was of pethidine abuse. He used to inject himself with pethidine, and that was in the early 70's shortly after he qualified and was also in general practice.

They also did not know that he had a past criminal history. The criminal history was that he had been charged with three counts of obtaining pethidine by deception, and two charges of forging prescriptions. He was convicted of those and to ease his conviction he asked for no less than 67 other offences of a similar nature to be taken into account. He was fined for this but the deal was from the General Medical Council that he had to undergo some sort of psychiatric treatment. He had that bit of inpatient treatment and then he was released into the world again with no restrictions on his diagnosing or prescribing.

Where did it all occur? It occurred here in the south end of Greater Manchester County. You see that Greater Manchester County in red is a similar sort of size to the Metropolitan Police Force. Scotland is up there and a different legal system, it is all green there.

There are different concentrations of officers and different bits of crime going on in different parts of the country.

For example, down here in Dyfed Powys in Wales there is not much going on. There is a big area, very few police officers, no crimes really except the odd offence against a sheep and that sort of thing. But nobody worries about that too much because all the police officers come from good farming stock anyway and a blind eye is turned. So that is all right.

Anyway, it happened right there in Hyde. This is a street map of Hyde, and it was on Market Street where Dr Shipman practised, round about there. You notice there are green and red dots, these represent pharmacies. There are eight of them in all. Don't worry about the different colours, that was just a police tactic thing. But there are eight pharmacies.

If you are going to forge or write prescriptions for your patients and pick them up for them as a favour and take them to them then there are a lot of pharmacies to go to just within walking distance. So no one pharmacist or chemist is going to notice there are going to be a lot of prescriptions for whatever they are prescribing.

I think that is probably all you need to know about Hyde. No it isn't. There is a Hyde Bypass going there, and the moral of the story is if you ever go in to that part of the world stay on the bypass because there is absolutely nothing to see in Hyde at all.

Suspicion arose because one of the local undertakers became concerned about the number of deaths that Dr Shipman was having. This was affirmed by the local doctor

who was Dr Linda Reynolds who recently moved into the area and noticed that things were not quite right. The things that were not quite right were that in Shipman's practice of about 3,000 people they, as the opposite practice had filled in 41 cremation forms for him, and in their practice of 10,000 they had requested him to fill in 14. If you divide 14 into 41 it is a little over three, and if you divide 3,000 into 10,000 it is a little over three, and if you multiply the little over three's together it comes over ten.

He was having ten times the death rate, or at least cremation certificate rate, that they were in a much bigger practice. Investigations by the police at this stage were negative. Dr Linda Reynolds informed the coroner, asked for a discreet enquiry to be carried out. What if she was wrong? One police officer was allocated to the case. It was a discreet enquiry and he found there was no problem, and the reason was he was collecting the death certificates from the cases, he was picking up the clinical notes from the family practition office and getting another doctor, an independent doctor, to look and see if the symptoms correlated with the cause of death and they did. But of course they did, because the records had been falsified retrospectively and he did not pick that up.

He was regarded as a conscientious doctor so, yes, he would be around when people died peacefully in their armchairs at home, or at the surgery. So there was a pattern coming up, elderly females dying in excess numbers, Shipman always present or nearby.

I have done general practice and I can tell you that

patients do not usually die when you are nearby or close. They don't always die when you are at home, but they're also more expected in the clinic. I think you can count on the fingers of one hand how many GPs have had patients die in their surgery.

The deceased was always in a relaxed posture. I know as a pathologist that we get people who drop dead on the stairs, in the bathroom, in bed - rarely in a relaxed posture. In the middle of giving lectures, things like that. Watch out, I am 65 now.

This constant story from the relatives, you know, implicit trust, "We had an admiration for Dr Shipman." Of course there was this age research project. There was some hint that he might have been taking blood samples - "taking blood samples", not giving injections - in order to send them for an age research project. Needless to say the police never found any evidence of this.

The suspicion arose, or the trigger arose from that suspicion because of this woman, Kathleen Grundy, who was a well-respected ex-Lady Mayoress who had been a sophisticated secretary in her time, what we would call an administrative assistant or something these days. She was fit, she was 81 and she used to go and look after what she called "the elderly people" and give them dinners at the age concern place, "the old people of late 60s and early 70s" as she described them.

She was found dead just before lunch time on 24 June by a couple of her assistants because she was supposed to be serving lunches and did not turn up. Dr Shipman had visited her at 8.30.

Then there was some concern about the Will. That

was the other thing that was suspicious. It came to light because a letter turned up at Hamilton Ward Solicitors in Hyde which said, "Dear Sir, I regret to inform you Mrs K. Grundy of" comma with an excess space there, "79 Joel Lane, Hyde" there should be a comma there if you are going to put a comma there, not a full stop. If you are going to put a full stop you should have a capital D there so this is very badly written. "I understand that she lodged a Will with you as I as a friend typed" - well, really, you should have a semi-colon there, and then cross that "as" out, and "I as a friend" so, you know, that sort of thing badly written by this J. or I. Smith who is a "good friend" of course, and the police never were able to find this I. or J. Smith ever.

Anyway, this is dated 30 June, that is when it is received by the lawyers. It is dated 28 June and this is the overall Will of Mrs Grundy and here is the top half of it. If I can read this out, "Hamilton Ward Solicitors of Century House." It says, "All my Estate and house, I leave all my Estate and house to my doctor. My family" - without an "a" - "are not in need and I want to reward him for all the care he has given to me" double space "and the people of Hyde" full stop, no space, "He is sensible" - well, if he typed this he is not very sensible, is he, "enough to handle any problems" double space "that this may give him." Well it did give him quite a few problems and he did not handle it that well. "My doctor is Dr" no space "H." no space "F." no space "Shipman" and the address and so on.

That is the top half of it, badly done. You would not expect an administrative assistant-type person to be

doing this. She did everything by beautiful copperplate handwriting anyway. Crucial bit, "I wish my body to be cremated." That would destroy the evidence wouldn't it? It is dated 9 June and it was sent to Hamilton Ward Solicitors then, but it was put on a pile of other work to do not opened, and it was only opened when that initial letter from "I." or "J. Smith" appeared.

This was witnessed by P. Spencer and Claire Hutchinson. P. Spencer was interesting. He was a guy who, how shall we say, had had interludes with the law and spent some time at Her Majesty's pleasure in one of Her Majesty's prisons. He ran a pet shop called Monkey Business in Hyde which I thought was very appropriate. He said, "Well, you know, yeah sure, Dr Shipman asked me to sign this form and witness it, and there was an old lady sitting in a corner. I don't know who she was and the form was covered over. He just said, 'Sign there' so I signed there."

If some geezer in a pub asks you to sign something you would say, "Well, what's this about? What do you mean you want me to sign this? What is it?" But when your doctor who has been treating you from the age of nine years asks you to sign something then you do it.

Claire Hutchinson had a bunch of kids around her. She had gone into the surgery with a bunch of kids. She did not know, as any woman here who has had more than one child realises or even one child, sometimes you don't know whether you are standing on your head or sitting down or what with children around you. So she just went in, signed it and went out again.

Those two witnesses were a problem. The suspicion

was by whom was this Will written? The style was not right for Kathleen Grundy, it was out of character, the date of receipt was all wrong, there were unaware witnesses and there was of course the issue of the fingerprint. This smudgy stuff here is where the police have finished doing the fingerprinting. Guess whose fingerprint it was? Dr Shipman, who denies all knowledge of it.

Up until this time the investigation had been run by Detective Stan Egerton, a great bloke. I do not have a picture of him unfortunately and he is dead now, but this is a sketch I did of him in the pub one night. This is a sketch of him I did after he'd had a couple of pints. This is a sketch of him I did after I'd had a couple of pints, and I am getting more Picasso-like by the minute.

So he went to see Detective Superintendent Bernard Postles who was a big noise. His job was to maximise the evidence; a very nice man, very friendly face, teddy bear cuddly sort of guy with an iron fist - just what you need for this sort of job. He had to coordinate the teams which included the interview teams for Shipman, the exhumation teams.

Can you believe there are professional exhumers? I did not know this. How often do you do exhumations? I have done a handful. Most people in the world have done less than I have and I have only done a handful. But there are somewhere in Britain somewhere, some time, someone is making a bypass somewhere and inevitably they go across consecrated ground and old churches, so there are professional exhumers who come and take all these to pieces, get rid of the bones and so on. So there are

professional exhumers.

I have actually been involved in one or two cases where professional exhumers have not been involved, and the police have ended up with injuries and suing the police force and stuff like that. So it was sensible to get the professionals in.

The autopsy team, that was easy. That is me and the mortuary technician. That was a small team. The toxicology team, and he was to avoid panic, especially amongst his patients. You did not want him to panic, "Dr Shipman is killing people. Run! Run!" you know, and that sort of thing. You did not want to induce panic in the suspect either because he knew that if Shipman was on to him he would close down the operation, cover his tracks and it would be even more difficult to pin him down.

He also had to disable the suspect and he asked my advice about that. I said, "Well, I don't know, you contact the General Medical Council. I think they'll stop him." He did and there was no good joy from that I am afraid. The General Medical Council took a very standoffish approach and said, "Well, has he been convicted of anything?" "Well, no, no, but we have prima facie." "Has he been convicted of anything?" "No, but we have quite good evidence." "Has he been convicted of anything?" "No." "We're not doing anything."

In the end he had to go to the local Medical Executive Committee and they had the power to suspend him. But it took three weeks during which time somebody else died. So the General Medical Council at that time were not very good. They have tightened up their act since then.

The statisticians he got involved showed that in 1992 the number of expected deaths versus the actual ones in females over 65 in his practice were about normal, and then they would double in '93, a little bit raised in '94, doubled in '95 and by the time we get to '97 he has three times the expected death rates.

What else did we have? We had falsification of medical records. Let's just have a look at this bottom entry here. It says by interesting coincidence 12 October 1996, that is 16 years ago to the day, "Today IBS again, Irritable Bowel Syndrome." Something that you do not have any pathology for so there is nothing you can prove or disprove. "Odd, pupils small", well, in opiate poisoning you get small pupils. "Constipated", in opiate poisoning you get constipation. "? Drug abuse, at her age ?" "? Codeine." I'm sorry, Codeine - Codeine is an opiate so it might be giving all these symptoms.

He is trying to cover up his tracks and the handwriting people tell us that he has actually done this retrospectively in a space that he found in his records. Wait and see. That's taken to the police that he does not think there is anything going wrong.

There was also computer evidence. The Computer Fraud Department were called in. They found that on his hard drive he had made retrospective entries. He would put down a cause of death at one time, and then he would go back either a few minutes or several days' later and enter symptoms that would match that cause of death, "Cause of death heart attack"; symptoms retrospectively introduced "Chest pain" et cetera. So Shipman thought he was clever but he was unaware of this ghost imaging system

which you have built in to computers.

'All in a hot and copper sky,
The bloody Sun, at noon,
Right up above the mast did stand,
No bigger than the Moon.

'Day after day, day after day,
We stuck, nor breath nor motion;
As idle as a painted ship
Upon a painted ocean.

'Water, water, everywhere,
And all the boards did shrink;
Water, water, everywhere,
Nor any drop to drink.

There was circumstantial evidence everywhere - forgery, falsification of records, strong suspicion of murder, circumstantial evidence of murder; but it was all salt water, it was not drinkable. There was no hard evidence.

What the police wanted was evidence of his modus operandi and that is where the exhumations came in. The first exhumation was interesting because we had to sit down and work out possible causes of death, both natural and unnatural. There are lots of causes of sudden unexpected death which is what we are talking about, but there are only three real common ones and there they are. Some form of coronary artery disease in all its varieties, brain haemorrhage as opposed to brain infarction, and pulmonary embolism. We have sort of covered the common

ones there.

With respect to the unnatural causes of death, strangulation, suffocation; you might find signs of damage to the bones in the throat with strangulation. Suffocation, you can suffocate people without leaving any marks although in an adult you would expect to see some signs of a struggle. Administration of a lethal substance such as a short-acting anaesthetic agent, such as Propofol or I suppose these days Midazolam; barbiturates, hard to get hold of; insulin, that might have been a good one, though it is not a very nice death. Today it is possible to tell the difference between some injected insulins and natural human insulin, but probably not easy to do then.

Potassium would be a good one, potassium goes all over the place when you measure it biochemically after death. Digoxin is quite a good one if the patient goes in for a routine hospital autopsy as opposed to a forensic autopsy, because it is not on the list or certainly wasn't on the list in the U.K. at that time of screening drugs. So you have to think about it and ask the toxicologists specifically to look for that, it is a different analysis.

Then opiates. We had a conference with a toxicologist shortly before we went into all this and Julie Evans said, "If we are really lucky and he has been really stupid he will have used Morphine." Well, let's wait and see.

The first autopsy, the given cause of death was "old age". I don't know about you or the physicians in the audience but for "old age" I need people to actually be old. I need them to have features of ageing; a bit of heart failure, a bit of respiratory failure, a bit of

brain failure, a bit of everything until they slowly degenerate and die. That certainly was not the case with Mrs Grundy. She was fit, healthy and then dropped dead. Well, did she drop dead?

She had no real significant morphological disease at autopsy at all, and that was lucky for us really because a lot of people when they are elderly do have natural disease. If she had had some coronary disease but was still alive we might have to attribute death to that. There were no needle puncture marks. This bothered the lawyers a lot, "Well, you would expect to see needle puncture marks, wouldn't you?" Well, no, not really as an ex-general practitioner and physician I know that you can give needle injections using fine needles such as insulin needles without leaving any mark at all, and they are more difficult to find after death when the skin has changed colour.

The toxicology results where that she had a lot of Morphine on board, quite enough to kill her, and that settled that. With that, we had the evidence from her. The police decided to go ahead with autopsies on 12 other cases. There were 20 available that we could have done, but the last eight were getting beyond the range where useful information would be obtained. We had problems with them. With the embalmed ones there was difficult dissection; trocar artefacts, you can see little holes all over here in the tissues. But there was good organ morphology because of the preservation and really good histology for microscopy. The tissues were so rigid with embalming and burial that the only way to gain access was to was to open them like a cupboard.

On the other hand, the ones that were decomposing without embalming were easier to dissect but had poor organ morphology, poor histology. Would they have poor toxicology? Well, we will see in a bit.

This is one of the ones that had been under for five years or so. You can see a rib cage there. You can actually make out flakes of bowel there, and if you are careful you can pick bits out. This is a jaw bone with the neck being held upwards and there is the hyoid bone, the horseshoe shaped bone at the top of the throat which you might expect to be damaged in a strangulation. There it is again arching around there. The thyroid cartilage which has a couple of prongs sticking up called superior horns were intact. I know you sometimes don't get damage to them in strangling, but at least because we could not see bruising we could say there is no obvious evidence of strangulation.

The other problem we had was with the skin morphology. We were looking for needle puncture marks all over the place. Often the skin was discoloured. If you scrape the superficial layers off you can often see better. Nothing to see, so we sometimes had to refract the skin and look for needle puncture marks underneath that - might be one but we are not really sure about that, and dissect out the veins and just see if we could see anything there.

All those things gave us technical problems. The brains were difficult as well. We had two sorts of brains. We had slurry brains and we had paste-like brains. This is a brain contained within the membrane, the dura that surrounds it, and with this sort of brain

the brain is just mush and it is very hard to see what you are looking at. But we were able to establish that there wasn't any obvious haemorrhage.

Other brains that had been underground for a bit longer had turned into paste-like material, and on section when they were cut we could see good definition of grey matter and good definition of white matter. I would be interested to hear what the experience of other pathologists is with exhumed bodies like this.

After all that, the toxicology result was good. Julie Evans did it on muscle and liver. Nine of the 12 cases had measurable amounts of Morphine up to two and half years after burial. The other three had Morphine probably present but not quantitatable so we could not really use those for court. So the toxicology was good, the morphology was good or better than expected, embalming was a mixed blessing really in that it helped preservation but at the same time it made the tissues difficult to handle.

I hate people who put up slides which are really complicated like this one, so I just thought I would wind everybody up with this. The left two columns are just my numbers, don't worry about those. The D.I. Interval is of the Death to Interment, so seven days between death and burial. U.K. - not United Kingdom but "unknown", "unknown", "unknown", "seven", "seven", et cetera.

Post Mortem Interval, the number of days between death and interment. The shortest one was 38 and the longest one was nearly five and a half years, just over five and a half years. "C.C." stands for Coffin Collapse, "yes, yes, yes, yes, yes, yes". You will see nearly all

the coffins collapse as soon as you put them under ground. The only one that didn't was a stoutly built one which had not collapsed but had leaked, so the body was covered in mud and water anyway.

I know we have this illusion that we are going to die and be placed like this and remain peaceful ever after. It is not real actually.

Embalming, "yes", "no", "yes", "yes", "no". What is interesting is the general preservation in some of the embalmed ones was not any better than some of the non-embalmed ones. These are the brains, "SL" for slurry, or sludge as we used to call it in Yorkshire and "P" for paste. The slurry ones really were not very well preserved at all, but the ones that had turned to paste after a year and a half or so were actually quite good definition.

For the pathologists in the audience, the "C" stands for claustrum in that one down there, at 1,426 days. We could even see the claustrum on that one so it was quite good.

Sorry, just to go back to the toxicology, "good", "good", "good", "good", "good", "good", "good" down to the last few. So up to two and half years we had really good toxicology.

So:

'I fear thee, ancient Mariner!
I fear thy skinny hand!
And thou art long, and lank, and brown,
As is the ribbed sea-sand.

The fear was this rather nice guy, Steven Karch, and I had become quite good friends with him over the years. He is a very famous medically qualified toxicologist, and the police were terrified of Dr Karch because he had been involved a year or two before in a Newcastle upon Tyne, not the Newcastle here in Australia, the Newcastle upon Tyne in the U.K. where they speak funny. "Gooin' dun du ta Wi'ly Bee, thut a loocul bootie speet" which means "I am going down to Whitley Bay, that's a local beauty spot" - "beauty", of course, being relative. "Git a coopal of bivvie", to "Get a couple of bevvies, or beverages" which means beers.

Anyway, that case had occurred there. Dr Moore was a GP who was looking after a terminally ill man with cancer of the colon. He had been injecting him with Morphine over a period of time to which he had become tolerant; and he would increase the dose, increase the dose, increase the dose. The police were very suspicious and concerned about this. People were paranoid about euthanasia at the time so they prosecuted this GP. What they did was they took the levels of Morphine in the body and they tried to extrapolate how much Morphine in terms of milligrams that would have meant giving.

Dr Karch came in and just blew the whole thing out of the water. First of all you do not know what his degree of tolerance to the drug is; secondly, he has a terminal disease anyway; and thirdly, there are serious calculational errors you can make in extrapolating from what is in the body to what might have been given.

The police thought that he would be procured by the defence and would blow the Shipman case out of the water,

so they hired him pre-emptively to work for the prosecution. You and I know that expert witnesses work for the truth and the Court, they do no work for the prosecution or defence no matter who hires them. But not everybody knows that. The police did not seem to understand that. Indeed, some expert witnesses don't understand that either. But let's not go down that road today.

He was used as an ideas man and worked with Julie Evans to ask questions like: Does embalming create an artefact with the Morphine levels? Does Morphine concentration change with time? Does dehydration change the concentration of Morphine or the way in which it has effects? Do muscle concentrations equal blood concentrations? Because we didn't have any blood, it all gets resorbed back into the body a few days after death; so we could only do muscle and liver, and Julie Evans worked with muscle.

Do the post mortem concentrations actually represent ante mortem concentrations? So Steven had Julie Evans with chunks of meat injecting them with Morphine and taking samples after weeks and just seeing what happened to them, and established that all these factors were all right. Was Morphine high enough to be the cause of death? If it was high enough to be the cause of death did it actually cause death? Because they might have died of coronary or brain haemorrhage or something instead.

All these questions were addressed. The big one for them, thinking defensive now, was: Can other sources of opiates be ruled out? A Kaolin and Morphine mixture is freely available in the United Kingdom as is - I am not

sure whether it is still is, actually - Dr Collis Browne's mixture which contains laudanum and chloroform and cannabis, believe it or not, and that is quite a good drink to have after a party. Could they have taken those?

Poppy seed cake; very popular in the U.K., especially the north of England. Where do you get Morphine and Heroin from? Poppies of course!

Anyway, Julie Evans did some calculations and figured out that they would have to be drinking flagons and flagons of Kaolin and Morphine, and eating sackfuls and sackfuls of poppy seeds in little parties around, in order to get anywhere near the levels of Morphine that were found in the bodies.

The other alternative, of course, was that these genteel old ladies were going down to Moss Side, which is sort of a rough area of Manchester and scoring a bag of smack from the local bad boys which, again, was pretty unlikely.

Could the degree of tolerance be established? You know, if you are building up tolerance you might not have died from it, and that is where hair testing came in. So we sent samples of hair off and they looked at Morphine levels at the top and at the bottom to see if they changed and there wasn't any Morphine in them. So these were fresh, one-off Morphine injections.

The trial. This was held at Preston Crown Court in an adversarial system as we have here. It was held in Preston Crown Court even though Manchester Crown Court was the obvious choice because it was felt that with the publicity a fair trial could not be had in Manchester. The fact that the whole of the world have heard about Dr

Shipman by this time did not seem to enter into the calculations. Anyway, it was nice to go to Preston Crown Court because they had an old assizes court with all the oak and stuff like you see, a beautiful court. So that is where it was held.

Richard Henriques was prosecuting. He is now a High Court Judge. The prosecution tactics were very different from the defence tactics. The prosecution tactic was to examine each case individually; so one day I would be going up to Crown Court to give evidence on one case, then three or four days later I would go up. So I was up and down to Preston Crown Court like a yoyo from Manchester.

The defence on the other hand, which was quite clever, decided that they would examine all the cases, cross-examine on all the cases at the same time. There were nine cases which I was supposed to keep in my head ready for cross-examination. They elected not to cross-examine after each one that was presented for the prosecution.

This sort of presented me with a problem because I was due to give evidence, I think it was Tuesday, 16 November, and that was good because I was not on call, the weekend was free, I thought, "Great, I can research these cases, give evidence on the Tuesday and that will be the end of it." As it happened they got through the witnesses really quickly and by Wednesday, 10 November I got a call from the police saying they wanted me up in Preston Crown Court for cross-examination on the Thursday, the 11th.

I went up on the 11th, but the problem with the Wednesday was that I had had a couple of suspicious deaths and I had a couple of routine autopsies to do. I'd had

some hurried brunch about 11 o'clock in the morning, I had missed lunch, I had missed dinner. I was living on my own at the time, got back home about 11 o'clock in the evening and like most men who live on their own there are a few tins that need cooking. I was starving. A few things in the freezer that needed defrosting - that was just too much, I couldn't do that.

There was some cereal and there was a lot of milk so I had a bowl of cereal, and the cereal I had was Fruit 'n Fibre. You know how it is when you have one bowl of cereal, it's never really enough, is it? So I had a second bowl of Fruit 'n Fibre - absolutely totally ravenous - and then I realised how nice it was and had a third bowl of Fruit 'n Fibre. Then after that - after that - I thought, "Oh, I'm in court tomorrow."

Now, I do not know whether we have any gastroenterologists here who know about the gastroenterological transit times after fibre doses and what follows, but it is about 12 hours for me, and I was due to give evidence at quarter to 11 in court. So in court I can't say I exactly disgraced myself, but I was - shall we say - I had a lot of gas on board.

11 November, Remembrance Day, 11 o'clock - at 11 o'clock the Judge called for two minutes' silence and everybody stood up. You cannot believe how long two minutes is with your cheeks clenched tightly together! When everybody sat down and there was a rumbling of chairs you cannot believe what sort of a relief that was - except to Bernard Postles who was sitting right behind me there.

Anyway, the defence case had decided to do them all at the same time, and they asked questions about natural

disease - very sensible. They kept on and on all day about natural disease. Well, you know, "With coronary artery disease can you get microemboli breaking off?" "Yes." "Can this cause problems with the mi-cut?" "Yes, it can." "Did any of these patients have coronary artery disease?" "Yes, they did." What about emphysema?" "Yes, they had lung disease as well."

It is very difficult in Court. Not like a Coroner's Court where you have free-rein, but in a Crown Court you cannot say, "Yes, they had emphysema and the last thing you want to do is give someone a respiratory depressant like Morphine." The barristers were very clever to keep me away from being able to respond like that, so it was actually a well-constructed defence case or defence examination even though they did lose in the end.

The result was that on 30 January he was convicted of 15 murders. Nine of the 12 exhumations formed the core of the hard evidence and there were six on other evidence.

Subsequent to that John Pollard, one of our best Coroners, did inquests on the remaining cases. There were 27 in all, three on the exhumations which we didn't have the hard evidence for. He just has to work of balance of probability. He decided they were all unlawful killings.

There were 24 others outside those. He decided that 23 were unlawful killing. He did not want to get involved with the other one because there was an issue of mercy killing about it and euthanasia was rife, and he did not really want to get involved with that.

Dame Janet Smith commenced her big Inquiry and looked at all the cases that had died in Dr Shipman's care and published her results on 19 July of the first phase.

She found that of the total 887, natural deaths occurred in 589, there was unlawful killing in 200 in addition to the 15 murder convictions that he already had. So that is 215, and a strong suspicion of unlawful killing in 45. That makes 260 optimistically, or 215 definitely. There was insufficient evidence in 38.

If you look at that a different way these are the convictions, two per cent. Those are the ones that Dame Janet Smith said were unlawful killings. If you just confine yourself to those that is 25 per cent, one is every four person who died in Dr Shipman's practice throughout his career was killed by him. Dame Janet Smith had no doubt about this.

People say, "Well, they were all elderly females." No, not quite. The age range was from 41 to 93 and there were males as well. But it was nearly a 4:1 ratio.

Just an overall view from his early medical days down here, these are the killings he is supposed to have done. There were breaks here when he changed practice, changed practice there. But overall there is an upward trend in his killing behaviour. This is 1988. He was part part-way through 1998. Who knows where he would have gone after that.

Why did he do it? You can tell me. Was it due to money? Did he really inherit anything from this Will? Did he really believe it would go through? It was a poorly forged attempt. He did not know that she had other property besides the house that he was claiming on the Will.

Was it power? If so, was it power over life and death? Is there something thrilling about killing

someone? Is it a slippery slope? Did he start giving Morphine to people who were ill and needed it, and then it got more and more exciting to give them more? Was he addicted to this? Was he insane? Was he suffering from some form of psychopathy or delusional state? Or was he just evil?

It is actually anybody's guess I think and I can talk more about that but I won't because of time. The implication is that we are a vulnerable society. Two criminal doctors? I don't actually think there are many of those about. I think the bigger danger is poorly trained doctors, criminal nurses and the criminal public. In the context of naïve doctors, "Yes, yes, he is dead but he did complain of chest pain, Doctor, before he died." "Oh, yes of course, that must be a coronary then. I will sign him up. No autopsy." "Yes, yes, he did have terrible abdominal pain." "Well, maybe that was the cyanide you were giving him or something."

Eighty per cent of cases do not come to the Coroner's attention. The Coroner's system has problems. As I have said, 20 per cent are reported to the Coroner in New Zealand. It is more than that in the U.K. About 14 per cent of the population get autopsied in New Zealand. It is about 24 per cent in the U.K., nine per cent in Scotland, between nine and 12 per cent according to David Ranson who I was chatting to this morning in Melbourne.

Doctors are indeed the gatekeepers because they are in control of the medical certificate of the course of death and the cremation certificates. A bigger problem we have is who decides who should have an autopsy? At the moment it is lawyers and they base most of their decisions

on medical information. So you have non-medically qualified people making decisions on medical issues. Some people don't like that, I just present it to you as something to think about.

The solution by Dame Janet Smith was that we should have medical coroners supported by death investigators. You have proper death investigators going around talking to families instead of the odd policeman who gets the job every six months or nine months. The family doctor should have their power of certifying the cause of death removed and just be given the power to certify the fact of death. That information should be provided to the medical coroner. He then decides whether you should have an autopsy, perhaps does it if he is a pathologist, and if there are legal implications refers them to a higher level. So the coroners do what they are good at, holding inquests. The doctors would of course be obliged to provide medical history and opinion to the medical coroner.

Well, nothing really much has happened. Both the United Kingdom and New Zealand have tinkered with the coroner system. But they don't seem to have addressed the underlying issues to me. This happened to the Broderick Report in 1974 as well. The Government sort of ignored that as well as Dame Janet Smith's Inquiry.

Dr Shipman hanged himself in his cell in Wakefield Prison on 13 January 2004, a few days before his 58th birthday. It would be the case that his wife would have suffered limitations in pension benefits had he been alive for a little bit longer. So the charitable view is that he killed himself in order to preserve his wife's

pensionable income. Well:

The Mariner, whose eye is bright,
Whose beard with age is hoar,
Is gone: and now the Wedding-Guest
Turned from the bridegroom's door.

He went like one that hath been stunned,
And is of sense forlon:
A sadder and a wiser man,
He rose the morrow morn.

Well, I can't really speak for the rest of the team but certainly I rose a sadder and wiser man at the metaphorical "morrow morn" because we had a healthcare killer who was a doctor - embarrassing. All of us who are medically qualified we failed to detect him. There was failure of the regulating bodies and there was a failure of the coroner system and a failure of the government to act. So that is a sad story really.

But on the bright side, and there is always a bright side, Bernard Postles got an MBE. Richard Henriques got a knighthood. John Rutherford got a night out at the local pub with the junior police officers, but I wouldn't want it any other way.

Ladies and Gentlemen, as ever I dedicate this talk to those many people who lost their lives at the hands of Shipman who need not necessarily have done so.

Thank you so very much for your attention.

MR REGOS: Dr Rutherford has indicated that he will take questions if anyone has them. There is a microphone so if

you are interested in asking a question could you please put up your hand, wait for the microphone and then please stand up and say your name and ask your question. Thank you.

DR RUTHERFORD: This is the difficult bit of the evening for me.

QUESTION: Thank you, Doctor. Firstly, just in the list of names. We see that there were three Cheetham's named there. Where there three victims in the one family?

DR RUTHERFORD: Yes. As we go through you will see several identical surnames crop up. There were several people in some families who were killed, yes.

QUESTION: Did Dr Shipman give evidence at his trial?

DR RUTHERFORD: Yes, he did. He remained what has been described as arrogant to the end. He always adopted an arrogant air and there is historical evidence from his family background that this was maybe imbued by a stern parental influence from his ambitious mother, although we don't know really whether that is true or not. He was keen to give evidence himself.

Richard Henriques was very subtle but clever in his examination of Dr Shipman and got Dr Shipman to look at the evidence, "The Morphine is there, do you deny that?" "No." "How do you think it got there?" "Well, it could have been." "Well, it's likely to be injection, isn't it?" "Yes, I do, I admit that." "Where did the person die?" "In the surgery." "How soon does it take for someone to die?" "Well, a few minutes?" "How many people were in the room at the time?" "Well, there, there - only." He had to concede that there was only him. So they actually got him to incriminate himself as part of

the examination.

So it would have been wiser perhaps for him not to give evidence but he thought he could and I guess it turned out badly for him.

QUESTION: David (indistinct) speaking, Doctor. A fascinating, extraordinary story. I understand you believe despite that worst serial killer in the history of - despite the trial, do you (indistinct) if I understand you correctly there was basically nothing that was happening in terms of medication in the United Kingdom following (indistinct) further to that?

DR RUTHERFORD: There have been changes. The General Medical Council has changed. The Royal College of General Practitioners has changed. In fact, all the Royal Colleges have changed.

They have advised for example with general practitioners that none of them should work in isolated practice any more, and that spread through to the forensic pathologists even. In the United Kingdom we were told that we could not work as isolated practitioners any more, we had to work as part of a group practice, peer monitoring and all that. That is all good. Those things did happen.

What has not happened is a serious revision of the coroner system, and even a consideration as to whether a medical examiner system like what you have in the United States might be better. I thought that maybe in the United Kingdom with all this there was an excellent opportunity while public opinion was high that we could take the best of the medical examiner system in the United States, the best of the coroner system in the United

Kingdom, Australia, New Zealand, and meld the two. You have a tier of forensic pathologists or medically qualified doctors looking at the people as they come through, or the death certificates as they come through, doing the autopsies as or not; and then if there is a problem that needs an inquest, that needs an enquiry, refer it on to those people who are good at dealing with those things, the coroners.

That is what I would have expected and hoped to happen. There are interesting things that we also see as a sort of slight peripheral thing and that is sometimes our cases, our homicides, go to court: Crown Court, High Court and twelve good men and true, a team of prosecuting barristers, a team of defending barristers and a highly qualified and respected judge cannot decide what is happened, and that case gets bounced back to the coroner and one single man then has to decide whether it is unlawful killing but he cannot say who, or not unlawful - whatever it is.

There are lots of interesting irregularities in the system to do with partly the adversarial nature of it. So I would have expected a big change, but it has not really happened. There have been some, I do concede that.

QUESTION: I was just wondering whether you knew whether in any other jurisdiction there were any changes referable to the Shipman experience?

DR RUTHERFORD: I can tell you from discussions with David Ranson that something slightly better is happening in Melbourne for which you should be proud, and that is the Registrars of Births and Deaths are being asked to bounce certificates that do not look quite right. A team of a

pathologist and a forensic physician and some other people look at these cases and decide retrospectively whether it would have been a good idea to have autopsies on these people or have some sort of further investigation.

So the groundwork is being laid to obtain information, possibly statistical information about all the things that are going wrong and what might be looked at again to see if the system might be changed a little more. So one or two little bits and pieces are happening, but we have never had the wholesale change that would have been ripe to do at the time.

QUESTION: Hi, I'm Anthony (indistinct). I know you said you wouldn't do it, but I am really fascinated to know what the motivation was? What did he - why did he do it?

DR RUTHERFORD: Why did he do it? I will give you the general world opinion and then I will give you my opinion and I will argue that they are equally valid. That was a joke - I am not sure if they really are.

I have spoken to a lot of psychiatrists in various forensic conferences around the world and they say, "Yes, Dr Shipman. Well, you know, we do look at these serial killers and they usually take their secret to the grave. When we do get success we only get success by interviewing them two or three times a week for two or three timed hours each session over a period of three to six months, and only then do we start to break the surface of finding out what is going on with people."

Dr Shipman never agreed to see or talk to anyone about this. The general world opinion is that we do not know and will never find out, and this is how serial killers work, and maybe they don't know either. There is

obviously something going on but probably at a subliminal, subconscious sort of level.

I think it is a psychopathic thing of being desensitised. He was not the obvious psychopath who went around squashing frogs and tearing the legs off rabbits and things as a kid. But he was a little bit aloof and different from the rest of the kids at school. He would go to the pub with his mates - because he played rugby, sort of centre field somewhere if you are interested, and I am a quite keen rugby person myself - but instead of getting in with the lads and having a pint and singing bawdy rude songs he would just sit quietly in a corner and smile a bit but not really get involved. So he was a little bit out of it like that.

That is sort of bordering psychopathy personality disorder. Then when you have a job like medicine where you inject people with Morphine and you see how easy it is for them to die and you sort of find it interesting in an abstract sort of way, and you dissociate your emotions from that and just find it interesting. It just gets more, and more, and more, and builds up.

I think it was something like that. I don't think he was particularly evil, I don't think he was particularly psychologically disturbed. I think it was just something that grew. There you are, for what it is worth.

QUESTION: My name is Zoe Cohen(?) I understand that there have been some recent changes in the regulations within Australia with (indistinct) system for increased accountability in response to several medications like (indistinct) and also (indistinct) which requires health

professionals to report colleague's that they feel may be suspicious or perhaps not acting in common practice, so from the accepted reasonable practice. I was wondering if you feel that that plays a role in reasonable regulation and there is also the other side where the cases that present to the coroner there is a large proportion that come late, cold sort of cases where the body doesn't arrive, or the body not in and these are unreported suspected, or unexpected deaths and those cases that have, they are looking at assessing the deaths, apparently bring in more reporting.

DR RUTHERFORD: With respect to the latter, I applaud that. I have heard of the MBI system and I think that is a great idea and I am not sure I can say anything about that. With respect to the first point about doctors working in a context and colleagues reporting other colleagues if they are not quite happy about them, I also think that is a good thing but has to be handled sensitively. That has grown out of the Shipman situation I think.

That even occurs with us as pathologists. We do not go around killing people - we don't need to really do we - but audit has become an increasing part of our lives. Certainly in Wellington we have Friday afternoons dedicated toward it where Martin Sage flies up from Christchurch, Kate White comes down from Palmerston, and we meet in Wellington and do an audit of all the cases that we are concerned about.

We can't do every case but we do what we can and I think we would not be doing that were it not for cases like Shipman. So I think the answer to your question, if that first part was a question, is yes, it is happening.

But it is doctors regulating doctors. Doctors have lit up to this and thought, "Well, you know, we have got to do something" and they are.

I suppose what I am a little disappointed about is the lack of government thinking or input into how the system, which I think a lot of us agree, have some faults, could not be changed in a radical sort of way. But, yes, I agree with you and I think it is great.

MR REGOS: Thank you, last question.

QUESTION: Dr Rutherford, thank you very much for your talk. One comment I would like to make and a question also was that it seems to me that Dr Shipman has some competition as the worst serial killer because certainly some of the Nazi doctors like Heinrich Himmler come to mind and their motivation is even harder to understand (indistinct). Were there any protocols that were recommended as to in what circumstances a person's Will in terms of what they want, how they want their body to be disposed of and whether the deceased's wishes could be overridden in the event they die unexpectedly so that at least their tissue samples can be taken before the body is cremated and stored for some years or whatever until the Will had been proved or whatever, and it seems to me that what sort of a baffling case like Dr Shipman it would have been very difficult or possibly have been better if a body be exhumed.

DR RUTHERFORD: Yes, lots of stuff to answer there or respond to at least. Yes, the Nazi problem is - I dare not even go there, that is just huge. All I can talk about is Britain's most prolific serial killer and what we know about him. Why do they do it? Who really knows?

Certainly in the Hitler Nazi situation it is all words. People very much underestimate the power of words. It was one man, Hitler, managing to convince a whole nation that he was right about wiping out races.

It is just phenomenal and managed to convince medical men, either directly himself or through intermediaries that it was okay to do experiments. This is just mindset. It is not because they were beaten into doing it, it was just people talking, the power of words. I do not really think I am capable of going into that other than to say I respect what you say, I think you are absolutely right, that is a massive thing.

In terms of what little recommendations might be advised by people like Dame Janet Smith about how to handle things, she was thinking more on a bigger scale of getting medical doctors to look at each case. Again, I would not really want to go into the details otherwise we will here all night. My attitude would be if you just took a sample of blood from everyone who died, which would be an easy thing to do, and just stored it somewhere - you don't need very much, you could store quite a lot, throw it away after five years if nothing has happened - that might be an easier way of starting initial investigations off. Other than that I think I am not sure I can say any more.

MR REGOS: Thank you, and I apologise for those who still had questions. Maybe you could raise them with Dr Rutherford later in the evening. I call on Dr Phoebe Mainland to deliver the vote of thanks.

DR MAINLAND: What an extraordinary story. I think we are very privileged to be addressed by someone who has had

firsthand involvement in the development or the un-development of it.

As you mentioned, John, one of the horrors is that it was a doctor who was the worst serial killer in Britain, someone who was meant to be respecting life. As you mentioned, it is not only an abuse of the trust of the doctor/patient relationship but also the trust and respect of the community towards the profession, and that has been very much damaged.

You did mention the changes of the General Medical Council and we have mentioned the changes in the Australian Medical Board, and I do hope that that may help detect and prevent some of these things.

But I think also what was fascinating for me was the insight, a small insight perhaps, into the mind of a serial killer which from the beginning of your talk of his addictive behaviour and whether this was an extension of that, and whether or not his, on review, obvious muck up of the Will was almost his cry for help.

Overall it was a fantastic and intriguing presentation. On behalf of the members and guests of the Medico-Legal Society of Victoria I would like to thank you sincerely for your presentation tonight.

DR RUTHERFORD: You are welcome. Thank you. Can we have dinner now?

- - -