CHAPTER TEN

Raising Concerns: the Death of Mrs Renate Overton Revisited

Introduction

10.1 In October 2003, the Inquiry heard further evidence concerning the case of Mrs Renate Overton, about which oral evidence had previously been heard in December 2002. The case is described in detail in the First and Third Reports.

10.2 Mrs Overton was admitted unconscious to Tameside General Hospital on the evening of Friday, 18th February 1994. Shipman had given her a lethal overdose of diamorphine, having attended her home following a report that she was suffering an asthma attack. She never regained consciousness after his intervention and she died in hospital on 21st April 1995. Many doctors and staff at the hospital believed that there had been something wrong with her treatment. They thought that Mrs Overton's collapse had been provoked by an overdose of 20mg morphine, which was inappropriate for an asthmatic. They understood that Shipman had injected the drug intravenously as a 'stat' or bolus dose, that is, a dose given quickly and 'in one go'. Notwithstanding their belief that the collapse was due to inappropriate treatment by Shipman, their concerns were not reported and no investigation was therefore initiated.

10.3 In the Third Report, I concluded that, if there was any duty to report, that duty fell upon Dr Murtaza Husaini, the consultant cardiologist, and Dr Ceri Brown, the consultant anaesthetist, who, in the early stages following Mrs Overton's admission, were jointly responsible for her care. I concluded that no such duty lay on the nursing staff or the junior doctors. They knew that the consultants were aware of the circumstances and they were entitled to expect them to take appropriate action.

10.4 At the time of writing the Third Report, I deferred the question of whether Dr Husaini and Dr Brown were under a duty to report their concerns about Mrs Overton's case and whether they should be criticised for their failure to do so. It was clearly appropriate that I should consider those questions after gaining further understanding of the nature of the duty as promulgated by the General Medical Council (GMC), of the options for reporting available to the two consultants and of the culture within the medical profession at the time, matters which the Inquiry was to consider in the Stage Four hearings. During those hearings, both doctors were given, but declined, the opportunity to give further evidence. They were, of course, by that time aware of my findings in the Third Report. They were represented at the relevant hearings and put forward witnesses whose evidence the Inquiry agreed to consider.

10.5 Questions also remain as to what would have happened if Dr Husaini and Dr Brown had reported their concerns. Would the facts have been investigated fully either locally or by the GMC? Would the seriousness of Shipman's conduct towards Mrs Overton have been recognised and would there have been any further investigation that might have uncovered his other criminal conduct? Would Shipman have been deterred from killing merely by the fact of any investigation that was undertaken? These questions are linked with the question as to what would have happened if Dr David Bee, consultant pathologist,

had reported more carefully following his conduct of an autopsy on Mrs Overton's body in 1995 and had Mr Peter Revington, HM Coroner for Greater Manchester South, decided to hold an inquest. Their conduct was fully considered in Chapter 13 of the Third Report.

Was There a Duty to Report?

Dr Husaini's Position

10.6 When he gave evidence in December 2002, Dr Husaini acknowledged that, as a consultant in charge of Mrs Overton's care, he was under a duty to report to a relevant authority his concerns about Shipman's treatment of Mrs Overton. He said that he realised that this treatment had been quite unorthodox and showed that Shipman might be a danger to patients. In fact, he claimed that he had been so concerned that, in 1994, he had reported the facts to Mr Revington, to Mr Roger Butterworth (Chief Executive designate of the NHS Trust responsible for Tameside General Hospital), to Mrs Lynn Nuttall (the Trust's Business Manager) and to Mr Charles Howorth (then legal adviser to the North West Regional Health Authority). For reasons that are fully set out in the Third Report, I rejected his evidence and found that he had not reported his concerns to anyone. His claim having been rejected, it follows that he must be criticised for having failed to do that which he acknowledged to be his duty. However, this criticism must be viewed in the light of the culture and practice of the time.

Dr Brown's Position

10.7 Dr Brown agreed that he had not reported Shipman's treatment of Mrs Overton to anyone in authority. He gave several reasons why he had not done so. First, he asserted that, at the time when Mrs Overton was under his care, he believed that the circumstances of her collapse were so uncertain that he could not reasonably act. I rejected that contention. I found that his state of mind was encapsulated in the words of a witness statement that he made to the police at the beginning of 1999, in which he said of his opinion in 1994:

> **'It was my opinion at the time that the patient's initial management by the general practitioner was highly unusual, even dangerous. If the initial diagnosis of an asthmatic attack was correct, it was treated appropriately with the nebulisers. Intravenous Morphine plays no part in the management of patients with asthma outside the hospital. There is a statement in the notes by the admitting physician that she** (*Mrs Overton*) **may have had chest pain, although this contradicts the clear statement of the casualty officer that she had no chest pain prior to her collapse. While intravenous Morphine has a place in the management of acute myocardial infarction (heart attack) I have always understood that it should be given intravenously, in small amounts, with time between doses to assess the affect** (*sic*) **of the drug. In addition, it would be essential to monitor the heart rate and blood pressure of the patient in order to detect any signs of a cardiovascular collapse. In my experience of managing patients who have developed wheeze following a heart**

attack, I have never seen a dose of 20mg of Morphine used. I should add that I am familiar with the administration and effects of Morphine because in my work as an anaesthetist I regularly administer Morphine intravenously to patients undergoing surgery. I am also familiar with the use of Morphine post-operatively in patient-controlled analgesia pumps and it is common for these pumps only to allow 1mg of Morphine to be given at a time with five minutes elapsing between doses of Morphine.'

10.8 Second, Dr Brown also said that he believed the only possible route open to him was to make a complaint to the GMC. He was unaware of any local NHS procedure or mechanism for pursuing a complaint against a general practitioner (GP). He did not think he could report the matter to the GMC because he did not think he had sufficient information on which to base a complaint to that body. He did not think that the hospital notes were enough.

10.9 Third, Dr Brown also said that considerations of professional etiquette played a part in his decision not to make a report. He said that, as part of their training, doctors are taught to be very slow to criticise other doctors or to pass opinions on them. He felt that there was a tension between a duty to report a colleague's misconduct and the need to avoid an accusation against a colleague that might turn out to be false. He said that he was worried that, if he made a report, the GMC might criticise him for disparaging Shipman. In the Third Report, I accepted that Dr Brown genuinely held these reservations about medical etiquette. His decision to telephone the Medical Defence Union (MDU) for advice before giving the police a statement about Shipman's treatment of Mrs Overton confirms that. As recently as 1999, he was hesitant about criticising a fellow practitioner, even one who had been arrested for murder.

10.10 Fourth, Dr Brown said that he felt that he ought to honour the wishes of Mrs Overton's family that no complaint should be made against Shipman. As I explained in the Third Report, Dr Brown had told Dr Michael Overton, Mrs Overton's brother, that Shipman had given morphine to his sister. Dr Overton, who is a GP, knew that it was wrong to give an opiate drug to an asthmatic. However, Dr Brown agreed that he had not told Dr Overton how much morphine he understood had been given or that what was given had apparently been injected as a 'stat' or bolus dose. He contended that he had said enough to enable the family to decide whether they wanted to proceed with a complaint. He said that, if they had been anxious to proceed, he could have provided more information. They had decided not to make a complaint and Dr Brown considered that it was therefore reasonable for him to do nothing further. In the Third Report, I expressed concern that Dr Brown had not given the Overton family enough information to allow them to make an informed decision as to whether to proceed with a complaint.

10.11 Each of Dr Brown's explanations must be considered in the light of both the culture and the framework for reporting concerns at the time of Mrs Overton's death.

Guidance from the General Medical Council: the Nature of the Duty to Report

10.12 I shall consider first what the GMC had to say in its publications about the duty of a doctor to report the conduct of a colleague. It appears that this duty has evolved in two relevant

respects over the past 30 years. First, 30 years ago, it was unusual for the GMC to take disciplinary action in respect of poor clinical practice. In general, the GMC would take disciplinary action only against doctors who appeared to have been guilty of misconduct. Mr Alan Howes, an officer of the GMC between 1977 and 2002, said that the most common forms of misconduct were known as 'the three As', denoting 'advertising, abortion and adultery'. Nowadays, many doctors appearing before the Professional Conduct Committee (PCC) of the GMC face charges relating to their clinical practice. Second, there is now a clear obligation on doctors to report a colleague who presents or might present a risk to patients whereas, in the past, that duty was less clear and the emphasis was on avoiding the unjustified denigration of colleagues.

10.13 For many years until about 1995, the GMC provided to all doctors on the register a guide to GMC functions, procedures and disciplinary jurisdiction. This guide was known as the 'Blue Book'. Theoretically, all doctors should have read the Blue Book in order to keep abreast of any changes in the advice given or the requirements imposed upon them by their regulatory body. However, evidence to the Inquiry suggests that most doctors did not do so. Some did not read it at all; others would give it a cursory glance and take in only the main messages.

10.14 As I shall explain in Chapter 15, historically the GMC regarded itself as being under a duty to protect the public by taking disciplinary proceedings against doctors guilty of serious professional misconduct (SPM). The Blue Book of 1971, entitled 'GMC Professional Discipline', provided guidance as to the kinds of offences and professional misconduct that might lead to disciplinary proceedings. The emphasis was on misconduct and breaches of medical ethics, rather than on bad clinical practice. It stressed that the question of whether a particular course of conduct amounted to SPM was a matter to be decided by the Disciplinary Committee of the GMC (the predecessor of the PCC) on the evidence in that particular case. The categories of misconduct described were not to be regarded as exhaustive. It concluded, in words that remained largely unchanged in December 1993:

> **'Any abuse by a doctor of any of the privileges and opportunities afforded to him, or any grave dereliction of professional duty or serious breach of medical ethics, may give rise to a charge of serious professional misconduct.'**

10.15 During the 1970s, there was very little change in the guidance contained in the Blue Book. Advice against deprecating the skill, knowledge, qualifications or service of a colleague appeared in the section dealing with advertising and canvassing. Such advice was aimed at preventing doctors seeking to enlarge their own practices by denigrating the practices of others.

10.16 In August 1977, the new edition of the Blue Book, entitled 'Professional Conduct and Discipline', was published. In a section headed **'Neglect or disregard of personal responsibilities'** it was stated that the GMC might institute disciplinary proceedings:

> **'... when a doctor appears seriously to have disregarded his professional duties to his patients, for example, by failing to visit or to**

provide treatment for a patient when necessary. ... The Council is not concerned with errors in treatment or diagnosis.'

The message seemed to be that the GMC would take action on clinical matters, but only those entailing a conscious decision by the doctor to act as s/he did, in the knowledge of the likely consequences. Negligence, even if gross, would not give rise to disciplinary action. The concluding words in that section might well have been interpreted to exclude the administration of a dangerous overdose of medication, administered in good faith but with gross negligence.

10.17 In 1983, the corresponding passage in the Blue Book was altered so as to enlarge the areas of clinical treatment where action might be taken. It read:

'The Council is not ordinarily concerned with errors in diagnosis or treatment, or with the kind of matters which give rise to action in the civil courts for negligence, unless the doctor's conduct in the case has involved such a disregard of his professional responsibility to his patients or such a neglect of his professional duties as to raise a question of serious professional misconduct.'

The message had not substantially changed, however. Moreover, there was a difficulty for practitioners in that the advice was circular. The GMC was saying that it would act on cases of SPM but that errors in diagnosis and treatment would be subject to disciplinary action only if they were serious enough to raise a question of SPM. Practitioners must have wondered how serious cases had to be before the GMC would become involved.

10.18 The 1985 Blue Book contained a new feature, which was a statement of the standards of medical care that the public was entitled to expect. This was no doubt of assistance to practitioners. However, it was clearly not intended that a failure properly to meet these standards would give rise to SPM proceedings before the GMC. It would not surprise me if doctors still remained in doubt as to what types of clinical mishap were capable of amounting to SPM.

10.19 In 1983, the BBC Television programme 'That's Life' had broadcast an item highly critical of members of the medical profession for having failed to report concerns relating to incompetent laser treatment given by a doctor to patients. Many GMC members were angry with the BBC for having broadcast the programme. The GMC nevertheless accepted the recommendation of its Executive Committee that the GMC should inform doctors in the next GMC Annual Report that **'there may be circumstances in which it would be the responsibility of doctors to report to the Council evidence which may be regarded as raising a question of serious professional misconduct by a professional colleague'**. Thereafter, the April 1987 edition of the Blue Book set out for the first time the ethical obligation of a doctor to report a professional colleague who it was thought might have committed SPM or might have been suffering from serious impairment of health. The Blue Book pointed out that:

'... a doctor has a duty, where the circumstances so warrant, to inform an appropriate body about a professional colleague whose behaviour may have raised a question of serious professional misconduct, or whose

fitness to practise may be seriously impaired by reason of a physical or mental condition. Similarly, a doctor may also comment on the professional performance of a colleague in respect of whom he acts as a referee.'

10.20 I should observe that, more than ten years earlier, the Report of the Committee of Inquiry into the Regulation of the Medical Profession (the Merrison Committee) had suggested that doctors who had information giving them good reason to believe that the conduct of another doctor was putting patients at risk were under an ethical duty to act on that information.

10.21 In December 1990, in the GMC Annual Report, Dr (later Sir) Donald Irvine, then Chairman of the GMC Standards Committee, announced a further shift in the GMC's approach to the reporting of concerns about colleagues. He acknowledged that passages in past editions of the Blue Book, about the disparagement of colleagues, might have discouraged a doctor from making well-founded criticisms of colleagues or from reporting possible misdemeanours. Sir Donald went on to explain that the Standards Committee proposed that the focus of the GMC's guidance should be altered in order to emphasise the duty of doctors to take appropriate action when a colleague's performance might be deficient. The warning against disparagement was to be given a secondary place. The GMC approved the new guidance, which was then incorporated in the February 1991 Blue Book. It said:

'Doctors are frequently called upon to express a view about a colleague's professional practice. This may, for example, happen in the course of a medical audit or peer review procedure, or when a doctor is asked to give a reference about a colleague. It may also occur in a less direct and explicit way when a patient seeks a second opinion, specialist advice or an alternative form of treatment. Honest comment is entirely acceptable in such circumstances, provided that it is carefully considered and can be justified, that it is offered in good faith and that it is intended to promote the best interests of patients.

Further, it is any doctor's duty, where the circumstances so warrant, to inform an appropriate person or body about a colleague whose professional conduct or fitness to practise may be called in question or whose professional performance appears to be in some way deficient. Arrangements exist to deal with such problems, and they must be used in order to ensure that high standards of medical practice are maintained.

However, gratuitous and unsustainable comment which, whether directly or by implication, sets out to undermine trust in a professional colleague's knowledge or skills is unethical.'

10.22 The change widened the duty to report. Whereas previously the duty had arisen only in the case of concern about behaviour that might amount to SPM or serious impairment of fitness to practise, it now included a duty to report a doctor **'whose professional**

performance appears to be in some way deficient'. This seemed to involve a far lower threshold for reporting. It was suggested to the Inquiry that, if doctors had followed this advice to the letter, they would be reporting their colleagues very frequently. It may be that the words were wider than was intended. It seems to me that the passage intended to convey that deficient performance should be reported only **'where the circumstances so warrant'**. Although the passage might have left doctors in doubt about where the threshold for reporting lay, it was at least clear that the duty was an important one and, if a doctor was in doubt about whether the duty arose, it was always open to him or her to take advice. The passage made clear that it was gratuitous, unsustainable comment made with the intention of undermining trust in a colleague that would be regarded as unethical.

10.23 The passage did not give explicit guidance as to who was **'an appropriate person or body'** to whom a report should be made. Nor did it describe the arrangements that existed for dealing with any concerns reported. No doubt that was because the **'appropriate person or body'** would vary according to the circumstances. So would the **'arrangements'**. It may well be that guidance on those matters was not necessary; doctors could very easily take advice, if in doubt, from their medical defence organisation.

10.24 As I have said, this new guidance was incorporated in the February 1991 Blue Book. Subsequent issues, published in April and May 1992 and in January and December 1993, contained no changes of significance. The December 1993 edition was current at the time of the hospitalisation and death of Mrs Overton.

Attempts to Publicise and Explain the New Guidance

10.25 It appears that the new guidance probably received some publicity in the press. In August 1992, the GMC issued a document entitled 'Form of Response to Press Inquiries' which emphasised the importance of doctors reporting colleagues whose conduct was putting patients at risk and warned that doctors who did not follow the guidance might have to answer to the GMC. It is unclear what provoked the production of this document or how widely it was published, if at all.

10.26 The message was confirmed the following year. On 15th July 1993, the GMC issued a press release arising out of the case of Dr Behrooz Sohrab Irani, a locum consultant anaesthetist whom the PCC had found guilty of SPM in connection with his dangerous management of a patient who had suffered serious brain damage under his care. The evidence showed that Dr Sean Dunn, Chairman of the Anaesthetics Division of the NHS trust which managed the hospital where Dr Irani had worked, had received earlier reports of poor practice by Dr Irani but had not acted upon them. Although aware of these reports, Dr Dunn had written a favourable reference for Dr Irani, enabling him to get a job elsewhere. The press release of July 1993 concluded:

> **'Finally, there are appropriate procedures for response to reports of evident and dangerous incompetence; doctors have a duty to activate those procedures promptly, in the interests of the safety of patients, where such cases arise.'**

10.27 Dr Dunn was charged with SPM and his case was heard by the PCC in March 1994. He was found guilty. The decision was a warning to doctors that, if they had reason to believe that a colleague's conduct or professional performance posed a danger to patients, they were under a duty to act on that belief. Doctors were advised that, before taking action, they should do their best to establish the facts. References should be carefully considered and should be issued in good faith. If the doctor was in doubt about a colleague, it would be unethical to provide a reference. There was another reminder that procedures existed for responding to reports of evident and dangerous incompetence. The decision concluded:

> **'At all times patient safety must take precedence over all other concerns, including understandable reticence to bring a colleague's career into question.'**

10.28 The Dunn case was reported in the news section of the British Medical Journal. The relevant article quoted the concluding words from the GMC decision. According to the article, **'The GMC used Dr Dunn's case to send a message to the profession about its duty to protect patients even if this means reporting a colleague or refusing to give a reference.'** Dr Gerard Panting, Communications and Policy Director at the Medical Protection Society, said that the case served to emphasise the need to ensure that doctors took positive action when they saw that patients were at risk. Other evidence given to the Inquiry suggests that the main message received by the profession from the case of Dr Dunn related to the need for honesty and accuracy in the giving of references.

10.29 While, in my judgement, the position of the GMC had been made clear in 1991, certainly any doctor who kept up to date by reading the Blue Book and the medical press should have been aware, by July 1993 at the latest, that s/he was under a professional obligation to report to an appropriate authority any concerns that s/he might have that a colleague had been guilty of SPM or that the colleague's practice had put patients at risk of harm. I recognise that some doctors might not have read the relevant publications. But, whether or not they in fact knew of it, all doctors should have known they were under that duty from that time. I recognise too that doctors might not have had a very clear idea in their minds about what sort of conduct amounted to SPM. However, I do think that all doctors should be able to recognise what types of conduct are putting patients at risk of harm. It was that kind of conduct which was in issue in Mrs Overton's case. She had, after all, suffered the most serious harm possible short of immediate death and her treatment was regarded by Dr Brown as **'highly unusual, even dangerous'**.

10.30 Although the GMC's position as to the existence of the duty of a doctor to report concerns about colleagues had now been made clear to the profession, no specific guidance had been given as to where a report should be lodged. So far as the GMC was concerned, it would always advise that reports of conduct that could not amount to SPM should be pursued locally; if arising out of treatment within the NHS, this should be done by the local NHS body. Even reports of conduct that might amount to SPM would be sent back by GMC staff or screeners to be dealt with locally, unless the report was of conduct that was perceived as giving rise to a risk to the public. I shall deal with this topic at greater length in Chapter 18.

10.31 The GMC might well have thought it unnecessary to advise doctors about their local NHS procedures. It was reasonable to assume that a doctor working in the NHS would know about the local procedures relevant to his/her work. Perhaps the GMC should not have assumed that all doctors would know about the local procedures relevant to those parts of the NHS in which they did not work. For example, a GP might not know about the procedures governing hospital doctors and *vice versa*. However, the GMC might reasonably have supposed that a doctor who knew that s/he ought to make a report would be able to find out to whom it should be made.

Evidence of How the Duty to Report Actually Operated in the NHS in 1994

10.32 It was submitted on behalf of Dr Brown that, even though a doctor's duty might have been made clear by the GMC, the practice within NHS hospitals in 1994 did not reflect the GMC guidance. It was argued that, at that time, the culture was such that many doctors in Dr Brown's position would not have reported their concerns about Shipman's treatment of Mrs Overton. The Inquiry gathered evidence on these issues from a variety of sources. Already, during Stage Two, there had been evidence from the medical, nursing and administrative staff at Tameside General Hospital. In the Stage Four hearings, the area of enquiry was extended to include the practice within the Trusts responsible for three hospitals comparable in size to Tameside General Hospital. The Medical Directors of these Trusts gave evidence. They were Mr Alan Turner (consultant urologist and Medical Director since 1993 of Peterborough Hospitals NHS Trust), Dr Christopher Bateman (Medical Director from 1994 until 1996 at St Richard's Hospital, Chichester) and Mr Ian Harrison (consultant in general surgery at Southport Hospital, Merseyside, and Medical Director of Southport and Ormskirk NHS Trust since 1991).

10.33 On the same issues, the solicitors representing Dr Brown and Dr Husaini supplied witness statements from Professor Alan Aitkenhead and Dr John Givans. Professor Aitkenhead is Professor of Anaesthesia at Queen's Medical Centre, University of Nottingham; he has experience of advising claimants and defendants in clinical negligence claims and also of sitting on the MDU Cases Committee, which decides whether clinical negligence actions against MDU members should be defended or settled. Dr Givans qualified as a doctor in 1958; after a period in the Army, he was in general practice for 25 years, retiring in 1991. He had served on a medical service committee (MSC) for about ten years from 1973. He had been a full-time secretary of two local medical committees (LMCs). Since retiring from general practice, he has done consultancy work for the MDU, assisting doctors appearing before MSCs or, more recently, independent review panels. He has remained, therefore, in contact with the mainstream of clinical general practice.

10.34 The medical defence organisations and the British Medical Association provided written evidence. Dr Panting also gave oral evidence.

Awareness of the Duty to Report

10.35 It was generally agreed by the witnesses giving evidence in Stage Four that the climate of reporting concerns about the clinical practice of colleagues in 1994 was dramatically different from what it is today. Doctors are now much more aware of their duty to report

concerns than they then were and are much more willing to do so. Mr Turner thought that the change began with the Irani and Dunn cases but that a more far-reaching effect was caused by the publicity surrounding the GMC's action against Dr John Roylance, Chief Executive Officer of the United Bristol Healthcare NHS Trust, for his failure, over a long period, to act upon concerns about the high failure rate of paediatric heart surgery at the Bristol Royal Infirmary. Awareness of events in Bristol began following the death of a young child, Joshua Loveday, in January 1995, but the GMC hearing after which Dr Roylance was erased from the medical register was not concluded until 1998. Dr Givans said that doctors did not understand that they had a duty to report until about 1996. Until then, they tended to presume that their colleagues had acted in good faith and to give them the benefit of any doubt that existed in a particular case.

10.36 Mr Butterworth, who was, as I have said, Chief Executive designate of the NHS Trust responsible for Tameside General Hospital, said that it was unusual for a member of the hospital staff to report a concern about a GP. Nevertheless, in 1994, a serious incident such as that involving Mrs Overton should have been reported. If, however, the overdose had been perceived by those treating Mrs Overton as a 'genuine mistake', it might not have been reported; Mr Butterworth added that, in those circumstances, it might not be reported, even today. Nor would the incident be reported (in 1994 or even today) if the consequences were not serious. As the consequences were serious in Mrs Overton's case, Mr Butterworth said that, in 1994, he 'would have expected to have been told'.

10.37 Mr Timothy Dunningham, who was a consultant orthopaedic surgeon at Tameside General Hospital in 1994 and later became its Medical Director, said that he knew of no instance where a hospital (or hospital doctor) had made an official criticism of the conduct of a GP. It was more usual for the patient or family to pursue any concerns.

10.38 Dr Panting said that doctors with a particular interest in ethical issues had always known that they were under a duty to report a colleague where there was a problem that threatened patient care. But that was not so in the case of the profession at large. Many doctors were not familiar with, or interested in, issues connected with medical ethics. Medical ethics were not taught, as they ought to be, as part of the undergraduate course; nor were they usually taught during the post-registration year. A young doctor would hear his/her seniors discussing ethical issues but s/he might well hear attitudes that were not right. When faced with a question such as whether or not to report a colleague, if a doctor did not ask the advice of his/her medical defence organisation, there was a danger that s/he would rely not on the Blue Book, but on more general 'handed-down' values. Dr Panting himself lectures to groups of doctors on ethical issues and is often surprised at the degree of ignorance displayed. Moreover, the pronouncements about the duty to report made in the late 1980s and early 1990s were not very newsworthy. He did not think that the cases of Dr Irani and Dr Dunn had had a great impact. He also had understood that the real message of Dr Dunn's case was about giving honest references, not about reporting bad practice. Dr Panting said that the number of doctors who read the Blue Book was probably quite small. Mr Turner, Professor Aitkenhead and Dr Givans agreed. Only Dr Bateman said that he thought that every consultant should and would have read it. Mr Harrison said that most doctors would have 'browsed' the Blue Book for a short time but that would be all.

10.39 Professor Aitkenhead said that, both before and after 1987 (when the Blue Book set out the obligation for the first time), most consultants would have been aware that their duty was to report concerns about colleagues whose behaviour raised a question of SPM or whose fitness to practise might be seriously impaired by reason of a physical or mental condition. However, in 1994, unless it was clear that 'gross negligence' had occurred, or that there was a pattern of poor performance, a doctor would not have been expected to make a report about poor clinical treatment given by a colleague. The perceived inadequacies would be discussed informally with the doctor or at audit meetings at which the doctor might or might not be present, in the hope that the failings would be identified and steps taken to avoid recurrence. Of course, such options would not be available to a hospital doctor who was concerned about the performance of a GP. Dr Givans said that, even by 1994, the guidance published by the GMC had not been effective in altering the culture that had previously prevailed so as to ensure that reports were made to an appropriate authority.

The Fear of Being Accused of Disparagement

10.40 It seemed to me, from a reading of the various relevant editions of the Blue Book, that the advice against disparagement of another doctor was mainly (if not exclusively) directed against the evil of enticing patients away from a colleague. If that was the case, then it did not appear to me that the advice could ever have acted as a deterrent to a doctor who was thinking of reporting to an appropriate authority genuine concerns about a colleague, affecting patient safety.

10.41 Dr Bateman and Dr Panting both agreed that the advice against disparagement could not have had a discouraging effect on a doctor who was minded to report a genuine concern in 1994. Dr Panting said that, in earlier years, the advice in the Blue Book had had the effect of discouraging some doctors.

10.42 Professor Aitkenhead said that he did not see the warnings against disparagement as having been a major obstacle to reporting poor treatment, but they had discouraged some doctors. Dr Givans said that, before about 1996, all doctors were imbued with a culture that emphasised the dangers of criticising the professional performance of a colleague in the absence of firsthand evidence to support such criticism.

10.43 My view is that a careful reading of the Blue Book should never have discouraged a doctor from reporting concerns about a colleague to an appropriate authority, certainly not after 1991. However, on the evidence, I accept that in fact it did discourage some doctors. That was why, in December 1990, Dr (later Sir) Donald Irvine had announced the shift in focus of the GMC advice. If it is true that very few doctors read the Blue Book with any diligence, it is perhaps not surprising that old-fashioned ideas about the disparagement of a colleague, learned as a student or young house officer, remained current long after they had been rejected by the GMC. In my judgement, since 1991, the advice in the Blue Book about the duty to report concerns affecting patient safety has been clear. It seems likely, however, that the culture against reporting persisted somewhat longer, possibly because so few doctors read the Blue Book and instead retained in their minds the ideas adopted during their early training.

The 'One-Off' or 'Genuine' Mistake

10.44 On many occasions during the course of the Inquiry, witnesses said that a doctor would be unwilling to report a colleague who had made a mistake if it appeared that what had taken place was a 'one-off' or 'genuine' error. The argument is that all doctors make mistakes sometimes; a 'one-off' mistake connotes the type of mistake that does not represent part of a series or pattern of mistakes. A 'genuine' mistake connotes an error that does not arise from a fundamental problem with the doctor's practice but is of a type that any doctor might occasionally make, despite the exercise of all reasonable care. It is the kind of error that causes doctors to be forgiving and to say, 'There, but for the grace of God, go I.'

10.45 It is understandable that a doctor will be reluctant to report a colleague for an error that the doctor thinks s/he might him/herself have made. However, if a doctor is considering whether or not to report a concern and is going to make a judgement about whether the mistake was a 'one-off' or 'genuine' one, s/he is likely to need more information than is usually available. Yet it appears that doctors often assume that the missing information would confirm that the mistake was 'one-off' or 'genuine', even though the known facts are neutral or might even suggest otherwise. In other words, the benefit of the doubt arising from the missing information is given to the doctor.

10.46 Even the doctors giving evidence to the Inquiry displayed this kind of approach. In his written evidence, Mr Turner observed that Shipman's **'mistake'** when treating Mrs Overton might have been a **'one-off'**. He said that, so far as he was aware, this was a single episode. Accordingly, he himself might have decided not to report it. Similarly, Dr Bateman said that, if the doctor enjoyed a good reputation and if it was thought to be the first time such an incident had occurred, he would not have expected the case to be reported. He explained that 'one's first inclination' was to think that the doctor had made a 'one-off' mistake. The doctor would have been given the benefit of the doubt.

10.47 Professor Aitkenhead said that, around the time of the incident involving Mrs Overton, the perception that the incident might have been a 'one-off mistake' would have had a significant bearing on a doctor's decision whether to report. If there was evidence of an error or an instance of poor practice by a doctor who was thought to have a good track record as a competent and caring doctor, there would have been a tendency not to report, but instead to give the benefit of the doubt to the doctor. That might also have been so even where the doctor who was considering whether or not to report had no knowledge at all about the other doctor's general performance.

10.48 Dr Givans said that, if a doctor believed there had been a 'genuine one-off' accident involving a hitherto well-respected clinician, the culture in 1994 was not to report. In the course of his evidence, Dr Givans – in common with other doctors – drew attention to potential *lacunae* and inconsistencies regarding the collapse and admission of Mrs Overton in order to explain why Dr Brown's decision not to report was reasonable. It was clear from what he said that he was displaying the approach which I have described above. He put on the known facts the construction of events most favourable to the doctor. Dr Givans recognised the danger of a culture in which doctors take it upon themselves to decide that a matter does not require investigation on the grounds that they themselves,

without even asking for the account of the colleague whose conduct is at issue, have concluded that s/he is not blameworthy. However, he told the Inquiry that this was 'a fact of life'.

10.49 Professor Aitkenhead suggested that it would be far too onerous to expect doctors to report all errors. As I understand his evidence, he was suggesting that it was reasonable for a doctor to make his/her own assessment of whether the mistake was serious enough to warrant reporting. He produced a French academic article, illustrating that what he said was well known to all people who work in intensive care units (ICUs), namely, that about 8% of admissions to an ICU result from an error in medical treatment. In the majority of such cases, he said, the receiving staff would be aware of that fact. They could not be expected to report all such cases. I accept that a doctor considering whether to report has to make some judgement as to the seriousness of what has happened, although if the mistake has resulted in an admission to an ICU, it must be serious, almost by definition. Moreover, these days, local reporting of the incident would be mandatory. What the doctor must certainly not do, in my opinion, is to base the decision whether or not to report on assumptions or speculation about issues on which s/he has no evidence.

The Insufficiency of Evidence

10.50 Dr Brown claimed that one of the reasons he did not report Shipman was that he did not have enough information to do so; he did not think that the hospital notes were sufficient for the purpose. I must confess that, before hearing the evidence in Stage Four, I was unimpressed by that argument. I believed that he would have known that it would be sufficient for him to report his concerns to an appropriate authority, which would then decide whether to investigate and pursue them. However, it became clear to me during Stage Four that the Tameside Family Health Services Authority (FHSA), which was at that time responsible for primary care in the area, would have expected to be presented with the evidence in support of such concerns and would have carried out little or no investigation of them. Nor would the GMC have carried out such investigation unless and until a decision was made by the PPC to refer the case to the PCC.

10.51 Dr Panting found it understandable that a doctor in the position of Dr Brown might hesitate to report a concern because of a feeling that he did not have enough of a 'handle on the facts'. However, he said that the true obligation was to decide whether he had reasonable grounds to think that there was a problem, in which case he should report what he knew to the appropriate authority.

10.52 Mr Harrison thought that, in 1994, a doctor would have had to feel very sure of his ground before reporting a colleague to the GMC. Dr Givans said that doctors were 'terrified' of being involved with the GMC and were wary of possible criticism. He also said that a doctor would need 'solid evidence which would stand up in court' before going to the GMC. According to Professor Aitkenhead, 'very, very few' doctors in Dr Brown's position in 1994 would have made a report directly to the GMC. Even if it was thought that there had been gross negligence, it was exceptionally unusual for doctors to report each other to the GMC, unless acting in an official capacity such as that of Medical Director of a NHS trust.

10.53 I have now heard a great deal of evidence about the GMC procedures over the last 30 years and I do accept that there is some foundation for the belief that the GMC would have expected the case to have been investigated before it would have been willing to pursue it. It would not have been sufficient for Dr Brown simply to outline his concerns. However, I do not accept that there would have been any reason for a doctor to fear that s/he would be criticised for reporting a case that had not been fully investigated. If Dr Brown had written a letter containing the kind of detailed and clear opinion that he provided for the police in 1999, it is likely that the GMC would have accepted the case and embarked upon its procedures, the first stage of which would have been to obtain Shipman's response. Having said that, I do accept that the GMC would not have undertaken any further investigation of the facts unless and until its Preliminary Proceedings Committee (PPC) had decided, on the basis of Dr Brown's statement and Shipman's response, that the case ought to be referred to the PCC.

Local Procedures

10.54 Dr Brown told the Inquiry that he thought the only way in which he could report Shipman was to write to the GMC. He was not aware of any local procedures by which a concern could be raised by a hospital consultant about a GP. In 1994, at Tameside General Hospital, there was no formal mechanism for reporting concerns about the actions of a GP. However, Mr Butterworth said that, if any report about a local GP had been brought to him or to the Medical Director designate, he would have made enquiries of the FHSA as to the appropriate way to proceed. I do not think Mr Butterworth would have expected one of his consultants to prepare a fully investigated case before telling him about a concern. Mr Turner said that if Dr Brown had been at the hospital in Peterborough and had reported his concerns about Shipman's treatment of Mrs Overton, he (Mr Turner) would have taken matters forward. I do not think any consultant reporting a concern in this way could reasonably have felt in any danger of being accused of disparagement.

10.55 I accept that Dr Brown did not know by what mechanism such a concern could be investigated. I also accept that many hospital consultants would have been in a similar position of ignorance. However, I cannot accept that it would have been difficult for any doctor to find out this kind of information. A doctor could ask his/her medical defence organisation for advice and would have been advised as to his/her duty (in a way that accurately reflected the GMC's position) and would have been told how s/he could go about making a report either to the GMC or through local mechanisms. Also, it must have been obvious to Dr Brown that he could have sought practical advice in discussion with consultant colleagues. I was amazed by the evidence of Dr Husaini and Dr Brown, who both said that they did not even discuss Mrs Overton's case with each other, let alone the issue of what should be done about reporting concerns which, apparently, they both felt. An obvious source of advice within the Trust would have been the Medical Director designate.

10.56 It seems to me that, however uncertain Dr Brown might have been about having sufficient evidence with which to make a report to the GMC, no such difficulty would have arisen in respect of a report made to the appropriate medical authority in the locality.

10.57 In mitigation of Dr Brown's position, I accept that it was very unusual for a hospital consultant to raise a concern about a GP. It seems that there was a view that a hospital doctor did not have the same sense of responsibility for the actions of a GP as s/he had for a colleague in the hospital. Dr Bateman could remember no case in 20 years of practice in which a hospital doctor had reported concerns about a GP to the relevant primary care organisation. It appears that, in 1994, the chances of a hospital consultant reporting a concern about a GP's treatment of a patient were even lower than the chances of him/her reporting a colleague in the hospital, despite the fact that the duty to do so was clear.

The Views of Other Doctors as to Whether Dr Brown Should Have Reported His Concerns in 1994

10.58 Several doctors expressed a view about whether they thought a doctor in the position of Dr Brown should have reported his concerns about Shipman in 1994. In the main, their view was that he should have done so.

10.59 In his statement to the Inquiry, Mr Turner said that, in 1994, he would not have expected most consultants in the position of Dr Brown and Dr Husaini to report their concerns, although they might have done so informally. In oral evidence, he said that, having reflected upon Dr Brown's description, in his police statement, of his state of mind in 1994, and upon the fact that the injection appeared to have been given as a bolus dose, he would have expected Dr Brown to have reported his concerns.

10.60 Mr Dunningham said that, if he had been on duty at the time of Mrs Overton's collapse in 1994, he would have 'taken matters further'. He would have been sure that Shipman could not have thought that 20mg morphine was an acceptable dose for Mrs Overton in the circumstances. Any doctor would have known that such an amount of morphine should not be given intravenously to a patient with asthma. This was a very serious mistake. He could not have understood or condoned the giving of 20mg as a bolus intravenous injection. Although he found it difficult to discard the benefit of hindsight, he maintained that had he been in Dr Husaini's or Dr Brown's position, he would have reported his concerns about Shipman, initially by discussing it with the Medical Director designate or a senior colleague. However, he also said that, had the outcome of any discussion with colleagues been a general consensus that nothing should be done, he considered that it was reasonable, given the culture of the time, to do no more than inform Dr Overton of the circumstances.

10.61 Despite his evidence about the action he would have taken, Mr Dunningham said that he found that Dr Brown's decision to do nothing was understandable. However, when he gave this opinion, Mr Dunningham was under the impression that Dr Brown had explained his concerns fully to Dr Overton and had felt that he need do nothing more. What his view would have been had he been aware of the limited information that Dr Brown gave to Dr Overton, I do not know. Even on the basis of his understanding of the position, Mr Dunningham recognised that Dr Brown's decision to leave the issue of whether to complain with the family was fraught with danger. First, the family might decide to take the matter no further. Second, there was a risk that Shipman might, through negligence (the most likely explanation for his conduct that would have been considered at the time), do

the same thing again. Mr Dunningham said that the decision was nevertheless understandable, in the light of the relationship that existed at that time between GPs and consultants. He thought that Dr Brown was entitled to respect the family's view by leaving the matter there; this was a course that the majority of doctors at the time would have followed.

10.62 Mr Harrison said that, in 1994, he would not have expected a consultant to report a single error on the part of a colleague. There was, he said, a tolerance of errors as long as they were not persistent. When he had read the brief written account provided to him by the Inquiry of the circumstances surrounding Mrs Overton's admission, he had entertained some doubts as to what had occurred; he had wondered whether Mrs Overton had in fact had an asthma attack or whether she might have suffered chest pain as the result of left ventricular failure. He had wondered exactly what was meant by a bolus injection. In other words, when he first looked at the facts of the case, he thought that Dr Brown might have seen Shipman's actions as not unreasonable. However, in oral evidence, he said that if it was Dr Brown's view that Shipman's management had been **'highly unusual, even dangerous'** (the phrase used in his police statement), he should have discussed the matter with colleagues within the hospital to seek confirmation that his interpretation was correct. If it was, then action would have been appropriate and Dr Brown could have taken advice from his Medical Director designate.

10.63 Dr Givans agreed that most people would have taken the view that Shipman's management of Mrs Overton was **'highly unusual, even dangerous'**. Dr Givans accepted that the guidance from the GMC imposed a duty on a doctor to report his/her concerns in such circumstances, but he maintained that many doctors sharing Dr Brown's view would have failed to comply with that duty in 1994. Dr Givans said that many consultants would have acted as Dr Brown did. The culture on reporting was that 'one just did not do it'. Dr Givans was not saying that this attitude was right, just that it was prevalent.

10.64 Professor Aitkenhead said that he would not have expected the circumstances of Mrs Overton's collapse to be reported. He took a different view about the appropriateness of Shipman's treatment of Mrs Overton from that expressed by all other medical witnesses to the Inquiry. He regarded the administration of 20mg morphine to Mrs Overton as not necessarily wrong. I think he is mistaken in that respect; I am quite satisfied, from all the evidence I have heard, that the administration of such a dose to an asthmatic patient by a GP in the patient's home would be dangerous. Professor Aitkenhead's view on that issue was, however, bound to affect his opinion about Dr Brown's decision not to report Shipman.

Informing the Family

10.65 In the Third Report, I found that Dr Brown's admitted failure to tell Dr Overton of the suggested dose and mode of administration of the morphine amounted to a withholding of important information. This information would have been highly relevant to the family's decision whether or not to make a complaint about Shipman. I was surprised by and critical of this failure.

10.66 This withholding of information was condemned by most of those who gave evidence in Stage Four. Dr Panting said that he would have expected a doctor in Dr Brown's position to have provided the family with all relevant information so that they were fully informed as to what had given rise to his concern. Mr Turner agreed, although he said he had come across cases in other hospitals where that had not taken place. Dr Bateman agreed that the best policy towards families is openness, so that they acquire a full understanding of events. Dr Givans expressed surprise that Dr Brown did not draw the morphine dosage to Dr Overton's attention. Mr Harrison said that a doctor should explain all the important elements of his/her concern about the treatment in order to enable a relative to make a proper judgement as to how to proceed.

10.67 Professor Aitkenhead said that a doctor should not tell a family that a mistake had occurred and then minimise it, or omit components of the treatment which compounded or were an important part of the mistake. However, he also told the Inquiry that, in 1994, the tenor of the advice given by hospital employers and the medical defence organisations was that doctors should not admit to or seek to attribute blame when a mishap occurred. Doctors would be advised to withhold from relatives information as to the mechanism of injury which might point more towards fault than against it. The advice was that it would be appropriate to do no more than to suggest to relatives that they might wish to complain about what had happened. The effect of this attitude was that relevant information suggesting liability or fault on the part of a hospital or doctor was sometimes withheld from the families and never became known to them. That evidence accords with my own experience of clinical negligence work at the Bar in the 1980s and early 1990s. Professor Aitkenhead acknowledged that the situation in 1994 was unsatisfactory. He said that the problem still persists, although to a lesser extent. That evidence accords with my more recent experience of clinical negligence work while on the Bench in the late 1990s. Professor Aitkenhead said that in 1994 doctors were afraid that disciplinary action might be taken against them if they made adverse comments about the treatment provided by their hospitals. He could not identify any case in which this had occurred but believed that there had been such incidents. The perception was that a doctor might be penalised, for example by the withholding of discretionary merit award points, if s/he said something that caused the hospital to suffer financial loss through a clinical negligence claim.

10.68 Professor Aitkenhead told the Inquiry that it was common for a hint to be given to a patient's family by a doctor that a matter should be investigated, without specifically criticising a colleague's actions. In the context of Mrs Overton's case, he suggested that it would have been reasonable to have told a fellow doctor, such as Dr Overton, only that morphine had been given to an asthmatic and then to have left that doctor to decide whether to ask any more questions. This was so even though the fellow doctor might well infer, from the limited information given, that there were no other causes for concern.

10.69 In my view, the dropping of hints, or the giving of incomplete information, is and was completely unacceptable. All patients and relatives are entitled to a full factual account of the treatment given and the events that have occurred. If a doctor believes that a colleague has made a serious mistake, s/he should explain the basis of his/her concern to the patient or relatives. If s/he feels uncertain as to whether the treatment was wrong but believes that it might have been, s/he should give a clear indication to the patient or

relatives that some doctors would take the view that a mistake had been made and that it would be appropriate to take advice. Having said that, I accept that the practice of dropping a hint was common in 1994.

10.70 In the Third Report, I expressed some surprise that Dr Brown did not record the extent of his concern in Mrs Overton's hospital notes. I was particularly concerned because the reason he gave for not doing so seemed to be based on the need to protect the doctor or hospital rather than to assist the patient. Dr Brown's view that he should not do so did not, however, surprise Dr Panting. Had he been asked to advise Dr Brown, he would have advised against recording his concerns in the notes as it would have served no useful purpose. Dr Bateman agreed and said he would have expected only a factual account to be written. I can see that, provided the concern was passed on by the doctor, it might serve no purpose to record the nature of the concern in the hospital notes. What is really to be deprecated is the failure fully to inform the family, as I have set out in the preceding paragraph.

A Final Consideration of the Positions of Dr Brown and Dr Husaini

10.71 At the beginning of this Chapter, I summarised Dr Brown's suggested reasons for not reporting his concerns. I now return to evaluate them in the light of the evidence I have heard. I have already said that Dr Brown's state of mind soon after Mrs Overton's admission was that Shipman's treatment of her had been **'highly unusual, even dangerous'**. It had plainly had a disastrous effect.

10.72 It is clear from the evidence that Dr Brown was, and should have known that he was, under a duty to report to an appropriate authority any concern of a serious nature affecting the safety of patients. In my judgement, Dr Brown's concern about Shipman's treatment of Mrs Overton fell into this category. Dr Brown has never claimed that he was unaware of the existence of this duty, rather he considered that it did not apply to him in the particular circumstances. It was enough, in his view, that he had given information to the family and left it to them to make a complaint if they chose to do so.

10.73 Dr Brown did not, however, provide the family with the full information necessary for them to make an informed decision as to whether they wished to make a complaint. He told Dr Overton only that Shipman had given Mrs Overton some morphine. He enquired whether Dr Overton appreciated the significance of giving morphine to an asthmatic patient. Dr Overton said that he did. Dr Overton was not told that Shipman had apparently given 20mg, a wholly inappropriate dose, or that he appeared to have given it as a 'stat' or bolus dose. In my judgement, if Dr Brown thought it appropriate to pass to Dr Overton the responsibility of deciding whether Shipman's conduct should be looked into, he should have ensured that Dr Overton was fully informed. In criticising Dr Brown in this respect, I recognise that, at the time, there were some doctors, probably many, who would have acted as he did.

10.74 However, in my view, it was not acceptable for Dr Brown to excuse himself from his own duty by passing the decision to Dr Overton, certainly not once he realised that the Overton family had decided to do nothing. By that stage, Dr Brown knew or should have known that

it was up to him and Dr Husaini to take any action that was required. I accept that it was reasonable for Dr Brown to take into account the family's wishes but, even if the family had expressed a strong wish that no action should be taken, Dr Brown could not be absolved from all responsibility. As Dr Husaini has recognised, the circumstances gave rise to a duty to report. Both Dr Husaini and Dr Brown were aware that Shipman's treatment of Mrs Overton was unacceptable and had gravely injured her. They knew nothing about what Shipman thought about the treatment he had given. He might have mistakenly picked up the wrong ampoule. But, for all they knew, he might have been under the impression that 20mg morphine was appropriate treatment for an asthmatic patient apparently suffering from chest pain. If he was under that impression, his patients were at risk of serious harm. In those circumstances, the duty lay jointly on Dr Husaini and Dr Brown to make a report to an appropriate authority. The right course would have been for one of them to speak to Dr Overton and to explain why, notwithstanding the family's decision not to complain, the consultants felt unable to let the matter pass, on patient safety grounds. I think it likely that, had such a conversation taken place, Dr Overton and Mrs Sharon Carrington, Mrs Overton's daughter, would have agreed to co-operate, so long as Mrs Overton's parents were not required to be involved.

10.75 What would have been an appropriate authority to which the doctors could have reported their concerns? It is clear that there were two possibilities. The consultants could have made a report to the GMC or they could have made one locally in Tameside. I can well understand Dr Brown's reluctance to make a report to the GMC. For one thing, he might have been uncertain whether an error of the kind he believed had been made would amount to SPM. Also, I accept that doctors believed (not unreasonably) that, before they could properly approach the GMC, they had to investigate the facts fully and present a case, rather than just report a concern without something more to back it up. I accept that it would have been difficult, and indeed probably inappropriate, for Dr Brown and Dr Husaini personally to undertake any further investigation of Shipman's conduct. I also accept that some doctors hesitated to report a colleague to the GMC because they feared that they might be accused of disparagement. I have said that any doctor who took an interest in ethical matters and kept himself up to date would have known that there was no danger of that, provided the report was made in good faith. However, I accept that Dr Brown held that outdated view. Taking these factors into account, I would not criticise Dr Brown and Dr Husaini for not having taken their concerns direct to the GMC, if they had reported them locally.

10.76 However, there was no local report. None of the explanations advanced by Dr Brown amounts to a real excuse for that. Dr Husaini claimed that he did make a report to Mr Butterworth. In fact, I have found that he did not, but it is clear that Mr Butterworth would have been an appropriate person to whom such a complaint could have been made. If Dr Brown was at a loss regarding to whom he should speak in Tameside, he could have asked the MDU for advice. MDU staff could have explained to him the local arrangements for the disciplining of GPs. They might have told him that, in order to lodge a formal complaint, it was necessary to identify a complainant and that, in the light of the family's attitude, that might have presented a problem. They might well have advised him to speak to the Medical Director of his own Trust or to approach the FHSA or the LMC. They would

certainly not have left him without a lead. They would have assured him that, provided his concerns were genuine, as they plainly were, he was under a duty to act and would not be accused of disparagement; nor would he be expected to have carried out a full investigation. In short, I am critical of both Dr Husaini and Dr Brown for their failure to make any attempt to report their concerns to an appropriate person or body in Tameside. The fact that neither of them telephoned their medical defence organisation for advice convinces me that they did not even give the matter serious consideration.

10.77 My criticism of these doctors is tempered by the evidence that I have heard about the actual practice of reporting concerns in NHS hospitals in 1994. Quite simply, the culture was that it was 'not done'. The leadership of the profession, over a substantial period of time, is responsible for that culture. By 1994, both Dr Brown and Dr Husaini had been qualified as doctors for many years. For the bulk of their professional lives, it had been normal practice to turn a blind eye to the faults of colleagues. In my early career at the Bar, it was extremely difficult to find a medical expert who would give evidence which was critical of a colleague, even though the treatment complained of was grossly negligent and even though the two doctors were not acquainted. The evidence I have heard is, therefore, consistent with my own experience. In the late 1980s and early 1990s, the GMC took active steps to change this culture of mutual protection. It might be said with some force that it could and should have acted sooner. However, starting around 1987, it did begin to act. A minority of doctors responded. Some had already recognised the duty that was by then clearly promulgated. But many did not. Many members of the profession were, and perhaps still are, very conservative. Their deeply rooted *mores* were not to be changed overnight and it required the tragedy at the Bristol Royal Infirmary to bring the message home. So, although I am critical of Dr Brown and Dr Husaini for their failure to comply with their professional duty to report a doctor whose conduct gave rise to a danger to patient safety, I moderate my criticism by accepting that, in 1994, a majority of doctors in this country would probably have acted in a similar way.

10.78 There remains one outstanding issue concerning Dr Brown. For reasons explained above, I am critical of him for failing to give Dr Overton a full account of his concerns. He gave 'a hint' but not a proper explanation. However, I temper that criticism because I accept that, in 1994, it was common practice to withhold relevant information about mishaps from patients and relatives. Such conduct was not acceptable but I recognise that many doctors, possibly a majority, would have acted in the same way. Some might well not have mentioned it at all.

10.79 Finally, I turn to the position of Dr Husaini. In the Third Report, I was severely critical of the evidence that he gave. He sought to persuade me that he had reported his concerns but I am quite satisfied that he did not. I think that by the time he came to provide his witness statement to this Inquiry, Dr Husaini felt embarrassed or ashamed about his failure to report his concerns. I accept that Dr Husaini cared very much about what had happened to Mrs Overton and he did a great deal to help and support her family during her 14 month stay on ward 17. I think that, when Dr Husaini realised how serious Shipman's conduct towards Mrs Overton had been, he persuaded himself that he had reported his concerns appropriately but that others had failed to act upon them. In not reporting his concerns at

the time, as he should have done, he acted in the way that many other doctors would have done at that time.

Causation

The Immediate Consequences of a Report of Concern

10.80 Had Dr Brown or Dr Husaini reported their concerns to Mr Butterworth or to the Medical Director designate or to some other person in a senior position, such as Mrs Linda Lloyd, the Hospital's Director of Operations, then, in all likelihood, the report would have been passed to the Tameside FHSA. Mr Butterworth said that he did not know what the arrangements were for investigating a concern about a GP but he explained how he would have gone about finding out. As it would immediately have appeared that the allegation involved a potential breach of Shipman's terms of service, the report would probably have led to MSC proceedings, provided that a suitable complainant could be identified. I have already said that, if the consultants had explained to the Overton family their decision to report Shipman, a member of the family might well have been prepared to co-operate by acting as complainant. However, if they had not, there might have been a difficulty in finding a suitable complainant. If Dr Brown had been willing to act as complainant, the MSC might have been prepared to accept him. If not, it would have been possible for the Tameside FHSA to act as complainant itself, in which event the case would have been transferred to the MSC of an adjacent FHSA. I acknowledge that such a course of action would have been unusual. If no satisfactory solution had presented itself to the FHSA, the decision might well have been taken to report the case straight to the GMC.

10.81 The case might also have reached the GMC by other routes. The consultants might have reported to that body direct or the case might have been referred there after the MSC hearing via the Family Health Services Appeal Authority (FHSAA). A further possibility is that, if an inquest had been held after Mrs Overton's death in 1995, the Coroner might have reported Shipman's role in the matter to the GMC.

Shipman's Likely Response

10.82 By whatever route the case had been reported, and whether to the FHSA or to the GMC, it is necessary to consider what Shipman's likely response would have been and how convincing it would have appeared. To answer this question, it is helpful to look again at the note Shipman made in Mrs Overton's medical records concerning her admission to hospital:

> **'V** (*visit*) **Called at 8.50.**
> **arrived 9.15 – Acute Asthma**
> **given nebuliser**
> **Pulmicort nebul.** × **1**
> **Ventolin nebul** × **5ml.**
> **BP 150/100. HR 120/m**
> **Resp** > **30.**
> **After nebuliser A/E** = **BS good**

not cyanosed
Approx 9.30 collapsed C/O chest
pain sweating + pulse thready
given IV diamorphine 10mg stat (only
dose in bag)
Settled then ?arrested
Laid down ECM × 5
Daughter called
MTM/established patient
ECM/not cyanosed
pupils dilated fixed
Ambulance called. pupils dilated
ECM/maintained
MTM/
15 mins Ambulance crew IV Adrenaline
IV Lignocaine. Intubated pink
pupils fixed dilated'.

Then, continued on a separate sheet:

'H/R. established output OK
(*illegible*) **No respiration established**
→TGH
CAS S/N informed of arrival
× diagnosis + Rx'.

10.83 I am quite sure that in making this note, which was uncharacteristically detailed for him, Shipman was seeking to paint a picture which was consistent both with the circumstances as Mrs Carrington knew them and with his having provided appropriate care to Mrs Overton in difficult circumstances. I think it most likely that his explanation would have been along the following lines. He would have said that he had attended Mrs Overton and had treated her acute asthma attack appropriately with a nebuliser, achieving good relief from her symptoms. Some time later, but while he was still with her, Mrs Overton had begun to complain of chest pain. Shipman would have said that, knowing (as he would have claimed he did) that Mrs Overton had some coronary heart disease, he believed that her chest pain was due to a cardiac episode and was unrelated to her asthma. As the pain seemed severe and as Mrs Overton appeared very distressed, he had decided to administer some diamorphine. He had with him only one ampoule, containing 10mg. He made it up and administered some of it intravenously. He would probably have said that he did not administer all 10mg but had paused to observe its effect, which was satisfactory, for a few moments until Mrs Overton had suddenly collapsed. He had realised that she had stopped breathing and he could find no pulse. He had run to call Mrs Carrington and the two of them had started resuscitation. If asked why he had given as much as 10mg of diamorphine, he might well have said that he was unsure how much he had in fact given although he knew that he had not given the whole dose. He might well have claimed to be unsure of the amount given owing to the shock of Mrs Overton's sudden collapse. He might well have said that he had recorded that he had given 10mg

in order to account for the use of the ampoule. He had used the word **'stat'** to indicate that he had given the dose 'there and then' as opposed to having prescribed it for future use.

10.84 If the circumstances had been appropriately investigated, Shipman would have found himself in serious difficulty defending his conduct. In particular, although he would have been able to refer to a recent (probably fabricated) entry in Mrs Overton's medical record suggesting that she had had cardiac symptoms on 10th February 1994, a battery of tests following her admission to hospital showed that she had not suffered a recent heart attack. Moreover, the autopsy in 1995 revealed no ischaemic heart disease. Thus, an investigation in 1994 would have cast doubt on Shipman's claim that Mrs Overton had had a heart attack and, if the investigation had continued into 1995, it would have demonstrated that Mrs Overton could not have had any cardiac episode at all. Second, Shipman's claim that he had given less than the recorded 10mg of diamorphine would have come under scrutiny. Why say that the 10mg ampoule was the **'only dose in bag'** if he had administered only a part of the available ampoule? The excuse of **'only dose in bag'** appears to be an explanation for giving 10mg. Why say he gave it as a **'stat'** dose? Third, if Mrs Carrington had made a statement, it would have been known that Shipman had administered something to Mrs Overton after she had collapsed and was unconscious. What could that have been? His record is silent on the subject. If he were to claim that Naloxone or adrenaline had been given (either of which would have been appropriate), he would have to explain why this was not mentioned in the notes. Finally, the terrible outcome suffered by Mrs Overton was absolutely consistent with her having been given a gross overdose of diamorphine.

The Case before the Medical Service Committee

10.85 I have already said that, if one of the consultants had explained the situation fully to Dr Overton and had said that he must make a report even if the family did not, I think the family would probably have co-operated. A case would have been mounted against Shipman and I think it likely that an oral hearing by the MSC would have been ordered. It is possible that Shipman would have 'put his hands up' and suggested that he had inadvertently given more diamorphine than he should have done. He had done this in 1990 when a complaint about an error in the prescribing of anti-convulsant medication had been made on behalf of one of his patients, Mr W. In that case, the MSC dealt with the matter without an oral hearing. However, in Mrs Overton's case, taking into account the discrepancy between the account Shipman would have given (based on the entry he made in the GP records), and what was recorded in the hospital records, it is likely that the Chairman of the MSC would have ordered a hearing. This would probably have taken place in early 1995. It might have occurred before Mrs Overton died, in which case the results of the autopsy would not have been available. Shipman would have been charged with a failure to render Mrs Overton all necessary and appropriate personal medical services of the type usually provided by GPs, a breach of paragraph 12 of the terms of service set out in Schedule 2 to the NHS (General Medical Services) Regulations 1992. There would have been no evidential difficulty if Mrs Carrington had given evidence and if one of the consultants (probably Dr Brown on account of his relevant expertise) had provided expert opinion as to

Shipman's conduct. It might also have been sensible for the family to have asked for one or more of the staff on duty at the time of Mrs Overton's admission to hospital to be called to give evidence as to what Shipman had said and how the hospital records had come to be made.

10.86 It is possible that the MSC might have accepted Shipman's account and acquitted him of any breach of the terms of service. However, given the problems that would have been faced by Shipman, as outlined above, I think it likely that he would have been found to be in breach of paragraph 12. I think it likely that the conclusion of the MSC would have been that Shipman had made a serious error and had given an overdose of diamorphine, owing either to carelessness or to lack of knowledge of its effect. I do not think it at all likely that the MSC would have suspected him of causing deliberate harm. Nor do I think it would have gone into the question of where he had acquired the diamorphine. Many doctors carry diamorphine in their bags as a matter of course. They buy it on requisition from a pharmacy and keep their own controlled drugs registers (CDRs). The concern would have been over his clinical competence rather than his observance of the regulations relating to controlled drugs. That Shipman was carrying a 10mg ampoule of diamorphine in his bag would not have aroused any concern.

10.87 Nor am I convinced that the MSC would have formed the view that Shipman had prepared a false record, either in relation to the entry prior to 18th February 1994 in which he claimed Mrs Overton had reported cardiac symptoms or in relation to the occasion of her collapse. It might have done. If it had, obviously it would have formed a much more serious view than otherwise. On balance, I think it unlikely that it would have made such a finding unless the evidence was crystal clear; it would have been unwilling to make such a finding if there was any plausible explanation for the discrepancies between Shipman's record and the facts as it had found them to be.

10.88 When considering what penalty to recommend, the MSC would have been informed that two other findings had been made against Shipman within the last five years. These cases are described in detail in Chapter 6. The MSC would have been told of the findings in the case of Mr W and Mrs B. The case of Mr W involved the prescribing of the wrong amount of anti-convulsant medication, an error which had caused significant harm. For that breach of his terms of service, Shipman had been warned but there had been no financial penalty. In the case of Mrs B, Shipman had failed to visit the patient when he should have done. He was warned and a withholding of £800 from his remuneration had been ordered. As a result, I am sure that a significant withholding in excess of £1000 would have been made in Mrs Overton's case and would have been upheld by the FHSAA after advice from the Medical Advisory Committee. I think the likelihood also is that the case would then have been referred to the GMC. That would not have come about until late 1995 at the earliest, and more likely well into 1996.

10.89 Without family support for pursuing the case, the position would have been more complex. In Dr Givans' considerable experience, very few cases were brought before the MSC by persons other than the patient him/herself or a member of his/her immediate family. However, occasionally a complaint was made to the FHSA by a third party (for instance, a community nurse). In such cases, the FHSA took over the role of complainant

in accordance with the procedure I have described in Chapter 6. Thus, while it would have been possible to proceed without the participation of the family, particularly that of Mrs Carrington, it is less likely that the complaint would have proceeded before a MSC.

The Inquest

10.90 Had there been an inquest, informed by an appropriate autopsy report which would have recorded the potential role of opiates in Mrs Overton's death, Mr Revington would have heard evidence about the circumstances of the death. This might have included evidence from Dr Brown and Dr Husaini. It is too speculative to say what would have been the verdict of the Coroner or the jury. However, there is a real possibility that the Coroner might have taken the view that the death had been caused by Shipman's action in administering an overdose of diamorphine. If so, it would have been open to him to refer Shipman to the GMC. Whether he would have done so, I find it impossible to say. Examination of some of the cases comparable to Mrs Overton's case, which were considered by the GMC at about the same time, reveals that coroners did not always refer such cases to the GMC, even where there had apparently been gross negligence.

The General Medical Council

10.91 I consider, first, what would have happened if Dr Brown had reported Shipman to the GMC and it had decided to consider the case rather than to advise Dr Brown to report the matter locally. The relevant GMC procedures are dealt with in Chapters 18–21. The first stage would have been for the report to be considered by a member of the office staff. I am satisfied that, since it was being brought by a senior doctor, the case would then have been passed to a medical screener. It is likely that, before the screener considered the case, Dr Brown's report would have been sent to Shipman and his response sought. There would not have been any other investigation by the GMC. Internal Guidance from 1994 reflected the rarity of the cases in which the GMC undertook any investigative role. The Guidance stated:

> **'The onus to produce evidence is almost entirely on the complainant, and not on the GMC, because the GMC does not have much by way of investigative powers at the preliminary stage of the procedures; its powers of subpoena are confined to cases being heard by the PCC or Health Committee.'**

Then, in the next paragraph, it stated that:

> **'In a very small number of cases, however, the medical preliminary screener may consider, on the advice of the office, that the matters alleged are so serious that a thorough informal investigation should be carried out locally by the Council's solicitors, who will then attempt to investigate the case and take statements, insofar as potential witnesses are prepared to co-operate.'**

10.92 It then pointed out that it was not possible, because of limited resources, to investigate many cases of potential SPM in this way. Thus, and this is consistent with what Dr Brown thought, as well as what the MDU and other organisations were advising, if any investigation or evidence gathering was to be done, it had to be done locally and would not be done by the GMC, at least not during the early stages.

10.93 Thus, the documents before the medical screener would probably have been limited to Dr Brown's letter of complaint and Shipman's response to it. The GMC might have asked Dr Brown to send the hospital notes and Shipman would probably have sent the relevant extracts from Mrs Overton's GP records. Dr Krishna Korlipara, who was a GMC medical screener from 1998 until 2004 and gave oral evidence to the Inquiry in November 2003, was of the view that Shipman's case would have been passed by the medical screener to the PPC. I accept that that would probably have occurred. Dr Korlipara also said that the PPC would have referred the case on to the PCC. He may be right, although, in the course of Stage Four, I have seen some cases that have been closed by the PPC which were every bit as serious as this one would appear to have been. For example, in the case of Dr JK 07, which was considered by the GMC in the late 1990s, there was compelling evidence that the doctor had injected an overdose of lignocaine (a local anaesthetic given before an operative procedure) and that this had caused the death of a young patient. The GMC obtained medical evidence from an eminent professor in anaesthesia (who was also a member of the GMC) which expressed the view that the dose given was unacceptably large and suggested that the doctor had been guilty of SPM. However, the PPC decided that it was not necessary to refer the matter to the PCC and issued a warning to the doctor as to his future practice I will describe the case in greater detail in Chapter 20.

10.94 Although I am uncertain about it, I do accept that Mrs Overton's case might well have gone through to the PCC. Had it reached the GMC after an adverse finding by the MSC or after criticism by the Coroner, the case would have been quite likely to go through to the PCC. Would there have been a finding of SPM? Dr Korlipara said that he thought there would have been and that there was a possibility that Shipman might have been erased from the register. Alternatively, he said, there might have been a period of suspension, or conditions might have been imposed, restricting Shipman's freedom to prescribe controlled drugs.

10.95 Assuming that the case had been sent to the PCC for hearing (in which case the GMC solicitors would have undertaken any further investigation they considered necessary, in preparation for the hearing), I cannot predict whether there would have been a finding of SPM. It is possible that there would have been. However, if there had been, I do not think it would have resulted in erasure. I reach that conclusion after scrutinising a number of similar cases dealt with by the GMC at about this time. The following cases are, in my view, relevant.

Dr JC 02

10.96 Over a period of two years in the early 1990s, Dr JC 02, a GP, caused the deaths of two patients by administering excessive doses of diamorphine. Both deaths led to inquests. The first death was apparently caused by the doctor having given 15mg diamorphine. At

the inquest, the Coroner suggested to the doctor that he (the Coroner) had received expert evidence that the appropriate dose was between 5 and 10mg. The doctor said that he remembered a conversation with a GP in Scotland who had advised him never to give less than 15mg as a smaller dose would 'only irritate the patient'. The Coroner returned a verdict of death by misadventure but did not refer the case to the GMC. About 12 months after the first inquest, the same doctor came before the same Coroner. This time, the doctor reported having administered 20mg diamorphine. The Coroner reminded the doctor that he had in the past had occasion to admonish him about his injudicious use of diamorphine and the doctor said that he would never use it again. The Coroner returned a second verdict of death by misadventure and referred the case to the GMC. The case came before the PCC and the doctor was found guilty of SPM. He was made subject to eight months' conditional registration with the requirement that he should not prescribe or possess diamorphine and should undergo retraining in the use of **'therapeutics'**. When his case was considered by the PCC, after the expiry of the eight-month period, the case was referred to the Health Committee, which later found the doctor's fitness to practise to be impaired by reason of ill health and imposed further conditions on his freedom to practise.

Dr JF 02

10.97 In the early 1990s, a consultant orthopaedic surgeon reported to the GMC a GP, Dr JF 02, who had given 100mg diamorphine to a patient who then suffered a respiratory arrest. The patient was successfully resuscitated. The case came before the PCC and, following a finding that he was guilty of SPM, the doctor's registration was made subject to conditions for a period of six months. He was required to pursue a structured programme of retraining in the use of scheduled and controlled drugs. At the hearing, it was accepted by the PCC that this had been an isolated incident. In fact, an unrelated complaint of indecent assault, made at about the same time against the same doctor, had foundered because the complainant had not supported the complaint with a statutory declaration as was necessary at that time.

Dr JG 03

10.98 In the early 1990s, Dr JG 03 gave propranolol to a young female asthmatic patient with the result that she died following respiratory depression. At the inquest, the doctor produced and relied on falsified computerised medical records. The purpose of falsification had plainly been to mislead any subsequent investigation into his conduct. There was a verdict of accidental death and the police became involved. The doctor was charged with manslaughter and perverting the course of justice in respect of the falsified records. He was acquitted of manslaughter but convicted of perverting the course of justice and was sentenced to six months' imprisonment. On reference to the GMC, the PCC found that the doctor's care of the patient had fallen deplorably short of a reasonable standard and found him guilty of SPM but, because of the period of imprisonment served and other factors regarded as mitigating the severity of the offence, he was made subject to one year's conditional registration. The conditions were that he should undergo assessment by and follow guidance (about the keeping of full, accurate and contemporaneous medical

records) from his Regional Adviser in General Practice. The Inquiry did not come across any case similar to that of Mrs Overton, in which the doctor had been erased, although in one case the doctor was erased after failing to comply with conditions imposed on his registration, following a similar episode.

The Overall Effect of Reporting Shipman

10.99 I have already said that I think it unlikely that the true extent of Shipman's criminality would have come to light, or even have been suspected, as the result of any report by Dr Brown or Dr Husaini. Nor do I think that a report or a referral to the GMC would have resulted in Shipman being erased from the medical register. He would have been free to continue in practice with or without a short interlude of suspension or of restricted practice. However, a period of suspension would necessarily have led to some curtailment of his criminal conduct, as would the imposition of a condition not to prescribe or administer controlled drugs. It would have been much more difficult and risky for him to obtain illicit supplies of diamorphine, his preferred drug. Indeed, if notice of any restriction were to have been properly circulated he might have had great difficulty in obtaining a supply.

10.100 In the First Report, I drew attention to the fact that Shipman did not kill for a period of three months after Mrs Overton's admission to hospital. In my view, if any disciplinary processes had begun, this period of abstinence would probably have been lengthened. There would have been a beneficial effect, even if the processes had not resulted in any penalty or restrictions upon his registration. I think it likely that Shipman would have stopped killing for a significant time. However, I cannot say for how long.

10.101 A finding of a breach of his terms of service would, I think, have had some salutary effect on Shipman. I think even this would not have been great, as MSC proceedings are held in private and relatively few people would have been aware of the proceedings and the finding. There might have been some talk in the town and this might have taken the shine off his reputation. It is unlikely that people would have realised the seriousness of what he had done. It appears that the findings against Shipman in the case of Mr W and Mrs B did not significantly harm his reputation. They were, of course, much less serious than the complaint in respect of Mrs Overton. It is possible that the MSC complaint about his prescribing an excessive quantity of anti-convulsant medication for Mr W contributed to the slowing of his criminal activity in 1990 and his complete abstinence in 1991, although in the First Report I have identified at least one other possible reason for these features. It does not seem, however, that the MSC complaint about his treatment of Mrs B had any lasting effect on his behaviour; during 1993, he regularly obtained single diamorphine ampoules to replenish the stocks he needed to kill his patients. A complaint in 1994 about his treatment of Mrs Overton might have had a more salutary effect. First, he had killed her. Second, he had done so using diamorphine. Third, this would have followed quite shortly after the other complaints.

10.102 If Shipman had been criticised by the Coroner at an inquest into Mrs Overton's death in 1995, the effect on his future course of conduct might have been very significant. Inquests are held in public and are usually reported in local newspapers. If the Coroner had made it plain that Shipman had given Mrs Overton a dangerous dose of diamorphine, several

things might have happened. First, Shipman's reputation would have been dented to some extent. Some of his patients, some of his patients' relatives, his staff and some of his colleagues might have been a little less trusting of him than they otherwise would have been. Fellow GPs, when asked to sign cremation Forms C, might have been more careful when endorsing his opinion as to the cause of death. Mrs Ghislaine Brant, the pharmacist at the premises next door to Shipman's surgery from where he obtained most of his supplies, might have reflected upon Shipman's use of 30mg ampoules of diamorphine in 1993 and she might have resolved to scrutinise his prescriptions more carefully in future. His staff might have been less trusting of him if and when, from 1995, the death rate in his practice increased significantly. It is not possible to say whether these suspicions would ever have been enough to lead to his detection. I think it likely that Mr David and Mrs Deborah Bambroffe, the funeral directors who came to suspect Shipman of killing his patients, would have felt more confident about raising their concerns and might have done so rather sooner than they did. If they had mentioned their concerns earlier, the members of the Brooke Practice might have realised sooner than they did that the death rate among Shipman's patients was abnormally high and might have made their report to the Coroner sooner than they did. If, when the West Pennine Health Authority became aware of a police investigation, it had also known of the outcome of the MSC hearing in relation to Mrs Overton, Dr Banks' approach to the examination of medical records might have been more open-minded and the result might have been different. The greatest effect in my view would have come from Shipman's awareness that he was not completely trusted, as he had been before. That, I think, would have made him more careful and would have restricted the number of patients he felt confident to kill. In short, I believe that publicity or any kind of disciplinary action or even the threat of it would have had a restricting effect on Shipman and lives would have been saved. I cannot say how many.