CHAPTER FIFTEEN

An Analysis of Dr Banks' Role

Finding a Benchmark

15.1 It is necessary now to revert to the contribution of Dr Banks to the police investigation and to make a more detailed and critical examination of his review of the medical records.

15.2 When it appeared that it would be necessary for me to assess the adequacy of Dr Banks' examination of the medical records of Shipman's deceased patients and the reasonableness of his conclusions, it was decided that I should be given some benchmark by which to judge him. The Inquiry sought the assistance of Dr Frances Cranfield, a general practitioner of about 20 years' experience. On the face of it, her professional experience as a general practitioner seemed comparable to that of Dr Banks. She was asked to consider the same records as had been examined by Dr Banks in March 1998. She was told what background information Dr Banks had received (that is the information from Mrs Parkinson's note) and was asked to advise as to the adequacy or otherwise of Dr Banks' review and whether his apparent conclusions were reasonable and consistent with his professional duty in the circumstances. In evidence, Dr Cranfield said that she tried to approach her task, putting from her mind her knowledge that Shipman had been convicted of murdering his patients. If she had had only the background knowledge available to Dr Banks, she would have examined the records for signs of gross mismanagement, rather than criminality, although the presence of the police and the mention of donations to a fund might mean that she would have had the possibility of criminal behaviour in the back of her mind.

15.3 Unfortunately, no limit was imposed on the time Dr Cranfield was to spend on this task. It was not known at that time that Dr Banks had spent only five hours on his review. In the event, Dr Cranfield spent about 45 hours on the task and produced a very detailed analysis of what the records revealed. Simply on account of the time taken for the task, it would not have been fair for me to compare the results of her work with that of Dr Banks. However, further reasons emerged why I could not use her work as a yardstick by which to judge Dr Banks. She had undertaken some training in forensic medicine; she had acquired considerable experience as an expert witness and had a good deal of practice in writing reports.

15.4 For those reasons, it would be unfair for me to judge Dr Banks' work against that of Dr Cranfield. Accordingly, I shall not lengthen this Report by undertaking a review of her findings. Suffice it to say that I found her report and evidence most illuminating. She demonstrated very clearly that, if the police had instructed an expert of her calibre and expertise to examine the records in March 1998, they would have been advised that there were substantial reasons for concern about Shipman's conduct. Dr Cranfield observed many worrying features of Shipman's records. I mention only one in detail. She recognised, from the records, that several of Shipman's patients appeared to have been found dead, not long after he had visited them, and that he had apparently left them alone, not anticipating that they were about to die. Yet, when they died suddenly and unexpectedly later that day, Shipman was prepared to certify the cause of death and not

to refer the deaths to the coroner. That trend of sudden death shortly after a visit would have caused Dr Cranfield to think that Shipman's treatment of his patients was substandard. After looking at the tranche of cases which Dr Banks had seen, she said she would have suspected criminal behaviour in the form of gross negligence. In fact, she went on to examine more cases and these would have caused her to take an even more serious view. Had Dr Cranfield reviewed the medical records which Dr Banks saw, the outcome of the first investigation might well have been very different. That observation is not necessarily intended as a criticism of DI Smith's decision to accept assistance from Dr Banks, at least in the first instance.

15.5 The Inquiry also received a report written by Dr Nina Moorman, a general practitioner and formerly a part-time medical adviser to a health authority. In 2000, Dr Moorman had been asked, in connection with the WPHA's proposed disciplinary proceedings against Dr Banks, to review the 15 sets of medical records which Dr Banks had examined in March 1998. She had concluded that Dr Banks' review of the records was perfectly satisfactory, given the circumstances in which he was asked to undertake the task. Partly as a result of that opinion, the Health Authority discontinued the disciplinary proceedings.

15.6 Examination of a chart prepared by Dr Moorman revealed that she had noted that, in five of the 14 deaths, the situation revealed by the records suggested that the death should have been reported to the coroner. Yet she knew that Shipman had made no such report. To be fair, she did not know whether Shipman might have 'discussed' the death with the coroner and received 'permission' to issue the MCCD. However, she dealt with this issue in her report by saying that Dr Banks should not be criticised for any lack of care because, in her view, **'he did express concerns about a number of deaths to the Police and this might have been given more weight in the investigation by the Coroner, which appears to have been under consideration until 21 May 1998'**. It is a matter of concern to me, although I do not think that this occurred to the WPHA or those advising them, that, in giving her opinion, Dr Moorman went beyond her proper function as an expert and descended into the arena as an advocate for Dr Banks. It was for her to advise on what the records should have revealed to a medical adviser applying himself with reasonable skill and care to the task in hand. She could also properly have indicated the degree of concern which the records would have raised in her mind and the terms in which a reasonable medical adviser would have reported to the police. It would then have been for others to compare Dr Banks' actual performance with what she had said was reasonable. Many professional people, asked to express an expert view, do not fully understand the purpose and limitations of expert evidence.

15.7 Notwithstanding the shortcomings of Dr Moorman's report, the Inquiry decided to call her to give evidence. When the Inquiry received Dr Cranfield's report and found that she was critical of Dr Banks, it was thought that, in fairness to Dr Banks, an expert who was known to be supportive of him should also be called. When Dr Moorman gave evidence to the Inquiry, she accepted that, apart from the five cases she had identified which should in her view have been reported to the coroner, there were other features revealed by the records which gave rise to concern. She agreed that it was a cause for concern that, in seven of the 14 cases, the death appeared to occur soon after a visit by Shipman at which he had not recorded in the notes any indication that the patient was seriously ill. She

agreed that, if Dr Banks had noticed this feature, he should have mentioned it to the police. She said that it would also have been appropriate for Dr Banks to raise these concerns with Shipman on a case-by-case basis. She then added that it was her belief that he had done so. This confirms me in my view that Dr Moorman did not understand the limitations of the expert's role. Once again, she had gone beyond her remit and had taken up Dr Banks' cause.

15.8 I was unable to accept the opinion advanced in Dr Moorman's written report. That part of her oral evidence which consisted of true expert opinion tended to suggest that there were features to be noted in the records which should have been mentioned to the police.

15.9 It follows that, despite the Inquiry team's best efforts, I was left to make my own judgement of Dr Banks. Fortunately, despite some uncertainty about his ability to give evidence on account of recent ill health, Dr Banks was able to face detailed questioning about his examination of the medical records. My conclusions are based almost entirely upon admissions made by him and necessary inferences from his evidence.

Concerns about Shipman's Failure to Report Deaths to the Coroner

15.10 Shortly before giving oral evidence, Dr Banks was asked to reconsider the medical records he had first examined in March 1998. By this time, he had received the evidence of Dr Cranfield. He prepared a final written statement. First, having made the point that he had spent only five hours on the task and had not been able to read every single document within the records, he helpfully identified those documents which, by reference to the information recorded in his chart, he inferred he must have seen and examined at the time. Second, he identified the deaths of Mrs Bertha Parr, Miss Mabel Shawcross, Mrs Cissie Davies and Mrs Winifred Healey as deaths that ought to have been referred to the coroner because there was insufficient information in the medical records to permit adequate diagnosis of the cause of death. It should be noted that Dr Banks was not saying that he personally would have reported these cases; he was saying that any reasonable doctor would have reported them, at least if the only information available was that recorded in the notes. As all relevant material ought to be recorded in the notes, it would appear that, in each of these cases, there was cause for concern that not enough was known about the case to permit an adequate diagnosis of the cause of death.

15.11 In his final written statement, Dr Banks also identified five other cases in which he said that he personally would have reported the death to the coroner because he would not (on the basis of the information contained in the available records) have been sufficiently sure of the cause of death. However, he said that it would not have been universal practice to do so. He said that he was uncertain whether or not he had mentioned these cases to DI Smith but I am satisfied that he did not. These cases were those of Mr James King, Mrs Norah Nuttall, Miss Muriel Harrison, Mrs Pamela Hillier and Mrs Joan Dean. He said that these cases would not have caused him any concern in March 1998, as he would have assumed either that the medical records were incomplete or that Shipman had additional information, not recorded, from which a proper diagnosis could have been made. It appears that Dr Banks' approach to his task was affected by a readiness to find an innocent explanation for anything that might give rise to concern.

15.12 It is to be noted that Dr Banks did not claim that, in March 1998, he had not had time to examine the records so as to identify the four cases which should have been reported and the five cases which he personally would have reported. He was suggesting that he had in fact identified them. In three of the four cases, he said he believed that he had mentioned them to DI Smith as being reportable.

15.13 When giving oral evidence, Dr Banks was taken through all the sets of medical records he had examined in 1998. He stressed that, on the earlier occasion, he had not had time to examine every document within the records or to cross-check that the information which appeared on a summary card accurately reflected the detailed entries in the notes. I accept that that was so and that it was a reasonable approach to the task, as he understood it. He repeated that he had been asked to see whether the common features were present and said that he also looked to see whether or not the medical history was generally consistent with the cause of death as recorded by Shipman in the records. It seems to me that, while five hours was not long enough to undertake an in-depth study, it was sufficient to allow him to assess the adequacy of the information from which to diagnose a cause of death and to look for common features. Dr Banks did not suggest the contrary. In my view, in undertaking that limited review, he should also have had the time and opportunity to notice any strikingly unusual features which might give rise to concern of any kind. I did not understand Dr Banks to dissent from that. In any event, if Dr Banks had felt that he required more time to perform the task he had been asked to undertake, he could have asked for it.

15.14 Throughout his evidence, Dr Banks repeated that he had approached his task in the belief that it was unthinkable that Shipman might have harmed his patients but that he had, nonetheless, undertaken the work carefully.

15.15 I do not propose to lengthen this Report by a detailed consideration of each set of records examined by Dr Banks and an analysis of his opinion about them. Suffice it to say that, while giving oral evidence to the Inquiry, Dr Banks confirmed his view that there were four cases which, he said, should definitely have been referred to the coroner and six (as opposed to five) cases which he personally would have reported to the coroner, rather than certify the cause of death himself. In addition to the five cases mentioned earlier, he had identified another, that of Mrs Bianka Pomfret. However, he said that some doctors would not take that view about those six cases and would be prepared to certify the cause of death. Some doctors were much stricter than others about the circumstances in which they were prepared to certify. Some coroners, he said, imposed more stringent rules than others in respect of the cases that they required to be reported. I accept that this is so.

15.16 Dr Banks' evidence about his attitude to Shipman's failure to refer cases to the coroner was inconsistent. At one stage, he said that he had not thought that Shipman's failure to refer cases to the coroner was a cause for concern. He himself had not practised as a general practitioner in the Hyde area and did not know what the coroner expected. He also thought he did not have access to all the information that had been available to Shipman. He thought Shipman might have certified the cause of death because he wished to save the relatives from the additional distress of an autopsy. He thought that he ought to give Shipman some advice about his practice in relation to coroners' referrals. He felt that Shipman's practice was lax but he did not regard this as a cause for concern.

15.17 Inconsistently, at another stage of his evidence, Dr Banks claimed that he believed he would have been sufficiently concerned about Shipman's failure to refer the most obviously reportable deaths to the coroner that he would have mentioned the deaths to DI Smith. I do not think he can have been as concerned as he claimed. If he had identified and been concerned about the four cases which, he said, should definitely have been reported to the coroner, I do not think he would have told Mrs Parkinson on Friday, 27th March 1998 (as, according to her note, he did) that there were **'a couple of cases'** about which he was concerned. Dr Banks was anxious to persuade me that by **'a couple of cases'** he had meant 'a few'. I think it unlikely, although not impossible, that Mrs Parkinson would have written **'a couple of cases'** if Dr Banks had used the expression 'a few'. However, I find it hard to accept that Dr Banks would have used the expression **'a couple'** or even 'a few' if he had four cases in mind. I think he would probably have said there were four. If Dr Banks had had in mind that there were another five or six cases that some doctors, including him, would think it right to report, one would expect his level of concern to have been raised further. It would then be most unlikely that he would use so casual an expression as **'a couple'** or 'a few'. On the basis of his own assessment of the propriety of Shipman's certification of these ten cases (or nine, if Mrs Pomfret is excluded), it seems clear to me that Dr Banks should have felt some real concern about Shipman's willingness to certify deaths rather than refer them to the coroner. Yet, whether he used the expression **'a couple'** or 'a few', it is clear that he did not. Dr Banks agreed that he would not have used those expressions if he had had nine or ten cases in mind.

15.18 I note also that, whereas Dr Banks now says that four cases should definitely have been referred to the coroner, DI Smith had the impression that Dr Banks was saying that he personally would have referred them, implying that it would have been within the limits of reasonable conduct for a doctor to decide not to report such a case to the coroner. Although, for reasons I have previously explained, I do not regard DI Smith as a generally reliable witness, I am inclined to accept his evidence on this point. I say that, first, because a low level of concern is reflected in Mrs Parkinson's note made on 27th March and there would be no reason for Dr Banks' attitude to have changed by 1st April. Second, if Dr Banks had said that Shipman had failed to report even two deaths (let alone 'a few' or four) which any reasonable doctor would have known he should report, I think it is likely to have made some impression on DI Smith. Third, when writing his report for the Health Authority, which was his earliest known account of these events, Dr Banks said that he had **' ... expressed concern that in a number of cases there was insufficient evidence in the records on which to base a cause of death and that I personally would have arranged a post-mortem'**.

15.19 It appears to me that Dr Banks cannot have identified four cases as requiring referral to the coroner. Had he done so, and had he also identified five or six other less clear-cut cases, this would have given rise to a substantial degree of concern. I am satisfied that Dr Banks' actual level of concern was low and was properly reflected by Mrs Parkinson's note. I can only conclude that Dr Banks' examination of the records, and the judgement he brought to bear, were adversely affected by his inability or unwillingness to open his mind to the possibility that any doctor might harm his patients, particularly Shipman, of whom he thought well.

Concern about the Common Features

15.20 Dr Banks said that he had not noticed any common features between the deaths. It will be recalled that one of the common features Dr Banks understood he was supposed to look for was Shipman's presence at or around the time of death. As he was taken through the 14 sets of records, Dr Banks' attention was drawn to the fact that, in seven cases, the records showed that Shipman had seen the patient not long before the death was discovered. In each case, the notes recorded that he had visited on the day of death (or, in one case, on the day before). The medical records did not suggest any serious cause for concern about the patient's health; certainly, there was nothing that appeared to presage death. Yet the patient had been found dead later that day (or, in one case, early the following day). These cases were those of Mrs Elizabeth Battersby, Mrs Mavis Pickup, Mrs Pomfret, Mr King, Mrs Davies, Mrs Hillier and Mrs Nuttall. Dr Banks said that he did not know whether he had noted these similarities. In my view, they were plainly very remarkable and significant. It is unusual for a patient to be found dead within a few hours of a doctor's home visit in circumstances where the doctor did not appear to have felt any concern for the patient's health. Such an event might suggest that the visiting doctor had misdiagnosed the patient's condition. If this kind of misdiagnosis were to happen once within six months, that might not be thought significant but if such an event were to occur seven times in six months, one would expect any doctor to notice it and to be concerned.

15.21 Yet it appears that Dr Banks did not notice this common feature. In the **'Who Saw'** column of his chart (in which he had intended to record who had been present at or around the time of death), Dr Banks noted Shipman's name in no fewer than ten of the 14 cases. However, it appears that he was interested, not in whether Shipman had been present shortly before the death was discovered, but in whether Shipman had found the body. That, he said, was not always clear from the records. In any event, he said, he did not regard it as strange that Shipman should have been around at the time of the death, as it was common for a general practitioner to be called to a death. That is plainly true and I can understand why presence after the death would not give rise to suspicion. It had been suggested to Dr Banks that Shipman often appeared to be the one to find the body and he is right to say that it was not always possible to tell from the records whether or not he had done so. However, if Dr Banks had only applied his mind to the slightly different but related question of Shipman's presence shortly before the death was discovered, he would have noticed a factor of real significance and concern.

15.22 In evidence, Dr Banks agreed that there were some common features to be found in the 14 sets of records. One striking feature was that most deaths involved elderly females. Of the 14 deaths, 13 were women. Given the overall population mix, that is unusual. Ten of the 14 deceased had been aged over 70; that does not seem in any way remarkable. Another concern expressed was that the deaths had occurred at home. Of the 14 deaths, 12 had died in their own private homes; the other two were in residential care or nursing homes. I would have expected that to strike Dr Banks as unusual.

15.23 Dr Banks said that he did not appreciate that there was a high incidence of some of the features that he had been asked to look out for. He said that he had been told that the deaths which caused concern had all the common features. So, as he found deviations

from the pattern, he concluded that there was no pattern. I find it hard to credit that a doctor of Dr Banks' experience could have taken so simplistic a view. I think this must be an attempt at an excuse which, in fact, does him little credit. Any person of even modest intelligence would realise that, if a doctor was suspected of killing his patients using a similar method each time, one would expect to see a pattern of similarities between the deaths. However, one would not expect that pattern to be found in every patient's death; one would expect that some patients would happen to die naturally; their deaths would not conform to the pattern. I do not think that Dr Banks could have taken so simplistic a view of his task. The way he put it to Mrs Parkinson was that no two cases were the same. That is very different from saying that there is no pattern of significance because there is no factor present in all cases.

15.24 There can be no doubt that Dr Banks should have noticed that all but one of the deaths was of a female patient. This was one of the matters of concern and it was an odd feature. I think he should also have been slightly puzzled at the high incidence of home deaths. I also think that he ought, in the circumstances, to have noticed that, although there was no clear evidence that Shipman found his patients dead, he had seen the patient shortly before the death was discovered in an unusual number of cases. I conclude that Dr Banks' search for the common features was superficial.

Signs of Substandard Care

15.25 Dr Banks said that he had not considered the records to see if they revealed any signs of substandard care. He had not been asked to do so and he would have thought it dangerous to do so, as he thought the records might be incomplete. He was then taken through some cases which, in the submission of Leading Counsel to the Inquiry, showed clear evidence of substandard treatment such as would give rise to concern in the mind of any doctor who examined the records with reasonable skill and care.

15.26 The first was the case of Mrs Elizabeth Battersby, whose records show that she died of a pulmonary embolism, supposedly following a deep vein thrombosis, for which she was not admitted to hospital but was treated at home on an oral anticoagulant. Dr Banks said that he thought the records might be incomplete and that, if they were complete, they would have shown that Shipman had taken advice from the hospital about treatment at home. In other words, it appears that his approach to the records in this case was to look for an innocent explanation for anything unusual. He agreed that, when he examined Mrs Battersby's records again, in September 1998 (by which time Shipman was under investigation for the murder of Mrs Kathleen Grundy), he expressed the opinion that Shipman's standard of care was unacceptable. His explanation for this change of view was that, by September, he had a different mindset. In March, he would have found it inconceivable that Shipman might have harmed a patient. By September, his mind was open to that possibility. In March, he had not thought that there was any reason for concern about this death and had not thought that it should have been reported to the coroner. He now accepted that the records did reveal cause for concern and a reason to refer the case to the coroner. That meant that he conceded that, in all, 11 of the 14 cases ought perhaps to have been referred to the coroner.

15.27 Another set of records about which Dr Banks was asked were those of Mrs Mavis Pickup. Shipman had certified that Mrs Pickup had died of a cerebrovascular accident or stroke. The records showed that Shipman visited her on the day of her death. He recorded a history of symptoms that sounded like either a transient ischaemic attack or a minor stroke, from which Mrs Pickup seemed to be recovering. No treatment had been prescribed. Mrs Pickup was said to have been confused. She was found dead later in the day. When asked whether he felt any concern on reading that Mrs Pickup had been in a confused state and yet had been left alone, Dr Banks said that it was not clear whether Mrs Pickup had been left alone. However, he agreed that it was clear that she was alone when found dead later in the day. He did not think this seemed strange or worrying. He agreed that the history, which suggested a minor stroke earlier in the day followed by an overwhelming stroke leading to sudden death, was an unusual combination and that a sudden death would not have been expected following a slight stroke. However, Dr Banks said, it was not impossible that that had occurred and he had not seen the combination as unusual at the time. If he had thought it was unusual, he would have put it down to inaccuracy in the records. He agreed that his approach was affected by his belief that Shipman was a competent and respected practitioner. In any event, Dr Banks recorded no concern about Mrs Pickup on his chart and did not think that the circumstances of her death warranted a report to the coroner.

15.28 It is clear from the cases of Mrs Battersby and Mrs Pickup that Dr Banks approached his examination of the medical records in the belief that there would be no cause for concern. In my view, Dr Banks' prior knowledge of Shipman made him an unsuitable person to form any judgements about Shipman's actions or competence. Dr Banks said that he thought that his prior knowledge of Shipman would have made it inappropriate for him to write a commentary on Shipman's work but he felt that it was acceptable for him to undertake the task of extracting facts from the records. I see the distinction that Dr Banks sought to draw. However, in my view, even the extraction of facts calls for the exercise of some judgement, particularly where, as here, the facts are not clearly set out and inferences have to be drawn.

Findings

On the Basis of the Medical Records that Dr Banks Actually Considered

15.29 In my view, Dr Banks failed to see that which was there to be seen on a careful and open-minded examination of the records. He failed to recognise features that tended to support the concerns expressed. Why? I do not think the problem was that he was lazy or did not care. I think he is a reasonably conscientious man, although I do not think he would usually exert himself beyond the call of duty. I think he simply could not open his mind to the possibility that Shipman might have harmed a patient. Accordingly, instead of searching for the odd features, he anticipated that all would be normal. For such features as did strike him as odd, he immediately found an innocent explanation. I think also that he thought that the expression of concern by the general practitioner was probably underlain by professional jealousy or some other personal animosity. That attitude too was born of his prejudice in favour of Shipman.

15.30 In mitigation of this failure, I accept that Dr Banks was not given all the information he could and should have been given. It should have been spelled out to him that a general practitioner, who appeared to be a responsible person, was concerned that Shipman might be killing his patients and that these concerns were shared by an undertaker. The Coroner had referred the matter to the police for investigation. He should have been told of the comparative death rates of the two practices concerned. I think there is a real possibility that, if Dr Banks had been fully informed, his mind might not have been quite so tightly closed against the possibility of Shipman's guilt.

On the Basis of the Medical Records that Dr Banks Might Have Considered

15.31 It remains to consider what the outcome might have been if the staff at the Tameside register office had identified all the deaths of Shipman's patients certified by him in the previous six-month period. Instead of receiving a bundle of 19 (or 20) copy certificates, DI Smith would have received 31. I have said that I do not think this would have had any significant effect on DI Smith's approach to the investigation. What would have been the effect on Dr Banks? Not only would Dr Banks have known of more deaths, he would also have examined more sets of records.

15.32 Dr Banks said that he did not know the average death rate for patients of a general practice. The figure he was given, 16 cremations in three months, did not strike him as particularly high. If that figure did not strike him as high, then it seems highly unlikely that 31 deaths in six months would have made any impression on him. However, the position is not quite so straightforward. Dr Banks said that he noticed that the 14 sets of records he looked at initially covered a period of six months and he said that he 'assumed' that the figure of 16 cremations in three months was wrong. His view that the death rate was not abnormal might have been affected by his assumption that the figures were wrong anyway. If DI Smith had had 31 copy certificates and if he had provided all or nearly all the names to the Health Authority, Dr Banks would probably have accepted the figures as accurate. It is impossible to say whether the death rate would have then appeared to him as high. I can only say that the chance that he would have thought the death rate abnormal would have been increased.

15.33 However, Dr Banks would also have examined a larger number of sets of records. It is impossible to say with certainty how many he would have seen. I think DI Smith would probably still have withheld the names of Miss Maureen Ward and Mr Harold Eddleston initially, on the grounds that the deaths were certified as being due to cancer. I think it unlikely that the records for any death occurring after 1st March 1998 would have been available. It is therefore unlikely that Dr Banks would have examined the records of Mrs Irene Chapman, Miss Ada Warburton or Mrs Martha Marley. Accordingly I estimate that he probably would have seen nine additional sets of records, making 23 in all. The additional records would have related to Mrs Bessie Swann, Mrs Enid Otter, Mrs Florence Lewis, Mrs Mary Walls, Mrs Elizabeth Baddeley, Mrs Kathleen Wagstaff, Mrs Alice Black, Mrs Laura Linn and Mrs Irene Berry.

15.34 Of these nine additional cases, it is noteworthy that all the deceased were women. Shipman had been present at three of the deaths (those of Mrs Walls, Mrs Linn and

Mrs Wagstaff) although, in the case of Mrs Linn, her husband had also been present. Shipman appeared to have been present alone with the patient at the other two deaths. This was an unusual feature and was a cause for concern. Of the nine deaths, there were six in which the question of a report to the coroner should have been raised in Dr Banks' mind. These were Mrs Swann (whom Shipman had not seen for three months), Mrs Walls and Mrs Black (in respect of whom there was no information about the cause of death), Mrs Baddeley (where it was not clear when Shipman had last seen her and the records did not support 'old age' as the cause of death) and Mrs Wagstaff and Mrs Berry (where there was no adequate correlation between the medical history and the given cause of death).

15.35 Although there was an abundance of relevant information available for Dr Banks to see, much of which tended to support the concerns which had been raised, I cannot say with confidence that Dr Banks would have realised the significance of this additional material if he had seen it. The same trends were present in the tranche of 14 in roughly the same proportion as they were present in the whole group of 23. Ten deaths out of 14 and 16 deaths out of 23 raised a question of a report to the coroner. Yet, Dr Banks expressed only a mild degree of concern about **'a couple'**, or possibly 'a few', of the group of ten. Of course, I recognise that the chance that Dr Banks would register some real concern would have been enhanced if he had seen 23 sets of records rather than 14. However, I cannot say that he would probably have expressed real concern to DI Smith if he had seen all the available records.

Dr Banks' Duty to Report to Senior Officials Within the Health Authority

15.36 Dr Banks also faced criticism for his failure to inform a more senior member of staff at the WPHA of the nature and purpose of the request that he had received from the police in relation to the examination of medical records. As I have observed, he did not mention the matter to anyone senior to him although, of course, Dr Bradshaw, his 'job share' partner, was aware of what he was doing.

15.37 The most obvious person Dr Banks might have told was his immediate line manager, Mrs Jan Forster, Director of Primary Care. The view of Mrs Forster, and of those senior to her in the Health Authority, was that Dr Banks should have told her of DI Smith's request and of his intention to comply. Yet, she agreed that Dr Banks' job description did not make plain the scope of his discretion to make his own decisions about his work. That is plainly so. Dr Banks said that, as he is medically qualified and Mrs Forster is not, he took it that he was entitled to undertake, without reference to her, tasks which appeared to fall within the scope of his work as a medical adviser. He said that, before the amalgamation of the Tameside and Oldham Family Health Services Authorities in 1996, he had a very large measure of autonomy. This had never been officially changed. He felt that the decision to examine these records was one he could properly take alone. He accepted that, with hindsight, it would have been better if he had consulted Mrs Forster but contended that he should not be criticised for his failure to do so.

15.38 I accept that submission to a large extent. I think it was an error of judgement on Dr Banks' part that he did not tell Mrs Forster. He underestimated the potential seriousness of the

request and the possible implications for the Health Authority. However, I do not think it could be said that he overstepped the boundaries of his authority.

15.39 If Mrs Forster had been told, there would have been two probable consequences. First, she would probably have ensured that relations between the police and the Health Authority were put on a more formal basis. I think it likely that Mrs Forster would have required the police to submit a formal written request either for disclosure of the records or for assistance with the examination of the records. Such formality would have focussed the minds of both the police and the Health Authority on what exactly was required. I think it would also have brought home to Dr Banks the seriousness of the concerns. It would have been less easy for him to dismiss the suspicions as inconceivable.

15.40 Second, and even more important, I think it likely that Mrs Forster would have realised that, as Shipman was known to the medical staff within the WPHA, it would be preferable for the police to seek expert advice elsewhere. DI Smith would not have known whom to consult and might well have asked the advice of Mr Postles. Had he done so, there is a real possibility that the police would have instructed someone with a greater degree of expertise (to say nothing of greater objectivity) than Dr Banks. They might well have found and instructed Dr John Grenville, whom they used when they needed advice during the second investigation. I have no doubt at all that Dr Grenville's examination of the records would, like Dr Cranfield's, have resulted in the realisation that Shipman's conduct was far from normal. That is another way in which this investigation might have reached a different conclusion.

15.41 Mrs Forster's main criticism of Dr Banks was that he did not keep any proper record of the request he received from the police or of what he had done and the conclusions he had reached. I accept the validity of that criticism. However, Dr Banks' failure in this respect did not affect the outcome of the investigation.

15.42 It was also suggested that Dr Banks should have informed Dr Ellis Friedman, the Director of Public Health Medicine, about the police request. Dr Banks pointed out that his job description required him to liaise with Dr Friedman but that he was not expected to report to him. That I accept. I do not think that Dr Banks' decision to examine the records without first speaking to Dr Friedman could be described as misconduct.

15.43 I have already observed that Dr Banks is open to criticism in that he did not speak to Dr Friedman about the death rate in Shipman's practice. As Director of Public Health Medicine, Dr Friedman knew a good deal about death rates. He said he would have regarded the figure provided by DI Smith to Mrs Parkinson (16 cremations in three months) as rather high. Dr Friedman would have realised that the 16 cremations would not be the total number of deaths in the three-month period. He would have realised that there would be other deaths followed by burial and still others which had taken place in hospital. I think that the figure would have rung an alarm bell in Dr Friedman's mind even if he had not been told that the unknown general practitioner had been worried by it. This concern would or should have been relayed to DI Smith, who would then have begun to appreciate the significance of the numbers and comparative death rates. He would then have known that the investigation could not be closed.

15.44 DI Smith shares some of the responsibility for the failure of Dr Banks to refer the issue of death rates to Dr Friedman. If, during his discussion with Dr Banks, DI Smith had mentioned the comparative death rates and the unknown general practitioner's concern about them, the matter might have been taken forward. DI Smith had never understood the importance of the comparative death rates. Here was a chance to have them explained to him. But he never even asked. I find it profoundly disappointing that these two experienced professional men should have met to discuss whether there was evidence in the medical records to support the suspicion that Shipman might be killing his patients and yet neither the doctor nor the policeman thought of discussing the death rate.

15.45 If DI Smith had told Dr Banks of the comparative death rates of the two practices, I think it likely that Dr Banks would have referred the matter to Dr Friedman. I cannot say so with certainty, as relations between him and Dr Friedman were not good. Indeed, had relations been better, Dr Banks might have decided to discuss the whole issue of the suspicions about Shipman with Dr Friedman. That is speculation. As I have said, I am sure that if the death rates had, for any reason, been mentioned to Dr Friedman the police would have realised that further enquiries were necessary. This is another route by which the failure of this investigation might have been averted.

Dr Banks' Suspension and the Disciplinary Proceedings Against Him

15.46 As Shipman's trial approached and the extent of his criminality began to emerge, senior officials in the Health Authority appreciated that the Authority might be subject to criticism for its part in the failed police investigation. Dr Banks was asked to report on what he had done. There was some difference of opinion among senior officials as to whether Dr Banks ought to have reported DI Smith's request for assistance to his line manager or to Dr Friedman. However, Dr Banks continued at work and (apart from a brief reference at a meeting, which was taken no further) there was no suggestion that disciplinary proceedings might be taken. Indeed, during Shipman's trial, Dr Banks attended the hearings as the Health Authority's representative.

15.47 It was not until the jury had retired and conviction appeared imminent that any suggestion was made that Dr Banks might face disciplinary action. Mr Alan Langlands, the Chief Executive of the National Health Service Executive, took the view that Dr Banks should be suspended from duty pending an investigation with a view to disciplinary action. The Health Authority was reluctant to take this course but was persuaded to do so and Dr Banks was informed of this decision on 26th January 2000. He was to remain under suspension for over seven months.

15.48 The disciplinary investigation revolved around three potential areas of criticism, which were eventually formulated into charges. In summary it was alleged that:

(a) He had failed to refer the police request to the Executive Board, having regard in particular to the unusual fact that the investigation had been prompted by another general practitioner and to the high number of deaths. This was said to constitute marked inadequacy in the exercise of his medical professional competence or conduct.

(b) He had failed to take greater care in investigating the issue, given the high number of deaths and the involvement of another general practitioner, the Coroner and the police.

(c) He had failed to consider adequately the context of the request to examine the medical records and to assess appropriately the need for further investigation.

15.49 The Health Authority instructed solicitors to advise and they, in turn, instructed counsel. Two suitable experts were identified and were asked to consider the records examined by Dr Banks and to advise on the adequacy of his review. Dr Chris Veal was of the opinion that the medical records disclosed cause for concern which should have been brought to the attention of senior management in the Health Authority and the police. Dr Moorman thought that Dr Banks had behaved **'entirely appropriately'**. The opinions were put to counsel who, after a conference with the doctors at which Dr Veal appears to have modified his views significantly, advised that the disciplinary process should be abandoned. In view of the expert evidence and legal advice that they received, the Health Authority cannot, in my view, be criticised for their decision to abandon the proceedings. Dr Banks was reinstated on 14th August 2000 and remained at work until he suffered a heart attack in November 2001.