CHAPTER TWELVE

Shipman's Methods of Obtaining Diamorphine in the Years from 1993 to 1998

Introduction

12.1 I have said that, after August 1993, Shipman ceased to obtain diamorphine supplies by prescribing and collecting single 30mg ampoules. From late 1993, he was able to resume what I believe had been his preferred method of obtaining supplies throughout his period in Hyde and was a method he had also used in Todmorden. He would take for himself supplies of the diamorphine that he had prescribed in the names of patients who had some form of cancer, even though some might not be in need of the drug. In this Chapter, I shall describe the circumstances in which he obtained the large quantities of diamorphine which he used to kill a great number of patients between late 1993 and his arrest in 1998. I shall do so by reference to the patients whom he used as a means of obtaining his illicit supplies.

1993

Mr Raymond Jones

12.2 In October 1993, Mr Raymond Jones was found to be suffering from terminal cancer. By November, he was in need of diamorphine for pain relief and he had been given a syringe driver. Shipman visited him quite frequently and the district nurse attended regularly to replenish the syringe. On Monday, 15th November 1993, three 30mg ampoules were dispensed for him at the pharmacy at 23 Market Street and, on 16th and 20th November, twenty 100mg ampoules were dispensed. Finally, on 26th November, fifteen 100mg ampoules were dispensed. These supplies were almost certainly collected from the pharmacy by members of Mr Jones' family and not by Shipman, although I cannot rule out the possibility that Shipman collected the supply on 26th November. As I said in Chapter Seven, the controlled drugs register (CDR) does not record the identity of the person who collects the medicine. Mrs Ghislaine Brant, the pharmacist manager, dispensed all supplies except for the last.

12.3 Mr Jones' patient drug record card (PDRC) is no longer available and so it is not possible to see what record was made of the administration of the drugs, or indeed what the residue was when Mr Jones died on 27th November. Shipman collected whatever had been left over. Fifteen hundred milligrams had been obtained on the day before the death, and it is likely that more than 1000mg was left over. This would be consistent with the recollection of Mr Jones' widow who told the police that Shipman removed two or three boxes of diamorphine ampoules from the sideboard. She said that she was grateful that he did so because it saved her the inconvenience of returning them to the pharmacy. He left behind various other medicines. At Shipman's trial, it was suggested to Mr Jones' widow by Shipman's counsel that Shipman had destroyed the drugs at the premises but she denied that this was the case. At present, there is no requirement that the destruction of a patient's unused controlled drugs should be witnessed by a second person or that any record

should be made of the destruction of such drugs. I shall have to consider whether such requirements should be introduced.

1994

Mrs Mary Smith

12.4 The CDR from 23 Market Street shows that, on 17th May 1994, a supply of ten 100mg ampoules of diamorphine was dispensed in the name of Mrs Mary Smith. Mrs Smith had been diagnosed as having lung cancer in 1993. Her condition deteriorated during 1994 and she was prescribed morphine sulphate tablets for pain relief. On 17th May, Shipman made a note in her medical records that he had prescribed diamorphine by syringe driver. In fact, Mrs Smith did not need diamorphine and was never issued with a syringe driver. I have no doubt that the drugs prescribed on 17th May in Mrs Smith's name were, in fact, collected by Shipman and never reached the patient. Later, Shipman killed Mrs Smith, possibly using some of the diamorphine he had obtained in her name.

12.5 Shipman's conduct in prescribing in Mrs Smith's name, presenting the prescription and collecting the drugs for himself, was criminal. He committed the offences of obtaining by deception and unlawful possession of the controlled drugs. These were the same offences of which he had been convicted in 1976 in relation to pethidine. However, whereas in 1975 suspicion fell on Shipman largely because of the quantities he was obtaining for the practice on requisition, a prescription for a modest amount such as this, prescribed in the name of an elderly patient, would never be noticed. Shipman's name appeared in the CDR only as prescriber. A requirement that the collector of drugs should be identified in the CDR would help to alert a pharmacist or a chemist inspection officer (CIO) to the fact, if it were the case, that a particular health professional was making a habit of collecting controlled drugs, ostensibly on behalf of patients. If CIOs were alert to cases where a health professional collected drugs, it would be possible to carry out a cross-check with other health professionals involved with the patient or with other records relating to the patient, to find out whether the patient was in fact receiving the drugs. I shall consider later whether and how this might be done.

Mr Eric Davies

12.6 Mr Eric Davies, a patient of Shipman, died a natural death at Hyde Nursing Home on 8th September 1994. On 23rd July 1994, five 100mg ampoules of diamorphine were dispensed at 23 Market Street, by a colleague of Mrs Brant, in accordance with a prescription issued by Shipman in Mr Davies' name. In fact, Mr Davies did not need diamorphine and did not receive it. His medical notes record that Shipman visited him on 22nd July but do not record that diamorphine was prescribed. At his trial, Shipman said that he had prescribed diamorphine on account of Mr Davies' brain tumour. However, on being shown a letter from Mr Davies' consultant, he agreed that Mr Davies had not needed diamorphine. Shipman then claimed that he had prescribed the drug for Mr Davies' future use. He also claimed that he had told the staff at the nursing home where Mr Davies was resident to collect the drugs. I am sure that Shipman presented the prescription himself and kept the drugs.

12.7 As in the case of Mrs Smith, described above, Shipman's conduct in respect of Mr Davies was criminal but was very unlikely to be detected, as there was nothing about it that would arouse suspicion, at least unless the pharmacist came to be sceptical of his reasons for collecting the drugs. I shall consider later how the legal controls might be changed so as to improve the chances that such illegal conduct could be detected.

1995

Mr Frank Crompton

12.8 Mr Frank Crompton was a patient of Shipman. On 28th February 1995, ten 100mg ampoules of diamorphine were dispensed by Mrs Brant on prescriptions issued by Shipman in Mr Crompton's name. On 18th March 1995, ten 10mg ampoules of diamorphine were dispensed. There is no note in his medical records that Mr Crompton was prescribed opiates and his treatment never involved a syringe driver. The diamorphine dispensed was never, apparently, administered. Shipman killed Mr Crompton at his home on Friday, 24th March 1995. Two days later, he certified that the death was due to a coronary thrombosis.

12.9 At his trial, Shipman was asked about the supply of diamorphine to Mr Crompton. He gave a most implausible reply. He said that Mr Crompton had prostate cancer, which had been successfully treated, albeit with the possibility of secondary cancer. This might have been true. Shipman claimed that he had given Mr Crompton the first prescription for diamorphine on about 28th February, although the drug was not needed at the time. Shipman expressed the opinion that it was good practice to make provision for the time when the drug would be needed. This account was plainly nonsense. The amount prescribed was very large, appropriate for use with a syringe driver. If it were proper to supply a controlled drug 'just in case', it would be appropriate to supply only a small amount. But, in any event, Mr Crompton never suffered severe pain and never needed any diamorphine.

12.10 When asked where the ten 100mg ampoules had gone to, Shipman said that Mr Crompton had destroyed them. Shipman claimed that Mr Crompton had said that he had decided to get rid of the drug and that he had crushed the ampoules with his foot. According to Shipman, Mr Crompton admitted that his actions in destroying his first supply had been 'a little hasty' and he promised that, if Shipman were to give him another supply of drugs, he would keep them safe in his house, in case he needed them. Shipman had therefore given him another prescription. There can be no doubt that Shipman presented both prescriptions, collected the drugs and kept them for himself. This case is yet another example of the method Shipman had used in respect of Mrs Smith and Mr Davies. The implausibility of his explanation demonstrates that it would be difficult for a dishonest doctor to get away with obtaining a large quantity such as was involved in this case if his/her conduct came to the attention of anyone in authority. However, Shipman's conduct in this case would never have come to light had it not been for the investigation into the death of Mrs Kathleen Grundy in 1998.

Mrs Clara Hackney

12.11 On 13th April 1995, ten 100mg ampoules of diamorphine were dispensed at the pharmacy at 23 Market Street against a prescription issued by Shipman in the name of Mrs Clara Hackney. Mrs Hackney was suffering from terminal cancer. However, until very shortly before her death, she was not in severe pain. Her medical records do not suggest that she needed diamorphine. Certainly, there was no question of her needing a syringe driver for which the 100mg ampoules would have been appropriate. On 14th April, Shipman visited Mrs Hackney and hastened her death by the administration of a lethal dose of diamorphine. Exactly how much he gave her I am not sure. It was probably about 30mg.

12.12 At his trial, Shipman was asked about Mrs Hackney and said that he had given her 10mg diamorphine for pain on the day of her death. He agreed that he had not made a note of this in her medical records. When asked what had happened to the rest of the diamorphine, he claimed that Mrs Hackney's sister had destroyed it by crushing the ampoules. I am quite satisfied that Shipman presented the prescription and obtained all ten ampoules himself. He might have used one of them, or part of one of them, to kill Mrs Hackney. This case illustrates the same problems of detection as I described above.

Mr James Arrandale

12.13 In July 1995, Shipman obtained some diamorphine prescribed in the name of Mr James Arrandale, who died from non-Hodgkin's lymphoma on 28th July 1995. For about a week before his death, Mr Arrandale was in need of diamorphine from a syringe driver. The district nurses set it up. Shipman prescribed the drugs, a member of the family collected them from the pharmacy and the district nurses attended each day to recharge the syringe driver. They recorded each administration on the PDRC. This card provides something of an audit trail although, as I have explained in Chapter Eight, the process of recording starts only at the house and the opening balance is not reconciled with the quantity of drug that leaves the pharmacy. In this case, the PDRC shows that Mr Arrandale was being given 40mg diamorphine each day until the day of his death, when the dosage was increased to 60mg. According to the PDRC, all supplies coming into the house were in 10mg ampoules. In the course of the week, forty 10mg ampoules were entered onto the card and a total of 300mg was administered. That would leave ten 10mg ampoules unused after the death. However, examination of the CDR at the pharmacy shows that, in addition to the forty 10mg ampoules that were entered into the PDRC, two prescriptions for five 100mg ampoules were also dispensed, one on 27th July and the other on 28th July. These supplies were not entered onto the PDRC. It is clear that Shipman must have presented those prescriptions and kept the drugs for himself.

12.14 Shortly after Mr Arrandale's death on 28th July, Shipman attended the house and confirmed the fact of death. He removed the syringe driver. He signed the PDRC, saying that he had destroyed the remaining drugs. That implied that he had destroyed them at the house. In fact, he did not; he took them away, telling Mr Arrandale's widow that he would dispose of them. It is now known that he did not do so, but kept them for himself. Four 10mg ampoules of diamorphine found at Shipman's house after his arrest were traced, by their batch number, to Mr Arrandale's supply. When asked about this, Shipman

claimed that he had destroyed six ampoules but had kept the rest. He had no rational explanation as to why he had done that.

12.15 In this case, Shipman used two different methods to obtain an illicit supply. First, he issued extra prescriptions in the name of a patient with a genuine need; he presented them at the pharmacy and collected the drugs, keeping them for himself. This type of conduct is difficult to detect. Collecting drugs for a patient who is terminally ill will usually be seen as an act of kindness. It might be seen as insensitive for a pharmacist to query the actions of a doctor who appeared to be considerate of the needs of a patient and his/her family. Second, Shipman took possession of unused diamorphine, as he had done in the case of Mr Jones.

Mr Peter Neal

12.16 In late September 1995, Shipman obtained a supply of diamorphine in the name of Mr Peter Neal, who died of cancer on 23rd September 1995. From 18th September until his death, Mr Neal needed diamorphine from a syringe driver. The district nurse was visiting to recharge the syringe driver and was keeping a PDRC.

12.17 The 23 Market Street CDR shows that, on Monday, 18th September, ten 30mg ampoules of diamorphine were dispensed against a prescription issued by Shipman in the name of Mr Neal. On Friday, 22nd September, ten more 30mg ampoules were dispensed and the PDRC shows that, on that day, 150mg was administered to Mr Neal, on Shipman's instructions. According to the PDRC, that left a stock of six 30mg ampoules. From the CDR it is seen that a second supply of diamorphine (this time three 100mg ampoules) was dispensed for Mr Neal on 22nd September, but this supply was never entered into the PDRC and it is very likely that Shipman collected it and kept it for himself.

12.18 The events of 23rd September are not clear. Mrs Neal asked Shipman to attend, as her husband was in pain. Shipman put the available diamorphine in the syringe and, when this proved insufficient, he left the house saying that he would fetch more. He returned some time later, and put more diamorphine in the syringe. Within a short time, Mr Neal became comfortable; he died later that day. It is not possible to say how much diamorphine Shipman administered to Mr Neal that day. From the rather informal and confusing entry Shipman made on the PDRC, it appears that he might have given 400mg, or possibly even 600mg, although this might well have been a deliberate over-estimate. After the death, Shipman returned and wrote on the PDRC that he had destroyed 'all the drugs'. The amount destroyed was not specified. The pharmacy CDR shows that, on 23rd September, two separate supplies of diamorphine were dispensed for Mr Neal. The first comprised three 100mg ampoules and the second was for seven 100mg ampoules. The time when the drugs were dispensed is not recorded so it is quite possible that the second supply was made after Shipman knew of Mr Neal's death. Whatever the amount of diamorphine Shipman gave Mr Neal that day, it is clear that far more was obtained from the pharmacy than was given to Mr Neal. I estimate that there was an excess of 1000mg, which Shipman must have retained for himself.

12.19 This case illustrates the present lack of control over controlled drugs when they have left the pharmacy. It underlines the need for a formal record to be kept of the movement and usage of diamorphine.

Mr Kenneth Woodhead

12.20 Mr Kenneth Woodhead died at his home on 14th December 1995. He had advanced lung cancer. On the morning of the day of his death, his pain was such that he needed diamorphine from a syringe driver. Shipman prescribed ten 100mg ampoules, which were brought to the house in two boxes, each containing five ampoules. A district nurse set up a syringe driver using, on Shipman's instructions, 200mg diamorphine. That would last for 24 hours. Later in the day, Shipman attended, gave Mr Woodhead an injection and left. Mr Woodhead died very shortly afterwards. I have found that Shipman probably hastened his death by a short period.

12.21 Soon after the death, Shipman returned to the house, dismantled the syringe driver and told Mr Woodhead's sister-in-law that he would take the remaining drugs for destruction. He wrote on the PDRC that he had taken all the drugs for disposal. The following day, the district nurses attending to remove property found that there were three 100mg ampoules of diamorphine at the house. They destroyed them and recorded the destruction. They saw Shipman's note on the PDRC and must have assumed that he had taken away the full box of five ampoules for disposal but had mistakenly left the box of three. They had no reason to be suspicious about his conduct.

12.22 At his trial, Shipman claimed that he had destroyed the five ampoules in Mr Woodhead's kitchen, although that is not consistent with what he wrote on the PDRC. In the absence of a requirement that this destruction be witnessed, there could be no strong evidence to refute this. With the benefit of hindsight, I am sure that Shipman used one of the ampoules in the box of five to hasten Mr Woodhead's death and kept the rest of the box for himself. This case too illustrates the need for a proper record of the administration and destruction of controlled drugs after they have left the pharmacy.

1996

Mr Keith Harrison

12.23 Mr Keith Harrison, who died of lung cancer on Thursday, 6th June 1996, had been using diamorphine in a syringe driver for just over ten weeks by the time of his death. He was in significant pain and his tolerance of the drug had become very high. In the middle of April, he was receiving 600mg daily and this increased to 900mg one month later. In the few days before his death, he was receiving 2400mg daily. Because of the large quantities he needed, the supplies came as 500mg and 100mg ampoules. The district nurses filled the syringe twice daily. Mr Harrison received his morning dose of 1200mg at 8.30am on the day of his death when the remaining stock was recorded on the PDRC as one 500mg and ten 100mg ampoules. There would be sufficient for the evening but more would be needed for the next morning. As a general rule, Mr Harrison's family collected his drugs from the pharmacy but, on occasions, a family friend who worked at the pharmacy delivered them. Before the day of the death, there had been only one occasion when Shipman had delivered them himself. The PDRC tallied with the amounts dispensed for Mr Harrison until the day of his death.

12.24 Mr Harrison died in the early afternoon. His widow telephoned Shipman, who attended. He made an entry on the PDRC, saying:

> **'Patient Died 14.30**
>
> **All Drugs Destroyed.'**

This was countersigned by the district nurse in attendance, Mrs Barbara Sunderland. She recalls destroying the remaining drugs by swilling them down the sink. To her, the expression **'All Drugs Destroyed'** meant that the stock balance recorded on the PDRC had been disposed of. However, alongside the entry to which I have referred, Shipman also wrote:

> **'returned to Chemist for destruction'**.

These two statements are mutually inconsistent.

12.25 Examination of the 23 Market Street pharmacy CDR shows that, on the day of Mr Harrison's death, 12,000mg diamorphine was dispensed on a prescription in Mr Harrison's name. Mrs Brant accepted that Shipman must have collected it. As the CDR does not record the time of a transaction, only the date, it is not clear whether Shipman collected the drugs before he knew of Mr Harrison's death or afterwards. I suspect that, when Shipman attended the house after the death, he was in possession of the extra 12,000mg and deliberately made a confusing and internally inconsistent note in the PDRC which he could later use to substantiate an explanation if questions were asked about the collection of 12,000mg diamorphine for Mr Harrison that day. In the event, no questions were asked about this enormous quantity until Shipman came under suspicion two years later for other reasons. I say that not as a matter of criticism of anyone. But it is alarming that so large a quantity of diamorphine, enough to kill about 360 opioid-naïve people, could be dispensed and handed over with so little control over its future movement. I am sure that Shipman obtained 12,000mg diamorphine on that occasion. At his trial, Shipman said that he had brought the new supply of diamorphine to Mr Harrison's house and that it had all been destroyed there. The lack of any requirement to have destruction witnessed and recorded meant that it was difficult to challenge this assertion. Mr Harrison's widow and the district nurse did not accept that the new consignment had been destroyed but it should not be necessary for such important matters to turn upon the recollection of the individuals present. A formal record should be mandatory.

1997

Mrs Maureen Jackson

12.26 In early July 1997, Shipman acquired more diamorphine, probably 800mg, from Mrs Maureen Jackson. Mrs Jackson was suffering from cancer and, for about two weeks before her death on 7th July 1997, had been in need of diamorphine administered through a syringe driver. The district nurses were attending daily and kept a PDRC. The amounts of diamorphine entered into the PDRC tallied with the amounts entered in the 'drugs supplied' side of the CDR at the 23 Market Street pharmacy until 3rd July. On that day, 2300mg was dispensed on a prescription issued by Shipman in Mrs Jackson's name.

Shipman's entry in the PDRC suggests that he brought only 1500mg into the house that day.

12.27 Now that Shipman's propensity for stealing diamorphine is known, it is reasonable to infer that he had diverted part of Mrs Jackson's supply to his own use. However, this case illustrates the way in which unwarranted suspicion could fall upon either the pharmacist or the district nurse involved. If it had been discovered that 2300mg had been prescribed, but that Mrs Jackson had only benefited from 1500mg, several people could have been suspected of dishonesty. The pharmacist could have diverted part of the supply, putting only 1500mg into the package to be handed over. Second, the person collecting and delivering the drugs could have stolen part of the consignment. In this case, it was Shipman, but any person, a relative, friend or neighbour, could have diverted part of the consignment. Last, the district nurse who received the package of drugs could have taken some of them and entered the balance into the PDRC. It seems to me that a better system of record keeping is required, not only to deter and detect dishonest conduct but also to protect innocent participants in the process.

1998

Mr Lionel Hutchinson

12.28 In about 1996, Mr Lionel Hutchinson, a patient of Shipman, developed prostate cancer. He was successfully treated with hormone therapy and lived for some time after the events I am about to describe. On 1st November 1997, 1000mg diamorphine was dispensed from the 23 Market Street pharmacy against a prescription issued by Shipman in Mr Hutchinson's name. On 7th January 1998, another supply of diamorphine was dispensed on a prescription issued by Shipman in Mr Hutchinson's name. The overwhelming probability is that Shipman presented both these prescriptions, collected the drugs and kept them for himself. It is very unlikely that Mr Hutchinson knew anything about them. This illegal obtaining by Shipman would not have come to light unless he had been investigated in respect of Mrs Grundy's death.

12.29 At his trial, Shipman admitted that, at the time when he wrote these prescriptions, Mr Hutchinson had had no need for diamorphine. He claimed, as he had claimed in the cases of Mr Davies and Mr Crompton, that he was prescribing in anticipation of some possible future need. He said that he had given the first prescription to Mr Hutchinson and believed that the drugs had been dispensed; he did not know what Mr Hutchinson had done with them. He denied therefore that he had collected the drugs himself. In respect of the second prescription, Shipman claimed that he had issued it because Mr Hutchinson had told him that he had left his first supply of drugs in his holiday caravan in Blackpool and needed an additional supply while at home in Hyde. Mr Hutchinson had died by the time of the trial and could not be asked about this highly implausible explanation. If Shipman's name had appeared in the CDR as collector, there could have been no doubt who collected. However, the recording of the collector's name in the CDR will only help in the detection of offences if the record is inspected by someone with the necessary combination of diligence, knowledge and scepticism.

Mr John Henshall

12.30 In Chapter Eight, I described how, on 6th July 1998, Shipman stole five 10mg ampoules of diamorphine from the stock prescribed for and kept at the home of Mr John Henshall, who was suffering from cancer. Shipman simply took the drugs and made an incorrect entry on the PDRC. Mrs Marion Gilchrist, the district nurse, noticed the discrepancy and asked Shipman about the stock shortage. After some prevarication, he told her that he had taken the ampoules to repay a colleague from whom he had previously borrowed a similar amount. She thought this was poor practice but did not suspect him of dishonesty and did not report him.

12.31 By this time, Shipman had killed his last victim, Mrs Grundy, and had aroused the suspicions of her daughter, Mrs Angela Woodruff, by forging a will in which Mrs Grundy left all her property to him instead of to her family. The fact that Shipman obtained diamorphine illicitly on 6th July suggests that he intended to kill again. However, on 19th July, Mrs Woodruff visited Mrs Claire Hutchinson, one of the patients whom Shipman had involved as a witness in his plot to forge Mrs Grundy's will. Soon afterwards, Mrs Hutchinson told Shipman that Mrs Woodruff had visited her and he must have realised that Mrs Woodruff was likely to report her concerns to the police. He had not killed again by the time of his arrest on 7th September 1998.

Conclusion

12.32 That Shipman was able to obtain large amounts of diamorphine in the ways I have described and to avoid detection for so long demonstrates the need for improved record keeping of controlled drugs at and after the time of dispensing. Four measures come to mind. First, the recording in the CDR of the identity of a person collecting controlled drugs from the pharmacy would draw attention to anyone who made a practice of this. Second, the opening of a PDRC (or some similar document) at the pharmacy, on which the amount of controlled drug prescribed and dispensed could be recorded, would or should deter, or allow the detection of, the doctor who wishes to divert part of the supply before delivery of the rest to the patient's home. Third, the keeping of a running record by the district nurses would be more likely to result in the detection of malpractice if someone inspected the completed PDRCs. The PDRCs would also be available, for linkage with the pharmacy and medical records, in the event of an investigation. Fourth, if the destruction of unused controlled drugs had to be witnessed and recorded, the opportunity for theft would be much reduced. I shall consider each of these possible measures in Chapter Fourteen.