

## FOREWORD

This Report deals with the Fourth Stage of Phase Two of the Inquiry. It covers those parts of my Terms of Reference which required me, by reference to the case of Harold Shipman, to enquire into the performance of the functions of those statutory bodies, authorities, other organisations and individuals with responsibility for monitoring primary care provision and to recommend what steps, if any, should be taken to protect patients in the future.

The Inquiry has examined the powers and functions of the primary care organisations which administered general medical services during the years between 1974, when Shipman commenced work as a general practitioner (GP) and 1998, when he ceased practice following his arrest on suspicion of murder. I have also considered the important changes made since 1998 in the arrangements for the monitoring of GPs and the introduction of measures for the remediation of any deficiencies uncovered by such monitoring.

The General Medical Council (GMC) is the body responsible for keeping the register of all doctors practising in the UK. Only the GMC has the power to erase a doctor's name from the medical register. It can also suspend the doctor from practice or impose conditions upon his/her registration. It exercises these powers through its 'fitness to practise' procedures. The GMC's powers are the 'teeth' by which all other monitoring processes can ultimately be enforced. It follows that the GMC plays an essential part in the monitoring of GPs and in the protection of patients from doctors who might harm them either deliberately, recklessly or by reason of some deficiency in their practice. The Inquiry has examined the way in which the GMC has operated its fitness to practise procedures from the 1970s until the present day and has considered the proposals for the new procedures which have just come into operation. I have also examined the GMC's proposals for the revalidation of doctors, due to come into effect in 2005.

During this stage, the Inquiry has received an enormous amount of documentary evidence, including 386 witness statements and 126 responses to the Consultation Paper, 'Safeguarding Patients', which was issued in October 2003. Ideas for change were discussed at seminars held in January 2004. I am grateful to all those who provided statements of evidence or written responses and to those who attended the hearings and seminars in person. I must mention particularly the participants from overseas who made presentations to the Inquiry explaining how doctors are monitored in their countries. All these contributions have been of value to me and have, I believe, enabled me to reach conclusions that are soundly based in evidence.

The publication of this Report marks the end of the Inquiry's examination of the wider issues associated with Shipman's activities, although it is my intention to publish a further short Report dealing with Shipman's activities while working at Pontefract General Infirmary between 1970 and 1974. It is, therefore, appropriate at this stage for me to express my thanks to all those who have worked on the Inquiry. Those who remain have worked together for almost four years and my debt of gratitude to them is immense. The administrative team, led, until recently, by Oonagh McIntosh, has provided not only a smooth-running internal machine but also the Inquiry's interface with witnesses and the public, particularly the families of Shipman's victims. If they have found that the Inquiry has treated them with sympathy and consideration, I have Oonagh and her team to thank for it. Henry Palin, Solicitor and Secretary to the Inquiry and his assistant, Ita Langan, have managed all the investigations, the document handling and the publication of the Reports. Their dedication has been unswerving and their contribution immense. At one time, their team

comprised about fifteen solicitors and paralegals. Three have stayed to the end: Martin Beckett, Tony Kitson and Thomas Thwaites. I am grateful to them not only for their staying power but for the care and thoroughness of their work, which has been vital to the Inquiry's processes. Allan Dyde, a retired detective inspector who knew Hyde well, joined the team for six weeks in February 2001 and proved so useful that we could not let him go. The IT team has been indispensable to what was an (almost) paper-free Inquiry. Helen Whitehorn has taken much (if not quite all) of the stress out of preparing the Reports for publication. Aneez Esmail has, throughout the Inquiry, been an invaluable source of advice and inspiration. Finally, I am indebted to Counsel, Caroline Swift QC, Christopher Melton QC, Anthony Mazzag and Michael Jones. I recognise that the Inquiry has lasted longer and has kept them from their practices for longer than any of us expected. I appreciate the hard work and very long hours that all members of the legal team have put in. The Inquiry has taken over their lives and they have put up with that with unfailing cheerfulness. I have enjoyed their company and their friendship. I wish them all well as they return to 'normal life'.

The subject matter of this Inquiry was such that the enormity of Shipman's crimes, his breach of trust and the effect that these had on the families of his victims and the people of Hyde were never far from my mind. In the early stages, my first concern was to give the families the answers they needed. However, as the ambit of the Inquiry's work widened to include an examination of death certification, controlled drugs regulation and the monitoring of GPs, I came to realise that the Inquiry could turn the tragedy of Shipman's criminality into something of benefit to society in the future. Whether the Inquiry succeeds in that respect is for the judgement of others. If it fails, it has not been for want of trying.