CHAPTER THREE

The Appointment of General Practitioners and the Administration of General Practice prior to 1980: Shipman's Appointment to the Donneybrook Practice

Introduction

3.1 When Shipman's crimes came to light, there was a general feeling of disbelief that the authorities responsible for the provision of primary health care had not detected his aberrant activities and taken action to remove him from practice years before. The discovery that he had been convicted in 1976 of criminal offences in connection with controlled drugs (a fact which it was understandably assumed must have been known to those authorities) only served to increase that feeling.

3.2 Shipman was in general practice from 1974 until 1998 with a break of two years (from September 1975 to October 1977), following his departure from Todmorden. Over that period of more than 20 years, there were significant changes in the way that general practice was organised. Since 1998, the pace of change has quickened still further. Many new arrangements have been introduced, some as a direct result of the discovery of Shipman's activities and others as part of wider moves to improve the quality of care within the NHS. The framework within which general practice is conducted today is very different from that which existed in the 1970s and 1980s.

3.3 In this Chapter and in Chapter 4, I shall describe the arrangements which were in place for regulating the activities of general practitioners (GPs) during the time when Shipman was in general practice. In Chapter 5, I shall set out the changes which have occurred since he ceased practice in 1998. The details of many of the arrangements that I shall describe were complex. For present purposes, it is necessary only to summarise the position briefly. I shall deal only with the arrangements as they affect England. I shall also consider the actions of those responsible for appointing Shipman to his position in general practice in Hyde in 1977.

The Wider Professional Regulatory Framework

3.4 Today, there are approximately 34,500 GPs in active practice. Most work wholly within the NHS. A few practise privately. Many NHS practitioners perform a small amount of private work in addition to their NHS work. The NHS bodies which, over the years, have had responsibility for the provision of primary health care (and to which I shall refer collectively as 'primary care organisations' (PCOs)) have never had any responsibility for GPs working in the private sector.

The General Medical Council

3.5 Until recently, the only organisation with the power to regulate doctors practising in the private sector was the General Medical Council (GMC). The GMC was established under the Medical Act 1858. In order to be entitled to practise, a doctor must appear on the

medical register held by the GMC. The GMC is required by Parliament to ensure that those admitted to the register are competent. Until November 2004, it was required also to take action on a doctor's registration when, following a complaint, that doctor was shown to have become unfit to practise by reason of serious professional misconduct, serious impairment of health or seriously deficient performance. Under new procedures introduced in November 2004, it will take action on a doctor's registration if it is satisfied that his/her fitness to practise is impaired to a degree justifying action on registration. It is the GMC alone that can remove a doctor's right to practise anywhere in the UK. It can do so whether the doctor practises in the NHS or in the private sector.

Local Medical Committees

3.6 Locally elected committees of GPs (known as local medical committees (LMCs)) have had statutory recognition since 1911. Their original purpose was to give GPs a voice in the administration of general practice. In fact, the wide range of functions exercised by LMCs means that they have more than just a voice. Members of a LMC, in particular the secretary and chairman, can wield considerable power and influence. First and foremost, LMCs are political groupings, which represent the interests of local GPs in consultations and discussions with PCOs. They provide advice and support to local practitioners. LMCs also have a formal statutory role in disciplinary and complaints procedures involving GPs. They have the power to nominate representatives to membership of certain committees, including disciplinary committees. They have a statutory right to be consulted on a wide range of issues affecting GPs. They can also be a valuable source of information and intelligence to the PCOs.

3.7 Members of a LMC may, by virtue of their position, be appointed members of PCOs. Shipman was secretary of the LMC for Tameside between 1981 or 1982 and 1988. As a representative of the LMC, he had a place for some time on the Executive Board of the Tameside Family Practitioner Committee (FPC), the PCO which at that time had responsibility for Tameside.

3.8 Mr William Greenwood, Assistant Administrator (later Deputy General Manager) of the Tameside FPC from 1983 until 1990, gave oral evidence. In the 1970s, he had held more junior posts at the Tameside FPC and acknowledged that his firsthand knowledge of this period was limited. He recalled that, in some circumstances, the LMC and the FPC would work together to resolve matters of mutual concern. However, the LMC was vigilant in protecting GPs against any perceived interference by the FPC in professional matters. On occasions, FPC staff had wished to carry out surveys asking questions of GPs. The LMC would not co-operate in the surveys. It resisted any attempt by the FPC to 'step out of the mould of administrators'.

Before 1974

3.9 The National Health Service Act 1946 placed responsibility for the provision of general medical services (together with pharmaceutical services, dental services and ophthalmic services) with 117 executive councils. For the purpose of this Report, I am concerned only with medical services, which were to be provided by GPs. From the inception of the NHS

in 1948, GPs enjoyed the status of self-employed professionals providing services under a national contract, the General Medical Services (GMS) Contract. As independent contractors, rather than direct employees, their relationship with the NHS was very different from that of doctors employed in secondary care (i.e. hospitals) within the NHS.

3.10 The GMS Contract is an agreement between GPs and the Government about arrangements for the supply of medical services. Until April 2004, the responsibilities of GPs were set out in terms of service, breach of which could result in disciplinary action. Payment for services was governed by the Statement of Fees and Allowances (the 'Red Book'), published by the Secretary of State for Health (SoS) after negotiation with the profession. Both the terms of service and the Red Book were subject to review from time to time.

3.11 In the early years, most GPs were single-handed practitioners. Standards of practice were extremely variable. Practice premises were frequently inadequate. Remuneration was based entirely on the number of patients on a GP's list. This gave rise to competition for patients which did not necessarily lead to an improvement in quality of care.

3.12 In 1966, a new GMS Contract brought major changes to general practice. Under the new Contract, contributions were paid by the NHS towards the cost of providing practice premises and of employing practice staff. A new group practice allowance was introduced, together with payments for out of hours work. The effect of these changes was to encourage GPs to improve the range – and, to some extent at least, the quality – of services provided. Group practices were formed and modern health centres, with improved facilities, were built. The new system of funding for GPs had a significant impact on the relationship between general practice and the NHS. It meant that GPs became to some extent financially reliant on the FPCs. Some say that the 1966 Contract marked the beginning of modern, team-based general practice.

From 1974: the Structure and Functions of the Family Practitioner Committees

3.13 In 1974, the year when Shipman started in practice, the NHS was subjected to the first major structural change since its foundation. Fourteen regional health authorities (RHAs) were established. Their role included responsibility for planning and for the allocation of resources to 90 area health authorities (AHAs). The AHAs had responsibility for establishing FPCs for their areas. These FPCs replaced the executive councils. The AHAs had statutory responsibility for providing family health services, including medical services. The duty of administering those services was given to the FPCs. The authorities with responsibility for Tameside were the North West RHA, the Tameside AHA and the Tameside FPC.

3.14 In general, FPCs were governed by an executive board, comprising a chairman and 30 members, 15 of whom were from the contractor professions (i.e. GPs, dentists, opticians and pharmacists). The eight medical members were nominated by the LMC. There were 15 lay members also. The chairman could be either a lay or a professional member. FPCs had no officer (i.e. employee) members. The most senior member of staff was an administrator, who would have an assistant. Those two members of staff would be

appointed by the Department of Health and Social Security (DHSS). The entire staff of an average FPC would number no more than about 25.

3.15 FPCs were responsible for ensuring access to, and the availability of, medical services to the local population. In addition, they had responsibilities for

(a) maintaining their medical lists

(b) the remuneration of GPs

(c) administering the terms of service for GPs

(d) implementing a mechanism to deal with GPs who breached their terms of service.

3.16 The task of the FPCs was to ensure that the systems prescribed for discharging their various functions were properly implemented. One witness described the FPCs as 'really just pay and rations organisations'. They had no management role. Nor did they have any responsibility for professional competence or quality of care. These were matters left entirely to the profession. The FPCs had no access to independent medical expertise. The LMCs assumed responsibility for maintaining professional standards locally. Nationally, as I have already said, the GMC was responsible for regulating the professional conduct of the doctors on its register.

The Medical List

3.17 Each FPC was required to keep a medical list of doctors in its area who had undertaken to provide general medical services. Applications by doctors for inclusion on a medical list were made in three different circumstances:

- where a member of an existing group practice retired, died or left for other reasons and a replacement was required
- where a single-handed practitioner died or ceased practice, leaving the practice vacant
- where there appeared to be a demand for an additional doctor.

In each case, a decision had to be taken as to whether a vacancy should be declared. The FPC could not itself take that decision. Instead, it was taken by the Medical Practices Committee (MPC), a national body whose function was to ensure an equitable distribution of GPs across the whole of England and Wales.

3.18 When a vacancy was declared in order to replace a member of an existing practice, the role of the FPC in the appointment of a doctor to fill that vacancy was very limited. I shall refer to that role in greater detail at paragraphs 3.51–3.54, when I describe Shipman's appointment to the Donneybrook practice. When a vacancy arose in either of the other two circumstances mentioned above, the FPC was responsible for advertising the vacancy and for shortlisting and interviewing candidates. The FPC would then make recommendations to the MPC, which was responsible for making the final selection.

3.19 The power of a FPC to remove a GP from its list was limited to cases where the GP had died, had ceased to be a registered practitioner, had failed to provide medical services

for a period of six months or where the GP's registration had been erased or suspended by the GMC. In certain circumstances (see paragraph 3.24 below), a FPC could make representations to the NHS Tribunal that a doctor should be removed from its list. The NHS Tribunal was a non-departmental body with judicial powers. Its purpose was to protect family health services from doctors who prejudiced their efficiency. The Tribunal had the power to remove a doctor from a FPC's list or to declare that the doctor should not be employed in any capacity connected with the provision of medical services.

Remuneration

3.20 FPCs were responsible for the payment of GPs, in accordance with the increasingly complex scheme of fees and allowances set out in the Red Book. Some of those allowances (e.g. those for postgraduate and vocational training) were designed to provide an incentive to improve standards. However, they were very limited in scope.

The Terms of Service

3.21 Once a GP was included on the medical list, s/he was subject to terms of service which were set out in the National Health Service (General Medical and Pharmaceutical Services) Regulations 1974 (the 1974 Regulations). The terms of service imposed a number of requirements on GPs, including the following:

- to render to their patients all necessary and appropriate personal medical services of the type usually provided by GPs
- to keep adequate records of the illnesses and treatment of their patients on forms supplied for that purpose by the FPC
- to order, by issuing a prescription, any drugs or appliances which were needed for the patient's treatment.

3.22 Other terms covered such matters as the acceptance and termination of responsibility for patients, responsibility for the provision of deputies and assistants, provision of proper and sufficient accommodation at practice premises and the provision of medical certificates. It was the responsibility of FPCs to administer the terms of service and to take action on any matters arising from such administration.

Failure to Comply with the Terms of Service

3.23 FPCs also had responsibility for putting in place and administering a disciplinary mechanism for dealing with cases where it appeared that a GP had failed to comply with his/her terms of service. Each FPC was required by the National Health Service (Service Committees and Tribunal) Regulations 1974 to establish at least one medical service committee (MSC). The function of the MSC was to hear complaints against GPs of alleged failures to comply with their terms of service. Three lay members of the FPC sat on the MSC, together with three doctors appointed by the LMC and the chairman. The chairman was a lay person, and did not necessarily have to be a member of the FPC.

3.24 The task of processing complaints and providing secretarial and administrative support for the MSC was undertaken by staff of the FPC. However, it was the MSC which took the decision whether or not a GP had breached his/her terms of service and which recommended any further action it thought appropriate. The FPC would then consider the MSC's report and would decide what action to take. It could recommend to the SoS that a warning should be issued or that an amount should be withheld from the GP's remuneration. It could, in certain circumstances (and after consultation with the LMC), impose a limit on the number of patients on a GP's list. In a serious case, the FPC could make representations to the NHS Tribunal that a doctor's continued inclusion on its medical list would be prejudicial to the efficiency of the services it provided. Efficiency could be affected if the GP posed a threat to patients or if the standard of care provided fell far short of that which the NHS and patients had a right to expect. Such representations could result in the GP's removal from the FPC's list and, in an extreme case, from all NHS lists. Referrals to the Tribunal were, however, very rare and the procedure very cumbersome. The FPC had no power itself to remove a doctor from its list (save in the limited circumstances referred to at paragraph 3.19) or to impose conditions on his/her continued inclusion on the list.

3.25 Where, after consultation with the LMC, it appeared to a FPC that a doctor was incapable of carrying out his/her obligations under the terms of service by reason of physical or mental illness, it was open to the FPC to require the doctor to supply a medical report to the LMC. However, the FPC was not able itself to choose the practitioner who prepared the report, to specify the aspects of the doctor's health to be dealt with in the report or to see the report when prepared. All these functions were performed by the LMC. All the FPC was entitled to was a report from the LMC, setting out the views of the LMC about the doctor's fitness to discharge his/her obligations. Even if the report showed that the doctor was unfit to practise, the FPC could not remove him/her from practice, or make alternative arrangements for patient care, without first consulting the LMC and then obtaining the consent of the SoS.

The Limited Role of the Family Practitioner Committees

3.26 In summary, the role of the FPCs was very limited and in some respects rather curious. They were responsible for administering the provision of general medical services, but had little control over the GPs responsible for providing those services. Issues of standards and quality of care were regarded as matters for regulation by the profession itself. FPCs were the recipients of complaints, which might include complaints about the quality of services, but could exert little or no influence over that quality. They had limited opportunity for direct contact with the GPs on their lists and, as I shall go on to explain, little information about them.

3.27 In the 1970s, there was a recognition in some quarters (notably by the Royal College of General Practitioners) that standards of care among GPs were extremely variable and, in the case of some, unacceptably low. Some members of the profession began to take steps aimed at raising standards. At that time, FPCs did not undertake any monitoring of clinical performance or of the quality of the services offered. Insofar as any monitoring of GPs was undertaken, it was done by the Regional Medical Service (RMS).

The Regional Medical Service

3.28 The RMS consisted of medical and supporting administrative staff employed by the DHSS and based in six divisions in England. Each division was headed by a senior medical officer who was designated a divisional medical officer. The divisional medical officer was supported by a number of regional medical officers (RMOs). The RMOs had two distinct functions. First, they provided medical opinions for DHSS benefit schemes. Their other role was to advise and generally to liaise with GPs. They made visits to every GP on a regular basis, usually once every one or two years. These visits were mainly of a routine pastoral nature. A wide range of issues affecting the organisation of general practice in the area was discussed. Visits were also used to carry out inspections of practice premises and to discuss GPs' prescribing habits. RMOs advised GPs on their duties in respect of controlled drugs and were authorised by the SoS to inspect their controlled drugs registers (CDRs) and stocks of controlled drugs. Until the 1960s, RMOs would examine clinical records to ensure that they were being maintained properly. That practice had fallen into disuse by the mid-1960s.

3.29 Since RMOs were, at one time, virtually the only direct link between GPs and the DHSS, the information collected at practice visits provided a potentially valuable insight into the way general practice was functioning on the ground. Information in the form of regular reports (not reports of individual practice visits) was passed by the RMOs to divisional medical officers for dissemination within the DHSS. There was no formal arrangement for communicating this information to the relevant FPC for each area. Some RMOs made a practice of liaising closely with their local FPCs, but this did not always happen.

3.30 In the course of his/her dealings with a GP, a RMO might be alerted to the possibility that the GP was prescribing excessively, or that s/he was failing to exercise reasonable care when issuing medical certificates or that s/he was not keeping proper medical records. In any of those circumstances, disciplinary proceedings could result. If that happened, the SoS would refer the matter for adjudication, not to the FPC, but to the LMC. This was because such issues as medical certification, record keeping and prescribing were regarded as matters to be regulated by the medical profession, not by those responsible for administration. The LMC would then report its findings and recommendations to the SoS, who would decide on an appropriate penalty. If a withholding of remuneration was directed, the SoS would instruct the FPC to put this into effect. Other than this purely administrative action, the FPC had no part to play in these disciplinary processes. The evidence given to the Inquiry suggests that, in fact, these processes were rarely invoked.

Shipman's Appointment to the Donneybrook Practice

3.31 Following his departure from Todmorden, Shipman worked for about 20 months in the Community Child Health Services in Newton Aycliffe, County Durham. There, he conducted clinics and advised on child development. In the summer of 1977, he responded to an advertisement which had been placed in the medical press by doctors practising at Donneybrook House in Hyde. They were seeking a replacement for Dr John Bennett, who had recently left the practice.

Arrangements within the Practice

3.32 The arrangements between the seven doctors of the Donneybrook practice were somewhat unusual. The practice had been formed by the amalgamation of three separate partnerships. Following the amalgamation, two of the doctors who had formed one of the pre-existing partnerships continued to operate a single list of patients. The two doctors shared the care of those patients. The other five members of the practice each operated his own individual list. All seven members of the practice shared staff costs and other expenses. For most purposes, they were treated by the Tameside FPC and its successors as a single partnership.

3.33 Following the departure of Dr John Bennett, six doctors continued to practise at Donneybrook House. They were Dr John Smith (the senior partner), Dr Derek Carroll, Dr Geoffrey Bills, Dr William Bennett, and two relatively new recruits, Dr Geoffrey Roberts and Dr Ian Napier, who had joined in 1975 and 1976 respectively. It was Dr Roberts' first post in general practice. Dr Napier had worked for two or three years in another practice in Stockport before joining the Donneybrook practice. Dr Bills and Dr Carroll continued to operate a shared list. The others worked virtually as single-handed practitioners, save that they organised themselves into two groups for the purpose of providing cover for half days. Dr John Bennett and Dr Roberts had formed one group and Dr Smith, Dr William Bennett and Dr Napier formed the other.

3.34 Dr Smith, Dr Bills, Dr Roberts, Dr Napier and Dr Jeffery Moysey (who joined the practice in 1983) gave oral evidence to the Inquiry. Dr Carroll and Dr William Bennett provided statements.

Preliminary Steps

3.35 Although most of those involved have no clear recollection of this part of the process, it seems that, when Dr John Bennett left, the doctors at the Donneybrook practice must have notified the FPC. The procedure was that the FPC would make a report to the MPC and would obtain approval in principle for the appointment of a replacement doctor. That approval was received in July 1977. It would have been something of a formality. At the time, Tameside was a 'designated' area, which meant that a high level of need for doctors had been identified by the MPC. The Donneybrook practice was a busy practice and a replacement doctor would plainly have been necessary. When the members of the Donneybrook practice received confirmation that they could proceed to select a replacement, they placed advertisements in the press.

3.36 After Shipman's application had been received, a decision was taken to interview him. Dr Roberts' recollection was that recruitment was difficult at that time, there was a poor response to the advertisements and Shipman was the only applicant interviewed. Dr Bills also remembered that this was a difficult time at which to recruit. Dr Napier believed that there were a number of other applicants from whom to choose. Other members of the practice had little recollection of the matter.

The Interview

3.37 There was some difference of recollection also as to whether there was only one interview or a preliminary interview followed by a more formal meeting between Shipman and his

wife, Mrs Primrose Shipman, and members of the practice. Dr Roberts recalled an interview conducted by Dr Smith, Dr Bills and himself. He believed that Mrs Shipman was present for some or all of the time. Dr Bills did not remember Mrs Shipman being there. Dr Smith remembered Mrs Shipman attending. Dr Napier believed that he too attended an interview and, from his description of what was discussed, it appears that this must have been the same occasion as the others described. He said that Mrs Shipman was not there. It may be that, as Dr Roberts has suggested, Mrs Shipman was present for only part of the time. That might account for the different recollections about her presence.

3.38 All those present remembered that Shipman volunteered information about problems he had experienced in Todmorden. Dr Smith said that Shipman referred to himself as 'making a confession' about what had happened there. He told the interviewing panel that he had become depressed as a result of being required to undertake an unfair share of the work at his former practice. Dr Roberts understood that Shipman had resorted first to treating himself with anti-depressant medication and that he had subsequently become addicted to pethidine.

3.39 Other members of the interviewing panel remembered only that he had become addicted to pethidine or a similar drug. Dr Roberts remembered Shipman telling them that he had been convicted of criminal offences in connection with his drug taking. Dr Roberts had understood that these were in contravention of the Misuse of Drugs Act 1971. He had not appreciated that they had involved the forgery of prescriptions and offences of obtaining drugs by deception. Indeed, he was surprised when he read in the Inquiry's First Report the nature of the offences of which Shipman had been convicted. Dr Napier recalled no mention of any involvement with the criminal courts. Dr Roberts said that Shipman also told the interviewing panel that he had received a warning from the GMC and that he had undergone treatment by a psychiatrist. Of the doctors who interviewed Shipman, only Dr Napier gained any impression of how long the conduct had continued. He told the Inquiry that he had in his mind a period of about six months, although he did not know how he had gained that impression. It seems likely that Shipman generally underplayed the seriousness of the events that had occurred in Todmorden and gave a self-serving account of how and why his difficulties had arisen. However, the interviewing panel would not have realised that.

3.40 Despite the problems that Shipman had described to them, it is clear that the impression of him formed by members of the interviewing panel was generally favourable. Shipman seemed enthusiastic and energetic. He had an interest in, and recent experience of, child development (which was an expanding field at the time). He also had an interest in preventive medicine. He appeared to be candid about his past history and to be mature in his approach to it. His story about his treatment at his previous practice was plausible, given the climate at the time. In short, he won the confidence and sympathy of his interviewers.

Subsequent Enquiries

3.41 Following the interview, it was resolved that enquiries should be made of the GMC, of the Home Office (in order to determine whether any restriction had been imposed on his

prescribing) and of the psychiatrist who had treated Shipman. It is not clear whether this was Dr Ronald Bryson, under whose care Shipman had been when an inpatient at The Retreat (a private hospital in York where he was treated following the discovery of his drug abuse), or Dr Hugo Milne, who saw him as an outpatient thereafter. It seems likely to have been the latter, as he would have had more recent knowledge of Shipman. In any event, Shipman provided the necessary details and Dr Roberts was deputed to make the enquiries.

3.42 Dr Roberts ascertained from the GMC that Shipman was registered, with no restrictions on his practice; in fact, the GMC had no power to impose such restrictions at that time, but Dr Roberts would not necessarily have been aware of that. Witnesses from the GMC have confirmed that Dr Roberts would not have been informed that Shipman had a fitness to practise (FTP) history, i.e. that he had been the subject of a warning (in the form of a letter) in respect of convictions which had been reported to the GMC. Warning letters were treated as confidential between the GMC and the doctor concerned. In fact, as I have said, Shipman had told the interviewing panel that he had received a warning from the GMC.

3.43 Dr Roberts then spoke to the Home Office. He said that he was told that there was no restriction on Shipman's ability to prescribe. Mr Frank Eggleston, the Senior Drugs Inspector at the Home Office's Bradford office in 1977, gave oral evidence. He could not remember dealing with Dr Roberts' query and there is no record of it on file. One of the other inspectors may have spoken to Dr Roberts. Their approach would, he believed, have been broadly the same as his own. He would have told the caller whether or not Shipman had been made the subject of a direction restricting his ability to prescribe. He would not have volunteered any further information, even information (e.g. about the circumstances giving rise to a criminal conviction) which was already in the public domain. He would not have wanted to damage Shipman's employment prospects and would, therefore, have been very circumspect in what he said.

3.44 Dr Roberts then spoke to the psychiatrist. He recalled that he was told that Shipman had had an addiction problem, had undergone a period of detoxification, had been treated for depression and had finished his treatment. He recalled no discussion about the underlying cause of Shipman's problems, or about the circumstances of the offences of which he had been convicted. Dr Roberts was concerned to know whether Shipman was fit to take up general practice and he recalled that, put simply, he received the answer 'Yes'. Dr Napier recalled being told subsequently that the psychiatrist had expressed the view that it would be a great loss to medicine if Shipman were unable to practise. That view would have reflected the sentiments contained in the letter written by Dr Milne and submitted by Shipman's solicitors to the GMC at the time that Shipman's case was under consideration in 1976.

3.45 Dr Roberts also remembered speaking to one of Shipman's former partners at Todmorden. He said that he received 'some vitriol' about Shipman at first and was told that Shipman had stolen or misappropriated pethidine from the practice. However, he was also told that, despite his problems, Shipman had been a good GP. Dr Roberts did not recall any discussion about Shipman's addiction and did not think that such a discussion would have been appropriate in the circumstances. Nor had he raised with Shipman's

former partner the suggestions that Shipman had been overworked when at the practice. Dr Roberts believed there would have been little to be gained by doing so since all he would have got would have been a different point of view from that of Shipman. Shipman's account of his experiences at the practice had been convincing and Dr Roberts was prepared to accept it. The impression Dr Roberts was left with was that:

> **'... Shipman had been a man with problems which had led to his leaving the practice but his basic skills as a GP were good'**.

3.46 Dr Roberts believed that he would have spoken to Shipman's employers in County Durham although he had no specific recollection of doing so. That would have accorded with his usual practice. There seems little doubt that Shipman would have received a positive reference from that quarter. In short, the enquiries undertaken by Dr Roberts did nothing to undermine the account that Shipman had given of his problems and the favourable impression that the panel had formed during the interview.

The Decision to Appoint

3.47 Dr Roberts recalled that he imparted the information he had collected to his partners informally, rather than at a practice meeting. Both Dr William Bennett and Dr Carroll remembered being told of Shipman's drug problem, which appeared to have been treated and resolved. Neither remembered being aware that Shipman had been convicted of any criminal offences. Dr Carroll said that he was not aware of Shipman's convictions until the conclusion of the trial in 2000, when they received a good deal of publicity. Even had he known of them, he said, it would not have affected his view that Shipman should be appointed. Dr Bennett was certain that he was unaware that Shipman had forged prescriptions. He said he would have regarded that as a serious matter and would have been uncomfortable having a partner who had been convicted of offences of dishonesty. It is quite likely that the fact of Shipman's criminal convictions was not explained to Dr Bennett or Dr Carroll. Little emphasis appears to have been placed on that aspect by those who interviewed Shipman. It is quite possible, therefore, that they did not regard it as sufficiently significant to pass on to the others.

3.48 Dr Napier told the Inquiry that he had felt some hesitation about appointing Shipman, since there were other applicants for the job and he felt there was a risk that Shipman might relapse into his former habit of drug taking. Dr Smith acknowledged that Dr Napier may have questioned whether it was right to take on Shipman but does not recall any strong opposition to his appointment. None of the other doctors remembered there being any dissent on the issue. In any event, a decision was taken to appoint Shipman for a probationary period of either three or six months. That was the usual basis on which appointments were made as it gave both sides an opportunity to ensure that they were able to work satisfactorily together. During the probationary period, Shipman was to take on the usual duties of a GP principal and to assume responsibility for Dr John Bennett's list of patients. The legal formalities were not concluded until the expiration of the probationary period.

3.49 Dr Roberts explained that, in making their decision, members of the practice took their lead from the GMC. The GMC, which they believed would have had knowledge of all the

facts relating to Shipman's drug taking activities, had found that Shipman was fit to practise. It was not for the practice to go behind that finding. He told the Inquiry that, if Shipman had been subject to restrictions on his practice (e.g. prescribing restrictions), he would not have been taken on, since this would have caused practical difficulties in his day-to-day professional life. Similarly, if he had been subject to professional supervision, this would have been a bar since there was no one available at the practice with the necessary experience to exercise formal supervision over him. If the treating psychiatrist had said that Shipman was not ready for practice or that he required professional supervision, this would also have been a decisive factor. As it was, all the indicators appeared to be positive.

Controlled Drugs

3.50 Several members of the practice recalled that, at some time, Shipman had said he did not intend to keep controlled drugs. It may be that he expressed this intention at interview, although Dr Bills had no recollection of it. Dr Roberts remembered being informed of Shipman's intention and of the name of the drug (Fortral) which he was proposing to use for pain relief in place of a controlled drug. In accordance with their way of running their practices, members of the practice maintained their own supplies of controlled drugs for use in emergencies. There was no supply of drugs available to all members of the practice, as there had been at Todmorden, and no CDR in common use.

Shipman's Application for Inclusion on the Medical List

3.51 Once the practice had made its selection, Shipman applied to join the medical list held by the Tameside FPC. The application form (as prescribed by the 1974 Regulations) required details of his medical qualifications, the practice that he intended to join, the nature of the services (e.g. maternity and contraception services) he was to provide and his current employment. He was required to identify the proposed geographical area of his practice, his practice premises, his surgery hours and telephone details. Shipman also completed a supplementary questionnaire in which he indicated, *inter alia*, that he had been a principal in general practice previously and had practised in the area of the Calderdale FPC. This questionnaire was for statistical purposes only. Shipman was issued with various other forms of an administrative nature which he was required to complete. No information was sought or given about his disciplinary record or about any criminal convictions he might have.

3.52 Having received Shipman's application for inclusion on its list, the FPC checked with the GMC that he was on the register. Without registration, he would not, of course, have been eligible for admission to the list. The FPC would not have enquired of the GMC whether Shipman had a FTP history, i.e. whether he had previously been disciplined by the GMC. As I have said, the GMC would not have provided any further information, even if asked. There was no contact with his previous employers or with the Calderdale FPC. No references were taken up or sought. Having satisfied themselves that Shipman was registered with the GMC, staff at the Tameside FPC sent his application to the MPC, together with the FPC's report supporting his application.

3.53 The MPC granted the application. A vacancy had been declared and the practice had made its choice of candidate. Provided that the relevant procedures had been properly complied with, approval of the application would have been automatic. Once the MPC's approval had been given, Shipman's name was included on the medical list. The fact that he was to serve a probationary period was a matter between him and the other members of the Donneybrook practice. So far as the FPC was concerned, Shipman was free to practise as a GP principal.

Conclusions

The Role of the Tameside Family Practitioner Committee

3.54 The involvement of a FPC in the process of appointing a doctor to replace a member of an existing practice was extremely limited. Its role was purely administrative. The FPC acted as little more than a conduit for the provision of information to the MPC. The function of the MPC was purely to ensure that patients in all parts of the country had reasonable access to a GP. It was not concerned with issues of quality of care. Neither the FPC nor the MPC sought, or would have expected to be provided with, any qualitative evidence about the competence or performance of a GP applying to replace a member of an existing practice. Even when dealing with other types of vacancy – where the FPC and MPC were more actively involved in the selection process – no information about such matters as disciplinary findings or criminal convictions would have been available to them. Those were matters solely between doctors and their regulatory body, the GMC. It was the GMC's task, not that of the FPC, to decide whether a doctor was fit to treat patients. The role of the Tameside FPC in the appointment of Shipman must be viewed in this context.

The Role of the Members of the Donneybrook Practice

3.55 At Shipman's interview, the members of the Donneybrook practice were impressed by his enthusiasm, his energy and his interest in child health. They were (with the possible exception of Dr Napier) disarmed by his apparent frankness about his past history and convinced by his assurances that his problems were now behind him. They had some sympathy with the predicament in which he claimed to have found himself at his former practice.

3.56 Dr Roberts had learned from the GMC that Shipman was registered without restriction. It was clear, therefore, that the GMC, which was assumed to have considered the full facts of his case, took the view that he was fit to practise. It is not, in my view, surprising that the members of the Donneybrook practice should have been prepared to accept the GMC's view without question. From the Home Office, Dr Roberts had ascertained that no restriction had been placed on Shipman's prescribing, as would have been possible following his conviction for drug offences in February 1976. This would have tended to suggest that he was not thought to be at particular risk of misusing controlled drugs in the future. Furthermore, the message from the psychiatrist who had treated Shipman was extremely positive; it was to the effect that Shipman had had a problem which had been satisfactorily resolved. A partner in the practice from which he had been dismissed spoke well of his abilities as a GP. The information provided by his employers, for whom he had

been working for 18 months or so, would also have been encouraging. Those who were aware of Shipman's intention not to carry controlled drugs in the future no doubt found that reassuring.

3.57 In my view, the members of the Donneybrook practice cannot be criticised for their decision to give him a chance by recruiting him. It may be that they were to some extent influenced by the lack of other suitable candidates for the vacancy. However, Dr Roberts emphasised that there was no question of 'making do'; the feeling was that Shipman would be a positive asset to the practice. I note that no one appears to have considered what patients might think about the appointment of a doctor with Shipman's past history. That would have been typical of attitudes at the time.

3.58 It is clear that those members of the Donneybrook practice who were aware of Shipman's previous dishonesty did not focus on that aspect of his conduct. Insofar as they were concerned about his conduct and behaviour in the future, it was the risk of a relapse into drug taking, not a perpetuation of his former dishonest behaviour, that they feared. In my judgement, they cannot be criticised for their failure to attach more significance to the fact that Shipman had been convicted of offences of dishonesty. Even now, dishonest conduct by a doctor, undertaken in order to obtain drugs illicitly, is regarded by many as 'just part of the illness'. In my view, it was reasonable for them to follow the lead given by the GMC in regarding Shipman as fit to practise, notwithstanding his past dishonesty.

Should the Family Practitioner Committee Have Been Told?

3.59 None of the members of the Donneybrook practice considered telling the FPC of Shipman's history, or seeking the advice of the FPC about whether it was wise to appoint a former (albeit apparently reformed) drug addict to the practice. In his capacity as secretary of the LMC, Dr Roberts had regular meetings with the administrator of the FPC, with whom he had a good personal relationship. However, the possibility of consulting the administrator about Shipman's appointment did not occur to him. Dr Roberts considered the role of the FPC to be facilitative only. He would not have seen it as the function of staff at the FPC to advise. He would not have thought to notify them of Shipman's past history. Indeed, he said that he would not have known what the FPC would do with that information, if it had been given. Dr Roberts' attitude accurately reflects the evidence I have heard and read about the somewhat distant relationship between GP practices and FPCs in the 1970s. Mr Greenwood did not seek to criticise members of the Donneybrook practice for not having notified the FPC about Shipman's past. Indeed, his evidence emphasised the limited part which the FPC played in the appointment process. I am satisfied that no criticism can be levelled at members of the Donneybrook practice in respect of their failure to inform the FPC about Shipman's past history.

Should Arrangements Have Been Made for Shipman to Be Supervised?

3.60 Once Shipman started at the Donneybrook practice, no arrangements were made for exercising any form of supervision over him or for monitoring his clinical practice. Should members of the Donneybrook practice be criticised for that failure? Dr Roberts said that this was not the way things were done in 1977. Monitoring and supervision of GPs was not

part of the culture of the time. This assertion derives some support from the fact that the GMC itself had no power to order restrictions or conditions on practice at that time. Supervision of a colleague would undoubtedly have caused practical difficulties since members of the practice were busy, worked independently of each other and had full lists. If they had believed that Shipman required supervision, he would not have been taken on. As I have said, the risk which Shipman's colleagues would have had in mind would be that of a relapse into drug taking. Certainly, Dr Smith, as senior partner and GP to Shipman and his family, was aware of the need to ensure that Shipman did not revert to his drug taking habits. However, Dr Smith observed no sign of renewed drug taking and noted that Shipman was working well and appeared to have plenty of outside interests.

3.61 I think that, insofar as they considered the matter, the members of the practice would have thought that they would be alert to signs of any recurrence of Shipman's drug taking, so that, if it occurred, they would notice and could take appropriate action. In the event, there is no evidence that Shipman ever returned to taking drugs after his time in Todmorden. In my view, the members of the Donneybrook practice cannot be criticised for not having arranged any monitoring or supervision for Shipman. They would have had no idea how to go about this. It had not been suggested by the GMC or Shipman's psychiatrist that supervision was necessary. Such an arrangement might have been construed as showing a lack of confidence in Shipman's rehabilitation. The authorities (the GMC and the Home Office) had decided that Shipman was fit to practise without restrictions on his prescribing. His colleagues relied on that. Judged by the standards of the time, their conduct was, in my view, entirely reasonable.

The Effects of Non-Disclosure

3.62 As I have said, members of the Donneybrook practice did not inform the Tameside FPC about Shipman's past. Nor did the information that Shipman was required to provide in support of his application to join its list include any information about his disciplinary or criminal record. That was not the fault of the FPC, which was merely following the prescribed procedures. It was not thought appropriate or necessary in the 1970s for FPCs to be provided with such information. Given its restricted function, that is perhaps not surprising.

3.63 The effect was that it was not until 1998, when the police investigation into the death of Mrs Kathleen Grundy was underway, that the West Pennine Health Authority, which had by that time succeeded to the responsibilities of the Tameside FPC, became aware of Shipman's convictions. Thus, throughout the 21 years of their association with Shipman, the various bodies responsible for the provision of primary care in Tameside believed that they were dealing with a professional man of probity. They were unaware that there might be special reasons for maintaining a close watch on Shipman and, in particular, on his prescribing of controlled drugs.

3.64 The importance of PCOs having ready access to full information about the past history of GPs who apply to join – or who are already included on – their lists is a matter to which I shall return later in this Report.