CHAPTER TWO

The Conduct of Phase Two, Stage Four of the Inquiry

Terms of Reference

2.1 The Terms of Reference of the Inquiry relevant to the subject matter of Phase Two, Stage Four ('Stage Four') are as follows:

> **'(c) by reference to the case of Harold Shipman to enquire into the performance of the functions of those statutory bodies, authorities, other organisations and individuals with responsibility for monitoring primary care provision and the use of controlled drugs; and**
>
> **(d) following those enquiries, to recommend what steps, if any, should be taken to protect patients in the future ...'**.

The Subject Matter

2.2 During Stage Four, the Inquiry examined the arrangements for monitoring general practitioners (GPs) which were in place between 1974 and 1998, when Shipman was in general practice. This examination included consideration of the following:

- the adequacy of the monitoring arrangements operated by primary care oganisations (PCOs) and other bodies, and their efficacy in detecting poor clinical practice or aberrant behaviour
- the role of patient complaints within the monitoring system and the adequacy of the systems for dealing with patient complaints over the relevant period
- the role within the monitoring system of concerns about GPs which are raised by colleagues, by other healthcare professionals and by members of the public, and the adequacy of the steps which have been taken in the past to facilitate the raising of such concerns
- the operation of the regulatory and disciplinary systems which form an integral part of the overall monitoring process and the extent to which those systems have in the past worked effectively to support and reinforce local monitoring arrangements.

The Approach of the Inquiry

2.3 The Inquiry examined these topics in the light of all the information which it has accumulated about Shipman's crimes, about his medical practice, about his previous history of drug abuse and about the complaints made and the disciplinary action taken against him during the course of his career.

2.4 The Inquiry then proceeded to consider the changes to the systems that have occurred since 1998, as well as those planned for the future. Throughout Stage Four, I have approached the task of assessing the effectiveness and adequacy of these various systems – past, present and future – by reference to the duty imposed upon me by the

Inquiry's Terms of Reference to make any recommendations that I regard as being necessary for the future protection of patients. In order to understand the degree of protection afforded by the various systems, it has been necessary to look at the whole regulatory framework governing the work of GPs.

Evidence

2.5 I shall deal separately with the evidence collected by the Inquiry in relation to each of the topics listed above. A total of 386 witness statements and approximately 52,430 pages of documents have been scanned into the Inquiry's image database in connection with Stage Four.

Families

2.6 When providing their Inquiry witness statements for Phase One, the relatives and friends of Shipman's patients were invited to give their suggestions for changes to existing systems which, if effected, might provide additional safeguards for patients in the future. Many responded to this invitation and made helpful and constructive suggestions as to how the various systems might be improved. I have considered all those written suggestions and, during the course of the Stage Four hearings, the Inquiry received further evidence, both oral and written, from a number of relatives and friends of patients whom Shipman had killed.

Monitoring Arrangements

Local Monitoring Arrangements

2.7 The Inquiry's primary purpose in examining local monitoring arrangements was to consider whether there had been any failure on the part of the PCOs which had responsibility for primary care in Tameside during the period for which Shipman was in practice there. This entailed undertaking an examination of the arrangements that were in operation locally and comparing those local arrangements with the arrangements that were in place in other parts of the country during the same period. It also involved assessing whether those arrangements that were in place should have alerted the PCOs to the fact that Shipman's practice was unusual or aberrant in some way or that he was an 'outlier' in any respect.

Primary Care Organisations and Other Local Bodies

2.8 The Inquiry received evidence from officers of the successive PCOs which had responsibility for primary care in Tameside. The PCOs which had this responsibility in the past were the Tameside Family Practitioner Committee (FPC), the Tameside Family Health Services Authority (FHSA) and the West Pennine Health Authority (WPHA). The body with current responsibility is the Tameside and Glossop Primary Care Trust (PCT).

2.9 Written and oral evidence was received from administrative officers and medical advisers who had formerly been employed by the Tameside FPC, the Tameside FHSA and the

WPHA. These witnesses described the monitoring arrangements that were in place during Shipman's career and explained, by reference to contemporaneous documents contained in the files on Shipman held by the PCOs, what the various arrangements had revealed about Shipman's practice. The Inquiry also heard oral evidence from the Chief Executive and Medical Director of the Tameside and Glossop PCT about the monitoring arrangements which are currently in place and the developments which have occurred since 1998, when Shipman ceased practice.

2.10 In order to compare the performance of the various Tameside PCOs with that of their counterparts in other areas, the Inquiry circulated a questionnaire to a number of randomly selected strategic health authorities (SHAs) in England and Wales. The questionnaire asked detailed questions about the monitoring arrangements that had been in place over the previous 25 years. Nineteen responses were received from SHAs and PCOs (to whom the questionnaire had been passed by the relevant SHA) in different areas of England and Wales. Representatives of four of the respondent bodies were invited to provide further evidence and two of those representatives, together with the Medical Director of another local PCT, attended to give oral evidence about past and current monitoring arrangements in their areas.

2.11 In addition, the Inquiry received evidence from representatives of other local organisations, including the West Pennine (formerly Tameside and Glossop) Local Medical Committee (of which Shipman had in the past been secretary), and from doctors who had been employed by the former Regional Medical Service.

Monitoring of Prescribing by General Practitioners

2.12 Shipman acquired drugs to feed his own drug abusing habit in 1974 and 1975 and, virtually throughout his career in general practice, to kill patients. During the later years of his time in practice, some monitoring of GPs' prescribing was carried out locally. The Inquiry examined in detail the results of the monitoring of Shipman's prescribing and heard evidence about this from pharmaceutical advisers who had formerly been employed by the Tameside FHSA and the WPHA as well as from a pharmacy consultant who had been employed by the fundholding consortium of which Shipman was for some time a member.

2.13 In my Fourth Report, written at the conclusion of Phase Two, Stage Three ('Stage Three') of the Inquiry's hearings, I recommended measures which would make it far more difficult for a doctor or other healthcare professional to obtain illicit supplies of controlled drugs, and which would also make it more likely that a doctor who succeeded in obtaining drugs illicitly would be detected. One of the measures which has a valuable role to play is the monitoring of GPs' prescribing of controlled drugs. The evidence that the Inquiry received in Stage Three has informed my views on this topic. During the Stage Four hearings, the Inquiry received a written statement from Mr Barry Lloyd, Prescribing Information Consultant, who is retained by the National Prescribing Centre and the Prescription Pricing Authority (PPA) to develop and provide training in the use of prescribing information systems. Mr Lloyd attended the Inquiry office and gave a demonstration of the use of the ePACT.net system which is now used for the monitoring of prescribing. The Inquiry also heard oral evidence on this topic from Mr Michael Siswick, of the PPA.

The Appointment of General Practitioners

2.14 In 1977, Shipman was appointed to the Donneybrook practice in Hyde. This appointment was made at a time when he had been working outside general practice for over 18 months, following his dismissal from the Abraham Ormerod Medical Centre, Todmorden, in late 1975. His dismissal had occurred after the discovery that he had been illicitly obtaining and abusing controlled drugs. The Inquiry examined the circumstances of Shipman's appointment to the Donneybrook practice and of his admission to the medical list of the Tameside FPC. The Inquiry considered in particular whether the Tameside FPC knew of his previous history and, if not, whether it should have made enquiries which would have revealed that history. The role in the appointment process played by members of the Donneybrook practice was also considered.

2.15 Witness statements were obtained from seven members and former members of the Donneybrook practice, and all but two gave oral evidence. The Inquiry had previously obtained evidence from three of Shipman's former partners at the Abraham Ormerod practice for the purposes of its Phase One investigations. In addition, the Inquiry received evidence from other witnesses who had knowledge of the arrangements for GP appointments that were in operation in 1977. These included the Chairman of the former Medical Practices Committee, the body which was at that time responsible for ensuring an equitable distribution of GPs across the whole of England and Wales. The Inquiry also received written statements from a former administrator of the Calderdale FPC (which had responsibility for primary care in Todmorden at the time Shipman was in practice there), from two inspectors of the Home Office Drugs Branch (who had been involved in the detection of Shipman's drug offences), from a representative of the West Yorkshire Police and from a former employee of the General Medical Council (GMC). These witnesses gave evidence about the information that would have been provided to a person making an enquiry in 1977 to one of those organisations about Shipman's previous history of drug abuse or about the criminal and disciplinary proceedings resulting therefrom.

The Wider Picture

Evidence from National Bodies

2.16 The Inquiry received a detailed witness statement from Sir Nigel Crisp, Permanent Secretary of the Department of Health (DoH) and Chief Executive of the NHS in England, describing the development of the arrangements for the monitoring of GPs from the 1970s to date. Sir Nigel gave oral evidence to the Inquiry and outlined the further changes that were planned for the future. These further changes included those resulting from the new General Medical Services (GMS) Contract (introduced in April 2004), together with a new requirement (to be introduced by the GMC in 2005) that all doctors should undergo periodic revalidation. The DoH provided a considerable amount of further written evidence, both in response to specific requests by the Inquiry and generally. In addition, representatives of the DoH participated in the Inquiry's seminars.

2.17 Dr John Chisholm (Chairman, General Practitioners Committee, British Medical Association (BMA)) and Dr William Reith (former Chairman, Scottish Council of the Royal

College of General Practitioners (RCGP)) attended to give evidence about a range of matters, including the plans for the future revalidation of doctors. Professor Alastair Scotland (Chief Executive and Medical Director, National Clinical Assessment Authority (NCAA)) and Dr Linda Patterson (Medical Director, former Commission for Health Improvement (CHI)) gave evidence about the role and functions of their respective organisations. Dr Reith and Professor Scotland attended some of the Inquiry's seminars, as did Dr John Grenville, representing the BMA. Professor Aidan Halligan, Deputy Chief Medical Officer for England and Director of Clinical Governance for the NHS, also participated in some of the seminars.

2.18 The Inquiry received written statements and other communications in connection with this part of its investigation from a wide variety of organisations, including the National Patient Safety Agency (NPSA), the Audit Commission, the Commission for Healthcare Audit and Inspection (now known as the Healthcare Commission), the Patients Association, Patient Concern, the Association of Community Health Councils, the Commission for Public and Patient Involvement in Health, the Joint Committee on Postgraduate Training for General Practice, Action against Medical Accidents (AvMA), the National Association of Primary Care Educators UK and a number of postgraduate deaneries. Representatives of the Patients Association, of Patient Concern and of AvMA attended those of the Inquiry's seminars at which the topic of monitoring and related issues were discussed. Professor Dame Lesley Southgate, Professor of Primary Care and Medical Education, University College London, former President of the RCGP and the person responsible for designing the assessment instruments used in the GMC's performance procedures, also attended some of the seminars.

Evidence from Academics

2.19 In connection with the topic of monitoring GPs, the Inquiry commissioned two reports from academic experts. The first, written by Professor Richard Baker, Director, Clinical Governance Research and Development Unit, University of Leicester, addressed a number of specific issues identified by the Inquiry. The second, which constituted an overview of past, current and future arrangements for monitoring the quality of care provided by GPs, was written by Professor Martin Roland (Director, National Primary Care Research and Development Centre, University of Manchester), Professor Martin Marshall (Professor of General Practice, University of Manchester), and Dr Jonathan Shapiro (Director, 'Policy. Development. Partnership.' and Senior Fellow, University of Birmingham). Both Professor Baker and Professor Roland attended some of the Inquiry's seminars and Professor Baker also gave oral evidence.

Appraisal

2.20 At the time of the Inquiry's hearings, the new system for appraising GPs had recently come into operation. It was important for the Inquiry to examine how appraisal was being carried out and to examine both its relationship with local monitoring and clinical governance systems and its intended linkage with revalidation. Several witnesses gave evidence about their own experiences of appraisal in general practice or in hospital or other

settings. In addition, the Inquiry received a written statement from Dr Vikram Tanna, Appraisal Lead, Tameside and Glossop PCT, and heard oral evidence from two witnesses who were responsible for organising GP appraisal on behalf of their PCTs; one of the witnesses was himself a GP appraiser. The Inquiry also received from the Tameside and Glossop PCT a number of anonymised completed appraisal forms.

Dealing with Poor Performance and Serious Untoward Incidents

2.21 A further questionnaire, relating to the arrangements made by PCOs for dealing with doctors whose professional performance gives rise to concerns, was circulated to a random selection of 24 PCOs in England and Wales, all of whom responded. The Inquiry also distributed a questionnaire to six SHAs (all of whom responded), seeking information about their systems for dealing with serious untoward incidents.

Single-Handed Practice

2.22 After Shipman's conviction in January 2000, there were many calls for a move away from single-handed practice. It was suggested that Shipman would not have escaped detection over such a long period had he been working in a group practice. It was, therefore, necessary for the Inquiry to consider whether it was easier for Shipman to carry out his crimes because of the arrangements that existed in the practices where he worked and, also, to consider the merits and drawbacks of single-handed practice.

2.23 The Small Practices Association is a national body representing the interests of single-handed and small practices and its Chairman, Dr Michael Taylor, gave oral evidence to the Inquiry. I also heard oral evidence from Dr Hugh Whyte, Senior Medical Officer, Directorate of Health Policy and Planning, Scottish Executive Health Department, about the position of small and single-handed practices in Scotland. The Inquiry also received a statement from Mrs Ann Lloyd, Director of the NHS Wales Department of the National Assembly for Wales, dealing with the Assembly's policy on single-handed medical practitioners.

2.24 Several witnesses called to give evidence on other topics provided their views and experience of small and single-handed practices. The Inquiry sent a questionnaire to 15 randomly chosen PCTs, seeking information about their attitudes towards such practices and about any special arrangements they made to support them. The DoH provided relevant policy and statistical material.

Monitoring Mortality Rates

2.25 One aspect of monitoring which assumed particular significance after the discovery of Shipman's crimes was the monitoring of mortality rates. No monitoring of the mortality rates among Shipman's patients had been carried out prior to his investigation and arrest. The Inquiry received written evidence from a number of former members of staff of the WPHA about the statistical information relating to GP patients and GP patient deaths held by the WPHA during the period of Shipman's practice and about the uses to which that information was put. The evidence also related to the analyses of Shipman's mortality rates

which had been carried out by the WPHA after Shipman's arrest in September 1998. The Inquiry also considered the clinical audit of Shipman's practice which was carried out by Professor Baker. At the conclusion of the report on the results of his clinical audit, Professor Baker had recommended that the systems for monitoring GPs should be reviewed and extended to include routine monitoring of GP patient mortality rates.

2.26 The Inquiry had first to consider whether the successive PCOs with responsibility for Tameside had been at fault in not instituting any monitoring system during the period of Shipman's practice there. In order to discover what, if any, steps PCOs in other parts of the country had taken to monitor mortality rates, the Inquiry distributed a questionnaire to all SHAs in England and health authorities (HAs) in Wales, requesting information. Responses were received from all 33 SHAs and HAs. Following receipt of the responses, the Inquiry sought and obtained further evidence from a number of PCOs which had undertaken analyses of mortality rates in the recent past. The Inquiry also obtained written evidence from NHS bodies in Northern Ireland and Scotland about steps which were being taken to develop monitoring systems in their areas.

2.27 The Inquiry commissioned Dr Paul Aylin, Clinical Senior Lecturer in Epidemiology and Public Health, Imperial College School of Science, Technology and Medicine, to report on the feasibility of setting up a national monitoring system for GPs and to advise on an appropriate method of analysis. Dr Aylin and a team of colleagues from Imperial College carried out the necessary work and prepared a written report. In July 2003, they gave a presentation of their work to the Inquiry.

2.28 In October 2003, Dr Aylin's work, together with wider issues relating to the monitoring of GP patient mortality rates, was discussed at a two-day seminar, which was attended by a number of experts in the field, together with representatives of the BMA, the RCGP and the former CHI. Also participating in the seminars were three representatives from PCOs who had experience of monitoring and/or investigating GP patient mortality rates. Dr Kathryn Booth (Chair, Northern Ireland General Practice Mortality Regional Group) and Dr Mohammed A Mohammed (Senior Research Fellow, Department of Public Health and Epidemiology, University of Birmingham) told the seminar about the pilot project for monitoring mortality rates which was then being undertaken by the Eastern Health and Social Services Board in Northern Ireland.

Patient Complaints and Local Disciplinary Procedures

2.29 The Inquiry's first purpose in considering the patient complaints and disciplinary procedures was to examine Shipman's involvement in those procedures and to consider whether the subject matter of any complaints made against him should have alerted those who operated the procedures to his criminality. It was also necessary to consider the part played by the complaints and disciplinary procedures within the wider context of the arrangements for monitoring and, more recently, for clinical governance. The examination of detailed evidence relating to the operation of these procedures by reference to a number of particular cases was helpful to me when I came to formulate my proposals for change.

2.30 The Inquiry received information from the WPHA relating to the complaints made to the PCOs responsible for Tameside about Shipman between 1977 and 1996. Shipman had twice been disciplined following patient complaints, once by the Tameside FPC in 1990 and once by the Tameside FHSA in 1993. Those two cases were also reported to the GMC. An earlier complaint to the Tameside FPC in 1985 had been dismissed. Mr Steven Rawlinson, a friend of the deceased patient whose death was the subject of the 1985 complaint, gave oral evidence. The mother of the deceased patient provided a written statement. Mr William Greenwood, then Assistant Administrator at Tameside FPC, later Assistant Director of Primary Care, WPHA, gave oral evidence about his experience of the local operation of the procedures, including his involvement in the complaints brought against Shipman. Statements were provided by ten members and former chairmen of the medical service committees that adjudicated on those complaints and five of them – some medical and some lay – gave oral evidence.

2.31 Miss Andrea Horsfall, formerly Deputy Consumer Liaison Manager, WPHA, gave oral evidence about her experience of the procedures that were in place after 1st April 1996. As a result of the changes in procedures, the WPHA had less involvement in the resolution of patient complaints than previously and there were far fewer disciplinary hearings. Mr Geoffrey Lamb, a former senior convenor at the WPHA, provided a statement about his involvement in the procedures that followed unsuccessful local resolution of a complaint.

2.32 Mr David Laverick, former Chief Executive of the Family Health Services Appeals Authority, gave oral evidence and supplied statistical information about the later stages of the disciplinary processes. His evidence on that topic was supplemented by witness statements from Mr Brian Hubbard (a junior colleague of Mr Laverick), Mr Paul Burns (Mr Laverick's successor as Chief Executive) and Dr William Miller (former Chairman of the Medical Advisory Committee).

2.33 The Inquiry also received 14 responses to a questionnaire sent by the Inquiry to a number of healthcare organisations on the subject of complaints, in particular complaints about GPs. The questionnaire asked – among other things – what changes they would like to see made to the existing NHS complaints procedures. Representatives of the RCGP, the BMA, the DoH, the National Care Standards Commission (NCSC, now part of the Healthcare Commission), the Association of Medical Secretaries, Practice Managers, Administrators and Receptionists (AMSPAR), the Consumers' Association (now known as Which?), the Office of the Health Service Ombudsman, the NCAA, the Healthcare Commission and the GMC attended a seminar dealing with patient complaints and the investigation of complaints.

The Raising of Concerns

2.34 The scale and number of Shipman's crimes and the long period over which they were perpetrated raised the possibility that concerns might have been raised about his activities in the past and that those concerns might have gone unheeded by the authorities. The Inquiry set out to discover whether there had been anyone who had felt such concerns and, if so, whether they had made their concerns known. In the event, it was clear that very few people had harboured any suspicion at all about Shipman. In the

case of those few people who had, the Inquiry wished to establish whether they had voiced their concerns and, if so, why those concerns had not been acted on. If there were people who had had concerns, but had not voiced them, I wanted to establish why that was so and to explore ways in which such people could, in the future, be encouraged to come forward.

Concerns about Shipman

2.35 The Inquiry focussed on several specific groups of people who might have had particular reason to become concerned about Shipman's activities.

Families and Friends

2.36 The first of these were the relatives and friends of Shipman's victims. When providing their Inquiry witness statements for Phase One, in connection with the Inquiry's investigation of the deaths of Shipman's patients, relatives and other witnesses were asked whether they had had any concerns about the death in question. In preparation for Stage Four, those witness statements were examined again and the witnesses who had said they had had concerns at the time the death occurred were asked to provide further information. Witnesses were asked to explain why (if such was the case) they had not voiced their concerns at the time. They were asked whether they would have known to whom they should take those concerns. They were also asked to suggest ideas for change which might make it easier for people to bring forward similar concerns in the future.

Members of the Donneybrook Practice

2.37 The next group that the Inquiry considered were the members of the Donneybrook practice, where Shipman killed at least 71 patients between 1977 and 1990. I have already referred to their evidence earlier in this Chapter.

Members of the Practice Staff

2.38 The third group which the Inquiry considered was Shipman's practice staff. They had worked in close proximity to him at the Market Street Surgery and it was clearly important to ascertain whether any members of staff had known or suspected anything of his criminal activities. Members of the practice staff had provided a considerable amount of background evidence to the Inquiry for the purposes of its Phase One investigations. In preparation for Stage Four, they were shown schedules containing details about the deaths of patients of the practice and were asked what, if anything, they could recall about those deaths. Lengthy witness statements were provided by Sister Gillian Morgan (nurse practitioner), Mrs Alison Massey (practice manager), Mrs Carol Chapman (receptionist), and Mrs Judith Cocker (receptionist). Two other members of staff, who had worked at the practice for short periods, also provided witness statements. All these witnesses gave oral evidence to the Inquiry. Mrs Margaret Walker (computer operator) had emigrated by the time of the Inquiry hearings. She had provided a very detailed witness statement before her departure. Another witness, who had worked temporarily as a nurse at the practice, provided a written statement.

Other Healthcare Professionals

2.39 The Inquiry also obtained written evidence from three other healthcare professionals, who had been based part-time at the Market Street Surgery, but had had little involvement with the day-to-day running of the practice. The evidence of Mrs Marion Gilchrist, the district nurse attached to Shipman's practice between 1995 and 1998, was heard by the Inquiry during Stage Three. The evidence of Mrs Ethel Dooley and Mrs Barbara Sunderland, district nurses who occasionally stood in for Mrs Gilchrist, was also heard during that stage.

Others Who Had Concerns

2.40 The Inquiry received evidence, both oral and written, relating to suspicions about Shipman which had arisen in the minds of Mrs Christine Simpson (resident manager of Ogden Court, a sheltered housing development in Hyde), Mr John Shaw (a local taxi driver), Mrs Dorothy Foley and Mrs Elizabeth Shawcross (home helps) and Mrs Shirley Harrison (relative of one of Shipman's victims and neighbour of another). Mr Shaw, Mrs Foley, Mrs Shawcross and Mrs Harrison had told nobody in authority of their concerns. However, Mrs Simpson told the Inquiry that she had informed her line manager, Mrs Janet Schofield, a housing officer employed by the Manchester and District Housing Association (now part of the Harvest Housing Group), of her concerns. Mrs Schofield did not accept that Mrs Simpson had communicated this information and Mrs Schofield gave oral evidence about the matter to the Inquiry.

2.41 During Phase Two, Stage One (which related to the first and unsuccessful police investigation into the deaths of Shipman's patients), the Inquiry heard evidence about the mounting concerns of Mr David Bambroffe and Mrs Deborah Bambroffe, which had led eventually to Mrs Bambroffe communicating those concerns to Dr Susan Booth of the Brooke Practice. That communication had the effect of heightening the concerns already felt by the late Dr Linda Reynolds, another member of the Brooke Practice. In March 1998, she reported her concerns, and those of her partners, to the local Coroner and thus initiated the first police investigation. Mr and Mrs Bambroffe, together with Mr Nigel Reynolds (Dr Reynolds' widower) gave oral evidence in Stage Two; they provided further witness evidence for the purposes of Stage Four, in which they set out their views about steps which might be taken to make it easier for those who had concerns to bring them to the attention of the appropriate authorities.

Concerns of Colleagues

2.42 The case of Mrs Renate Overton, which I deal with in Chapter 10, featured prominently in the First and Third Reports and oral evidence surrounding the circumstances of her death and its aftermath were heard in December 2002. In my Third Report, I found that two consultants at Tameside General Hospital (Dr Ceri Brown and Dr Murtaza Husaini) had been aware in February 1994 that Shipman had administered (they believed negligently, rather than deliberately as I found in my First Report) an overdose of morphine or diamorphine to Mrs Overton such as to cause severe brain damage which led, 14 months later, to her death. They had not reported the matter to anyone in authority. At the time of

writing the Third Report, I deferred the question of whether they were under a duty to report their concerns about Mrs Overton's case and whether they should be criticised for their failure to do so. I decided that I should consider those questions after the Stage Four hearings at which evidence was to be received on wider issues concerning the duty to report, the options for reporting available to the two consultants and the culture within the medical profession at the time. At the same time, I heard some evidence about the change in culture since then.

2.43 I had already heard, during Stage Two, evidence on those topics from the two consultants themselves and from other members of the medical, nursing and administrative staff at the Tameside General Hospital. For the Stage Four hearings, the Inquiry gathered evidence from a variety of other sources. The Medical Directors of three trusts responsible for hospitals comparable in size to Tameside General Hospital gave oral evidence. The solicitors representing the two consultants supplied witness statements from Professor Alan Aitkenhead, Professor of Anaesthesia, Queen's Medical Centre, Nottingham and Dr John Givans, a retired GP who does consultancy work for the Medical Defence Union. Both gave oral evidence. The medical defence organisations and the BMA provided written contributions and Dr Gerard Panting, of the Medical Protection Society, also gave oral evidence. The two consultants declined the opportunity to give further evidence although they were represented at the hearings.

The Wider Picture

Public Concern at Work

2.44 The Inquiry received written and oral evidence from the organisation Public Concern at Work (PCaW), which offers help and encouragement to organisations (in particular NHS organisations) that wish to create and foster a culture in which staff feel safe to raise concerns. It has also set up and administers a telephone helpline that provides free confidential legal advice and practical assistance to individuals who are considering raising concerns. Mr Guy Dehn, Director, PCaW, gave oral evidence to the Inquiry about the development over recent years of measures to encourage people with genuine concerns about malpractice to make their concerns known, and to protect those who take such action from suffering detriment as a result.

Concerns of Practice Staff and Healthcare Professionals

2.45 I wished to understand the difficulties faced by GP practice staff and healthcare professionals who have concerns (in particular, concerns relating to poor clinical practice or other behaviour which might pose a risk to patients) about doctors and other healthcare professionals, and to explore ways of reducing those difficulties. Mr Dehn addressed these issues in his evidence and the Inquiry also heard evidence from Mr Ian Hargreaves, retired Regional Director, Royal College of Nursing (RCN), and Mrs Debra Davies, Counter-fraud and Performance Manager of the former Iechyd Morgannwg HA. Relevant evidence was also received from a number of organisations, including AMSPAR, the British Association of Medical Managers, the Consumers' Association (now known as Which?), the Nursing and Midwifery Council, the Community Practitioners' and Health

Visitors' Association and the Association of Chief Police Officers. Mr Simon Bennett, of the DoH, provided a witness statement dealing with these matters, which were also discussed at a seminar attended by, among others, representatives from PCaW, AMSPAR, the RCN and the DoH.

Concerns of Home Helps, Wardens of Sheltered Housing Developments and Residential Care Assistants

2.46 Home helps, wardens of sheltered housing developments, residential care assistants and those in other similar employment may be in a position to observe poor clinical practice or other behaviour by doctors and other healthcare professionals that might put patients at risk. The Inquiry wished to explore the arrangements in place for the bringing forward of such concerns. The Inquiry obtained from 14 local authorities examples of the 'whistleblowing' policies currently in place for employees in the fields mentioned above. The Inquiry also received written and oral evidence from persons with responsibility for organising home help and warden services in the Tameside area and in other parts of Manchester. Further written evidence was provided by a number of organisations, including the NCSC, the Care Standards Inspectorate for Wales, the Care Commission (Scotland), the Local Government Management Board, UNISON and Age Concern.

The General Medical Council

The Areas of Interest for the Inquiry

2.47 The final topics to be considered by the Inquiry were the fitness to practise (FTP) procedures operated by the GMC, the body which is responsible for the registration of doctors and which plays a central part in the regulation of the profession, and the GMC's future plans for the revalidation of doctors. The Inquiry's interest in the GMC's FTP procedures arose in a number of different ways. First, it was necessary for the Inquiry to examine the GMC's treatment of Shipman in 1976, when his conviction for drug offences was reported to it, and to decide whether that treatment was, by the standards of the time, adequate and appropriate. Many people had expressed the view that to deal with a doctor convicted of drugs offences by means of a warning letter was inappropriate and had not provided adequate protection to patients. I had to consider whether Shipman's case was a 'one-off' or whether it was, in fact, typical of the way in which cases of that kind were dealt with at the time.

2.48 In 1976, the procedures later developed by the GMC for dealing with sick doctors (the health procedures) were not in operation. They were introduced in 1980 and were aimed primarily at the rehabilitation of the doctor concerned. The Inquiry was told that, had they been in force at the time of Shipman's referral to the GMC, Shipman would have been dealt with under those procedures because he had been diagnosed as having a drug dependency. It was, therefore, necessary for the Inquiry to examine the operation of the health procedures from their inception in 1980 to date, in order to ascertain whether the outcome of Shipman's case would have been different if he had been dealt with under the health procedures. I also had to consider whether the way in which the GMC has in the

past dealt with drug abusing doctors like Shipman has afforded adequate protection to patients.

2.49 It was also necessary for the Inquiry to consider whether it would have been more appropriate for drug abusing doctors (particularly those who, like Shipman, had been convicted of serious criminal offences) to have been dealt with by means of the GMC's procedures for disciplining doctors who have, or might have, been guilty of serious professional misconduct (SPM) (the conduct procedures) as an alternative to (or as an adjunct to) dealing with them under the health procedures. This necessarily involved an examination of the operation of the GMC's conduct procedures.

2.50 The regulatory and disciplinary procedures operated by the GMC form an integral part of the overall monitoring system. If a complaint is received by a PCO about a GP's conduct or performance, or if the results of routine local monitoring suggest that s/he is performing poorly, the doctor might be referred to the GMC with a view to action being taken on the doctor's registration. The threat of action on registration provides the 'teeth' for the local monitoring process and the effectiveness or otherwise of the GMC's FTP procedures may be determinative of the success of local monitoring arrangements. If the GMC does not act, or responds inadequately and, as a result, a doctor who presents a risk to patients is permitted to continue in practice, the monitoring process as a whole is undermined. This interdependence of local systems and those of the GMC provided an additional reason for the Inquiry to examine the GMC's health and conduct procedures, and also its performance procedures, into which doctors whose professional performance has been identified locally as deficient may be referred. The Inquiry has also explored the interrelationship between NHS GP complaints and disciplinary procedures and the FTP procedures operated by the GMC. In particular, the Inquiry considered two complaints about Shipman that were reported both to the local NHS authorities and to the GMC and examined how those complaints were handled by those bodies. The Inquiry has considered the need for interlinking standards, criteria and thresholds to be applied by decision-makers locally and by those involved in making decisions at the various stages of the GMC's FTP procedures.

2.51 From 2005, the GMC intends to introduce a requirement for every doctor to undergo periodic revalidation as a condition of continuing to hold a licence to practise. Revalidation is defined in the Medical Act 1983 (as amended) as an **'evaluation of a medical practitioner's fitness to practise'**. The introduction of the requirement for revalidation will give the GMC a direct responsibility for the monitoring of doctors, including GPs. If the effect of revalidation were that every doctor on the register were to be required to demonstrate an acceptable and objectively measurable standard of competence and performance, this would be a highly significant addition to the current monitoring arrangements for GPs. The development of the proposals for revalidation has, therefore, been of considerable interest to the Inquiry. I have considered the different proposals for carrying out the revalidation process which have been put forward by the GMC over recent years, with a view to determining whether the various models proposed would give patients adequate protection against incompetent, poorly performing and aberrant doctors.

2.52 It is intended that those doctors whose fitness to practise is in doubt (and who cannot, therefore, be revalidated in the usual way) will be referred into the GMC's FTP procedures (frequently, but not invariably, in the form of a case with a performance element). Thus, the FTP procedures will underpin the revalidation process. However rigorous the initial process of evaluating doctors for the purposes of revalidation might be, it would be rendered useless if the FTP procedures were to operate so as to allow doctors who had not attained the required standard of competence and performance to remain in practice. The interrelation between revalidation and the FTP procedures, therefore, provided an additional reason for the Inquiry to examine the effectiveness of those procedures.

2.53 The case of Mrs Overton also raised issues relating to the GMC. One of the reasons advanced by Dr Brown for not having reported the incident was that the GMC would not have acted on such a complaint. He did not think he had sufficient information on which to base a complaint. He was also worried that, if he made a report, the GMC might criticise him for disparaging Shipman. In order to enable me properly to assess the weight of this piece of evidence, it was necessary for the Inquiry to examine how cases of serious, apparently 'one off', incidents such as that involving Mrs Overton would have been dealt with by the GMC in the early and mid-1990s. The facts of the case of Mrs Overton were also used by the Inquiry to test how an incident of that type would have been dealt with by the GMC (as well as by local NHS bodies) in the more recent past.

2.54 Two further issues relating to the GMC arose directly in Shipman's case. The first of these was the inability of the GMC, when Shipman was under investigation for murder – and even after his arrest – to take any steps to suspend him from practice. Under the arrangements then in place, the GMC was powerless to take action until he had been convicted of murder, over a year later. The second issue related to the provision of information about Shipman's previous history. The PCOs responsible for the provision of primary care in Tameside remained unaware of Shipman's previous history until the time of the second police investigation in August 1998. Most of his patients had no idea that he had previously been reported to the GMC for drug abuse. These factors have led me to consider whether information of this kind held by the GMC should be made more readily available to NHS bodies and other organisations with an interest in knowing, and also to patients.

2.55 The GMC has recently introduced new FTP procedures. In line with the requirement placed upon me to make any recommendations I believe necessary for the protection of patients, I regarded it as appropriate to examine the proposed new procedures and to consider the extent to which they provide adequate protection for patients.

Witnesses from the General Medical Council

2.56 The Inquiry heard oral evidence from Mr Robert Gray, who was Assistant Registrar of the GMC in 1976 and had been involved in processing the report against Shipman. Another member of the administrative staff at the time provided a written statement. Oral evidence was also given by Dr Derek Llewellyn, a member of the Penal Cases Committee (PeCC) which decided to close Shipman's case and send him a warning letter, rather than referring the case for a public hearing before the Disciplinary Committee. Dr Ronald Bryson, one of the consultant psychiatrists on whose evidence the PeCC relied when making its decision, provided written evidence.

2.57 The witnesses who gave evidence relating to more recent events were in general chosen by the GMC, after consultation with the Inquiry. Two former members of the administrative staff, one of whom had been employed by the GMC between 1977 and 2002, gave oral evidence about practice and procedures in the 1980s and 1990s. Two senior current members of the administrative staff described the practice and procedures which had been in operation more recently. Several former and current members of the GMC, both medically qualified ('medical') and non-medically qualified ('lay'), provided written evidence. Oral evidence was given by Dr Krishna Korlipara (current medical member and former medical screener), Dr Sheila Mann (former medical member and health screener), Mr Stephen Brearley (current medical member, who explained the GMC's plans for revalidation) and Mr Robert Nicholls and Dr Arun Midha (both current lay members). Professor Sir Graeme Catto, current President, and Mr Finlay Scott, Chief Executive and Registrar, also gave evidence, both separately and together. Dr Malcolm Lewis (current medical member and former medical screener) and Mr Robin Macleod (current lay member) represented the GMC at the Inquiry's seminars.

Other Witnesses

2.58 Professor Isobel Allen, Emeritus Professor of Health and Social Policy, University of Westminster Policy Studies Institute, has carried out a considerable amount of research, commissioned by the GMC, into the operation of its FTP procedures, in particular its conduct procedures. With colleagues, she produced two highly detailed Reports based on her research, one in 1996 and one in 2000, together with a further Paper in 2003. She attended the Inquiry to give oral evidence. Sir Donald Irvine, immediate past President of the GMC, provided a considerable amount of written evidence (including his book, 'The Doctors' Tale', published in 2003) and gave oral evidence in relation to the GMC's FTP procedures, its plans for revalidation, and other issues relevant to Stage Four. Several other witnesses gave written statements, among them Miss Isabel Nisbet, then seconded to the Council for the Regulation of Healthcare Professionals (now known as the Council for Healthcare Regulatory Excellence (CRHP/CHRE)). She explained the role of the CRHP/CHRE in overseeing the regulatory functions of the GMC. Mr Sandy Forrest, Director of the CRHP/CHRE, attended two of the Inquiry's seminars. Detective Chief Superintendent Bernard Postles (now retired) and Mrs Jan Forster, formerly Director of Primary Care, WPHA, provided witness statements dealing with their attempts between August and October 1998 to secure Shipman's suspension from practice.

Drug Abusing Doctors

2.59 As I have explained, the Inquiry wished to examine whether the way in which the GMC has dealt with drug abusing doctors in the past provided adequate protection for patients and to consider whether it would be appropriate for it to deal with such doctors differently in the future. The Inquiry commissioned a report from Dr Andrew Johns, Consultant Forensic Psychiatrist, South London and Maudsley NHS Trust, who has special expertise in the subject of substance abuse. The report dealt with the issues of substance misuse by doctors, the risks posed by a rehabilitated doctor, the likelihood of relapse into drug taking and assessing the risk of relapse. Dr Douglas Fowlie, Consultant Psychiatrist, Grampian

Primary Care NHS Trust, provided a witness statement, dealing with his experience of treating and supervising doctors, and of advising the GMC, in cases of substance abuse, Dr Johns, Dr Fowlie, Professor Sir Michael Rawlins (former Chairman, Advisory Council on Drug Misuse), Dr Kit Harling (Director of NHS Plus, DoH) and Dr Jolyon Oxley (Honorary Secretary, National Counselling Service for Sick Doctors) participated in one of the Inquiry's seminars at which this topic was discussed.

Case Files

2.60 In order to compare the handling of Shipman's case in 1976 with that of other similar cases reported to the GMC during the mid- to late 1970s, and subsequently under the health procedures, the Inquiry sought and obtained a large number of files concerning drug-related cases dealt with by the GMC. The Inquiry was primarily concerned with cases where the doctor had obtained drugs for his/her own use, rather than those where there were allegations of irresponsible prescribing, the illicit supply of drugs to others or conduct of that nature. The Inquiry also obtained case files relating to cases (both drug-related and not) where the doctor's honesty had been in issue. In order to examine the way in which the GMC would have dealt with the case of Mrs Overton, had it been reported, the Inquiry obtained some files relating to cases involving allegations of clinical negligence or poor clinical practice in connection with the prescribing and administration of drugs which had been reported to the GMC in the mid-1990s and subsequently. Witnesses from the GMC were asked to comment on the contents of some of the case files both in writing and in their oral evidence.

2.61 The Inquiry also sought and obtained files in a small number of recent cases falling within certain categories and chosen at random. The object of this was to illustrate the working of various aspects of the GMC's FTP procedures as they were in 2003. Relevant witnesses were asked to comment on the contents of the case files both in writing and orally.

2.62 The Inquiry has not undertaken any detailed audit of cases dealt with by the GMC. However, the case files have been used to illustrate the way in which the FTP procedures worked in practice at various times of their operation. They have provided a valuable insight into the operation of the procedures which are not in general open to public scrutiny. I refer to some of the cases in Chapters 16 to 24 of this Report. Also referred to are published decisions of the Professional Conduct Committee and decisions of the Privy Council and the High Court relating to appeals against decisions of the GMC's FTP committees and applications for judicial review of decisions made by the GMC. Where the circumstances of the case under discussion are not in the public domain, the doctors involved have been given code numbers and some details (such as dates) have been omitted so as to preserve confidentiality.

Additional Evidence

2.63 The Inquiry received responses to a questionnaire which had been circulated by Alexander Harris, the solicitors representing the Tameside Families Support Group, to those families and friends of Shipman's patients 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 be dealt with. The Inquiry itself wrote to a range of organisations, asking for their views. Thirty one responses were received. In addition, the Inquiry issued questionnaires to a random selection of PCTs, enquiring about their experience of dealing with the GMC; six responded.

Documentary Evidence

2.64 The evidence to which I have referred above does not, of course, represent the whole picture. In addition, I have been able to examine and consider documents from the following sources.

The West Pennine Health Authority and Its Predecessors

2.65 Very shortly after the establishment of the Inquiry in 2001, the WPHA provided files of its documents relating to the monitoring activities of the PCOs during Shipman's time in practice there. Some of these documents were of a general nature and some related specifically to Shipman. Since the initial delivery of documents, the WPHA has responded to requests from the Inquiry to provide further documents and other information.

The Department of Health

2.66 The DoH provided a considerable amount of background material, including consultation documents, Government White Papers, circulars, reports, guidance and directions, covering the period from the 1970s to the time when Shipman ceased practice and beyond. This has enabled me to put in context the various arrangements in place in Tameside, and to understand the development of the arrangements for regulating GPs over the last 30 years or so. The Inquiry also obtained a limited number of documents which survived from the time when the Regional Medical Service had responsibility for visiting GPs.

The Royal College of General Practitioners

2.67 The RCGP provided the Inquiry with documentation recording its involvement in the developments in the arrangements for regulating GPs, which has plainly been extremely significant. Documents relating to the RCGP's various quality awards and markers and to its proposals for the appraisal and revalidation processes have also been supplied.

The General Medical Council

2.68 Annexed to Mr Scott's various witness statements were approximately 9000 pages of documents relating to the operation of the GMC's FTP procedures. Subsequently, the GMC has provided a large amount of further documentation, some at the specific request of the Inquiry and some on its own initiative. Included among these documents have been the briefing papers, minutes and transcripts relating to recent meetings of the Council.

Other Organisations

2.69 In addition, I have received a wealth of documentation from other organisations, notably the NCAA, CHI, the NPSA, the BMA and PCaW.

Academic and Professional Journals and Other Professional Publications

2.70 With the assistance of the Medical Advisor to the Inquiry, Dr Aneez Esmail, the Inquiry team collected, from academic and professional journals and other publications, a large amount of published literature dealing with, *inter alia*, the regulation and disciplinary systems for GPs, tools for the monitoring and evaluation of GPs, GP appraisal, proposals for the revalidation of doctors, the raising of concerns, NHS complaints systems, the monitoring of GP patient mortality rates and the operation of the GMC's FTP procedures. I have referred to some of this literature in the course of this Report.

2.71 The period for which the Inquiry has been considering these topics has been a time of change for the profession, with the introduction of GP appraisal and of the GMC's new FTP procedures, the creation of new bodies (such as the Healthcare Commission and the CRHP/CHRE), the development of recently created organisations (such as the NCAA and the NPSA), the introduction of the new GMS Contract and the impending introduction of revalidation. All these changes have been debated and discussed in the professional publications which are produced regularly. These publications have provided a useful insight into the attitude of members of the profession to the various developments that have been effected or proposed.

The Inquiry's Own Consultations

2.72 In preparing for Stage Four, the Inquiry began by seeking the views of a large number of organisations and individuals who were thought likely to have an interest in some or all of the topics to be considered during Stage Four. As a result of these and subsequent enquiries, the Inquiry was able to identify those persons and organisations who might be able to provide evidence and other material which would assist the Inquiry. In addition, as I have already mentioned, the Inquiry has issued various questionnaires and requests for information and documents.

2.73 During the Stage Four hearings, the Inquiry published a Consultation Paper, 'Safeguarding Patients: Topics for Consideration at the Stage Four Seminars'. The purpose of the Consultation Paper was to provide a focus both for written responses and for discussion at a series of seminars held by the Inquiry in January 2004. The Inquiry received written responses from 95 individuals and organisations. The views expressed in those responses were considered and discussed at the seminars.

2.74 The seminars covered six different topics and extended over eight days. Participating in the seminars were representatives of organisations and individuals with an interest and expertise in the topics under discussion. I have mentioned above many of those who participated. Many of the views expressed during the Inquiry's consultation process are referred to in this Report.

The International Perspective

2.75 One of the seminars, lasting two days, was devoted to a discussion of the systems in five other jurisdictions. Dr Perry Pugno (Director, Division of Medical Education, American Academy of Family Physicians, USA) told the Inquiry about the current arrangements

for the monitoring and recertifying of family doctors in the USA, together with changes to the recertification process planned for the future. He also described the operation of the National Practitioner Data Bank, a publicly accessible database of information about family practitioners. On the second day of the seminar, he described the way in which complaints against family doctors are processed in the USA. Dr André Jacques (Director, Practice Enhancement Division, Collège des Médecins du Québec, Montréal, Canada) told the Inquiry about the systems for monitoring the performance of family practitioners used in the province of Québec. He also described the regulatory role of the College. Dr Rocco Gerace (Registrar, College of Physicians and Surgeons of Ontario, Toronto, Canada) described the systems of monitoring of family physicians in operation in the province of Ontario, together with the plans for the Maintenance and Enhancement of Physician Performance programme, a system of revalidation, to be introduced in the future. Dr Gerace also spoke about the regulatory role of the College. Mr Ronald Paterson (Health and Disability Commissioner, New Zealand) described the system for dealing with patient complaints in New Zealand and, in particular, his own role as an independent investigator of complaints about individual healthcare professionals and healthcare systems. Professor Chris van Weel (Head of Department of General Practice and Social Medicine, University of Nijmegen, The Netherlands) spoke about the arrangements for regulating general practice in his country. Professor Baker and Professor David Newble (Professor of Medical Education, Head of Department of Medical Education, Director of Learning and Teaching, Faculty of Medicine, University of Sheffield) each attended one day of this seminar.

Before the Oral Hearings

The Arrangements for the Distribution of Evidence

2.76 The arrangements for the distribution of evidence were the same for Stage Four as for Phase One. They are described at paragraphs 3.17 and 3.18 of my First Report. As in Phase One, all the evidence available to the Inquiry was released into the public domain by means of the Inquiry website except where material had to be redacted to respect confidentiality or to protect the identity of individuals not directly concerned with Shipman.

The Public Meeting

2.77 On Monday, 17th March 2003, the Inquiry held a Public Meeting, at which I explained the arrangements for Stages Three and Four of Phase Two.

Representation

2.78 Before and after the Public Meeting, I granted leave to various individuals and organisations to be represented before the Inquiry during the Stage Four hearings and, for some, recommended funding for that representation at public expense. A list of participants in Stage Four and their representation can be seen at Appendix A of this Report.

Salmon Letters

2.79 Before the Stage Four hearings began, the Solicitor to the Inquiry, Mr Henry Palin, sent letters (known as 'Salmon letters') to those persons and organisations whose conduct might be the subject of criticism by the Inquiry. The potential criticisms were clearly identified in those letters.

2.80 In the event that any further potential criticisms came to light at or after the hearings, these were the subject of further Salmon letters. Recipients of Salmon letters were given the opportunity to respond to the potential criticisms in writing, as well as in the course of their oral evidence at the hearings.

Broadcasting

2.81 I had given permission for the Stages One, Two and Three hearings to be broadcast in accordance with a protocol which had been prepared by the Inquiry and was designed to ensure that Inquiry material would not be misused. That protocol was slightly amended in September 2002. Those arrangements caused no difficulties during Stages One, Two or Three and I received no representations suggesting that they should be discontinued. I therefore gave permission to recognised organisations to broadcast during Stage Four, provided that they complied with the slightly amended protocol, clarifying the broadcasters' duties in respect of websites. During Stage Four, I received and granted six applications from witnesses that their evidence should not be broadcast. I also directed that certain parts of the evidence relating to the way in which the GMC had handled individual cases should not be broadcast and that the public screens should not be used for the display of documents during those parts of the hearings when those cases were being discussed. This was in order to respect the confidentiality of the doctors who were the subjects of those cases.

The Oral Hearings

2.82 The oral hearings were held in the Council Chamber at Manchester Town Hall. The Stage Four hearings took place between Monday, 14th July 2003 and Thursday, 18th December 2003.

2.83 The arrangements for the oral hearings, and for the publication of evidence, were the same as for the Phase One hearings. They are described at paragraphs 3.28 to 3.36 of my First Report. The public gallery at the Town Hall remained open, and transcripts and other documents were posted on the Inquiry's website after each day's hearing.

2.84 Volunteers from Tameside Victim Support Witness Service attended to assist family witnesses and three other witnesses when they attended to give evidence at the Stage Four hearings, but were not required during the remainder of these hearings. I remain most grateful to Tameside Victim Support Witness Service for all the assistance they have given during the course of the Inquiry.

2.85 In general, witnesses who gave oral evidence during the Stage Four hearings were called by Counsel to the Inquiry. However, in the interests of fairness, those witnesses who had

received Salmon letters were given the opportunity of making an opening statement of their evidence in response to questions by their own counsel or solicitor, before being questioned by Counsel to the Inquiry. None of the recipients of Salmon letters in Stage Four availed themselves of this opportunity.

Submissions

2.86 Following the conclusion of the Stage Four hearings the representatives of those individuals and organisations who had been granted representation made written submissions. Counsel to the Inquiry also produced written submissions relating to certain specific issues. I offered an opportunity to all representatives to make representations that I should hear oral submissions but received no such representations. Although I have not, in the course of this Report, made many direct references to the written submissions received, I have considered them with care and have taken them fully into account when reaching my conclusions.

The Seminars

2.87 The seminars were held in the Council Chamber at Manchester Town Hall on Monday 19th, Tuesday 20th, Thursday 22nd, Friday 23rd, Monday 26th, Tuesday 27th, Thursday 29th and Friday 30th January 2004. A total of 37 participants took part in the discussions at the various seminars. A list of seminar participants can be seen at Appendix B to this Report. Those discussions were led by Leading Counsel to the Inquiry. Although structured, the discussions were significantly less formal than the oral evidence given during the usual Inquiry hearings.

2.88 Participants in the seminars had submitted written responses to the Inquiry's Consultation Paper in advance and expanded on those responses during the course of the seminars. Persons attending the seminars as observers were able to raise points through Counsel for the consideration of seminar participants. After the seminars, the Inquiry received a number of further responses, both from participants who wished to confirm or revise views previously expressed, and from people who had attended the seminars, or who had become aware of the discussions that had taken place, and wanted to contribute their own opinions. A list of respondents to the Consultation Paper appears at Appendix C to this Report.

2.89 I found the seminars, and indeed the whole consultation process undertaken by the Inquiry, extremely valuable in clarifying my thoughts and helping me to formulate my recommendations for the future.

The Structure of This Report

2.90 In Chapters 3 and 4 of this Report, I shall describe the arrangements for administering and monitoring the provision of primary care during the period of Shipman's time in general practice, between 1974 and 1998. I shall also consider the circumstances of Shipman's appointment to the Donneybrook practice and of his move to single-handed practice in

1992. In Chapter 5, I shall consider the changes to the arrangements for administering and monitoring the provision of primary care which have occurred since 1998.

2.91 Chapter 6 will cover the system for dealing with complaints about GPs prior to 1996 and the way in which complaints against Shipman, made in 1985, 1990 and 1992, were handled. In Chapter 7, I shall discuss the patient complaints system which has been in operation since 1996 and the new system which has now been partially introduced.

2.92 The subject of Chapters 8, 9, 10 and 11 is the raising of concerns. Chapter 8 describes the experience of those few people who had concerns about the deaths of Shipman's patients. Chapter 9 examines whether the staff at Shipman's practice knew of, or had reason to suspect, his criminal activities. Chapter 9 also looks at the position of practice staff, and at the difficulties which they may face in bringing forward any concerns they might have about doctors and other healthcare professionals within the practice. Chapter 10 is devoted to issues connected with the death of Mrs Overton. Chapter 11 deals with general issues relating to the raising of concerns in the employment context and in other circumstances and to steps that might be taken to provide further protection for persons who wish to bring forward genuine concerns.

2.93 In Chapter 12, I describe the current arrangements for clinical governance and the limitations of those arrangements. Chapter 13 deals with the position of single-handed practitioners and the steps which should be taken to avoid them becoming professionally isolated.

2.94 Chapter 14 contains a discussion of the feasibility and desirability of the monitoring of GP patient mortality rates, the experience of those bodies which have undertaken such monitoring in the past and the way in which it might be organised in the future.

2.95 Chapter 15 provides an introduction to the section of the Report dealing with the GMC's FTP procedures and its plans for revalidation. In Chapter 16, I shall examine the GMC's handling of the report of Shipman's conviction for drug-related offences in 1976. Chapter 17 deals with the difficulties of defining the concepts of SPM and seriously deficient performance, on which the old conduct and performance procedures were based.

2.96 In Chapter 18, I examine the processing of complaints undertaken by the administrative staff of the GMC which has, in the recent past, resulted in 65% of cases being rejected at that early stage. In Chapters 19 to 22, I examine the screening process, the work of the Preliminary Proceedings Committee and the Professional Conduct Committee and the operation of the GMC's health procedures. In Chapter 23, I consider the way in which the GMC has dealt with drug abusing doctors in the past and the changes which I consider should be made in the future. Chapter 24 contains an examination of the operation of the GMC's performance procedures. Chapter 25 considers the new FTP procedures and, in Chapter 26, I examine the GMC's proposals for the revalidation of doctors. Chapter 27 sets out my proposals for change.

The Effect of the Evidence

2.97 In Stage Four, the Inquiry has covered a wide range of issues and has received an enormous amount of evidence. In this Report, I have set out some parts of the evidence

in detail but, in general, I have recorded only my observations and conclusions based on all that I have heard and read. The evidence is available on the Inquiry's website for those who wish to read it. I am conscious that there are some aspects of the evidence to which I have referred only briefly. For example, I have scarcely mentioned the fascinating presentations received at the international seminars. This does not mean that they have not been of value or that they have not influenced my thinking; they have. It means only that I have had to be selective. This Report is already long and has taken several months to write. I would not have wished to delay its publication any longer.