CHAPTER NINE

Raising Concerns: the Role of the Practice Staff

Introduction

9.1 General practices are focal points for the provision of primary medical care. That care may be provided by general practitioners (GPs) as well as by a range of other healthcare professionals including midwives, health visitors, counsellors, district nurses and practice nurses. These other healthcare professionals will typically be employed by a primary care trust (PCT) or other healthcare trust or, in the case of a practice nurse, by the practice itself. In addition, there will be practice managers and administrative/clerical staff, in general employed direct by the practice, whose task it is to organise and manage the smooth running of the practice.

9.2 In this Chapter, I shall first examine the staffing arrangements in Shipman's practice at 21 Market Street, together with the extent to which his staff were, or should have been, aware of or alerted to his criminal activities. I shall then go on to consider the channels of communication open to staff for the purpose of reporting any concerns they may have about members of the practice in which they work or about other healthcare professionals employed there.

The Staff of the Market Street Surgery

9.3 When it first became known that Shipman was under investigation for forgery and murder, the staff employed at his surgery – like many of his patients – remained loyal to him. At that time, they believed that Shipman was the victim of a terrible mistake. With the widening of the police investigation and Shipman's subsequent arrest, the surgery became the focus of public attention. A locum was appointed and the practice and its staff continued to function. However, public anger mounted, particularly after Shipman's conviction for murder in January 2000. Strangers visited the surgery and abused the staff. The windows of the surgery were broken and the practice received hundreds of abusive telephone calls after the surgery telephone number appeared in at least one national newspaper. Even when away from work, members of staff were liable to be recognised and subjected to ostracism, harassment and abuse. Underlying all these events appeared to be a general assumption that those who worked at Shipman's surgery must have known that Shipman was killing his patients.

9.4 If the surgery staff had indeed been aware of what Shipman was doing and, for some reason, chose to remain silent and to allow his criminal activities to continue, that would plainly be a very serious matter. If, on the other hand, the staff were completely unaware of what was happening, it is important for their sake that this is stated clearly and unequivocally. Even if the evidence shows that staff did not know of Shipman's criminal activities, the question still arises whether, given the information available to them, they should at least have realised that something was amiss and taken action to bring it to the attention of the appropriate authorities. With these issues in mind, the Inquiry has examined the information available to individual members of staff at the time and their state of knowledge over the relevant period.

The Members of Staff

9.5 At the time of his move to the Market Street Surgery in August 1992, Shipman took with him three members of staff from the Donneybrook practice. They were Mrs Judith Cocker (receptionist), Mrs Alison Massey (receptionist) and Sister Gillian Morgan (practice nurse). He recruited Mrs Carol Chapman, one of his patients, as an additional receptionist. Mrs Margaret Walker (computer operator), who had also worked at the Donneybrook practice for a short time, joined the Market Street Surgery in August 1993 when the new computer was installed. All those members of staff remained in employment at the Market Street Surgery up to the time of Shipman's arrest in September 1998 and beyond.

9.6 Other staff were employed at the surgery for part of the period in question. Mrs Lee Leech worked there between September 1993 and June 1994, mainly entering patient histories onto the new computer. She also worked as a part-time receptionist for approximately six months in 1995 in the absence, first of Mrs Chapman, and then of Mrs Massey. Mrs Jayne Kenyon was employed as a receptionist from the beginning of 1995 until August 1996. After Mrs Kenyon's departure, Shipman's wife, Mrs Primrose Shipman, worked as a part-time receptionist at the practice, covering staff holidays and sickness and some Saturday mornings until the time of Shipman's arrest. Ms Susan Elliot deputised for Sister Morgan while the latter was on maternity leave in 1995.

9.7 There were also a number of other professionals who were attached to the surgery. Mrs Alison Worthington, a health visitor, was based at the premises from 1995 and had an office upstairs. She spent short periods of time there each day. She had little to do with the practice, save that she held a weekly vaccinations clinic for babies there. Mr Colton Reid, a counsellor, held sessions at the surgery for about ten hours a week until some time in 1995. His wife, Mrs Madeleine Reid, a midwife, ran an antenatal clinic at the surgery once a week throughout Shipman's time there.

9.8 Mrs Chapman, Mrs Cocker, Mrs Leech, Mrs Kenyon, Mrs Massey and Sister Morgan gave oral evidence during the Phase Two, Stage Four hearings. Mrs Shipman had given evidence during Phase One. Mrs Walker, Ms Elliot, Mrs Worthington and Mr and Mrs Reid provided statements to the Inquiry.

9.9 It is necessary to consider the evidence relating to the various members or groups of members of staff separately, since the nature and extent of their respective knowledge about deaths of patients differed according to their individual roles.

The Reception Staff

9.10 Between them, Mrs Chapman and Mrs Cocker provided full-time cover for the reception desk. They had an arrangement whereby each would work mornings (8am until 1pm) one week and afternoons (1pm until about 6pm) the next. A third receptionist was on duty from about 10am until approximately 2pm. Until the end of 1994, this was usually Mrs Massey. From the beginning of 1995 until August 1996, Mrs Kenyon worked this shift. Meanwhile, Mrs Massey's duties changed somewhat and her hours were extended. She was then based for part of her time in an upstairs office, although she continued to assist at the reception desk as and when necessary. The receptionists worked Saturday mornings on

a rota system although, towards the end of Shipman's time at the surgery, Mrs Shipman covered most Saturday mornings.

9.11 The reception staff were responsible for answering the telephone, booking appointments for patients with Shipman, Sister Morgan and Mrs Reid, arranging for Shipman to visit patients at home and recording requests for repeat and acute prescriptions. They also liaised with other agencies, such as hospitals, Social Services and the ambulance service. They would type letters and file such items as consultants' letters and test results in patients' medical records. Once the medical records became computerised in 1993, the receptionists were responsible for entering information (which had been previously identified by Shipman) from such items onto the computer record before filing them. From 1997, Mrs Chapman had the title of 'building manager' and was responsible for such matters as arranging any maintenance work which Shipman decided was necessary. Mrs Cocker's special responsibility was to keep records of visits made by the deputising service and of out of hours visits made by Shipman. In 1997, her title changed to that of 'senior receptionist'.

9.12 Members of staff told the Inquiry that, during the working day, the staff were kept very busy, dealing with patients and with various other duties. The main opportunity for social contact occurred at lunchtime when members of staff tended to congregate at the reception desk to eat their meals. Even then, patients sometimes came in and the telephone might ring. The receptionist who was working the afternoon shift would often arrive a little early so as to eat her meal with other members of staff. Messages would be passed and news exchanged. Sometimes, Shipman would join his staff for lunch before leaving for his visits.

9.13 When a patient died and Shipman certified the cause of death, he would complete the Medical Certificate of Cause of Death (MCCD) and place it in an envelope. He would then hand it to the reception staff who would keep it in a designated place at the reception desk until someone – usually a member or members of the patient's family – came to collect it. When members of a deceased patient's family came to collect the MCCD, the reception staff would offer their condolences. If the relatives were upset, the receptionists would attempt to arrange for them to see Shipman. After a death, the reception staff would take out the patient's medical records and enter on the computer record the fact that the death had occurred. They would then place the medical records in a box ready for delivery to the West Pennine Health Authority (WPHA) (formerly Tameside Family Health Services Authority (FHSA)). Also in the box would be the medical records of patients who had left the practice for other reasons. When the box became full, Mrs Chapman would deliver the box to the WPHA's Hyde office, which was on her way home. She estimated that this happened about once every six or eight weeks.

9.14 When a patient died in the community, the practice might be informed of the death in the first instance by a relative of the patient, by the staff of the residential home in which the patient had lived, by the deputising service (if the death occurred out of hours) or by the police or a coroner's officer. News of a death would usually be communicated to the reception staff. Sometimes, Shipman himself would tell them, when he returned from his visits, that a patient had died. On some occasions, he would ring from a patient's home

to say that the patient had died. At times, the first the reception staff would know of a death would be when Shipman handed them the MCCD for collection by the patient's relatives. News of deaths which had occurred would be passed from one receptionist to another as they went on and off duty. Both Mrs Chapman and Mrs Cocker accepted in evidence that they would have come to know about the vast majority (if not all) of the deaths of Shipman's patients which had occurred in the community within a short time of the death. By contrast, they would not necessarily be told of a death which had occurred in hospital until some time after it had occurred. If the relatives did not inform the practice of a death in hospital, the first intimation would be when formal notification was received from the hospital some time later.

9.15 The receptionists would receive requests from patients for Shipman to visit. They would record such requests in the practice visits book and, latterly, also on a visit request form. When a request for a visit was received, the receptionist taking the message would also get out the patient's medical records and put them in a designated place ready for collection by Shipman. When the visit request forms came into use, they would be wrapped around the records. On his return from a visit, Shipman would usually enter a note of the visit in the computer record, then give the medical records back to the reception staff. He would inform them of any patients he intended to visit again and of the period within which the further visit was to be made. A member of staff would then enter the patient's name and the word 'revisit' in the visits book for the appropriate date. The medical records for those patients to be revisited and for any other pre-booked visits for that day were taken out and put ready for collection first thing each morning.

9.16 A receptionist working the morning shift would therefore be aware of most of the visits to be made by Shipman that day. She might not know about visits arranged by the colleague who worked with her for part of the morning shift. Nor would she generally be on duty when Shipman returned to the surgery after making his visits. The receptionist on the afternoon shift would not necessarily know which patients Shipman was due to visit. Mrs Chapman said that she would usually look to see where he was going and at what time he was likely to return to the surgery. Mrs Cocker said that she would do this sometimes, but not always.

Mrs Carol Chapman

9.17 Mrs Chapman left school at 15 and underwent no formal vocational training of any kind. She had various jobs, all of an administrative/clerical type. Before beginning work at the Market Street Surgery in 1992, she had no previous experience of work in a medical setting. It is of significance that Mrs Chapman's husband had died suddenly of a heart attack at the age of 34. He had had no history of heart problems. The experience of that death had made Mrs Chapman only too well aware that death can occur suddenly and without warning.

9.18 A most remarkable and distressing feature of Mrs Chapman's recruitment to the Market Street Surgery is that, by the time Shipman invited her to work for him, he had already killed her aunt, Mrs Mary Winterbottom (in September 1984), and her mother, Mrs Nellie Bardsley (in December 1987). Shipman had claimed to have found Mrs Winterbottom dead and he had told the family that Mrs Bardsley had died in his presence while he was

telephoning for an ambulance. Mrs Chapman told the Inquiry that she had had no suspicions whatever about these deaths. Indeed, if she had harboured any suspicions, it is inconceivable that she would have agreed to work for Shipman.

9.19 Mrs Chapman and other members of the practice staff were questioned in detail by Leading Counsel to the Inquiry about the deaths of Shipman's patients. In particular, they were asked about:

- the number of deaths which occurred, particularly deaths in the community
- the fact that clusters of deaths occurred from time to time. Sometimes, two deaths occurred on one day; on other occasions, several deaths occurred within a short period.
- the fact that five deaths had occurred at the surgery premises over a period of three and a half years
- the fact that it was not unusual for deaths to be discovered shortly after Shipman had visited, or apparently by Shipman himself when he arrived at a patient's house. Nor was it unusual for Shipman to be present when a patient died.
- the fact that many of the deaths occurred suddenly in patients who had previously appeared to be reasonably fit and active.

9.20 Mrs Chapman was adamant that she had not thought there was anything odd or unusual about any of these features. She knew that many of Shipman's patients were elderly and ill and, if a death occurred, she would assume that the patient had been more unwell than she had thought. Even when she heard of the death of a younger, fitter person, the experience of her husband's death caused her to accept it as something that happened from time to time. She said that she accepted events as they occurred. She did not attempt to analyse the circumstances of each death, nor did she detect that any patterns were emerging. Until 1998, she was not aware that the number of deaths in the practice was in any way abnormal. She did not believe that she had seen the practice newsletter of March 1997, which recorded the occurrence of 63 deaths over the previous 12 months. However, she said that it would not have surprised her if she had. Mrs Chapman told the Inquiry that she was aware that Shipman would sometimes visit patients without an appointment if he was not too busy, just to see how they were. She did not think that he did this frequently, nor did she find it in any way unusual.

9.21 Mrs Chapman was on duty at the time of three of the five deaths which occurred on the surgery premises, those of Miss Joan Harding (on 4th January 1994), Mrs Dora Ashton (on 26th September 1995) and Mrs Ivy Lomas (on 29th May 1997). I have found that Shipman killed all three. Mrs Chapman said that Miss Harding looked poorly on the day of her death. She was not suspicious about her sudden death. In the case of the second death, Shipman told her that Mrs Ashton was not well and that he wanted her to go to hospital but she was refusing to do so. He asked Mrs Chapman to telephone Mrs Ashton's son and get him to try to persuade her. Mrs Chapman did this and went into the examination room to tell Mrs Ashton. She found her dead. She then went to tell Shipman the news and got the impression, when she did so, that he already knew. She was distressed at the death as

Mrs Ashton had been a friend of her mother. She did not reflect on Shipman's apparent knowledge of the death until after he had come under suspicion. On the third occasion, Shipman called Mrs Chapman into his consulting room and told her that Mrs Lomas had died. Mrs Chapman then attempted to make contact with Mrs Lomas' son and, having failed to do so, called the police. The police officer who attended raised no concerns about the death. Mrs Chapman told the Inquiry that she saw nothing unusual or suspicious in the fact that these deaths occurred on the surgery premises. She assumed that it was something that happened from time to time.

9.22 Mrs Chapman was asked about a comment which she had written on an internal practice document in late January 1996. Mrs Massey had been preparing a new job description for Mrs Chapman. She had given the draft job description to Mrs Chapman for her comments on the list of duties which should be included in the document. Mrs Chapman wrote on the top of the document:

> **'Can't think of anything else except finding dead bodies in examination rooms.'**

The comment plainly referred to the death of Mrs Ashton whom, as I have said, Mrs Chapman had found dead in the examination room three months previously. In a written statement to the Inquiry, Mrs Chapman said that the comment was an example of the **'black sense of humour within the surgery'**. In oral evidence, she said that it was 'just our (*i.e. the staff's*) way of dealing with things'. She said that the comment might have appeared flippant, but that 'you have to deal with things like deaths in a surgery'. She suggested that she might have felt particularly 'down' at the time she wrote the comment. She did not think that, when writing it, she had in her mind that there was anything 'funny' (in the sense of 'odd') about the death. I accept that evidence and indeed, I do not believe that, if Mrs Chapman had had any real suspicions about Mrs Ashton's death at the time, she would have written the comment in the way she did, especially since Mrs Ashton had been a friend of her mother.

9.23 There were other deaths which had a particular significance for Mrs Chapman. Mrs Elsie Hannible, who was Mrs Chapman's aunt, died in July 1996. I have found that Shipman killed her. Shipman informed Mrs Chapman of the death on his return to the surgery that day, although it was some time later (probably at Mrs Hannible's funeral) that Mrs Chapman learned that he had been present at the death. Far from finding that odd, she says that by that time she was beginning to think that it was the norm. Mrs Irene Chapman, Mrs Carol Chapman's mother-in-law, died on 7th March 1998. I have found that Shipman killed her. Shipman told Mrs Chapman that he had visited her mother-in-law and found her unwell. When he returned later in the day, it was to find her dead. Neither the death of Mrs Hannible nor that of Mrs Irene Chapman excited Mrs Carol Chapman's suspicions.

9.24 The death of Mrs Mavis Pickup, on 22nd September 1997, shocked and upset Mrs Chapman. I have found that Shipman killed Mrs Pickup. Mrs Chapman had spoken to Mrs Pickup a few hours before her death, when Mrs Pickup had been distressed, but not apparently ill. When Shipman told her of Mrs Pickup's death, Mrs Chapman expressed surprise and observed that, when she had spoken to Mrs Pickup, 'she was only crying'.

She told the Inquiry that she was seeking a medical explanation from Shipman for what had happened. She did not consider the possibility that Shipman might have been involved in the death. Mrs Chapman was also very shocked to hear of the death of Miss Maureen Ward (who was only 57) on 18th February 1998. Shipman was convicted of Miss Ward's murder. Mrs Chapman had seen Miss Ward at the surgery the day before her death and exchanged a joke with her. When Shipman told Mrs Chapman of the death, she was annoyed and turned her back on him. She told the Inquiry that she was angry with Shipman, not because she suspected him of being responsible for the death, but because he had been the bearer of the bad news. She was angry that Miss Ward had died at a time when, as I have explained in Chapter 8, she had so much to live for. Mrs Chapman's annoyance with Shipman deepened when he gave one version of the circumstances of his involvement in the aftermath of Miss Ward's death to her and another to other members of staff. When Mrs Chapman pointed this out, Shipman suggested that it was she who was in error. She believed the error was his. Despite her annoyance, however, she put the difference down to confusion or misunderstanding and it did not arouse her suspicions.

Mrs Judith Cocker

9.25 Mrs Cocker left school at the age of 16 or 17. She underwent no formal vocational training. Subsequently, she worked in various capacities, mainly of a clerical and secretarial nature. In about September 1988, she obtained part-time employment as a receptionist with the Donneybrook practice. There, she was one of six or seven receptionists, working for seven doctors. She carried out general reception duties. Mrs Cocker said that, while at the Donneybrook practice, she became aware on occasion that a death had occurred. However, she got no impression of the frequency with which this happened, or of the circumstances in which deaths took place. She had a general impression that most deaths occurred in hospital, rather than at home. She did not specifically remember the deaths of any of Shipman's patients during that period.

9.26 Once at the Market Street Surgery, Mrs Cocker – like Mrs Chapman – says she accepted events as they occurred. The number and pattern of deaths did not strike her as abnormal or in any way suspicious. Over the years, the proportion of deaths occurring in hospital decreased. However, Mrs Cocker says it never occurred to her that an abnormal number of patients were dying at home. She was aware from what she was told by patients, and by Shipman himself, that many elderly people did not wish to be admitted to hospital but preferred to be cared for, and to die, at home. She was aware that Shipman liked to keep his patients living at home for as long as possible and she therefore did not find it surprising that they died at home.

9.27 Mrs Cocker recalled the circumstances of two deaths in particular. The first was that of Mr John Stone on 24th April 1996 and the second was that of Mrs Elsie Cheetham on 25th April 1997. I have found that Shipman was responsible for both deaths. Shipman visited Mr Stone and it seems that he must have telephoned the surgery and asked Mrs Cocker to inform Mr Stone's son, Mr Ronald Stone, that his father had died. Shipman's claim (which Mrs Cocker does not recall) was that, when he arrived, Mr John Stone was already dead. Mrs Cocker did remember telephoning Mr Ronald Stone (whom she knew) and telling him of his father's death. Almost exactly a year later, Mrs Cocker took a call from

Mrs Cheetham, who said that she was having a 'funny do' and requested a visit from Shipman. Mrs Cocker contacted Shipman via his pager. Shortly afterwards, he telephoned the surgery and told Mrs Cocker that Mrs Cheetham was dead. Mrs Cocker informed the family of the death. On the same day, Mrs Cocker took another telephone call from Shipman, informing her that Mrs Jean Lilley had died. When asked by Leading Counsel to the Inquiry whether the fact that she had received two such telephone calls on one day had struck her as an odd coincidence, Mrs Cocker said she had 'never thought anything about it'. She had just accepted what Shipman said at face value because she trusted him.

Mrs Lee Leech

9.28 Mrs Leech was a qualified teacher. She obtained employment at the Market Street Surgery as a result of her friendship with Mrs Shipman. She had no previous experience of working in a medical setting. During her first period of employment, she worked mainly in a small room some distance from the reception desk. If that room was unavailable, she would use a computer anywhere in the building, sometimes in an upstairs room. She helped out occasionally on the reception desk but, apart from that, had little contact with what was going on there. During the second period for which she worked at the surgery, Mrs Leech carried out basic reception duties. She had little recollection of the procedures which followed a death.

9.29 During her two periods of employment at the practice, two deaths occurred on the surgery premises. Mrs Leech was at work on the morning that Miss Harding died. (For a brief account of the circumstances of Miss Harding's death, see paragraph 9.57.) Mrs Leech knew that Sister Morgan had assisted in the attempt to resuscitate Miss Harding. She described how Sister Morgan, in particular, seemed shocked by the death, which suggested to Mrs Leech that it must have been an unusual event. Later, she was told of a second death in the surgery, probably that of Mrs Bertha Moss, whom I have found that Shipman also killed. She remembers a sense of surprise that another person had died on the premises, although she was not at all suspicious. She had not regarded Miss Harding's death as in any way suspicious, so had no reason to be suspicious about the death of Mrs Moss.

9.30 Of the other deaths which occurred during her period of employment, Mrs Leech did not have much recollection. She did not get to know many of the patients personally and knew little of their state of health. She did not recall feeling any surprise at the number of deaths. Nor does she remember being told of occasions when there was a proximity in time between Shipman's visit and the time of the patient's death. She assumed from observation that most of Shipman's patients were elderly and ill. She thought many of them might have been suffering from employment-related conditions. She said that none of the permanent staff appeared concerned at the number or circumstances of the deaths and she took her lead from them.

Mrs Jayne Kenyon

9.31 After leaving school, Mrs Kenyon worked as an assistant in three chemist's shops. The last of these was the Norwest Co-op Pharmacy, next to the Market Street Surgery. While

working there, a vacancy for a receptionist arose at the surgery and Mrs Kenyon successfully applied for the job. She performed duties similar to those of Mrs Chapman and Mrs Cocker. During her time at the surgery, she gained a Diploma in Medical Reception Services, awarded by the Association of Medical Secretaries, Practice Managers, Administrators and Receptionists (AMSPAR).

9.32 Mrs Kenyon agreed that, during her time at the practice, the reception staff would have known about most of the deaths that happened, particularly those in the community. She recalled that there were occasions when a relative would telephone the surgery to report a death and would say that Shipman had visited earlier on the day the death occurred. Sometimes, Shipman would tell the staff that he had been present when a patient died. She said that she would probably have assumed that the patient had wanted a visit because s/he was ill and that the illness had caused the death. However, she had little recollection of her thought processes at the time. She had no idea of the number of patients who were dying and nothing with which to compare that number. She did not remember any discussion among the staff about the fact that the number of deaths was high. She saw no pattern in the deaths.

9.33 Mrs Kenyon was on duty when Mrs Moss died at the surgery premises on 13th June 1995. She remembered little of the events surrounding the death. She was not asked to call an ambulance and did not question this as she assumed that Shipman knew what he was doing. She thought that she would have discussed the death with other members of staff afterwards. However, no one expressed any concerns and she assumed that patients did sometimes die in doctors' surgeries. She did not remember being told that this was the second death which had occurred on the surgery premises.

9.34 Mrs Kenyon was also at work when Mrs Ashton died at the surgery three months later. She saw nothing surprising in the fact that two deaths had occurred on the premises within a short time. A third death, that of Mrs Edith Brady, occurred on the surgery premises during the period of Mrs Kenyon's employment. It took place shortly before her wedding when Mrs Kenyon was having a few days off to make preparations. She did not return to work until three weeks later and could not recall being told of Mrs Brady's death.

9.35 When her employment at the Market Street Surgery was terminated through lack of funding, Mrs Kenyon went to work for two single-handed practices. At one practice, she entered data onto a computer. At the other, she worked as a receptionist. Looking back, she now recognises that fewer deaths occurred at those practices than at the Market Street practice and that more of the deaths occurred in hospital. However, neither the number of deaths among Shipman's patients, nor the fact that so many occurred at home, struck her as unusual at the time.

The Practice Manager

Mrs Alison Massey

9.36 After leaving school, Mrs Massey attended secretarial college and thereafter worked in various capacities, mainly secretarial and administrative. In May 1991, she started part-time work as a receptionist at the Donneybrook practice. Prior to that time, she had

no experience of working in a medical setting. While at Donneybrook, Mrs Massey carried out general reception duties. She had little contact with Shipman.

9.37 After the move to the Market Street Surgery, Mrs Massey continued to work as a receptionist, carrying out similar duties to those of Mrs Chapman and Mrs Cocker. She was not on duty when Shipman returned from his visits, except when she was covering for one of the other members of staff during holiday periods. Mrs Massey was appointed practice manager in early 1994. Initially, her duties remained unchanged but she gradually assumed greater responsibility for administrative work within the practice. She obtained an AMSPAR Diploma in Practice Management in 1996. However, Shipman continued to take all the significant decisions. Indeed, towards the end of his time at the practice, Mrs Massey was becoming somewhat dissatisfied with the level of responsibility that was given to her. As she began to exchange views with other practice managers, she realised that they were playing a more active role in the running of their practices than she was permitted.

9.38 From time to time, Mrs Massey became involved in audit activities. One of the audits she carried out, in 1997, entailed looking at the reasons why patients had left the practice. The intention was to find out from those who had transferred to another practice within the same area why they had chosen to do so. In the course of the audit, it was necessary for Mrs Massey to ascertain how many patients over a period of six months had left the practice by reason of death. A computer printout was obtained; it seems that Mrs Massey must have done this. The printout contained 31 names, 29 of which clearly related to patients who had died. It was not wholly clear from the document whether or not the other two patients were dead. Mrs Massey said that 29 deaths would not have seemed a high number to her as she would have had nothing with which to compare it.

9.39 Another of Mrs Massey's responsibilities was the production of practice newsletters. She said that it was Shipman's idea to record the number of births and deaths in the newsletter. He seemed to think that people would be interested. She was responsible for incorporating the numbers into the newsletters. She said that, although she now realises that the numbers of deaths were high, they had not struck her as such at the time. Nor had she noticed that the numbers appeared to be rising.

9.40 Mrs Massey had a clear recollection of the death of Miss Mary Andrew, on 8th April 1993. I have found that Shipman killed Miss Andrew. She had telephoned the surgery and reported to Mrs Massey that she had a pain at the top of her back. A short time later, Shipman returned to the surgery and told Mrs Massey that Miss Andrew had died. Mrs Massey understood that the cause of death was a heart attack. She was shocked and upset and expressed her surprise to Shipman. On looking back, she remembers him 'smirking' and has the impression that he was laughing at her shock. However, she said that, at the time, the focus of her concern was that she might not have treated Miss Andrew's call with sufficient urgency. She had no suspicion that Shipman might not have acted properly. After that incident, Mrs Massey said that she was very careful when dealing with patients complaining of pains. If she had any doubts, she would consult Shipman about what to do.

9.41 Mrs Massey told the Inquiry that, even after she had ceased to spend all her working time as a receptionist, she would still have known about the majority of deaths which occurred at patients' homes. Like Mrs Chapman and Mrs Cocker, Mrs Massey noticed no striking or unusual association between Shipman's visits and the deaths of patients. Nor was she surprised at the occurrence of deaths on the surgery premises; she knew of four out of the five at the time. She was at work at the time of one of those deaths, that of Mrs Brady. I have found that Shipman killed Mrs Brady. At Shipman's request, Mrs Massey accompanied him into the examination room where Mrs Brady was lying dead. Shipman pressed Mrs Brady's chest with both of his hands for a short time. Mrs Massey understood that he was attempting resuscitation. She was shocked at the sight of Mrs Brady's body but harboured no suspicions. She was unaware at the time that Shipman had told Mrs Brady's family that Mrs Massey had helped him to administer artificial resuscitation. She learned this during evidence given at the inquest into Mrs Brady's death, held in 2001. Until that time, Mrs Massey had always had nagging suspicions that, despite his conviction, Shipman might not be guilty. The evidence she heard at the inquest convinced her of his guilt.

9.42 Mrs Massey could not remember a death, other than that of Mrs Brady, at which she was aware that Shipman had been present. She did not know that he had a habit of visiting patients unannounced and was surprised when she subsequently became aware of this fact.

The Computer Operator

Mrs Margaret Walker

9.43 Mrs Walker had worked at the Donneybrook practice for a period of 12 months between 1989 and 1990. For the first six months, she carried out general clerical duties. Latterly, she worked as a computer operator. Before starting work at the Donneybrook practice, Mrs Walker had been employed by the local council and in a number of part-time positions with other employers. After leaving the Donneybrook practice, she had a period off work due to ill health and then obtained clerical jobs, first with the Tameside FHSA and then in a travel agency.

9.44 After joining the Market Street Surgery in 1993, Mrs Walker's duties included printing repeat prescriptions, typing such documents as medical reports, creating computer records for new patients, entering information from consultants' letters into computer records and collating information for use in audits. Initially, Mrs Walker worked from 10am until 1 or 2pm. Over time, her hours were extended to 9am until 2pm. She worked in an upstairs room at the surgery. She occasionally assisted on the reception desk when the practice was short-staffed.

9.45 The practice computer was linked to the WPHA computer system. When a patient died or transferred to another practice, the WPHA would remove the patient's name from the practice list. On being notified of the removal, Mrs Walker would print off the latest version of the patient's computer record and place it with the patient's other medical records ready for despatch to the WPHA. She estimated that she printed out about 85% of the final computer records. Mrs Massey did the rest. In addition, Mrs Walker and Mrs Massey

shared the task of ascertaining from information held on computer the numbers of patient deaths for inclusion in the practice newsletters.

9.46 By virtue of her involvement with these tasks, Mrs Walker was in a position to gain an overview of the number of deaths which occurred and their approximate frequency. She pointed out, however, that she would often be unaware of the circumstances surrounding a death or of the fact that Shipman had visited a patient shortly before the death was discovered. Occasionally, Shipman would observe to her that he had found a patient dead in a chair or in bed, but Mrs Walker said that these were isolated comments and she noticed no particular pattern to the deaths. Furthermore, she was not in a position to compare the number of deaths occurring at the Market Street Surgery with those at any other practice.

9.47 Nor did Mrs Walker set out to monitor the level of deaths within the practice. She did, however, notice that there were two 'peaks' during her employment at the practice when the number of deaths occurring appeared higher than at other times. I shall refer to these 'peaks' in more detail below.

The Practice Nurse

Sister Gillian Morgan

9.48 Sister Morgan qualified as a registered general nurse in 1983. Before working with Shipman, she had become his patient in 1984. She worked first on an acute medical admissions ward for the elderly and then at a hospital for the elderly. She then had two years' absence from work through sickness, after which she trained as an occupational health nurse. However, she was unable to get a job in that field and, in September 1988, she was appointed as the practice nurse for the Donneybrook practice. At first, she provided nursing services to four of the seven doctors at the practice, including Shipman. Subsequently, two more nurses joined the practice and the work was shared between the three of them.

9.49 Sister Morgan's work included screening for coronary heart disease and asthma, applying dressings, taking blood pressures and blood samples and performing other nursing duties. The practice was a busy one. Sister Morgan saw Shipman on a regular basis, both casually and in order to discuss individual patients as necessary. She found him the most approachable of the doctors at the Donneybrook practice.

9.50 After the move to the Market Street Surgery, Sister Morgan ran chronic disease clinics for the management of hypertension, heart disease, asthma and diabetes. She also ran a 'MOT clinic', carrying out general health checks on patients aged over 30. The rest of her time was spent giving injections, taking blood samples, taking cervical smears, applying dressings and carrying out other nursing tasks. She had her own room, which was down the corridor from the reception desk, near to Shipman's consultation room. She worked a 24 hour week, mainly in the mornings but with one late shift, usually on a Friday.

9.51 Sister Morgan had frequent contact with the reception staff. She would liaise with them about the making of appointments and other administrative matters. She saw Mrs Massey and Mrs Walker daily and sometimes ate lunch with the other staff in the reception area.

On other occasions, she had a sandwich in her room. She saw Shipman every day. On most mornings, she had to see him in relation to a query about a patient or some other topic. She had coffee with him after surgery once or twice a week.

9.52 Between 1996 and 1998, Sister Morgan studied for a Master of Arts (MA) degree in Independent Practice (Nursing). She spent one day a week at Leeds University and one morning a week on study leave. At other times, she worked at the surgery as usual. On completing her degree course, Sister Morgan underwent an assessment of her clinical competence. This was carried out by Dr Alan Banks, then Medical Adviser at the WPHA. Following the assessment, she was appointed a nurse practitioner. In his assessment report, Dr Banks recorded the fact that a significant part of Sister Morgan's work consisted of taking a history from a patient, making an examination and a provisional diagnosis, arranging investigations and treatment and referring the patient as necessary. Sister Morgan told the Inquiry that she would make her own judgements about diagnoses, investigations, treatment and referrals. She would then make suggestions to Shipman as to how the patient should be managed. He would either accept her assessment or see the patient for himself and reach his own conclusion. As a nurse, Sister Morgan did not have the authority to sign a prescription, to order certain types of investigation or to refer a patient, other than to a dietician or chiropodist. Accordingly, it was necessary for Shipman to be involved in any decisions relating to these matters.

9.53 Sister Morgan told the Inquiry that it had never occurred to her that Shipman's medical records were in any way deficient. There appeared to be enough information there for her to see what had happened previously. Since Shipman left the practice, she has had the opportunity of seeing the notes of other doctors and comparing them with his. She now thinks Shipman's notes 'probably were brief'. She emphasised that they were adequate for her purposes. They were not, however, adequate for all those who used them. Mrs Massey recalled that some locums who worked at the practice had difficulty in ascertaining patients' medical histories because Shipman's notes were either illegible or incomplete. Mrs Massey said that she and other staff assumed that Shipman carried a lot of information in his head, since he did not appear to write much down.

9.54 Sister Morgan remembered little about deaths which occurred while she worked at the Donneybrook practice. She did not get to know the individual patients there in the same way as she did at the Market Street Surgery. She could remember no formal system by which she was notified of a death. She told the Inquiry that she did not feel that she had got any clear impression of the number of people who were dying, the frequency with which deaths occurred or the causes of patients' deaths. Nor did she get any impression of how many people died in hospital. While at the Donneybrook practice, an unfortunate incident occurred when the practice sent an invitation to a patient to see one of the nurses. The patient had died some time before. The relatives were upset and angry. From that time on, Sister Morgan resolved to do her best to ensure that this type of mistake did not happen again.

9.55 Once at the Market Street Surgery, Sister Morgan tried to ensure that she was informed of the death of any patient under her care. The receptionists would inform her of the deaths of patients on the chronic disease registers. They would leave messages in her diary.

When she had been away from the surgery for a period, she would ask whether anyone had died in her absence. She would also see envelopes containing MCCDs at the reception desk and would know then that a death had occurred. She felt – but did not know for certain – that she heard about most deaths in the practice by one means or another. She said that she often did not know the circumstances of a death, just the fact that a patient had died. At times, she would hear more details from other members of the practice staff. Sister Morgan said that she did not find it surprising when the patients she was monitoring died of a cause associated with their chronic disease. She said that, if a patient had chronic disease, the likelihood was that s/he had developed a condition which had caused the death. It all seemed very plausible to her. Sister Morgan would not have been surprised to hear that a patient had died on the same day as a visit by Shipman if the reason for his visit was that the patient was ill. Nor did she detect any pattern to the deaths, e.g. that they tended to have sudden causes, rather than to result from chronic conditions such as terminal cancer. The patients who died tended to have high-risk factors for conditions causing sudden death. She did not recall ever being told that Shipman had discovered a patient dead or that a patient had died in his presence. She was aware of only one incident, when Shipman had left the patient for a short time and gone back to find her dead. That was the death of Mrs Irene Turner, which is described at paragraphs 9.63–9.65 below.

9.56 Sister Morgan said that she was able neither to form an impression of the overall number of deaths, nor to say whether the number of deaths in the practice was unusually high. When planning an audit (probably in 1993), Shipman told Sister Morgan that the practice had approximately 40 births and 40 deaths a year. WPHA records show that Shipman had 46 patient deaths in 1993. The number of births is likely to have been significantly less. The numbers of deaths for 1995, 1996 and 1997 were significantly larger. Sister Morgan did not recall seeing the numbers of deaths set out in the practice newsletters and said that, even if she had, they would not have meant much to her. She said that, even now, she has no idea how many deaths per thousand patients could be expected each year in a general practice.

9.57 Sister Morgan was involved in the events surrounding the death of Miss Harding, who died on 4th January 1994. Miss Harding's was the first of the five deaths which occurred at the Market Street Surgery premises. Shipman came into Sister Morgan's office and said that he needed her. He told her that a patient had collapsed. She accompanied him to his examination room. Miss Harding was lying there, pallid and motionless. Shipman instructed Sister Morgan to perform cardiac massage while he attempted mouth-to-mouth resuscitation. They continued for several minutes before Shipman indicated that they should stop. Sister Morgan believed this decision was correct as there were no signs of life. Shipman felt Miss Harding's pulse but Sister Morgan does not recall whether he looked at her pupils. She does not recall him using a stethoscope. Sister Morgan remembered, when asked by the Inquiry, that resuscitation equipment comprising a bag containing a bag and mask and an airway for resuscitation was kept at the surgery, together with a supply of adrenaline. She said that at the time she was on 'automatic pilot' so it did not strike her as surprising that Shipman was not using this equipment. Subsequently, when she was asked to give a statement about the death to the police in

1998, she wondered why it had not occurred to her to go and get the equipment herself. In the event, Shipman had appeared to have no difficulty in establishing an airway. Prior to this time, Sister Morgan had performed about four resuscitations following cardiac arrests. She had had training in resuscitation during her occupational health course and an update after her arrival at the Market Street Surgery.

9.58 Sister Morgan had no suspicions about Miss Harding's death and no doubts that the resuscitation attempt had been genuine. An ambulance had been called for Miss Harding but was later cancelled. Sister Morgan had only a vague recollection of this. She said that she would not have been surprised if Shipman had ceased his efforts to resuscitate Miss Harding before an ambulance (which would have taken between 10 and 20 minutes to reach the surgery) had arrived, as they were making no progress. Dr John Grenville, who gave evidence during Phase One of the Inquiry, disagreed. He said that it would have made no sense to have started resuscitation and then to have ceased before the ambulance arrived. It would, of course, make sense if, as I have found, the resuscitation was a sham, designed to convince Sister Morgan and others that Shipman had made a genuine attempt to save Miss Harding's life.

9.59 In evidence, Sister Morgan told the Inquiry that she and Shipman discussed the death later that same morning. She asked him if she had done the cardiac massage correctly. She did not recall any discussion about the failure to use the resuscitation equipment. In evidence, she seemed at first to suggest that she had not thought about this failure from the time of the incident itself until giving her police statement in 1998. However, afterwards, she suggested that it might have occurred to her later when she 'pondered on it, maybe that night'. She believed that, if she had thought about the failure to use the resuscitation equipment and had not mentioned it to Shipman, it would be because she was busy with other things and had overlooked doing so.

9.60 It seems to me unlikely that Sister Morgan ever considered the failure to use resuscitation equipment until she came to give her police statement, or possibly even later. If she had given the matter any thought at the time, it seems highly likely that she would have discussed it with Shipman and that she would have been concerned to ensure that no such failure occurred again.

9.61 Sister Morgan understood that Miss Harding had appeared ill when she arrived at the surgery and that she had died of a coronary thrombosis. She said that she would have expected such a death to be reported to the coroner and was unaware that it had not been. She knew that a death had occurred on the premises at the Donneybrook practice during her time there so she did not regard such a death as particularly unusual. She was not aware that the patient who had died at the Donneybrook practice, Mrs Mary Hamer, had been a patient of Shipman.

9.62 Sister Morgan was also at work when Mrs Ashton died at the surgery. Sister Morgan played no part in the events surrounding the death and believes that she heard about it later that same day from Mrs Chapman. She did not wonder why no resuscitation had been attempted and she said that she was unaware that no ambulance had been called. She was absent from the surgery on maternity leave or holiday at the time when the other three deaths occurred there. Sister Morgan said that she did not count up the deaths which had

occurred on the surgery premises, nor did she consider them in their totality. The deaths were spread over three and a half years. She did not give any thought as to whether adequate resuscitation techniques had been used on each occasion. She assumed that Shipman would have done what was appropriate at the time.

9.63 In a statement made to the Inquiry, Sister Morgan mentioned three deaths in particular which had caused her some initial surprise. However, she said that in each case she was able to marry up the fact of the death with some other information that made it seem part of a natural process. The first of the deaths was that of Mrs Turner on Thursday, 11th July 1996. Shipman was convicted of her murder. Mrs Turner, who was a diabetic, telephoned the surgery on the morning of her death. Sister Morgan spoke to her. She says that Mrs Turner told her that she had been vomiting for several days and had stopped taking the medication she had been prescribed for her diabetes. Mrs Turner's family told the police that the problem was that Mrs Turner had a cold and was bringing up phlegm and occasionally being sick. They said she was concerned that she was bringing up her medication and telephoned the surgery to ask for advice. Sister Morgan was adamant that Mrs Turner had told her that she had stopped taking her medication several days before. This would have been contrary to the instructions which Sister Morgan gave to diabetics, namely that if they were unwell (particularly if suffering from vomiting and diarrhoea) they should telephone the surgery and should not stop their medication until they had received advice. Sister Morgan says that she told Mrs Turner she should have contacted the surgery earlier. She went on to suggest that Shipman should visit Mrs Turner.

9.64 Shipman visited later the same day. Sister Morgan recalled seeing him after that visit. He told her that he suspected that Mrs Turner had a 'water infection' and that he had brought a urine sample back to the surgery for testing. She thinks that Shipman also told her that Mrs Turner was poorly and should have gone into hospital. Sister Morgan believes she learned of Mrs Turner's death on the following Monday, 15th July. She was aware that Shipman had gone back to Mrs Turner's house on 11th July and found her dead. She does not remember being told the cause of the death. She says that she was taken aback by it. She worried that she had 'missed something'. She also wondered whether, if Mrs Turner had followed her instructions, she would still be alive. She was concerned that she might not have communicated the instructions adequately to Mrs Turner and subsequently made sure that she emphasised the importance of following her instructions when talking to diabetics.

9.65 Sister Morgan said that, although she was concerned that she herself might have missed something, she had no such concerns about Shipman. It did not occur to her that, in leaving Mrs Turner, Shipman might have underestimated the seriousness of her condition. She said that all the care that she had ever seen him provide had been appropriate, so there was no reason for her to doubt him on that occasion.

9.66 The second death mentioned by Sister Morgan was that of Miss Ward, which, as I have said, occurred on 18th February 1998. Sister Morgan saw Miss Ward on 5th February. She gave her inoculations needed for a foreign cruise which she was about to take. She was told of Miss Ward's death later, possibly at a staff meeting which took place the day after the death. Sister Morgan thought what a shame it was that Miss Ward had not been able

to go on her holiday. She learned that Miss Ward had died of 'cancer with secondaries'. It did not occur to her that it would be unusual for someone to be fit and looking forward to a holiday one day and dead as a result of cancer with secondaries within a fortnight. Other members of the practice staff were, of course, aware that Miss Ward had been into the surgery only the day before her death and had appeared in good health then. It is clear that Miss Ward's death was a topic of discussion among the staff and, although Sister Morgan does not remember being told about her recent visit to the surgery, it is likely that she was. In that event, the suddenness of her death would have been even more striking and unusual.

9.67 Thirdly, Sister Morgan referred to the death of Mrs Margaret Waldron on 6th March 1998. I have found that Shipman killed Mrs Waldron. On 4th March, Mrs Waldron, who was 65 and, according to Sister Morgan, 'a very glamorous lady', went to see Sister Morgan in connection with her cholesterol level. Sister Morgan remembered that Mrs Waldron mentioned also that she had backache. Sister Morgan therefore prepared a prescription for a pain-relieving drug and took it for Shipman to sign. Sister Morgan was later told that Mrs Waldron had died of a heart attack. She told the Inquiry that she knew that backache could be an atypical sign of a heart attack and that a high cholesterol level was a risk factor. She said she went on to consider her own actions and whether she could have altered the outcome in any way. She said that she did not follow that consideration through and ask herself whether, in not investigating Mrs Waldron's complaint of back symptoms, Shipman himself might have been at fault.

9.68 In fact, at the time that she saw Sister Morgan, Mrs Waldron had been suffering from low back pain and sciatica for three days. That is evident from a letter which Mrs Waldron wrote at the time and from a conversation she had with a friend just before visiting the surgery. Sister Morgan did not think that the site of the pain or the presence of sciatica was mentioned to her, even though she would have posed specific questions about both these matters. However, Mrs Waldron was a state registered nurse and an articulate woman. It is inconceivable that she would not have given an accurate history in response to Sister Morgan's questions. It is clear that she would have said that the pain was in her lower back and/or leg. That being the case, Mrs Waldron's symptoms could not sensibly have been linked with her subsequent heart attack.

The Other Healthcare Professionals

9.69 The other healthcare professionals attached to the Market Street Surgery (including Ms Elliot who deputised briefly for Sister Morgan in 1995) had no detailed knowledge of events within the practice, or of the number of patient deaths occurring. Insofar as they had any dealings with Shipman, they were impressed with what they saw. They also referred in their witness statements to the fact that they were aware of the high regard in which Shipman was held.

9.70 For the sake of completeness, I should mention Mrs Marion Gilchrist, the district nurse assigned to Shipman's practice from April 1995 until after his arrest in 1998. She was not employed directly by Shipman but by the Tameside and Glossop Community and Priority Services NHS Trust. However, she worked very closely with Shipman. She met him at least

once a week and may have communicated with him more frequently. She formed a very favourable view of Shipman. She found that he knew his patients and their extended families and circumstances very well. He visited patients frequently and went to a lot of trouble and appeared to care genuinely for them. She was particularly impressed by the terminal care that he provided. She would not be aware of the deaths of many patients unless they were those for whom she was providing nursing care. Usually, they would be quite poorly. She was never surprised by the death of any of Shipman's patients; nor did she ever suspect that he might have harmed a patient. She said that had she had any suspicions, she would have raised them with her team leaders. I should briefly mention that Mrs Gilchrist suggested that financial considerations could operate to discourage the raising of concerns. She made this suggestion in the context of fundholding, saying that she and her colleagues were warned that if a consortium of GPs became unhappy with the district nursing service that she and her colleagues provided, it would be entitled to seek those services from an alternative local provider. I can see how this could operate on the mind of a district nurse who was undecided about whether to raise a concern that s/he had about a GP. It would operate far more strongly, of course, if the nurse were directly employed by the GP.

The Practice Staff's Awareness of the Number of Deaths

9.71 In a statement made to the Inquiry, Mrs Walker said that she thought that she noticed the first 'peak' in the level of deaths perhaps a year or two after she started work at the practice. That would have been in 1994 or 1995. Records held by the WPHA show that Shipman had 58 patient deaths in 1995 – up from 37 deaths the previous year. I have found that he killed at least 30 patients in 1995. It seems likely, therefore, that Mrs Walker may have noted the first 'peak' some time during 1995. The WPHA records show that Shipman had 48 patient deaths in 1996 and 57 (possibly 59) in 1997. I have found that he killed at least 37 patients in 1997. It may well be that the second 'peak' referred to by Mrs Walker occurred some time during 1997.

9.72 Mrs Walker described one or two incidents – probably at the times of the 'peaks' of which she spoke – when she recalled wondering why so many deaths were occurring. She said that she wondered whether Shipman could be 'missing something in his diagnoses'. She said that her husband recalled her posing this question to him on one occasion. One incident she remembered had happened at her birthday celebration at the surgery on 15th July 1997. Shipman returned, having visited a patient who had died. This would have been Mrs Muriel Grimshaw, who was found dead on 15th July, having died the previous day. Shipman was convicted of her murder. Mrs Walker recalled a feeling of embarrassment when the news of the death was announced. She cannot now remember whether the embarrassment was on Shipman's part or her own. No one else present appeared to recall this incident.

9.73 Mrs Walker remembered observing to her husband once that another patient had died that day. He replied, 'You do work in a doctor's surgery', suggesting that deaths were only to be expected given the nature of her work. She accepted this explanation and her concern receded for the time being. On each occasion when Mrs Walker contemplated the possibility that deaths might be due to some omission on Shipman's part, she

dismissed the notion. He was held in high esteem by patients, the consultants to whom he referred patients appeared to confirm the diagnoses he had made and others praised his knowledge and abilities.

9.74 In her statement, Mrs Walker referred to light-hearted comments among members of the surgery staff about the apparent association between the large earrings which Mrs Chapman liked to wear (and which Shipman disliked) and the occurrence of a death. According to Mrs Chapman, the association had first been made by Shipman and was subsequently referred to whenever a death occurred. Mrs Heather De-Rome, the daughter of Mrs Eileen Robinson and herself one of Shipman's patients, recalled an occasion when Mrs Chapman came in during a consultation with Shipman to tell him that a patient had died. Shipman referred to Mrs Chapman's earrings and linked them with the death; this was clearly a running joke between the two. Eventually, Mrs Chapman said that the comments began to 'get to' her. After Mrs Elizabeth Battersby died, in December 1997, Mrs Chapman did not wear any earrings for a week.

9.75 Mrs Walker emphasised that the fact that comments were made did not indicate that the staff had any real concerns about the deaths. I accept this and, indeed, the fact that such remarks were made – and to Shipman – demonstrates, in my judgement, the absence of any real concerns. Rather, the comments were, on the part of the staff at least, an example of the sort of black humour often resorted to by those who have to deal with the fact of death on a regular basis. For Shipman, of course, it was quite another matter.

9.76 Mrs Walker also described an occasion when, having read a book entitled *Mort*, she joked with Shipman that it would be a good name for him. He appeared to take her suggestion in good part. Other members of staff have also suggested that Shipman may occasionally have been referred to as 'Dr Death' and 'The Grim Reaper'. Mrs Leech recalled Mrs Chapman using the latter term when she visited the surgery some time after she left. This could have been at any time up to Shipman's arrest. She said there had been a lot of deaths in the practice and she remembers Mrs Chapman making a jocular remark. Mrs Chapman does not remember using the term and no one else has any recollection of this incident. The evidence about the use of such names by surgery staff is not entirely clear but, even if they were used, I am confident that they were not intended seriously to imply that Shipman was criminally responsible for the deaths of his patients.

9.77 In the early part of 1998, things began to change. Mrs Chapman said that, by 1998, the staff had begun to notice the number of deaths which were occurring and that 'eyebrows would be raised' when somebody died. It is clear that there was discussion among some members of staff at least about the number of deaths. Mrs Chapman said that she thought that Shipman might be getting a little bit tired. She considered the possibility that this might be causing him to 'miss something' in his diagnoses. She says she did not voice that thought to others. Whether she did or not, it is clear that the same idea had occurred to both Mrs Walker and Mrs Massey. The belief that Shipman was getting tired might have been supported by the fact that he was known to be seeking a partner in the practice in the early part of 1998. It might therefore have been thought that he felt in need of assistance in managing his workload.

9.78 Mrs Chapman, Mrs Massey and Mrs Walker spoke of an occasion, probably in February 1998, when the subject of the number of deaths was brought up in the presence of Mrs Shipman. Mrs Walker and Mrs Massey were present at the time. Mrs Massey said that Mrs Chapman was also present although Mrs Chapman believed that she was not. She did, however, recall that the conversation was reported to her later. Mrs Massey said that the staff were puzzled and were questioning why so many patients were dying. Mrs Shipman shrugged her shoulders and remarked that Shipman was having (or had had) what she termed 'a run of bad luck'. The surgery appointments sheets show that Mrs Shipman covered for Mrs Cocker on the mornings of 19th, 20th and 23rd February 1998. In the ten days before 19th February, there had been five deaths. Miss Ward had died on 18th February. It seems likely that the conversation referred to took place at around this time. Mrs Chapman was working in the afternoons that week. That would explain why she does not recall being present. The fact that Mrs Cocker was absent during this period would also explain why she recalled nothing of this discussion.

9.79 Sister Morgan told the Inquiry that, at various times when there had been a run of deaths, members of the practice staff would pass comment on this, usually associating it with the fact that it was winter or with a 'flu outbreak. However, she recalled no other discussions about the number of deaths occurring at the practice, even in 1998. She was not present at the time of the conversation involving Mrs Shipman. She said it had never occurred to her that Shipman might be failing his patients in any way, whether as a result of tiredness or otherwise. Sister Morgan expressed doubt that any such discussions had taken place at all before the police investigation began in August 1998. If there had been such discussions, she felt that Mrs Walker and Mrs Cocker (and, she would have hoped, Mrs Massey and Mrs Chapman) would have told her about them. However, it is clear from Mrs Chapman's evidence that this would not have been the case. She told the Inquiry that the other staff would not include Sister Morgan in any such discussions because of her loyalty to Shipman ('she would never hear anything said against him') and because she was 'very, very sensitive'. The fact that Sister Morgan was unaware that the deaths were under discussion, therefore, does not mean that no such discussions took place.

9.80 Indeed, it is clear that Mrs Walker, Mrs Chapman and Mrs Massey were experiencing some concerns about the number of deaths by February 1998. I accept, however, that their concerns were unformulated and amounted to no more than a consideration of the possibility that Shipman might, through tiredness or some other cause, have been omitting to diagnose potentially fatal conditions. They had no suspicion that anything was seriously amiss. If they had, Mrs Walker and Mrs Massey would not have broached the subject with Mrs Shipman. In the event, the high level of deaths continued for less than five weeks after the time when their conversation with Mrs Shipman is likely to have occurred. During that time ten more patients died. I have found that eight of them were killed by Shipman. After 24th March, the rate of deaths dropped. I have found that the reason for that was that Shipman became aware of the first police investigation which had resulted from the report of Dr Linda Reynolds to the Coroner. In the three months that followed, there were only three deaths which occurred at a patient's home. Insofar

as the staff had been concerned, they must have derived considerable reassurance from the slowing of the death rate.

How Shipman Was Viewed

Before Shipman's Arrest

9.81 Mrs Chapman and Mrs Cocker had been patients of Shipman before their employment with him started. They had a high regard for his skills and believed him to be a good and caring doctor. Mrs Cocker, Mrs Massey and Sister Morgan were happy to move with him from the Donneybrook practice to the Market Street Surgery and to stay with him throughout his time there. It is clear that he must have been a good employer and that the surgery was a pleasant place in which to work. Of the three lay members of staff, it seems that Mrs Cocker got on with Shipman best. She shared jokes with him and she was sympathetic when he became 'nowty' (i.e. short-tempered or irritable). Mrs Chapman was less forbearing. It is plain that she got the impression that Shipman regarded what she termed 'the hired help' as intellectually inferior to himself and that he would seek to demonstrate their inferiority from time to time by using complex medical terminology. Mrs Massey regarded Shipman with respect and had a good working relationship with him. However, she had begun to feel some resentment that he would not allow her to manage the practice in any true sense. Mrs Walker also seemed to have a good relationship with Shipman and was able to tease him. However, she was careful not to overstep the mark.

9.82 Of all the staff, Sister Morgan had the closest relationship with Shipman. She had a very high regard for his abilities, as both a patient and a fellow professional. She had the opportunity of seeing him with patients and of observing his rapport with them. She found him approachable when she took queries to him about individual patients and receptive to her ideas about treatment and other matters. He encouraged her to develop her skills and supported her in her attempts to obtain further professional qualifications.

9.83 All the staff trusted Shipman as an individual and as a professional. All were aware of the high regard in which he was held by his patients and by the community at large. He appeared well respected also by his medical colleagues and by the local medical community generally.

After Shipman's Arrest and Conviction

9.84 Mrs Chapman described how, after Shipman had been arrested and the practice had been taken over by a locum, she soon noticed that the death rate dropped markedly. Patients died in hospital or nursing homes. Mrs Chapman could not remember a death which had occurred at a patient's home after Shipman's departure. Patients tended to be bedbound in the period immediately before death. She began to realise the significance of the fall in the death rate. Also, as the practice staff began to make statements to the police and to discuss the circumstances of various deaths among themselves, she noticed a pattern of association between deaths and visits from Shipman. Sister Morgan said that she did not notice any difference in the number or pattern of deaths after Shipman

left the practice. She said that she was struggling to remain at work at the time and could not take in the significance of any changes which occurred.

9.85 On 12th October 1998, Mrs Chapman made a statement to the police about the death of Mrs Ashton. The following day, she telephoned the police to express her concerns about Mrs Pickup's death. In the same telephone call, or a second telephone call made within minutes of the first, Mrs Chapman also told the police that she was worried about the death of her mother, Mrs Bardsley. She told the Inquiry that she reported her mother's death to the police following a conversation with Mr Peter Wagstaff. He had told her some details about the death of his mother, Mrs Kathleen Wagstaff, which had occurred during a visit from Shipman. Mrs Chapman was struck by the similarity between the circumstances of Mrs Wagstaff's death and that of her own mother. She realised for the first time that what was being suggested about Shipman might actually be true. Although she could not remember the date of that conversation, it seems likely that it took place shortly before 13th October 1998.

9.86 As I have mentioned, the same realisation did not come to Mrs Massey until much later, at the inquest of Mrs Brady in 2001. Like Mrs Chapman, she has now come to terms with the fact of Shipman's guilt. Mrs Walker, Mrs Cocker and Sister Morgan are unable to do so, even now. Their difficulty is in reconciling the caring doctor whom they liked and trusted with the calculating killer the evidence shows him to have been.

Conclusions

The Lay Members of Staff

9.87 I am quite satisfied that none of the administrative staff had any knowledge or suspicion of Shipman's criminal activities. Up to and beyond the time of his arrest, the staff admired him and trusted him implicitly. If Mrs Chapman or Mrs Cocker had had any suspicions about him, I think it unlikely that they would have remained as his patients. If Mrs Massey and Mrs Walker had had any concerns that Shipman might be responsible for the high number of patient deaths they had noticed, it seems to me that the last person they would have mentioned it to (apart from Shipman himself) would have been Mrs Shipman. That the staff should have had such difficulty in coming to terms with the reality of Shipman's guilt is also consistent with their claims that their trust and confidence in him had been complete. Mrs Chapman was the first to accept that the allegations were true; she was the one whose relatives he had killed.

9.88 The practice staff are not to be criticised for their failure to realise that there was anything seriously amiss. They had no knowledge or experience of how many deaths might be expected in a general practice the size of Shipman's. Even those who had worked at the Donneybrook practice had no awareness of what was usual and unusual. When the deaths were occurring, the staff had no contact with others working in similar circumstances with whom they might have discussed an apparent increase in patient deaths. They knew that Shipman had quite a lot of elderly, ill patients. They knew that it was his declared policy to allow them to stay at home and die at home, rather than to be admitted to hospital. If reassurance had been required, they would have gained it from

their realisation that Shipman appeared to be uniformly admired and respected. They personally had every reason to trust Shipman and they did not have the knowledge or experience to evaluate him professionally. There must be an end, once and for all, to any suggestion that the practice staff 'must have known'. They did not. Nor could they reasonably have been expected to.

The Practice Nurse and District Nurse

9.89 I must consider the positions of Sister Morgan and Mrs Gilchrist separately. This is not because I am of the opinion that they were suspicious of Shipman; indeed I am quite satisfied that they were not. I consider them separately because, by reason of their professional training, knowledge and experience, they were in a better position to evaluate Shipman's conduct than were the lay members of staff.

9.90 I can deal very briefly with Mrs Gilchrist. Although she worked quite closely with Shipman, she was not part of the surgery team and would not have been aware of the frequency with which his patients were dying. Many of the patients Shipman killed were in reasonably good health; certainly they were not sufficiently unwell to require Mrs Gilchrist's services. Mrs Gilchrist was not present when a death occurred in the surgery. She did not take her lunch break in the surgery and share the news of the day with the practice staff. I find it wholly unsurprising that she had no suspicions about Shipman's conduct.

9.91 Sister Morgan was in a different position. Not only was she a very highly qualified nurse, she worked in extremely close contact with Shipman throughout the period in which he killed most frequently. I accept without hesitation that she did not suspect him of wrongdoing. The question is whether she ought to have done, or at any rate whether she ought to have realised that all was not as it should have been.

9.92 From the evidence I have heard in Stage Four of the Inquiry, I have formed the view that an experienced nurse is often well placed to observe professional misconduct or poor performance by a doctor with whom s/he works. This is particularly so where the nurse is present during consultations, or works, for example, in an operating theatre. I accept that Sister Morgan did not often work alongside Shipman in that way. I have no doubt at all also that, whenever Sister Morgan was present at a consultation, Shipman's conduct would have been impeccable.

9.93 There were a few occasions on which I would have expected a nurse in Sister Morgan's position to feel a sense of unease about events within the practice. One was the occasion of Miss Harding's death, in January 1994, when Shipman required her to help with resuscitation and yet did not ask her or anyone else to fetch the resuscitation equipment. She said that, being utterly absorbed in what she was doing, she did not think of calling for it herself. I accept that she did not, and do not criticise her for that, although I would have expected a nurse in her position at least to realise immediately afterwards that full use had not been made of the available resources. I would certainly have expected her to feel some concern about this and to discuss it with Shipman. I do not think she ever did.

9.94 I accept that, after Miss Harding's death, Sister Morgan asked Shipman whether she had carried out her part of the resuscitation procedure correctly. Indeed, that she should do

so seems to be illustrative of her relationship with Shipman. I think the relationship was one of master and pupil; he would lead and she would follow; he was to teach and she to learn. She might suggest a course of action but he would decide. To some extent, this is inevitable in a professional relationship between a doctor and a nurse, where the doctor must take overall responsibility for decisions. However, I have the clear impression that this professional relationship was more 'unequal' than many such. I think that the inequality stemmed partly from the fact that it was a 'one-to-one' arrangement. Most doctors work with several nurses and most nurses with several different doctors. However, I think the main cause of this inequality was the personalities of Shipman and Sister Morgan. Shipman had a strongly dominant personality. Sister Morgan admired and respected him very deeply. He inculcated admiration quite deliberately; I think that admiration was expected of employees. Indeed, I think it unlikely that anyone who did not admire Shipman would have stayed long in his employment. Sister Morgan, on the other hand, is not, in my view, a strongly independent personality. I think she was content to follow Shipman's guidance at all times. I do not suggest that she was not a competent, conscientious and hardworking nurse; I think she was. However, I do not think there would have been any circumstances where she would have thought that her own opinion was correct and that Shipman's might be wrong. That being so, I find it unsurprising that Sister Morgan should have questioned her own contribution to the resuscitation of Miss Harding but not Shipman's organisation of it.

9.95 The death of Mrs Turner in July 1996 was another occasion when Sister Morgan might have felt a sense of unease. On this occasion, too, Sister Morgan questioned whether she had given sufficiently clear instructions to Mrs Turner about seeking advice before stopping her medication. She did not question whether Shipman had failed to appreciate how ill Mrs Turner apparently was when he left her to return to the surgery.

9.96 I think also that Sister Morgan must lack the degree of curiosity that most people have. In about 1993, Shipman told her that, in the practice, they could expect approximately 40 births and 40 deaths each year. Sister Morgan had no idea what the usual death rate was. She did not notice that, in each ensuing year, there were far more than 40 deaths in the practice. I do not find that wholly surprising; the number of deaths might not be a matter of particular interest. But I do find it surprising that, after Shipman had been arrested, charged and eventually convicted of multiple murder – murder committed almost under her nose – Sister Morgan has still not found out what the usual death rate is.

9.97 In my view, Sister Morgan's lack of curiosity explains her failure to notice the strange features of two deaths that occurred in early 1998. I find it remarkable that Sister Morgan did not realise that it was strange that Miss Ward could apparently die of cancer with secondaries when, to Sister Morgan's personal knowledge, she had been in the surgery two weeks earlier for pre-holiday inoculations. In fact, it is likely, in my view, that Sister Morgan was aware that Miss Ward had been in the surgery only the day before her death. I am not saying that so sudden a death from secondary cancer is impossible, but it must be an unusual occurrence. I would have expected Sister Morgan to wish to discuss that death with Shipman. Nowadays, in most practices, such a death would be the subject of a 'significant event audit', where the clinical team would discuss the adequacy of the treatment provided. In a single-handed practice, I would expect it to be the norm for the

doctor to discuss such an event with his/her nurse. What is more, after her experience at Leeds University while studying for her MA, I would have expected Sister Morgan to know that such was the usual practice. Yet it appears that, if there was any discussion, it can have taken place at only a superficial level.

9.98 The second death that should, in my view, have puzzled Sister Morgan was that of Mrs Waldron. I am afraid that I am unable to accept Sister Morgan's evidence that, after Mrs Waldron's death, she came to the conclusion that the back pain of which Mrs Waldron had complained a day or two before her death must have been a sign of developing heart trouble. I am quite satisfied that, if Sister Morgan had asked about the site of Mrs Waldron's back pain, as I think she probably did, Mrs Waldron would have told her that it was in her lumbar spine. Sister Morgan cannot have thought that this was a sign of heart trouble. I am driven to the conclusion that Sister Morgan has persuaded herself of that explanation while preparing for her appearance at the Inquiry. I do not suggest that she has done so dishonestly, merely that she has sought for and found an acceptable explanation for her own thought processes. However, the explanation does not bear examination. I have come to the conclusion that Sister Morgan did not think carefully or independently about Mrs Waldron's death. I think that she did what she always did about anything that Shipman said; she accepted what he said without question or independent thought.

9.99 I repeat that I accept that Sister Morgan did not suspect Shipman of wrongdoing. I criticise her only to the extent that I do not think that she applied independent or objective thought to events within the practice that ought to have puzzled her but did not. I do not suggest that, had she thought more carefully, she would have realised that Shipman was killing his patients. I think that that would have been too great a step to contemplate. However, had she shown greater curiosity and independence of mind, she might have acted as a deterrent to Shipman. He might have been wary of her. As it was, I think it likely that he recognised that she always deferred to him professionally and knew that she would not question what he told her.

9.100 I do not think that such an unequal relationship would be likely to arise between a doctor and a nurse in a group practice. There, as a rule, there are several doctors sharing the assistance of several nurses. It is unlikely that a one-to-one professional relationship, such as existed between Shipman and Sister Morgan, would ever arise. I regard such relationships as unsatisfactory. They tend to deprive both parties of the professional objectivity that is fostered by working with a number of colleagues. There is another factor present in the relationship between a GP and his/her practice nurse: they are employer and employee. This is in contrast with the position in a hospital setting, where doctors and nurses are all employed by the NHS trust or hospital authorities and the doctors do not have the power of dismissal. In general practice, the nurse's dependence on the doctor for her employment is likely to make it even more difficult for her challenge the doctor.

The Lasting Effects

9.101 The effects on members of Shipman's practice staff have been profound and lasting. Several have suffered from recurrent ill health in the period since his crimes became known. Neither Mrs Chapman nor Mrs Cocker is working at present. Mrs Walker has

moved to another country. Mrs Massey has moved to a different type of work. Both she and Mrs Chapman feel that they have been used and their trust utterly betrayed by Shipman. As a result of the hostility she has encountered, Mrs Cocker feels unable to go alone into the town centre of Hyde. Sister Morgan told the Inquiry that the events of the past few years have had a serious impact on her personal and professional life.

9.102 The lives of all the staff who worked for Shipman have indeed been changed irrevocably as a result of his crimes. Further damage has been done by the distressing accusations made against them to the effect that they 'must have known' of Shipman's criminal actions at the time. I hope that the fact that I have found those accusations to be wholly unfounded may assist in dispelling any doubts which remain in the minds of some people.

The Raising of Concerns by Practice Staff

9.103 I have found that Shipman's practice staff had no significant concerns about him or his clinical practice. Yet, in other circumstances, practice staff may be uniquely well placed to notice signs of poor clinical practice by a doctor or other healthcare professionals with whom they work. They may become aware of complaints from patients, locums and others with whom they have dealings. They may observe instances of poor practice or aberrant behaviour for themselves. They may become aware of failures of organisation within the practice (e.g. poor record keeping) which might put patients at risk. The Inquiry was anxious to discover how easy it would be for a member of staff of a GP practice who possessed this sort of information to report it.

The Problems Faced by Practice Staff

9.104 The Inquiry was told that staff employed in GP practices can experience particular difficulty in raising concerns about the performance of healthcare professionals within the practice. GP practices are small organisations and there may be conflicts of loyalties and a reluctance to bring criticism about one member of the practice to the attention of his/her colleagues. This reluctance is likely to be increased where a lay member of staff has concerns about clinical care. He or she may well feel unable to challenge the actions of a healthcare professional, believing that his/her concerns may prove to be unfounded and fearing the consequences. There may also be a perception (whether justified or not) that, if a concern is raised, the doctors will 'close ranks', with the result that the concerns will go unheeded. Members of staff may be worried that, if they voice their concerns, their relationships with their employers and colleagues will be irretrievably damaged. The smaller the practice, the greater these problems are likely to be. In a single-handed GP practice, for example, there is likely to be no one within the practice to whom a member of staff could voice a concern about his/her employer. In a serious case, where the doctor's fitness to practise may be in doubt, the raising of concerns could have a direct impact on the livelihoods of those employed in the practice.

9.105 These problems are exacerbated by the fact that the staff of GP practices often function in isolation, both from staff in other practices and from the local primary care organisation (PCO). They may have no experience of working in another practice. They may have no idea what procedures are usual and what are entirely outside the norm. They may be uncertain whom to turn to for advice.

9.106 The problems that I have identified were discussed at one of the Inquiry's seminars. Mrs Pauline Webdale represented AMSPAR at the seminar. She is a practice manager herself and, in addition, has experience in advising AMSPAR members how to raise concerns. She confirmed that doctors can often be reluctant to deal with complaints or concerns about a colleague. In those circumstances, it can be necessary for staff to go outside the practice in order to get their concerns dealt with. Staff who are contemplating such action are often concerned that they may be branded as 'troublemakers' as a result of their actions.

9.107 There are signs of a greater awareness on the part of practice staff of their role in protecting patients. Ms Anna Myers, Deputy Director, Public Concern at Work (PCaW), told the Inquiry that it was her impression, from enquiries she had received at PCaW, that the knowledge of Shipman's activities, and of the criminal activities of other GPs, had made practice staff 'very alive' to the fact that it was important to raise with their local PCT any concerns that they might have.

The Need for a Change of Culture

9.108 Mrs Webdale hoped that, in the future, the culture within general practice would change so that more concerns could be dealt with internally, without the necessity to approach an outside organisation. In the practice Mrs Webdale manages, staff are encouraged to report anything that they feel is 'untoward'. Forms are provided for staff to complete. These forms are used to record the occurrence of all sorts of incidents, including matters affecting health and safety or encounters between members of staff and disgruntled patients. Forms are also completed following more serious incidents, such as a mistake made by a locum or an assistant GP. Mrs Webdale thought that the practice of routinely recording and reporting minor matters encouraged and facilitated the reporting of more significant concerns when the need arose.

9.109 Ms Myers endorsed this approach, observing that, if there was a culture whereby concerns were raised on a daily basis as they occurred, this would remove any sense that the raising of concerns was 'deviant behaviour'. Mrs Debbie Mellor, representing the Department of Health (DoH), emphasised that what the DoH was aiming to do was to achieve an open culture, in which it was accepted practice for people to raise their concerns.

9.110 Mrs Webdale also spoke of the importance of ensuring that all members of the staff within a GP practice – including the most junior – feel that their views are of value. She described efforts to introduce a less hierarchical structure within practices, whereby junior members of staff did not regard the doctors as 'untouchable' but, instead, felt able to exchange opinions with them.

Raising Concerns Outside the Practice

9.111 At the seminar, there was a general view that the ideal situation was one where members of staff, whatever their status, felt able to raise concerns openly within the practice. However, even if the culture changes in the way suggested, there will still be times when it is not feasible for members of staff to raise their concerns within the practice, particularly a single-handed practice. For example, had Shipman's staff had concerns about the deaths of his patients, it would hardly have been possible for them to raise those concerns with Shipman himself. They would have had to have gone outside the practice.

9.112 When Shipman's staff were asked what they would have done if they had felt concerns about Shipman, the receptionists said that they would have spoken to Mrs Massey as practice manager. Had that not been possible for any reason, they would have thought it appropriate to approach the WPHA direct. Mrs Massey said that she would have gone to the WPHA although, at the time, she would not have known which member of staff at the WPHA to contact. She would have appreciated a closer relationship with a member of staff whom she got to know and felt confident in approaching. She said that she could also see an advantage in having an independent body from which a member of staff could get initial advice as to whether and how to proceed and where to direct a concern.

9.113 Sister Morgan would have been in a rather better position. Had she had any concerns, she could have spoken to her clinical adviser, or a nursing adviser at the WPHA. Her professional body, the Royal College of Nursing (RCN), was also available to give advice and support. The PCT in whose area Sister Morgan was working at the time she gave evidence to the Inquiry did not employ a nursing adviser, so Sister Morgan had no identifiable contact there. However, the RCN would have advised her on whom to approach and would have accompanied her to any interview if necessary.

9.114 The other healthcare professionals had their own channels of communication and support. Mrs Gilchrist, for example, could have approached both the RCN and her own employers (through her line manager) if she had had any concerns.

9.115 Mrs Webdale said that if she, as a practice manager, had a concern about a doctor in the practice, or if such concerns were reported to her, she would involve the local medical committee (LMC) or PCT. If the concern was of a sensitive nature – such as an allegation of drug abuse by a doctor – she would go to the LMC. She felt that PCTs were, as yet, ill-equipped to deal with concerns of this kind. When facing potentially sensitive issues, it was important to have a relationship with the person in whom one was confiding. She had not yet been able to form the necessary relationships with staff at her PCT. She had considerable confidence in the Clinical Governance Lead there, but said that he had a 'huge' remit and could not do everything. It was for that reason that she would have approached the LMC.

9.116 Other participants at the seminars considered that PCTs were not perceived by staff as being sufficiently approachable. This may be because they are relatively new organisations, have experienced a high turnover of staff and because practice staff have not yet had the time to form relationships with staff at the PCTs. In addition, however, it was

said that PCT staff have a wide range of responsibilities and sometimes cannot manage them all.

Addressing the Problems Faced by Practice Staff

A Practice 'Whistleblowing' Policy

9.117 Ms Myers said that, in her view, the correct approach was for PCTs to help GPs to understand the value of encouraging staff to raise concerns within the practice whenever possible. However, practice staff should be told that, if they felt unable to raise their concerns internally, they should approach a named individual at the PCT. That individual might be the Clinical Governance Lead, or someone else. She believed that practices should regard the PCT as a 'safety net', not as the first port of call for a member of staff who had concerns. She agreed that it would be helpful if the named individual at the PCT was known to practice staff before the need to approach the individual arose. She said that she was not suggesting that a member of staff should be prevented from approaching a different individual at the PCT whom s/he felt more confident about talking to but, for those who did not know whom to approach, a name should be provided.

9.118 Mrs Webdale emphasised that each GP practice should have a written 'whistleblowing' policy, setting out the steps that should be taken by staff who wished to raise a concern. She said that it should be a 'living document', which developed over time and of which everyone in the practice was aware. It seems that many practices have no such policy. In September 2003, Dr Linda Patterson, then Medical Director of the Commission for Health Improvement (CHI), told the Inquiry that CHI had found that there were 'significant gaps' in the application of PCT whistleblowing procedures to GP practices and staff. Among the practices CHI had reviewed at that time, only 24% had reported having a whistleblowing policy. CHI believed that more should be done by PCTs to ensure that GPs and their staff were aware of the procedures to be followed. The RCN also expressed the view that PCTs had a responsibility for ensuring that GPs were aware of the mechanisms available to them to raise concerns about professional practice.

9.119 At the time of the Inquiry's seminars, the DoH was working with PCaW on the preparation of guidance for GPs on how to develop and implement a whistleblowing policy for healthcare professionals and other staff in their practice. The Inquiry has now seen a draft of that guidance and of the whistleblowing policy contained in it.

9.120 The draft policy assures staff that the practice welcomes genuine concerns and is committed to dealing with them responsibly, openly and professionally. It emphasises that staff should raise concerns while they are **'just concerns'**, rather than wait until the level of concern escalates. It assures staff who may wish to raise genuine concerns that they will not lose their jobs or suffer retribution as a result of doing so. Nor will they be asked to provide proof that their concerns are well founded. The draft policy encourages the bringing forward of concerns openly. It sets out in general terms what will happen after a concern is raised and stresses that a person raising a concern will, insofar as is possible, be kept informed of what is being done in response to the concern.

9.121 The draft policy suggests that a member of staff should raise a concern with his/her line manager. If that is inappropriate for some reason, or has not proved effective, the draft

policy advises an approach to the practice manager or to a named GP within the practice. Staff are advised that, if they are unable to raise the concern internally, or if it has not been dealt with properly, they should approach a named contact at the PCT. Contact details are given. The draft policy is clear and reassuring in tone. It contains contact details for PCaW and also mentions that free independent advice may be available from the trade union or professional organisation to which the member of staff belongs.

9.122 The guidance to GPs suggests that a draft policy should be prepared and discussed at a staff meeting after which a practice policy should be agreed. There should be liaison with the PCT. Staff should be briefed on the content of the policy and a poster, reinforcing the message, should be displayed. Employment contracts should be amended as necessary to harmonise with the whistleblowing policy.

Training

9.123 Mrs Webdale emphasised the need for general practice staff to be trained, not only so that they were familiar with the procedure to be followed if they wished to raise a concern, but also so that they were aware of wider clinical governance issues. AMSPAR produces an induction pack for new staff which, if implemented properly at practice level, provides a comprehensive grounding for new staff. It includes the topic of raising concerns. Mrs Webdale said that the training for new staff now covers a much broader range of issues than was the case in the past. This includes clinical governance issues, which she regarded as very important. Mrs Webdale also contributes to educational events for GP practice staff, at the invitation of PCTs. She sometimes goes into practices to provide on-site training. She felt that more GP practices were recognising the value of good training for their administrative staff.

Closer Links with the Primary Care Trusts and with Staff from Other Practices

9.124 I have mentioned the problem of isolation of staff, both from other practices and from staff at the PCTs. Staff may feel that they have no one whom they can consult about their concerns. At the seminar, Mrs Webdale described the directory covering the area of the Norfolk, Suffolk and Cambridgeshire Strategic Health Authority. This contains the names of practice managers and staff who possess particular expertise on different topics upon which staff might need advice. With the assistance of the directory, practice staff are in a position to consult someone with experience in the relevant field. The fields of expertise listed in the directory include the raising of concerns. Mrs Webdale also spoke of arrangements for the sharing of staff between practices.

9.125 Mrs Sue Antrobus, representing the RCN, emphasised the importance of PCTs establishing networks of practice nurses. Dr Grenville felt that it was also important to promote links between practice nurses and district nurses. Dr Patterson described to the Inquiry various steps that she believed could be taken by PCTs in order to strengthen their links with GP practice staff. These included the provision of occupational health facilities and of arrangements for mentoring and peer support.

9.126 Some respondents to the Inquiry's Consultation Paper felt that a major problem lay in the fact that practice staff were employed by GPs, rather than by the PCTs. GPs were

sometimes reluctant to release staff to attend training and clinical governance meetings. As a consequence, it could be difficult for PCTs to form relationships with practice staff. Mrs Stephanie Farr, Head of Service (Children), Castle Point and Rochford PCT, said that her PCT was trying to encourage contact with practice staff but that practices were not always co-operative. Dr Grenville said that, in his area, there was a practice managers' group in each PCT, which met on a regular basis. His impression was that the role of the PCOs in training administrative staff had diminished with the advent of the PCTs, largely because the PCTs had so many functions to fulfil. He hoped that this role would be revived in time. Mr Robin Macleod, representing the General Medical Council, said that, in some areas, PCTs did not have the money to fund staff training.

The Role of the Primary Care Trust in Supporting Practice Staff

9.127 The position of a member of staff who voices a concern may become untenable, especially within a small or single-handed practice. The making of a complaint or the raising of a concern about either a doctor or a colleague may well destroy the working relationship within the practice. Mrs Webdale observed that the 'ideal' would be for practice staff to be employed by PCTs direct, but this was not a realistic prospect. However, if a member of staff were forced to leave a practice as a result of having raised concerns, she said that she thought that the PCT should support him/her in finding another job. She said that she was aware of some staff who had preferred to leave their posts, rather than to raise a concern about the practice in which they worked. She felt that PCTs should take steps to find out why a member of staff had left a practice. One possibility would be to design questionnaires to be completed and submitted to the PCT by staff leaving GP practices. These questionnaires could be collated and, if any trend emerged in relation to a particular practice, this could be followed up. Mrs Webdale felt that the exercise might contribute to the PCT's understanding of staff training needs and, also, to its ability to recognise when staff at a practice required help and support. By contrast, Dr Grenville, for the British Medical Association, believed that such a process would be unwieldy. He suggested that it would be better for PCTs to concentrate on encouraging practices to take steps themselves to find out why members of staff were leaving. It would then be for the practice to take action to eliminate any problems that were revealed.

The Way Forward

9.128 I agree with those who say that every GP practice should have a written policy setting out the procedure to be followed by a member of the practice staff who wishes to raise concerns about any matter, in particular about the clinical practice or conduct of a healthcare professional within the practice. The draft policy that has been developed by the DoH and PCaW seems an excellent starting point. However, a written policy is effective only if staff are aware of it and have the confidence to follow its guidance.

9.129 The first stage of any such procedure should be for staff to raise any concerns they may have within the practice. However, it is not enough just to include an exhortation to do so in a written policy. Staff will be discouraged from bringing forward their concerns within the practice if they find that, when they do so, they are met with lack of interest, irritation

or even outright hostility, and that no steps are taken to act upon the concerns. Much will depend upon the attitude of the doctors in the practice. If they show that they positively value the observations and criticisms of staff, there will be a much more open culture within the practice and it will be much easier for staff to raise a serious concern if one arises. It seems to me that the kind of practical arrangements described by Mrs Webdale would be a useful model. It should become the norm for every untoward incident or concern, whether minor or serious, to be brought to the attention of those responsible for managing the practice.

9.130 The practice policy should give staff the name and contact details of an individual at the PCT to whom the staff can take any concerns that they feel unable to raise within the practice. It seems to me clear that the 'second port of call' for concerns should be the PCT, rather than another organisation such as the LMC. It is the PCT which has responsibility for clinical governance within primary care; if there are problems with doctors or other healthcare professionals within a practice, it is important that the PCT is aware of them. This is particularly important if issues of patient safety arise. The recent Report of the independent investigation into how the NHS handled allegations about the conduct of Clifford Ayling (the Ayling Report) highlighted the 'ambiguous role' played by the local LMC in that case. The Ayling Report emphasised that it was not the role of LMCs to act on information which suggested that patient safety was being compromised. That was the role of the PCT or the relevant professional regulatory body. I would suggest that the guidance within a written policy should make clear, not only that the appropriate 'second port of call' should be the PCT, but also why it is important that the PCT should be made aware of concerns.

9.131 Occasionally, a healthcare professional or other member of staff may have a concern that is so sensitive that it would be difficult to raise it locally. Concerns of the kind that staff might have had about Shipman would be an example. It would have taken a great deal of courage for a member of staff to have raised concerns with the WPHA about Shipman's death rates. Access to advice from an organisation well away from the area would make the prospect of making a report much less daunting. To provide for this situation, the policy should contain details of organisations, such as PCaW, from which staff can obtain free independent advice. If the 'single portal' or 'clearing house' for the signposting of complaints and concerns, which I have referred to elsewhere in this Report, is created, the policy should set out the contact details for that also.

9.132 Practices should be encouraged to train their staff in the procedures set out in their policy and to reinforce that training regularly. It should form part of the induction process for new staff. The policy itself should be reviewed and updated (e.g. by ensuring that the named contacts and contact details are still current) at regular intervals; as Mrs Webdale said, it should be a 'living document'.

9.133 In addition to any training given by GP practices, PCTs should provide information and training about whistleblowing policies direct to practice staff. The training should be placed in the context of general clinical governance issues. Staff should be made aware of the important role they can play in promoting clinical governance within their practices and in protecting patients. PCTs should designate at least one individual to act as a

contact for practice staff who have concerns to communicate. Every effort should be made to ensure that the designated individuals are personally known to practice staff. It would help if there could be an element of continuity so that staff did not continually have to deal with different individuals. The designated individuals should not merely act as recipients for concerns, but should also offer general support and advice to practice staff.

9.134 Special arrangements should be made for staff in single-handed and small practices. The written policies for such practices should refer to the particular difficulties which staff in such practices might face in voicing concerns and should recognise that they might prefer to raise their concerns with the PCT, rather than internally, in the first instance. Extra efforts should be made to promote links between the PCT and the staff of single-handed and small practices and to involve the latter in training and other events. I note that the Ayling Report referred to the need for PCTs to pay particular attention to developing and supporting the independence of practice managers in single-handed practices. I would endorse this recommendation, but would also like to see it extended to other staff within GP practices – in particular, practice nurses.

9.135 In order to reduce the problems caused by isolation, initiatives that promote the 'cross-fertilisation' of staff between one GP practice and another should be encouraged wherever possible. I have in mind here the arrangements mentioned by Mrs Webdale for the sharing of staff and the mentoring and peer support schemes that exist in some areas. The dissemination of ideas and information between staff in different GP practices should, it seems to me, increase the capacity of staff to recognise behaviour and clinical practice that fall completely outside the norm.

9.136 At the Inquiry, the issue arose as to whether practice staff who raise genuine concerns about their GP employer are adequately protected from reprisals by the provisions of the Public Interest Disclosure Act 1998 (PIDA). I describe the provisions of the PIDA in Chapter 11. Although practice staff technically enjoy the protection of the Act, there are two potential problems. The first is that the PIDA requires a whistleblower to raise his/her concerns within the employer's organisation before raising them outside. If the whistleblower goes straight to an outside body, much of the protection of the PIDA will be lost. This provision is really designed to discourage whistleblowers from 'going public' before they have raised their concerns internally. However, the protection of the PIDA is not lost if the whistleblower raises his/her concerns with a person or body that the employer has suggested as a suitable recipient for those concerns. Thus, if a GP practice's whistleblowing policy suggested the PCT as a suitable recipient, the protection of the PIDA would not be lost if the staff member raised his/her concerns with a PCT employee. The same should apply in the event that a 'single portal' or 'clearing house' were to be set up. If it is thought that there is any doubt about the application of the principle I have mentioned, then I suggest that the PIDA should be amended to clarify this.

9.137 The second problem is a more general one. Any protection provided by the PIDA will be ineffective if the staff member raises a concern about someone within the practice (for example a doctor or practice nurse) and if, as a result, the working relationships within the practice break down. The right to retain the employment is then an empty one. I think that the provisions of the PIDA were drafted with large organisations, rather than small ones, in

mind. I do not think that it would be practicable to amend the PIDA to remedy this problem. However, in the event that a staff member 'blows the whistle' on a practice and cannot continue to work there, the PCT should, in my view, assist the employee to find a post in another practice wherever possible.

9.138 Whether or not it would be sensible or practical for PCTs to collect 'exit questionnaires' from staff leaving GP practices I am not sure. The only way to find out would be to run a number of pilot schemes and assess the results. It does not seem to me that this would be difficult to organise. However, I would have thought that, if PCTs ensured that there was a member of their own staff whose responsibility it was to maintain relationships with practice staff, staff with problems would naturally turn to the PCT for help and there would be no need for questionnaires.

9.139 I agree with Dr William Reith who, speaking on behalf of the Royal College of General Practitioners, emphasised the need for concerns to be properly followed up by PCTs. His comments reflected the concerns of many, namely that, if practice staff see a consistent pattern whereby no action is taken in respect of concerns that are raised, that will inevitably discourage them from reporting concerns in future. There are other reasons why concerns expressed by practice staff should be properly investigated and acted upon. A member of the staff of a GP practice is likely to think long and hard before bringing a concern to the PCT; it is not a step that s/he is likely to take lightly. He or she is likely to be one of the few people who work closely with the doctor or other healthcare professional concerned and who would be in a position to become aware of poor clinical practice or aberrant behaviour. While it is of course possible that his/her concerns may be unfounded, they may well be justified and, in the interests of good clinical governance, it is vital that they are taken seriously and subjected to proper investigation. I shall say more about how I believe PCTs should respond to such concerns later in this Report.