CHAPTER ELEVEN

Shipman's Use of Controlled Drugs in Hyde from 1977 to 1993

Introduction

11.1 Shipman commenced practice at Donneybrook House in Hyde on 1st October 1977. He became one of seven doctors in the practice. At interview, earlier in the year, Shipman had told some of the Donneybrook doctors that he had had a problem with controlled drugs and had been convicted of controlled drugs offences. He had also said that he did not intend to use controlled drugs in future. They were no longer necessary for analgesia as there was a new drug on the market called Fortral (pentazocine) which was not controlled and provided a suitable alternative to the opioid drugs in common use.

11.2 Before Shipman was offered the position, Dr Geoffrey Roberts, one of the members of the practice, telephoned the General Medical Council (GMC) and the Home Office to satisfy himself that there was no current restriction on Shipman's prescribing rights. The Donneybrook doctors would not have invited Shipman to join the practice if his prescribing rights had been fettered in any way. They operated in the main as single-handed practitioners, sharing premises and staff. Dr Roberts was told that Shipman was not subject to any restrictions.

11.3 During the 14 years for which he practised at Donneybrook House, Shipman killed 71 patients, and the deaths of 30 other patients give rise to suspicion. On 1st January 1992, he set up in practice as a fully independent single-handed practitioner, albeit still from rooms within Donneybrook House. On 24th August 1992, he moved to his new premises at 21 Market Street. During the years 1992 to 1998, he killed 143 patients and the circumstances of a further nine deaths give rise to suspicion. Shipman usually killed by giving an intravenous injection of diamorphine. I have already explained in Chapter One how Shipman was able to obtain his supplies of diamorphine. In this Chapter and the next, I shall examine his actions in greater detail and will consider why the systems of regulation and inspection then in force failed to detect his activities. I shall concentrate in particular upon a sequence of single 30mg ampoules of diamorphine that Shipman obtained in 1993. That sequence was unusual and might have been expected to arouse suspicion on the part of the pharmacist dispensing the drugs and the chemist inspection officer (CIO) who examined the controlled drugs register (CDR) at the pharmacy concerned.

11.4 In an attempt to identify all Shipman's sources of supply of controlled drugs, the Inquiry examined the CDRs from nine pharmacies in and around Hyde. Although a pharmacy is required to keep its CDR for only two years after the last entry, some had been kept for much longer. One extended back as far as 1967. Examination of the CDRs revealed that the great majority of controlled drugs prescribed by Shipman had been dispensed at the pharmacy at 23 Market Street. Only very occasionally were entries relating to Shipman found in the CDRs of other pharmacies. This is not surprising, as 23 Market Street was conveniently located close to both the Donneybrook and the 21 Market Street practices.

11.5 The first entry in the surviving CDR for the pharmacy at 23 Market Street was made on 1st October 1991. From the registers of other pharmacies, some of which go back much

further, it appears that no other pharmacy had dispensed ampoules of diamorphine prescribed by Shipman before that date. It seems reasonable to infer that, even before he moved to the Market Street premises, diamorphine prescriptions written by Shipman were dispensed mainly, if not exclusively, at 23 Market Street. Because so few entries in Shipman's name were found in CDRs from other pharmacies, I consider that the CDR from 23 Market Street provides a virtually complete picture of Shipman's prescribing of diamorphine after 1991.

The Period Prior to October 1991

11.6 Having seen the methods by which Shipman obtained large quantities of pethidine in Todmorden and the similar means that he employed to acquire diamorphine in the 1990s, I have inferred that he probably used similar methods during the intervening years. In the First Report, I explained my belief that, during the 1980s, Shipman obtained most of his supplies by over-prescribing for the needs of his terminally ill patients and retaining any supplies that were left over after their deaths. I noted a disturbing correlation between the periods during which he would have had access to supplies prescribed for a patient with cancer and the occasions on which he killed. I think it unlikely that he ever ordered diamorphine on requisition. That was the method that had resulted in his detection in 1975. I think he would have been very anxious to avoid being detected for a second time. By taking possession of drugs left over after a patient's death, he would not be vulnerable to detection. He would have known that there was no continuing record of drugs, even injectable controlled drugs with a high black market value, once they left the pharmacy. It is probable that, on occasions, Shipman also obtained supplies by collecting a patient's drugs from the pharmacy and retaining part of the consignment for himself. Probably, he would have hesitated to do that in the early days, as it was known to the authorities that he had used that method in Todmorden. However, as time went by, I am satisfied that he resumed that practice. His willingness to collect drugs from the pharmacy for a patient and to remove excess supplies after the death fitted well with his carefully created reputation as a caring doctor, who would 'go the extra mile' for his patients.

11.7 Between 1978 and 1983, Shipman did not kill frequently. However, from 1984 until 1989, he killed between eight and twelve times a year with no long intervals between the deaths. He probably obtained his supplies of diamorphine from cancer patients. For example, two patients died in January 1985; both had been taking diamorphine for their cancer pain. In one case, there is evidence that he took away the unused drugs; I think it likely that he did so in the second case too. There followed a spate of four killings during February 1985 and six during the rest of the year. Similar connections can be traced during the next four years, during which time Shipman killed 39 patients. For reasons that I do not fully understand, Shipman killed only one patient between November 1989 and October 1991. During that time, he had decided to leave Donneybrook House and to set up on his own at 21 Market Street, next door to the pharmacy at 23 Market Street.

The Pharmacy at 23 Market Street, Hyde

11.8 The pharmacy at 23 Market Street is a busy retail pharmacy. For many years it traded under the name Battersby's and this continued following its acquisition, in September

1991, by Mayfair Chemists (Hyde) Limited (Mayfair), a company owned by Mr Peter Rothman and his wife. In October 1991, Mr Rothman engaged Mrs Ghislaine Brant as the pharmacist manager at Battersby's. He had the premises refurbished and provided a well-equipped dispensary. He installed a computerised system of keeping patient medication records (PMRs).

11.9 Mr Rothman's company had two other pharmacies; one was located in Chadderton, near Oldham, and the other at premises in The Square, Hyde. Mr Rothman was based at the Chadderton pharmacy, although he would visit the other two shops once or twice a week. During the early 1990s, he was the superintendent pharmacist for Battersby's. As well as his managerial duties, Mr Rothman, who had qualified as a pharmacist in 1955, liked to keep up an active interest in dispensing. He would provide cover when one of his pharmacists was off sick, on holiday or having a day off. In 1993, he underwent heart surgery and decided to reduce his business activities. He told the Inquiry that the company owned the premises and business until 1st September 1995 when all three businesses were sold to United North-West Co-op Healthcare Limited.

Mrs Ghislaine Brant

11.10 Mrs Brant graduated in pharmacy at the University of Manchester in 1977. She underwent a one-year pre-registration course with Boots the Chemists (Boots) and obtained her professional qualification in July 1978. She then worked as a relief or second pharmacist at Boots pharmacies throughout Greater Manchester. In about July 1979, she left Boots' employment and began working as a self-employed locum pharmacist. Within about a year, she was offered full-time employment by the proprietor of a pharmacy in Salford and she worked there until 1991, when the business was sold to a pharmacist who intended to manage the pharmacy himself and so had no need for her services.

11.11 At Battersby's, Mrs Brant worked a 40 hour week, which allowed her to take one day off in the working week. On her days off, and during her holidays, her position would be taken either by Mr Rothman himself or by one of the pharmacists working at Mayfair's Chadderton pharmacy. Occasionally, a locum would be employed. All the evidence suggested that Mrs Brant ran the pharmacy in Market Street very well. The premises were well kept; her dispensing was very efficient and there was no reason to question her managerial or professional abilities. Under the new ownership, Mrs Brant continued as manager of the pharmacy and still occupied this position at the time of the Inquiry hearings. So far as I am aware, she continues to give satisfaction to her employers.

11.12 It was Mrs Brant's misfortune that, within 12 months of her appointment, Shipman moved into the surgery premises next door to the pharmacy. As a result, Mrs Brant was responsible for dispensing the great majority of Shipman's prescriptions for diamorphine during the following six years. In particular, she was responsible for dispensing all but one of a series of 14 prescriptions for single ampoules of 30mg diamorphine that Shipman wrote between February and August 1993. The other prescription was dispensed by Mrs Janice Beesley, who usually worked at the Chadderton pharmacy. As I have indicated, this series of prescriptions was very unusual and must be closely scrutinised.

The Other Staff

11.13 A number of other staff were employed at Battersby's in the early 1990s. Mrs Christine Williamson was a very experienced dispensing assistant who, in 1984, had returned after a maternity break to work full-time at Battersby's. She was still working at the pharmacy in 2003. Mrs Elizabeth Pilkington began working at Battersby's in 1984. She was employed as a counter assistant. She was to qualify as a dispensing technician in 1998. She left the pharmacy in September 2001. Mrs Beesley was based at the Chadderton pharmacy but, in common with others who worked there, also worked at 23 Market Street as an occasional relief pharmacist between 1991 and November 1996. Mrs Karen Barham worked as an occasional relief pharmacist between 1990 and 1992. All held Mrs Brant in high regard and none had any reason to doubt her professional integrity or competence in any way.

Diamorphine Stocks and the Appearance of the Controlled Drugs Register from October 1991 to February 1993

11.14 Later in this Chapter, I shall have to consider whether Mrs Brant or Detective Constable (DC) Patrick Kelly (then recently appointed as CIO) should be criticised for not making a report to an appropriate authority about the series of prescriptions for single 30mg ampoules of diamorphine dispensed on prescriptions issued by Shipman during 1993. In order to make that assessment, I shall have to compare the appearance of the diamorphine section of the CDR in the period between October 1991 and February 1993 with its appearance in the following seven months. Copies of the relevant 'drugs supplied' pages (but not the 'drugs obtained' pages) appear at Appendix A.

11.15 The CDR from 23 Market Street is well kept, neat and legible although much of the handwriting is very small. It was in the standard printed form issued by the National Pharmaceutical Association and complied with the requirements of the Misuse of Drugs Regulations 1985, then in force. The periodic visits of the CIO are recorded, at which times 'out of date' drugs were often destroyed.

11.16 On 1st October 1991, twenty 30mg ampoules and five 5mg ampoules of diamorphine were received from the wholesaler; on the same day twenty 30mg ampoules were dispensed to a patient on the prescription of a general practitioner (GP), whom I shall call Dr A. Mrs Brant said that the drugs must have been specially obtained on request, probably for a patient with cancer. She explained that, in the early 1990s, it was not her practice to keep a stock of any drug that was not often called for. The pharmaceutical wholesalers that supplied the pharmacy responded very quickly to any order. There could be up to four deliveries a day.

11.17 The CDR shows that, on 13th November 1991, some diamorphine linctus was dispensed for a patient of Dr B and, the following day, a delivery was received replacing the diamorphine powder that had been used in the linctus. On 3rd December 1991, DC Alan Jackson (DC Kelly's immediate predecessor) attended and witnessed the destruction of four out of date 10mg ampoules.

11.18 On 18th February 1992, Dr A purchased five 5mg ampoules on requisition. Either some of those ampoules obtained on 1st October 1991, or some others previously held in stock, must have been supplied to him.

11.19 On 6th March, twenty five 30mg ampoules were dispensed for a patient on a prescription written by Dr C, and on 10th March, the same quantity was dispensed for the same patient, this time prescribed by Dr D, who worked in the same practice as Dr C. It appears likely that the patient in question was terminally ill. Fifteen of the 50 ampoules dispensed had been obtained by the pharmacy on 5th March, probably because one of the doctors then informed the pharmacy that supplies were going to be needed. Twenty more were obtained on 6th March and 25 more on 10th March, making 60 in total. The 'spare' ten ampoules were not dispensed for the patient in question (it is possible that s/he had died) and they remained in stock. This is important to note, because they probably represent the stock (or part of the stock) which was later to be dispensed on prescriptions written by Shipman for single 30mg ampoules. On 11th March, the pharmacy also obtained ten 100mg ampoules but the CDR shows that these were returned to the wholesaler on the same day. On 16th March, some linctus was dispensed on a prescription issued by Dr B.

11.20 Shipman's name had not appeared as the prescribing doctor in the CDR by this time. It appears likely that he was not caring for any patients needing diamorphine. Significantly, I have not found that he killed any patients during this period, although I am suspicious about the death of Mrs Annie Powers, who died on 10th January 1992.

11.21 On 16th March 1992, a prescription written by Shipman for two 30mg ampoules of diamorphine was dispensed. This is the first time his name appears in the CDR. The drug was prescribed in the name of a male patient who subsequently transferred to another doctor and has since died. The Inquiry has obtained the patient's medical records; they do not show that he was prescribed diamorphine in March 1992. Nor do they reveal any condition that would have justified such a prescription. It seems likely, therefore, that Shipman obtained the drugs for his own purposes. Mrs Brant could not remember whether Shipman collected the drugs on behalf of this patient, although she thought he had not because her recollection was that she did not meet him until after he had moved into 21 Market Street, when he held an opening for the surgery. She thought that these two 30mg ampoules might have been collected by a nurse or a member of the surgery staff. I think that Mrs Brant is almost certainly wrong about this. It is highly unlikely that a district nurse would have collected drugs other than at the specific request of the patient. These drugs were not needed by the patient and the prescription for them was not recorded in the patient's medical notes. They were plainly intended for Shipman's personal use. It would have been quite out of character for Shipman to allow anyone else to collect his illicit supplies of diamorphine.

11.22 On 19th March 1992, the Royal Pharmaceutical Society of Great Britain (RPSGB) inspector, Mr David Young, witnessed the destruction of five out of date 10mg ampoules of diamorphine. It is not possible to tell whether any more remained in stock because the CDR does not provide for an opening stock or a running stock balance.

11.23 Between May 1992 and February 1993, there was very little activity recorded in the CDR. On 15th May 1992, five 10mg ampoules of diamorphine were purchased and the same quantity was supplied on a requisition signed by a GP, Dr E, presumably for his emergency supply. On 21st October 1992, a prescription for diamorphine in solution was dispensed for a patient of Dr F. In December 1992, a pack of 5mg ampoules was purchased and the same quantity was supplied to a GP, Dr G, apparently for emergency use. There were no purchases or supplies of 30mg ampoules.

11.24 In summary, during the 16 months before February 1993, the diamorphine section of the CDR showed ten dispensings. The names of eight different doctors appeared; no doctor's name appeared more than twice, whether as prescriber or as having sought a supply on signed order. The quantities and form of the drug dispensed were variable.

The Abnormal Pattern of Prescribing and Dispensing of Diamorphine in 1993

11.25 The diamorphine section of the CDR from 23 Market Street shows that, between 22nd February and 27th August 1993, Shipman issued 14 prescriptions (in the names of 13 different patients), each for a single 30mg ampoule of diamorphine. This is a most unusual amount to be prescribed as a single dose for therapeutic purposes. The dose was far too large to be intended for use in the treatment of acute pain and far too small to be intended for the relief of chronic pain in terminal illness. As one of the RPSGB inspectors observed, it is 'neither one thing nor the other'. For an opioid-naïve patient, 30mg would be a fatal dose.

11.26 Mrs Brant accepted that she was responsible for dispensing the drug and making the entry in the CDR in each case save one. The relevant entries are made in her distinctive hand. Although the CDR does not record who collected the drugs, Mrs Brant accepted that Shipman usually collected them himself and I think that he did so in each case. Mrs Brant said that her understanding was that Shipman wanted the drugs for the relief of cardiac pain suffered by patients. She said that it did not occur to her that Shipman's prescribing practice was unusual or suspicious and she did not think of reporting it to anyone or drawing it to the attention of the CIO.

11.27 As I observed in the First Report, for several months during 1993, Shipman's pattern of killing his patients was very closely related to his obtaining of diamorphine. Six of the 14 prescriptions were dispensed within a few days after the death of the patient in whose name they were issued. Four of the 14 prescriptions were issued on the day of the death of the patient in question. Two patients in whose names prescriptions were dispensed told the court at Shipman's trial that they were not aware that the prescriptions had been issued and that they had had no need of diamorphine. Of those GP records of the deceased patients which are still available, none contains any reference to the administration of diamorphine, although three sets of records (those of Miss Mary Andrew, Mrs Edna Llewellyn and Mrs Amy Whitehead) refer to the intravenous administration of 10mg morphine sulphate or morphine on the day of the death. I have explained in the First Report how I came to find that, in those cases, Shipman misrepresented in the notes the amount and the type of opiate given. Diamorphine is two or three times as strong as morphine and morphine sulphate.

11.28 It is clear that, during that year, Shipman used these single 30mg ampoules of diamorphine to kill patients. I say that with the benefit of hindsight. The question I must now address is whether, without the benefit of hindsight and in the light of what was known to her at the time, Mrs Brant should have noticed this unusual pattern of prescribing and have been suspicious about it. Later, I shall consider what would have happened if this pattern of prescribing had been noticed and investigated.

Mrs Brant's Professional Obligations

11.29 In Chapter Seven, I summarised the contents of the current edition of the booklet published by the RPSGB, entitled 'Medicines, Ethics and Practice – A Guide for Pharmacists' (the MEP Guide). Mrs Brant was shown extracts from the edition current in April 1993 and agreed that she was familiar with it. It set out the professional duties of pharmacists in a Code of Ethics, which comprised both principles and more detailed obligations. The Code was supplemented by guidance on interpretation.

11.30 The first principle of the Code was that:

> **'A pharmacist's prime concern must be for the welfare of both the patient and other members of the public.'**

11.31 Obligation 1.7 under that principle said that:

> **'A pharmacist must exercise professional judgment to prevent the supply of unnecessary and excessive quantities of medicines and other products, particularly those which are liable to misuse, or which are claimed to depress appetite, prevent absorption of food or reduce body fluid.'**

11.32 Mrs Brant accepted that it was her duty to check that the dosage of medicine prescribed was not excessive for the patient. That, she said, would be her approach when handing over medicine to a member of the public, but she considered that, when medication was being handed over directly to a GP, she was entitled to assume that s/he would use the drug appropriately. I cannot accept the distinction she sought to draw. The main reason why a pharmacist should check that the dosage of a drug is appropriate is that the prescribing doctor might have ordered an inappropriate dose. If s/he has, s/he might have done so because s/he made a slip of the pen or, alternatively, s/he might have made the error through ignorance of the appropriate dosage range. The pharmacist is quite likely, by reason of his/her training and expertise, to have a greater technical knowledge of the drug than the doctor. I do not think therefore that a pharmacist should be excused from exercising his/her professional judgement simply because s/he is handing the drug to a doctor rather than to a member of the public. However, if, on enquiry by the pharmacist, the doctor were to say that s/he knew that the quantity prescribed was greater than should be administered and that s/he intended to use only part of the drug prescribed and throw away the rest, it would, in my view, be reasonable for the pharmacist to assume that the doctor would give the patient an appropriate dose. In any event, even though the pharmacist might be satisfied that the patient would not come to harm, s/he still had a duty to **'prevent the supply of unnecessary and excessive quantities of medicines'**.

11.33 Guidance on Obligation 1.7 was in the following terms:

> **'*Drug Misuse.***
>
> **Many prescription only medicines and Controlled Drugs have a potential for misuse or drug dependency. Care should be taken over their supply even when it is legally authorised by prescription or signed order. A pharmacist should be alert to the possibility of drug dependency in health care professionals and patients and should be prepared to make enquiries to ensure that such medicines are to be used responsibly.'**

11.34 Mrs Brant said that, in 1993, she was aware of the possibility of drug dependency among doctors. However, I accept that she was not aware, and had no reason to suspect, that Shipman had a history of drug abuse. I accept that Mrs Brant and all the staff shared the widely held view that Shipman was a competent, conscientious and caring practitioner.

Mrs Brant's Understanding of the Appropriate Dosages of Diamorphine

11.35 I have explained that a single 30mg dose of diamorphine was a very unusual quantity to prescribe; it was 'neither one thing nor the other'. The Inquiry wished to know what Mrs Brant's understanding was of the usual dosages of diamorphine for various purposes. Her attention was drawn to the British National Formulary (BNF) for 1993, which gave guidance as to the appropriate dosages of diamorphine for the various conditions for which it can be prescribed. The guidance read:

> **'Acute pain, *by subcutaneous or intramuscular injection*, 5 mg repeated every 4 hours if necessary (up to 10 mg for heavier well-muscled patients)**
>
> ***By slow intravenous injection*, quarter to half corresponding intramuscular dose**
>
> **Myocardial infarction, *by slow intravenous injection* (1 mg/minute), 5 mg followed by a further 2.5–5 mg if necessary; elderly or frail patients, reduce dose by half**
>
> **Acute pulmonary oedema, *by slow intravenous injection* (1 mg/minute) 2.5–5 mg**
>
> **Chronic pain, *by mouth or by subcutaneous or intramuscular injection*, 5–10 mg regularly every 4 hours; dose may be increased according to needs, intramuscular dose should be approximately half corresponding oral dose, and quarter to third corresponding oral *morphine* dose ...'**

11.36 Mrs Brant accepted that this guidance was consistent with her understanding of the properties of diamorphine and her experience of the quantities of diamorphine that had been requested by doctors for their personal stocks. She confirmed that, for a patient with myocardial infarction or symptoms suggestive of it, appropriate treatment for the pain would be the administration of 2.5mg to 5mg diamorphine, or less in the case of a less

well-muscled patient, but possibly more if necessary. Larger doses would be appropriate for cancer pain.

11.37 Mrs Brant was asked whether she realised that 30mg diamorphine was a far greater dose than would be needed to treat a patient with acute pain. At first, her response was that Shipman was an experienced doctor who knew what dose he needed to give and that he could work out how much he should give from a larger ampoule. She then said that other doctors were prescribing 30mg ampoules for acute pain and that, in some patients, that was the necessary dose. She agreed, however, that it was 'pretty unusual' as a single dose. When asked whether these other doctors were using 30mg as a single dose for opioid-naïve patients, she replied that she did not know whether the patients in question were opioid-naïve. I am quite sure that Mrs Brant knew that 30mg diamorphine would be an excessive dose for an opioid-naïve patient suffering an acute episode of pain.

The Events of 1993 in Detail

11.38 I will now deal with the events in 1993 in some detail. I shall examine them from the point of view of Mrs Brant, bringing into account only the information that was, or should have been, available to her. Pharmacists do not have access to a patient's medical records and a prescription does not carry any indication of the condition for which the medication has been prescribed. In Chapter Seven, I explained the difficulties that this can create for pharmacists when assessing the appropriateness of a particular prescription. Pharmacists do, in general, have access to the PMRs kept by the pharmacy where they work. If the patient uses a particular pharmacy exclusively, a very useful picture can be built up in such records. The Inquiry has obtained the PMRs for some of the patients for whom Shipman prescribed a single ampoule of diamorphine in 1993. No record is available in some cases. That may be because no record was ever created in that patient's name. It is possible that a record was created but is no longer available. However, in each case where a PMR was kept and is available to the Inquiry, it has been found that these single ampoule prescriptions for diamorphine were not entered into the record.

The Week of 22nd to 26th February 1993

11.39 On Monday, 22nd February, Shipman presented two prescriptions for single 30mg ampoules of diamorphine. One was in the name of Mrs Louisa Radford and the other in the name of Mr Harold Freeman. The pharmacy held a PMR for Mr Freeman but this prescription was not entered. For the reasons explained in paragraphs 11.19 and 11.21, Mrs Brant must have had more than eight 30mg ampoules in stock at this time, because, before ordering any further supplies on 1st July, she was to supply Shipman with 12 single ampoules and to dispense ten more on a prescription for a patient of another doctor on 30th June.

11.40 When giving oral evidence to the Inquiry, in May 2003, Mrs Brant said that the first time she dispensed a diamorphine ampoule for Shipman was probably on 22nd February 1993, although as I have said in paragraph 11.21, it is highly likely that she dispensed two 30mg ampoules for him on 16th March 1992. She recalled that Shipman came into the pharmacy, saying that he had to make an emergency visit to a patient who had suffered a suspected

heart attack, for which he needed an ampoule of diamorphine. If Mrs Brant's recollection is right, that patient would have been Mrs Radford, for whom no PMR is available. Mrs Brant thought that Shipman initially asked for a 5mg ampoule but she told him that she had none in stock so he then asked for a 10mg ampoule. She told the Inquiry that she understood, from the fact that he was seeking a 5mg or 10mg ampoule, that Shipman did not keep an emergency stock of his own. She said that she went to the controlled drug cabinet, where she found that she had only 30mg ampoules in stock. She told the Inquiry that she believed that she had had no stock of 10mg ampoules since the destruction carried out by Mr Young in March 1992. She claimed that she had had no requests for 10mg ampoules since her arrival in Hyde and that, when the existing stock had gone out of date, she would not have replaced it. In fact, she supplied five 10mg ampoules to Dr E on 15th May 1992 and purchased the same quantity on the same day. It is quite possible that she purchased these ampoules specifically for Dr E because she did not have any in stock but it is also quite possible that she supplied existing stock to Dr E and replaced the ampoules with new stock. This would be sensible stock rotation. However, I accept that there is no evidence to contradict her belief that she had no 5mg or 10mg ampoules in stock on 22nd February 1993.

11.41 Mrs Brant said that, because she had only 30mg ampoules, she had to give Shipman one of those. She said that there could not have been any 5mg or 10mg ampoules in her stock, because, if there had been, that is what she would have given him. She emphasised that it was open to Shipman to use less than the full 30mg, if appropriate, and to throw away the rest. She could not remember whether, at the time of making his request, he had already written a prescription for 5mg or 10mg. She said that he might have had an empty prescription pad in his hand or he might have brought her a prescription. She was sure, however, that he had written out a prescription for a 30mg diamorphine ampoule before he left the shop.

11.42 When providing a statement for the police in 1999, Mrs Brant identified each of the 14 entries in the CDR covering the single 30mg ampoules. She then said:

> **'I can recall that when I asked Dr Shipman about these prescriptions he stated that the drugs were being used for patients with suspected chest pain and heart attacks which** *(sic)* **he was going to visit.'**

11.43 At the trial, in 1999, Shipman's counsel asked Mrs Brant whether she had any independent recollection of the individual occasions on which Shipman had prescribed diamorphine or whether she was dependent for her recollection on the CDR. She said that she was dependent on the CDR. She was asked specifically whether she remembered the prescription for Mrs Radford and she said that she did not.

11.44 In 2002, when Mrs Brant provided a statement for the Inquiry, she was asked about the series of single ampoules prescribed in 1993. She did not say that she had any recollection of what Shipman had said to her at the time. She explained that she had not noticed any particular pattern to Shipman's prescribing. She said that it was not her practice to look for a pattern. Each prescription would be examined individually and, if it was correctly presented and there were no other concerns about it, it would be dispensed.

11.45 In oral evidence to the Inquiry, Mrs Brant said that she could not remember Shipman coming in for a second time on 22nd February with a prescription for Mr Freeman. She postulated that he might have come in later in the day and issued a prescription to 'replenish' his stock, having already administered a quantity of diamorphine to the patient from that stock, although she could not remember that he had done so. When a doctor administers a drug from his/her own stock to a NHS patient, s/he ought to reclaim the cost of the drug, which s/he has paid for, from the Prescription Pricing Authority. He or she is also entitled to claim an administration fee. It appears that some doctors cannot be bothered to go through this procedure and prefer to issue a prescription in the name of the patient and keep the drug to 'replenish' their own stocks. The practice of 'replenishing' is unlawful, because the actual drugs dispensed under a prescription ought to go to the patient in whose name they are prescribed. However, I was told that 'replenishing' is not uncommon. It seems to me a relatively minor offence and I understand that some pharmacists turn a blind eye to the practice. I think Mrs Brant did so. At one stage in her evidence she implied that it was acceptable; at another, she said that she knew that the correct procedure was for the doctor to buy his/her own stock on a signed order. She did not know what the procedure was for the doctor to reclaim the cost of the drugs if and when s/he had administered them to a patient. It was clear from her evidence that she did not think that the practice was dishonest.

11.46 I find it strange that Mrs Brant should claim to remember the first supply on 22nd February but not the second. She said that she could not think 'back that far' but, since both supplies took place on the same day, and since the two were so similar, I think that she would be bound to remember the second supply if she could remember the first. I am driven to conclude that she could in fact remember neither. In my view, her evidence as to what she could recollect is unreliable. I think that, by the time she was about to give oral evidence to the Inquiry, she knew how unusual Shipman's demands for single 30mg ampoules were and felt vulnerable to criticism. Also, she had come to realise for the first time that she might well not have had any 5mg or 10mg ampoules in stock. She realised this because her legal representatives had, very carefully and quite properly, analysed both the receipt and the supply sides of the CDR in preparation for the Inquiry hearing. I think that, when she realised that, she persuaded herself that she had given Shipman 30mg ampoules that day because that was all she had. I am quite satisfied that she gave Shipman 30mg ampoules that day because that is what he had prescribed. We know now that Shipman would not have wanted 5mg or 10mg ampoules. He wanted 30mg ampoules for the purpose of killing patients. Mrs Brant could not know that, of course, but I am entitled to take that knowledge into account when assessing the reliability of her evidence as to the events of 22nd February. If her recollection of this day is faulty, as I find it to be, I cannot be satisfied that Shipman came in twice. He might have come in only once and asked for two ampoules for different patients.

11.47 Mrs Brant accepted that she dispensed a 30mg ampoule of diamorphine on a prescription issued in Mr Freeman's name and did not make an entry in his PMR. She could not explain why normal practice had not been followed in this respect. As a rule, the making of an entry in the PMR is an integral part of the dispensing process. The prescribing information is typed into the PMR and the computer is then used to print out a label for the drug package.

Mrs Brant claimed that she would have put a printed label on the packet containing the drug she gave Shipman but accepted that no entry was made by her or by the dispenser in the PMR. She said that it was possible to use the computer system to print a label without making an entry in the PMR. I wondered why a pharmacist would want to do that. It was explained to me that, sometimes, after the prescription had been entered into the PMR, the printer might malfunction. In that event, the pharmacist would wish to make a second attempt at printing without making a second entry in the record. That makes sense but it does not explain what happened on that occasion because there was no entry in Mr Freeman's PMR for that day.

11.48 There must have been some reason for this departure from the usual use of the PMR system. It is possible that Mrs Brant believed that, in writing a prescription in Mr Freeman's name, Shipman was 'replenishing' his own stock because he had given Mr Freeman some diamorphine earlier in the day. However, that explanation would be inconsistent with Mrs Brant's claim that Shipman had come in earlier in the day asking for an emergency supply for Mrs Radford, which, she said, led her to believe that he did not keep a stock of his own. However, as I have concluded that her recollection of the events of this day is unreliable, it is quite possible that she believed that Shipman usually kept a stock of one ampoule of diamorphine for emergency use and that he had had to replace it twice in one day. If that were so, Mrs Brant might well have realised that the ampoule that she dispensed, ostensibly for Mr Freeman, was not going to him but was going into Shipman's stock. If so, it is possible that she might have thought it unnecessary or inappropriate to make an entry in Mr Freeman's PMR. However, she denied that that would have been her practice. She said that, if a doctor told her that s/he was replenishing stock of a drug that had been used on a patient by prescribing the drug in the name of that patient, she would enter the prescription into the patient's PMR. The only explanation I can think of for Mrs Brant's failure to enter this prescription into the PMR is that she did not make out a printed label and therefore did not use the computer system at all. It may well be that she just put an ampoule into a package and wrote on it the name of the drug and nothing more.

11.49 On Friday, 26th February, two more prescriptions for single 30mg ampoules of diamorphine were presented, in the names of Mrs Olive Heginbotham and Mrs Lillian Ibbotson. The Inquiry does not have a PMR for Mrs Heginbotham and the PMR for Mrs Ibbotson does not cover 1993. Mrs Brant said that she had no recollection of either of these transactions. She could not even remember whether Shipman himself came in. She stressed that Fridays were usually very busy. That I accept. However, she must have approved the dispensing of these ampoules and she must have found time to enter them in the CDR.

11.50 Mrs Brant was questioned closely about her thought processes when agreeing to dispense two more 30mg diamorphine ampoules only a few days after the first two. She claimed that she trusted Shipman completely and that it had never occurred to her to think that there might have been any reason not to dispense the prescriptions he presented. She also described the nature of her professional relationship with Shipman. She said that she had formed a very favourable view of him even before she met him, from what her customers said about him. This view was confirmed when she got to know him. She found that he was always willing to take the time to explain the reasons for his choice of

medication. Sometimes, he would ask her advice about the availability of different types of drug. Once, he asked her to remind him if ever he prescribed a proprietary brand of drug when he could have prescribed a generic product.

11.51 Mrs Brant said that she was confident in Shipman's competence; she thought he knew what he was doing. She said that it had not occurred to her that Shipman's requests for single 30mg ampoules were strange. She said that, from time to time, they spoke about the patients for whom these drugs were prescribed and Shipman always gave her a plausible explanation for what he was doing. She could not now remember what these explanations were. When asked whether she recognised the use of a single 30mg ampoule as strange and inappropriate prescribing, she said that she did not and that she had trusted Shipman's judgement. In my view, had she thought about it at all at the time, she would have recognised that his prescribing was strange and inappropriate.

The Period from March to June 1993

11.52 On 22nd March, Shipman obtained a single 30mg diamorphine ampoule in the name of Mrs Whitehead and another, on 12th April, in the name of Miss Andrew. No PMRs have been found for these patients.

11.53 By this time, the diamorphine supplies page of the CDR must have had a most unusual appearance. Instead of a variety of doctors' names appearing in the prescriber's column, Shipman's name appeared in six consecutive rows. Mrs Brant said that she now recognises that this was a strange pattern of prescribing, although at the time she had not seen it as such; she had seen it simply as a treatment that Shipman was using at the time. That is not in my view a satisfactory answer, as to give 30mg of diamorphine to a patient who is suffering from cardiac pain (which is what she maintained she believed was the use to which the drugs were put) is not a reasonable course of treatment. A much smaller dose should have been given. If Shipman was repeatedly taking 30mg ampoules but using only about 5mg, this was wasteful and the dispensing of it contrary to Obligation 1.7 of the RPSGB Code of Ethics. Mrs Brant should have suggested that he should prescribe a smaller ampoule, which she would obtain for him. It seems that she never suggested this. The records suggest that she did not purchase any diamorphine ampoules during this period.

11.54 Mrs Brant maintained that it was not her practice to look out for prescribing patterns; she said that, if an individual prescription was satisfactory and there were no other causes for concern, a pharmacist should dispense the drug. I do not accept that opinion as it is not consistent with a pharmacist's duty, as set out in the MEP Guide, to be aware of the possibility that doctors might seek to divert drugs to their own use. Indeed, I think that a pharmacist is under a duty to look out for any sign of potentially unlawful or unethical prescribing by doctors. However, Mrs Brant pointed out that one or two single 30mg ampoules is not a large quantity of diamorphine and would not immediately give rise to the suspicion that the doctor was addicted or was supplying to someone who was. I accept that that is so. I also accept that Mrs Brant had no other reason to suspect Shipman of drug addiction. The question is whether, by reason of the frequent repetition of the requests for 30mg ampoules, not interspersed with any other requests more typical of a GP's use of

diamorphine, Mrs Brant should have realised that his pattern of prescribing was very odd. I accept that, in fact, she did not realise that it was.

11.55 Mrs Brant said that Shipman always gave her plausible explanations but she has not been able to recall what any of them were. I do wonder if he perhaps told her that he liked to keep a 30mg ampoule about him in case of emergency, acknowledging that, if it was a cardiac case, he would have to throw some away but also ensuring that, if more than 5mg or 10mg was ever necessary, he would have enough. Mrs Brant has not suggested that as an explanation. However, I had the impression for much of her evidence that she was not thinking very clearly. I think she found the experience of giving evidence very stressful and I am not unsympathetic about that. Plainly, she was flustered because she could see clearly by that time how obvious and unusual the pattern of prescribing was and that she had failed to appreciate it at the time. I do wonder whether she was also embarrassed because she did not wish to admit that she knew that these single prescriptions were not in fact going to the named patients but were for Shipman's personal stock. If she knew that this was not the correct procedure, she might have been reluctant to admit to it, even though it was not the most serious matter.

11.56 On 17th April, Shipman prescribed an ampoule in the name of Mrs Sarah Ashworth. This was dispensed by Mrs Beesley, who was working as a relief in Mrs Brant's absence. I shall consider her position in greater detail below. She made no entry in Mrs Ashworth's PMR.

11.57 On 27th April, Shipman obtained two more single ampoules, in the names of Mrs Fanny Nichols and Mrs Marjorie Parker. A PMR was available for Mrs Parker, although it is not known whether there was one for Mrs Nichols. Mrs Brant made no entry in Mrs Parker's record. She said that she had no recollection of dispensing these two ampoules.

11.58 On 5th May, Mrs Brant dispensed two more single 30mg ampoules on prescription in the names of Mrs Llewellyn and Mrs Nellie Mullen. There was a PMR for Mrs Llewellyn but Mrs Brant did not make an entry in it. No PMR for Mrs Mullen has been found. Mrs Brant appeared to have no recollection of the events of this day. She maintained that it still did not occur to her that either the individual prescription or Shipman's pattern of prescribing was unusual.

11.59 On 20th May, Shipman obtained another ampoule in the name of Mr Ernest Ralphs. There is no PMR for Mr Ralphs. When Mrs Brant entered the transaction in the CDR, the page was almost full. Only one line remained at the bottom. Every line on that page save the first recorded the dispensing of a single 30mg ampoule prescribed by Shipman in the name of a different patient. Yet Mrs Brant did not notice anything unusual. The bottom line was filled on 30th June 1993, when a box of ten 30mg ampoules of diamorphine, prescribed by another GP, Dr H, was dispensed for a patient who appears to have been terminally ill. To replenish her stock of 30mg ampoules, Mrs Brant ordered five more on the following day.

The Period from July to August 1993

11.60 At the beginning of July, five 10mg ampoules of diamorphine were purchased for the pharmacy. However, their arrival did not cause Shipman to switch to that size of ampoule. This confirms my view that he had never wanted 10mg ampoules at all.

11.61 The next entry in the supply side of the diamorphine register recorded the visit of DC Kelly, the CIO, on 12th July. He signed at the top of a new page to indicate that the CDR had been inspected. It is common ground that DC Kelly did not notice anything unusual about the previous page of the diamorphine register and that Mrs Brant did not draw his attention to it. Nor did she tell him that Shipman had personally collected all the supplies recorded on that previous page.

11.62 In the CDR, there then followed three entries relating to large amounts of diamorphine prescribed by Dr C for a patient who appears to have been terminally ill. Then, on 14th and 27th August, Shipman prescribed the last two single 30mg ampoules in the names of Mr Ralphs (again) and another patient. There is a PMR for the latter patient, but Mrs Brant did not make an entry in it when she dispensed an ampoule of diamorphine in his name.

11.63 Thereafter the CDR resumed a more normal appearance. Shipman's name continued to appear but was interspersed with entries relating to other GPs. After this time, when Shipman prescribed diamorphine, he did so in a much more usual way, typical of the treatment of terminal illness. There was no reason why Mrs Brant should have been concerned about those entries. The abnormal pattern had ceased.

Mrs Brant's Failure to Report This Sequence of Prescriptions

11.64 Ought Mrs Brant to be criticised for her failure to notice or to be concerned about the pattern of Shipman's unusual prescribing and collecting of diamorphine in 1993? It is common ground that, if she had noticed it and had realised that it was unusual, she should have reported it to an appropriate authority.

11.65 I am satisfied that, as a pharmacist, Mrs Brant was under a duty to keep a lookout for abnormal prescribing patterns that might suggest illegal or irresponsible prescribing of controlled drugs. A number of witnesses with experience of examining CDRs told the Inquiry that the series of entries in 1993 was obviously or strikingly unusual. I think even Mrs Brant found it difficult to explain how she had not regarded it as odd. Mr David Young, an inspector from the RPSGB, initially said that he did not notice anything unusual about the record but then said that, on further reflection, he did. On Mrs Brant's behalf, it was said that everyone who now sees the record has the benefit of knowing that it relates to a mass murderer who was using the individual ampoules to kill his patients. I recognise the power of hindsight, but I have been careful to look at these issues in the light of what was known to Mrs Brant at the time and in the light of the impression of Shipman that it was reasonable for her to have formed.

11.66 My own view is that the series was unusual, and conspicuously so. First, because, for the individual patients, the amount of the drug prescribed was 'neither one thing nor the other'; it was too much for acute pain and too little for terminal care. Each entry save one related to a different patient. This would not make sense as, usually, patients who need diamorphine in such a quantity continue to need it for some time. Second, the appearance of the CDR during these few months was quite unlike its previous appearance and quite unlike any diamorphine supplies page that I have seen in any other CDR examined in the course of the Inquiry. On the previous page of the CDR in question, the record showed prescriptions for a variety of quantities and sizes of ampoules of the injectable form of

diamorphine, interspersed with prescriptions for a different form of the drug, e.g. in solution for oral administration. In the series under examination, entry after entry was for the same number of the same size of ampoule containing the same injectable form of the drug. I recognise that doctors have their own styles of prescribing, but, if the use of single 30mg ampoules of injectable diamorphine was to be regarded as Shipman's style, it appears to have been a very unusual one. As it happened, the unusual appearance of the register was emphasised by the absence of any entries in the names of other doctors. Had the Shipman entries been interspersed with entries relating to other doctors, its unusual appearance would have been less obvious.

11.67 In my view, the CDR would have looked odd even at the end of the week beginning 22nd February but, by July, when there was a column of 12 similar entries, the appearance was quite remarkable, especially when compared with the previous page. Other witnesses said that they had never seen a CDR with this appearance before and Mrs Brant did not suggest that she ever had. Mrs Brant also knew that Shipman himself had collected each of the ampoules. That in itself was an odd feature. Of course, doctors do call into pharmacies to collect emergency supplies from time to time but, if that was what Shipman was doing, he was doing it with unusual frequency.

11.68 I have sought to make full allowance for the advantage of hindsight that everyone now has in commenting on this page of the CDR. I have also borne in mind Mrs Brant's reputation as a competent and careful pharmacist. Nonetheless, I have come to the conclusion that this series of entries was sufficiently unusual to call for enquiry and explanation. In my view, in failing to notice the unusual nature of this series of transactions, Mrs Brant fell below the standard to be expected of a competent and conscientious pharmacist.

11.69 Why did Mrs Brant not notice this series of entries? She was under a duty to watch out for abnormal patterns that might suggest illegal or irresponsible prescribing of controlled drugs. Being an honest person, she would have reported any such signs that she noticed. I think the explanation for her failure to notice this series of prescriptions lies partly in her own attitude towards her work and partly in the influence Shipman had over her.

11.70 First, Mrs Brant did not regard it as part of her duty to look out for unusual prescribing patterns. In her Inquiry statement, she said that, provided a prescription was correctly presented and there were no other concerns about it, it would be dispensed. Second, I think that Mrs Brant was careful and conscientious about her own direct responsibilities but was less concerned about ensuring that those about her also complied with theirs. I am satisfied that she had a proper regard for her duty towards patients. She would look carefully at a prescription to ensure that the dosage was appropriate. She was plainly conscientious about her duties in relation to the CDR. It is carefully completed. I think she would also be careful to ensure that she did not dispense a controlled drug prescription unless all the statutory requirements were met. I think she was quite strict with her staff; she 'ran a tight ship'. However, I do not think it would have worried her if she had thought that a doctor was 'replenishing' his/her stocks by prescribing in the name of a patient whom s/he had already treated. She knew that this practice was not technically correct but thought that it was convenient and not dishonest. Provided that she did not know for a fact that the doctor was replenishing, her own conduct could not be criticised. I do not believe

that she would have been greatly concerned to think that a doctor was prescribing much more of a drug than was needed for the patient and throwing away what was unused. I do not think she saw it as an important part of her duty to be responsible for the actions of her fellow professionals.

11.71 It follows that, to some extent, the explanation for Mrs Brant's failure lies within her own approach to her job. However, in my view, of far greater effect upon her was Shipman's personal influence. Shipman was an extremely devious man. In 1992, when he met Mrs Brant, he probably had no terminally ill patients who would have been a means for him to obtain diamorphine. When he decided that he wanted some diamorphine, he would not at that time have been able to follow his usual procedure of over-prescribing for, and stealing from, a cancer patient. He must have realised that he would have to devise a new method. He would, I am sure, have been wary of obtaining the drug on requisition. That had led to his detection in 1975. Also, he had claimed to the medical adviser of the Tameside Family Health Services Authority (FHSA) that he did not keep stocks of controlled drugs or a CDR. For this reason, he devised a method of obtaining diamorphine that was intended to appear lawful and inconspicuous. The individual prescriptions were not for large amounts and, if interspersed in the CDR with a variety of prescriptions for other forms of diamorphine prescribed by other GPs, would not be very noticeable. The practice of collecting drugs on behalf of a patient would be seen as usual for him, although unusual for other doctors. However, I am quite certain that he would have recognised that he could be vulnerable to detection if the pharmacist noticed anything unusual. It would have been important to him to ensure that the pharmacist had complete confidence in him. It may be that Shipman recognised that Mrs Brant was not inclined to ask probing questions. Whether or not he did so, I think it highly likely that Shipman set out to win Mrs Brant's trust and confidence and to erode such professional objectivity as she had towards him. I am sure he would have been particularly pleasant towards her. He would, as he often did, have talked about the principles on which he conducted his practice in such a way as to inspire admiration and respect. He would always have had time to explain to Mrs Brant why he was prescribing as he was. He would have asked her advice. She might well have found this flattering. I think he was capable of being very charming when it suited him; I have little doubt that it suited him to be charming to Mrs Brant. I think she came to trust and admire him to the extent that she lost all professional objectivity and, when Shipman came into the pharmacy, she treated him as a friend. I think they probably chatted about this and that. Sometimes, the conversation would have included Shipman telling her a tale about a patient he was going to see or had just seen. The tales might or might not have been based on truth. Mrs Brant did not question what he was doing or why. In my judgement, she is to be criticised for losing her professional objectivity but must be excused to a large extent because she was the victim of a deliberate deception by an accomplished liar.

Mrs Janice Beesley

11.72 I mentioned earlier that, on 17th April, Mrs Beesley dispensed one of Shipman's prescriptions for a single 30mg diamorphine ampoule in the name of Mrs Ashworth. She said that she could not remember the transaction and this is not surprising. In her written

statement, she said that she would not have thought that the prescription for a single 30mg ampoule was in any way unusual. However, in oral evidence, she said that the dose was unusually large as a single dose. In her experience, doctors usually took 5mg ampoules for emergency use and prescribed a box of 30mg ampoules for treating cancer pain. She said that she thought she would have wanted to know from Shipman why he had prescribed a 30mg ampoule and claimed that he must have given her a satisfactory explanation. That is possible, although it is hard to think what he might have said to justify the request for a single ampoule as large as 30mg. However, Mrs Beesley said that, if Shipman had said that the patient was having a heart attack and if he had persisted in requesting 30mg, she would probably have let him have it.

11.73 Mrs Beesley did not enter this prescription in Mrs Ashworth's PMR. She claimed that it would have been her usual practice to do so and could not explain why she had not done so in this case. She agreed that, had she looked at Mrs Ashworth's PMR, she would have seen nothing that would have suggested that Mrs Ashworth might need strong analgesia. She said that it was possible that, if Shipman had come into the pharmacy himself, she might not have looked in the PMR. I cannot understand why the presence of the doctor would prevent her from following her normal practice, unless perhaps Shipman claimed to be in a desperate hurry and encouraged her to hand over the ampoule without making an entry in the PMR or printing a label. Either at the time of dispensing the ampoule or later, Mrs Beesley entered the transaction in the CDR but said that she did not notice the column of six similar transactions immediately above her own writing. Owing to my own familiarity with the record, I find that surprising but I accept the truth of Mrs Beesley's assertion.

11.74 I have the impression that Mrs Beesley is a competent and well-organised pharmacist. I accept that she would have recognised that 30mg diamorphine was a very unusual single dose and would have been likely to ask Shipman what it was for, unless he volunteered an explanation in advance of any enquiry from her. I think that is quite likely to have happened. I think he might well have said that he needed the drug very urgently and that he had written a prescription for 30mg 'to be on the safe side' or something of that nature. I do not criticise Mrs Beesley for dispensing one single 30mg ampoule on that one occasion.

Mr Peter Rothman

11.75 In 1993, Mr Rothman was the joint owner (with his wife) of Mayfair, which owned the pharmacy at 23 Market Street. All retail pharmacies operated by a body corporate have to have a superintendent pharmacist. In 1993, Mr Rothman was the superintendent of the pharmacy in Market Street. The question arose whether, in his capacity as superintendent, Mr Rothman was under a duty to make a regular inspection of the CDR and whether he should, in so doing, have noticed the entries relating to the unusual series of prescriptions for single 30mg diamorphine ampoules.

11.76 Under section 71 of the Medicines Act 1968, the supply of medicinal products in a pharmacy business must take place either under the personal control of the superintendent (who must be a pharmacist) or subject to the direction of the superintendent and under the personal control of a manager or assistant who is a

pharmacist. As Mrs Brant (or in her absence another pharmacist) was in personal control of the supply of medicinal products from the premises, the duties of Mr Rothman, as superintendent, were limited to the giving of 'directions' for the proper running of the business.

11.77 Mr Rothman expressed the opinion that his position as superintendent did not require more than that he should be satisfied that the business was properly run. He said that this would include being satisfied that the CDR was properly kept. He said that he visited the premises once or twice a week and was satisfied with the way in which Mrs Brant exercised personal control. He said that he did not inspect the CDR, although he knew that it was properly kept because, from time to time when working as the pharmacist on duty, he would have to make entries in it himself. He said that he did not notice the page of the diamorphine section on which the unusual series of entries was written. Unless he inspected the CDR, it is apparent that he would be very unlikely to notice that series, as he had had no occasion to write on that page.

11.78 Mr Stephen Lutener, former Head of Professional Conduct at the RPSGB, agreed with Mr Rothman that the duty of a superintendent to give directions would not normally be expected to include a regular inspection of the CDR. That evidence does not surprise me and I accept it without hesitation. Indeed, it would seem very surprising if the giving of 'directions' were to include such a routine task. Strictly speaking, it should be enough for the superintendent to tell the pharmacist manager to keep the CDR properly. In the early stages of a new manager's employment, it might well behove a superintendent to look at the CDR quite carefully to ensure that the manager was completing the register with apparent care and accuracy. However, once satisfied that that was being done, I would have thought it impossible to criticise a superintendent pharmacist for making no further inspections of the contents of the CDR, provided that, from time to time, s/he checked to ensure whether or not the CDR was still being kept. I am quite satisfied that Mr Rothman did that and he is not to be criticised for not noticing that one page of the diamorphine section contained a series of very unusual entries.

Detective Constable Patrick Kelly

11.79 DC Kelly of the Greater Manchester Police (GMP) was appointed as a CIO in April 1993. As I have explained in Chapter Nine, his duties included the inspection of pharmacies in Tameside. Before his appointment, he had worked in the GMP Drug Squad but this entailed mainly the keeping of observations on drug dealers. Otherwise, he had no training in, or experience of, controlled drugs or the work of retail pharmacies. DC Jackson, the previous occupant of the post, had retired before DC Kelly's appointment. Accordingly, DC Kelly's training for the post was to accompany DC Robert Peers, an experienced CIO, for half of each working day over a period of about three weeks. DC Peers was available for only half of each working day because he was also a police 'sniffer dog' handler. He started work very early in the mornings, before the pharmacies had opened, and finished in the early afternoon. Accordingly, DC Kelly's opportunity to make accompanied visits to pharmacies was limited. Also, DC Peers' work was not entirely typical of the work to be done by DC Kelly. DC Peers was responsible for the pharmacies in the city centre, where a substantial number of drug addicts obtained

their supplies. DC Kelly was to be responsible for the outer areas, where addicts were less in evidence.

11.80 DC Kelly told the Inquiry that, as a result of his training with DC Peers, he understood that the most important features of the job were to audit the supplies of controlled drugs held at the pharmacies, to supervise the destruction of out of date supplies and to monitor the use of methadone by addicts. He had read the Home Office guidance notes and knew that his duties included the policing of the pharmacists themselves and also that he should keep a watch for irresponsible prescribing by doctors. However, I think that the guidance notes did not mean a great deal to him until he had had several months' or even a year or two's experience in the job. Initially, he seems to have thought that irresponsible prescribing was prescribing wastefully, so that the patient had a lot of drugs that would never be used. It would not be surprising, therefore, if he regarded this aspect of his work as less important than the supervision of drug addicts. He was, in any event, ill equipped to recognise a case of irresponsible prescribing if he saw one. He knew very little about the properties of individual controlled drugs or the quantities in which they might be used for therapeutic purposes. He had read in the guidance notes that he was to look out for doctors who collected drugs from pharmacies but did not understand why he should do so, even though the notes explain the reason for this advice.

11.81 DC Kelly started inspecting on his own in May 1993. He was responsible for inspecting over 400 pharmacies. He estimated that, by July, he had probably visited about 150. He said, and I accept, that, in the first few months, he was very dependent upon the information given to him by pharmacists. Also, he was so conscious of his own lack of knowledge that he would hesitate to question a pharmacist, other than in general terms.

11.82 DC Kelly agreed that he inherited the card index system operated by his predecessor. I do not think that he had a very clear idea of what he was supposed to enter on these cards, besides the names of drug addicts. One might have expected that DC Kelly would have followed the practice of DC Peers, who had taught him the job. DC Peers said that, as well as recording the names of drug addicts, it was his practice to record the name of every patient who was prescribed diamorphine (even in a modest amount) on the first occasion the drug was prescribed. DC Jackson (whose cards DC Kelly inherited) initially said that he did not record every first prescription of diamorphine but, on further reflection, thought that he must have done. I do not think that DC Kelly had a clear recollection of what he recorded in respect of patients who were not drug addicts. It appears to me that the primary purpose of these cards was to record the names of all known drug addicts, so that the Home Office could be notified and enter the names on the Index of Addicts. In other respects, I think that the rules were not clear.

11.83 DC Kelly made his first visit to the pharmacy at 23 Market Street on 12th July 1993. Although he cannot remember doing so, he accepted that he had examined and signed the diamorphine section of the CDR. He signed at the top of a new page. The previous page was the one recording the series of Shipman's 12 prescriptions for single 30mg ampoules. Every line, save the first and last, recorded a similar transaction. DC Kelly said that he did not notice anything unusual about that page. It is common ground that Mrs Brant did not mention it to him or suggest that there was anything unusual about it. DC Kelly said it would

not have struck him that it was unusual for a doctor to prescribe exactly the same amount for a lot of patients. Nor would he have known that 30mg was a large ampoule for a single dose of diamorphine. Although he had a copy of MIMS (a reference book similar to the BNF, which provides information about drug dosages) with him, he did not look at it on this occasion. He knew that diamorphine was used to relieve severe pain in terminal cancer cases and said that he would have expected to see several entries of prescriptions for the same patient. He said that what 'threw' him was seeing the names of so many different patients. However, he did not ask Mrs Brant about the entries. He did not think that he would have entered the name of each patient on the card for that pharmacy. (It is not possible to check this as the cards have been destroyed.) Nor, so far as he could remember, did he ask Mrs Brant whether the doctor had collected any or all of the drugs. I am quite sure that he did not.

11.84 It appears to me that, at least at this early stage of his appointment as a CIO, DC Kelly was not capable of recognising the unusual features of this CDR. He was completely dependent upon the pharmacist in charge to draw any unusual matters to his attention. He was also diffident about asking the advice of a pharmacist or raising any matter that puzzled him, because he did not wish to reveal his lack of knowledge. Because Mrs Brant did not say anything to him about this page of the CDR, this opportunity for Shipman's illicit practice to be detected was lost.

11.85 Is DC Kelly to be criticised for his failure to recognise that there was something unusual about this page of the CDR? Every other CIO who gave evidence about these CDR entries said that he believed that he would have recognised the unusual nature of the entries. In general, the CIOs said that they would have asked Mrs Brant about the transactions and that any further course of action would have depended upon her response to their questions. I recognise that all the CIOs had the benefit of some years' experience when giving evidence to the Inquiry, as well as the benefit of hindsight. However, even DC Kelly agreed that, to an experienced CIO, the CDR would appear very unusual and would call for some enquiry. In fact, he was at something of a loss to explain how he could have failed to notice it.

11.86 At the time, DC Kelly was undoubtedly very inexperienced as a CIO. He had not had the benefit of a very satisfactory training or induction for his new position. In my view, he cannot be criticised for his failure to realise that a single 30mg ampoule of diamorphine was an inappropriate dose. However, he must, in my view, be criticised for his failure to notice that the appearance of this page of the register was quite unlike any page of a diamorphine section of a CDR that he had seen, either with DC Peers during his training or in the 150 pharmacies he had inspected since starting work on his own two months earlier. It should have appeared highly unusual even to someone who knew nothing about the properties and usual doses of diamorphine. In my view, a reasonably competent police officer, with only two months' experience as a CIO, if conducting him/herself with reasonable diligence, should have noticed that this page was very unusual. Although I am critical of DC Kelly, his failure is mitigated by the inadequacy of the training he had received before being put to work unaccompanied.

11.87 Assuming that he did not do so, ought DC Kelly to have recorded every patient's name in the 1993 sequence on a card? If he had done so, would the unusual nature of the entries

have been more likely to strike him? I think the answer to the second question must be that it would. It must have been unusual for him to enter more than three or four names onto the cards in the course of a single visit; to enter more than ten would have been remarkable and rather burdensome. He might well have shown the cards to his colleague, DC Peers, who would, I think, have recognised that Shipman's prescribing was unusual. Having said that, I am not persuaded that the rules relating to the card system were quite as clear cut as DC Peers (in particular) suggested. As I have said, I think that the main purpose of the card system was to record the names of addicts and perhaps also to check that the pattern of prescribing diamorphine to patients with terminal illness followed a 'normal' course; in other words, that the amounts prescribed increased and then stopped. I do not think that it was ever mandatory to record the name of every patient who received a single dose of diamorphine. In practice, it would be rare to see a prescription for a single dose of diamorphine and I think DC Peers probably thought that he recorded every patient who received diamorphine, when, in fact, he might not have done. In short, I think there was an element of discretion for the CIO not to record the occasional small or single prescription. I do not specifically criticise DC Kelly for his probable failure to record the names of these patients as a matter of routine. I criticise him only for his failure to recognise that they were unusual in the sense of being different from anything he had seen in his short experience as a CIO.

11.88 What would have happened if DC Kelly had asked Mrs Brant about these entries? I think her first reaction would have been to tell him that she had no concerns about Shipman; he was a very good GP and well respected and popular with patients. If she had said something like that, I think DC Kelly would have accepted her opinion and would probably have put the matter from his mind. It is quite possible that Mrs Brant might have mentioned to DC Kelly that Shipman had called into the pharmacy to collect these single ampoules. A reasonably competent and moderately experienced CIO would then have heard the ringing of a powerful alarm bell. However, I doubt that DC Kelly would have recognised the significance of that information. He said that, in the early days, he did not understand why the guidance notes said that CIOs should look out for doctors who collected drugs. Nonetheless, it is quite possible that he might have asked DC Peers about the significance of a doctor collecting drugs from a pharmacy. DC Peers would have explained and, in the ensuing discussion, might well have come to realise that the CDR that DC Kelly had seen was most unusual. By that means, it is quite possible that an investigation might have been set in train.

11.89 If DC Kelly had asked Mrs Brant about Shipman's single ampoule entries, it is quite possible that, while giving reassurance at the time, Mrs Brant would later have reflected more carefully about Shipman. It is possible that she might have realised that his prescribing and collecting was odd, even though she trusted him completely. She might have resolved to speak to him about it on the next occasion that he requested a 30mg ampoule, although I think she would have found it difficult to do so in a challenging way. She might have shown the register to Mr Rothman, the superintendent of the pharmacy. She might have sought advice from Mr Young, the RPSGB inspector for the area. Had she spoken to either of those people, I think it likely that some investigation of Shipman's conduct would have been initiated.

Greater Manchester Police

11.90 I have said that the training of DC Kelly left him poorly equipped to undertake his duties as a CIO. For that shortcoming, the GMP must be responsible. It is clear that the GMP did not appreciate the specialist nature of the role of CIOs, requiring, as it did, training in the ability to recognise excessive or unusual prescribing and dispensing of controlled drugs. To be properly equipped, a CIO needs some knowledge of the uses and abuses of the most common controlled drugs and some understanding of the signs to look out for in order to detect bad or illegal practice. Thus, a combination of theoretical knowledge and supervised experience is needed.

11.91 At least until 1999, none of the GMP CIOs was adequately trained at the start of his/her employment in that capacity. I have the impression that, with experience, they all became competent. Since 1999, the CIOs have been better trained. Some of them, such as DC Michael Beard, have the combination of enthusiasm and ability necessary to make outstandingly good CIOs. However, the situation is not entirely satisfactory. All the CIOs are left very much to their own devices. Even those who, through experience, become competent would in my view benefit from better management and direction from senior officers.

11.92 In criticising the GMP for the inadequacy of the training provided to its CIOs and the lack of direction given subsequently, there are two important points mentioned in Chapter Nine that mitigate such criticism. First, so far as CIO services are concerned, the GMP appears to be one of the better police forces in the country. It has for many years had two dedicated CIOs and, in recent years, has increased the number to three. It is unusual for these officers to be taken off their CIO duties, although it does happen from time to time. Since the Wakefield course began in 1999, all three of the current CIOs have attended. Second, the GMP has applied significant resources to the work of the CIO, despite the fact that some of its senior officers, at least in recent years, have been of the opinion that the functions of a CIO are not proper police work. Detective Chief Superintendent Peter Stelfox considers that the work could well be done by civilians and that it does not bring benefit to the police commensurate with the resources expended on it. As I have said, as long ago as 1922, the Commissioner of the Metropolitan Police expressed the view that pharmacy inspection should be carried out by those with practical knowledge of the retail pharmacy business. That point of view is even more valid today than it was then. The scope of the duties of the CIO and the range of controlled drugs with a potential for abuse have both greatly increased. In the light of these factors, it is to the credit of the GMP that it devoted resources to the work of the CIOs to the extent that it has done.

Mr David Young

11.93 In Chapter Nine, I explained that the main purpose of the pharmacy inspections carried out by the RPSGB is the promotion of good and safe pharmaceutical practice by checking compliance with the statutory requirements and the Society's Code of Ethics. Thus, their scope is far wider than that of CIO inspections; in particular, they do not focus on controlled drugs, save to satisfy the inspectors that the pharmacist appears to be complying with the legislative requirements.

11.94 During an inspection, the usual practice of the RPSGB inspectors, including that of Mr Young, was to examine a CDR to ensure that it was being kept, that the entries were legible and that there were no worrying alterations. To check for these matters, most of the inspectors said that they would usually look at the morphine register, which they would expect to be the most heavily used. They might or might not look at the diamorphine register. In the course of such an examination, an inspector would not be looking out for signs of irresponsible prescribing; s/he might notice such signs but, if s/he did, it would be more by luck than design. One inspector spoke of an occasion when he happened to notice a marked imbalance between the quantity of drugs acquired and that supplied. Of course, if a pharmacist expressed concern about entries that suggested irresponsible or illegal prescribing, the inspector would look at them and discuss with the pharmacist what course of action should be taken. He or she might undertake to report the matter to the relevant primary care trust or to the Home Office Drugs Inspectorate (HODI).

11.95 In paragraph 11.22, I mentioned that Mr Young visited the pharmacy at 23 Market Street on 19th March 1992. It is not clear now whether that was a routine visit of inspection or a visit at the request of the pharmacist for the purpose of witnessing the destruction of controlled drugs. In any event, he signed the diamorphine register to say that he had witnessed such destruction. He might possibly have noticed that a doctor called Shipman had prescribed two 30mg ampoules for a patient three days earlier but there would have been no reason why that should have struck him as odd. The patient might well have just begun to need the drug for palliative care. It is not entirely clear when Mr Young next visited the pharmacy. His records are no longer available. He might have visited again in November 1992. A record of his presence in another pharmacy in Hyde has been found and Mr Young says that he might have visited the pharmacy at 23 Market Street on the same day. Otherwise, it appears that he did not visit the pharmacy until April 1994. He cannot say whether he would have looked at the CDR at all on that occasion. Certainly, there is no reason to think that he looked at the diamorphine section. He cannot be criticised for not doing so. Nor can the RPSGB be criticised for not requiring their inspectors to pay closer attention to the content of CDRs. It has never been their duty to do more than ensure that the pharmacy is being properly run and the legislation complied with.

The Home Office Drugs Inspectorate

11.96 Elsewhere in this Report, I discuss the question of whether the arrangements whereby retail pharmacies are inspected by CIOs is satisfactory. I have described those arrangements in Chapter Nine. In short, taking the country as a whole, the arrangements operated to a variable degree of satisfaction. It might be said that the HODI should have recognised the shortcomings of the existing system and should have sought to improve it. It might have pressed for improved training and complete coverage across the country. It might have drawn attention to the difficulty that many CIOs experienced in detecting irresponsible prescribing. It might have suggested that this task should be undertaken by inspectors with greater clinical knowledge of controlled drugs. It might equally be said that the Advisory Committee on the Misuse of Drugs or the Association of Chief Police Officers should have recognised the shortcomings of the system and done something about it. However, the fact is that improvements cost money, resources are always tight and there

was no pressing reason to think that any great harm was being caused by the imperfections in the existing system.

11.97 The discovery of Shipman's crimes has shown that, in Tameside, in 1993, the arrangements did not work as well as they should have done and that, if DC Kelly had had better training or more experience, it is possible that Shipman's illicit obtaining of diamorphine might have been detected. However, in 1993 and in previous years, the HODI had had no particular reason to be concerned about the way in which the system operated in Greater Manchester. The GMP had CIOs in post and the HODI inspectors in the Northern Region would have known that in, say, 1992, the GMP CIOs were efficient. They might also have known that, in the summer of 1993, when DC Kelly was new in post and very inexperienced, coverage in the outer areas of Greater Manchester was not as good as it had been. That is not to say that they were under a duty to do anything about it. They would expect that time and experience would put matters right, as I think to a large extent they did. In my view, the HODI is not to be criticised because the system of pharmacy inspection failed to detect Shipman's unusual prescribing pattern in 1993.

What Would Have Happened?

11.98 What would have happened if either Mrs Brant or DC Kelly had noticed the unusual pattern of Shipman's prescribing and had decided that it warranted a report or investigation? To a very large extent, any consideration of this question is speculative. I shall be unable to reach any firm conclusions. However, it is necessary to consider what might have happened.

11.99 One possibility is that, if Mrs Brant had appreciated the unusual nature of Shipman's requests for 30mg ampoules, she might have asked him why he wanted them and suggested that, if it was for emergency use or for the relief of acute pain, she could supply smaller ampoules. She might well have had such a conversation on Friday, 26th February 1993. Shipman had asked for four 30mg ampoules in one week. If she had queried his actions at any stage during this course of conduct, I am sure he would have offered her a plausible explanation for his requests. However, I also think it quite likely that he would have stopped using this method of obtaining supplies. He would not have wished to give rise to any suspicion of unusual practice. Without supplies, he could not have killed. He probably did not have another cancer patient from whom he could steal supplies until November 1993. He might have considered using another pharmacy but that might have appeared strange in view of the proximity of the pharmacy at 23 Market Street to his own surgery. The lives of some of his 1993 victims would probably have been saved. I have no doubt that Shipman would have resumed killing when he had another source of supply.

11.100 Had DC Kelly and Mrs Brant discussed the appearance of the CDR during the inspection on 12th July, I have said that it is likely that Mrs Brant would have sought to reassure DC Kelly that Shipman was a thoroughly reliable doctor. DC Kelly would have had no expertise to bring to their discussion. Only if he had mentioned the discussion to his colleague, DC Peers, would there have been any chance that concern would have been raised such as to cause a report to be made to the HODI. Even DC Peers might have taken the view that, if the pharmacist was not worried, there was no need for a report; the

amounts of drug were not so large as to give rise to a real suspicion of addiction or dealing. But it is possible that there might have been a report to the HODI. It is also possible that a conversation with DC Kelly might have caused Mrs Brant to reflect more deeply on the matter. She might then have either spoken to Shipman (with the result mentioned above) or possibly decided to speak to Mr Rothman or to contact the RPSGB inspector, Mr Young. In this way too, it is possible that Shipman's prescribing might have come to the attention of the HODI.

11.101 If a report had been made to the HODI, history might possibly have been different. Mr Graham Calder, one of the HODI inspectors, said that the patterns of Shipman's prescribing would have alerted them to the possibility that he was diverting the drugs. Tucked away in the HODI files was the information about Shipman's previous convictions in relation to pethidine in 1976. I am satisfied that the files would have been retrieved. The inspectors' natural reaction, on learning that Shipman had been prescribing another opiate drug in an unorthodox way and collecting it from the pharmacy himself, would have been to suspect him of self-administration. I think the HODI would have launched an investigation.

11.102 What would it have found? First, it would have found that he was not obtaining supplies from any other pharmacy in the Hyde area. I cannot say with certainty that Shipman was not obtaining supplies from outside the area of Greater Manchester, but I consider that it would have been virtually impossible for the HODI to find out whether or not he was. NHS prescriptions would show up in prescribing analysis and cost (PACT) data, but private prescriptions and requisitions would not. The HODI would have been left to investigate the reasons why he had obtained the 12 or 14 ampoules he had obtained at the time its enquiries took place. I have no doubt that the HODI inspectors would have interviewed him.

11.103 What would Shipman have said? I think he would have been unlikely to say that he was using the drugs himself. I think he would have feared that an apparent return to addiction would result in referral to the GMC and possible action on his registration. I think it likely that he would have claimed that he had needed the drugs for patients who were suffering from heart attacks. He would have been able to refer to various patients in whose records he had noted that he had given morphine. Whether their records would still have been available to him to show to the inspectors, I cannot say; they might have been returned to the Tameside FHSA following the patients' deaths. The inspectors might well have asked why Shipman always took a 30mg ampoule, whereas other doctors usually kept 5mg or 10mg ampoules for emergency use. Shipman might well have advanced the same explanation that he used at his trial in 1999, namely that he had got into a 'bad habit' of prescribing more than he needed; he would use what was necessary and throw away the rest.

11.104 It is impossible for me to say whether the HODI inspectors would have been content with his explanation. I would not criticise them if they had been. This strange prescribing would not seem to be very sinister; the individual amounts were not large and the supplies were not obtained with anything like the frequency with which Shipman had obtained pethidine in the 1970s. They might have just warned him to change his 'bad habit' and, if so, I think it likely that he would have done so.

11.105 On the other hand, it is possible that the HODI inspectors would not have been satisfied with his explanation. If they had remained suspicious and decided to contact the patients for whom the drugs had been prescribed, they would have discovered, first, that all but two of the patients had died and they might have found out that six of them had died before Shipman prescribed the drug (although it is far from certain that their enquiries would have extended so far as to establish the dates of death). To explain that, Shipman would have had to suggest that he was 'replenishing his stocks' by prescribing in the name of a patient to whom he had given the drug on an earlier occasion. The two patients who were still alive would have said that they had not received any diamorphine and had had no need for it. This would have confirmed the inspectors' suspicion that Shipman was keeping the drugs, or most of them, for himself. They might have felt it worthwhile to bring in the police with a view to prosecution for unlawful possession of the drugs and, possibly, obtaining them by deception, although I think it unlikely that a prosecution would have proceeded. The amounts of the drug involved were not great. It would have been necessary to involve patients and relatives as witnesses. There would have been a real possibility that Shipman's explanations would have been accepted by a court, had he been prepared to run the risk of a trial.

11.106 Even if the inspectors had uncovered evidence strongly suggesting that Shipman had been keeping the diamorphine for himself, it is unlikely, in my view, that they would have come to suspect him of using it to kill his patients. That possibility would have been almost unimaginable. I think it unlikely that the quality of his care of his patients would have been investigated. Only if the relatives of the deceased patients had been interviewed and if one or more of them had expressed extreme surprise at the suddenness of the death would this possibility have occurred to anyone. Most of Shipman's victims at this period were in poor health, although their deaths did come as a shock and a surprise to their relatives. Had the inspectors or police decided to obtain the medical records of Shipman's deceased patients, they would have found that, in three cases (those of Miss Andrew, Mrs Llewellyn and Mrs Whitehead), Shipman had recorded that he had administered 10mg morphine or morphine sulphate to the patient shortly before death. He would have said that he had done it to relieve pain and that would have appeared to be a reasonable explanation. However, he would not have been able to explain where the morphine had come from. Also, the inspectors would have found that in no case had Shipman recorded that he gave diamorphine. In five of the deceased patients' records (those of Mrs Ashworth, Mrs Heginbotham, Mrs Mullen, Mrs Nichols and Mrs Parker), there was no reference to the administration of any drug before death. If Shipman had said that he had given diamorphine to these patients, it would have appeared that his record keeping was very slack but it might not have occurred to anyone that he had given an overdose and caused the patient's death deliberately. All the patients were quite old. It is just possible that the combined effect of a diligent police officer and a concerned relative might have given rise to the suspicion of deliberate harm. However, in my judgement, this is unlikely.

11.107 There is little doubt in my view that, if the HODI had embarked on an investigation, it would have had a salutary effect on Shipman's conduct. The more thorough the investigation, the more alarmed Shipman would have been and the longer the period for which he would have desisted from killing.