CHAPTER SIX

Complaints and Discipline prior to April 1996

Introduction

6.1 I have already observed that one element of the local governance of general practitioners (GPs) was the disciplinary process initiated and executed at local level. Soon after the inception of the Inquiry, I learned that, following complaints by patients, Shipman had been disciplined on two occasions by the primary care organisations responsible for Tameside, in 1990 and 1993. Before describing the circumstances giving rise to those complaints and the disciplinary proceedings that followed, I shall explain the legislative and procedural background at the relevant time.

General Practitioners' Terms of Service

6.2 As I have explained in Chapters 3 and 4, between 1974 and September 1990, family practitioner committees (FPCs) were responsible for administering the arrangements for primary care. In September 1990, FPCs were replaced by family health services authorities (FHSAs). GPs were not in a direct contractual relationship with the FPC or FHSA but operated instead under the General Medical Services (GMS) Contract, a national agreement with Government. The FPC/FHSA administered the local operation of the GMS Contract. Under the provisions of the National Health Service (General Medical and Pharmaceutical Services) Regulations 1974 (the 1974 Regulations), the arrangements made by FPCs (later the FHSAs) with doctors for the provision of general medical services had to incorporate the GPs' terms of service.

6.3 The GPs' terms of service covered a wide range of topics, but in the specific context of complaints they provided as follows:

> **'General**
>
> **3. Where a decision whether any, and if so what, action is to be taken under these terms of service requires the exercise of professional judgement, a doctor shall in reaching that decision not be expected to exercise a higher degree of skill, knowledge and care than general practitioners as a class may reasonably be expected to exercise.'**

This paragraph set the standard by which the doctor's conduct was to be judged as that reasonably to be expected of the reasonably competent GP.

6.4 The terms of service relevant to the subject matter of the complaints made against Shipman were as follows:

> **'Service to Patients**
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> **13. Subject to paragraph 3, a doctor shall render to his patients all necessary and appropriate personal medical services of the type usually provided by general medical practitioners. He shall do so at his practice premises or, if the condition of the patient so requires,**

elsewhere in his practice area or at the place where the patient was residing when accepted by the doctor ... the doctor shall not be required to visit and treat the patient at any other place. Such services include arrangements for referring patients as necessary to any other services provided under the Health Service Acts and advice to enable them to take advantage of the local authority social services ...

14. A doctor shall, unless prevented by an emergency, attend and treat any patient who attends for the purpose at the places and during the hours for the time being approved by the Committee ...'

and

'Records

30. A doctor shall –

(a) keep adequate records of the illnesses and treatment of his patients on forms supplied to him for the purpose by the Committee, and

(b) forward such records to the Committee on request as soon as possible, and

(c) within 14 days of being informed by the Committee of the death of a person on his list and in any case not later than one month of otherwise learning of such a death, forward the records relating to that person to the Committee.'

6.5 The wording above is taken from the 1974 Regulations but it remained essentially unchanged in the later Regulations. In April 1990, some changes were made to the 1974 Regulations upon the coming into force of the National Health Service (General Medical and Pharmaceutical Services) Amendment (No. 2) Regulations 1989. However, these changes were not of significance for the purposes of this Chapter. The National Health Service (General Medical Services) Regulations 1992 consolidated and amended the 1974 Regulations and set out new terms of service which were also largely unchanged.

The Framework of the Complaints and Disciplinary System

6.6 By the National Health Service (Service Committees and Tribunal) Regulations 1974 (the 1974 Service Committees Regulations), FPCs (and later FHSAs) were required to set up service committees for each contractor service to investigate complaints of alleged failures to comply with the terms of service. The 1974 Service Committees Regulations were the subject of numerous amendments, particularly by the National Health Service (Service Committees and Tribunal) Amendment Regulations 1990. The National Health Service (Service Committees and Tribunal) Regulations 1992 consolidated the earlier Regulations and amendments and made further amendments. These Regulations governed complaints received after 1st April 1992 and continued in force until 1996.

Informal Procedures

6.7 Not every complaint received by a FPC/FHSA contained an allegation capable of amounting to a breach of a GP's terms of service. Complaints not containing such allegations could not be referred to a service committee but they might be amenable to informal resolution, by discussion between the parties, which would have the effect of restoring the relationship of trust and confidence between doctor and patient. Some complaints, even those which might amount to an allegation of a breach of terms of service, were not apparently very serious and it might appear inappropriate for them to lead to formal disciplinary proceedings. In such cases, an officer of the FPC/FHSA might seek to resolve the complaint informally through discussion, provided that the complainant consented. Prior to 1990, there were no centrally or officially directed informal complaints procedures. Different areas had different arrangements which had evolved locally.

6.8 The position changed in 1990. On 7th March 1990, the Secretary of State for Health (SoS) gave directions to FPCs to establish conciliation processes. The procedure to be followed depended on the apparent seriousness of the patient's complaint. For less serious matters, an officer of the FPC (after September 1990, the FHSA) would try to resolve the problem in correspondence. For more serious cases, the matter could be referred to conciliation. Lay conciliators were appointed who were accountable to the FPC/FHSA, and each FPC/FHSA, after consultation with the local medical committee (LMC) for its area, drew up a list of professional advisers to whom the lay conciliators would have access. Guidance was given as to the types of case that were not suitable for these informal procedures and should be dealt with by the more formal medical service committee (MSC) procedure. Potentially serious breaches of terms of service were to go to the MSC. These included such complaints as an allegation of a failure to respond to a patient's repeated requests to visit, an allegation that the doctor had failed to relieve severe pain in terminal illness or a complaint that the patient had been unable to contact the doctor.

Formal Procedures

Dealing with a Complaint

6.9 If a complaint against a GP was received from, or related to, a patient who was or had been entitled to receive general medical services from a GP on the FPC/FHSA's list, and if the complaint appeared to amount to a potential breach of the GP's terms of service, it would be referred to the chairman of the FPC/FHSA's MSC. As a rule, the complaint had to be made by the patient or by another with the patient's authority. However, if the patient had died or was under the age of 16 or was incapable, by reason of old age, sickness or other infirmity, of making the complaint him/herself, a complaint could be made by another person. Complaints had to be made within eight weeks (from 1990, 13 weeks) of the event giving rise to the complaint, unless the MSC was satisfied that the failure to give notice of the complaint in time was occasioned by illness or other reasonable cause and provided also that the GP or the SoS consented to the investigation of the complaint out of time. From 1992, the functions of the SoS were delegated to the Family Health Services Appeal Unit (FHSAU).

6.10 Although no such specific procedure existed before 1990, if, after 1990, the substance of the complaint did not sufficiently appear from the written statement of the complainant, the FPC/FHSA had to request the complainant to provide such further particulars as the FPC/FHSA reasonably required.

6.11 The MSC consisted of a chairman, three lay members of the FPC/FHSA and three practitioner members appointed by the LMC for the area. In practice, in Tameside, the LMC nominees were LMC members. The position of chairman could not be filled by a doctor, so, in practice, chairmen were lay members of the FPC. Another lay member of the committee would be designated as deputy chairman.

6.12 A decision whether a complaint should be accepted for investigation was taken by the chairman of the MSC. If s/he decided that the complaint disclosed reasonable grounds to believe that the doctor had breached his/her terms of service, an officer of the FPC/FHSA would send to the GP the written statements of complaint and (after 1990) details of the terms of service alleged to have been breached. The GP had to submit his/her written response within four weeks, or longer if agreed by the MSC. Where a response was received from the GP, the FPC/FHSA copied this to the complainant and invited his/her written observations within 14 days, or longer if agreed.

6.13 The chairman of the MSC would then decide whether an oral hearing should take place. In general, an oral hearing would be directed where there was an apparent conflict of evidence between the complainant and the GP. If there was no such conflict, the chairman could direct that the matter be considered by the MSC without an oral hearing. An officer of the FPC/FHSA would usually seek to ensure that any relevant medical records were available. He or she would also give notice to the parties (i.e. the complainant and the GP) of the meeting of the MSC at which the matter was to be considered and of particulars of the breaches alleged. If there was to be an oral hearing, the parties were required to submit any documentary evidence and the names of any witnesses. It was a matter for the parties what evidence was adduced.

The Medical Service Committee Hearing

6.14 A meeting of the MSC would be convened to deal with the consideration of one or more complaints. All members of the committee might attend but often this proved impossible. After 1990, the quorum required to hear a complaint was a chairman (or deputy), two lay members and two medical members. Before 1990, three members could constitute a quorum, provided that there was at least one lay and one medical member present. A duly authorised officer of the LMC could attend. One or two authorised officers of the FPC/FHSA would attend to assist the committee. The complaint might be dealt with on the papers or after an oral hearing. Oral hearings were conducted on an adversarial basis and followed the procedure of a civil trial. They were held in private but the parties could attend until the deliberation stage was reached. A party could be accompanied by someone to assist in the presentation of the case but, if that other person was a barrister or a solicitor, s/he could not address the committee or question witnesses. Usually, a representative of the GP's medical defence organisation would appear on his/her behalf. Sometimes, the complainant had the assistance of someone from the local Community Health Council

(CHC). The role of advising and supporting complainants throughout the whole complaints process, was an adjunct to the CHCs' main function, which was to provide a focus for public consultation on a wide range of health issues. However, it was a role that many CHCs appear to have filled very effectively.

6.15 If a new allegation, relevant to the complaint under consideration, was introduced in the course of the hearing, the chairman had to decide whether it should be admitted. Such a new complaint could be admitted only if it had been made within the time limit. If a new complaint was admitted out of time, the whole proceedings were liable to be declared void on appeal.

6.16 After the evidence and the submissions of the parties (if any), the committee would deliberate on its findings of fact and conclusions as to whether there had been a breach. Until this stage, members of the committee would have been told nothing of the GP's past disciplinary record. If they found that a breach had occurred, they would be told of any breaches found against the doctor in any MSC report made within the preceding six years before being asked to consider what penalty to recommend to the FPC/FHSA. At the end of the proceedings, the committee would instruct an officer of the FPC/FHSA to write a report on the evidence, findings and recommendation as to penalty, if any.

6.17 If a party failed to attend, the case might be adjourned but it could be concluded without a hearing. After 1990, if the complainant refused to attend or failed to confirm that s/he intended to attend, the MSC could report on the complaint without holding a hearing. Unless the GP consented to disposal without a hearing, however, the report could not contain any recommendation adverse to him/her.

6.18 For cases in which the FPC/FHSA itself wished to bring a complaint against a GP, the matter could be referred to the MSC of another FPC/FHSA. This would usually arise where the complaint did not affect a specific patient, e.g. in a case of fraud. This arrangement was also available in cases in which it was thought desirable for other reasons. An example would be if the GP complained against was a member of the MSC or was personally known to members of the MSC for the area in which s/he practised.

6.19 The MSC was not bound by the strict rules of evidence. The Department of Health and Social Security (from 1988, the Department of Health (DoH)) issued guidance notes about various matters, including the admissibility and weight of certain types of evidence. In summary, the MSC had a broad discretion as to whether it should hear or look at any particular evidence and what weight to attach to it.

The Medical Service Committee Report and Penalties

6.20 Prior to 1990, the MSC's report had to state its findings of fact and the inferences drawn. From 1990, the report additionally had to provide the committee's reasons for drawing such inferences. The report was presented to the FPC/FHSA. If the MSC found that the doctor was in breach of his/her terms of service, the MSC might recommend that previous breaches of the doctor's terms of service should be taken into account. After 1992, the report also had to contain details of the material evidence received, all findings of fact, the reasons for any inferences drawn and the recommendations for action by the FHSA.

6.21 The FPC/FHSA considered the report. It was bound by the MSC's findings of fact and had to give reasons for any departure from its recommendations. On penalty, the FPC/FHSA could, in accordance with the Regulations:

(a) impose a limit on the number of patients included in the GP's list. This would be recommended where it was concluded that the doctor was, because of his/her large list, unable to give an adequate service to all the patients on his/her list

(b) (before 1990) recommend to the SoS that the GP should pay any expenses incurred by the patient by reason of the breach of terms of service and/or that an amount should be withheld from his/her remuneration; (from 1990) itself determine that the GP should pay any expenses incurred by reason of the breach of terms of service and/or determine that an amount not in excess of £500 should be withheld from the GP; in relation to amounts in excess of £500, even after 1990, the FPC/FHSA could only recommend to the SoS, and could not determine, that there should be a withholding

(c) make representations to the NHS Tribunal that the continued inclusion of the GP in its medical list would be prejudicial to the efficiency of the services in question; in other words, recommend that the GP be removed from the medical list

(d) (before 1990) recommend to the SoS that the GP should receive a warning to comply with his/her terms of service more closely in the future; (from 1990) itself determine that s/he should receive such warning

(e) (from 1992) send any documents connected to the complaint to the General Medical Council (GMC). Prior to 1992, this had been considered unnecessary because the SoS was supposed to report appropriate MSC cases to the GMC on the recommendation of a body known as the Medical Advisory Committee (MAC), which I shall describe below. Guidance notes issued to FHSAs by the DoH had appended to them guidance, previously drawn up for the MAC, as to the types of case that should be reported. The guidance for the MAC referred to the April 1987 edition of the GMC publication 'Professional Conduct and Discipline' (known as the Blue Book; see Chapter 17), but also made clear that any misconduct regarded as **'seriously prejudicial to the medical care of patients'** should be reported.

Appeals to the Secretary of State for Health

6.22 Both the doctor and the complainant had a right of appeal to the SoS in respect of any adverse determination. Thus, either party could appeal against a finding that a breach had or had not occurred, against a decision on the extension of a time limit or against a sanction imposed by the FPC/FHSA. In 1992, the SoS devolved those appellate functions to the FHSAU, which was set up at the Yorkshire Regional Health Authority. This body would also hear cases that were referred to it because the recommended sanction was a withholding of over £500 and required endorsement by the SoS. On 1st April 1995, the FHSAU was established as a Special Health Authority and changed its name to the Family Health Services Appeal Authority (FHSAA); in November 2001 its name changed to the Family Health Services Appeal Authority (Special Health Authority) (FHSAA (SHA)).

6.23 The SoS's delegated functions were exercised by an officer of the FHSAU or, later, the FHSAA and FHSAA (SHA). In practice, therefore, appeals were determined by the Chief Executive or his/her deputy. If the Chief Executive was of the view that it was necessary to resolve conflicts of evidence, s/he could appoint a panel to conduct an oral hearing. The panel would comprise a barrister or solicitor as chairman and two doctors, one from a panel nominated by the British Medical Association (BMA). The panel conducted the oral hearing but reported back with a recommendation as to whether or not there had been a breach; the Chief Executive or his/her deputy made the final decision.

6.24 The Chief Executive had the power to seek advice and a recommendation from the MAC and was specifically required to do so in the case of specified failures to comply with terms of service (broadly speaking, those involving the exercise of clinical judgement). According to Mr David Laverick, who was Chief Executive of the FHSAA from 1st October 1995 until 31st August 2001, it was his practice always to involve the MAC although his predecessors probably did so, according to his evidence, only when specifically required to do so by the Regulations. The MAC comprised six members, who were appointed by the SoS. The Chairman and his/her deputy were to be doctors of no less than ten years' standing, selected by the SoS after consultation with the BMA. Of the remaining five members, three were chosen from a BMA panel of about 24 doctors and the others from a panel selected by the SoS.

6.25 When Mr Laverick arrived in post, he was concerned about what appeared to him to be inconsistencies in the recommendations made by the MAC in apparently comparable cases. He was also concerned that the doctors on the MAC seemed to see themselves as advocates for the GP under review. As a result, Mr Laverick sought to introduce guidance as to the amount to be withheld in different types of case. For a very minor first breach of the terms of service, he suggested that the appropriate penalty would be about £250. Where there was a relatively serious first breach, the figure would be around £750–£1000. In relation to second or third breaches or cases with a clear lack of care or disregard for the NHS, Mr Laverick suggested that the penalty should be a recovery in the range of £1500–£3000 depending on the circumstances. After the introduction of the guidelines, Mr Laverick said that the recommendations of the MAC became more consistent and he felt able to follow them in about 90% of cases.

6.26 In some cases the FHSAU/FHSAA would refer cases to the GMC. Mr Laverick's recollection was that, when he arrived in 1995, there were criteria in place which had originated from the GMC, whereby the FHSAA was to notify the GMC of any finding of a breach of what was then paragraph 12 of the terms of service (the obligation to provide personal medical services of the type usually provided by GPs) and also of any withholding of more than £750. After his arrival, Mr Laverick had discussions with representatives of the GMC at which he sought to enlarge, in the face of some opposition from the doctors' representatives, the categories of case that were being reported beyond those cases where there had been a finding of a breach of terms of service. His view was that a wider range of cases involving clinical shortcomings should be reported. He said that his view prevailed and that, thereafter, the FHSAA reported cases involving such issues as a doctor's failure to recognise the limits of his/her professional competence, to

keep professional skills and knowledge up to date, to keep adequate patient records, to take an adequate history or to perform a competent physical examination.

Appeals to the Health Service Ombudsman

6.27 In 1973, the office of the Health Service Ombudsman (also known as the Health Service Commissioner) was created. The Health Service Ombudsman looks into complaints made by or on behalf of people who have suffered because of unsatisfactory treatment or service by the NHS. He or she is independent of the NHS and the Government and his/her services are free. However, until 1st April 1996, the Ombudsman had no jurisdiction over complaints about GPs.

Complaints Made against Shipman: 1985 to 1993

6.28 The Inquiry investigated complaints made against Shipman primarily in an attempt to see whether the system of complaints in operation at the material times was capable of revealing or providing clues about his criminal activities. As will be seen, I have concluded that none of the complaints that were determined by a MSC provided much of a clue as to Shipman's true nature. However, I have decided to set out the circumstances of these complaints because their examination illustrates some of the shortcomings of the system and also throws light on what is needed in any system for the satisfactory handling of complaints.

6.29 The Inquiry asked the West Pennine Health Authority (WPHA) to provide all its records relating to complaints made against Shipman. The WPHA sent files relating to 18 cases and logs recording the bare details of ten more. However, on examination, most of these were found not to be complaints against Shipman personally. Some were complaints about his staff; some were complaints made by his patients but relating to their treatment by other doctors. One, set out in a letter from Miss Beatrice Clee, was not a complaint at all but a request for advice about the various drugs Shipman had prescribed for her. Of those complaints which were directed against Shipman himself, some were resolved through the informal procedures. There was very little information on file and the Inquiry has not sought to look into those cases. However, there were three complaints against Shipman that had been referred to a MSC, as they related to an alleged breach of his terms of service. I shall describe these three cases below.

The Case of Mr J

6.30 Two related complaints were brought by the mother of a patient of Shipman, Mr J, who had died from pulmonary fibrosis in July 1985 at the age of 29. The first related to the treatment provided by Shipman between 1977 and the patient's death in 1985; the second alleged a breach of patient confidentiality. I shall refer to Mr J's mother as Mrs J.

6.31 In her letter of complaint, dated 16th August 1985, which had been drafted at her request by Mr Steven Rawlinson, Mr J's closest friend, Mrs J said that her son had been registered with Shipman since 1977. Mr J had been a self-employed bricklayer and had enjoyed good health except that he suffered from a troublesome cough, particularly in winter. She

alleged that Mr J consulted Shipman on two occasions in 1984 (once in the summer and once in December), complaining of breathlessness. Shipman had told him that his problem was 'all in his mind'. Her son had consulted Shipman again in February 1985, when a chest x-ray had been arranged. On arrival at the clinic where the x-ray was to be taken, the technician had asked Mr J whether he actually had a chest condition. When Mr J said that he did, the technician remarked that the letter of referral said that it was psychosomatic. Following the x-ray, Shipman had advised Mr J that, apart from a couple of white patches, the lungs were normal. Mrs J said that her son's health had deteriorated from that time; his cough had continued and he had lost weight.

6.32 Mrs J said that, in May 1985, her son had noticed blood in his sputum and had returned to see Shipman, who prescribed an antibiotic and an asthma inhaler. She said that her son had insisted on a more thorough examination and Shipman had reluctantly agreed to refer him to a consultant chest physician at the local hospital. An appointment was offered for 22nd July 1985. In early June, Mrs J, deeply concerned about her son's deteriorating health, had contacted Shipman and it was agreed that a private appointment with the consultant should be arranged. At that appointment, on 20th June, the consultant expressed concern about Mr J, took various samples for tests and, a few days later, admitted Mr J to hospital. Mrs J understood that, at the time of admission, the diagnosis was unclear, but tuberculosis and viral pneumonia were mentioned as possibilities. After a week in hospital, no positive diagnosis had been made but Mr J's condition appeared to have stabilised and he was discharged home on 2nd July. By 9th July, he had relapsed and was readmitted, obviously very ill. Various tests were carried out. On 19th July, Mr J underwent a bronchoscopy and biopsy. He died very shortly afterwards.

6.33 Mrs J expressed the opinion that Shipman had been negligent. She did not provide particulars of that allegation but asked a number of questions from which it is apparent that she was concerned that Shipman had not examined her son sufficiently thoroughly, had underestimated the seriousness of his condition and had regarded it as psychosomatic. This had resulted in a delay in treatment. She was also concerned that, when agreeing to refer her son to a chest physician, Shipman had not asked for an expedited appointment.

6.34 Mrs J also alleged that, on a social occasion while her son was in hospital, Shipman had divulged confidential information about his condition to a couple – I shall call them Mr and Mrs G – who were patients of his and also friends of Mr J. The allegation was that Shipman had told Mr and Mrs G that Mr J might have tuberculosis. Mrs G was pregnant and had visited Mr J in hospital. Mrs J said that she thought Mr and Mrs G would be unwilling to provide evidence of this, as they remained on Shipman's list. This complaint, which Shipman later denied, fell outside the remit of the MSC; its proper destination was the GMC. I shall say no more about it, save to observe that it is not satisfactory for a complainant to have to take two related complaints to two different bodies.

6.35 On 3rd September 1985, the Chairman of the Tameside MSC considered the papers and decided that they disclosed reasonable grounds for complaint. An officer of the FPC sent the complaint to Shipman for his response. Shipman responded by letter dated 10th September 1985. Papers recovered by the Inquiry from Shipman's surgery show that, before submitting his response, Shipman had taken the advice of his regional Medical

Defence Union representative on the content of his draft response. He was warned that, in view of the conflicts of evidence between his account and that of Mr J's mother, he should expect to be summoned to an oral hearing.

6.36 Shipman's response began with a brief account of past history. He referred to consultations in January and March 1979, and on 13th June and 26th September 1980. None of those consultations related to a chest condition. He then recounted the history of the chest condition, beginning with a consultation on 15th April 1985. This was a detailed account and gives every appearance of having been extracted from clinical records. The account was silent as to whether there had been any consultations at all between 1980 and 1984 or one in February 1985, but the implication was that there had not been.

6.37 Shipman said that, on 15th April 1985, Mr J had complained of breathlessness. A diagnosis of bronchitis was made and an antibiotic prescribed. Shipman arranged a chest x-ray for the next day. It would appear that this was the consultation which Mr J's mother thought had taken place in the February. Shipman denied that he had said that Mr J's condition was 'psychosomatic' but agreed that he did sometimes advise patients that wheeziness could be exacerbated by anxiety. Shipman said that the x-ray showed active infection and a further course of antibiotics was prescribed on 7th May. On review on 21st May, Shipman found that Mr J was wheezy, had a cough and had lost a stone in weight in three months. Lung function testing showed a peak flow rate (PFR) of 300 litres per minute (which is very poor for a man of Mr J's age). Shipman prescribed a Ventolin inhaler and arranged various tests for 24th May. In his response, Shipman described the results of these tests, which appeared to include blood and urine tests but no further x-ray, and claimed that the results were very suggestive of a chest infection; he said that he had wondered whether Mr J had tuberculosis.

6.38 Shipman said that Mr J attended again on 4th June and, because he was no better, Shipman decided to refer him to a chest physician. The referral letter, dated 6th June, said that Mr J had presented early the previous month (that would be in May) with a tight wheezy chest and a cough productive of green phlegm. On review after a course of antibiotics, the finding was of wheezy expiratory rhonchi and a PFR of only 300. (There was no mention of the weight loss.) He had prescribed Ventolin and said that he had arranged an x-ray, the result of which was compatible with active chest infection. (That was misleading; the x-ray had been taken in April.) He said that at the **'recent'** review, the PFR had **'crept'** up to 500 litres per minute but, he wrote, **'the obvious question is have we got a young man who has asthma or is this the remains of a chest infection?'** I note three interesting features of this letter. Shipman misled the consultant as to the history, stating that he had first seen Mr J in early May and had arranged the x-ray in late May. He had not; those events occurred in April. Second, he made no reference to weight loss, which might well have been a sign of a progressive condition. Third, there was no hint in the letter that Shipman suspected tuberculosis or any other condition requiring urgent attention. The letter positively suggested a non-urgent situation.

6.39 Shipman then stated that on 14th June 1985, at the request of Mr J's mother, he had arranged a private consultation with a consultant. In fact, he used the same (misleading) referral letter as before. The consultation took place on 20th June and, on that day, the

consultant notified Shipman that his diagnosis was that Mr J had bronchiectasis with minimal airway obstruction. The consultant prescribed a broad-spectrum antibiotic and advised Mr J to continue with the inhaler. A fuller letter from the consultant followed, dated 2nd July, recording complaints of breathlessness over seven years, with copious expectoration, worse during the winter months. The letter also mentioned the loss of two stone in weight. From the letter, it appears that, after the consultation, the consultant examined a chest x-ray (probably the one taken on 16th April) and thought that its appearance raised a diagnosis of pulmonary tuberculosis. Mr J was to be admitted for further investigation.

6.40 Shipman's response completed the history by reference to two hospital discharge letters. The first, dated 8th July, reported that Mr J's diagnosis remained unclear, although it was believed that he had a chronic bronchiectasis. His symptoms had improved while he was in hospital and he had been discharged home. However, Mr J had relapsed a few days after discharge and had been readmitted on 11th July. The second hospital discharge letter, written after Mr J's death, informed Shipman that Mr J had died of diffuse idiopathic pulmonary fibrosis. The letter showed that no firm diagnosis had been made until after a biopsy had been carried out.

6.41 Shipman's response included the suggestion that Mr J had been considered as a possible AIDS sufferer and implied that barrier nursing techniques had been put into effect for that reason. The inclusion of this reference to AIDS appears to me to be wholly unnecessary and can only have been designed to cause distress or offence. The discharge letter makes it plain that the tests for AIDS were negative. There is no reference to barrier nursing techniques in the discharge letter, and it appears from elsewhere in his response that Shipman himself believed that, if barrier nursing was in use, it was on account of the possibility of tuberculosis and not AIDS. In any event, barrier nursing was not used for patients with AIDS, even in 1985.

6.42 Finally, Shipman said that he had fulfilled his terms of service. He had examined Mr J on a number of occasions. He had arranged a chest x-ray, made a working diagnosis and given treatment; subsequently, when the patient had not improved, he had referred appropriately. He pointed out that the serious and terminal nature of Mr J's illness had not been apparent until his second admission to hospital. Shipman appended a description of diffuse idiopathic pulmonary fibrosis, the condition from which Mr J had died.

6.43 In response to Shipman's letter, Mrs J sent a lengthy reply, again drafted by Mr Rawlinson. For present purposes, I need only refer to a few points from it to make it clear that she felt that there were issues to be tried. She repeated that her son had consulted Shipman about his chest before 15th April and suggested that the MSC should obtain not only her son's clinical records, but also the surgery appointments sheets. She repeated that it was Shipman's opinion that her son's problems were 'all in his mind'; this had been a running joke between him and Mr Rawlinson. She drew attention to Shipman's claim that he had suspected tuberculosis in late May and yet had not requested an urgent appointment with the consultant. She noted the inaccuracy of Shipman's claim to the consultant that he had first seen Mr J in early May when, by his own account, he had first seen him on 15th April. She appended a report from the consultant, which outlined the history and the autopsy

findings and expressed the opinion that Mr J's idiopathic pulmonary fibrosis had developed over a few years. The consultant said that it was a very rare condition in the young; in his long career, he had never seen a case in one so young. He said that there was no satisfactory treatment for the condition, although steroids had been tried.

6.44 The Chairman of the MSC then considered all the available correspondence and gave his opinion that a hearing of the case was not necessary. He was not required to give reasons for that decision and it appears that he did not do so. Unfortunately, the full FPC file is no longer available and it has not been possible for the Inquiry to see what issues were drawn to the Chairman's attention. In particular, it is not clear whether or not any consideration was given to the fact that some of the allegations related to a period more than eight weeks before the lodging of the complaint or whether that fact influenced the decision reached.

6.45 At some time after that, but before the case came before the MSC for decision, Mr J's mother sent a further letter in which she said that it would be **'interesting'** to know what had happened to her son's medical records for the period September 1980 to April 1985 (about which period Shipman's response had been silent).

6.46 At the meeting of the MSC on 4th December 1985, the Committee comprised Mr Jack Millin (its acting chairman), Mrs Joyce Howarth, Mr Peter Jackson, Dr Thomas Cooksey, Dr Terry Hughes (who was not a medical doctor but an engineer), Dr Winston Jackson and Dr Dennis Milner. The minutes of the meeting record that three cases were considered, two (including that of Mr J) without an oral hearing and one after a full oral hearing. The minute of Mr J's case said that the MSC received the correspondence relating to the complaint, considered the case and resolved that a report be prepared for the FPC, recommending that the complaint be dismissed.

6.47 The report, which was drafted by Mr William Greenwood, then Assistant Administrator at the Tameside FPC, listed all the material before the Committee. At paragraph 17, the report stated that the Committee had had available the patient's medical records. It was recorded that after **'very careful'** consideration of all these items, the MSC had agreed with the previous decision of the Chairman of the MSC that a hearing of the case was not necessary. No reasons were given for that conclusion.

6.48 Mr Greenwood then accurately set out the test to be applied in considering the main complaint, saying that the MSC had to consider whether or not Shipman had exercised due skill and care in arriving at a diagnosis and whether he had placed himself in a position where he could reasonably exercise that skill. The report then recorded the findings of fact. The MSC recorded the periods for which Mr J had been Shipman's patient but made no reference to any consultations in 1984 or 1985, prior to 15th April 1985, despite Mrs J's insistence that he had consulted Shipman during this time. The report then set out a brief résumé of the history, taken, it was said, from the medical records. The account followed that given in Shipman's response. The conclusion was that there had been no unreasonable delay in Shipman's treatment of Mr J. There was no reference to Mr J's failure to improve with treatment or to his weight loss. Nor was it mentioned that Shipman had not asked for an urgent appointment although he apparently suspected tuberculosis. The Committee found that Shipman had exercised reasonable judgement; he had arranged an x-ray and had referred the patient for a consultant opinion. The Committee

plainly regarded the unusual nature of the condition and the difficulty of diagnosis as important factors. It was said that there was no mention in the notes that Shipman considered the illness to be psychosomatic in nature. The Committee concluded that there had been no breach of terms of service.

Evidence at the Inquiry

6.49 Mr Rawlinson gave evidence to the Inquiry. He said that he had been dissatisfied with the result of the complaint and thought that it should have been upheld. He agreed that, at the time, he had been very distressed about the death and very angry. He now realises that helping Mrs J to make her complaint was a means of venting his anger. He is an intelligent man and I think he recognises that he might not have been as objective at that time as he would normally be. He expressed his opinion, held at the time, that the MSC was a closed club, which would protect the doctors from criticism. He added that, on re-reading the papers at the time of the Inquiry, he still had the same impression.

6.50 Mr Rawlinson went through what he now remembered of the details of his friend's illness and confirmed the accuracy of what had been stated in the original complaint. He repeated his concern about Shipman's apparent unwillingness to take Mr J's condition seriously and the delay in obtaining a consultant's appointment and setting in train further investigations.

6.51 He was asked whether he was aware of the time limits that meant that, unless special permission had been given, the MSC would have been unable to look into matters that had occurred more than eight weeks before the date of the complaint. He said that he was not and he now thinks that he and Mrs J were not told about that rule. However, it is not possible to check whether he is right about that, as the only parts of the FPC file to have survived are those documents provided to the MSC.

6.52 Mr Rawlinson also expressed the view that Mrs J and he were not kept sufficiently abreast of what was going on. They did not know how the complaints procedure worked. They did not know what medical records were available and to what extent they were looked at. There was no attempt to clarify the issues; the process seemed to be: complaint – response – reply. They had expected that the MSC would itself investigate what had happened. Mr Rawlinson had made suggestions about the conduct of the investigation (including obtaining the surgery appointments sheets and Mr J's medical records) and had not realised that investigation was left to the parties. He felt it would have been valuable to have had an oral hearing. He also said that he did not know that it would have been possible to appeal against the MSC's decision. However, I think it is likely that he would have been made aware of that. I think it likely that Mrs J was advised of that at the time she was informed of the decision. That would be the usual procedure and I think it likely that Mr Greenwood would have followed it. It is not possible to check this point because part of the file is no longer available.

Evidence from Members of the Medical Service Committee

6.53 The Inquiry sought to find out why the Chairman of the MSC had decided not to hold an oral hearing and why the Committee sitting on 4th December had decided to ratify that

decision. The official report threw no light on those issues. The Inquiry also sought to discover more about the Committee's reasoning and the way in which it had handled the case.

6.54 It seems likely that the Chairman of the Tameside FPC, Mr Basil Sabine, who was also the Chairman of the MSC, probably took the initial decision not to order an oral hearing. Mr Sabine is now deceased. He was not able to attend the MSC meeting on 4th December and, in his absence, the meeting was chaired by Mr Millin (who was too unwell to provide evidence to the Inquiry). Of the other members of the MSC, the Inquiry was able to locate Mr Jackson, Mrs Howarth, Dr Jackson, Dr Milner and Dr Cooksey. All five provided witness statements; Mr Jackson and Dr Cooksey gave oral evidence.

6.55 Dr Cooksey said that there was usually an oral hearing if there were disputes of fact. In his written evidence, he said that, on reading this case, it appeared to him that the issues were clear and it would not have surprised him that the Chairman had decided not to hold an oral hearing. When giving oral evidence to the Inquiry, he accepted that there was an issue between the parties as to whether Shipman had seen Mr J with reference to his chest complaint before April 1985. He also appeared to accept that there was an issue about whether, if Shipman suspected that Mr J might have tuberculosis, it was reasonable to refer him to a consultant on a non-urgent basis. However, he said that he thought that the Committee had taken the view that, whatever had been done, it would not have made any difference to the outcome. This, he thought, might have had a bearing on its decision. If that were so, it would mean that the Committee had addressed its mind to the wrong question, as the test was whether what Shipman had done was reasonable, not whether reasonable treatment would have made any difference to the outcome. When asked about the degree of care with which the MSC had considered the non-oral cases (of which there were two on 4th December as well as an oral hearing), Dr Cooksey said that the MSC was 'supporting the decision of the Chairman who had decided that this was the right course of action'. He accepted that the main business of the day was the third case, which was to have an oral hearing. I feel bound to observe that I myself would have found it difficult, in one day's work (and it is not clear whether the Committee sat for the whole day or only half), to give **'very careful'** consideration to all the material and records in this case, another one like it and yet another in which there was to be an oral hearing, even if I had read the papers in advance.

6.56 Mr Jackson, a solicitor, was a lay member of the MSC. He said he did not know why the Chairman had decided in advance not to hold an oral hearing. However, he did say that the MSC would not look at allegations relating to events occurring more than eight weeks before the date of complaint, unless an application to extend time had been agreed or granted. He made the point that the Committee's report stated that there were no entries in the records showing that Shipman thought the problem was psychosomatic. That is so, but it was pointed out to him that the report did not deal with the question of whether there were any entries at all during the earlier period. Mr Jackson's response to that was that any consultations in the earlier period were 'out of time'. He also pointed out the difficulty of deciding the case on hearsay evidence. He explained that the mother would not have been able to give direct evidence of what Shipman had said; Shipman had denied saying that he had treated the condition as psychosomatic. However, hearsay evidence of what

a deceased person has been heard to say is often received; to refuse to hear it might cause real injustice. The weight to be attached to it must be carefully considered. If the records had contained entries in 1984 relating to a cough or shortness of breath, and if there was no sufficient record of examination and observations, the Committee might have inferred that the hearsay evidence was correct. There was no bar to receiving such evidence and, indeed, the DoH notes of guidance, to which I have already referred, specifically mentioned that hearsay evidence could be admitted, subject to warnings about the weight that should be attached to it.

6.57 Dr Jackson, one of the medical members, said in his statement to the Inquiry that he did not know why it had been decided not to hold an oral hearing. Most cases had one. He speculated that the decision might have been taken to avoid further distress for the mother. Dr Milner said in his witness statement that he was unable to say why the decision had been taken.

6.58 In her statement to the Inquiry, Mrs Howarth said that she could not remember the case but, from reading the papers, she thought there were several reasons why the MSC would have decided to ratify the previous decision not to hold an oral hearing and to dismiss the complaint. She thought that the evidence about what had happened at earlier consultations would have been regarded as hearsay. The notes contained no reference to Shipman's belief that the problem was psychosomatic. I have already commented on those points. She also thought that it appeared that there were no consultations during the earlier period (although, in fact, it is not clear whether there were or were not). She pointed out that it appeared that Mr J had been able to continue at work and therefore it was reasonable to infer that he had not been seriously ill until towards the end, when Shipman's actions, as recorded in the notes, were clear and seemed appropriate. She mentioned that the condition was very rare and difficult to diagnose. That may have been so but the question for the MSC was not whether Shipman should have diagnosed the condition but whether he had provided proper medical care on each occasion when he had seen the patient.

Observations

6.59 Given the incomplete information and material available to me, I cannot reach any conclusion as to whether this complaint was, in fact, properly handled. However, I am left with a number of concerns. I do not know whether Mrs J was advised about the time limits. In my view, she should have been so advised and told of the possibility of applying for leave to extend the scope of the complaint. It may be that she was advised and decided not to apply or that she applied and permission was not granted. It is possible that she applied, permission was granted and the complaint included the events of 1984. If so, the decision did not deal adequately with this earlier period. It seems to me that there should have been an oral hearing, even though some of the evidence would have been hearsay. There were clear conflicts of evidence about Shipman's attitude and his reluctance to refer Mr J to a consultant. If an oral hearing had been held, the Committee might have paid more attention to the allegation that Shipman claimed to have suspected tuberculosis in late May but did not seek an urgent appointment with the consultant. It appears that at least one member of the Committee (possibly more) regarded his role as one of supporting the

Chairman's decision. It may be that some members of the MSC did not understand the question they should have been asking and that they took into account irrelevant considerations.

6.60 Mrs J and Mr Rawlinson were dissatisfied with the process and the outcome and, so far as the process is concerned, this is understandable. In criticising the process, I am not criticising the individuals concerned. They were doing things in the usual way. But the process does not seem to have been designed to provide the complainant with an understanding of what had happened. There was no investigation of this complaint and no attempt to sort out the issues and see what evidence was required or available to deal with each issue. If someone had asked Mr Rawlinson what delay he was complaining about, he would have included his concern about the alleged inactivity during 1984 and early 1985. Someone would have had to explain that, under the rules, the MSC could not look into that unless leave was sought and granted. I would have expected it to be granted. Someone should have looked at the records and made plain in the decision what entries, if any, there were in 1984. If there were none, and Mrs J continued to say that her son had visited Shipman in that year, the surgery appointments sheets could surely have been obtained. At the end of the day, the whole question of whether Mr J consulted Shipman at all in 1984 was left in the air.

6.61 Mr Rawlinson also felt there was a lack of independence on the part of the MSC. At the time of this complaint, Shipman was secretary of the LMC and he had held that position since about 1981. As secretary, he was automatically a member of the FPC. In Tameside at that time (although this was not a requirement of the Regulations), all members of the MSC were also members of the FPC. Thus, Shipman was a colleague of all of the members of the FPC and the MSC, both lay and medical. Dr Cooksey said that he served on the LMC from the late 1960s until 1994 and was chairman from 1977 until 1983. During his term as chairman, he worked with Shipman as secretary. Dr Jackson said that he was chairman of the LMC for two years in the 1980s, although he was not sure whether he still held that position in December 1985. In view of the dates of Dr Cooksey's chairmanship, it seems entirely possible that Dr Jackson was indeed chairman of the LMC at the time of the hearing. Mr Greenwood told the Inquiry that he had thought it inappropriate that the conduct of a local GP should be reviewed by his/her local colleagues. I agree. It is not surprising that Mr Rawlinson felt that the MSC was a closed shop. Even if the members were scrupulously fair, there was no appearance of independence.

The Case of Mr W

6.62 In 1990, a complaint was made about Shipman's treatment of a patient whom I shall call Mr W. He was aged 39 and suffered from epilepsy. He also had learning difficulties although he lived an independent life. No doubt it was on account of those difficulties that the complaint was brought on his behalf by his sister, Mrs L. By letter dated 6th January 1990, Mrs L reported that her brother had been diagnosed with epilepsy and had been advised by a consultant at the local hospital in 1986 that he should take ten tablets a day of Epilim 200mg. It appears that Shipman had, in fact, always prescribed eight tablets a day but nothing turns on that point. On 14th November 1989, Shipman had issued a repeat prescription for Epilim but, instead of prescribing 200mg tablets, he had prescribed

500mg tablets, to be taken at the usual rate of eight per day. On 7th or 8th December, having consumed 76 of the 500mg tablets, apparently over a period of nine days, Mr W fell downstairs. Some days later, Mrs L found him in a very poorly state, sitting in a chair. It appears that he had become incontinent and had developed 'bedsores'. He and his partner, who also had learning difficulties, had been unable to summon help. He was admitted to hospital where he still remained three weeks later.

6.63 The complaint was directed to the Tameside FPC. In September 1990, the FPC's functions were transferred to the Tameside FHSA which continued to deal with the complaint. The Chairman of the MSC instructed the FPC to seek Shipman's response to the complaint. Shipman responded in July 1990. He admitted that he had made an error and said that he could not understand how it had happened; he had had Mr W's notes in front of him when writing the prescription. He thought perhaps he had been distracted. He drew attention to the failure of the dispensing pharmacist to notice the error. He reported that Mr W had now recovered from the episode and had been transferred to sheltered accommodation, which was more suited to his needs. He also explained that the practice had recently become fully computerised and that, in future, once the correct dosage had been entered, errors of this type should not occur, as the repeat prescription would be prepared from data within the system.

6.64 Shipman's response was sent to Mrs L's solicitor who replied, challenging various aspects of Shipman's response, although none of the areas of dispute was material to the determination of the complaint. Although, initially, the Chairman of the MSC was of the view that there would have to be an oral hearing, in the end it was agreed that this would not be necessary. On 12th December 1990, the case was dealt with at a meeting of the MSC which was not attended by either party. Inevitably, Shipman was found to be in breach of paragraph 13 of the terms of service. The report of the hearing concluded with a recommendation that Shipman should be warned to comply with his terms of service more closely in the future but there was no recommendation for a withholding of remuneration. This was the first time that Shipman had been found in breach of his terms of service. This finding and recommendation were accepted by the FHSA. Shipman did not appeal against the finding or the warning. The SoS was notified and endorsed the steps taken by the FHSA. Shipman was notified to this effect on 20th March 1991. The case was not reported to the GMC.

6.65 I make only two comments about this very simple case. First, it took almost a year to bring the matter to a conclusion. That is longer than is desirable. Second, it shows how, if steps have to be taken to discipline a doctor, an adversarial system that focusses on standards that have to be met by a doctor has the potential to provide a suitable means of discovering the facts on which disciplinary action is to be based.

6.66 In view of Mr Rawlinson's complaint that, in 1985, the MSC seemed to be a closed shop, I have considered the degree of independence of the MSC from Shipman in 1990. I note that, in the letters informing the members of the Committee of the date on which the complaint would be dealt with, members were warned to consider whether they ought to disqualify themselves. They were told not to sit if they had an interest in the question to be determined or had some association with any of the parties. The letter advised that

'personal friendship or close business or social relations would disqualify but not – by themselves – mere acquaintance or official contacts'. In 1990, Shipman was no longer secretary of the LMC; he had resigned in 1988. He was no longer a member of the FPC which had, in any event, been replaced by the FHSA. However, he had been secretary of the LMC and on the FPC for about seven years and he must have been well known to many current members of the FHSA and MSC. Major Robin Tarr, a member of the MSC which heard the complaint in respect of Mr W, said that he knew Shipman from the FPC and that, when they first met, Shipman had invited him to look round the Donneybrook practice, to see how a general practice worked. He had found the visit very useful. He said that his acquaintance with Shipman had not affected his decision in the case. Mr Jackson, who chaired the MSC, said that Shipman had a good reputation in the area and was not regarded as careless. He had known Shipman through sitting on another FPC committee of which they were both members and, although he regarded him as a bit of a maverick, he and other lay committee members had been impressed by him.

6.67 In the light of the advice they were given, I do not criticise the members of the MSC who decided not to disqualify themselves. However, I think that, in the interests of ensuring that justice was done and seen to be done, it would have been preferable if there had been a policy that, when a GP member (or recent former member) of the FPC/FHSA was due to come before the MSC, the case should be transferred to the MSC of a neighbouring FPC/FHSA. Indeed, one might go further and say that it would be preferable that any disciplinary action against a GP should be determined by people from another district who have no personal knowledge of him/her. Such a policy would avoid the danger that any dissatisfaction on the part of a disappointed complainant might focus on the lack of impartiality of the tribunal. In this case, the complainant might have taken the view that the penalty was too lenient.

The Case of Mrs B

6.68 On 4th March 1992, Mr B made a complaint in respect of medical services provided to his wife on Wednesday, 26th February 1992. Mrs B was an elderly woman and a patient of Dr Jeffery Moysey, a colleague of Shipman at the Donneybrook practice. Dr Moysey and Shipman had an arrangement whereby they covered for each other on half days. On Wednesdays, Dr Moysey worked until about 10.30am, after which time Shipman covered for him.

6.69 In the letter of complaint, Mr B said that his wife had been ill on Sunday, 23rd February. Dr Moysey had visited on the Monday and had diagnosed a stroke. He had promised to call back 'in a couple of days'. He had also promised to arrange for a consultant domiciliary visit and for district nurses to attend. A nurse had attended on 24th, 25th and 26th February. On Wednesday, 26th February, Mrs B's condition had worsened and the family had expected a visit from Dr Moysey. When he had not arrived by midday, her son (Mr B's stepson) had telephoned the surgery to ask for a visit. He had told the receptionist that Mrs B's condition was worse; he was to say at the MSC hearing that he thought she had had another stroke. The receptionist had said that it was Dr Moysey's half day but that Shipman was covering for him, and that a message would be passed to him as soon as he came in. A short while later, the receptionist had telephoned Mrs B's home and told

Mrs B's son that Shipman had returned but had said that it was not necessary to visit, as Dr Moysey had seen Mrs B two days before. Mrs B's son had repeated his request for a visit, stressing (as he was to say at the hearing) that his mother's condition had deteriorated. He also was to say at the hearing that he had mentioned that she was a heavy woman and was incontinent and that they were having difficulty in lifting her. The receptionist went to speak to Shipman again but reported to Mrs B's son that he refused to come out as it would not be right for him to 'go over' Dr Moysey's decision that there was no need for Mrs B to be admitted to hospital. A while later, the family had called an ambulance and Mrs B was taken to hospital.

6.70 Shipman's response to the complaint was robust. He agreed that he had been deputising for Dr Moysey on the day in question and that he had received a request to visit Mrs B. However, he said that he had made a careful note of the request and the action he took. He enclosed a copy of the note, said to have been made at the time, which read:

> **'Telephone message request for visit.**
>
> **Seen JOM** (*Dr Moysey*) **23.2 92 CVA**
>
> **Domiciliary Arranged**
>
> **Dr Moysey to visit 48 hours ? today**
>
> **Visit because husband unable to cope as elderly**
>
> **NO worse than seen by Dr Moysey**
>
> **Visit arranged for mane** (*the next morning*)
>
> **For Dr Moysey to reassess'**.

6.71 Shipman asserted that he had not been told that Mrs B's condition had deteriorated. In his view, the complaint had arisen because there had been a misunderstanding about when Dr Moysey would revisit. He denied that he was in breach of his terms of service.

6.72 Dr Moysey's response, so far as is relevant for present purposes, was that, when visiting on 24th February, he had found that Mrs B had had a slight stroke from which she appeared to be recovering. He had made suitable arrangements for her care at home. He had not made any definite arrangement to revisit but had said he would call later in the week. On the Thursday after his half day, one of the receptionists had informed him that Mrs B had been taken into hospital and that there was no need to visit her at home. He denied that he was in breach of his terms of service.

6.73 After some initial clarification of the issues, the complaint was transferred to the MSC of the Manchester FHSA because Dr Moysey was a member of the Tameside MSC. A hearing was ordered and took place on 8th September 1993. Both doctors were alleged to be in breach of paragraph 13 of their terms of service. Mr B was represented by the secretary of the Tameside and Glossop CHC.

6.74 Mr B gave evidence and expanded upon his written complaint. In particular, he provided a clear description of the deterioration in his wife's condition that had occurred on the morning of 26th February. He also explained how it was that the family had not telephoned

the surgery until shortly after noon. They had been expecting Dr Moysey to attend; he had said he would call 'in a couple of days'. Mr S, Mrs B's son, also gave evidence and provided more detail of the conversations he had had with the receptionist on 26th February. He asserted that his mother's condition had deteriorated that day and that he had explained that to the receptionist. He said that the receptionist had reported back that Shipman would not come out because Dr Moysey had seen Mrs B two days earlier and it would not be right to 'go over' his opinion that she did not need to be admitted to hospital.

6.75 Dr Moysey gave evidence. He confirmed his written statement. He gave a very full account of his examination of Mrs B and the reasons why he had decided on the Monday that Mrs B should remain at home. He explained the arrangements he had made and his plans for her future management. He described the arrangement he had with Shipman and said that he had never sought to restrict the way in which Shipman treated his (Dr Moysey's) patients.

6.76 Shipman gave evidence. He confirmed his written statement and said that he could not remember the incident at all. He was dependent upon the note he had made. He said that he had not spoken directly to Mr S because the reception staff were very experienced; he had felt he could rely on the receptionist to report accurately what had been said. He said that it was his usual practice to ask the receptionist to find out whether or not there had been any deterioration in a patient's condition. He said that, according to what he had heard from the receptionist, there had been no deterioration in Mrs B's condition. He suggested that the receptionist might have 'overstepped the mark and misinterpreted' the family's request for a visit and said that he would accept responsibility for that. He said that he had not been able to ask the receptionist to attend the hearing because he had been unable to identify which receptionist had taken the message and, in any event, once the message was passed to the doctor, it became his responsibility. He had not produced the practice visits book, in which requests for visits were recorded, and said that he was not sure whether it was still available, 18 months after the event. He was unable to explain why the receptionist should have quoted medical ethics to Mr S. He agreed that, if a relative said there was a deterioration in the patient's condition, the doctor should visit. He said that he believed he had put himself in a position to make a clinical judgement but agreed that, if the evidence of the family was to be believed, he had not done so. He declined to make a closing submission.

6.77 The MSC found that Dr Moysey was not in breach of his terms of service. In the case of Shipman, they preferred the evidence of Mr B and Mr S to that of Shipman. The MSC noted Shipman's failure to produce the visits book (which they thought should have been kept safe as soon as the complaint was received) or to call the receptionist to give evidence before the MSC. The MSC found that Shipman had twice refused to attend Mrs B on 26th February and, before doing so, had not placed himself in a position to make a proper professional judgement. He was in breach of paragraph 13 of his terms of service. After hearing about the previous breach in the case of Mr W, in 1989, the MSC recommended that £800 remuneration should be withheld and that Shipman should be warned to comply more closely with his terms of service in future.

6.78 In its decision, the Committee mentioned Shipman's written note in connection with Mrs B (which by implication they had found was not accurate) but did not comment on whether

it might be deliberately misleading, as opposed to genuinely mistaken. Shipman had claimed that he had made the note contemporaneously. It stated unequivocally that there had been no deterioration. With the benefit of hindsight, it is clear that Shipman had done, in this case, what he is now known to have done in many cases; he had made a false and self-serving record. At first, it seemed to me that the MSC must have regarded the note as false. However, on further reflection, it appears likely that it might have thought that Shipman genuinely misheard or misunderstood what the receptionist said to him and that the fault on his part was not to speak either to Dr Moysey, to ascertain whether he intended to visit later that day, or to Mr S directly, so as to put himself in a position to make a judgement as to the need for a visit. In other words, it seems that the Committee did not necessarily find him guilty of a deliberate refusal to visit or of a deliberate fabrication of a false note.

6.79 Mrs Elsie Gilliland, the Chairman of the MSC, who presided at the hearing, remembered that her view was that Shipman had made no attempt to assess the patient. She said that the Committee had been sceptical of Shipman's failure to call the receptionist or to produce the visits book, and thought his excuses for not doing so were not very satisfactory. She also said that members of the Committee were conscious of the possibility that Shipman had looked at the visits book and knew that it did not support his case. She could not go so far as to say that she thought he was being dishonest. I can well understand her thought processes.

6.80 The recommendations of the Manchester MSC were accepted by the Tameside FHSA. Shipman did not appeal against the finding or the penalty. On 22nd October 1993, notice of the result was sent to the FHSAU and, on 26th May 1994, the penalty was confirmed by the Chief Executive on behalf of the SoS. In accordance with the powers, conferred by the National Health Service (Service Committees and Tribunal) Regulations 1992, that I mentioned earlier in this Chapter, the case of Mrs B was sent to the GMC, together with the papers in the case of Mr W.

6.81 The GMC papers show that the GMC decided to take no action. It was of the view that the case of Mr W was too old to reopen and that the case of Mrs B would be difficult to investigate because Shipman had not made an admission. The GMC seems to have thought that it would not be possible to make a finding as to Shipman's conduct, despite the fact that the MSC had been able to do so. The view was that the case demonstrated only poor performance rather than serious professional misconduct. I shall deal in detail with the GMC's handling of this case in Chapter 19.

6.82 I note that the proceedings took 18 months to be brought to a hearing. No doubt some of this delay was due to the need to transfer the case from Tameside to Manchester. But, even so, the delay was far too long. This case is a good example of the weakness of the MSC system, in which the Committee had no power to call for documents or summon witnesses. The system did not provide for an independent investigation of the facts but left the parties to carry out their own investigation, to the extent that they were either willing or able to do so. In this case, an independent investigator would have been able to take possession of the visits book, which was likely to have contained the best contemporaneous record of what Mr S had said to the receptionist. Also, such an

investigator would have been able to identify the receptionist. It is inconceivable that the receptionists would not have recognised the writing in the visits book.

6.83 In the event, I am confident that the MSC reached the right conclusion. However, it did not, for understandable reasons, detect that Shipman had made a false record in an attempt to pass off his own shortcoming as a misunderstanding by the receptionist or between him and the receptionist. Had all the evidence been available, greater insight into Shipman's conduct would have been gained.

Observations on the Three Complaints

6.84 Bearing in mind that Shipman was an established serial killer of his patients, it seems remarkable that such complaints as were made about him in the years between 1977 and 1996 were not of a more serious nature. No complaint was received about his treatment or failure to treat any patient whom he had in fact killed. Even if they had been investigated in great detail, the three complaints that I have just described would not have thrown any light on Shipman's true character as a murderer. With the benefit of my knowledge of Shipman's habitual dishonesty, I have detected signs of dishonest behaviour in the cases of Mr J and Mrs B. However, such signs were by no means obvious and it is not surprising that they were not detected at the time.

6.85 The only case of which I am aware which could have led to a complaint that might have resulted in the detection of Shipman's true nature was that of Mrs Renate Overton. Shipman injected her with an overdose of diamorphine in February 1994 but she survived, in a persistent vegetative state, until April 1995. As I have already recorded in the First and Third Reports and as I shall mention again in Chapter 10 of this Report, the medical staff at Tameside General Hospital were aware that Shipman had administered a dangerous dose of opiate. It was not suspected that he had acted deliberately. Mrs Overton's family was alerted to the possibility that Shipman had been negligent. However, no complaint was made.

6.86 The handling of the three complaints illustrates some of the shortcomings of the system in operation during the years before 1996. First, they show that, at least where there was to be an oral hearing, there might well be unacceptable delay. Second, the case of Mr J illustrates the difficulties that could arise from the imposition of time limits. Third, the cases illustrate the problems which could occur when it was left to the parties to investigate and prepare the case and to decide what evidence should be presented. Doctors had the benefit of assistance from skilled advisers from their medical defence organisation but complainants did not. They might have the advice of a representative of the CHC but, if not, they would be seriously disadvantaged. Even with such advice, a complainant might well feel disadvantaged in presenting the case. More serious than that was the complainant's lack of resources of investigation. Mrs J suggested the production of documents that might help her to prove her case but had neither the power nor the resources to obtain them. Finally, the case of Mrs J and Mr W illustrate the problems that can arise where the composition of the committee does not give the appearance of complete impartiality.

6.87 As I shall explain, it was not only complainants who felt a degree of dissatisfaction with the pre-1996 procedures. Many doctors found the proceedings very stressful, particularly as they were disciplinary proceedings which might well result in punishment or even referral to the GMC. It is possible that Shipman found them stressful and it does appear that, during the currency of the cases of Mr J and Mr W, Shipman reduced the frequency with which he killed patients. In the 12 months before September 1985 when he was notified of the complaint against him in the case of Mr J, Shipman killed 13 patients and I suspect him of killing a further five. He did not kill at all during the four months between notification and the conclusion of the case on 4th December 1985. In the following month, between 17th December 1985 and 7th January 1986, he killed four patients. Similarly, in connection with the case of Mr W, Shipman killed only one patient during the period of about ten months of the currency of the proceedings. He killed again very soon after they had been concluded. The proceedings in the case of Mrs B were very protracted. In the remaining nine months of 1992 after notification of the complaint, Shipman killed only one patient. However, in the first eight months of 1993, before the hearing in September, Shipman killed 13 patients and I suspect him in respect of another.

6.88 I do not know whether this change in the pattern of Shipman's killing was in any way related to the currency of disciplinary proceedings. I mention the possibility because, in my First Report, I suggested other possible reasons for the variations in the rate of killings. The Inquiry had not then fully investigated the complaints against Shipman and I had not appreciated that the proceedings might have had a deterrent effect.

Recognition of the Need for Change

6.89 In considering these three complaints, I have drawn attention to a number of shortcomings in the MSC system. These shortcomings are typical of the kind of criticism that was being widely expressed about the complaints system in the early 1990s. In June 1993, the SoS appointed an Independent Review Committee under the chairmanship of Professor (later Sir) Alan Wilson, Vice-Chancellor of Leeds University. Its Terms of Reference were:

> **'To review the procedures for the making and handling of complaints by NHS patients and their families in the United Kingdom, and the costs and benefits of alternatives to current procedures, and to make recommendations to the Secretary of State for Health and other health ministers.'**

6.90 The Wilson Report, entitled 'Being Heard', was published in May 1994. It said that the existing arrangements for handling complaints were too complex, too lengthy and too confrontational. MSC reports often failed to give a satisfactory explanation of the decision reached. The requirement that a complaint must constitute a breach of the terms of service was too restrictive. The system appeared to be biased in favour of the GP. The time bars were too technical and restrictive.

6.91 The Report recommended radical changes. The Government invited reactions to and comments upon the Wilson Report before issuing its own response, entitled 'Acting on Complaints', in March 1995. Public response was largely favourable and the Government

accepted virtually all the recommendations of the Wilson Report. It proposed new procedures which were to come into force on 1st April 1996. I shall describe the recommendations of the Wilson Report and the Government's proposals for change in the next Chapter.