CHAPTER SIXTEEN

The General Medical Council's Handling of Shipman's Case in 1976

Introduction

16.1 Following Shipman's conviction, in January 2000, on 15 counts of murder (carried out by injecting each of his victims with an overdose of diamorphine, an opiate drug), it came to light that, in 1976, he had been convicted of a series of offences in connection with another opiate drug, pethidine. These offences included not only unlawful possession of the drug but also obtaining pethidine by deception and forgery. The offences had been committed over a period of about 14 months. Many people, shocked at this discovery, suggested that the General Medical Council (GMC) ought to have erased Shipman's name from the medical register in 1976. It was said that, if the GMC had 'struck him off' the register then, Shipman would not have been able to perpetrate his later crimes. In fact, he had been permitted to continue practising. It has not, so far as I am aware, been suggested that the GMC should have recognised Shipman as a potential murderer, only that he should have been dealt with much more severely for the offences he had committed at that time.

16.2 In this Chapter, I shall describe the disciplinary procedures operated by the GMC in 1976 and will consider the way in which Shipman's case was handled. So far as I am able, I shall examine the reasons why it was handled as it was. Because I wished to set the handling of Shipman's case in context, the Inquiry sought disclosure of the files of all the drug-related cases considered by the GMC's fitness to practise (FTP) committees in the years 1975 to 1980. I wished to examine cases of a similar type to Shipman's, so as to see whether the way in which his case was dealt with was in any way exceptional. I also wished to understand the policy considerations that lay behind the decision in his case and to gain some insight into the criteria applied by the GMC when considering cases involving drug-related offences. After examining these issues, I shall explain my conclusions about the reasonableness of the GMC's decision in Shipman's case.

The General Medical Council Staff in Post in 1976

16.3 In 1976, the GMC's administrative staff was headed by the Registrar, Mr Martin Draper. It seems that he had been at the GMC from about 1950 or 1951. In 1976, Mr Robert Gray was Assistant (later Deputy) Registrar. He had previously worked in colonial, then university, administration. He had joined the GMC in November 1971. From that time until about June 1976, and from a date in 1980 until his retirement in February 1988, Mr Gray was Head of the GMC's Discipline Division. In that capacity, he was responsible, under the supervision of the Registrar, for dealing with administrative matters relating to the disciplinary procedures of the GMC. Also working in the Discipline Division was an administrative assistant, Mr Adrian Williams (who was employed between December 1970 and May 1977), and a second administrative assistant, who has not been identified. The Discipline Division also had secretarial and typing staff. Mr Gray gave oral evidence to the Inquiry. Mr Williams provided a witness statement. Mr Draper's state of health was such that he

could not assist the Inquiry by providing a statement or attending to give evidence. He died in August 2004.

The General Medical Council's Procedures in 1976

The Power of the General Medical Council to Act in Respect of a Conviction

16.4 In 1976, the GMC was governed by the Medical Act 1956, as amended by the Medical Act 1969 (the 1956 Act). At that time, the only FTP procedures in operation were the conduct procedures. The health procedures were not introduced until 1980 and the performance procedures did not come into effect until 1997.

16.5 In 1976, the amended section 33 of the 1956 Act provided:

> **'(1) Where a fully registered person –**
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> **(a) is found by the Disciplinary Committee to have been convicted (whether while so registered or not) in the United Kingdom or the Republic of Ireland or any of the Channel Islands or the Isle of Man of a criminal offence; or**
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> **(b) is judged by the Disciplinary Committee to have been (whether while so registered or not) guilty of serious professional misconduct,**
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> **the Committee may, if they think fit, direct that his name shall be erased from the register or that his registration therein shall be suspended (that is to say, shall not have effect) during such period not exceeding twelve months as may be specified in the direction.'**

The Disciplinary Committee (DC) of the GMC therefore had jurisdiction under section 33 to take disciplinary action in respect of a criminal conviction or in respect of conduct amounting to serious professional misconduct (SPM). The procedures for dealing with conviction cases and with cases involving complaints of SPM ('conduct cases') were different. Shipman came before the GMC by reason of his conviction. I shall, therefore, confine my description of the GMC procedures at the time largely to the procedures relating to conviction cases.

16.6 It should be noted that, in 1976, the term **'convicted ... of a criminal offence'** did not include a finding of guilt in respect of which a doctor was placed on probation or was discharged conditionally or absolutely. Nor did it include a criminal offence for which a doctor had been cautioned by the police, despite the fact that a police caution would not have been administered in the absence of an admission of guilt.

16.7 The GMC's primary source of information about convictions was the police, who were required by a Home Office Circular of 1973 to report to the GMC convictions which might reflect on a doctor's suitability to continue in his/her profession. In particular, the police were required to report offences involving violence, indecency, dishonesty, alcohol or drugs. Although the police were not obliged to report findings of guilt where a doctor had been made the subject of a probation order or a discharge (and where there was,

therefore, no 'conviction'), Mr Gray told the Inquiry that, in practice, they usually did so. If a finding of guilt in respect of which a probation order or discharge had been imposed was brought to the GMC's attention, the GMC might elect to proceed by treating the matter as a complaint of SPM.

16.8 All conviction cases, other than those for minor motoring offences not involving alcohol, drugs or injury to others, were referred by the GMC staff to the Penal Cases Committee (PeCC). The PeCC was the predecessor of the Preliminary Proceedings Committee (PPC). It had the task of deciding which cases should go forward 'for inquiry' (i.e. for hearing) by the DC. The DC was the equivalent of the present Professional Conduct Committee (PCC).

16.9 The General Medical Council Disciplinary Committee (Procedure) Rules Order of Council 1970 (the 1970 Rules) provided that cases involving convictions should be submitted by the Registrar to the President of the GMC or to a member ('screener') nominated by him. However, in practice, the President and the staff had an arrangement whereby all cases of conviction (save the most serious, which went to the President) were referred by staff directly to the PeCC without the intervention of the President/screener. When notification of a conviction came into the GMC office, the staff would usually attempt to obtain information about the circumstances of the offence for which the doctor had been convicted. This information would most commonly come from the police or the Home Office. When the staff considered that there was sufficient information, the case would be placed on the agenda for the next meeting of the PeCC. Meetings of the PeCC took place three times a year.

The Penal Cases Committee

16.10 The PeCC consisted of the President of the GMC (or a member of the GMC nominated by him) who chaired the Committee, together with one elected, medically qualified ('medical') member of the GMC, one lay member and three medical members drawn from the GMC's Branch Councils for England and Wales, Scotland and Ireland respectively. In April 1976, Sir John (later Lord) Richardson, a consultant physician, was President. Other members of the PeCC were Professor (later Professor Sir) William Trethowan (a consultant psychiatrist), Dr Derek Llewellyn (a general practitioner (GP) from the England and Wales Branch), Dr William Fulton (a GP from the Scotland Branch) and Dr Thomas Murphy (Ireland Branch). The lay member, Miss Ruth Cohen, had retired the previous year and had not yet been replaced. The legal quorum was three. The PeCC was advised by a legal assessor, who was present at all its meetings.

16.11 By rule 6(1) of the 1970 Rules, the PeCC, having considered a case, was required to determine either:

> **'(a) that no inquiry shall be held in the case by the Disciplinary Committee, or**
> **(b) that the matter in question shall, in whole or in part, be referred to the Disciplinary Committee for inquiry either at the next meeting of that Committee or at such future meeting as the Penal Cases Committee or the President may determine'**.

The Inquiry was told that no written criteria existed to guide members of the PeCC in deciding whether a case should be referred to the DC. Mr Gray told the Inquiry that he did not believe that any criteria were necessary. He was of the view that the group of people involved was so small and their involvement in the work so regular that they knew upon what principles to act. The 1970 Rules themselves provided no criteria; they appear to have given the PeCC an unfettered discretion. I shall return to the issue of principles and criteria later.

16.12 Rule 6(3) provided that:

> **'Before coming to a determination the Penal Cases Committee may if they think fit cause to be made such further investigations, or obtain such advice or assistance from the Solicitor or Counsel instructed by him, as they may consider requisite.'**

16.13 The first possible outcome of a case considered by the PeCC was a referral to the DC for inquiry at a public hearing. The second possible outcome was no referral to the DC. The third possible outcome was a request for further information or legal advice. If such a request was made, the PeCC would adjourn consideration of the case until the information or advice had been obtained. It was also possible, in certain circumstances, for the PeCC to make a 'provisional determination'. This option was not relevant to Shipman's case and I shall not, therefore, consider it further. It is important to note that the PeCC had no power to suspend a doctor's registration pending determination of his/her case by the DC, even if the doctor appeared to pose a danger to patients. Nor did it have any power to impose conditions on a doctor's registration.

16.14 I shall now consider briefly the various possible outcomes.

Referral to the Disciplinary Committee for Hearing

16.15 If the PeCC decided to refer a case to the DC, the doctor would be notified of that fact, and of the matters to be considered by the DC and the arrangements for the hearing. He or she would be given the opportunity of submitting evidence to the DC.

No Referral to the Disciplinary Committee

16.16 If the PeCC decided not to refer a case to the DC, the 1970 Rules required the Registrar to inform the doctor of the decision of the PeCC in such terms as the PeCC might direct. On occasion, the PeCC used this provision to direct that a letter be sent to the doctor concerned, warning him/her about his/her future conduct. The January 1976 edition of the GMC publication 'Professional Conduct and Discipline' (known as the Blue Book) set out a description of some circumstances in which warning letters would be sent:

> **'Warning Letters**
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> **Not every conviction or allegation of professional misconduct necessitates an immediate reference to the Disciplinary Committee for formal inquiry, although repeated offences may do so. It is the usual practice to send warning letters to a doctor who has been convicted for**

the first time of offences such as driving a motor car when under the influence of drink, or whose professional conduct appears to have fallen below the proper standards, in order that the doctor may reconsider his habits and conduct.'

It seems to me that one would not have expected, on reading this passage from the Blue Book, that a warning letter would be used in a case as serious as one involving multiple offences of obtaining controlled drugs, illegally and dishonestly, in the context of professional practice.

16.17 Mr Gray explained that, in general, warning letters were sent by the PeCC in conviction cases, rather than in conduct cases. This was because, in conduct cases, the misconduct would not usually have been proved by that stage. Thus, a letter warning a doctor about his/her conduct would not have been appropriate. The exception to this would be if the doctor had admitted the misconduct, for example if s/he had been charged with criminal offences and had pleaded guilty but had been conditionally discharged so that s/he had not, technically, been 'convicted'. Mr Gray told the Inquiry that a 'hierarchy' of warning letters had developed, depending on the PeCC's view about the seriousness of the doctor's behaviour. The Inquiry's examination of the outcomes of cases dealt with by the PeCC at its meetings in the mid-1970s showed that warning letters of various degrees of severity were considered appropriate for a variety of offences. For example, the PeCC gave instructions in a case of theft/shoplifting for a 'letter of disapproval' to be sent, in a case of drink driving for a 'warning letter', in the case of a failure to provide a specimen of blood or urine and of theft of a credit card for a 'severe warning letter' and, in another similar case, a 'strong warning letter'. However, no criteria were developed and no written guidance prepared.

16.18 The 1970 Rules provided that, where a decision had been taken not to send a case to the DC and the GMC subsequently received notification of a further conviction or a complaint of SPM against the same doctor, it was open to the GMC to deal with both the previous conviction and the new conviction or complaint of misconduct together, as if the earlier decision not to refer to the DC had not been made.

Request for Further Information

16.19 As I have indicated, the 1970 Rules gave the PeCC the power, if it thought fit, to cause further investigations to be made, or to obtain legal advice, before taking a final decision. This would plainly be a useful power if members felt it impossible to make a decision without obtaining a further piece of information or clarifying their legal position. However, the Inquiry's examination of cases involving convictions for drug-related offences considered by the PeCC in the mid- to late 1970s suggests that the power to adjourn for further investigations was being used for a rather different purpose, namely to exercise a degree of continuing supervision over a doctor who had been abusing alcohol or drugs. I shall discuss this use of the power to adjourn in greater detail later in this Chapter.

Procedure

16.20 The PeCC sat in private and made its decisions on the basis of written evidence and submissions. It dealt with a large caseload at each meeting, often as many as 30 or 40

cases. No witnesses were called to give evidence. The doctor who was the subject of the proceedings was not invited to attend. In the case of a complaint alleging SPM, the PeCC would usually have before it a response from the doctor, explaining his/her conduct. The 1970 Rules required that, before a case involving a complaint alleging SPM was sent to the PeCC, the doctor should be given the opportunity to furnish such an explanation. In conviction cases, however, there was no requirement at that time to invite the doctor to provide an explanation unless and until the case had been referred by the PeCC to the DC. The reason for this lay in the different procedures for dealing with convictions and complaints. In cases involving an allegation of SPM, the explanation given by a doctor for his/her conduct might be a relevant factor to be taken into account by the PeCC when deciding whether that conduct amounted or might amount to SPM. However, a conviction was treated by the GMC as conclusive evidence that the doctor was guilty of the offence of which s/he had been convicted. The 1970 Rules, therefore, reflected the intention that any explanation from the doctor relating to the circumstances of his/her conviction should, in general, be relevant only to the issue of what sanction was to be imposed by the DC. Despite the fact that there was no requirement in the Rules that a doctor should be asked to provide an explanation in a conviction case before the case was considered by the PeCC, the Inquiry's examination of the files of drug-related conviction cases dealt with by the PeCC in the mid- to late 1970s shows that doctors were often asked to provide an explanation and most did so. Indeed, in several cases where it appears that no such request was made, the doctor nevertheless proffered an explanation.

16.21 The minutes of the PeCC contained only a bare recital of the decisions reached. The PeCC was not required to give any reasons for its decisions.

The Disciplinary Committee

16.22 The DC consisted of the President (or another member of the GMC nominated by him), together with 18 other members of the GMC, at least six of whom were elected medical members and at least two of whom were lay members. The legal quorum was five. By 1976, it was no longer the practice (as had been the case until 1973) for the President to chair both the PeCC and the DC. Instead, the President chaired the PeCC, and the DC was chaired by a medical member, Mr (later Sir) Robert Wright, who had been nominated for this purpose by the President. The DC was advised by a legal assessor. Its hearings were held in public save in exceptional circumstances. Its deliberations were, however, conducted in private. Hearings of the DC were reported in the press and in public journals. Its procedures resembled in many respects those of a criminal court. Doctors who were the subject of proceedings before the DC were invited to, and usually did, attend the hearing. In general, they were legally represented, usually by solicitors and counsel instructed by their medical defence organisations. The doctor could give evidence and call witnesses. The DC's caseload for a single meeting was such that it could give more lengthy and detailed consideration to each case than could the PeCC.

16.23 In a conduct case, the allegations (or some of them) might be denied and the DC might hold a full hearing. The DC would have to make findings of fact and decide whether the facts which it had found proved amounted to SPM. If so, the DC would go on to consider the appropriate sanction. In a conviction case, the DC would be concerned only to

establish the gravity of the offence and to take account of any mitigating circumstances, before imposing a sanction. It was common for testimonials and other evidence about the doctor's character to be adduced by those representing him/her. The DC would take account of any adverse finding against the doctor which had been made by the DC in the past.

16.24 There were four courses of action open to the DC at the conclusion of a hearing in a conviction case or following a finding of SPM. The first was to admonish the doctor and conclude the case. The second was to postpone judgement, thereby effectively placing the doctor 'on probation'. Postponement could be *sine die* or to some specified future date or meeting of the DC. The third possible course was to direct that the doctor's registration should be suspended for a period not exceeding 12 months. The fourth option was to direct erasure of the doctor's name from the medical register.

16.25 I shall now consider briefly those four courses of action.

Admonishment and Conclusion of the Case

16.26 Admonishment by the DC would constitute a public warning. It might be reported in the press. It would form part of the doctor's FTP history. If an enquiry was subsequently made about that history, the enquirer should have been informed about the warning or supplied with a copy of the relevant DC minutes in which it was recorded.

Postponement of Judgement

16.27 Although the 1970 Rules provided for the postponement of judgement by the DC, they did not give any guidance as to the circumstances in which the power to postpone should be exercised. Assistance could, however, be derived from the Blue Book current at the time. The January 1976 edition stated:

> **'The primary duty of the Disciplinary Committee is to protect the public. In any case the Committee must therefore first consider whether the public interest requires it to remove the doctor's name from the Register, or to suspend his registration. Subject however to this overriding duty to the public the Committee considers what is in the best interests of the doctor himself. Largely for this reason the Council has evolved a system of postponing judgment, especially in relation to offences arising from abuse of drink or drugs, in order that the doctor may satisfy the Disciplinary Committee that he is able to conduct himself properly and to overcome any addiction to alcohol or drugs. In severe cases of addiction, however, the Committee may consider it necessary to order suspension while the doctor undergoes treatment.'**

The Blue Book went on:

> **'Postponement of Judgment**
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> **In any case where judgment is postponed, the doctor's name remains on the Register during the period of postponement. When postponing**

> **judgment to a later meeting the Committee normally intimates that the doctor will be expected before his next appearance to furnish the names of professional colleagues and other persons of standing to whom the Council may apply for information, to be given in confidence, concerning his habits and conduct since the previous hearing. The replies received from these referees, together with any other evidence as to the doctor's conduct, are then taken into account when the Committee resumes consideration of the case. If the information is satisfactory, the case will then normally be concluded. If however the evidence is not satisfactory, judgment may be postponed for a further period, or the Committee may direct suspension or erasure.'**

It should be noted that the Blue Book referred only to the DC, it made no reference to the fact that the PeCC might use its power to adjourn in order to postpone judgement on a doctor who had abused alcohol or drugs.

16.28 I shall discuss the use of the DC's power to postpone judgement at greater length later in this Chapter.

Suspension

16.29 In cases where the DC had elected to suspend a doctor's registration, it was open to it to resume consideration of the case before the end of the period of suspension. It could then, if it considered it appropriate, extend the original period of suspension or order erasure. Before resuming consideration of the case, the DC could, as when postponing judgement, ask the doctor to give the names of referees from whom information might be sought as to his/her habits and conduct since the suspension had been imposed. This information would be taken into account when the DC resumed consideration of the case. The Blue Book made clear that only if there was evidence that the doctor had not conducted him/herself properly, or that s/he was addicted to drink or drugs and had not responded to treatment, was the DC likely to order further suspension or to direct erasure at a resumed hearing. Again, it should be noted that, when the DC resumed consideration of a case following a period of suspension, the GMC staff did not attempt to find out about the doctor's conduct from an independent source. The doctor produced his/her own referees. Usually, in a case in which the doctor had been convicted of offences in connection with drugs of addiction, s/he would be expected to produce one or more reports from the consultant psychiatrist in charge of his/her treatment.

Erasure

16.30 The most severe sanction which could be imposed by the DC was erasure of a doctor's name from the medical register. No guidance appears to have been issued as to what type of case might warrant erasure and what factors might appropriately be considered in mitigation of the offence or conduct. If imposed, erasure prevented a doctor from practising and remained effective unless and until the doctor made a successful application for restoration of his/her name to the register. An application to restore could be made once ten months had elapsed after the original erasure order took effect. If the

first application for restoration was unsuccessful, a further period of ten months had to elapse before another application could be made. There was no limit on the number of applications for restoration that could be made. The January 1976 edition of the Blue Book pointed out that:

> **'The names of many doctors which have been erased have subsequently been restored to the Register, after an interval.'**

16.31 It was clear, therefore, that erasure was not necessarily intended to be permanent. The Blue Book explained that the DC examined every application to restore on its merits, having regard, among other considerations, to the nature and gravity of the original offence, the length of time since erasure and the conduct of the applicant in the interval.

Differences between the Proceedings and Powers of the Disciplinary Committee and of the Penal Cases Committee

16.32 To summarise, the main differences between the proceedings and powers of the PeCC and those of the DC were that the DC held a formal hearing in public and the PeCC held a meeting in private. The doctor usually attended and was represented at a hearing before the DC; indeed, it would be likely to create a poor impression if s/he did not attend. The doctor was not invited to attend meetings of the PeCC. Nor was s/he represented at such meetings. The PeCC made its decision on the basis of written material only. A hearing before the DC was likely to be reported in the press and any person making a specific enquiry of the GMC should have been told the outcome. The proceedings of the PeCC were confidential. The DC had the power of erasure and suspension; the PeCC did not.

Offences Involving Drugs and Dishonesty

16.33 The January 1976 edition of the Blue Book set out examples of certain kinds of offence and of types of professional misconduct which had in the past given rise to disciplinary action by the GMC. This was intended as guidance to doctors about what type of behaviour was unacceptable. The Blue Book made clear that the examples were not exhaustive. The issues of whether a particular course of conduct amounted to SPM, and of the gravity of a conviction, were, it was said, matters to be determined by the DC after considering the evidence in each individual case. There was no suggestion that the PeCC should concern itself with such issues.

16.34 The examples given in the Blue Book which are relevant to Shipman's case include the following:

> **'(iii) Abuse of controlled drugs**
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> **Disciplinary proceedings have been taken in cases in which a doctor has been found to have prescribed or supplied drugs of addiction or dependence otherwise than in the course of bona fide treatment.**
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> **Disciplinary proceedings have also been taken against doctors convicted of offences involving drugs which were committed in order to gratify the doctor's own addiction, or where a doctor has been convicted**

for driving or being in charge of a motor vehicle when under the influence of a drug or has treated patients when under the influence of drugs.'

and

'(vii) Offences involving dishonesty, indecency or violence

Disciplinary proceedings have been instituted against doctors convicted of criminal deception (obtaining money or goods by false pretences), forgery, fraud, theft, indecent behaviour or assault. A particularly serious view is taken of such offences if committed in the course of a doctor's professional duties or against his patients or colleagues.'

Shipman's case involved the prescription of controlled drugs otherwise than in the course of *bona fide* treatment, allied with offences of criminal deception and forgery, perpetrated over a significant period of time and committed to gratify his own addiction or dependence. The reader of the Blue Book might well have expected that a **'particularly serious view'** would be taken of such conduct.

The Report of the Merrison Committee

16.35 In 1975, the Report of the Committee of Inquiry chaired by Dr (later Sir) Alec Merrison into the Regulation of the Medical Profession (the Merrison Report) was published. For some time before publication of the Merrison Report, there had been mounting concern about the capacity of the existing regulatory system to deal adequately with the problem of sick doctors. The problem was twofold. First, the GMC could act only if a doctor had been convicted of a criminal offence or if s/he was found guilty of SPM. Even then, the sanctions available to the DC were limited. For example, the GMC considered itself powerless to act where a doctor was known to be a chronic alcoholic (and thus a risk to patients) but had not been convicted of a criminal offence and had not committed any act amounting to SPM. Thus, it was felt that the existing procedures failed to provide adequate protection for patients.

16.36 The other problem was that, in cases where it was possible to use the GMC's disciplinary procedures to deal with sick doctors, those procedures were punitive in nature and, in the case of proceedings before the DC, were conducted in public. Many people felt that this was an inappropriate – even an inhumane – way of dealing with doctors who were suffering from a physical or mental illness. Mrs Jean Robinson, who later became a lay member of the GMC, said of this period:

'There was great uneasiness that doctors who were unable to cope because of mental or physical illness – some in a pathetic state – had in the past been hauled up before a public hearing which was the equivalent of a criminal trial. I myself thought it outrageous that the body which set the standard for medical confidentiality was not preserving it for doctors themselves, by allowing them private hearing and supervision for health problems (such as mental illness) ...'.

16.37 Sir Donald Irvine, who was a member of the GMC from 1979 and President between 1995 and 2002, told the Inquiry that, in the 1970s, there was serious under-reporting by doctors of colleagues who were known to be a risk to patients because of an illness. The prime cause of that under-reporting was the threat of GMC action against the sick doctor, which could only (at least officially) be punitive. There were also concerns about the local arrangements for dealing with sick doctors which were, according to Sir Donald, 'patchy, ill co-ordinated and largely ineffective'.

16.38 The Merrison Committee had before it no reliable statistics showing the size of the problem but was confident that it was **'not small'**. The GMC had given evidence to the Committee to the effect that the largest category of cases of psychiatric illness arose from an addiction to drink or drugs which was **'associated with'** and **'accentuated the results of some other concurrent personality disorder'**.

16.39 The Merrison Committee had no doubt that there was an urgent need for the GMC to be given powers to deal with sick doctors. Its Report stated:

> **'The need for the GMC to have power to control the right to practise of sick doctors is so overwhelming and so obvious that it seems to us amazing that the GMC has continued for so long without such a power. There are very sick doctors, and by no means all of them have enough insight into their condition to retire from practice before they endanger their patients. Those who do continue to practise can be completely stopped from doing so only if they commit a criminal offence or do something which constitutes serious professional misconduct. That is not a rational way of ordering matters.'**

16.40 The Merrison Committee recommended the establishment of a Health Committee (HC) and arrangements for a stage of 'conciliation' before a formal hearing by the HC. The purpose of this conciliation would be to give a doctor the opportunity to agree to an examination by an expert and to enter into voluntary undertakings as an alternative to the case proceeding to a formal hearing. If the doctor complied with his/her undertakings, there would be no need for a formal hearing by the HC. The hope was that many doctors would be capable of rehabilitation. The Merrison Committee recommended that, if rehabilitation failed, the HC should have power to impose conditions on, or to suspend, registration. However, the Merrison Committee did not recommend that the sanction of erasure of a doctor's name from the register should be available to the HC. The GMC's health procedures, modelled on the recommendations contained in the Merrison Report, were introduced by the Medical Act 1978 and came into effect in August 1980.

16.41 The Merrison Committee emphasised, in its general discussion of the GMC's FTP procedures, the underlying purpose of those procedures:

> **'The GMC's actions towards those unfit to practise should be directed to the protection of the patient, not the punishment of the doctor. This should, in our view, be the case even where the question of his fitness to practise arises on account of professional misconduct. For a doctor to have his name erased from the register, and to be in effect deprived of**

> **his livelihood, is a very serious penalty, but that it is a penalty is a side effect rather than a purpose of regulation ... certainly an atmosphere of punishment may ... discourage members of the profession or of the public from notifying the GMC of matters which ought to be brought to its attention; especially, for example, of mental illness which also involved professional misconduct ...'**.

16.42 Shipman's case was dealt with by the GMC in 1976. Sir Donald Irvine observed that, by then, there was a **'huge sense of relief'** in the medical profession at the prospect of the introduction of more satisfactory ways of dealing with sick doctors. In particular, it was felt that, once the new health procedures were introduced, doctors would be more confident about reporting colleagues who were a risk to their patients and in need of help.

16.43 Dr Llewellyn told the Inquiry that, as a member of the PeCC, he had regarded the introduction of the health procedures as 'essential'. Without them, the PeCC would sometimes have no choice but to refer a sick doctor to the DC. This, he said, 'could often only harm the doctor'. He said that, when the health procedures came in, the profession felt much easier because doctors were 'being treated fairly'.

16.44 Once the health procedures were introduced in 1980, the GMC was able formally and openly to adopt a rehabilitative approach to cases in which a doctor's criminal behaviour or misconduct appeared to result from physical or mental illness. In 1976, preparations were being made for the forthcoming changes. This was a time of transition for the GMC. The events connected with its handling of Shipman's case must be viewed in that context.

16.45 Mr Alan Howes, who was involved with the conduct procedures more or less continuously between June 1980 and 1994, told the Inquiry that it was difficult, looking back, to put oneself into the context of the time immediately following the publication of the Merrison Report. The Report had just averted a huge threatened revolt within the medical profession in connection with the GMC's proposal to impose an annual retention fee. Mr Howes said that 'anything the GMC did in those days so far as the profession was concerned was certainly treading on eggshells'. He said that the work of the GMC FTP committees at that time had to be viewed in this context. He also said that such issues as 'protecting the public interest' were not in the forefront of people's minds in the 1970s. I interpose to say that, if that is right, it should not have been the case. It appears from the passage I have cited at paragraph 16.41 that the protection of patients was certainly at the forefront of the minds of those on the Merrison Committee. Indeed, the Blue Book said that the primary duty of the GMC was to protect the public.

16.46 Mr Howes went on to say that, in the late 1970s, the GMC's FTP committees were 'struggling with a process which everybody knew was not working satisfactorily for sick doctors'. The GMC was waiting for new legislation to introduce the health procedures and, in the meantime, the PeCC (and probably the DC too) was struggling to do the best it could with cases with a health element. He said that, once members of the PeCC saw that a doctor's problems were rooted in an illness, they would have focussed on the illness, not on other factors of the case, unless they saw them as extremely relevant to the doctor's current or future medical condition.

16.47 The Merrison Committee had also recommended that the PeCC should be replaced by a Complaints Committee. Its main function would be **'to consider, on the information available, whether prima facie evidence had been assembled that a doctor was not fit to practise'**. As the final filter of complaints, the Complaints Committee would not hold hearings but would either **'refer cases for further action or direct that the matter be closed, arranging for all interested parties to be informed in either case'**. The Merrison Committee did not appear to envisage that the Complaints Committee would make substantive decisions or impose sanctions. It would, however, be given the power to order temporary suspension of a doctor's registration where the doctor posed a serious danger to the public. In the event, the PeCC was replaced by the PPC which, as I will later explain, continued, as the PeCC had done, to adjudicate on cases to a limited extent. The Merrison Report also recommended that the GMC should establish a small investigating unit to collect evidence in connection with complaints made against doctors.

Standards, Thresholds and Criteria

16.48 Although the 1956 Act and the 1970 Rules provided a very wide discretion as to the manner in which the GMC performed its disciplinary function, and although no standards or criteria were formally laid down for the exercise of that discretion, it does appear that some underlying principles existed to guide the DC and the PeCC. As I have explained, the Blue Book said that the primary duty of the GMC was to protect the public; subject to that overriding duty, the DC would consider what was in the best interests of the doctor concerned.

The Primary Duty to Protect the Public

16.49 Plainly, the protection of the public (and, in particular, of patients) was, or should have been, an important criterion for consideration by both the PeCC and the DC. If no public or patient protection issues arose, both Committees would be free to give priority to the doctor's own best interests. In a case where the doctor was, or appeared to be, addicted to drugs, the Committees would, no doubt, wish to consider how s/he should best be rehabilitated. In the case of the PeCC, it would be relevant to consider whether it was in the doctor's best interests to be dealt with sooner and in private, rather than later and in public. Common sense would dictate that it would almost always be better for the doctor to be dealt with sooner and in private. However, if the PeCC were to be loyal to the GMC's primary duty, it would have to take proper steps to find out whether the doctor's continuance in practice did or might present any risk to patients or the public. It would seem to me obvious that, if any such risk existed, the case ought to have been referred to the DC for the possible application of the wider range of sanctions available to that Committee. Yet there was a fundamental problem for the PeCC in considering the issue of risk and patient protection. The PeCC reached its decisions on the basis of outline information only. It might decide to refer a case to the DC **'for inquiry'**. The understanding was that only at that inquiry stage would the full facts become known. Only at that stage would the doctor appear before members of the GMC and only then would the DC have an opportunity to make a full assessment of whether the doctor did or might present a risk to patients. Thus, if the PeCC were to decide to deal with a case itself, there would be a danger that it would reach a conclusion based on incomplete and inadequate information.

The Seriousness of the Offence or Complaint

16.50 As with any body involved in operating a disciplinary process, the PeCC was concerned about the seriousness of the misconduct with which it had to deal. In deciding whether to refer a case to the DC **'for inquiry'**, the PeCC would take into account the seriousness of the allegation of misconduct or of the convictions under consideration. There were no written standards, thresholds or criteria, nor even any guidelines, to assist members of the PeCC in assessing seriousness. The passage from the January 1976 edition of the Blue Book, which I quoted at paragraph 16.16, seemed to be saying (although not with complete clarity) that some single convictions or allegations of misconduct would be serious enough to warrant referral; others would not. However, if an offence was repeated, the case might be referred to the DC even though a single offence of the same nature would not be. It is not clear whether that meant that the case would be more likely to be referred if the doctor were convicted, on one occasion, of multiple offences than if s/he had made repeated appearances before the courts. Also, the Blue Book gave no indication of how serious the offence or series of offences must be before referral would be warranted. Bearing in mind that the powers of the DC to impose any sanction on a doctor for misconduct (where no conviction was recorded) were limited to cases in which the DC found the doctor guilty of SPM, it seems to me that the only sensible threshold for referral, in a conduct case, would have been whether there existed a reasonable prospect of establishing SPM. In later years, when the GMC did have some written criteria, that was the threshold standard of seriousness for referral to a disciplinary hearing. By analogy, it seems to me that, in respect of convictions, the only sensible measure of seriousness would have been whether the conduct underlying the convictions was of a seriousness equivalent to conduct which could amount to SPM.

16.51 However, even if such a standard had been explicitly laid down, it would not have been easy to apply in practice. The Inquiry has been told that opinions on what amounts to SPM can differ quite widely. In Chapter 17, I shall describe how, in the context of a discussion about the operation of the PCC (the successor to the DC) during the years in which he was a member, Sir Donald told the Inquiry that debates about whether conduct amounted to SPM gave rise on occasion to strong disagreement and generated much 'heat' and 'emotion'. In the 1970s, there was very little guidance as to what kinds of conduct did or did not amount to SPM. That has remained the case ever since.

16.52 In due course, I shall examine the extent to which the PeCC applied any consistent criteria of seriousness when deciding whether or not to refer a case to the DC. As I shall show, analysis of the cases examined by the Inquiry shows that many conviction cases were not referred by the PeCC to the DC despite the fact that, on any view, the underlying conduct was serious. Shipman's is a case in point. Convictions involving multiple offences of obtaining controlled drugs by deception (which must necessarily have entailed dishonest conduct) must, in my view, have been sufficiently serious to require referral. Moreover, the material published by the GMC at the time would have caused both doctors and public alike to expect that they would be referred. Yet some such cases were referred to the DC; some were not.

16.53 Many cases of doctors convicted of drug-related offences were indeed referred by the PeCC to the DC. At the PeCC meeting held in January 1976, of the 14 cases of doctors

convicted of drugs offences, nine were referred to the DC, and one was adjourned to the next meeting, when it was adjourned again and eventually closed without referral to the DC. The outcome of the other four cases is not known but it does not appear that they were referred to the DC. At the PeCC meeting of April 1976 (at which Shipman's case was considered), of the nine drug-related conviction cases, only one was referred to the DC. The rest (save for one, of which the outcome is not known) were either adjourned or were closed with a warning letter.

16.54 Examination of the facts of the cases considered at the January and April 1976 meetings of the PeCC suggests that it was not the seriousness of the conduct underlying the offences that determined whether a case was referred to the DC. For example, five of the doctors referred to the DC by the PeCC at its January 1976 meeting had been convicted of controlled drugs offences, committed over a significant period of time. All had become addicted to the drug in question. In each case, there appeared to have been an element of dishonesty in the obtaining of the drug. On the other hand, the cases of three other doctors and of Shipman himself involved convictions for offences of a similar degree of seriousness and yet were not referred to the DC by the PeCC at its April 1976 meeting.

16.55 An examination of the files in these cases suggests that the factor that made the difference was whether the doctor produced some evidence that s/he was undergoing psychiatric treatment or was at least under some form of medical supervision. In 1976, as I have indicated, there was no requirement in the Rules that a doctor convicted of offences should be asked for his/her explanation of the circumstances of the offence(s) for which s/he had been convicted before the PeCC met to consider his/her case. However, the practice of asking such doctors for their explanation and of giving them the opportunity to produce medical and other evidence before the PeCC hearing was growing. As we shall see, Shipman himself was given that opportunity and took it. I can see that, to some extent, the PeCC was taking account of its duty to protect patients; it was relying upon the material supplied by the doctor to assess whether the doctor was fit to practise. However, it appears from the cases that the Inquiry has examined that, if any helpful material was produced, the PeCC would very readily be prepared to conclude that the doctor was not a risk to the public and could be allowed to continue in practice, subject either to a period of continued medical supervision (which would be achieved by adjourning consideration of the case to a later meeting) or by closing the case with a warning.

The Maintenance of the Honour and Reputation of the Medical Profession

16.56 Dr Llewellyn told the Inquiry that, in deciding whether or not to refer a case to the DC, the PeCC would also consider whether the doctor's conduct had brought the profession into disrepute. I would have expected it to do so, as the GMC has always recognised the importance of maintaining the honour and reputation of the medical profession and the confidence of the public in the profession and in the GMC's regulation of it. One of the reasons why the DC (later the PCC) has always sat in public and has always allowed publication of its decisions has been to maintain public confidence in the performance of its disciplinary function. Where a doctor has been convicted of criminal offences, the facts underlying the convictions are in the public domain. They may not have received the attention of the national press but they will be known in the locality in which the doctor lives

and/or practises and are highly likely to have come to the attention of his/her patients. Assuming that the GMC handles the doctor's case in a way which properly protects the public and the doctor's patients, the confidence of the public in the GMC will be enhanced by publication of the decision. If such a conviction case is dealt with in private, there is a danger that members of the public who know about the conviction will think that the GMC has done nothing.

The Penal Cases Committee's Use of the Power to Adjourn

16.57 I have mentioned that the PeCC's power to adjourn a case was given for the purpose of allowing it to make further investigations or to obtain legal advice. However, it is clear from the cases the Inquiry has examined that the power was sometimes used in order to exercise a degree of control over a doctor who had been abusing alcohol or controlled drugs. The case might thereby remain under the jurisdiction of the PeCC for a year or more. Sometimes, the PeCC would adjourn a case more than once, even when there was evidence on the second or subsequent occasion that the doctor had relapsed. In a case where the doctor had not yet sought psychiatric treatment, the PeCC would sometimes direct that s/he should do so and would adjourn the case to a later meeting, requiring a report to be produced from a psychiatrist for consideration on that occasion. If the doctor was already under the care of a psychiatrist, the PeCC would express its expectation that the doctor would remain under medical supervision during the period of adjournment. The doctor would usually be asked to provide the GMC with the name of the supervising psychiatrist and with the names of other professional colleagues who could provide confidential information about his/her progress. If the doctor failed to co-operate with the GMC or relapsed into drug taking or alcohol abuse, the possibility of referring the case to the DC remained open. However, as will appear from the following two examples, the focus of the PeCC appears to have been upon the rehabilitation of the doctor.

Dr JA 04

16.58 In the case of Dr JA 04, the doctor had been convicted, in the mid-1970s, of obtaining morphine by deception, apparently for his own use. He was dealt with at the Crown Court and asked to have a large number of offences taken into consideration. As soon as his offences had come to the attention of the police, he had obtained psychiatric treatment and was able to put a report before the Judge when being sentenced. He was fined. The case came before the PeCC. Plainly, the underlying conduct was serious enough to warrant referral to the DC. At the time when his case came before the PeCC, the doctor was practising as a GP and was under psychiatric supervision. He had parted company with his former partner and had been practising as a single-handed GP. He was seeking another partner. I would have thought that the fact that he was practising alone gave rise to a risk to patients. However, the PeCC adjourned consideration of his case for eight months, saying that he was to remain under medical supervision. In the interim period, the doctor was, of course, free to practise and the supervision was of his state of health, not of his practice. There appears to have been an assumption that there was no risk to the doctor's patients.

16.59 At the time it next considered the case, the PeCC had before it material which ought to have given rise to concern for the welfare of the doctor's patients. The doctor's own letter gave a glowing account of his rehabilitation. He had acquired a new partner who, he said, had been made **'fully aware'** of his conviction. All was going well, he said, in every respect. However, the new partner told the GMC that, although Dr JA 04 had told him, at an early stage, that he had been convicted of a drugs offence, he had deceived him as to the true extent of his criminality, of which the partner had only just become aware. This had caused difficulties between them. Also, the partner said that Dr JA 04 had put a prepared reference for the GMC before him for signature. The partner had refused to sign it because the contents were not true. He expressed concern about Dr JA 04's state of health and was not able to offer a **'proven opinion'** about whether or not Dr JA 04 had given up the use of drugs. Also, the report of the treating psychiatrist was quite guarded about the truth of the doctor's claim to be off drugs and about the prognosis for rehabilitation. Some favourable references were received from medical colleagues, but they appeared to be friends of the doctor. In addition, the GMC had received a letter from a practitioner holding an important medical office in the locality in which the doctor practised. This letter had expressed concern on the part of the local medical community that the doctor had been convicted of a serious offence and yet the GMC had **'taken no notice'**. This material should, in my view, have rung a loud alarm bell about the safety of the doctor's patients. However, the case was still not referred to the DC but was adjourned again by the PeCC on the same terms as before. On the next occasion the PeCC considered reports and references which, again, were by no means wholly supportive. One referee asserted that the doctor was still taking drugs and expressed the view that, for his own good and for the reputation of the medical profession in the area in which he practised, the doctor should be temporarily erased from the medical register. Notwithstanding that, the PeCC adjourned the case for a further year. The Inquiry has not been able to discover how this case was eventually resolved.

16.60 Mr Howes told the Inquiry that it was difficult for him to understand why the PeCC had not referred this case to the DC at the time of its second or third consideration of the case, in view of the ambivalent reports it had received. I feel bound to observe that, on the material before it, the PeCC cannot have been satisfied that the doctor was not still using morphine or that he was not a risk to patients. In my opinion, this case demonstrates a failure by the PeCC to give proper weight to the need to protect the doctor's patients. The case should have been referred to the DC on the first occasion and, if not then, certainly when it came back before the PeCC on the second occasion. It seems that, once the PeCC had decided to keep the case to itself and to go down the 'rehabilitation route', there was a reluctance to depart from that course and little weight was given to the concerns being expressed about the doctor's conduct.

16.61 In respect of the concerns expressed by the local medical community that the GMC appeared to have taken no notice of this case, Mr Howes agreed that dealing with the case in private might have damaged the GMC's credibility. I must observe that, if the public had known how the GMC was dealing with that case, its credibility would not have been enhanced.

Dr JA 08

16.62 In another case (that of Dr JA 08), the doctor had been convicted, in the mid-1970s, of obtaining pethidine by deception. He had been self-administering the drug in large quantities, up to 1000mg per day. His case came before the PeCC. The psychiatric report, prepared for the criminal proceedings by a former colleague of the doctor, said that the doctor was not addicted to the drug and was fit to practise without any restriction on his prescribing rights. In fact, when the PeCC first considered the case, the doctor had already relapsed and was again taking large amounts of pethidine daily. In other words, the psychiatrist's report did not reflect the position as it was by the time of the PeCC's meeting. However, the PeCC was unaware of that fact and adjourned Dr JA 08's case to its next meeting, which was to take place three months later. Meanwhile, the doctor was still practising as a GP. A month after the PeCC's first consideration of his case, he was admitted to a psychiatric hospital. Shortly before the meeting of the PeCC at which his case was due to be considered for the second time, the hospital psychiatrist reported to the GMC that the doctor could soon return to work, provided that he had no access to pethidine. At that meeting, the PeCC learned that the doctor had in fact already relapsed at the time of its earlier decision. However, it adjourned the case again, this time for a year, to give the doctor **'a further opportunity to rehabilitate'**. He was free to resume general practice, with no restriction on his access to pethidine. A year later, the case was concluded, without a referral to the DC, on the basis of a further report provided by the psychiatrist who had been a colleague of Dr JA 08. The report was favourable but that psychiatrist's previous report had turned out to be inaccurate; it had advised that the doctor was fit to practise without restriction when, in fact, he was not. Yet, the PeCC acted upon the favourable opinion of the same psychiatrist. In so doing, it appears to me that the PeCC did not have the safety of patients at the forefront of its collective mind.

The Propriety and Wisdom of the Practice of Repeated Adjournments

16.63 When Mr Gray was first asked in evidence to the Inquiry about the PeCC's use of its power to adjourn for further investigation, he said that he did not recall the PeCC ever using the power in order to keep a doctor under surveillance. If the PeCC had felt that were necessary, it would have been better, he said, to refer the doctor to the DC. However, having read the papers in some of the cases decided by the PeCC in the mid-1970s, Mr Gray accepted that it had in fact been quite common practice for the PeCC to adjourn and, in effect, to put a doctor under compulsion to seek treatment and to produce reports at a later meeting of the PeCC.

16.64 Mr Howes commented on the cases heard by the PeCC in the 1970s. He said that it seemed to him that the PeCC had been using the power to adjourn in order to see whether a doctor who was under medical treatment or supervision would sustain the improvement s/he had made over a period. He described it as a 'lighter touch' than putting the doctor 'on probation', as the DC might have done. He thought it had been appropriate for the power to adjourn for further investigations to be used in this way, provided that it was short-term. He said:

> **'If the Penal Cases Committee wanted to get more information or a better picture of the doctor before deciding whether to refer to the Disciplinary**

Committee I think that was reasonable. If they were to do it for year after year, for example, that would be inappropriate.'

16.65 Mr Howes observed that the PeCC and the DC, in using their powers to adjourn and postpone, were in effect 'playing at being a Health Committee'. This was at a time when the Merrison Committee had made its recommendations and the health procedures were in the course of preparation. They had not come into effect.

16.66 Leading Counsel to the Inquiry suggested to Mr Howes that the function of the PeCC in relation to a conviction case was to look at the conviction, to assess its gravity and to decide whether it should go to the DC. The DC was the Committee charged with imposing the appropriate sanction. That being the case, she suggested that it was not the function of the PeCC to adjourn a case for the purpose of keeping a doctor under supervision, let alone repeatedly to bring the doctor back on adjourned hearings. Mr Howes agreed that, considered today, the suggestion was 'obviously a valid one'. However, he pointed out that, at the time, there appeared to have been no objections from the GMC's legal assessors. Nor had there been any objection from the medical defence organisations. In fact, as I pointed out, it was highly unlikely that the medical defence organisations would have objected as, so far as those indemnified by them were concerned, an adjournment by the PeCC would be preferable to a referral to the DC. Leading Counsel had not suggested to Mr Howes that the practice of making repeated orders to adjourn was unlawful; she had suggested only that it was not the PeCC's function to keep a doctor under prolonged supervision. The practice of adjourning so as to effect supervision might also have been unlawful but that was not the point. The point was that the practice as followed was not appropriate for the PeCC.

16.67 In the two cases I have described, I can clearly recognise the desire of the PeCC to help the doctor towards rehabilitation. However, I cannot detect the application of the supposed precondition to the GMC's freedom to do that, namely the principle that the primary duty of the GMC was to protect patients. A doctor who had been abusing controlled drugs had surely presented a risk to patients in the past. The PeCC did not seek to find out whether any harm had been suffered; I can see that such enquiries might sometimes be difficult to undertake. But, while there remained a risk of a relapse into drug taking, there must have remained some risk to patients. In my view, to allow a GP who was at risk of a relapse to continue in practice, without any real supervision, plainly exposed patients to risk of harm. It seems to me that these decisions by the PeCC to adjourn final consideration left patients at risk.

The Use of Warning Letters by the Penal Cases Committee

16.68 It seemed to me, on reading rule 6(1) of the 1970 Rules, that the function of the PeCC was to act as a filter, determining which cases should go through to the DC and which should not. However, it is clear that the powers of the PeCC were wide enough to allow it to close a case with the issue of a warning and that the GMC considered that it was proper for the PeCC to do so where appropriate. There was no internal guidance as to when that course would be appropriate. The passage in the January 1976 edition of the Blue Book, which I quoted at paragraph 16.16, suggested that it would not be used in cases of any real

gravity. Yet it is clear from some of the cases examined by the Inquiry that warning letters were used by the PeCC in cases where the doctor had been convicted of quite serious controlled drugs offences.

Dr JA 18

16.69 In one case (that of Dr JA 18), the doctor had admitted a series of about 125 offences of obtaining controlled drugs (dexamphetamine) by deception, for his own use, over a period of at least two and a half years. He had issued prescriptions in the names of patients, presented them to the pharmacy and kept the drugs for himself. It appears that, at court, he claimed that he had taken the drugs only in order to give himself the energy to work on the building of surgery premises for the new practice he had recently set up. He claimed that he had never been dependent on the drugs and had given them up as soon as he was seen by the police. He had also sought psychiatric help. He was conditionally discharged by the court but was reported to the GMC. After receiving a very favourable psychiatric report, which said that the doctor had a strong personality and was determined to stay off drugs, the PeCC closed his case with a warning letter. This case bears strong similarities to that of Shipman and was dealt with in a similar way. Unfortunately, it is not easy to see what criteria were applied as the PeCC did not record the reasons for its decisions. It does not appear from the file that the PeCC had any independent information about any possible risk to patients. From the file, it appears that the only detailed information available to the PeCC was provided by the doctor and the treating psychiatrist. When it was asked for information about the case, the Home Office Drugs Branch had said only that the case was **'simply one of a practitioner obtaining drugs for his own consumption'**.

16.70 The doctor's explanation, written on his behalf by Hempsons, solicitors to the Medical Defence Union (MDU), painted a picture that might, in itself, have given rise to some concerns for the welfare of his patients. Among other things, it was said that, at times, while he was building the new surgery, the doctor had been staying up all night, several nights a week, to do the building work and was running the practice during the day. He had taken the drugs to help him to cope with these strains. If this account was true, I find it hard to imagine what kind of condition he must have been in during the day. However, when the doctor's account and that of the psychiatrist are read together, they paint an even more worrying picture. It was said that the doctor had begun taking drugs five years earlier, while in partnership with another GP, from whom he had parted the following year. The psychiatrist attributed this parting to no more than a personality clash but the other GP was not asked for his/her account. That was before any question of building work arose. The doctor told the psychiatrist that, during the building work, he was taking about 120mg of the drug per day. He claimed that he had not been aware of any **'perceptual distortion'** on taking the drugs and had not felt any **'let down'** on cessation. He had not taken the drugs for pleasure, only for this **'strictly functional purpose'** (by which I understand him to mean to help him to cope during the building works). However, he had not stopped taking them (or obtaining them unlawfully) when the building work was finished, although he claimed to have reduced his dosage to about 60mg a day. There was no material before the PeCC from which it could have checked the truth of that assertion. The doctor's

justification for his continued consumption was the need to renovate his home in his free time while running the practice during the day. I feel bound to wonder how the PeCC could have concluded that this case did not need to go to the DC. Before reaching any conclusion about this case, I would have wished to question the accuracy of the doctor's accounts and his judgement in treating patients while subjecting himself to the punishing regime he had described. To achieve that, the case would have had to go to the DC.

Conclusions about the Criteria Applied by the Penal Cases Committee

16.71 It appears to me that, in the cases of doctors convicted of controlled drugs offences, the seriousness of the underlying conduct and of the dishonesty involved was not regarded by the PeCC as an important factor in deciding whether a case should be referred to the DC. It seems that, if any information was available to the PeCC from which it could conclude that there was an expectation of rehabilitation, the case would be closed with a warning letter and that, if the evidence suggested even a prospect of rehabilitation, the case would be adjourned to another meeting in the expectation that the doctor would remain in contact with his/her psychiatrist. No enquiries were made as to whether the doctor's drug addiction had had any adverse effect on his/her patients in the past. The police investigation would be unlikely to cover such matters. It is clear to me that, although the issue of patient protection may have been considered, the PeCC was very easily satisfied that there was no risk. In practice, the interests of the doctor in rehabilitation were not merely taken into account but were allowed to predominate.

The Approach of the Disciplinary Committee to Cases Involving Drug-Related Convictions

16.72 Examination of the files of those drug-related conviction cases that were referred to the DC shows that that Committee was very unlikely indeed to suspend a doctor from practice and even more unlikely to erase him/her from the medical register. A far more likely outcome was the postponement of the decision to a subsequent meeting, or even several postponements spanning a period of as much as two or three years. Such cases would then be closed with or without an admonishment. When a case was postponed, the doctor would be required to produce reports describing his/her treatment and progress and naming referees of whom enquiry could be made. It should be noted that, when seeking information about the progress made by a doctor who had been addicted to drugs, the GMC staff were not instructed to obtain reports from an independent source. The psychiatrist treating the doctor was usually asked to report and the doctor was asked to name referees of his/her own choosing. Among the cases examined by the Inquiry, I have found none in which the DC had concluded at a resumed hearing that the information about the doctor was sufficiently unsatisfactory to warrant suspension or erasure. From the cases examined, of which some examples are given below, it appears to me that the DC's objective was to postpone a decision in the case until such time as the doctor was rehabilitated. Throughout the process, the doctor was permitted to practise and was subject to only minimal supervision.

Dr JA 09

16.73 In the case of Dr JA 09, the doctor was convicted of a series of offences of obtaining morphine and pethidine by deception. She had issued prescriptions in the names of

patients, had presented them herself and had kept the drugs for her own use. The offences spanned a period of about 14 months. In the mid-1970s, the PeCC referred the case to the DC and the case came on for hearing two months later. It appears that a psychiatric report was produced, although this is no longer available. The minutes of the DC meeting record that the case was postponed for four months. The doctor was told that her conduct gave rise to a **'potential source of danger to your patients'**. I interpose to say that this expression was often used in decisions of the DC, from which I infer that it was indeed the view of the GMC at that time that a doctor who took drugs presented a risk to patients. The decision to adjourn was taken in order to allow the doctor to demonstrate that she was responding to treatment and would be able to fulfil the assurances of good behaviour she had given. At the next meeting, it emerged that the doctor had not kept up her medical treatment. The minutes do not record what material was before the DC but they do record that the doctor was exhorted to seek medical treatment immediately and to continue with it regularly. Notwithstanding the doctor's failure to keep up her treatment, the case was adjourned, this time for 12 months. Nothing more was said about the risk to patients and no steps were taken to ensure that the doctor's patients were not harmed. A year later, the DC learned that the doctor had not maintained regular contact with a psychiatrist in the intervening period. Again, the minutes do not record what information was available to the DC. Notwithstanding the doctor's failure in that regard, her case was adjourned for another year. She was advised that it was **'in her best interests'** to consult a psychiatrist regularly. Again, nothing was said about her patients and no steps were taken to protect them. The Inquiry has been unable to find out what happened to this case. The doctor's name does not appear in the minutes of the DC for the following year. It may be that she had died or retired. It seems unlikely that she was suspended or erased by the DC, as such an outcome would surely have been recorded in the minutes. This doctor was allowed to practise for well over a year, possibly longer, in circumstances where she must have presented some risk to patients.

Dr JA 11

16.74 In the case of Dr JA 11, the doctor was convicted of offences of failing to record in his controlled drugs register (CDR) quantities of Palfium that he had purchased on requisition. He was fined £25. In the mid-1970s, the PeCC referred the case to the DC. In a sense, this was a technical breach of the record keeping requirements of the Misuse of Drugs Regulations 1973; it did not involve dishonesty. It appears that the doctor was taking the drug himself. The DC adjourned the case so that a psychiatric report could be obtained. At its next meeting, the case was closed. The minutes do not record what information was available or why that decision was reached. Nor is there any reference at either stage to the risk to patients.

Dr JA 10

16.75 In the case of Dr JA 10, the doctor was convicted of dishonestly obtaining Dexedrine by issuing prescriptions in the names of patients who did not need and did not receive the drug. He was also convicted of offences in connection with his failure to keep a CDR. His conduct had persisted for nearly a year. At a meeting of the PeCC in the mid-1970s, the

case was referred to the DC. Two months later, the DC postponed the case for four months, requiring the doctor to identify his treating psychiatrist and other referees. The minutes refer to his dishonesty and to the risk to patients arising from his conduct. At the next meeting, the case was adjourned for a further four months on a similar basis. In the November, the case was closed; the doctor was not admonished.

Dr JA 12

16.76 In the mid-1970s, Dr JA 12 was convicted of obtaining drugs by deception and asked for 25 similar offences to be taken into consideration. It appears, therefore, that his course of conduct had extended over several months. His case was referred to the DC and came on for hearing two months later. It was adjourned for a year and the doctor was required to provide the names of his psychiatrist and referees. The following year, the DC considered a report from a psychiatrist who said that the doctor was fit to practise but recommended a further period of supervision. However, the DC decided to conclude the case, advising the doctor to continue with his supervision. It was not in a position to find out whether the doctor did do so or not.

General Comment

16.77 There are a number of common threads running through the cases of this era involving doctors who had been abusing controlled drugs. These are apparent not only in the cases I have described but also in other cases examined by the Inquiry. The first is that it appears to me that the DC used its power to postpone judgement in order to assist in the rehabilitation of doctors who had committed criminal offences as the result of a drug addiction. However, the extent to which the DC could provide adequate protection for patients in the meantime was very limited. I accept that it had no power to impose conditions on the doctor's right to continue in practice. However, it generally achieved the co-operation of the doctor in accepting treatment through the implicit threat of suspension or erasure if s/he failed to co-operate and it could have done far more to protect patients by requiring undertakings from a doctor as the price of not being suspended.

16.78 The second is that, when postponing or adjourning a case to allow an opportunity for rehabilitation, the PeCC and the DC always left it to the doctor concerned to choose the psychiatrist who would provide the report at the end of the period of postponement or adjournment. The GMC made no attempt to assemble a list of approved psychiatrists, of whose independence the GMC could be satisfied, and who could be instructed to examine the doctor and to report to the GMC. There was no requirement that a doctor's assertion that s/he had ceased taking drugs should ever be put to an objective test, as, for example, by urine analysis, although occasionally this would be done. All was taken on trust. No doubt that trust was well placed in many cases but it would be surprising if it always was.

16.79 The choice of referee was also left entirely to the doctor, who was free to request assistance from friends. As we have seen, some doctors would actually prepare a draft reference for a colleague to sign. The referee did not have to state the nature of his/her relationship to the doctor (although s/he sometimes did), or say to what extent s/he had had the opportunity to observe the doctor during the period of adjournment.

16.80 The degree of 'supervision' which took place during a period of adjournment or postponement was very light and was not, in my view, sufficient to protect patients. The only requirement was to 'remain under the supervision of' a psychiatrist. This would usually involve only limited, occasional contact. As I have said, the GMC did not at this time have the power to impose conditions and requirements that it acquired later under the health procedures. However, it could have assumed those powers had it wished to do so by inviting a doctor to give undertakings or to consent to conditions and requirements as an alternative to suspension or erasure. I have in mind such conditions as not working in general practice, working only in a supervised post and not possessing or prescribing controlled drugs. Another possible safeguard would have been a requirement that a partner or senior colleague should be asked to maintain a watch over the doctor and to provide regular reports to the GMC.

16.81 The other common thread running through all these cases is the complete absence of any attempt by the GMC to find out whether the doctor's drug taking habit had in fact given rise to any problems for patients. No enquiries were made to see whether complaints had been made to practices, hospitals or family practitioner committees (FPCs). The GMC would have no idea whether a doctor might have been sued for negligence as a result of incidents caused by his/her drug dependence. Even where the reports available suggested underlying problems within a doctor's practice, no enquiry was made. This again suggests that, at least in cases involving a doctor convicted of drugs offences, the protection of patients did not rank very high in the considerations of the GMC.

The Shipman Case

16.82 Against that background, I shall turn now to consider the GMC's handling of Shipman's case. I described Shipman's abuse of controlled drugs in Todmorden briefly in my First Report and at greater length in my Fourth Report. For present purposes, I shall confine my account to those matters which had, or might have had, a bearing on the GMC's handling of his case.

The General Medical Council Is Notified of Shipman's Convictions

16.83 Shipman was convicted and sentenced at the Halifax Magistrates' Court on 13th February 1976. The GMC was informed of his conviction by a letter from the West Yorkshire Police (WYP) dated 8th March 1976. To the letter was attached a schedule, setting out details of the offences of which Shipman had been convicted. These comprised three offences of dishonestly obtaining drugs by means of a criminal deception, two offences of forgery of a NHS prescription and three offences of unlawful possession of a controlled drug (pethidine). The schedule also recorded that 74 similar offences had been taken into consideration. Shipman had been fined £75 on each charge and ordered to pay £58.78 compensation to the local FPC, i.e. Calderdale FPC, on whose list he was included at that time.

16.84 No further details of the offences to be taken into consideration were given and it does not appear that the GMC ever sought or obtained a list. No details of the offences survive; the police and court files, which would have contained a list, have now been destroyed.

However, it is clear from contemporaneous press reports that 67 of the 74 offences concerned the obtaining of pethidine by deception and that the remaining seven were offences of forgery.

16.85 The letter from the WYP, written in March, was the first intimation that the GMC had of Shipman's involvement in criminal proceedings. Shipman had admitted the offences to the police and to an inspector from the Home Office Drugs Branch in November 1975, and was charged shortly afterwards. A doctor was under no obligation to inform the GMC of the fact that s/he had been charged with criminal offences, or indeed of his/her conviction when it occurred. Nor were the police under any duty to inform the GMC of a doctor's involvement in criminal proceedings unless and until s/he had been convicted of an offence.

16.86 In 1976, advance warning of a doctor's involvement in criminal proceedings before s/he was convicted of an offence would not have been of any practical benefit to the GMC. As I explain in Chapter 20, it had no power to take interim action, e.g. by suspending the doctor's registration or by imposing conditions on it. In 1980, the GMC acquired limited powers to make interim orders. The limited nature of those powers meant that, in 1998, the GMC was unable to suspend Shipman's registration, despite the fact that he had been arrested on a charge of murder. In 2000, wider powers were conferred on the GMC, and a new Interim Orders Committee created, as a direct result of the public concern caused by the GMC's inability to act in Shipman's case.

The General Medical Council Requests Further Information

16.87 On receipt of the letter from the police, Mr Gray endorsed it with a note to Mr Williams, requesting him to ask both the police and the Home Office Drugs Branch for further particulars and then to **'draft'** (by which I think he meant prepare the case by drafting a memorandum) for the April 1976 meeting of the PeCC. Mr Williams duly wrote to the WYP and to Mrs Susan Powrie at the Home Office Drugs Branch.

16.88 Mr Williams' letter to the WYP requested **'a brief account of the circumstances surrounding the offences'**. It concluded:

> **'The Committee will be particularly concerned to know whether the drugs involved were improperly obtained by the practitioner for self-administration or for other purposes.'**

Mr Gray explained to the Inquiry that, if Shipman had obtained drugs for the purpose of self-administration, this would mean that he had been dishonest, that he had used the drugs improperly and that he had abused his professional privileges. However, he would not have been regarded by the GMC as being a danger to the public in the same way as he would have been if he had supplied drugs to others. I shall refer to the effect of this distinction later in this Chapter.

The Response of the Police

16.89 The WYP responded by letter dated 22nd March 1976, saying that it was **'contrary to practice to supply extracts from police reports to outside bodies in cases such as**

this'. The letter did, however, offer the officer in the case, Detective Sergeant (DS) George McKeating, for interview. He would not be permitted to sign a written statement but would be able to answer questions on any matters upon which he was competent to give evidence. The letter also indicated that DS McKeating would attend a hearing on receipt of a *subpoena*. Details of the charges which would be levied for interviewing DS McKeating, and for his attendance at a hearing, were given.

16.90 Mr Gray said that some police forces were more co-operative than others in providing information. They were generally reluctant to provide information in writing about anything which had not been proved in a criminal court. Mr Williams thought that the response from the WYP was **'a bit unusual'**. His recollection was that the police were usually more helpful than they had been in this case.

16.91 Detective Chief Inspector (DCI) Bryan Dent, of the WYP Drug Squad, provided a witness statement to the Inquiry. He was a young detective in the late 1970s, so had no personal knowledge of the procedures then in force. However, he had done some research and believed that the police would have been conscious at that time of the fact that interviews with an accused person were regarded as confidential to the criminal justice process. A recent decision in the courts had, he believed, led to a policy of refusing to release transcripts of interviews or reports and other exhibits which had come into the possession of the police during an investigation. However, supplementary information would be provided if an officer was interviewed. DCI Dent suggested that this was a means, in effect, of circumventing the embargo on releasing documents. While it was not the practice at that time for an officer to sign a statement recording what had been said at the interview, s/he would reiterate the contents of the statement if subsequently subpoenaed to give evidence at a hearing.

16.92 Mr Gray saw the letter from the WYP when it came in. He told the Inquiry that the offer to provide information, although kind, was not very helpful to GMC staff at this stage in the proceedings. It was clear that DS McKeating would not be permitted to sign a statement which could be put before the PeCC. If Mr Gray had interviewed DS McKeating and had taken notes, he could not, he said, have put those notes before the PeCC since they would not have been 'evidence'. The PeCC did not hear oral evidence, so DS McKeating could not have been subpoenaed to attend before it. However, Mr Gray said that, if the case had been referred by the PeCC to the DC, DS McKeating would 'almost certainly' have been subpoenaed to attend and give evidence. In his witness statement, Mr Gray said that he could recall having had several telephone calls with police officers that had cast valuable light on the circumstances behind convictions. However, he did not telephone DS McKeating on this occasion.

16.93 It seems to me that, when considering a conviction case, it would always have been helpful to the PeCC and to the DC to have some background information from a police officer with personal knowledge of the case. A mere schedule of offences may not convey a very clear impression of the degree of misconduct. For example, the *modus operandi* of an offence is not always apparent from the schedule, and information about it may be very revealing. Also, the immediate response of a person when accused of an offence may often be revealing of his/her attitude towards it.

16.94 Mr Gray was asked whether he would have thought of interviewing DS McKeating and of submitting to the PeCC a note, setting out the evidence which the officer could be expected to give if he were called before the DC. Mr Gray replied that he had not regarded it as his function to do that and that no one had ever suggested that he should. His practice was to submit to the PeCC only 'objective, good evidence'. He would have been concerned that, if he had summarised for the PeCC the evidence which the officer was expected to give and, in the event, the officer had not 'come up to proof' when giving evidence before the DC, he (i.e. Mr Gray) would be criticised. Mr Gray said that, in any event, there was enough information from the police and the Home Office to justify the staff in referring the case to the PeCC without seeking further evidence. He said that there was enough evidence also to justify the PeCC referring the case on to the DC if it had thought fit. Had the PeCC done so, any additional information which DS McKeating could have given would, Mr Gray said, have come to light when he was called to attend the DC hearing. That is so but, as the case was not referred to the DC, the evidence was never obtained.

16.95 The fact that any information coming from a police officer to the PeCC as a result of an interview conducted by a member of the GMC staff would have been hearsay (and therefore not, in Mr Gray's view, 'objective, good evidence') does not seem to me to be a good reason for not obtaining it. If the hearsay evidence were favourable to the doctor, no harm would have been done to his/her interests; if it were damaging to him/her and the PeCC decided to refer the case to the DC, the officer could be called to give evidence and the doctor's representatives would have the opportunity to challenge what s/he said. In any event, the PeCC was willing to accept a letter written by a solicitor representing the doctor, in which the doctor's account was set out. Such a letter also constitutes hearsay evidence and would not be admissible in that form as evidence of the truth of its contents. So it appears that the PeCC was prepared to receive hearsay evidence of the doctor's account but not of a police officer's.

16.96 Mr Gray annotated the letter from the WYP with comments addressed to Mr Williams. The note read:

> **'... Pl** (*please*) **speak. with previous pp** (*papers*) **(?one for solicitors)'**.

Mr Gray said that his note was suggesting that he and Mr Williams should discuss the possibility of asking the GMC's solicitors to take a statement from the police officer. It is not clear how such a statement would have been used or at what stage in the proceedings, although, in view of Mr Gray's evidence, it seems likely that it would have formed part of the preparation for a hearing before the DC rather than for submission to the PeCC. In the event, it does not appear that the suggested discussion ever took place, probably because a letter containing useful information was received from the Home Office Drugs Branch.

The Response of the Home Office

16.97 As I have said, Mr Williams had also written to Mrs Powrie at the Home Office Drugs Branch requesting **'a brief account of the circumstances leading up to'** the offences, together with any additional information which might assist the PeCC when it considered the case in April. Mrs Powrie responded in a letter dated 25th March 1976.

16.98 Mrs Powrie's letter informed the GMC that Shipman had first come to the notice of the Home Office Drugs Branch in July 1975. In fact, this was incorrect; Shipman had first attracted its attention in January and February 1975, when it was observed that he had collected large quantities of pethidine from two local pharmacies. Enquiries were made at that time and it was decided to maintain a watch on him and to see if anything further came to light. This information never became known to the GMC. That said, it is unlikely that it would have had any effect upon the outcome of the case, even had the GMC been aware of it.

16.99 Mrs Powrie went on to say that, in July 1975, it had been discovered that Shipman was obtaining large and regular supplies of pethidine on written requisitions for use in his practice and on prescriptions for a patient. Shipman had always collected the prescriptions for the patient, who was suffering from terminal cancer. It had subsequently come to light that he was not keeping a register of supplies of controlled drugs, whereupon he had been informed of the statutory requirement to do so.

16.100 The letter went on to relate how, in September 1975, it had been reported that Shipman had resigned from his practice and had admitted his addiction to pethidine after his purchases of large amounts of the drug had come to the attention of one of his partners. It had transpired that Shipman had also been obtaining pethidine on prescription, ostensibly for patients, and the facts were communicated to the WYP. The letter explained that, in an interview with an inspector from the Home Office Drugs Branch and a police officer in November 1975, Shipman had admitted committing the offences. He had said that he had begun to take pethidine in April 1974. The letter stated that Shipman had been receiving treatment for his addiction from Dr (Ronald) Bryson at The Retreat, York, and Dr (Hugo) Milne of Lynfield Mount Hospital, Bradford.

16.101 I explained in my Fourth Report that, in 1976, the Home Secretary had the power to make a direction in respect of a doctor who had been convicted of an offence under the Misuse of Drugs Act 1971 (MDA 1971). Under section 12 of the MDA 1971, the Home Secretary could direct that the doctor should be prohibited from possessing, supplying, prescribing or administering controlled drugs. Indeed, the Home Secretary still possesses the power to make a section 12 direction, although it has not been exercised for a decade or more. In her letter, Mrs Powrie indicated that the Home Office was considering whether action should be taken under section 12 of the MDA 1971. She said, **'... we should be glad if in this connection you would let us know the view taken by the Penal Cases Committee'**. As I explained in the Fourth Report, the Home Office paid considerable attention to the attitude of the GMC when considering whether to make a section 12 direction, as the GMC had greater experience in the field of drug misuse by doctors than did the Home Office. The main interest and experience of the Home Office lay in uncovering the illegal supplying of drugs.

16.102 On 1st April 1976, Mr Williams responded to Mrs Powrie's letter, promising to let her know in due course the decision taken by the PeCC. On the same day, he wrote to Shipman, informing him that his conviction had been reported to the GMC and telling him that a further communication would be sent to him when the PeCC had decided whether to take any action in relation to it. This was the standard letter sent to doctors in conviction cases

and, sometimes, it was the only letter which they would receive before their case was considered by the PeCC. I have already explained that it was not the invariable practice of the GMC at the time to ask for an explanation from the doctor at this stage in the proceedings. As I have said, however, the Inquiry has seen that it was often done in drug-related cases.

16.103 Mr Williams then prepared a memorandum for the attention of Mr Gray. The memorandum was dated 1st April 1976. Attached to the memorandum was the original letter from the WYP, together with the schedule of offences. It is probable that Mrs Powrie's letter was also attached. Mr Williams referred to the letter from the WYP and the schedule of offences attached to it. He indicated that Shipman had been positively identified as a doctor on the medical register. He mentioned his request for further information from the WYP and the response which, he said, **'made it clear that they are not prepared to provide any, short of being subpoenaed'**. This was not strictly correct, as the police had offered an interview with DS McKeating. It may be that Mr Williams realised that this would not be deemed appropriate and mentioned what he believed to be the only option likely to be acceptable. Mr Williams went on to say:

> **'Fortunately Mrs Powrie of the Home Office (Drugs Branch) has furnished a useful and comprehensive account of the particular circumstances of the offences and the attitude taken by the police will not therefore be detrimental to the information that we can provide for the Penal Cases Committee.'**

16.104 Mr Williams expressed uncertainty as to whether the total fine imposed on Shipman had been £225 or £600. Finally, he sought Mr Gray's authority to send the item to the PeCC. Mr Gray endorsed the memorandum with a request that Mr Williams should telephone the Magistrates' Court and find out how much Shipman had been fined. Mr Williams did so and learned that the total fine had been £600. I find it puzzling that Mr Gray should be concerned to find out how much Shipman had been fined and yet did not attempt to obtain a fuller account of Shipman's criminal conduct. In any event, Mr Gray was satisfied that the information was sufficient to go to the PeCC. He told the Inquiry that the information provided by the Home Office constituted what seemed to him to be 'a sufficiently complete story'. Accordingly, no further consideration was given to enlisting the assistance of the GMC's solicitors to obtain further information from the police at that stage.

Limitations on the Investigations Made for the Purposes of the Penal Cases Committee

16.105 In a witness statement to the Inquiry, Mr Gray said that, with a conviction case, the GMC needed to:

> **'... seek sufficient evidence of the circumstances** (*i.e. of the offences*) **to enable the Penal Cases Committee to assess the gravity of the case and the extent to which it revealed that the practitioner concerned was a danger to patients'**.

16.106 It seems to me that, if the PeCC had confined itself to making a decision on a broad brush basis as to whether or not a case should be referred to the DC on the grounds of either the gravity of the doctor's conduct or the risk to patients or both, it would have been reasonable for it to limit the evidence it received in the way described by Mr Gray. In a case of a doctor convicted of multiple offences involving the dishonest obtaining of controlled drugs over a period of time as the result of drug addiction, the broad brush approach should always have led to a decision to refer the case to the DC on the grounds of gravity and risk to patients. However, as I have already explained, the PeCC did not always confine itself to that type of broad brush approach; it would sometimes decide that a rehabilitative approach should be taken and that the doctor need not be referred to the DC, despite the obvious seriousness of the offences of which s/he had been convicted. In short, it would take, not a filtering decision, but the substantive decision. Quite apart from the fact that such decisions do not appear to me to have been appropriate for what was supposed to be a filtering committee, such substantive decisions would have required careful consideration of all the evidence. The PeCC would not have had access to all the evidence that would have been available to the DC.

The Evidence of Detective Sergeant McKeating

16.107 In Shipman's case, the PeCC did not have the evidence of DS McKeating that would have been available to the DC had the case been referred. If DS McKeating had been called to give evidence, he would have been able to explain Shipman's *modus operandi* and the extent of his dishonesty. He would have been able to describe the offences taken into consideration by the Magistrates' Court. DS McKeating would also have explained why, in some cases, Shipman had also been charged with forgery: on some occasions, Shipman had forged the signature of a staff member at the residential home where the patient lived. The patient was elderly and entitled to exemption from the prescription charge; if the patient had not appeared to claim exemption, the pharmacist would have wondered why. In my view, the forgery of a signature is a significant additional act of dishonesty over and above the dishonesty inherent in obtaining the drugs by deception. DS McKeating might also have mentioned Shipman's rather cavalier attitude towards his offending, which had been revealed during the interview conducted by himself and the Home Office Drugs Branch inspector. When describing to his interviewers how much of one patient's pethidine he had taken for himself, Shipman had said, **'Shall we say half for her and half for me?'** DS McKeating might also have expressed the view which he gave to the Inquiry that, from his assessment of the appearance of the collapsed veins in Shipman's arms, it appeared that Shipman had been injecting himself for much longer than the period covered by his known offending. DS McKeating told the Inquiry that it appeared to him that Shipman had been using drugs for about five years rather than the 14 months or so to which he had admitted.

16.108 What the DC would have made of this evidence is pure speculation. It may well be that Shipman (who would almost certainly have been present at the hearing) would have wished to challenge some of DS McKeating's evidence and he might well have given evidence himself. That would have given the DC a far better opportunity to assess Shipman than was available to the PeCC.

Evidence of the Possible Impact of a Doctor's Drug Taking on Patients

16.109 Another *lacuna* in the information available to the PeCC was any evidence of whether Shipman's addiction to pethidine had had any adverse effect upon his practice or patients. No enquiries were made by the GMC of Shipman's former partners or of the Calderdale FPC. It appears that it was settled GMC practice not to make any such enquiries in cases where the doctor had been abusing the drugs by self-administration and was not known to have been supplying them to others. Mr Gray said that there was a distinction between improper prescribing to others on a large scale, where the doctor had fomented addiction in patients or had otherwise endangered them, and a case where a doctor had, like Shipman, self-administered drugs. In the latter case, the PeCC was more likely to take a 'clinical' view, i.e. to regard the doctor as sick and to hope that s/he could be cured. The focus in a case of self-administration would be on the doctor and (if psychiatric evidence was available) on the psychiatrists' views of the case.

16.110 Mr Gray suggested to the Inquiry that it would have been difficult to obtain reliable evidence about whether a doctor's drug taking had had any impact upon his patients. First, he suggested that it would have been difficult to find out, in the case of a GP, which FPC to contact. I found that hard to accept and, indeed, Mr Gray later agreed in evidence that it would have been possible to trace the appropriate FPC and to find out whether it had received any relevant complaints about the doctor. Second, he said that although, in Shipman's case, it would have been possible to approach his former partners, they would probably have been 'edgy' about giving their views of Shipman because they would have known that the deprecation of colleagues was a disciplinary offence. When pressed about this, Mr Gray accepted that, if the GMC had approached Shipman's former partners and had asked whether his drug taking had impacted on his performance as a doctor, and if the former partners had answered honestly, they could not have been in danger (or sensibly have been afraid of putting themselves in danger) of disciplinary action by voicing any concerns they might have had. Mr Gray conceded that there would have been nothing (apart, he said, from 'the time factor') to stop the GMC from putting that sort of question to a doctor's colleagues as a matter of routine, in order to find out whether there were concerns that the doctor had presented a risk to patients. The 'time factor' referred to was the need to get cases onto the agenda for the next PeCC meeting. However, Mr Gray accepted that such enquiries could have been made. It is clear, however, that they were not. It was not usual practice to do so.

16.111 In his witness statement, Mr Gray suggested that, even if it had emerged that there had been problems about the quality of care that Shipman had given during his short career in general practice, it would not have been possible to prove that those problems had been occasioned by his abuse of pethidine. He sought to support his assertion by reference to the British National Formulary and the information contained therein about the speed at which the effects of pethidine wear off. He referred to the fact that there had been no complaint to the GMC during Shipman's period in general practice about his treatment of patients and that there had been no report to the GMC of any medical service committee (MSC) proceedings against him. That was indeed the case. However, there could have been (although there were not) multiple complaints about Shipman to the FPC. There could even have been (although there were not) ongoing MSC proceedings in which it was

alleged that he had been in breach of his terms of service. Since the GMC had not sought any information from the FPC, it could not have known whether or not there had been any complaints or whether there were any ongoing proceedings. All it could have been confident of was that, in respect of the period of approximately 19 months for which Shipman had been in general practice, no complaint about him was evident from the GMC's own records.

16.112 As it happens, in Shipman's case, an enquiry to the practice in Todmorden where he had worked would not have revealed any specific concerns about the safety of patients. Dr John Dacre, the senior partner, told the Inquiry that Shipman had been hardworking and that there had been no concerns about his competence. Dr Dacre was not aware that Shipman had unlawfully killed a patient in the terminal stages of cancer, as I have found he did. Nor did he know that Shipman had signed three Medical Certificates of Cause of Death in one day in circumstances which make me suspicious that Shipman was guilty of unlawful killing. Nor was he aware that Shipman had injected Mrs (now Professor) Elaine Oswald, a patient, with pethidine, shortly after she had taken some Diconal (prescribed by him), and that Mrs Oswald had suffered respiratory arrest as a result. It seems unlikely, even if the GMC staff had made enquiries of the practice, that they would have asked about Shipman's health. It seems unlikely, therefore, that Dr Dacre would have volunteered that Shipman had had a number of blackouts in the last few months of his practice in Todmorden and that, for that reason, Shipman's wife had been driving him when he visited patients. It is clear that the Calderdale FPC would have had no information about Shipman which they could have passed to the GMC, over and above that which they had been given by Shipman's former practice. If DS McKeating had been asked about issues of patient welfare, he would have told the GMC that there was no evidence of any patient being deprived of pethidine that s/he required. Neither DS McKeating, Dr Dacre nor anyone from the Calderdale FPC would have been able to give the GMC any significant clue as to Shipman's true character.

The General Medical Council Requests a Medical Report

16.113 The procedure in cases which Mr Gray considered ready to go before the PeCC was for the papers to be submitted first to the Registrar, Mr Draper. Accordingly, in Shipman's case, Mr Gray endorsed on Mr Williams' memorandum a note to Mr Draper, seeking his authorisation for the case to go to the PeCC. Mr Draper responded with a further note:

> **'Yes, but in cases like these, I think it would be helpful to invite the practitioner's observations and if he agrees, a confidential medical report? Do so now ...'**.

16.114 I have mentioned that, in conviction cases, a doctor would sometimes receive only a standard letter informing him/her of the fact that his/her conviction had been reported and was to be referred to the PeCC and promising a further communication when the PeCC had made its decision. Mr Gray said that a different letter, of the type suggested by Mr Draper, was sent when there was a suspicion that the doctor was an addict. In Shipman's case, the Home Office letter had referred to his **'addiction'** to pethidine and had mentioned that he had received treatment at The Retreat (a private hospital for the

treatment of psychiatric disorders) and that he was being treated for his addiction by named doctors whom Mr Draper would probably have known to be consultant psychiatrists. It seemed likely, therefore, that this was the explanation for his suggestion that Shipman should be asked to provide a medical report. However, an examination of the files relating to drug-related conviction cases dealt with by the PeCC in the mid- to late 1970s does not reveal any consistent pattern of requests for the doctor's explanation for the offence or **'observations'** and/or for medical reports. There were conviction cases where there was evidence that the doctor was or might be addicted but where no explanation or medical reports were requested. There were other cases where there was no evidence of addiction, but where, nevertheless, the doctor was requested to provide an explanation. It is not clear on what basis the decision to request an explanation and/or medical evidence was made. In Shipman's case, however, there was, as I have said, information that he had suffered from an addiction and was under medical care. Mr Draper obviously considered it appropriate to ask him to provide **'observations'** and, if he agreed, a medical report.

16.115 Accordingly, Mr Gray wrote to Shipman on 6th April 1976. He informed Shipman that the PeCC meeting was to be held on 28th April 1976. He invited him to submit any observations which he had on the matter of his conviction and to arrange for the GMC to receive a confidential medical report on his current condition. The letter said that any documents received from Shipman would be placed before the PeCC, together with information about his conviction.

16.116 Mr Gray told the Inquiry that where, as here, it was evident from the information in the GMC's possession that a doctor was already being treated for his/her addiction, it would be expected that any medical report requested by the GMC would come from the treating doctor. He did not recall that the GMC at that time (which was, as I have said, before the introduction of the health procedures) ever requested a doctor to submit to examination by a practitioner of the GMC's choice. The GMC did not make any stipulation about the topics which should be covered in a medical report, or about the questions that should be answered by the reporting practitioner. Mr Gray said that it would have been possible to go back to the author and query something which had been said in a report. However, he did not recall this being done 'because they were usually very good reports'. When asked whether there was ever any concern about possible lack of independence on the part of the practitioners who reported, he responded, 'I would have thought absolutely none'. He said that, when a report came into the office, the staff would read it, but would not query it, as they were not doctors. It would be attached to the papers in the case and sent with them to the PeCC.

16.117 Shipman acknowledged Mr Gray's letter, indicating that he had put the matter in the hands of Hempsons, the MDU solicitors. Hempsons sent a 'holding letter', promising to send Shipman's observations as quickly as possible.

The Evidence Provided by Shipman

The Letter from Shipman's Solicitors

16.118 In a letter dated 21st April 1976, Hempsons set out Shipman's observations about his conviction. Their letter indicated that Shipman's age was at that time about 30. It

suggested that Shipman **'did not make the right decision in going into general practice and particularly into partnership with little experience particularly on the administrative side of general practice'**. It expanded on what was put forward as the background to Shipman's drug abuse. The letter explained that Shipman had been put in charge of the ordering of controlled drugs for his practice. It was said that he had first administered pethidine to himself following a back strain, probably in the early part of 1974. (This appears to have been the first time it had been suggested that Shipman's abuse of pethidine had started in response to back pain. It was almost certainly untrue, but it was – and, indeed, still is – not uncommon for doctors in his predicament to claim that their drug use began with legitimate self-administration for pain relief.) The letter gave an account of the events surrounding the detection of Shipman's conduct and indicated that his partners had terminated his partnership immediately his drug abuse came to light. He had remained as a patient in The Retreat, in York, until 31st December 1975. It was pointed out that Shipman had admitted his conduct to his partners when first taxed with it and had subsequently admitted it to the police.

16.119 Bringing matters up to date, the letter stated that Shipman had obtained employment as a clinical medical officer, a full-time appointment in child health, with the Durham Area Health Authority (AHA). The letter said that the appointment had been made with his employers' full knowledge of the history of the matters set out in Hempsons' letter. Shipman had moved with his family to County Durham and, on the advice of Dr Bryson and Dr Milne, continued to attend outpatient appointments.

16.120 With their letter, Hempsons enclosed a psychiatric report from Dr Bryson, dated 29th January 1976, and one from Dr Milne, dated 26th January 1976. Both reports had been prepared for the purposes of the Magistrates' Court hearing. Both Dr Bryson and Dr Milne were highly experienced in their field. By 1976, Dr Bryson had practised at The Retreat for 25 years, 20 of them as a consultant psychiatrist. He had considerable experience of treating patients (including doctors and other professionals) who were suffering from alcohol and drug addiction. Dr Bryson provided two witness statements to the Inquiry, dealing with his treatment of Shipman and the contents of his report. He was not fit to attend the Inquiry to give oral evidence.

16.121 Dr Milne was a senior consultant psychiatrist and Director of the Regional Drug Unit for the Yorkshire Metropolitan area. He was not well enough to provide a statement to the Inquiry or to give oral evidence.

The Report of Dr Ronald Bryson

16.122 The report of Dr Bryson explained that he had first encountered Shipman when Shipman was admitted on 2nd October 1975 as a voluntary patient to The Retreat. Shipman had been referred there by Dr Milne. The reason for his admission was the development of an addiction to pethidine. Dr Bryson pointed out, however, that there were some **'unusual features'** to the addiction, which was **'intermittent'** and **'had not yet reached the stage of total compulsion and constant need'**. Withdrawal from pethidine had been instituted over a few days without complication.

16.123 Dr Bryson reported that, after withdrawal had been completed, it **'became obvious'** that Shipman was suffering from **'a moderately severe depressive or melancholic state'**. After discussion with Shipman and his wife, Dr Bryson had formed the view that this state had existed for **'something like 18 months previously'**. Shipman had not, it was said, recognised his illness or sought medical attention. Dr Bryson described Shipman's condition as **'endogenous depression, that is a type of depression which arises from some internal usually biochemical disturbance of brain function, rather than is precipitated by psychologically upsetting events'**. He described **'many characteristic features'** of the condition which, he said, Shipman had exhibited. Dr Bryson believed that the depressive disorder had probably pre-dated Shipman's **'attempt to keep going by unwise self-medication'**.

16.124 Dr Bryson went on to describe Shipman's background and his **'persistence and determination'** in overcoming family resistance in order to qualify in medicine. He had, it was said, found himself suited to general practice although he **'worried a lot about it and tended to over-identify with patients and their problems'**.

16.125 After Shipman had been treated with anti-depressant medication, there had been, Dr Bryson said, a **'dramatic improvement in his condition'**. He had **'not looked back since that time'**. He had **'very considerable insight into the nature of his illness'**. He had no cravings for pethidine and had not substituted **'any other form of self-medication'**. Dr Bryson observed:

> **'He has approached the problems of his future with great courage, common sense and determination, and I am impressed by the fact that he recognises the potential dangers in the future and is trying to take steps in his professional career to ensure that if he should ever become depressed, he does receive proper medical treatment, and he is also taking steps to ensure that he does not have ready access to drugs of potential danger to him.'**

Dr Bryson regarded the chance of relapse into drug dependence as **'extremely unlikely'** in view of the fact that:

> **'... if he were ever to suffer a recurrence of his illness** (*i.e. depression*) **it would be immediately recognized, and secondly the strength of his basic personality is such that having experienced this series of events, he would have the strength of character and determination to avoid a repetition'**.

Dr Bryson recommended that Shipman should continue under psychiatric supervision, **'even if at infrequent intervals'**, for several years. Arrangements had been made for this, with Shipman's full co-operation.

16.126 Dr Bryson explained to the Inquiry in a witness statement that, having observed Shipman's condition during the period of his withdrawal from pethidine, he had formed the view that Shipman had not been severely addicted. This view also derived support from Shipman's claim that he had been able to abstain from the drug for intervals during the period of his dependency. Even if Dr Bryson had believed that Shipman had been severely addicted,

however, he would not necessarily have regarded him as unfit to practise medicine for all time. His view would have depended on his patient's underlying personality. Dr Bryson said that, had he been dealing with a patient who had been severely addicted and who had a weak personality, he would have considered a relapse highly probable and would have suggested a change of career. Shipman, however, had a strong personality and Dr Bryson did not believe that he had had **'a full-blown addiction'**. As a consequence, Dr Bryson had felt that the possibility of a relapse into drug abuse was low. There was, he had recognised, a risk that this could occur if Shipman were to become depressed again. However, Dr Bryson had felt that Shipman had enough strength of personality, and enough support, to be able to deal with any further depression appropriately, rather than by self-medicating with pethidine.

16.127 Dr Bryson made no mention in his report of the effects of Shipman's drug abuse on his practice. In a witness statement to the Inquiry, Dr Bryson referred to the importance of verifying information given by a drug abusing patient. He observed that, as a group, such patients are secretive and lack insight. However, he said that he did not contact Shipman's former partners as he thought they would have been **'quite guarded'** in what they told him and that, consequently, he was unlikely to glean any useful information. Dr Bryson had considerable experience of treating doctors for addiction. This had led him to believe that former partners of a doctor, if approached, were likely to be concerned about the effect of what they said on the good name of their practice and also to be influenced by a desire not to do anything to make a future in medicine impossible for their former colleague. I infer from that that Dr Bryson believed that information from such a source was unlikely to be reliable.

The Report of Dr Hugo Milne

16.128 In his report, Dr Milne recounted how he had seen Shipman after his initial admission to the Halifax Royal Infirmary, immediately after his drug abuse had been detected. He said that, at this time, Shipman had been **'involved in the abuse of Pethidine to the extent of an addiction'** for about 18 months. Dr Milne had recommended admission to The Retreat. Subsequently, Dr Milne had discussed his case with Dr Bryson and had also seen the discharge summary prepared by Dr Bryson following Shipman's discharge from The Retreat. He had interviewed Shipman and his wife on the day he wrote the report, 26th January 1976.

16.129 Dr Milne said that, when he first interviewed Shipman in September 1975, he had become aware that Shipman had been suffering from a depressive illness for between 18 months and two years. Dr Milne believed that Shipman's pethidine abuse and addiction were a direct result of that depressive illness. He acknowledged that depressive illness was an **'unusual causation for an addiction'** but he had nevertheless been convinced of the accuracy of the diagnosis. The diagnosis had been confirmed by Dr Bryson. Dr Milne noted that, initially, Shipman was reluctant to accept his advice that he should be admitted to The Retreat, suggesting that he was **'not good enough'** to be admitted to such a hospital and wishing instead to be admitted to the acute psychiatric unit. Dr Milne attributed this to **'ideas of unworthiness and guilt'** which were part of his **'depressive psychosis'**.

16.130 As well as the unusual nature of the cause of the addiction, Dr Milne noted that there was another unusual feature. Despite the prolonged period for which he had been abusing pethidine, Shipman had told Dr Milne that he had been able to stop his drug taking in order to take his family on holiday and in order to be fit to drive his car while on duty. In fact, as I have mentioned earlier, it is now clear that, at some time prior to the end of September 1975, Shipman had stopped driving and had thereafter relied on his wife to drive him when he visited patients at their homes. This was probably as a result of the 'blackouts' which he had begun to suffer earlier that year. Mrs Primrose Shipman told the Inquiry that she thought she had been driving her husband around for only a matter of weeks before he ceased to practise in Todmorden at the end of September 1975. It does not appear that Dr Milne was aware of this history; nor was the GMC.

16.131 Dr Milne suggested that conflict between Shipman and his partners at the Abraham Ormerod Medical Centre might possibly have contributed to Shipman's depression which **'in turn released his Pethidene** (*sic*) **addiction'**. This seems to have been speculation on his part. Shipman had joined the practice only in March 1974 and his depression was said by Dr Milne to have been present for about 18 months to two years before the end of September 1975, when he first saw Dr Milne. If Dr Milne's thesis was correct, Shipman's conflict with his partners must have occurred immediately after his arrival in Todmorden since, according to his own account, he had started taking pethidine only five or six weeks later. Given the timescale, it is difficult to see how any problems in the relationship with his partners (even if such problems existed) could have made any significant contribution to Shipman's depression or dependence on pethidine. It is not clear from the report whether Dr Milne appreciated how recently Shipman had entered general practice and how shortly after his arrival at Todmorden he had begun to obtain drugs illegally.

16.132 Dr Milne said that, when he had seen Shipman on 26th January 1976, Shipman had been **'greatly improved'**; there was no longer any evidence of depression and his wife confirmed that he had made a good recovery. Dr Milne reported that, at one stage, Shipman **'did not consider his future within the Medical Profession'**, but both Dr Bryson and Dr Milne had advised him that **'this would not be reasonable'**. Dr Milne said that, when he saw Shipman on the day he wrote his report, Shipman had told him that he had applied for and been offered a job with the Durham AHA. At that stage, he had not informed his prospective employers about his past history. Dr Milne had advised him to do so and Shipman had taken his advice. Meanwhile, Dr Milne had discussed with Dr Michael O'Brien, Area Medical Officer of the Durham AHA, the question of Shipman's suitability for the job he had been offered. It had been agreed that the job offer would remain open, on the understanding that Shipman continued to see Dr Milne for **'the necessary treatment'** in the future. Dr Milne's report suggested that all these events had occurred on one day, 26th January. Although possible, this seems unlikely and it may be that they occurred over a rather longer period than that suggested by his report.

16.133 Dr Milne recommended that the Magistrates' Court should deal with Shipman by means of a conditional discharge with an undertaking to continue his treatment as an outpatient or by means of a probation order with a condition of treatment by Dr Milne. He suggested that a probation order, if imposed, should be for the maximum period of three years. It should be noted that, if Shipman had been dealt with in either of the ways suggested by

Dr Milne, he would not have been the subject of a conviction: see paragraph 16.6. In that event, the police would not have been under a duty to report to the GMC the fact that Shipman had pleaded guilty to offences at the Magistrates' Court, although, as I have said, in practice, they usually did. If the matter had come to the attention of the GMC, the GMC could not have dealt with it as a conviction. It would, however, have been open to the GMC to deal with it as an issue of SPM, had it chosen to do so.

16.134 Dr Milne had observed that there was **'no suggestion'** that Shipman had been **'unable to carry out his duties whilst on call because of the effects of Pethidine'**. In his report, Dr Milne had mentioned his discussions with Shipman and his wife. It seems unlikely that they would have volunteered information about any difficulties Shipman might have had in carrying out his duties. (It does not seem, for example, that they had told Dr Milne that, for some time, Shipman had not been driving as a result of blackouts.) Dr Milne also spoke of discussions with Dr Bryson and Dr O'Brien. Neither of them would have been in a position to know anything about the effects of Shipman's drug abuse on his care of patients. Although it was strictly true, therefore, that there had been no suggestion to Dr Milne that Shipman's patients had suffered as a result of his drug abuse, the reality was that he had not conducted any meaningful enquiry into the matter. It does not seem that Dr Milne spoke to Shipman's partners or to the Calderdale FPC.

Further Evidence

16.135 Enclosed with a letter dated 26th April 1976, which was delivered to the GMC by hand, Hempsons sent a letter from Dr O'Brien, containing information about Shipman's progress in his new job. Dr O'Brien said that Shipman had started work on 2nd February 1976, having obtained the job after interview and in open competition with other doctors. He said that the offer of the job had been made **'subject to satisfactory medical clearance'**. He said that, at that stage, Shipman had had an interview with Dr O'Brien in which he had described his recent difficulties. It is difficult to see how that account fits in with the chronology of events described by Dr Milne but, as I have said, it may be that Dr Milne's account of the timing of events was not completely accurate.

16.136 Dr O'Brien said that Shipman had told him that he had suffered from **'an episode of profound depression'**, during which he had used pethidine. He had discussed with Shipman and his wife the fact that legal proceedings and involvement with the GMC would follow. Shipman was clearly aware of the difficulties that he faced but Dr O'Brien had formed the view that **'he was capable of rehabilitation'**. Dr O'Brien said that he had discussed Shipman's case with both Dr Bryson and Dr Milne, who had confirmed his judgement. He had therefore confirmed the offer of employment on condition that Shipman should continue to have follow-up care from Dr Milne.

16.137 Once Shipman began working for the AHA, Dr O'Brien had had no further professional contact with him but he said that he had kept **'in close touch'** with professional colleagues in the district in which Shipman was working. He understood from them that Shipman had settled well into his new employment and was **'well received by both patients and professional colleagues alike'**. He had received no evidence to suggest any recurrence of **'his former difficulties'**. Dr O'Brien concluded by expressing the hope that the PeCC would be able to reach a judgement which would further Shipman's rehabilitation.

16.138 On 27th April 1976, Hempsons delivered by hand a further letter enclosing a further short report from Dr Milne, dated the previous day. Dr Milne reported that Shipman had seen him on several occasions since his discharge from The Retreat. Shipman was entirely happy in his new job and had shown no evidence of psychiatric abnormality. There was **'no evidence whatsoever'** that he was abusing any form of drug. Dr Milne did not say whether he had carried out any urine tests or inspected Shipman for syringe marks. He concluded:

> **'As far as I am concerned Dr Shipman is extremely well, and it would be to his advantage if he were to be allowed to continue in practice, and conversely it would be catastrophic if he were not to be allowed to continue in practice.**
>
> **I shall continue to see him here regularly.'**

16.139 It should be noted that although, in November 1975, Shipman had told DS McKeating and the Home Office Drugs Branch inspector that he had no intention of returning to general practice or of working in a situation where he could obtain pethidine, the GMC was never aware of this declaration of intent.

The Penal Cases Committee Meeting of 28th April 1976

Preparations for the Meeting

16.140 Shipman's case was considered at a meeting of the PeCC held on 28th April 1976. Mr Gray was present at the meeting, as was Mr Williams. Not surprisingly, by the time of the Inquiry hearings, neither had any personal recollection of Shipman's case. The minutes of the meeting are no longer available so it is not possible to say with certainty which members of the PeCC were present. The Inquiry was, however, able to contact Dr Llewellyn, who was known to have been a member of the PeCC in 1976. He could not recall whether he had been present at the meeting at which Shipman's case was considered. However, very shortly before he was due to give evidence to the Inquiry, Dr Llewellyn discovered in his attic a bundle of papers relating to the meeting. From those papers, it was clear that he had indeed been present, although he still had no positive recollection of it. Dr Llewellyn said that meetings of the PeCC were generally well attended and he would have expected all six members to be present.

16.141 On 28th April 1976, the PeCC was to consider 14 new conviction cases, including that of Shipman. In addition, there would have been some conduct cases and a number of cases which had come back to the PeCC after having been adjourned from a previous meeting. Examination of the minutes of meetings of the PeCC which took place in 1977 and 1978 (those for 1976 are not available) suggests that there could well have been approximately the same number of cases in those two categories as there were new conviction cases. Dr Llewellyn suggested that the bundle of papers for a meeting of the PeCC was usually about eight inches high.

16.142 Papers relating to the meetings of the PeCC were sent to members in several tranches. The first tranche would be despatched to their homes two weeks before the meeting. In Shipman's case, it appears that the first tranche consisted of the original letter from the

WYP, together with the schedule of offences which had been attached to it, and the letter from Mrs Powrie. There would then be a second tranche, containing the papers in cases which had not been included in the first tranche, together with some additional papers in cases which had formed part of the first tranche. In Shipman's case, the additional papers in the second tranche consisted of Hempsons' letter of 21st April and two copies (presumably the duplication was an error) of the report from Dr Bryson. Some material (in Shipman's case, the letter from Dr O'Brien and the second report from Dr Milne) would have arrived at the GMC office too late to be posted to members of the PeCC. These documents would be distributed on the day of the meeting and members would arrive early in order to be able to read the additional material. In Shipman's case, that third tranche of documents also included Dr Milne's first report, which had previously been omitted in error.

16.143 Dr Llewellyn explained that it was his practice, during the time when he had the papers for a meeting, to read them through, sometimes several times. He would annotate the papers with his provisional views as to how each case should be disposed of. In Shipman's case, he had originally written **'D.C.'**, meaning that it was his view that the case should be sent to the DC. He went on to say that, after he had read each successive tranche of papers, he would review his annotations. If his view about a case had changed as a result of the new material he had read, he would amend his annotation accordingly. He had not made any amendment in Shipman's case and concluded, therefore, that he had not changed his provisional view up to the point when he went into the meeting.

The Decision-Making Process

16.144 In the event, contrary to Dr Llewellyn's views as to how Shipman's case should be dealt with, the PeCC decided not to refer the case to the DC. Instead the case was concluded. Dr Llewellyn crossed out his original annotation and wrote beside it the word **'Close'**.

16.145 As I have explained, when Dr Llewellyn provided his first two witness statements to the Inquiry, he was not sure whether he had been at the meeting of the PeCC at which Shipman's case was considered. He said that, if he had been there, he did not remember what his view of Shipman's case had been. In his statements, he appeared supportive of the PeCC's decision to close Shipman's case and advanced various grounds on which the decision could be justified.

16.146 In his statements, Dr Llewellyn said that the task of the PeCC was to determine whether Shipman was fit to continue in practice. (I interpose to point out that such determination should in fact have been for the DC.) Dr Llewellyn explained the thinking behind the PeCC's decision as follows. He noted that the charges were serious, but that Shipman had been convicted and punished for those. No patients were directly involved. He said that the PeCC would have considered that the sentence for Shipman's convictions was adequate and would have gone on to consider his illness, i.e. his drug addiction and moderately severe depression. He mentioned the imminent introduction of the health procedures. Dr Llewellyn pointed out that Dr Milne and Dr Bryson were two eminent consultant psychiatrists. Shipman had been under their care for many months, including three months as an inpatient. They had been impressed by Shipman's efforts to become

rehabilitated. He had acquired a post in preventive medicine where he would not be required to prescribe for patients.

16.147 Dr Llewellyn also observed that the GMC was entitled to expect that the full circumstances of Shipman's drug abuse (including any effect it might have had on patients) would have been ascertained by the Home Office Drugs Branch and by the two psychiatrists who had reported. Nothing untoward had emerged about his clinical performance. Dr Llewellyn said that there was no evidence that Shipman was generally dishonest. He suggested that the sentence of the court for his dishonesty was adequate.

16.148 Dr Llewellyn went on finally to say in his statements that the PeCC would have been aware that the trauma of a referral to the DC would have added to Shipman's stress and, in a depressed patient, could precipitate further depression, even an attempt at suicide. The psychiatrists seemed to have controlled Shipman's addiction and depressive illness. He was continuing to receive outpatient treatment. His new employer was aware of his history and was keeping a close eye on him. He observed that, as **'a solution had been found locally'**, no purpose would have been served by a referral to the DC.

16.149 Once Dr Llewellyn had found the papers for the meeting, he realised, of course, that his provisional view of Shipman's case had been that it should be referred to the DC. In his third witness statement, he referred to the annotation of his papers and said:

> **'This suggests to me that at the Penal Cases Committee's consideration of Shipman's case, I may have been persuaded by my colleagues on the Committee that it was appropriate to close the case in the circumstances; or that during the consensus process my opinion was discounted.'**

16.150 In oral evidence, Dr Llewellyn explained that members of the PeCC held different opinions about doctors who abused drugs. He explained that he regarded the possibility of rehabilitating drug taking doctors to return to the medical profession as 'very slim'. He said:

> **'Yes, there are some alcoholics that are cured, there are some drug addicts who are cured but I personally would always look sideways at them. That may be unfair but that is my personal view.'**

16.151 Although Dr Llewellyn observed at one stage in his oral evidence that his own stance was that people who abused drugs were 'highly untrustworthy', it seems that he was speaking there of the time when the abuse was going on. He said later that he believed that the use of dishonest means to obtain drugs (e.g. by falsifying a prescription) during the period of abuse was 'part of the illness' and did not indicate a general propensity for dishonesty in other respects once the abuse had ceased. Dr Llewellyn said that that was why 'we (*i.e. the PeCC*) ... did not really consider the dishonest aspects, rather the clinical aspects'. However, he said that he would be sceptical about whether the abuser had truly been cured of his/her drug habit.

16.152 Dr Llewellyn said that the message of the reports of both Dr Milne and Dr Bryson had been that the prognosis was good but that there was a need for a period of supervision

lasting several years. He acknowledged that the only way that formal supervision could have been achieved was by sending the case to the DC. The DC had the power, if it chose, to postpone its decision, thereby putting a doctor 'on probation'. He said that, having read Dr O'Brien's letter, his view would have been that the news was encouraging but he would have been suspicious that Shipman might not comply with continued medical supervision by Dr Milne unless he was obliged to do so. He observed:

> **'... the only supervision for a person who is manipulative is one that has teeth; continual reporting to a responsible body who** (*sic*) **would have the mechanism to ensure that he came to them regularly and the power to punish him if he did not'**.

16.153 Obviously, it must have been difficult for Dr Llewellyn to disentangle his current views about Shipman's case (formed with the knowledge of what has happened since) and the views which he held at the time. He acknowledged this frankly and said that there were many positive aspects to the material produced on Shipman's behalf which might have caused him to have some 'thoughts in his favour' at the time. I think Dr Llewellyn's point was that, while it is clear from his annotation that he was in favour of referring Shipman's case to the DC when he went into the meeting, he might not have been as certain at the time that this was the only appropriate course, as his oral evidence about drug taking doctors might have suggested.

16.154 Dr Llewellyn explained that, during the time he was on the PeCC, there was never a vote. The process was one of consensus. Strong personalities gave the lead. Some cases would be dealt with very quickly; in others, there would be argument and, eventually, the Chairman would bring the discussion to a close and identify the view which he believed was held by the Committee or the majority thereof. If there were psychiatrists on the PeCC, they would have had strong views about Shipman's suitability to return to work, views which it would have been difficult for others on the PeCC to rebut. In saying this, Dr Llewellyn echoed the view expressed by Mr Gray in his witness statement, where he referred to the fact that Professor Trethowan, a psychiatrist, was a member of the PeCC. Mr Gray observed that **'he would I am sure have helped the Committee to conclude that the case as presented to them heralded no danger to the public'**.

16.155 The view of Dr Milne and Dr Bryson was that several years of further outpatient supervision was desirable. Dr Llewellyn agreed that, in order for the decision to close the case to have been taken by the PeCC, there must have been members of the Committee whose view was that no steps to compel Shipman's compliance with supervision were necessary. Those members must have been happy to accept that Shipman would undergo such treatment voluntarily. Dr Llewellyn wondered whether, in fact, they had thought that far ahead. He thought that the primary reason why the majority of the PeCC had decided not to refer Shipman's case to the DC was that they had felt that they could trust him.

16.156 It is hard to understand why, in the light of the recommendation for continued supervision contained in both psychiatric reports, the PeCC decided to close Shipman's case with a warning. Dr Bryson, despite his view that Shipman had a strong personality

and was facing the future with common sense and determination, thought that continued supervision was important. Dr Milne had recommended to the Magistrates' Court that it should take a course (by imposing either a conditional discharge or a probation order) that would entail either an undertaking, or an actual requirement, to continue treatment with Dr Milne. This suggestion had been rejected by the Court. It may be that the PeCC took the view that the Magistrates had concluded that supervision was not necessary. If so, that might well have been a misunderstanding on its part, as it is entirely likely that the Magistrates wished to impose some punishment on Shipman and to recoup the loss he had caused to the public funds. A fine and compensation order could not be combined with a probation order. In the light of the recommendation in the medical reports for continued supervision, it seems to me that, if the PeCC had wished to promote the rehabilitation of the doctor and to provide some protection for patients, the proper course would have been to refer the case to the DC. That Committee could have used its powers of postponement if, on learning more of the facts of the case, it had thought it appropriate to do so.

Observations on the Decision-Making Process

16.157 Dr Llewellyn's evidence cast useful light on the decision-making process of the PeCC. First, it appears that the PeCC regarded itself as having the function of deciding whether the doctor was fit to practise. I have already observed that that was the function of the DC and have expressed my concern that the PeCC did not confine itself to its filtering role but made substantive decisions in quite serious cases. When asked whether the PeCC should have confined itself to filtering cases, Dr Llewellyn said that that was 'valid thinking' and added that 'everybody had their own views on that'. I infer from that that there were differing views about whether the practice of the PeCC in going beyond its filtering role was appropriate. Yet it appears that there was no official discussion about the issue, nor any guidance as to the kind of case which it would or would not be appropriate to refer to the DC. It is apparent from other parts of Dr Llewellyn's evidence quoted above that members relied upon their own personal views and did not rely on sound professional judgement based on evidence. For example, I have in mind Dr Llewellyn's personal views about the prospects of rehabilitation of a doctor addicted to drugs. It appears that others must have had different views. Some views might be based upon medical scientific evidence and others not. It does not seem to me to be satisfactory to allow decisions to be taken on the basis of differing personal views of this kind, any of which might prevail in a particular case.

After the Penal Cases Committee Meeting

The Letter to Shipman

16.158 After the meeting, Mr Williams prepared a memorandum for the attention of Mr Gray. This recorded that the PeCC had determined that Shipman's case could be concluded. He continued:

> **'Later in the proceedings it became evident that the Committee wished letters sent to those practitioners whose cases were concluded to contain some admonitory element.'**

Mr Williams had drafted a letter to be sent to Shipman for approval by Mr Gray. Mr Gray made some revisions to the draft and sent it on for approval by the Registrar, Mr Draper. On 6th May 1976, Mr Draper wrote to Shipman. After rehearsing details of the information considered by the PeCC, the letter went on:

> **'The Committee instructed me to inform you that they take a grave view of offences arising out of an abuse of drugs and of offences involving dishonesty and to draw your attention to sections (iii) and (vii) on page 9 of the enclosed pamphlet. You would therefore be wise to assume that, if information relating to any further conviction of a similar nature should be received by the Council a charge would then be formulated against you on the basis of both the earlier and the later convictions and referred to the Disciplinary Committee of the Council for inquiry.'**

The **'enclosed pamphlet'** was the January 1976 edition of the Blue Book. The relevant sections were those quoted at paragraph 16.34.

16.159 Mr Gray said that the **'admonitory element'** of the letter to Shipman was the threat of a public inquiry by the DC if Shipman re-offended. Both Mr Gray and Mr Williams observed that, judged by the standards of the time, the letter sent to Shipman was in 'very strong terms'. The letter concluded by requesting a personal acknowledgement of receipt. Mr Gray explained that, if a doctor failed within six months to respond to a letter sent from the GMC by recorded delivery, his/her name could be erased from the register. This was (and, indeed, remains) a necessary power as it prevents a doctor from attempting to avoid disciplinary action by failing to respond to communications from the GMC. Shipman acknowledged the letter promptly and indicated that he understood its implications.

Communication with the Home Office

16.160 By a letter dated 3rd May 1976, Mr Williams informed Mrs Powrie, of the Home Office Drugs Branch, of the decision taken by the PeCC in Shipman's case. He said:

> **'In all the circumstances, and particularly in the light of a number of reports received on the practitioner's condition, the Committee determined that it would be sufficient to conclude the case.'**

No mention was made of the fact that a warning letter had been sent to Shipman, since that was regarded as a private matter between the GMC and the doctor and was not disclosed to persons or bodies outside the GMC.

16.161 The original letter from the Home Office Drugs Branch had asked for the **'view taken'** by the PeCC, not for its decision. I do not understand this to mean that the Home Office Drugs Branch wished to know what view the PeCC took about the need for a section 12 direction, only what the PeCC itself had decided to do. Mr Williams' letter expressed no opinion about the appropriateness of a section 12 direction. In evidence, Mr Gray said that the 1956 Act did not require the GMC to be a party to action by the Home Office to restrict a doctor's rights in relation to controlled drugs. He said that Mr Williams' letter had informed the Home Office Drugs Branch what the PeCC had done with the case, which was what had been requested. Mr Gray did not think that the PeCC would have expressed any view

about the possibility of restricting Shipman's rights, although it seems to me likely that the Home Office Drugs Branch would infer, from its decision to close the case, that the PeCC did not think that it was necessary to restrict Shipman's prescribing rights. At the time, the GMC itself had no power to impose any such restriction. The only way the GMC could stop a doctor from prescribing a particular type of drug was by the DC suspending his/her registration or erasing his/her name from the register. Mr Gray did not recall any attempt by the GMC to plug that gap in its powers by encouraging the Home Office to use the power which the Home Secretary possessed to make a section 12 direction.

16.162 By a letter dated 9th July 1976, Mrs Powrie informed Mr Williams that the Home Office was not proposing to take any action in the case. As I have explained in my Fourth Report, shortly before this time, the Home Office had adopted a new policy whereby section 12 directions were considered appropriate only in cases where the doctor's breach of the MDA 1971 entailed conduct which put the public at risk of harm. In effect, from about May or June 1976 onwards, section 12 directions were made only in cases where the doctor had supplied controlled drugs to addicts or had in some way caused the release of controlled drugs onto the 'black market'. Directions were not made in cases where the doctor had been taking the drugs him/herself. The Home Office was unable to explain to the Inquiry the reason for this change of policy. It is possible that the change of policy came about as the result of the publication of the Merrison Report, with its emphasis on treating drug abusing doctors as 'health cases' requiring rehabilitation. If the Report was understood to suggest that doctors who self-administered drugs were not a risk to patients, that would have been an error. The Merrison Report recommended that the powers of the GMC should be extended so that it could protect patients by imposing conditions and restrictions on a drug abusing doctor while s/he was undergoing rehabilitation. It did not suggest that patients were not at risk from such doctors.

The Effect of the Decision of the Penal Cases Committee

16.163 The effect of the decision of the PeCC was that Shipman was free to practise medicine in any field appropriate to his skills. He was able to prescribe controlled drugs in just the same way as any other doctor and without any special 'watch' being kept on his prescribing. Most importantly, he was free to return to general practice as soon as a suitable post presented itself.

16.164 Shipman was under no compulsion to continue with outpatient supervision. It is not known if he did so or for how long. Dr Milne's records are no longer available. Dr Geoffrey Roberts, a former member of the Donneybrook practice, told the Inquiry that he spoke to a psychiatrist (he was not sure whether it was Dr Bryson or Dr Milne) about Shipman's application to join the practice. That would have been in the latter half of 1977, probably August or September. His recollection was that he had been told that Shipman had had an addiction problem, that he had been treated for depression but that he had by then finished his treatment. If Dr Roberts' recollection is correct, it appears that Shipman was no longer under supervision at that time. Certainly the Inquiry has been unable to obtain any medical records that confirm the continuance of any treatment.

The Decision Not to Refer Shipman's Case to the Disciplinary Committee

16.165 The GMC submitted to the Inquiry that the decision in Shipman's case was reasonable and justifiable when judged against the practice and the standards of the time. It said that the PeCC had all the material it needed to make an informed decision. The psychiatric evidence showed that Shipman had recovered well and that the prognosis was excellent. Shipman had a job in which he would have no need to prescribe or use controlled drugs. The GMC suggested, therefore, that no useful purpose would have been served by referring the case to the DC.

16.166 The GMC also submitted that, even if the case had been referred to the DC, erasure would not have been considered appropriate. The likely outcome would have been an admonishment or postponement of judgement. The GMC said that, if the DC had postponed judgement, it is likely that the case would have been concluded within a year or so.

16.167 On the face of it, perhaps the most surprising feature of the GMC's handling of Shipman's case is that it was not referred to the DC. This seems to suggest that the case was not regarded as 'serious enough' to warrant referral although, as I have shown, other issues besides seriousness were taken into account by the PeCC when deciding whether a case should be referred. The availability of psychiatric reports and the content of those reports seem to have played a determinative role in the decision not to refer Shipman's case.

16.168 It is instructive to consider what would have happened if Shipman's case had been referred to the DC. Is it right, as the GMC suggests, that, even if the case had been referred, the outcome would have been much the same? To some extent this is speculative because the evidence available to the DC would probably have been different from that considered by the PeCC. DS McKeating might have given evidence throwing a more serious light on Shipman's conduct. Shipman might have given evidence, either to refute, qualify or explain some aspect of DS McKeating's evidence, or to underline some aspect of the psychiatric opinions. It is quite possible that, with the benefit of that additional evidence, the members of the DC would have formed a less favourable opinion of Shipman than did the PeCC.

16.169 Mr Gray was of the view that, if the case had been referred to the DC, the result would have been the postponement of a decision. As I have explained, postponement of a case by the DC generally appears to have led eventually to closure of the case with or without a reprimand. Mr Gray observed that it was 'fortunate' for Shipman that Mr Draper had decided that Shipman should be invited to provide a medical report. Had that invitation not been issued or accepted, Mr Gray believed that, on the basis of what had happened in other similar cases, the PeCC either would have adjourned the case for him to do so or would have referred the case on to the DC. If the case had been referred to the DC, the overwhelming likelihood is that the same medical evidence as was before the PeCC would have been collected by Shipman's solicitors and sent to the GMC before the meeting of the DC. The outcome would have been postponement. In effect, Mr Gray was saying that Shipman was fortunate because, if he had not received the invitation to submit a medical report, he would have had to undergo the increased trauma of a public appearance; yet the eventual outcome would have been similar.

16.170 In his witness statement, Mr Williams said that Shipman's was the sort of case that would generally have been referred to the DC. He thought that one reason it might not have been referred was the existence of favourable psychiatric reports. He believed that this must have been a **'borderline'** case. He found it difficult to say what might have happened had the matter been referred to the DC. He said that he was not always able to predict the decisions of the DC. He guessed that Shipman's registration might have been suspended but emphasised that this was simply a guess.

16.171 Statistics provided for the Inquiry by Professor Isobel Allen, Emeritus Professor of Health and Social Policy, University of Westminster Policy Studies Institute, and my own examination of drug-related cases dealt with by the DC in the late 1970s, suggest that it is extremely unlikely that Shipman would have been erased from the register. Suspension would have been a possibility but the cases examined suggest that it too would have been unlikely.

16.172 It seems to me that, to some extent, the outcome before the DC might well have depended upon the extent of any further investigation. If there had been little or no further investigation, the most likely outcome before the DC would have been very similar to what actually happened at the PeCC, namely closure with a reprimand. I have said that, if more evidence had been available, the DC might have taken a more serious view of Shipman's conduct than did the PeCC and might have formed a less favourable view of his rehabilitation and prognosis. In that event, I think the likely outcome would have been postponement for a period of 'probation'. As I have little doubt that Shipman would have behaved himself well while under observation, I agree with the GMC that it is likely that the case would have been concluded within a year or two at most.

Possible Criticisms of the General Medical Council's Handling of Shipman's Case

16.173 In examining the GMC procedures of 1976, I must be careful to avoid the benefit of hindsight and the knowledge that Shipman was to become a mass murderer. I shall consider his case as one of a drug abusing doctor about whom no later information is available.

The Failure by the General Medical Council to Erase Shipman's Name from the Medical Register

16.174 I have already observed that, when the fact of Shipman's previous convictions for drug offences became known, many people expressed the view that the GMC should have erased his name from the medical register in 1976. The combination of Shipman's abuse of controlled drugs over many months and his dishonesty in acquiring the drugs should, it was said, have made it clear that he was unfit to practise. There were expressions of shock and surprise in the media and elsewhere that Shipman's medical career should instead have been permitted to continue virtually without interruption.

16.175 In preparation for this part of the Inquiry, Alexander Harris, the solicitors representing the Tameside Families Support Group, circulated a questionnaire to those families and

friends of Shipman's victims for whom they act. The questionnaire sought views on, *inter alia*, the GMC's handling of Shipman's case in 1976 and the way in which doctors convicted of drugs offences should generally be dealt with. The majority of those responding to the questionnaire believed that doctors in Shipman's position should not be permitted to continue in practice. Several made the point that, since doctors inevitably have access to drugs, it is inappropriate for a doctor who has abused drugs in the past to continue in practice. Miss Suzanne Brock, the granddaughter of Mrs Edith Brock, held this view. She gave oral evidence to the Inquiry. She said that she considered that the GMC should have permanently erased Shipman's name from the register in 1976 because of the continuing temptation to abuse controlled drugs that he would inevitably face if he remained in practice.

16.176 It does not appear to be generally known that there is a substantial number of doctors practising in the UK today who have, in the past, been addicted to drugs and who have committed drug-related criminal offences. The way in which Shipman's case was handled was in many ways typical of the way in which most such cases have been dealt with over the past 25 or 30 years. In 1978, Parliament, acting on the recommendations of the Merrison Committee, effected the creation of the GMC health procedures. Since then, it has been official policy that, whenever possible, doctors who have become addicted to, or dependent on, drugs should be permitted to return to practice once rehabilitated. Such doctors have frequently resorted to dishonest means in order to obtain supplies of their chosen drug. Inevitably, therefore, many have convictions for criminal offences involving not only the unlawful obtaining or possession of drugs but also dishonesty. There has never been any suggestion that they should be treated differently from those who have no such convictions. As a result, they have been, in general, treated as 'health cases' and dealt with by way of the GMC's health procedures, which, in accordance with the recommendations of the Merrison Committee, do not involve the possible sanction of erasure.

16.177 It may be that the need to have a sufficient number of doctors available to staff the NHS was a factor behind the policy adopted by Parliament in 1978. It may also be that it was recognised that the practice of medicine can be a stressful occupation and that, because of a doctor's ready access to drugs, it gives rise to unusual temptations to abuse them. Presumably, when it passed the Medical Act 1978, Parliament was satisfied that many drug abusing doctors could be successfully rehabilitated and returned to practice without significant risk to patients. Whatever the underlying considerations, Parliament acted upon the recommendations of the Merrison Report in 1978 and the GMC's health procedures came into effect in 1980. In 1976, it must have been evident that this would happen soon.

16.178 Despite the policy which has been in place for over 25 years, it seems that it is by no means universally accepted that drug abusing doctors are capable of rehabilitation and can go on to lead useful and valuable professional lives. The real problem is that there is a gap between the public perception of official policy and the reality. In my view, the public must be made aware that it has been the policy of the GMC to encourage and assist drug abusing doctors to rehabilitate and to return to unrestricted practice. The public must also be made aware that this policy has been endorsed by Parliament. If there is real and

widespread concern about this policy – as seems to me likely – it must be brought into the open for public discussion and possible change. It may well be that, after examination of all the relevant evidence, the outcome of such a public debate would be the confirmation of current policy, with proper emphasis on patient protection during rehabilitation. It may also be that such debate would result in a general call for patients to be made aware of their doctor's past history of drug abuse, so that they can make an informed choice as to whether they wish to be treated by him/her. I shall say more about these matters later in this Report.

The Failure of the General Medical Council to Suspend Shipman

16.179 The Inquiry is aware that some people took the view that, although it would have been unduly severe to erase Shipman's name from the medical register, his registration should have been suspended until it was clear that it was safe for him to practise. Suspension was a sanction available to the GMC at the time. However, suspension was regarded as a punitive sanction rather than a rehabilitative one. I can understand why that was so, although I personally think that suspension need not necessarily be inconsistent with rehabilitation, provided that it is made plain to the doctor what is expected of him/her during the period of suspension. Depending on the nature of the doctor's problem, that might be an intensive period of psychiatric treatment or, if appropriate, re-education in some field of medicine. However, Shipman had already undergone intensive psychiatric treatment. Moreover, at the time when his case was considered, he was practising in a field of medicine in which he was exposed to far less temptation to abuse drugs than while in general practice. I can understand why the GMC, which took a rehabilitative approach to cases such as his, should have regarded suspension as inappropriate.

The Failure by the General Medical Council to Place Conditions on Shipman's Registration

16.180 Many of the families and friends of Shipman's victims believed that, even if Shipman's name had not been permanently erased from the register, his continued registration should have been subject to stringent conditions and he should have been closely monitored. Some said that such safeguards should have remained in place throughout the time he remained in practice. It was suggested that monitoring in cases such as his should have included random blood tests and regular medical examinations to check for other signs of a return to drug abuse. In addition, there should have been periodic inspections of prescriptions, medical records and other aspects of the doctor's clinical practice. Suggested conditions on registration included prohibitions on prescribing or administering controlled drugs and on single-handed practice, together with requirements that the doctor should work only under close supervision or in a setting other than general practice. The Inquiry heard oral evidence from Mrs Theresa Deeley, the daughter of Mrs Edna Llewellyn, who felt that the GMC should have continued to monitor Shipman throughout his career after he had been allowed to return to practice. She said that, because of his past history of drug convictions, he should not have been allowed to work as a single-handed practitioner at any stage of his career. This view was shared by Mrs Sally Freeman, the daughter of Mrs Margaret Waldron, who added that Shipman should have been denied access to controlled drugs for the remainder of his career.

16.181 Other responses to the Alexander Harris questionnaire suggested that conditions on practice might have been imposed for lesser periods, ranging from two to ten years. Mrs Sheila Caldecott, the daughter of Mrs Angela Tierney, told the Inquiry that, if Shipman's addiction had been caused by work-related stress, the GMC should have given serious consideration as to whether it was appropriate to allow him to return to general practice where he would have access to controlled drugs. She thought that Shipman should not have been allowed to continue in general practice but should instead have been confined to administrative or teaching posts without access to controlled drugs. She considered that a doctor such as Shipman might be allowed to return to general practice if, after a period of time, s/he could show that s/he had been successfully rehabilitated.

16.182 In fact, as I have explained, the GMC had no power in 1976 to impose conditions on Shipman's registration, nor to undertake any monitoring of his progress or practice. The DC was able to exercise a limited degree of influence over a doctor by postponing judgement and I have already suggested that it could have done far more by seeking undertakings from doctors to cover the period of postponement of its judgement. However, even if such undertakings had been required and given, they would have been restricted in time to the period of postponement and could not have been kept in place for more than a year or two at the most. Short of erasing Shipman's name from the register, the DC had no means of exercising any long-term control over him or his practice.

Collection and Verification of Evidence

16.183 It should, I hope, be apparent, from the cases I described earlier, that the way in which Shipman's case was handled was not in any way exceptional for the time. The underlying approach to cases of drug addiction was to take such action as would encourage the doctor's rehabilitation, provided that this created no obvious and immediate risk to patient safety. However, no enquiries were directed at discovering whether such a risk existed. If Shipman's case appears to have been dealt with more 'leniently' than others of similar gravity, that is explained by the supportive content of the psychiatric reports and the report from his new employer.

16.184 Very little evidence about Shipman's offences was collected before the case was put before the PeCC. Ideally, a committee making any decision on a case should have had a full picture of the facts. If a filtering decision only was to be made, it might have been reasonable to act on the basis of limited information, provided that there were clear guidelines about the type and gravity of case to be referred and that, where any doubt existed, it was resolved in favour of referring the case on to the next stage. However, if the PeCC were to be permitted to make a final decision on a case, other than one in which it was clear that no form of disciplinary action was appropriate, it needed a full picture of the facts. The justification for making so few enquiries about the circumstances of the case was that, if the case went to the DC, further enquiries would be made. However, the converse was that, if the PeCC decided to handle the case itself, no further enquiries would be made and conclusions would be reached on the basis of quite scanty information.

16.185 In Shipman's case, no attempt was made to discover whether or not his addiction to pethidine had had any impact upon the clinical care of his patients. Also, when information

was received from Shipman's solicitors, it was taken on trust. I am not, of course, suggesting that the solicitors would have misrepresented their instructions but, as any judge or magistrate knows, matters advanced in mitigation by lawyers on instructions from a client must be subjected to some critical scrutiny. The PeCC did not even have Shipman there to ask him or his representatives any questions. Shipman was able to claim through his solicitors that he had begun taking pethidine following a back injury. This was not checked, despite the fact that he had not mentioned it to either psychiatrist. He also attributed the start of his 'addiction' to depression caused by being unsuited to general practice. He was never asked about this, nor did anyone seem to notice that his depression must have begun or worsened within a matter of weeks of his entry into general practice. He started working in Todmorden in March 1974 and he began obtaining pethidine within about six weeks.

16.186 The GMC has submitted that it would have been a disproportionate use of its resources to embark upon a full investigation of Shipman's case. His case appeared to be quite unexceptional. That I accept and it would follow that, if Shipman's case should have been more closely investigated, so should many others. However, to say that thorough investigation would not be justified seems to put a limit on the value of patient safety. The underlying principle was supposed to be that, in a drug addiction case, the GMC would adopt a rehabilitative course provided that there was no reason to believe that patients would be put at risk. I do not think that that precondition could be satisfied without a reasonably thorough investigation of the background facts and without some independent check on matters being advanced in mitigation. At the very least, there should have been enquiries made of the police officer in charge of the case, of Shipman's partners and of the Calderdale FPC. The fact that such enquiries were not made suggests to me that the safety of patients was not the paramount consideration in this case or in other cases of this kind. The paramount consideration was the doctor's rehabilitation, contrary to what the GMC claimed at the time.

Reliance on Psychiatrists Selected by the Doctor

16.187 It is clear that, in cases of drug addiction, the GMC placed very considerable reliance on psychiatric reports. It was plainly right that it should do so, although, in my view, such reports should have been considered by the DC, in the context of full information about the case, and not by the PeCC. In general, and in Shipman's case, these reports were provided by psychiatrists who had treated the doctor concerned. It does not appear that it occurred to anyone in the GMC to question the factual basis of such a report or the validity of the opinions expressed in it. However, uncritical reliance on any expert report is unwise. Some reports are much better than others. Some psychiatrists (and other expert witnesses) are more 'independent' and impartial than others. Indeed, I know from my own experience both at the Bar and on the Bench that, until recent years, many expert witnesses did not recognise it to be their primary duty to give an impartial opinion to the court – or, in this case, to the GMC. It was felt that, provided that the court – or the GMC – was not actually misled, the expert was free to put forward the best possible case for his/her client/patient. I think that, in later years, the GMC recognised this problem and, as I shall explain in Chapter 22, it became the practice of the health screeners to instruct independent psychiatrists to report to the GMC.

16.188 In Shipman's case (and in others that I examined), the GMC accepted reports that had been commissioned primarily for use in the criminal courts. In such circumstances, there must have been a temptation for the psychiatrist to say what s/he could that was favourable to the patient/client. I do not suggest that either Dr Milne or Dr Bryson was biased towards Shipman. However, it appears from the reports that both psychiatrists accepted Shipman's account of events, without any real attempt to verify the facts. It is true that both psychiatrists had met and spoken to Mrs Shipman but it is unlikely that she would have provided an account substantially at variance with her husband's, given the purpose to which the reports were to be put. It does not appear, on the face of the reports, that the psychiatrists had spoken to anyone else about the history. I say that not as a matter of criticism. My own experience suggests that it would not have been usual to do so in the 1970s, whereas today it would be. Nor does it appear, on the face of the reports, that Dr Milne carried out any objective test of Shipman's assertion that he had given up pethidine. He may have conducted a test but, if he did, one might have expected it to be mentioned. Even if he did not, I am not critical of Dr Milne. Objective tests, such as urine tests, although available in the 1970s, were much less used then than now. Today, it would be most unusual for a psychiatrist to accept the word of a patient that s/he had given up a drug; it would be usual practice to carry out objective tests at times when the patient was not expecting to be tested.

16.189 It seems to me that, in the 1970s, the GMC accepted psychiatric reports, not only as opinion evidence, but also as a reliable statement of the facts recited. It appears to have assumed that the psychiatrist would have carried out any verification necessary. The extent to which this reliance was well placed must have been variable. In my view, a rather more sceptical approach would have been preferable, particularly in cases involving drug abusers, who are known often to be deceitful and whose cases might well have involved a degree of dishonesty. It is, of course, common practice for courts of law to receive and rely upon information in psychiatric reports. However, it is usual practice in the courts for a judge to scrutinise the factual basis upon which the expert opinion is based to see whether it is consistent with other sources of information. It seems to me that the GMC did not attempt such scrutiny. This may have been because the GMC dealt only with doctors and made the assumption (sometimes erroneously) that all were essentially honest. The courts, on the other hand, deal with all manner of people, many of whom are dishonest. It would have been possible for the GMC to investigate the truth of some of the facts asserted by Shipman and, no doubt, by other doctors in other cases. It would also have been possible for the GMC to write to reporting psychiatrists to invite them to cover various specific matters, to check the veracity of doctors' assertions where practicable and to use random urine tests before reporting that a doctor was drug-free. It would also have been possible for the GMC to remind reporting psychiatrists of the purpose for which their reports were required and to warn them that their opinions might be relied on when taking decisions affecting the safety of patients and the public. Of course, this would all have taken time and cost money. Once again, the GMC's willingness to act on material that had not been subjected to proper scrutiny suggests that public protection was not paramount.

16.190 Having said all that, I accept without reservation that the psychiatrists on whose reports the PeCC based its decision were essentially right in their prognosis that Shipman was unlikely to relapse into the habit of drug abuse. There is no evidence that he ever did so.

The General Medical Council's Approach to Dishonesty

16.191 One of the assumptions underlying the GMC's treatment of cases involving drug abuse was the theory that the dishonesty which often accompanies the unlawful procurement of controlled drugs is not a personal characteristic but represents a temporary departure from the doctor's usual high standard of probity. It is an almost inevitable accompaniment to the drug abuse. The assumption is that, as soon as the overpowering need to obtain the drug has been conquered, any danger of further dishonest conduct will automatically disappear. This theory was lucidly explained by Dr Douglas Fowlie, who has been a consultant psychiatrist for many years. He said:

> **'Dishonesty in the context of an escalating drug or alcohol dependence is different to dishonesty in the absence of a dependence on drugs or alcohol. Dishonesty in the context of an escalating dependence is not something that is the focus from the psychiatric perspective. Almost inevitably, an element of dishonesty will arise where a person has a dependence on a substance ...**
>
> **It is important to be aware, when one is considering dishonesty in the presence of an escalating dependence, that one of the facets of an illness of dependence is a selectively distorted perception of one's own behaviour. As a dependence escalates, the priority of the individual is obtaining the next fix of the drink or the drug. This is the overwhelming priority and other factors external to this diminish in their importance. When the perceptions become distorted, a lack of insight develops, and the illness can cause a distortion of what the previously non-dependent individual regarded as right and wrong. One of the features of a mental illness of dependence can be dishonesty. It would not be fair to say that a person who has a dependence on drugs or alcohol and engages in dishonest conduct as a result of that dependence is someone who should, as a matter of course, be regarded as a person with a propensity to dishonesty in the absence of such a dependence.'**

16.192 That theory is not shared by everyone from whom the Inquiry heard. I shall discuss its validity with regard to drug abusing doctors in Chapter 23. However, I accept that the theory explained by Dr Fowlie was widely accepted within the GMC in the 1970s and the way in which the GMC dealt with Shipman's case must be seen in that light. I remain concerned that, in Shipman's case, the theory was applied without detailed consideration of whether it was appropriate to do so in the individual case. If dishonesty is to be explained (and excused) by the compulsion to obtain drugs which results from the doctor's addiction, it must surely be important to consider whether s/he really is addicted. If s/he is not really addicted and if s/he is able to give up drug taking at will, the doctor is surely not subject to the degree of compulsion which will excuse his/her dishonesty.

16.193 According to both the psychiatrists who reported on Shipman, his drug taking habit had not yet reached the stage of real dependence; he was able to give up taking the drug for periods: for example when on holiday. Notwithstanding that, the assumption seems to have been made by the PeCC that Shipman's dishonesty was all 'a part of the illness'. Here

again, the PeCC's thinking seems to have been focussed, not on patient protection, but on the welfare of the doctor.

Conclusions

16.194 I am satisfied that the GMC conducted Shipman's case in a way that was typical of its conduct of such cases at that time. I have drawn attention to several respects in which the procedures and underlying assumptions of the day are to be criticised.

16.195 My main criticism is that the GMC failed to give adequate protection to the public when dealing with the cases of doctors who had been convicted of offences arising out of an addiction to controlled drugs. It is clear that its approach laid greater emphasis on the interests of the doctor than on ensuring the safety of patients. I recognise that, in the years between the publication of the Merrison Report and the introduction of the health procedures in 1980, the GMC was in a difficult position. The need for the health procedures was recognised but they did not yet exist. It is not surprising therefore that the PeCC and the DC tried to fill the gap by the use of their powers to adjourn or postpone. As Mr Howes put it, they were 'playing at being a Health Committee'. It seems to me that the problem was that they did not manage to strike the right balance. The Merrison Committee had proposed health procedures whereby patients could be protected at the same time as the doctor was rehabilitated. That was to be achieved by placing conditions and restrictions upon the doctor's practice and by requiring him/her to accept supervision. Like the Merrison Committee, the GMC considered that health issues should be dealt with in private. In the period between 1975 and 1980, the PeCC took upon itself the right to deal with cases in private rather than send them to the DC for public hearing. It did so because that was in the doctor's best interests. Also, both the PeCC and the DC appear to have been determined to provide an opportunity for rehabilitation, even though they were not in a position to provide adequate protection for the public by imposing conditions, restrictions and/or supervision. In fact, in my view, they could have done far more than they did to protect the public by giving a doctor the option of accepting conditions, restrictions and/or supervision with suspension or erasure as the alternative. That was not done. The result was that the GMC gave too much weight to the interest of the doctor in rehabilitation and too little to the need of the public to be protected from a doctor who had not yet been shown to have recovered from the addiction or dependence that had led him/her into criminal conduct.

16.196 My second major criticism is that the GMC made so little attempt to investigate the background to Shipman's case and others like it. In my view, a case such as Shipman's should have been regarded as giving rise to the potential for risk to patients. The background should have been investigated with that in mind. The Merrison Report had suggested the creation of an investigating unit within the GMC. The GMC does not appear to have recognised the wisdom of that suggestion and did not undertake investigations, save in the small minority of cases that had to be prepared for a full disciplinary hearing. Instead of investigating, the GMC invited observations from the doctor and the opinions of experts and did nothing to question, scrutinise or check the assertions made on Shipman's behalf.

16.197 I also consider that, in the period before the introduction of health procedures, a case such as Shipman's should always have been referred to the DC. The PeCC did not have a full picture and should have been making decisions only on a broad brush basis. It should not have been making detailed assessments of psychiatric evidence. Those were functions properly assigned to the DC, which had a smaller caseload to consider at any one meeting, and fuller information before it. The DC also had the opportunity to see, and sometimes to hear, the doctor. The DC should always have given careful scrutiny to the content of psychiatric reports and should have looked critically at the accounts of events there recorded. These would underlie the expert opinion and, if inaccurate, would invalidate it. The GMC should have appreciated the need to obtain reports from psychiatrists independent of the doctor and should have laid down requirements as to the content of such reports.

16.198 I recognise that, even if Shipman's case had been handled as I think it should have been, it is unlikely that the outcome would have been very different from the actual outcome. I accept that Shipman's registration would probably not have been suspended and that his name would certainly not have been erased from the medical register. He would probably have been put 'on probation' for a few years at most.

16.199 I do not criticise the GMC for its decision not to suspend Shipman or to erase his name from the medical register. First, it was the GMC's practice to deal with drug abusing doctors by helping them towards rehabilitation. It had not been publicly criticised for that. Members of the public were probably hardly aware of the prevailing policy; if they had been it is by no means clear that it would have been criticised. Far from being criticised, it appears that the Government of the day accepted the philosophy underlying the Merrison Report and its recommendations for the creation of health procedures. The philosophy was that sick doctors, including those who abused drugs, must be helped towards rehabilitation in a way that provided adequate protection for patients. That did not imply that the GMC's existing rehabilitative approach was wrong in principle.

16.200 Nor, in my view, can the GMC be criticised for failing to foresee that Shipman's foray into the abuse of pethidine might be the forerunner of something far more serious. In short, I reject any suggestion that, even if the GMC procedures had been satisfactory, they could have prevented Shipman's later criminality and saved many lives. It is possible that a period of 'probation' might have delayed the resumption of his illegal use of drugs on patients and might have saved the lives of one or two of his victims. I am quite satisfied, however, that 'probation' and the limited medical supervision that would have accompanied it would not have had any profound effect upon his future conduct.