

## CHAPTER ONE

### Extending the Inquiry's Investigations to Cover Shipman's Activities in Pontefract

#### Introduction

- 1.1 In September 1965, Shipman entered the University of Leeds School of Medicine at the age of 19. He spent five years there, training for his future medical career. Shipman left Leeds in 1970, having gained the qualification MB ChB (Bachelor of Medicine and Surgery).
- 1.2 From Leeds, Shipman moved to Pontefract General Infirmary (PGI) to embark on his compulsory period of employment in hospital. At that time, he had provisional registration as a doctor with the General Medical Council, entitling him to work only in a resident post in a hospital, or in another institution approved for the purpose of pre-registration service. In order to gain full registration, he had to complete a 12 month appointment as a house officer (HO). Between August 1970 and July 1971, Shipman spent six months as a HO in surgery and six months as a HO in medicine. In August 1971, he obtained full registration.
- 1.3 Thereafter, Shipman elected to spend a further 31 months at PGI. From August 1971 until the end of January 1972, he worked as a senior house officer (SHO) on the paediatric wards. In February 1972, he returned to the medical wards as a SHO for six months. Between August 1972 and the beginning of September 1973, he was back on the paediatric wards, this time as a registrar. Finally, between September 1973 and the end of February 1974, he spent six months as a SHO on the obstetric and gynaecological unit. He acquired a Diploma in Child Health in about December 1972 and gained a Diploma of the Royal College of Obstetrics and Gynaecology in 1974.
- 1.4 While working at PGI, Shipman responded to an advertisement in a medical publication and applied for a vacancy in a general practice based at the Abraham Ormerod Medical Centre, Todmorden. He was successful in his application and left PGI on 28<sup>th</sup> February 1974, starting in his new post on the following day. After a short probationary period as an assistant general practitioner (GP), Shipman became a junior partner in the Todmorden practice, with a view to becoming an equal partner in due course.
- 1.5 Shipman was dismissed from the Todmorden practice in late 1975, following the discovery that he had been obtaining pethidine illicitly for his own use. After a period of in-patient treatment at The Retreat, York (a hospital specialising in the treatment of addiction and other psychiatric disorders), and a period of employment with the Durham Area Health Authority as a clinical medical officer, Shipman applied for and obtained a post as a GP principal in the Donneybrook practice, which was based at Donneybrook House, Hyde, Greater Manchester. He remained at the practice until January 1992, when he set up his own single-handed practice. Initially, he operated the practice from Donneybrook House but, in August 1992, he moved to new premises at 21 Market Street, Hyde. He continued in practice there until his arrest in September 1998.

## The Inquiry's Previous Investigations into the Deaths of Patients in Todmorden and Hyde

- 1.6 The first of the Inquiry's Terms of Reference required it **'after receiving the existing evidence and hearing such further evidence as necessary, to consider the extent of ... Shipman's unlawful activities'**. During Phase One, the Inquiry carried out detailed investigations into the deaths of Shipman's patients during his time in practice in Todmorden and Hyde. In the Inquiry's First Report, published in July 2002, I set out my findings as to how many of his patients Shipman had killed. The Inquiry had examined 888 cases in all and I gave written decisions in 494 (493 deaths and one incident involving a living person) of those cases. In the remaining 394 cases, there was compelling evidence that Shipman was not responsible for the death. Those cases were closed. I concluded that Shipman had killed 200 of his patients (in addition to the 15 in respect of whose deaths he had been convicted) between March 1975 and June 1998. There were 45 deaths for which I found that a real suspicion arose that Shipman might have been responsible for the death, although the evidence was not sufficient to enable me to reach a positive conclusion that he probably had been. I found that 210 deaths occurred as the result of natural causes and not by reason of any action on Shipman's part. In addition, there were 38 deaths in respect of which there was so little evidence, or evidence of such poor quality, that I was unable to form any view at all. These were mainly deaths dating from the early years, in relation to which little documentary or witness evidence was still available.

## Previous Investigations Relating to Pontefract

- 1.7 During Phase One, the Inquiry received information about a death that had occurred at PGI in 1973. A relative of the deceased patient was expressing concern about the possible involvement of Shipman in the death. On investigation, the death proved to be completely unconnected with Shipman. As a result, the case was closed. The Inquiry was also made aware of concerns that had been expressed in January 2001 to the West Pennine Health Authority by a former cadet nurse at PGI. The concerns expressed related to Shipman's practice when performing lumbar punctures and when suturing wounds in the accident and emergency department and were otherwise unspecific. The Inquiry attempted to contact the former cadet nurse concerned but was unable to do so. No other suspicious deaths occurring in Pontefract were brought to the Inquiry's attention at that time.
- 1.8 During Phase One, the Inquiry also made enquiries about medical and nursing staff who would have worked with Shipman at PGI. The Pinderfields and Pontefract Hospitals NHS Trust, which was then responsible for PGI, contacted five former members of the nursing staff at PGI, who had little useful information to give about Shipman. The Inquiry obtained a witness statement from Mr Peter Howe, formerly a consultant obstetrician and gynaecologist at PGI. Information was also obtained from Dr John Turner, consultant physician at PGI at the time Shipman was employed there. Both consultants said that they were not aware of any sudden or unexplained deaths for which Shipman might have been responsible. Information was also obtained from a former administrator at the hospital and from five doctors, all of whom had been junior doctors at PGI at the same time as Shipman. None of these people raised any concerns about Shipman.

- 1.9 In April 2003, after the Inquiry had concluded its Phase One investigations, a communication was received from Mr Robert Sharpe, grandson of Mrs Kate Sharpe. He had just discovered that Shipman had certified the cause of his grandmother's death and was understandably concerned. He felt that the Inquiry should be aware of the circumstances surrounding the death although he made clear that the family had no conclusive evidence that any misconduct had occurred. The Inquiry team decided to investigate the death, obtained witness statements from Mr Sharpe and his sister and attempted unsuccessfully to obtain Mrs Sharpe's hospital and GP records. At that point, the investigation of Mrs Sharpe's case was subsumed into the wider investigation into deaths which had occurred at PGI.
- 1.10 When Mrs Primrose Shipman attended to give oral evidence during Phase One, she was asked by Leading Counsel to the Inquiry whether Shipman had performed any locum work in Pontefract during his time at PGI. She volunteered the information – previously unknown to the Inquiry – that Shipman had on occasion worked as a locum for a GP practice in Pontefract. She was unable to supply any further details. However, the Inquiry was able eventually to establish that Shipman had indeed acted as a locum at a practice run jointly by the late Dr Michael Hessel and his wife, Dr Gwendolen Hessel. The Inquiry contacted Dr Gwendolen Hessel, who confirmed that she and her husband had employed Shipman as a locum for short periods on an infrequent basis during his time at PGI. She said that they had had no suspicions about him and no concerns had been expressed to them about his work.
- 1.11 In the light of the information obtained by the Inquiry, and of the absence of concerns, it was not considered appropriate to carry out any further investigations into Shipman's time at PGI at that stage. On the basis of the evidence then available, I concluded that there was no evidence that Shipman had killed any patient while at PGI.

## **Concerns Are Expressed about Shipman's Time at Pontefract General Infirmary**

- 1.12 On 13<sup>th</sup> January 2004, Shipman died at Wakefield Prison. On 15<sup>th</sup> January 2004, Mrs Sandra Whitehead (formerly Miss Sandra Goddard) contacted the police. Mrs Whitehead had been a student nurse at PGI between October 1971 and October 1974. On 14<sup>th</sup> January 2004, she read a newspaper report of Shipman's death and realised for the first time that Shipman had worked with her at PGI for a short time. She became concerned that he might have been killing patients then. Mrs Whitehead was interviewed by West Yorkshire Police (WYP) on 21<sup>st</sup> January 2004. On 26<sup>th</sup> January 2004, WYP informed the Inquiry of Mrs Whitehead's concerns. It appeared to me that the Inquiry's Terms of Reference required that these concerns be investigated. The Inquiry team began its investigations immediately.

## **The Inquiry's Investigations**

### **The Evidence of Mrs Sandra Whitehead**

- 1.13 On 2<sup>nd</sup> February 2004, the Deputy Solicitor to the Inquiry interviewed Mrs Whitehead. Mrs Whitehead described how she had worked on Ward 1, the female medical ward, at

PGI, for three months, starting at the end of February 1972. At that time, Shipman had recently commenced his second six-month period working on the medical wards. He was a SHO.

- 1.14 Mrs Whitehead said that she had always had **'bad memories'** of her time on Ward 1 because of the high number of deaths that occurred there. She recalled in particular a day when there were three deaths. This had made a great impression on her. She remembered that, on many occasions when a patient had died, there would be an empty injection pack by the bed, indicating that an injection had been administered shortly before death.
- 1.15 Mrs Whitehead said that, when she realised that she had worked on the same ward as Shipman, she was **'very, very shocked'**. She said that the effect of this realisation on her was **'like hitting a brick wall at 60 miles an hour'**. She went on to say:

**'I felt I just knew he had been killing patients on that ward and it explained for me why there had been such a high death rate.'**

As I shall explain, Mrs Whitehead's impression that there was a high death rate on Ward 1 at the time she and Shipman were working together at PGI has proved to be correct. As she made clear to the Inquiry, Mrs Whitehead had no specific reason for linking Shipman with the deaths which had occurred on the ward. However, once she became aware that he had been there at the time, she felt instinctively that he must have been involved in causing the deaths. It was for that reason that she had taken the step of informing the police.

### Death Certificates

- 1.16 On 30<sup>th</sup> January 2004, the Inquiry obtained copies of all entries in the registers of deaths ('death certificates') held by the Pontefract Register Office (the register office at which the vast majority of deaths occurring at PGI were registered) where Shipman had certified the cause of death during the period between February and July 1972 (i.e. covering the period when it appeared likely that he had been working on the same ward as Mrs Whitehead). That exercise revealed that Shipman had issued 79 Medical Certificates of Cause of Death (MCCDs) during the relevant period (76 in relation to deaths occurring at PGI and three relating to deaths elsewhere).
- 1.17 In early February 2004, the Inquiry obtained possession of the original registers of deaths held by the Pontefract Register Office covering a ten-year period (from 1967 to 1977) spanning Shipman's time at PGI. Members of the Inquiry staff searched the registers and extracted and copied every entry relating to a death which had occurred at PGI during the relevant period. This work revealed that Shipman had issued a total of 133 MCCDs during his time at PGI between 1<sup>st</sup> August 1970 and 28<sup>th</sup> February 1974.
- 1.18 The MCCDs, whose contents would have been the source of the information contained in the death certificates, were no longer available.

### Cremation Certificates

- 1.19 The Inquiry initially sought from the local authority responsible for the Pontefract Crematorium (the crematorium where most patients who died at PGI would have been

cremated) all cremation certificates (also known as cremation forms) relating to deaths certified by Shipman. After a short time, however, the search was widened. In March 2004, the Inquiry took possession of all the original cremation certificates relating to deaths which had occurred at PGI during a five-year period (from 1<sup>st</sup> August 1969 to 31<sup>st</sup> July 1974) spanning Shipman's time at PGI. Members of the Inquiry staff searched the registers and extracted and copied every set of cremation certificates relating to a death which had occurred at PGI during the relevant period. A total of 766 sets of cremation certificates was identified by this means. Subsequently, the Inquiry team focussed its investigations on this five-year period.

### **Medical Records**

- 1.20 At an early stage of its investigations, the Inquiry made enquiries of the Mid Yorkshire Hospitals NHS Trust ('the Trust') about the availability of the hospital's medical records relating to patients who had died at PGI in the early 1970s. These enquiries revealed that the original paper records had been destroyed but that the medical records of some (but not all) of those patients had been copied and stored in microfiche archives. The Inquiry was told that there were difficulties in accessing some of the microfiche records because the index to part of those records had been lost. Between March and June 2004, 21 sets of medical records were located by the Trust and supplied to the Inquiry. It was not clear at that stage whether more records had in fact survived and the Inquiry team decided that it would have to make a search of the unindexed records. In April 2004, the Inquiry took possession of 52,353 sets of microfiche records held by the Trust. Members of the Inquiry staff searched the names of the patients to whom the records related, and extracted and copied those records relating to deaths certified by Shipman. In the meantime, a further 34,500 sets of microfiche records and 400 sets of records on spools of microfilm had been indexed by a commercial data company on the instructions of the Trust. Members of the Inquiry staff checked the index compiled by the data company against the list of patients whose deaths Shipman had certified.
- 1.21 Despite all this work, a total of only 28 sets of medical records (including those originally supplied by the Trust) were located out of the 133 cases in which Shipman had certified the death. In addition, the Inquiry requested the medical records relating to four deaths which had not been certified by Shipman, but in which the cremation forms completed by other doctors named Shipman as having been present at the death; as a result, one further set of records was obtained. The medical records obtained were not always complete. Some related to admissions to hospital before the admission during which the death occurred. Others were missing some parts of the record, for example the nursing notes or drug charts. Other sets of records appeared to be reasonably complete.
- 1.22 The Inquiry was informed that the GP records relating to the deceased patients had been destroyed.

### **Other Documentary Evidence**

- 1.23 The Inquiry sought from the Trust all relevant documents in its possession, including records relating to the handling and storage of controlled drugs, mortuary records, staff

rotas and ward registers. No documents from the relevant period were available, save for the PGI mortuary post-mortem book containing brief details of post-mortem examinations carried out at the hospital. The Inquiry also obtained from the West Yorkshire Archive Service the Minutes Book, containing minutes of meetings of the Pontefract and Castleford (formerly the Pontefract, Castleford and Goole) Hospital Management Committee during the period from 23<sup>rd</sup> April 1965 to 28<sup>th</sup> March 1974.

### **Evidence from Medical and Nursing Staff**

- 1.24 During February and March 2004, the Inquiry began the process of tracing and interviewing members of the medical and nursing staff, together with the Chief Pharmacist, who had worked at PGI at the time of Shipman's employment there. Witness statements have been taken from 61 former members of staff, together with two local GPs.

### **Review of Deaths at the Hospital by Professor Richard Baker**

- 1.25 In March 2004, the Inquiry team considered the information available from the death certificates and cremation certificates relating to deaths which had occurred at PGI during Shipman's time there. A decision was taken to commission a review of the death certificates, the cremation certificates and the available medical records. This review was carried out by Professor Richard Baker, Director, Clinical Governance Research and Development Unit, University of Leicester, who carried out the original clinical audit of Shipman's practice in Todmorden and Hyde, which was commissioned by the Chief Medical Officer and published in January 2001. Professor Baker was instructed in late March 2004 and provided some preliminary advice. However, he could not report fully until the Inquiry was satisfied that it had received all the available medical records that survived. A report, setting out the results of his review, was provided in July 2004 and appears at Appendix A to this Report, together with an addendum, dated December 2004. I have summarised Professor Baker's work in Chapter Six.

### **Evidence from the Relatives of Deceased Patients**

- 1.26 No steps were taken, at the outset of the Inquiry's investigations into deaths at PGI, to contact the relatives of the patients whose deaths Shipman had certified. The Inquiry team did not wish unnecessarily to worry the families who – unlike the families of Shipman's patients in Todmorden and Hyde – would not have been aware that Shipman had ever been involved with the care of their deceased relatives. Therefore, a decision was taken to carry out some preliminary investigations in order to ascertain whether there were any real grounds for concern about Shipman's activities at PGI before deciding whether to approach the relatives.
- 1.27 When the Inquiry received Professor Baker's preliminary advice, it was evident that grounds for concern did exist. I therefore decided that immediate steps should be taken to attempt to trace and interview relatives of the 133 persons whose deaths Shipman had certified. That exercise began in early April 2004 and was subsequently widened to include the four further deaths to which I referred at paragraph 1.22. With the assistance of enquiry agents and advertisements placed in the local press, the Inquiry succeeded in

tracing at least one member of the family (or a friend) of 117 of the 137 deceased patients. A total of 162 witness statements have been taken from relatives and friends.

### **Publication of the Evidence**

- 1.28 As with previous Phases of the Inquiry, all the evidence available to the Inquiry (save for medical records not directly relevant to the patient's death) has been released into the public domain by means of the Inquiry website.

### **The Decision-Making Process**

- 1.29 I decided that it was neither necessary nor appropriate to hold oral hearings in relation to the deaths at PGI. The evidence available in respect of the deaths is very limited and, in general, is not controversial. Where conflicts of evidence (in particular, conflicts between the recollection of witnesses and the contents of contemporaneous documents) do occur, they would be unlikely to be resolved by an oral hearing more than 30 years after the events with which they are concerned. It seemed to me that I was going to be in as good a position to reach a decision about the cause of death in an individual case after considering the relevant documents as I would be after hearing oral evidence.
- 1.30 I then considered whether it would be appropriate for me to write an individual decision in every case investigated by the Inquiry. It was clear that in some cases – in particular, any case where I decided that the death had resulted from criminal activity on the part of Shipman or where I suspected that that might be so – an individual decision would be necessary. However, it was also clear that, in some cases, the available evidence would be very limited indeed. There might be no medical records and, if the deceased person had been buried, no cremation certificates. Those members of the family who were involved in the events surrounding the death might themselves have died; the remaining members of the family might know little about the circumstances of the death or might be unwilling to assist the Inquiry. Even if there were relatives who recollected the circumstances surrounding the death, the fact that the death occurred in hospital would almost inevitably mean that their knowledge of the events leading up to the death would be less detailed than if the death had occurred at home. Thirty years ago, families were told far less about the progress and treatment of patients in hospital than is generally the case now. It was evident that, in many cases, I would be unable to come to any firm conclusion about what had happened. It seemed to me that, in cases such as these and also in those cases where I was able to say with confidence that the death had occurred as a result of natural causes, there would be very little to be gained from my writing an individual decision unless members of the deceased person's family specifically requested that I should do so.
- 1.31 Accordingly, family members were consulted and, in cases where the family did not wish to receive an individual decision, I have not written one, unless I felt it necessary to express some concern or suspicion. In each case where I have not provided a written decision, the family has been told of my finding. An alphabetical list of all the deaths considered by the Inquiry, together with my finding in respect of each, appears at Appendix B to this

Report. A chronological list is at Appendix C. The individual decisions are set out at Appendix D to this Report.

## The Structure of This Report

- 1.32 In Chapter Two of this Report, I deal with the layout of the wards at PGI, ward routines, the staffing arrangements and other general matters relating to the wards where Shipman worked during his time at the hospital. In Chapter Three, I examine the witness evidence relating to Shipman's career at PGI. Chapter Four deals with the storage and handling of drugs, both controlled and non-controlled, at the hospital.
- 1.33 In Chapter Five, I examine the evidence about the way in which deaths at the hospital were handled and the arrangements for death and cremation certification. Chapter Six describes the review of deaths at PGI carried out by Professor Baker. In Chapter Seven, I discuss my findings in relation to individual deaths in the context of the available background evidence and of Shipman's working history at PGI.
- 1.34 As well as the documents I have already mentioned, the Appendices also contain additional material about Shipman's time as a GP in Hyde that has come to light since publication of the First Report in July 2002. Further information about the death of Miss Beatrice Clee came to the Inquiry's attention during its Phase Two, Stage Four investigations. I had previously concluded that Shipman had killed Miss Clee. The new information provided further insight into the events leading up to the death but did not affect my conclusion. A summary of the new information appears at Appendix E. Mrs Georgina Francis requested the Inquiry to investigate the circumstances in which Shipman administered diamorphine to her in April 1996. Mr Carl Wright asked the Inquiry to investigate the death of his father, Mr Alfred Wright, which occurred on 30<sup>th</sup> March 1987. My decisions in these two cases can be found at Appendices F and G respectively.
- 1.35 In September 2002, Mr John (elsewhere referred to as Jonathon) Harkin, a former prisoner at Her Majesty's Prison, Preston, wrote to the Inquiry, claiming that Shipman had made disclosures to him at a time when he was acting as a 'listener' for Shipman in prison. In particular, Mr Harkin claimed that Shipman had boasted of taking 508 lives. Shortly afterwards, Mr Harkin's claims were repeated in the local and national press. The Inquiry team decided that Mr Harkin's claims must be investigated. The results of that investigation (with which, in the event, Mr Harkin and members of his family declined to co-operate) are set out at Appendix H.

## Comment

- 1.36 I would like to express my thanks to Mrs Whitehead for drawing her concerns to the attention of the police and for assisting the Inquiry. As will later appear, her concerns were not without foundation and, if it were not for her action in coming forward, the Inquiry's investigations would have been incomplete. I must also express my appreciation to the many former members of staff who have provided statements to the Inquiry, and to the Trust for its assistance in identifying and tracing witnesses and in providing the microfiched medical records and other information.



- 1.37 To the families, I must express my gratitude and offer my apologies. I am conscious that it must have been profoundly upsetting for many families to be told, so many years later, that Shipman had been involved in the treatment of their relatives and that he had certified the cause of death. This must have disturbed their peace, caused them anxiety and, in some cases, must have reawakened distressing memories. I deeply regret this. In those circumstances, I am particularly grateful that so many family members have been willing to assist the Inquiry's investigation.
- 1.38 At the end of the investigation, the general picture of Shipman's time at PGI is reasonably clear. Some additional light has been shed upon his personality and his attitudes. However, the evidence about the deaths of individual patients is, in general, unclear, despite the best efforts of the relatives and members of staff to assist. I regret that there are many cases in which I have not been able to provide the family with a definite answer to the question of whether Shipman played a part in their relative's death.



## CHAPTER TWO

### The Wards and Staffing Arrangements at the Hospital

#### Introduction

2.1 Pontefract General Infirmary (PGI) is situated at Friarwood Lane, Pontefract, West Yorkshire. PGI was founded in the nineteenth century as a dispensary funded by local donations and subscriptions. It became a NHS hospital in 1948, treating medical and surgical patients, both adult and paediatric. In the early 1970s, PGI was one of a number of hospitals in the locality which were under the control of the Pontefract, Castleford and Goole Hospital Management Committee. Several of those hospitals were not free-standing units but were annexes of PGI. PGI itself dealt primarily with acute cases. Patients who were convalescent, who required geriatric care or who were suffering from chronic conditions would usually be nursed in one of the hospital annexes. These annexes included Ackton Hospital (which dealt mainly with patients with chronic conditions and those who were convalescing from acute conditions), Warde-Aldam Hospital (which dealt mainly with convalescent patients), Gateforth Hospital (where patients with chronic chest conditions were treated) and Headlands Hospital (a geriatric hospital). Until recently, PGI was operated by the Pinderfields and Pontefract Hospitals NHS Trust. Since 2002, it has been part of the Mid Yorkshire Hospitals NHS Trust.

#### The Layout of the Hospital

- 2.2 The Inquiry has been told that, until the mid-1960s, PGI had approximately 100 beds, which were housed in the main hospital building. In the mid-1960s, the hospital was extended; a new wing was added which had the effect of increasing the number of beds by about 200. The new wing, which opened in about 1966, contained six new wards, known as Wards 1–6; new operating theatres, an x-ray department and a pathology department were built at the same time. The hospital had no intensive care unit, however, and, until 1973, no obstetrics unit. The new obstetrics unit, which opened in September 1973, was a two-storey building and was entirely separate from the main hospital building.
- 2.3 I shall briefly describe the accommodation as it was in the early 1970s. I shall also describe, where appropriate, the types of condition from which patients admitted to the relevant ward(s) would be suffering.

#### The Medical Wards

2.4 There were two adult medical wards. Patients admitted to one of those wards could be suffering from a wide range of conditions. These included conditions such as cancer, terminal illness of other kinds, cerebrovascular accidents (strokes) and other acute conditions. Cases of chest disease were very common, particularly among former miners. Patients with cardiac problems were also admitted to the medical wards. There was no specialist cardiac unit at the hospital at that time, although Ward 2 housed a small coronary care unit. Many of the patients were highly dependent and both medical wards were extremely busy. Although many elderly patients were treated on the medical wards,

there was also a significant number of younger patients (i.e. those in their 40s, 50s and 60s) who were suffering from chest diseases and cardiac and other conditions.

### **Ward 1**

- 2.5 Ward 1 was the female medical ward. It was situated below ground level immediately below Ward 2, the male medical ward. Ward 1 had 32 beds. It consisted of two separate areas, each containing 12 beds, which were situated at the ends of an 'L' shaped corridor. The beds in the main areas of the ward had curtains that were usually kept open but could be closed when necessary to give privacy.
- 2.6 Opening directly off the corridor were eight cubicles (sometimes referred to as '**side rooms**' or '**side wards**'), which were used occasionally for private patients but, in general, for those who were seriously ill. On occasion, if Ward 2 was full, male patients would be nursed in the cubicles on Ward 1. The cubicle doors were generally left partially open but could be closed when necessary. This might happen if the patient was very ill and his/her relatives were with him/her, or when the patient was undergoing some form of treatment. Otherwise, the doors would be left slightly open, thus enabling the nursing staff to keep an eye on the patient inside. The doors of the cubicles had porthole windows. There were two nursing stations on the ward. These were situated near to the entrances to the main areas of the ward and adjacent to the cubicles. At the entrance to the ward (which was situated along a further length of corridor extending off from the right angle of the 'L') was situated the sister's office and, opposite that, the treatment room.

### **Ward 2**

- 2.7 Ward 2, the male medical ward, was situated at ground level, immediately above Ward 1. Its layout was much the same as that of Ward 1. However, four beds in one of the main areas of the ward were designated as coronary care beds. They were equipped with portable cardiac monitoring equipment, which was linked to a console. The console was mobile. It was kept in the sister's office during the day and, at night, it was moved to the nursing station near the coronary care unit. Despite the fact that Ward 2 was a male ward, female patients with heart complaints could be admitted to the coronary care beds for a limited period, usually about three days, before being transferred to Ward 1. The coronary care beds were constantly in demand; it was possible, by moving the monitoring equipment around, to increase the number of such beds and this was sometimes done. Because of the space taken up by the coronary care beds and the necessary equipment, the total number of beds on Ward 2 was slightly less than on Ward 1.

### **Ward 3 and the Obstetrics Unit**

- 2.8 Until 1973, PGI had no obstetrics unit of its own and patients with gynaecological conditions were nursed on Ward 3. In September 1973, as I have said, the new obstetrics unit opened. It provided both antenatal and post-natal care. The ground floor of the new obstetrics unit dealt with out-patients. On the upper floor, there were wards for in-patients, each housing about eight patients. There were also a few individual rooms. After the new unit opened, gynaecological cases continued to be treated on Ward 3. Ward 3 was

situated on the first floor of the new wing above Ward 2. It had 32 beds and the layout was similar to that of Wards 1 and 2.

### **The Orthopaedic and Trauma Ward**

- 2.9 Ward 4, the orthopaedic and trauma ward, lay at the opposite end of the new wing from Ward 1. Its layout was similar to that of the wards already described. Shipman never worked on Ward 4 so I need not describe it further.

### **The Surgical Wards**

- 2.10 Patients were admitted to one of the two adult surgical wards with a view to undergoing general surgery of one kind or another. Following surgery, they would usually be nursed on one of the surgical wards although, on occasion, a patient might, after a period, be transferred to one of the medical wards.

### **Wards 5 and 6**

- 2.11 Ward 5 (the male surgical ward) and Ward 6 (the female surgical ward) were situated above Ward 4, on the ground and first floors respectively. They each had 32 beds, 24 in the main areas of the ward and eight in cubicles. The layout was similar to that of the wards already described.

### **The Paediatric Wards**

- 2.12 The paediatric wards were located in the original hospital building. The Hydes Medical Ward, a paediatric medical ward, was located in the basement of the building. Newborn babies who required medical treatment would be transferred from the local maternity unit (and, after September 1973, from the PGI obstetrics unit) to the Hydes Medical Ward. Also in the basement was the ENT (i.e. Ear, Nose and Throat) Ward, which treated both adults and children. This was known as the Hydes Surgical Ward. A third paediatric ward, the Leatham Ward, was situated on an upper floor. This was the children's surgical and orthopaedic ward.
- 2.13 The Hydes Medical Ward had six beds and six cots, together with two cubicles for children who were seriously ill or required special attention. In addition, there was a nursery with six **'treasure cots'** for babies up to about six months old.
- 2.14 The Leatham Ward had about 22 beds, including five in single cubicles. Most patients on the ward were surgical and orthopaedic cases. Patients in isolation or with medical conditions would be nursed in the cubicles.

### **The Accident and Emergency Department**

- 2.15 The accident and emergency department was situated in the original hospital building, near to the main entrance to the hospital.

## Ackton Hospital

- 2.16 As I have explained, Ackton Hospital was an annexe of PGI. It was situated about two miles away. It was the only one of the annexes at which Shipman issued any Medical Certificates of Cause of Death. For that reason, it is necessary for me briefly to describe the arrangements there. After the opening of the new wing at PGI in the mid-1960s, Ackton Hospital dealt mainly with patients who were suffering from chronic or terminal conditions or who were convalescent. Sometimes, patients were moved to Ackton Hospital because of a shortage of beds at PGI. Ackton Hospital had about 78 beds. It had no resident medical staff. Patients at Ackton Hospital who were suffering from general medical conditions were under the care of Dr Robert Forster, a local general practitioner (GP), who was employed part-time as medical officer, later hospital practitioner. There were also a number of beds for patients suffering from dermatological conditions; a consultant and two other part-time doctors cared for those patients. The Inquiry has been told that, on occasion, patients would be accommodated at Ackton Hospital and would be taken to and from PGI in order to receive any necessary treatment.

## General Staffing Arrangements at the Hospital

### The Medical Staff

- 2.17 All patients admitted to PGI were placed under the care of a named consultant in the appropriate specialty who had the ultimate responsibility for their care and treatment. Consultants would visit their patients, sometimes daily and sometimes less frequently. Day-to-day medical care was given by more junior doctors, mainly by registrars, senior house officers (SHOs) and pre-registration house officers (HOs). HOs were those who were just out of medical school and had provisional registration only. They were required to complete two six-month placements (one medical and one surgical) before gaining full registration. Once they were fully registered, it was open to them to leave the hospital and enter general practice. Many would stay, either to gain more experience which would be useful to them in general practice or other posts, or with a view to obtaining the qualifications and experience necessary for a career in hospital practice. Those who stayed would become SHOs and would be given a greater degree of responsibility for patients and for supervising the work of HOs. Some SHOs would go on to be appointed as registrars. The junior doctors (i.e. HOs and SHOs) would rotate at six-monthly intervals between placements on different wards. Registrars were responsible for the patients in the consultant's absence and also had the task of supervising the work of the SHOs on the ward. Some wards also had what were termed 'resident' or 'general' officers (either medical or surgical). The Inquiry has been told that the status of a resident medical or surgical officer was broadly similar to that of a registrar; they often had similar experience and capabilities. The number of registrar posts was limited and doctors who did not succeed in obtaining such a post would sometimes be employed as resident officers. Some wards also had clinical assistants (often local GPs) who worked part-time.
- 2.18 The junior doctors worked long hours and were kept extremely busy on the wards. The weekday routine was slightly different on each ward but it followed the same general pattern. There would often be a consultant's ward round at about 9am. The junior doctors

would arrive on the ward early, review the patients' notes and carry out their own preliminary rounds of the patients to ensure that all was ready for the consultant. Sometimes, a HO or SHO might be on the ward already, having been called out to see a patient by the night nurses. The consultant, usually accompanied by a registrar, one or more of the junior doctors on the ward and at least one senior nurse, would tour the ward and visit the patients under his/her care. Some consultants might have commitments elsewhere in the early morning and might therefore visit the ward to carry out their rounds at different times of the day. After the ward rounds were over, the junior doctors would prepare requests for blood tests and other investigations, write prescriptions and discharge letters and carry out any other necessary paperwork. In addition, there would usually be patients to be admitted to the ward. These patients would need 'clerking in'.

- 2.19 The process of clerking in a newly admitted patient was usually undertaken by the HOs. Each such patient would be examined. A full history would be taken and recorded in the notes. A provisional diagnosis would be made and any necessary treatment prescribed. The HO would seek advice from a SHO or registrar as necessary. The Inquiry was told that a nurse would usually be present during the clerking in process but this would not always be possible if the ward was very busy and other patients needed attention. If the HOs on a ward were busy, the SHO would clerk in patients.
- 2.20 Once these various duties had been completed, the junior doctors might be free to leave the ward. In general, they would return to their accommodation or the doctors' facilities within the hospital or go to study in the hospital library. They would remain available and would be liable to be summoned back to the ward if needed. The usual circumstances in which this would happen would be when a doctor was needed to clerk in a newly admitted patient or when a patient's condition had deteriorated and the nursing staff considered that a medical opinion was required or when a patient had died and a doctor was needed to confirm the fact of death and to make the necessary entry in the medical notes. In order to summon a doctor, a nurse (usually the senior nurse on the ward) would contact the hospital switchboard. The switchboard would 'bleep' the most junior doctor on duty (usually a HO), who would attend in response to the summons. If s/he required help from a more experienced doctor, s/he would contact the SHO. If the SHO was unable to deal with the situation single-handed, s/he would request help from a registrar or consultant. Junior doctors would, on occasion, return to the ward without being summoned in order to check on the progress of a patient or patients. They would also be required to administer some types of treatment (e.g. intravenous injections) which nurses were not permitted to administer.
- 2.21 The consultants attached to the surgical wards would carry out operations during the day. Junior doctors on the surgical wards would observe and assist in those operations. They would also assist with minor surgery cases in the Hydes Surgical Ward.
- 2.22 During the day, consultants would sometimes have out-patient clinics, at which the SHOs and registrars would assist. In the late afternoon (probably at about 5pm), pathology reports would come back and the junior doctors would be on the ward to receive these and to see whether the tests needed repeating or the patients' treatment needed changing. The late afternoon and the early evening was also a busy time for patient

admissions. Once they had finished their work, the junior doctors would leave the ward. Evening visiting would take place at 7pm and they would usually have left the ward before then. Any medical attention which was required after that time would be given by the doctor on call that night.

- 2.23 Junior doctors would be on call one night in every two or three nights. Often, the junior doctor on call would return to the ward in the late evening, with a view to dealing with any incipient problems at that time and thus to reduce, if possible, the number of calls during the night. At that time, the doctor might visit some of the patients to check on their condition. Doctors would be called to come out at night if a patient's condition deteriorated and medical attention was required or if a patient died. As well as regular on-call duties during the week, junior doctors were also on call every second or third weekend for the whole weekend. They usually had half a day off every week from 2pm.
- 2.24 The clinical or medical records relating to each patient were kept on a trolley in the sister's office, except during ward rounds, when they would be examined and updated by the medical staff as necessary. Observation charts (showing the results of observations such as temperature, pulse and respiration, blood pressure, and fluid intake and output) were kept at the foot of the patient's bed, together with details about any intravenous infusions that had been prescribed and administered. Drug record charts, showing other drugs that had been prescribed or administered, were kept in the sister's office. The junior doctors would usually be responsible for recording notes of significant matters such as admission details, the findings on clinical examinations and reviews of the patient's condition, details of any diagnosis made and of any drugs or other treatment prescribed and an account of any decision about the patient's management. Ideally, those notes should have amounted to a complete record of the involvement of the medical staff in each patient's care. However, Professor Richard Baker, Director, Clinical Governance Research and Development Unit, University of Leicester, who undertook a review of the surviving medical records relating to deaths being investigated by the Inquiry, formed the view that, almost certainly, the medical staff at PGI did not always record their findings on examination or their management decisions in the medical records. As a result, it was often impossible to get a clear and coherent picture of a patient's care and progress while in hospital. The failure to record findings and decisions in the medical records was not confined to Shipman. Nor was it peculiar to PGI. Professor Baker observed that it was typical of hospital practice in the early 1970s and should not be the subject of criticism aimed specifically at staff at PGI.

### **Nurses**

- 2.25 Nurses worked three shifts. Witnesses to the Inquiry have differed in their accounts of the starting and finishing times of the shifts but, broadly speaking, it seems that the shifts ran from about 7.15am until 4.15pm (day), from about 12.30pm until 9.15pm (afternoon/evening) and from about 9pm until 7.30am (night). At each change of shift, there was a handover, when the nursing staff going off duty would give a report to the incoming staff about the condition of the patients on the ward.
- 2.26 Visiting times were between 2.30pm and 3.30pm on Wednesday, Saturday and Sunday afternoons and between 7pm and 8pm every evening. If a patient was seriously ill and



possibly on the verge of death, his/her relatives would be permitted to visit as and when they wished. On occasion, they would stay overnight. There were no special facilities for this and relatives would have to sleep on a chair in the patients' lounge or (if the patient was occupying a cubicle) on a chair in the cubicle.

- 2.27 The nursing staff fell into a number of different categories. There were the state registered or 'trained' nurses (SRNs); they occupied the position of sisters or staff nurses. Then, there were the state enrolled nurses (SENs), who were not registered but who might on occasion, if very experienced, fulfil the role of staff nurse. There were also student or cadet nurses, sometimes collectively referred to as 'trainee nurses'. The trainee nurses were responsible for many aspects of patient care. They would carry out such tasks as giving patients bed baths, emptying bedpans, cleaning the ward sluices and feeding patients.
- 2.28 Each ward had a ward sister, who was the most senior nurse on the ward and was in overall charge of the ward. Ward sisters would usually alternate with one or more other senior sisters between the day and the afternoon/evening shifts. At night, there were several night sisters on duty, covering the whole hospital. One of the night sisters was usually assigned to Wards 1, 2 and 3 in order to supervise the coronary care unit. One night sister was designated as theatre sister and would be on duty in the operating theatre if it was in use. There would usually be a night sister in charge of the paediatric wards. Otherwise, the night sisters would be deployed throughout the hospital as required. They would organise admissions and would deal with any serious cases that came into the accident and emergency department.
- 2.29 Members of the nursing staff were required to note in a nursing record details of the nursing care given to the patient, together with any other significant events. Relevant information would then be transferred onto a card index (Kardex) system which was kept in the sister's office on each ward. Both the nursing record and the Kardex were updated twice daily by the nurse in charge of the ward, once at the end of the night shift (at any time between about 5.30am and 7am) and once at the end of the afternoon/evening shift (at any time between about 7.30pm and 9pm). No entries were made in the record by nursing staff working on the morning shift. Instead, any relevant information would be passed on orally to staff on the afternoon/evening shift by the sister in charge of the morning shift.

## Staffing Arrangements on Individual Wards

- 2.30 So far, I have dealt with the staffing arrangements generally in place at the hospital. The arrangements on individual wards varied. I shall describe those in place on the wards on which Shipman worked during his time at PGI.

### **The Medical Wards**

#### ***The Medical Staff***

- 2.31 For the purposes of medical cover, Wards 1 and 2 were treated as one ward. Patients in Wards 1 and 2 would be under the care of one of four consultants. Those consultants were Dr Warren Jordan (consultant chest physician), Dr John Turner (a consultant physician with a particular interest in cardiology), the late Dr Leslie Watson (senior consultant

physician) and the late Dr Robert Meikle (consultant gastroenterologist). Dr Turner and Dr Watson had the most patients on the two wards. Dr Jordan and Dr Meikle had fewer patients at PGI, but also had responsibility for patients at other hospitals. All four consultants were in post during both six-month periods for which Shipman worked on Wards 1 and 2.

- 2.32 In general, there would also be a registrar, a SHO and two HOs. During Shipman's first period of duty as a house officer on the medical wards 1 and 2, between February and August 1971, Dr Surinder Ahuja was the registrar. He was studying for his examination for Membership of the Royal College of Physicians. As a consequence of this and of other factors to which I refer in Chapter Three, he did not spend a great deal of time on the wards, although he was available to attend if required. He would also have been responsible for conducting out-patient clinics. The SHO was Dr Husain Syed Abbas. Shipman and Dr Jeremy Belk, who had been contemporaries at Leeds University, were the two HOs. The two of them shared the nightly duties, working alternate nights.
- 2.33 During Shipman's second six-month period on the medical ward, Dr Ahuja still occupied the position of registrar. Shipman was the SHO and the two HOs were Dr Nicholas Kounis and the late Dr Simon Bowden. Dr Kounis has told the Inquiry that, at least for the first few months of their six-month period on the medical wards, he and Dr Bowden would be on duty together and would alternate with Shipman. They would also work alternate weekends with Shipman. During this period, therefore, Shipman would have been on duty every other night and every other weekend. When the two HOs were on duty at night, Dr Ahuja would supervise them, thus ensuring that Shipman had one undisturbed night's sleep in two.

### ***The Nursing Staff***

- 2.34 The number of nursing staff on duty would vary during the day. According to the witnesses, the staffing levels on Ward 2 were quite high; this is said to have been attributable to the presence of the coronary care beds. At the beginning of the morning shift, there would be about five or six nurses on Ward 2. During the early afternoon, when two shifts overlapped, there could be as many as ten nurses on duty, although some would be taking their lunch break. This number would reduce to four or five during the late afternoon as the second shift went off duty and some nurses went for tea breaks. In the evening, there would be a minimum of two nurses on duty on Ward 2, while others were having their evening meal. By contrast, staffing levels on Ward 1 are described as low. Mrs Kathleen Naylor, ward sister in the early 1970s, said that there were rarely more than four members of staff on duty at any one time. These would usually be two sisters, a staff nurse and either a student nurse or both a SEN and a student nurse.
- 2.35 Overnight, there were usually two nurses (at least one of them a trained nurse) on both Ward 1 and Ward 2, with an auxiliary nurse acting as a 'runner' between the two wards. In addition, as I have said, a night sister would be assigned to Wards 1, 2 and 3 to supervise the coronary care patients. Unless required elsewhere, she would usually remain on Ward 2 and watch the cardiac monitors.

- 2.36 During both of Shipman's periods on the medical wards, Mrs Naylor was ward sister of Ward 1. For most of his first period on the medical wards, Mrs Iris Lightowler was the ward sister of Ward 2. In about July 1971, she was replaced by Mrs Anne Calverley (then Miss Anne Paley), who was ward sister for the duration of his second period there.

## **The Gynaecology Ward and the Obstetrics Unit**

### ***The Medical Staff***

- 2.37 Before 1973, the consultant in charge of the gynaecology ward was the late Mr Donald Keith. In addition, the hospital had the services of a visiting obstetrician and gynaecologist, Mr J M McKiddie. In April 1973, Mr Peter Howe, consultant obstetrician and gynaecologist, was appointed as a full-time replacement for Mr McKiddie. As well as the two consultants, the medical staff on Ward 3 and the obstetrics unit consisted of a registrar, three SHOs and a resident medical officer.
- 2.38 At the time that Shipman was a SHO in obstetrics and gynaecology, between the beginning of September 1973 and the end of February 1974, the registrar was Dr Narendra Saikia. Dr Anthony Baboolal and Dr Sarkis Kupelian were the other SHOs.

### ***The Nursing Staff***

- 2.39 The shift pattern for nurses on Ward 3 was similar to that for nurses on other wards. The sister in charge of Ward 3 was the late Mrs Kit Langley. The Inquiry has not enquired into the arrangements for nursing on the obstetric unit since no relevant deaths occurred there.

## **The Surgical Wards**

### ***The Medical Staff***

- 2.40 The consultants in charge of the surgical wards between August 1970 and February 1971, when Shipman worked there, were the late Mr James Rhind, the late Mr Patrick Anderson and Dr Leighton Bell. In addition, there was a resident surgical officer, Dr Rizvi Hasnain. He had joined the general surgery department at PGI in 1968; at that time, he was preparing for his examination for Fellowship of the Royal College of Surgeons. He was an experienced surgeon. The registrar was Dr Brian Gallagher. It is probable that there was no SHO during Shipman's time on the surgical wards. The HOs were Shipman, Dr Jeremy Belk and Dr Diane Gaubert.
- 2.41 Surgical HOs were required also to cover the Hydes Surgical (ENT) Ward. The consultant in charge of the Hydes Surgical Ward was Mr Kenneth Mayall. The Inquiry has been told that the HOs on the surgical ward also covered the Leatham Ward, which dealt mainly with paediatric surgical and orthopaedic cases.

### ***The Nursing Staff***

- 2.42 In the early morning, there would be two senior nurses on duty, together with a student nurse and possibly an auxiliary nurse. The numbers would be virtually doubled during the overlap of the two shifts and would reduce to three (usually, one SRN, one SEN and an

auxiliary) in the late afternoon. During the night, two nurses would cover Wards 5 and 6 with an auxiliary nurse acting as 'runner'. During Shipman's time on the surgical ward, the ward sister was Mrs Eileen Gallagher (then Miss Eileen Callaghan).

## **The Paediatric Wards**

### ***The Medical Staff***

- 2.43 At the time of Shipman's first six-month period on the paediatric wards, between August 1971 and January 1972, the consultant paediatrician in charge was Dr Douglas Pickup. On 1<sup>st</sup> January 1973, during Shipman's subsequent 13 month period on the wards, a second consultant, the late Dr Oliver Troughton, was appointed. In addition there was a clinical assistant in paediatrics and at least one SHO. During the first period of Shipman's employment on the paediatric wards, there was no registrar. Approval for the additional post of registrar was given by the Hospital Management Committee in May 1972 and Shipman was appointed registrar from August 1972. HOs were not usually employed on the paediatric wards. The Inquiry was told that the arrangement was that SHOs and registrars from the medical wards would provide medical cover when necessary. A SHO would be on call every two nights and a registrar the alternate nights.
- 2.44 The clinical assistant during both periods for which Shipman worked on the wards was Dr Peter McWilliam, a local GP, who was very experienced. During the first period, Shipman was the SHO. During his second period in the paediatric wards, Shipman was the registrar. From August 1972 until February 1973, the SHO was Dr Angela Pugh. In February 1973, Dr Baboolal succeeded her. From 1<sup>st</sup> August 1973 until Shipman left, just over four weeks later, Dr Philip Gordon was the SHO.

### ***The Nursing Staff***

- 2.45 In the early 1970s, the Hydes Medical Ward, the Hydes Surgical Ward and the Leatham Ward each had its own ward sister, together with other nursing sisters, staff nurses, SENs and student nurses. The night staff consisted of a sister, who covered the Hydes Medical and Surgical Wards and the Leatham Ward, a staff nurse or SEN and an auxiliary or student nurse. In an emergency, nurses from other parts of the hospital would assist.

## **Contact between Doctors and Patients**

- 2.46 One of the matters that the Inquiry wished to ascertain was whether, and, if so, to what extent, it would have been possible for a doctor to gain access to a patient without any other person being present. Members of the medical and nursing staff were asked about this.
- 2.47 So far as the medical and surgical wards were concerned, virtually all the witnesses agreed that the usual practice when a doctor intended to examine or administer treatment to a patient was for him/her to be accompanied to the patient's bedside by at least one nurse. Not only was this regarded as the correct etiquette, it was often necessary for practical reasons if the patient was unwell and required assistance with undressing or

getting into the appropriate position for examination. Also, if the doctor was male and intended to examine a female patient, he would usually be chaperoned by a female nurse.

- 2.48 If a doctor was called out to see a patient, whether during the day or night, a nurse would usually be with the patient when the doctor saw him/her and would be on hand to assist with any treatment that was required. The Inquiry was told that it would have been usual practice for the nurse to remain with the doctor throughout the time s/he was with the patient, save that the nurse might have had to leave momentarily in order to fetch something that was needed or to attend to another patient.
- 2.49 Mrs Calverley (ward sister, Ward 2, during the last part of Shipman's first period and the whole of his second period on the medical wards) made a distinction between doctors of different status. She said that all doctors of the status of SHO or above would be accompanied when examining a patient. By contrast, HOs would not always have a nurse with them unless there was a need for a chaperone or the patient required nursing care when being examined. Other members of staff did not make any such distinction between doctors of different status.
- 2.50 The usual procedures must inevitably have been subject to the exigencies of the moment. If a ward was short-staffed for any reason, the nurse accompanying a doctor might have to go off to deal with another patient and leave the doctor alone. Mrs Naylor (ward sister, Ward 1) said that there would be occasions when the ward was busy and no member of the nursing staff could be spared to accompany the doctor. If a doctor visited at a time when the handover between shifts was going on (so that the majority of the nursing staff on duty were congregated in the sister's office), the doctor might be able to gain access to a patient without being accompanied. Mrs Mary Laing, a night sister, observed that the nursing arrangements on the wards were **'very fluid'**. At night, it would not be uncommon for two nurses to be occupied with a patient on one of the main areas of a ward for up to 20 minutes at a time. In those circumstances, a doctor would have had free access to the cubicles on the ward.
- 2.51 Several witnesses told the Inquiry that it would not have been unusual for a doctor to go to see a patient alone, particularly if no treatment or examination was envisaged. This might happen if the doctor was concerned about the patient's condition and wished to check on him/her. A doctor might stay on the ward to keep an eye on a patient's condition and go to see the patient from time to time. If s/he did that, it seems unlikely that a nurse would be in attendance on the doctor all the time. The attendance of a nurse would be required only if there was a specific task to be carried out. Doctors would also use the ward as a place to study. Mrs Calverley records that Shipman was always studying either on the ward or in the library nearby, so that she never knew whether he was on or off duty. If a doctor who was studying on the ward went to look at a patient who was known to be unwell, this would be unlikely to attract any particular attention.
- 2.52 It is clear, therefore, that a doctor who was a familiar face in the ward, and who was regarded as competent and conscientious, would have had a virtually free run of the ward and of the cubicles in which those patients who were seriously ill were nursed. There would have been no reason for anyone to question a doctor's presence in those circumstances. Moreover, as I shall explain in Chapter Four, doctors would not necessarily be

accompanied when giving intravenous injections and, on occasion, would administer other drugs to patients while alone with them.

- 2.53 The Inquiry was told that, on the paediatric wards, it was usual for a nurse to accompany a doctor when the doctor was examining a child. If a child was ill and required attention, a nurse would remain continuously by his/her bedside. If a doctor was called out in those circumstances, the nurse would be present. Often, if the child was unwell, the parents would be present also.
- 2.54 Doctors sometimes remained on the paediatric ward at night, writing up notes or studying. Miss Ann Ward, ward sister on the paediatric wards, recalled that Shipman spent a lot of time (including time at night) studying in the ward's nursery. The nursery had a glass screen and was visible from the sister's office. Nevertheless, it would obviously have been possible for Shipman to gain access to a child in the nursery or, when the staff were busy, to children in other parts of the ward, including the cubicles. The Inquiry was told that doctors would not necessarily be accompanied when giving a child an injection.
- 2.55 The overall picture is of a hospital that was adequately, though not generously, staffed, in which a doctor who was known, established and trusted would, when on duty or on call, have had ready access to the wards. It would have been easy for Shipman to gain access to patients and, if he chose to do so, to be with them in the absence of a nurse.

## CHAPTER THREE

### Shipman's Career at the Hospital

#### Introduction

- 3.1 Shipman arrived at Pontefract General Infirmary (PGI) in August 1970. When he arrived, he had provisional registration only. In order to become a fully registered medical practitioner, he was required to work for 12 months (six months in surgery and six months in medicine) as a pre-registration house officer (HO).
- 3.2 Evidence received by the Inquiry from Miss Ann Ward, who worked at PGI in the 1970s and became a friend of the Shipman family, suggests that Shipman had always wanted to be a general practitioner (GP). At that time, there was no requirement for doctors entering general practice to undergo any specific training. It was not until 1981 that vocational training (consisting of at least a year spent as a GP trainee in an approved training practice, together with up to two years in educationally approved hospital posts within a number of defined specialties) became mandatory. It seems that some schemes for vocational training did exist; indeed, information available to the Inquiry suggests that PGI began to participate in such a scheme from about mid-1972. However, it was open to a newly qualified doctor to enter general practice immediately after gaining full registration.
- 3.3 In the event, Shipman elected to stay at PGI after the expiration of his year's mandatory service there. It is probable that he did this in order to gain further experience that would be of value when he entered general practice. This would not have been unusual. Alternatively, it is possible, despite Miss Ward's belief, that, at that time, he had not finally decided on his future plans and was considering the possibility of a career in hospital medicine.
- 3.4 Shipman's first post as a senior house officer (SHO) was on the paediatric wards. Although there was no requirement that a doctor entering general practice should have experience in paediatrics, such experience would plainly have been of benefit to a young doctor wishing to enter general practice and it may have been for that reason that Shipman spent six months on the paediatric wards. His time there was followed by a further period of six months on the medical wards. As a SHO, he would have been given a greater degree of responsibility than he had had when previously on the medical wards and it seems likely that he undertook this post also with a view to gaining experience that would be of use to him when he entered general practice.
- 3.5 At the end of Shipman's second six-month period on the medical wards (by which time he had been at PGI for two years), he went back to work in paediatrics, this time as a registrar. His appointment as registrar, after only a year as a SHO, suggests that, as various witnesses have said, he must have been well regarded by the consultant paediatrician in charge, the late Dr Douglas Pickup. It may be that Shipman was at that point contemplating the possibility of a career in paediatrics. During his 13 months as a registrar in paediatrics, Shipman obtained a Diploma in Child Health. At that time, there was no special examination for paediatricians. Those doctors who intended to make a career in paediatrics had to pass the examination for Membership of the Royal College of Physicians and to obtain the Diploma in Child Health.

- 3.6 At the end of his time on the paediatric wards, Shipman moved to work on the gynaecology ward (Ward 3) and in the hospital's new obstetrics unit. There, he reverted to the rank of SHO. The move to obstetrics and gynaecology would have provided further valuable experience for general practice. During his time working in obstetrics and gynaecology, Shipman obtained a Diploma from the Royal College of Obstetricians and Gynaecologists. Meanwhile, he had applied for and obtained a post at the Abraham Ormerod Medical Centre, Todmorden. His period in obstetrics and gynaecology finished on 28<sup>th</sup> February 1974 and he started in Todmorden on the following day.
- 3.7 From time to time while working at PGI, Shipman would assist in the accident and emergency department when there was a shortage of staff there. Dr Russell Cross, who had been a contemporary of Shipman at Leeds University, told the Inquiry that work in the accident and emergency department provided an opportunity to earn extra money and also to acquire greater experience for general practice.
- 3.8 In addition to his work at PGI, Shipman occasionally deputised for Dr Robert Forster, a local GP, who was the part-time medical officer (later hospital practitioner) at Ackton Hospital. Shipman provided cover for Dr Forster over some weekends and on other occasions. It appears that Shipman was deputising for Dr Forster in May 1971 and in April and July 1972 since, in each of those months, he was involved in certifying the cause of death of a patient who had died at Ackton Hospital.
- 3.9 Shipman also worked as a locum from time to time at a GP practice in Pontefract. The partners in that practice were the late Dr Michael Hessel and his wife, Dr Gwendolen Hessel. The Inquiry has been told that this happened two or three times a year, usually for a week or a fortnight at a time. It is clear that Shipman was working as a locum at the practice in June and December 1972 and in May 1973 since, in each of these months, he was involved in certifying the cause of death of a patient of the practice.
- 3.10 I shall now consider the evidence obtained by the Inquiry from members of the medical and nursing staff who worked alongside Shipman in his various placements at PGI.

## Views about Shipman

### The Period from August 1970 to January 1971: House Officer on the Surgical Wards

- 3.11 The Inquiry obtained witness statements from some of the medical and nursing staff who worked on the surgical wards during Shipman's time there. Statements were provided by Dr Rizvi Hasnain (resident surgical officer), Dr Brian Gallagher (surgical registrar), Dr Jeremy Belk (HO), Miss Jean Grandfield (sister, Ward 5), Mrs Margaret Sivorn (holiday relief sister, who worked temporarily on Ward 5), Mrs Eileen Gallagher (formerly Miss Eileen Callaghan, ward sister, Ward 6), Mrs Irene Torrible (formerly Miss Irene Dawes, sister, Ward 6), Ms Joan Sykes (night sister, Wards 5 and 6), Mrs Marlene Inman (night theatre sister), Mrs Jackie Walsh (sister, Hydes Surgical Ward) and Ms Margaret Nicholls (ward sister, Leatham Ward). During Phase One, the Inquiry



received a letter from Dr Diane Gaubert, HO on the surgical wards at the same time as Shipman.

- 3.12 It is clear that Shipman created a generally good impression when working on the surgical wards. Mrs Gallagher said that she could not fault him as a HO. Whatever he did, he did it well. The impression that she had was that he was a **'nice, caring young man'**. She said that he was, however, **'a little bit strange'** and **'not as jolly as other junior house officers'**. She observed that he had **'an arrogant side to him'** and **'you could not get close to him'**. Mrs Gallagher's husband, who was at that time the surgical registrar, found him very pleasant and thought he would make a **'lovely doctor'**.
- 3.13 Dr Jeremy Belk, who was his direct contemporary, did not warm to Shipman, although he was able to establish a reasonable working relationship with him. He recalled that Shipman was very certain about his own clinical judgement. At the time, Dr Belk envied Shipman's ability to be so sure. However, with hindsight, he could see that Shipman had been dogmatic. Dr Belk also described Shipman as **'a loner personality'**. He did not invite people to help him and kept them at arm's length. Dr Belk believed that Shipman would have intimidated nursing staff who might, therefore, have kept their distance unless he had specifically asked them for help. Dr Belk's former wife, Dr Doreen Belk, was also a junior doctor at PGI at the same time as Shipman and her husband. The two families lived near to each other in the hospital grounds and knew each other socially. Dr Doreen Belk found Shipman aloof and not easily approachable. She said that he had few friends. Her **'abiding memory'** of Shipman is of a man **'with a chip on his shoulder'**. This had first become evident when she and her husband were at medical school with Shipman. At Pontefract, his manner remained cold and she regarded him **'as a work colleague but never as a friend'**.
- 3.14 Dr Gaubert found nothing unusual in Shipman's medical practice or personal behaviour; she said that he **'always appeared confident and conscientious in his work'**. She remained in contact with him after he moved to Todmorden and remembered his writing a long letter, telling her about his drug addiction and treatment and appearing **'very positive'** about the future.
- 3.15 Mrs Torrible recalled Shipman as being confident and somewhat competitive with Dr Jeremy Belk; she got the impression that Shipman felt that he could do things better than Dr Belk. She observed that Shipman was well liked by the female patients, to whom he would speak in language that they could understand. Ms Sykes did not have a high opinion of Shipman or his medical abilities. However, she was very much in the minority.
- 3.16 The HOs on Wards 5 and 6 were also HOs for the Hydes Surgical Ward in the main building of the hospital. Mrs Walsh remembered Shipman as self-assured and confident. Indeed, she was amazed at his confidence, having regard to the fact that he was **'fresh from medical school'**. She believed that he was popular with both patients and nurses alike. The nursing staff particularly liked the fact that he would always come when he was called. She liked Shipman and remembers thinking that **'you knew that when you were with Fred you were safe'**.
- 3.17 Ms Nicholls told the Inquiry that surgical HOs also covered the Leatham Ward, which dealt solely with paediatric surgical and orthopaedic cases. She described Shipman as

**‘extremely pleasant and very helpful’, ‘very caring and conscientious’ and ‘very reliable’.** She had **‘nothing detrimental to say about him’.** Ms Nicholls knew Shipman from the time he started at PGI and would have seen him regularly during the later period when he worked as a paediatric SHO, then as a registrar.

### **The Periods from February to July 1971 and from February to July 1972: House Officer, then Senior House Officer, on the Medical Wards**

- 3.18 The Inquiry obtained witness statements from some of the medical and nursing staff who worked on the medical wards during Shipman’s time there. Statements were provided by Dr John Turner (consultant physician), Dr R K Prasad (formerly medical registrar, who, in 1971, still worked unofficially on the medical wards from time to time), Dr Jeremy Belk (the other HO during Shipman’s first period on the medical wards), Mrs Kathleen Naylor (ward sister, Ward 1, during both periods), Mrs Maureen Wadsworth (sister, Ward 1, during Shipman’s first period on the medical wards and for part of the second period), Mrs Pauline Burchill (state enrolled nurse (SEN), Ward 1, during both periods), Mrs Iris Lightowler (ward sister, Ward 2, until about July 1971), Mrs Anne Calverley (formerly Miss Anne Paley, sister and, from about July 1971, ward sister, Ward 2), Mrs Rosina Patrick (day sister, Ward 2, until about July 1971, then night sister, Wards 1 and 2), Mrs Jennifer Bratley (formerly Miss Jennifer Buckley, night sister, Wards 1 and 2, and, from some time in 1972, day sister, Ward 2), Mrs Diane Wakefield (trainee nurse, Ward 2, during Shipman’s first period on the medical wards), Mrs Elaine Moss (formerly Miss Elaine Metcalfe, part-time sister, Ward 1, until May or June 1971, then part-time sister, Ward 2), Mrs Molly Hinchcliffe (SEN on nights, Wards 1 and 2, during Shipman’s first period on the medical wards), Ms Lesley Atkinson (trainee nurse on nights, Wards 1 and 2, during Shipman’s first period on the medical wards), Dr Mohammed Sooltan (medical registrar from 1<sup>st</sup> July 1972), Dr Nicholas Kounis (HO during Shipman’s second period on the medical wards), Mrs Linda Byford (junior sister, Ward 1, during Shipman’s second period on the medical wards), Mrs Sandra Whitehead (student nurse, Ward 1, for three months during Shipman’s second period on the medical wards), Mrs Clara Robinson (night nurse on Wards 1 and 2 between about February and April 1972) and Miss Lesley Clark (relief sister, Wards 1 and 2, from about February to April 1972). The Inquiry has not succeeded in contacting Dr Husain Abbas (SHO during Shipman’s first period on the medical wards). A member of the Inquiry team has spoken to Dr Warren Jordan, retired consultant chest physician, but he has no recollection of Shipman.
- 3.19 The Deputy Solicitor to the Inquiry spoke to Dr Surinder Ahuja (medical registrar during Shipman’s first six-month period on the medical wards and during his second period until 30<sup>th</sup> June 1972) and prepared a draft statement based on her discussions with him. That statement was sent to Dr Ahuja, who lives abroad, for approval and signature. During the course of a further discussion, Dr Ahuja confirmed that the statement was accurate. However, he did not wish to sign it. He indicated that he was happy for the statement to be published and for the Inquiry to state in its Report that he had agreed its contents. His refusal to sign the statement appears to have resulted from a reluctance to speak ill of the dead. In these unusual circumstances, I have decided that the unsigned statement should be put on the Inquiry’s website in the usual way and I have referred to Dr Ahuja’s statement in the course of this Chapter.

- 3.20 During his time on the medical wards, and particularly during his six-month period as a SHO, Shipman gained a reputation for being extremely hardworking and dedicated. In his initial communication to the Inquiry, Dr Turner described him as **‘a doctor of average ability who appeared to carry out his duties conscientiously’**. Dr Kounis, who, as I have said, was one of the two HOs during Shipman’s second period on the medical wards, told the Inquiry that Shipman was **‘definitely the doctor who was running both wards’**. Shipman enjoyed the respect of the nursing staff and appeared to get on well with patients. Dr Kounis said in his witness statement that his abiding memory of Shipman was that he was **‘always on the wards’**. By contrast, Dr Ahuja, the medical registrar during both periods of Shipman’s time on the medical wards, spent much of his time studying. Dr Kounis described Shipman as a very hardworking doctor, who fostered good working relationships with the nurses and with the HOs. However, he said that Shipman was also an arrogant man.
- 3.21 In his unsigned witness statement, Dr Ahuja agreed that, during his time as medical registrar, he was studying for his examination for Membership of the Royal College of Physicians and, when he was not conducting out-patient clinics, attending ward rounds or assisting the HOs, tended to spend his time studying in the library. Dr Ahuja remembered Shipman as **‘keen and energetic’** and, like Dr Kounis, recalled that he **‘always seemed to be around on the medical wards’**. He described Shipman as arrogant and said that Shipman **‘felt he knew better than anybody else’**. Shipman constantly questioned Dr Ahuja’s professional judgement. Dr Ahuja put this down largely to Shipman’s youth and to the fact that he had just left medical school. However, he felt that it was also to some extent attributable to racial prejudice on Shipman’s part. Dr Ahuja said that he did not feel welcome on the medical wards, and as a consequence, went onto the wards only when it was necessary. Because of Shipman’s attitude towards him, he ceased to exercise any supervisory role over Shipman.
- 3.22 Dr Ahuja described two incidents that illustrated Shipman’s arrogance. The first incident was when Shipman snubbed Dr Ahuja publicly at a meeting attended by doctors of all seniorities. All those attending had been embarrassed by Shipman’s behaviour and, after the meeting, the late Dr Leslie Watson, one of the consultants on the medical wards, had apologised to Dr Ahuja and said that Shipman’s behaviour had been **‘unacceptable’**.
- 3.23 The second incident also involved Dr Watson. A patient in the coronary care unit had an irregular heartbeat and Dr Watson had arranged for this to be treated by defibrillating (i.e. administering an electric shock by means of a defibrillator) the patient. A date and time was fixed for this procedure, which was to be carried out by Dr Watson and Dr Ahuja. At the appointed time, Dr Watson and Dr Ahuja went to the ward, only to be told by the sister that Shipman had already carried out the procedure. At that time, Shipman was only a HO and his behaviour in carrying out a procedure which was to be undertaken by a consultant and registrar was highly unusual. Dr Watson was plainly angry. He did not challenge Shipman, but immediately walked off the ward.
- 3.24 Dr Prasad described the same incident to the Inquiry although he could not be certain that he had actually witnessed it himself, rather than having heard of it afterwards. He did not

like Shipman because of his arrogant manner. He observed that Shipman was more confident than the average HO.

- 3.25 Mrs Naylor, ward sister on Ward 1 throughout Shipman's time on the medical wards, described Shipman as pleasant and easy going. Mrs Lightowler, ward sister on Ward 2 during most of Shipman's first period on the medical wards, had little recollection of him. Mrs Calverley, who succeeded Mrs Lightowler, had a particularly good relationship with Shipman. She described him as **'extremely dedicated and extremely reliable'**. During his time as a SHO, she would always send for him if she had a problem on the ward and he would attend if called, whether or not he was on duty. Mrs Calverley said that his willingness to come out when called made life much easier on the ward. Mrs Calverley did not, however, call Shipman out at night, since she did not work nights. Mrs Calverley observed that Shipman sought her advice and appeared to value her opinion. He was never arrogant towards her. However, she noticed that he was slightly aloof and kept his distance from patients. He was enthusiastic, ambitious, and always studying. When on the ward, he was very much **'hands on'** and enjoyed teaching the more junior doctors. Mrs Byford recalled that Shipman was the **'sort of doctor who would stay around until he was happy with a patient's condition'**. She also observed that he was always quick to respond when called.
- 3.26 Other members of the nursing staff had different views about him. Ms Atkinson, who was a trainee at the time, described him as the most reliable junior doctor she had worked with. Mrs Robinson, also a trainee then, said that he was **'one of the nicest housemen I ever worked with'**. She said that he was polite and conscientious; if he was called out in the night, he was quick to respond and never grumbled. Mrs Robinson said that he **'was always very kind to patients and staff'**. However, Mrs Wadsworth described him as **'quite ingratiating towards people in authority'**. At the same time, he could be quite arrogant and patronising. He was well liked by many of his patients, as he used to make a fuss of them. She said that he was a **'a chameleon and would change the way he was depending on who he was speaking to'**. He sensed weakness in people and, if they were intimidated, would take advantage of that. With ward sisters and more senior doctors, he was **'very deferential and keen to make a good impression'**. She thought he was **'a bit odd'**. Mrs Patrick told the Inquiry that she did not warm to him. By contrast, Mrs Burchill, a SEN, found him very friendly, although she thought he was less charming and did not have as good a bedside manner as some of the other doctors.
- 3.27 Mrs Bratley described Shipman as **'very assertive and confident'**. His confidence bordered on arrogance on occasion. He was always willing to put himself out. If anything needed to be done on the ward, Shipman was the person to call and there was never any trouble in getting hold of him. Her experience was that, if a patient was *in extremis* or had just collapsed, Shipman would often be present, having been sent for by the HOs or the nurse in charge of the ward. She said that Ward 2 was a very busy ward and reliance would be placed on those individuals **'who seemed to know what they were doing'**. Shipman was plainly one such.

### **The Periods from August 1971 to January 1972 and from August 1972 to September 1973: Senior House Officer, then Registrar, on the Paediatric Wards**

- 3.28 The Inquiry obtained witness statements from some of the medical and nursing staff who worked on the paediatric wards during Shipman's time there. Statements were provided by Dr Peter McWilliam (a local GP and clinical assistant in paediatrics during both periods for which Shipman worked on the paediatric wards), Miss Ann Ward (ward sister, Hydes Medical Ward, during both Shipman's periods on the paediatric wards), Mrs Valeria White (sister, Hydes Medical Ward, during both Shipman's periods on the paediatric wards), Mrs Patricia Smith (formerly Miss Patricia Broadbent, night sister, Hydes Medical Ward, during both Shipman's periods on the paediatric wards), Mrs Margaret Calvert (part-time night sister, Hydes Medical Ward, during both Shipman's periods on the paediatric wards), Dr Angela Pugh (paediatric SHO from August 1972 to January 1973), Dr Anthony Baboolal (paediatric SHO from February to July 1973), Dr Philip Gordon (paediatric SHO from 1<sup>st</sup> August 1973), Mrs Jacqueline Hart (formerly Miss Jacqueline Cremin, staff nurse, Hydes Medical Ward, during Shipman's second period on the paediatric wards), Mrs Elaine Spiers (formerly Miss Elaine Peasant, auxiliary nurse, Hydes Medical Ward, from June 1973) and Ms Margaret Nicholls (ward sister, Leatham Ward, during both Shipman's periods on the paediatric wards).
- 3.29 Shipman appears to have been held in particularly high regard by most of those who worked with him on the paediatric wards. One witness, Mrs Mary Laing, said that the late Dr Pickup, consultant paediatrician, had described Shipman as **'the best house officer I've ever had'**. The fact that Dr Pickup (together with a colleague) appointed Shipman as his paediatric registrar appears to confirm that he was impressed by Shipman's capabilities. Dr McWilliam found Shipman **'an affable junior colleague'** and a **'competent and caring doctor'**. Indeed, he thought so highly of Shipman that he invited him to join his own GP practice to replace a partner who was retiring, an offer which, according to Dr McWilliam, Shipman **'politely declined'**.
- 3.30 Miss Ward said in her witness statement that she and Shipman **'used to get on like a house on fire'**. She became a personal friend of the Shipman family and remained in contact with them until about 1998. She described Shipman as **'a fantastic doctor'** and said that she had seen him **'bring babies back from the brink of death on a number of occasions'**. She acknowledged that, on occasion, Shipman could be **'a bit difficult and truculent'**; he was also patronising to some people, although never to her. Miss Ward recalled that Shipman studied constantly, frequently sitting reading in the nursery on the Hydes Medical Ward. When not reading, he would be around the paediatric wards. He was, she said, **'always a loner'**.
- 3.31 Mrs Hart said that Shipman and Miss Ward worked well together and made **'a very good team'**. She observed in her witness statement that **'if anyone could save a baby's life, those two could'**. She went on to say that, if a child of hers had been ill, she would have wanted Shipman to be on hand to help. Two other witnesses, one a doctor and one a senior nurse, told the Inquiry of the excellent care that Shipman had given to their children when they were being treated on one of the paediatric wards.

- 3.32 Mrs Calvert said that Shipman had a **'slight arrogance'** about him and was **'clearly a very clever man'**. He was, in her view, a very good doctor and very knowledgeable. She had the impression that Dr Pickup had a high opinion of him. However, she observed that Shipman did not listen to the nurses as much as other doctors did, despite the fact that Dr Pickup frequently reminded his junior staff of the importance of listening to the nursing staff.
- 3.33 Mrs Calvert described an incident which, she said, illustrated vividly Shipman's over-confidence. She was assisting Shipman with treating a patient in the accident and emergency department one night. It seems likely that Shipman was working as a casualty officer that night, while Mrs Calvert was at that time based in the accident and emergency department. The patient, who was in her late teens, had been involved in a road traffic accident and had a bad laceration of the leg; a sedative was required to calm the patient sufficiently to permit her laceration to be sutured. Shipman administered a 10mg injection of diazepam very quickly. Mrs Calvert believes he gave the injection intramuscularly. (The British National Formulary for 1974–76 gave the recommended dose of diazepam as 10mg by intramuscular or slow intravenous injection, to be repeated, if necessary, after not less than four hours.) Shipman administered a second and then a third 10mg dose. When he had given 30mg of the drug, Mrs Calvert became concerned, although the patient seemed to be tolerating it well. Mrs Calvert mouthed to Shipman the word **'thirty'**, by way of warning. However, he asked for a fourth 10mg ampoule and administered that without hesitation. Despite the fact that the patient suffered no harm as a result of the dose administered, Mrs Calvert said that, as a result of this incident, she formed the view that Shipman had too much confidence and **'absolutely no fear'**.
- 3.34 Dr Baboolal worked with Shipman both on the paediatric wards and on the obstetrics unit and gynaecology ward. He has told the Inquiry that he regarded Shipman as **'a strange and sinister man'**. He said that Shipman was one of the few doctors from PGI whom he could remember and that was because he was **'so odd'**. He said that he found Shipman's behaviour – in particular the way that he went out of his way to ingratiate himself with people – **'extremely strange and abnormal'**. Dr Baboolal said that he voiced his feelings about Shipman at the time but the staff and patients **'all loved him'** and did not view his behaviour in the same way. Dr Baboolal said that, when he learned later that Shipman had been convicted of offences relating to pethidine, he was not particularly surprised as he had formed the view that **'something was not right about him'**. He said that, when he heard about the murders, he was shocked by the scale of what Shipman had done. However, he had perceived some sort of **'psychological abnormality in him'** when he worked with him, so was not as surprised as he would have otherwise been.

#### **The Period from September 1973 to February 1974: Senior House Officer on the Obstetrics Unit and the Gynaecology Ward**

- 3.35 The Inquiry obtained witness statements from some of the medical and nursing staff who worked on the obstetric unit and/or the gynaecology ward during Shipman's time there. Statements were provided by Mr Peter Howe (consultant obstetrician), Dr Narendra Saikia (registrar), Dr Sarkis Kupelian (SHO), Dr Anthony Baboolal (SHO), Mrs Basheera Provisor (sister, Ward 3), Mrs Margaret Sivorn (sister, Ward 3) and

Mrs Elaine Spiers (auxiliary nurse in the obstetrics unit from about September 1973). Other witnesses also commented on Shipman's time in obstetrics and gynaecology.

- 3.36 Some of the witness evidence suggests that Shipman may not have been a great success when working in obstetrics and gynaecology. Dr Kupelian recalled that Shipman **'did not perform particularly well in the obstetrics unit'**. He said that Shipman was **'not very prompt with his work'** and his attitude was **'too laid back'**. As a paediatric SHO, Dr Gordon would sometimes be present when Shipman was delivering a baby. He described Shipman as **'a terrible obstetrician'**. He said that Shipman was too rough and often used too much pressure when carrying out forceps deliveries. He said that he only realised how bad an obstetrician Shipman had been when he did his own obstetrics placement later. Dr Baboolal, who had already had some experience in obstetrics before his arrival at PGI, was aware that Shipman had never done obstetrics before. He was unable to comment on Shipman's competence since the nature of the work in the obstetrics unit meant that the SHOs frequently worked alone, dealing with individual patients, and had little opportunity to observe each other. He did recall an occasion when another doctor, whose wife had been treated by Shipman, was complaining loudly to Shipman about the treatment which she had received and forbade Shipman ever to treat her again.
- 3.37 Mrs Spiers, who had been an auxiliary nurse on the paediatric wards before transferring to the obstetrics unit, recalled that the **'general talk'** was that Shipman was **'not very good in obstetrics'**. She herself was treated by Shipman in January or February 1974, when she had a miscarriage. Her account of events suggests that Shipman was careless about note-taking and probably incompetent in his treatment of her. She suffered a serious and life-threatening haemorrhage, which she was lucky to survive. Miss Ward, who had no personal experience of Shipman's work in obstetrics and gynaecology, nevertheless got the impression that he was not keen on the specialty; she thought this might have been due to a lack of patience on his part.
- 3.38 Mr Howe could not remember any particular problems with Shipman; nor could he remember Shipman being **'particularly bad at obstetrics'**. Mrs Sivorn found Shipman **'a nice man and a good doctor'**. Mrs Provisor did not remember him. But, from the evidence in the Inquiry's possession, it does seem, as I have said, that his reputation for competence was not as high during this period as it had been in his previous placements.

### **Shipman's Work Outside the Hospital**

- 3.39 In connection with Shipman's work at Ackton Hospital, the Inquiry obtained witness statements from Dr Forster and Mrs Carol Sadler, senior sister at Ackton Hospital. Dr Forster knew Shipman professionally. He found him **'fairly affable'** and believed that his reputation was that of a reasonably competent practitioner. Mrs Sadler had no recollection of him at all.
- 3.40 In connection with his work as a locum, the Inquiry sought information from Dr Gwendolen Hessel. She told the Inquiry that no one had expressed concern about Shipman's work in the practice, otherwise she and her husband would not have employed him again. He ceased to act as a locum for the practice when he left PGI. On one occasion, Dr Gaubert

gave locum cover to the Hessels' practice jointly with Shipman. As I have said, she found nothing unusual in his medical practice or personal behaviour. Nor was she aware of any sudden or unexplained deaths in the practice which could have been associated with Shipman.

## Conclusions

- 3.41 In my view, these impressions of Shipman, sketchy though they may be, are of real interest and value in building up an overall portrait of him as a young man. Some of the characteristics described during this early period were also to be found in the mature man and were essential features underlying his criminality.
- 3.42 As a GP in Hyde, Shipman developed a reputation as a very good doctor and for being caring and hardworking. That reputation earned him the complete trust and confidence of his patients and the respect of his professional colleagues. Because of this trust, confidence and respect, he was able to kill patients and avoid detection. His false explanations for events were accepted without question. It is clear from the evidence I have described above that Shipman was able to establish a high reputation at PGI, except in respect of his obstetric work. That he was effectively running the medical wards while only a SHO demonstrates the extent to which he had established his reputation and authority within a period of only two years. That will be a matter of some significance when I come to consider the large number of deaths that occurred on the medical wards during that period.
- 3.43 Another feature noticed by colleagues at PGI was the way in which Shipman ingratiated himself with senior staff, particularly senior nurses. In the Fourth Report, I described how he ingratiated himself with Mrs Ghislaine Brant, manager of the pharmacy next door to Shipman's surgery in Market Street, Hyde. He did this deliberately because it was necessary that Mrs Brant should have complete confidence in him. Then she would supply him with ampoules of diamorphine in circumstances where she ought not to have done, at least without asking him to justify his requests. Her admiration for and confidence in him deprived her of her professional objectivity. Shipman also developed a close working relationship with his practice nurse, Sister Gillian Morgan. In this relationship, Sister Morgan deferred to Shipman, without question, on all matters. It is, in my view, significant that, even as early as the 1970s, in Pontefract, Shipman was using the same techniques to gain the confidence of the nursing staff.
- 3.44 It is also a matter of interest that some colleagues found him arrogant and over-confident. Some regarded him as strange, sinister and odd. These people were in the minority; the majority admired him. A very similar pattern was to be found later. Most people admired and respected him; some colleagues found him difficult, arrogant and 'prickly'. In short, the evidence about Shipman as a young professional in Pontefract is entirely consistent with the picture of the mature GP in Hyde.



## CHAPTER FOUR

### The Arrangements for Storing and Administering Drugs at the Hospital

#### Introduction

- 4.1 If Shipman was killing patients at Pontefract General Infirmary (PGI), there seems little doubt that he must have been doing so by means of a drug or drugs. In the 1990s, when Shipman was practising in Hyde, it is clear that he was using diamorphine to kill his patients. Although there is no direct evidence about Shipman's acquisition of drugs in the late 1970s and 1980s, I had no difficulty at all in inferring that Shipman was using opiates (probably diamorphine) to kill his patients during that period also. I found that Shipman used an opiate (possibly morphine) to kill while he was practising in Todmorden.
- 4.2 The Inquiry has examined the available evidence about the way in which drugs were stored and handled at PGI, and the extent to which it would have been possible for Shipman to obtain controlled and other drugs while working at the hospital. I have looked at the available evidence about the drugs prescribed by Shipman and the extent to which he may have used those drugs inappropriately or with criminal intent. The Inquiry has received evidence about these matters from Mr John Barker, Chief Pharmacist at PGI at the time, as well as from many former members of the medical and nursing staff at the hospital.

#### Controlled Drugs

- 4.3 Until 1973, certain drugs (among them opiates such as diamorphine, morphine and pethidine) were classified as 'dangerous drugs'; the production, supply, prescription and possession of dangerous drugs were strictly regulated. After the coming into force in July 1973 of the Misuse of Drugs Act 1971 and the Misuse of Drugs Regulations 1973 (the 1973 Regulations), the term 'dangerous drugs' was replaced by the term 'controlled drugs'. Most controlled drugs falling within Schedule 2 to the 1973 Regulations (including diamorphine, morphine and pethidine) were required to be stored in secure conditions and their use was strictly regulated. For convenience, I shall use the terms 'controlled drugs' to mean those drugs which formerly came within the definition of 'dangerous drugs' and became known as Schedule 2 controlled drugs. Other drugs I shall refer to as 'non-controlled drugs'.

#### The Use of Controlled Drugs on the Various Wards

- 4.4 The extent to which controlled drugs were used, the purposes for which they were used and the types of controlled drug used varied as between the different wards at the hospital.
- 4.5 Mr Barker told the Inquiry that controlled drugs were not widely used on the medical wards at PGI in the early 1970s. They were, however, required in certain circumstances. Mr Barker's recollection was that the usual drug given for the relief of coronary pain was diamorphine, which would be administered by injection. He could not recall whether

pethidine was used on the medical wards at all. Diamorphine and morphine were given for the relief of pain in cases of terminal illness. In those circumstances, the drugs were often made up into an elixir, to be taken orally. On the other hand, Mrs Anne Calverley (formerly Miss Anne Paley, ward sister, Ward 2, from about July 1971) said that pethidine was used **'all the time'** on the medical wards. She said that it was given routinely to patients on the coronary care unit. Pethidine was also given to patients suffering from renal colic. Dr Nicholas Kounis, house officer on the medical wards in 1972, remembered that the drugs used for pain relief in the case of heart attacks were diamorphine and morphine.

- 4.6 Mr Barker said that, on the surgical wards, one of the drugs most commonly used was pethidine. It was used for the relief of post-operative pain and would be injected intramuscularly or intravenously. The Inquiry was told that controlled drugs were rarely used on the paediatric wards. Ms Margaret Nicholls, ward sister, Leatham Ward, said that controlled drugs were only really used for pre-medication (i.e. medication given prior to an operation by way of preparation for an anaesthetic) and were administered by the nursing staff. I shall deal with the use of pethidine in the obstetrics unit later in this Chapter.

#### **Obtaining Supplies of Controlled Drugs**

- 4.7 The arrangements for storing and administering controlled drugs appear to have been essentially the same throughout the hospital. Each ward maintained its own stocks of controlled drugs and its own controlled drugs register (CDR), in which details of the controlled drugs supplied to the ward and of those administered to patients were recorded. Fresh stocks of controlled drugs were ordered as required from the hospital pharmacy. Orders were recorded in the ward's controlled drugs book, which was separate from the CDR. A member of the nursing staff on the ward would enter into the controlled drugs book details of the controlled drugs required, together with his/her own name. The order would be communicated to the hospital pharmacy.
- 4.8 Often, one of the pharmacists from the hospital pharmacy would visit the ward to deliver the drugs ordered. If the controlled drugs were delivered by a pharmacist, s/he would make a physical check of the remaining stocks of controlled drugs held on the ward and would ensure that the stocks tallied with the entries in the ward's CDR.
- 4.9 On other occasions, a member of the nursing staff on the ward would collect the controlled drugs from the hospital pharmacy. The nurse would take the ward's CDR, as well as the controlled drugs book, to the pharmacy and the pharmacist would enter in the CDR details of the controlled drugs supplied. The details recorded in the controlled drugs book would include the name of the pharmacist who had supplied the controlled drugs and of the person who collected them. The pharmacist would also note the balance of the stocks of the relevant drug held by the ward, according to the controlled drugs book. If the drugs were collected from the pharmacy, there would be no physical check of the controlled drugs held in stock on the ward at that time. However, routine physical checks would be carried out by the pharmacists from time to time, in addition to those checks carried out on the occasions when drugs were delivered. According to Mr Barker, in the 1970s, routine checks took place about once every six months.

### **Arrangements for Storing Controlled Drugs**

- 4.10 Once on the wards, controlled drugs were stored in double-locked cupboards. The location of the cupboards varied from ward to ward. Mrs Calverley told the Inquiry that, every time the controlled drugs cupboard on Ward 2 was opened, a red light came on at the top of the cupboard, in the sister's office and in various other places on the ward. It is not known whether the same arrangement existed on every ward at PGI.
- 4.11 The senior state registered nurse (SRN) on duty on the ward at any time (usually a sister) held the keys to the controlled drugs cupboard and kept them on his/her person. The rule was that the nurse holding the keys should keep possession of them throughout his/her period of duty and should not hand them over to anyone else.

### **Arrangements for Administering Controlled Drugs**

- 4.12 No drug, whether controlled or non-controlled, was administered to a patient unless it had been prescribed by a doctor. The correct procedure was for the doctor to record details of the prescription on the patient's drug record chart (which was kept at the foot of the patient's bed), and for the appropriate drug to be obtained and administered in accordance with the prescription. Most drugs were administered by nurses. As well as administering drugs orally, members of the nursing staff would give intramuscular and subcutaneous injections. However, nurses were not permitted to give intravenous injections; these were always administered by doctors. On occasion, doctors might administer other drugs (including controlled drugs) which did not require intravenous administration. They would do this for reasons of convenience and in order to assist the nursing staff.
- 4.13 The witnesses gave slightly different accounts of the procedure to be followed when obtaining controlled drugs for the purpose of administration. In essence, however, the procedure was as follows. When a doctor prescribed a controlled drug for a patient, a request for the drug would be made to the nurse in possession of the keys to the controlled drugs cupboard. The correct procedure was for that nurse to go to the cupboard, together with another qualified person (usually a second SRN, but sometimes the doctor who had prescribed the drug). That second person was required to witness the obtaining of the controlled drug and to countersign the CDR. The controlled drugs cupboard would be unlocked and the required amount of the drug would be removed and checked to ensure that both the identity of the drug and the amount were correct. Details of the drug removed and the patient to whom the drug was to be administered would be entered in the CDR. The CDR would be examined and a check would be made to ensure that the amount of the drug left in the controlled drugs cupboard tallied with the relevant entries in the CDR. Both nurses (or the nurse and the doctor) would sign the entry in the CDR. The controlled drugs cupboard would then be locked.
- 4.14 If the controlled drug was in injectable form, it would be contained in an ampoule. The required amount of the drug would be drawn up into a syringe and the syringe placed on an injection tray, together with the ampoule (which might be empty or might have some of its contents left) and a clean swab. This would usually be done by a nurse but, in the case

of a drug which was to be injected intravenously, might sometimes be done by the doctor who was to give the injection. If the amount of the drug prescribed was less than the original contents of the ampoule, the residue would be disposed of after the injection had been given.

- 4.15 If an injection of a controlled drug was to be given by a nurse (i.e. if it was to be given intramuscularly or subcutaneously), a second nurse was required to witness the administration of the drug. If a doctor was to give the injection (in which case it would usually be given intravenously), a nurse would often accompany him/her and witness the administration; however, the evidence suggested that this was not always done. Before administration, a check would be made of the prescription and of the patient's name and the amount in the syringe. After administration, the patient's drug record chart would be signed to indicate that the drug had been administered.

### The Effectiveness of the System

- 4.16 If the system operated as it was intended to do, there would have been little opportunity for a doctor to obtain controlled drugs illicitly. The removal of controlled drugs from ward stocks was carefully monitored and required the presence of at least one SRN. There would have been no opportunity for a doctor to gain access to the controlled drugs stocks kept on the wards.
- 4.17 The general view of the witnesses was that the system for handling controlled drugs at PGI was very strict. Mrs Linda Byford, junior sister on Ward 1 from late 1971 or early 1972, said that, during nurses' training, the importance of taking all the proper precautions when dealing with controlled drugs was constantly **'drummed into'** trainees. Ms Lesley Atkinson, a trainee nurse in the early 1970s, said that the regime for the storage and administration of controlled drugs at PGI was **'very tight'** in the early 1970s. She compared it with her previous experience at PGI in 1957. At that time, an anaesthetist who was abusing controlled drugs had bullied newly qualified members of the nursing staff into giving her access to the stocks of controlled drugs held on the wards. That episode had ended in tragedy. Mrs Atkinson believed that it was possible that the regime had been strengthened as a direct result of that episode. Dr Kounis contrasted the regime at PGI with that at a hospital in Belfast where he had worked previously. There, doctors kept controlled drugs such as morphine in the pockets of their white coats for emergency use. That was not permitted at PGI, where the procedures were, according to Dr Kounis, **'quite rigid'**. Mr Barker said that it was rare for there to be an incident when controlled drugs could not be accounted for. There was an investigation into such an incident about every two years. The problem of controlled drugs **'going missing'** was more common in the operating theatres than on the wards. Mr Barker said that the vast majority of the ward sisters were very careful with controlled drugs. If they had **'the slightest apprehension'** that something was amiss, they would speak to Mr Barker and go through the CDR with him to find out where the anomaly lay. Mr Barker said that problems of this nature were a very uncommon occurrence. The former members of the medical staff at PGI who gave witness statements were generally of the view that it would have been difficult for a doctor to obtain controlled drugs at PGI. Several members of staff spoke of the checks by the nursing staff on the contents of the controlled drugs cupboard which were carried out

regularly and which would have revealed any discrepancy between those stocks and the entries in the CDR.

- 4.18 If the system had operated as described, it seems to me that the only way in which a doctor could have obtained controlled drugs undetected would have been by prescribing a drug for a patient and then administering a smaller amount than that prescribed, or administering none of the drug and, instead, keeping it for his/her own purposes. That would have been possible on the odd occasion but would have had its risks. First, it might have been difficult to avoid being accompanied by a nurse when giving the injection. Second, the doctor would not have been able to prescribe a quantity of the drug that was manifestly excessive for fear that this would be noticed. Thus, s/he would not have been able to obtain large quantities for his/her own purposes. Third, it would have been evident to the nursing staff whether a patient was in need of controlled drugs for pain relief or other reasons. If controlled drugs were prescribed in circumstances in which they were plainly not required, this might well have excited suspicion. If controlled drugs were needed, but were not administered or were administered in insufficient quantities, this too might have been evident to the nursing staff. All these factors would have placed serious constraints on a doctor who wished to obtain controlled drugs illicitly in this manner.

### **The Weaknesses of the System**

- 4.19 Some witnesses suggested to the Inquiry that the regime for handling controlled drugs did not always operate as it should have done. Mrs Mary Laing, formerly a night sister at PGI, recalled an incident in the 1980s when she saw a nurse make as if to hand over the keys of the controlled drugs cupboard to a doctor in response to a request. Mrs Laing admonished the nurse and reminded her that the keys were her responsibility and should be kept in her possession at all times. However, the incident illustrated the fact that some nurses might not have adhered strictly to the correct procedures. Mrs Laing observed that there were one or two **'slack'** nurses in the accident and emergency department at PGI during her time there. She implied that they might have departed from the accepted procedures on occasion. Mrs Iris Lightowler, ward sister, Ward 2, until about July 1971, acknowledged in her witness statement that it was possible that a newly qualified nurse, in awe of a doctor, might have handed over the keys to him/her. She said that she was **'100% sure'** that this would have happened, although she could not recall any specific occasion when it had.
- 4.20 Mrs Margaret Calvert, night sister on the paediatric wards in the early 1970s, did not remember a doctor ever asking her for the keys to the controlled drugs cupboard. However, she said that, if she had been very busy and a doctor had asked her for the keys, she would probably have given them to him/her. She said that she would have taken the view that the doctor **'had as much right to the keys'** as she herself did and she would have trusted the doctor concerned. Mrs Jacqueline Hart (formerly Miss Jacqueline Cremin), who was a SRN on the paediatric wards from about October 1972 until 1973, said that doctors were trusted implicitly and it would not be uncommon on the paediatric wards for a nurse to give the keys to the controlled drugs cupboard to a doctor who would go and help him/herself to whatever was required and would then administer the drug. She observed that some drugs (she gave the example of pethidine) would have had to be

checked by another qualified member of staff. Dr Kounis expressed the view that Shipman could have obtained drugs from the controlled drugs cupboard on a ward had he wished to do so. He said that the nurses liked Shipman and looked up to him; it was Dr Kounis' view that Shipman could have manipulated them to allow him to have whatever he wanted.

- 4.21 It is clear from the evidence that it might have been possible, on occasion, for Shipman to have gained access to the controlled drugs cupboard on a ward. Whether he was able to do this would have depended on the personality of the senior nurse on duty at the relevant time. There is no doubt that some would have refused a request for access to the controlled drugs cupboard; however, there may well have been some who would have acceded to Shipman's request.
- 4.22 Obtaining controlled drugs in this way and taking those drugs for his own purposes would have been fraught with risk. Shipman's request might have been refused. It might have been reported to others. The mere fact that he had made the request might have damaged his reputation in the eyes of the nurse to whom the request was made and of others. Moreover, any discrepancy between the stocks of controlled drugs contained in the controlled drugs cupboard and the entries in the CDR would have been revealed the next time a check was carried out and would have been likely to result in an investigation. That investigation might have linked the missing drugs to the fact that Shipman had had access to the cupboard. Even if Shipman had succeeded in obtaining drugs in this way on the odd occasion, repetition of this behaviour was liable to lead to detection. For that reason, I regard it as unlikely that Shipman used this method of obtaining controlled drugs with any frequency, if at all.
- 4.23 It seems to me that, if Shipman wished to kill a patient at PGI, he would have been unlikely to seek to obtain a controlled drug for that purpose. The risks of so doing would be substantial and, as I shall shortly explain, there were other drugs which were more readily available.

## Non-Controlled Drugs

- 4.24 Many witnesses made the point that, whereas the procedures for storing and handling controlled drugs would have made it very difficult for a doctor to obtain such drugs undetected, it would have been comparatively easy for a doctor to obtain non-controlled drugs, some of which could have been just as lethal as controlled drugs if administered inappropriately.

### Obtaining Supplies of Non-Controlled Drugs

- 4.25 Non-controlled drugs were ordered on ordinary stock requisition forms and there were no special procedures for monitoring their use or checking on stocks held on the wards.

### Arrangements for Storing Non-Controlled Drugs

- 4.26 The arrangements for storing non-controlled drugs depended on the drug concerned and on the requirements of the ward. Most non-controlled drugs, whether injectable or for oral administration, were kept in locked cupboards, either on the wards or in the treatment

rooms attached to the wards. The keys to such cupboards were usually kept hanging in the sister's room. Some non-controlled drugs (mainly drugs for oral administration) were contained in locked medicine trolleys which were kept chained to a fixed object in some part of the ward, ready for use on the regular medicine rounds. In addition, Ward 2 had an emergency 'crash trolley', which was kept in the coronary care unit. This trolley (which, according to Mrs Lightowler, might have been kept unlocked) contained drugs such as atropine, lignocaine, adrenaline, potassium chloride and intravenous fluids, for use when resuscitating patients who went into cardiac arrest. Certain drugs, including insulin, were kept in refrigerators in the treatment rooms.

- 4.27 The witnesses suggested that it would not have been unusual for a doctor to take the keys for the relevant drugs cupboard and to obtain the drugs required him/herself, without the intervention of a nurse. Mrs Lightowler said that, more often than not, the doctor would ask a nurse to obtain the drug for him/her. This would have happened on about 90% of occasions. However, on the remaining 10% of occasions, doctors would help themselves. There was no requirement for the obtaining of non-controlled drugs to be witnessed, nor for details of the drugs obtained to be recorded in any document. No checks of the stocks of non-controlled drugs were made on the wards with a view to detecting discrepancies. If a doctor were to obtain more of a non-controlled drug than was required to meet the needs of an individual patient being treated, this would not have been detected.

#### **Non-Controlled Drugs Commonly Used at the Hospital**

- 4.28 Various types of non-controlled drugs which were used on the wards would have been capable of being used to kill or to hasten death. When considering the appropriate dosage of each drug and its likely effects, it is worth noting that the British National Formulary (BNF) for 1974–76 (the earliest edition in the Inquiry's possession) carried the following warning:

##### **'PRESCRIBING FOR THE ELDERLY**

**It is a convention that the standard advice on the choice and dosage of drugs applies to adults and that modifications have to be made for children. But it is sometimes forgotten that the elderly are also in a special case, with the result that they may get drugs that do them no good, or which are harmful or even dangerous.'**

#### ***Potassium Chloride***

- 4.29 Potassium chloride was used on the medical wards in two forms. The tablet form (known as 'Slow-K') was given routinely when a patient was prescribed a diuretic. The purpose was to replace the potassium lost from the body consequent upon diuretic therapy. In addition, injectable potassium chloride was available. Ampoules of potassium chloride were kept on the 'crash trolley' for emergency use. Supplies of injectable potassium chloride were also kept in the treatment rooms on each ward. The medical staff would administer potassium chloride by adding an appropriate quantity of the drug to sodium chloride (saline) and dextrose solutions being given through a drip by means of slow

intravenous infusion. It was necessary to take care when doing this, since an overdose of potassium could give rise to a high plasma potassium, which was toxic. Mr Barker said that potassium chloride was potentially a very dangerous drug. It had to be diluted before use and, if a mistake was made and an overdose was given intravenously, this could cause cardiac dysrhythmia and a fatal cardiac arrest. The efficacy of potassium as a rapid and reliable means of causing death is demonstrated by the fact that it is one of the drugs used in executions by means of lethal injection.

- 4.30 As well as the risk of inadvertent overdose, there was the additional risk in the hospital setting of confusing potassium with sodium chloride. The two drugs were frequently kept side by side in hospitals and could readily be mistaken one for the other. Sodium chloride was routinely injected intravenously to clear a blocked vein and to flush drugs out of the tubing through which they were being injected. If potassium chloride were used for this purpose by mistake, this would invariably prove fatal. In recent years, the risks associated with the use of potassium chloride in hospital have become well recognised. A significant number of fatal errors resulting from its administration have occurred, as a result of which the practice of making the drug freely available to medical staff in hospital has been discontinued.
- 4.31 If, in the 1970s, a doctor had been intent upon administering a lethal drug, potassium would have been an obvious candidate. An overdose could have been injected intravenously and would have induced cardiac arrest rapidly and fatally and could not have been detected on post-mortem examination or in any toxicological analysis.

### ***Digoxin***

- 4.32 Digoxin is one of a group of drugs known as cardiac glycosides, which have specific effects on the heart muscle. Digoxin has the effect of increasing the power of contraction of the heart and of slowing the heart rate. In the 1970s, it was in common use for cases of heart failure and for certain types of heart arrhythmias, especially atrial fibrillation. The onset of effect of digoxin on the heart rate and the power of contraction of the heart, if taken orally, is between thirty minutes and two hours, with the peak effect occurring within two to six hours. If injected intravenously, the onset of effect is more rapid, being reduced to between five and thirty minutes, with the peak effect occurring between one and four hours after administration.
- 4.33 Digoxin comes in tablet and injectable form. Ideally, it should only be used by injection when the drug cannot be taken orally or when there is a need for a rapid effect. It is quite painful when given intramuscularly and should therefore be given intravenously. The BNF for 1974–76 recommended that digoxin should be given by means of intramuscular or slow intravenous injection. A slow intravenous injection would, in the early 1970s, have been administered by means of a syringe over a period of two or three minutes. An injection of digoxin given too rapidly can cause constriction of the blood vessels in the body and those supplying the heart and may result in undesirable clinical effects, such as chest pain. Nowadays, digoxin would be given by means of a drip or syringe driver over a longer period.



- 4.34 Mr Barker said that there was not a large margin between a therapeutic dose of digoxin and a toxic dose, so that care had to be taken when administering the drug. The dose for an adult recommended by the BNF for 1974–76 was 0.5–1mg. The BNF highlighted the risk of toxic accumulation of the drug in the body. Because of that risk, the BNF advised that small doses of the drug only were required for the elderly and children. High doses of digoxin can produce a variety of disturbances to cardiac rhythm, including heart block or fatal ventricular fibrillation. The giving of more than 10mg digoxin intravenously to a previously healthy adult (less in the case of an elderly or frail adult) is likely to result in cardiac arrest and death.

### **Largactil**

- 4.35 In the First Report, I referred briefly to Largactil, the proprietary name for chlorpromazine. The Inquiry received advice about its properties from Dr John Grenville (a general practitioner (GP)), from Professor Henry McQuay (Professor of Pain Relief, University of Oxford and Honorary Consultant, Oxford Pain Relief Unit) and from Professor Kevin Park (Professor of Pharmacology, University of Liverpool). Chlorpromazine is an anti-psychotic or neuroleptic drug, which can be used to manage agitated states in the elderly. Mr Barker told the Inquiry that Largactil was used at PGI to sedate patients, particularly disturbed geriatric patients and patients with psychiatric conditions. Largactil could be given in the form of tablets, elixir or injection. Mrs Calverley said that it was **'very rarely used'** on the medical wards; it was given to those patients who were disturbed or restless. The BNF for 1974–76 advised that small doses (25mg) were adequate when treating an elderly person in an agitated state. It went on to say that, in the emergency treatment of acute mania, a single injection of 100mg (less in the elderly) might bring the patient under control for the purposes of removal to hospital. The drug should be given by deep intramuscular injection to avoid irritation on administration.
- 4.36 A dose of 100mg Largactil would not be a lethal dose, even for an elderly person, but it could contribute to a patient's death. The mechanism would be by depression of the respiration or of the protective cough reflex of a frail person. This would be especially likely if the person already had a chest infection or a history of chronic obstructive pulmonary disease. Depending on the circumstances of the individual and the dosage given, death might ensue by this indirect mechanism after anything between a small number of hours and several days. The patient would go into a deep sleep quite soon after receiving the injection, a sleep from which s/he might well not wake, since death could follow as an indirect result of the injection.

### **Aminophylline**

- 4.37 Aminophylline belongs to a class of drugs known as xanthine bronchodilators. It was widely used in the 1970s and 1980s as a first line of treatment for severe acute asthma or bronchospasm. Aminophylline was, according to Mrs Calverley, **'standard treatment'** on the medical wards for patients suffering from acute left ventricular failure, asthma and various other chest conditions. It was administered by means of intravenous injection

(in which case a doctor would administer it) or as a suppository (in which case it would be administered by a nurse). The BNF for 1974–76 recommended a dose of 250–500mg by slow intravenous injection, repeated within 30 minutes.

- 4.38 Dr Aneez Esmail, Medical Advisor to the Inquiry, has advised me that an overdose of aminophylline or a dose given intravenously too rapidly could result in a severe arrhythmia of the heart, which could have the effect of causing or hastening death. Dr Grenville said that, if cardiac effects ensued, the patient would go into cardiac arrest **‘on the end of the needle’**. However, the occurrence of such arrhythmia and cardiac arrest would be unpredictable. The effect of an overdose might be to produce other symptoms which would not be life-threatening. Dr Esmail’s view, therefore, is that aminophylline is unlikely to have been used deliberately to induce death. It is possible, however, that, on occasion, Shipman might have administered the drug quickly, being reckless as to whether or not it caused cardiac arrest.

### **Valium**

- 4.39 Valium, the proprietary name for diazepam, is a benzodiazepine, which was used at PGI as a night sedative. Valium was available in tablet and injectable form. The BNF for 1974–76 recommended a dosage of 10mg, repeated if necessary at not less than four-hourly intervals, by intramuscular or slow intravenous injection.
- 4.40 The BNF for 1974–76 also described the benzodiazepines as **‘relatively safe drugs’** (this was before their addictive properties were recognised) and observed that overdosage produced **‘only progressive sedation without unexpected effects’**. However, Professor Richard Baker had advised the Inquiry that Valium can cause respiratory depression, especially when administered intravenously. If given intravenously in a large dose to a patient in a frail state, Valium could have the effect of causing or hastening death. Even if given intramuscularly, it can, according to Professor Baker, produce prolonged unconsciousness, thereby increasing the risk of death due to bronchopneumonia or venous thrombosis.

### **Shipman’s Use of Non-Controlled Drugs**

- 4.41 I have already said that, if Shipman wished to kill patients while at PGI, it seems unlikely that he would have used a controlled drug. The storage of controlled drugs was closely regulated and their use carefully monitored. It would not have been easy for Shipman to accumulate a supply of his own, as he was to do later, while working in Hyde. It seems to me to be far more likely that, if Shipman wanted to kill a patient at PGI, he would have used a non-controlled drug, which would have been readily available and the use of which was not monitored in any way.
- 4.42 The most certain way of killing a patient would have been for Shipman to have given an intravenous injection of a concentrated solution of potassium chloride. This would bring about rapid cardiac arrest and death. Potassium chloride was readily available and in general use on the wards. If Shipman was determined to kill a patient, that would be the method of choice. However, as I shall discuss in Chapter Seven, it is possible that, at this

early stage of his career, Shipman was more interested in experimenting with drugs, being reckless as to whether the patient lived or died. There are several drugs that would have been potentially lethal, especially when administered to the seriously ill patients resident on the medical wards. It is quite possible that Shipman experimented with such drugs, testing the effect of a dose greater than the recommended amount or the effect of rapid administration of a drug which should be given slowly. These potentially dangerous drugs included aminophylline, digoxin and drugs such as Largactil or Valium. All of these were in general use on the medical wards and their use would not have excited suspicion.

### Shipman's Abuse of Pethidine

- 4.43 The fact that Shipman began to obtain pethidine so soon (within six weeks) after his arrival in Todmorden on 1<sup>st</sup> March 1974 raised the obvious possibility that he had acquired the habit of taking the drug while he was at PGI, possibly when working as a senior house officer (SHO) in the obstetrics unit, where the drug was widely used for the relief of the pain suffered by women in labour. In the First Report, I reviewed the evidence then available and concluded that it was quite possible that Shipman was able to obtain pethidine illicitly while at PGI, just as he was able to do subsequently in Todmorden.
- 4.44 Having examined the additional evidence now available, I remain of the same view. I believe that it is likely, as I suggested previously, that Shipman developed his dependence on pethidine while working in the obstetrics unit. Dr Narendra Saikia, registrar in obstetrics and gynaecology at the time, told the Inquiry that pethidine was usually administered intramuscularly by nurses. However, doctors would also administer it on occasion. Dr Anthony Baboolal, SHO in obstetrics and gynaecology at the same time as Shipman, said that the obstetrics unit was very busy. He went on to say that, if Shipman had offered to administer an intramuscular injection of pethidine himself, instead of leaving a nurse to administer it, the nursing staff would have been grateful to him and would have regarded this as **'Fred being helpful as usual'**. Dr Baboolal suggested that it would have been possible for Shipman to have prescribed larger doses than were strictly necessary and to administer part and keep the excess for himself. Several other witnesses made the same suggestion. As I observed in the First Report, this method of obtaining the drug would have been similar to one of the ways in which Shipman obtained opiates later, while he was practising in Todmorden and Hyde. I think it is highly likely that this was the method which he used in Pontefract in order to obtain pethidine for his own consumption. It would not have resulted in any apparent discrepancy between the stocks of pethidine held in the controlled drugs cupboard and the entries in the relevant CDR. The fact that the doses prescribed by Shipman were higher than were actually required would not necessarily have been questioned. Doctors in the obstetrics unit tended to work alone, rather than in teams. Also, at the time Shipman worked there, the obstetrics unit was newly opened. No 'track record' would then have been established for the 'usual' amount of pethidine used on each ward there week by week or month by month.
- 4.45 Obstetrics and gynaecology was Shipman's last placement at PGI. He moved from there directly to Todmorden, where, as I have said, he was very soon obtaining large quantities of pethidine for his own consumption. No one at PGI detected the fact that Shipman was

or might have been taking drugs. The fact that no abnormality in Shipman's behaviour was noted during his time at PGI is not surprising; after all, the fact that he was consuming large quantities of pethidine while working in Todmorden also went unnoticed by his partners and others for more than a year before his eventual detection.

## CHAPTER FIVE

### Deaths at the Hospital and Death and Cremation Certification

#### Introduction

- 5.1 In this Chapter, I shall discuss the arrangements in place at Pontefract General Infirmary (PGI) for caring for patients who were close to death and for handling deaths when they occurred. I shall also examine the evidence about the way in which death and cremation certification was carried out at the hospital.
- 5.2 The majority of deaths that occurred at PGI (leaving aside those that occurred or were confirmed in the accident and emergency department, about which the Inquiry has little information) took place on the two adult medical wards. A significant number of deaths also occurred on the surgical wards. Deaths on the other wards were far less common.

#### The Care of Patients Who Were Close to Death

- 5.3 Many deaths that occurred on the medical wards were expected and were preceded by a gradual deterioration in the patient's condition. When a patient became seriously ill and was obviously near death, s/he would often be transferred into one of the cubicles on Wards 1 or 2. Mrs Iris Lightowler, ward sister, Ward 2, until July 1971, said that it was not her practice to use the cubicles to accommodate seriously ill and dying patients. She preferred to keep such patients in the main areas of the ward, provided that this did not cause distress to other patients. However, her successor, Mrs Anne Calverley (formerly Miss Anne Paley), who was the ward sister on Ward 2 throughout Shipman's second six-month period on the medical wards, told the Inquiry that, as a general rule, critically ill patients were nursed in the cubicles. It seems that this was also the practice on Ward 1 during both of the six-month periods Shipman spent on the medical wards.
- 5.4 If a patient was known to be dying, the medical staff attached to the ward would be involved in prescribing or administering appropriate pain relief but they would not necessarily be in constant attendance on the patient. It might have been evident that there was nothing more that the medical staff could do. The Inquiry was told that, in those circumstances, the nursing staff would give whatever care and comfort was needed. They would not always have time to stay with the patient continuously but would check on the patient at regular intervals. Sometimes, a member or members of the nursing staff would be present when the patient died. If a patient was known to be dying, his/her relatives would usually be informed and might well be with him/her at the time of death. On occasion, a patient would die alone and would be found dead, usually by a member of the nursing staff.
- 5.5 Sometimes, a patient's condition would deteriorate unexpectedly or there would be a sudden emergency whereby, for example, the patient went into cardiac arrest. In the event of a sudden deterioration, the nursing staff would summon a doctor to assess the patient and to administer any necessary treatment. The nurse in charge of the ward would arrange for the junior doctor (a house officer (HO) or senior house officer (SHO)) on call to be 'bleeped' by the hospital switchboard. If, when s/he arrived, the doctor needed

advice or assistance, s/he would summon a SHO (if it was a HO who was called first) or registrar. The Inquiry was told that, when a doctor arrived on the ward, the practice was for the nurse who had summoned him/her or another nurse (sometimes more than one nurse) to accompany the doctor to the patient's bed and to stay with the doctor to give any necessary assistance. Both the medical and nursing staff agreed that it would have been very unusual for a doctor who had been called out in those circumstances to be left alone with a patient, except for a short time if the nurse went to fetch something or was momentarily called away.

- 5.6 The Inquiry was also told that, if a patient's condition deteriorated unexpectedly and, s/he became seriously ill, the senior nurse on duty would attempt to contact the patient's relatives. If contact could not be established, the system was that the police would be informed and they would attempt to contact the relatives. The evidence was that family members would often be with a patient at the time of death, although the review of cremation certificates undertaken by Professor Richard Baker, which I describe in Chapter Six (and which included cremation certificates completed by doctors other than Shipman), suggests that relatives were present at 20% of deaths at most – probably fewer. It may be that family members were present at the time of death more frequently than this and that the doctors completing Form B failed to include this information. Alternatively, it may be that family members were not kept as well informed as the Inquiry has been told. Certainly, the Inquiry has examined some cases where it appears that members of the family were not notified of the fact that a death was imminent, even though there would appear to have been sufficient time for this to be done. However, even if no family member was present at death, it is likely that a member of the nursing staff would be in attendance. The evidence was that it would be most unlikely that a doctor would be present alone when a patient died.
- 5.7 When a patient went into cardiac arrest, resuscitation might be attempted. Resuscitation was not considered appropriate in all cases, whether or not it was attempted depended on the patient's age, the condition(s) from which s/he was suffering and his/her prospects of recovery. When resuscitation was attempted, there would often not be time to take steps to summon the patient's family until the emergency was over. The 'crash team', consisting of doctors and nurses, would be concentrating their efforts on saving the patient's life.
- 5.8 Mrs Margaret Calvert, formerly night sister, Hydes Medical Ward, told the Inquiry that, if the condition of a child deteriorated, a doctor would be called. At least one nurse would stay with the doctor and the child. She said that, if the child took a serious turn for the worse or his/her condition was found to be more serious than had initially been thought, his/her parents would be contacted immediately. Mrs Calvert had no recollection of any occasion when a doctor was alone at the death of a child and could not envisage the circumstances in which this could have happened. She said that, if a doctor had come to tell a nurse that a patient had died in his/her presence alone, that would have been '**glaringly unusual**' and would have '**warranted an explanation**'. Miss Ann Ward, ward sister, Hydes Medical Ward, considered that a doctor could have been alone at a child's death if the parents were not there for some reason and if the ward was short-staffed and the nurse who had been caring for the child was called away. However, she acknowledged that this would have been unusual. I think it would have been very unusual, if indeed it ever happened.

- 5.9 I shall return to the issue of presence at death later in this Chapter and elsewhere in this Report.

## Death Certification

### Confirming the Fact of Death

- 5.10 When it appeared that a patient had died, the first step to be taken by the nursing staff was to obtain confirmation that the patient was indeed dead. In the 1970s, in a hospital setting, such confirmation would invariably be provided by a doctor. If a doctor was present on the ward, s/he would be asked to confirm the fact of death. If no doctor was present, the senior nurse on duty on the relevant ward would summon the junior doctor on call. The doctor would confirm (if such was the case) that the patient was indeed dead and would record the fact of death (and, where known, the cause of death) in the patient's clinical notes. The nursing staff would then prepare the body for transfer to the hospital mortuary, to where it would be removed within a short time. Meanwhile, the patient's medical and other records would be sent to the hospital medical records office ('records office'). It was the records office that had the responsibility for making the necessary arrangements for certification of the cause of death and, if necessary, for the completion of the additional certificates needed for the purpose of cremation.
- 5.11 I have described the system of death certification fully in my Third Report. For the purposes of this Report, I shall summarise the system very briefly. The same system was in operation in the early 1970s as now.
- 5.12 Before a death can be registered, the cause of death must be certified by a doctor or, after a post-mortem examination and/or inquest, by the coroner. Apart from cases in which an inquest has been opened and the coroner has given specific authorisation, it is only when the cause of death has been certified and the death has been registered that burial or cremation of the body can take place. The first question to be determined after a death, therefore, is whether the cause of the death can properly be certified by a doctor, or whether the death should be reported to the coroner. The doctor who certifies the cause of death should be a doctor who has attended the deceased during his/her last illness. In a hospital setting such as PGI, the doctor would be a member of the medical team on the ward on which the patient had been treated. In practice, at PGI, the cause of death was usually certified by the doctor who was recorded in the clinical notes as having confirmed the fact of death.

### A Report to the Coroner

- 5.13 There are a number of circumstances where a statutory requirement to report a death to the coroner arises. These include deaths where there is reason to believe that the death was unnatural or caused by violence or neglect, or where the death appears to have occurred during an operation or before recovery from the effects of an anaesthetic, or where the cause of death is unknown. The law places the requirement to report a death falling within these categories on the registrar of births and deaths. In practice, however, the report to the coroner will usually be made by a doctor who has been involved in the

care of the deceased person. In this way, the coroner becomes involved earlier in the process and the family of the deceased person does not suffer the disappointment and delay consequent on attending the register office to register the death only to be told that the death cannot be registered but must instead be referred to the coroner.

- 5.14 In addition to the statutory circumstances which require a death to be reported to the coroner, there are frequently 'local rules' about reporting, which are laid down by coroners in different areas. One common 'local rule' provides that all deaths which occur within 24 hours of admission to hospital should be reported. The Inquiry has been told that this rule was in operation in Pontefract in the early 1970s. As I shall explain, there is reason to believe that Shipman did not always comply with it.
- 5.15 Dr John Turner, consultant physician on the medical wards in the 1970s, told the Inquiry that, if a death occurred within 24 hours of admission to PGI, a junior doctor would consult the coroner's officer in order to ascertain whether the coroner would permit the doctor to certify the cause of death. Dr Turner said that, if the coroner was happy with the history and clinical findings as related by the doctor, s/he would generally give permission for the doctor to certify the cause of death. If the patient was well known to his/her general practitioner (GP) and had been seen by the GP within 14 days before the death, the GP would be allowed to certify the cause of death. Otherwise, the coroner would direct a post-mortem examination and would certify the death, either after the post-mortem examination or following an inquest.
- 5.16 It does not appear, from what Dr Turner said, that the consultant in charge of the patient would necessarily play any part in the decision whether to report the death to the coroner or, if a case was reported, in any subsequent discussions with the coroner's officer. The Inquiry has not been told of any process by which the decisions of junior doctors about whether or not to report a death to the coroner were overseen or reviewed by a senior member of the medical staff or any other person at PGI. That does not surprise me. During Phase Two, Stage Two, I heard evidence that – even now – certification of the cause of deaths occurring in hospital is usually done by junior doctors and is often of poor quality. I was told about a number of cases which should obviously have been reported to the coroner by the junior hospital doctors who certified the cause of death, but were not. It was clear in such cases that there had been no supervision of the certification process by senior members of the medical team.
- 5.17 Post-mortem examinations would sometimes be conducted, usually at the instigation of the consultant under whose care the patient had been admitted. The purpose of such an examination (which is often known as a 'hospital post-mortem examination') would be to ascertain or confirm the clinical diagnosis of the cause of death, or for the purposes of research.

### **Completing the Medical Certificate of Cause of Death**

- 5.18 If the death did not come within any of the categories of death which had to be reported to the coroner (or if the coroner gave permission to certify) and if the doctor was confident that s/he could identify the cause of death, s/he would go on to complete the Medical Certificate of Cause of Death (MCCD). The MCCD requires the certifying doctor to give



only a limited amount of information, including the deceased person's name, age and date of death, together with the place of death, the date on which the certifying doctor last saw the deceased person alive and the cause of death. MCCDs are contained in books resembling large cheque books. Once the certificate has been completed, it is torn out of the book and given to the family of the deceased person to take to the register office. The certifying doctor completes the counterfoil, which remains in the book as a record of the certification. One witness suggested that the nursing staff would be responsible for collecting certificates from the records office and giving them to doctors for signing, but it seems likely that, on most occasions at least, MCCDs were signed in the records office and the nursing staff took no part in the process.

## Cremation Certification

### The System Generally

- 5.19 In my Third Report, I described in detail the system of cremation certification. The system was originally designed to prevent the concealment of crime by irrevocable disposal of a body where the death had been caused by violence or poisoning. Briefly, an application to cremate is made on Form A, which is usually completed by the deceased's closest relative or executor. The application to cremate must be accompanied by two medical certificates, the certificate of medical attendant (Form B) and the confirmatory certificate (Form C). These forms are examined by the medical referee at the crematorium; the post of medical referee is part-time and is usually held by a retired or practising GP or a doctor holding a position in public health. If satisfied with the contents of Forms A, B and C, the medical referee will sign Form F, giving authority to cremate. If the medical referee is not satisfied, s/he may order a post-mortem examination, refer the case to a coroner or decline to authorise the cremation.
- 5.20 Form B must be completed by a doctor who has attended the deceased person before death and has seen and identified the body after death. Form B asks a number of questions about the circumstances and cause of the death and the involvement of the certifying doctor in the deceased's care before death. Form B is usually completed by the doctor who issued the MCCD.
- 5.21 Form C must be completed by a doctor who has been registered in this country for not less than five years and who is independent of the deceased and of the doctor who signed Form B. The role of the doctor completing Form C is to provide independent confirmation, if s/he thinks fit, of the cause of death given by the Form B doctor and of the fact that the circumstances of the death were not such that it should be reported to the coroner. Before providing the necessary confirmation, the doctor completing Form C should view the body of the deceased and **'carefully examine'** it externally and should see and question the Form B doctor (although, in practice, many Form C doctors speak to the Form B doctor by telephone). He or she must declare on Form C that s/he has taken these steps. Form C also asks whether the doctor completing the form has seen and questioned any other person – another doctor (i.e. not the doctor who completed Form B), a person who nursed the deceased or who was present at the death, a relative of the deceased or anyone else – about the death. When the system of cremation certification was originally devised, the

obtaining of evidence from a source separate and independent from the Form B doctor was an important element of the system. It was intended to deter or detect wrongdoing on the part of the Form B doctor. I described in my Third Report how, over the years, the significance of this cross-check by the Form C doctor was forgotten and it became common for doctors completing Form C to question no one but the Form B doctor (and, sometimes, not even him/her). In effect, a Form C became little more than a 'rubber stamp'.

- 5.22 The Brodrick Committee, which examined, *inter alia*, the operation of the systems of death and cremation certification and which reported in 1971, recognised that Form C doctors were not carrying out the cross-checks which had been intended. The Committee concluded as a result that Form C was valueless and should be abolished. In the event, this was not done and the system remains unchanged more than 30 years later. In the early 1970s, there was no requirement imposed by the medical referees at crematoria in most areas of England and Wales that the doctors completing Form C should speak to anyone other than the Form B doctor in order for the cremation to be authorised. In a few areas, however, medical referees would not authorise cremation unless they were satisfied, from the answers on Form C, that the Form C doctor had spoken about the death to a person other than the Form B doctor. There was no such requirement at the Pontefract Crematorium.

### **The Operation of the System at Pontefract General Infirmary**

- 5.23 As with death certification, cremation certification relating to deaths of patients at PGI was organised by the records office. When it was known that a deceased patient was to be cremated, the doctor who had completed the MCCD would be summoned to the office in order to complete Form B. Completion of Form B carried a payment and was considered a 'perk' by junior doctors. Some hospitals had an arrangement whereby the fees for completing cremation forms were shared between the medical staff. PGI had no such arrangement, as a result of which the completion of a Form B brought with it a direct financial benefit to the individual doctor concerned.
- 5.24 Completion of Form C also attracted a payment. It does not appear that the Form B doctor had any 'say' about who should complete Form C. The records office would make all the necessary arrangements. As I have already explained, the Form C doctor had to be a doctor from a different medical team from that responsible for the deceased patient's care, and had to have been registered in the UK for not less than five years. During Shipman's time at PGI, Forms C were usually completed by doctors of registrar or similar status or (generally if there had been a hospital post-mortem examination) by a consultant pathologist.

### **Shipman's Forms B**

#### ***Presence at Death***

- 5.25 In Chapter Six, I refer to Professor Baker's findings of differences between features of Forms B completed by Shipman and those completed by other doctors at PGI. One important difference was the frequency with which, in response to the question on Form

B asking **'Who were the persons (if any) present at death?'**, Shipman answered **'self'**, thus suggesting that he alone had been present at the death. This difference was particularly worrying since, when Shipman was a GP in Hyde, he frequently suggested on Form B that he had been alone at a death when he had indeed been present alone and had caused the death. The presence of a GP at the death of one of his/her patients in the community is a most unusual occurrence. In hospital, with the greater proximity of doctors (especially junior doctors) to their patients, it is not quite so unusual. What is very uncommon, even in hospital, is for a patient to die in the presence of a doctor alone. Yet, out of the 66 Forms B completed by Shipman during his time at PGI, he claimed that this had occurred no fewer than 20 times.

- 5.26 Most of the witnesses observed that, if Shipman had indeed been present alone at the deaths of so many patients, that would have been highly unusual. Dr Charles Cook, who was a house officer on the medical wards between August 1971 and February 1972, said that it did not **'sound right'**. He said that **'at least one member of the nursing staff would always be with a doctor when a patient died, except for those sad occasions when the patient died alone'**. Dr Russell Cross, who trained with Shipman at Leeds University for two years and started at PGI in February 1972, said that it was **'not feasible'** that Shipman should have been alone with so many patients when they died. He pointed out that doctors attending upon a deteriorating patient would have been called back onto the ward by a nurse, who would stay with the doctor to administer treatment or comfort to the patient.
- 5.27 Dr Cross proffered an alternative explanation for Shipman's unusual response to the question on Form B. He suggested that, in fact, nurses would have been present with Shipman at the deaths, but that, by the time Shipman came to complete Form B, a day or two after the death, he might have forgotten the identity of the nurse or nurses who had been present. He could have made enquiries to find out their identities but, Shipman being somewhat arrogant, Dr Cross suggested that he might have decided that his own presence was sufficient and just put the word **'self'** on the form. When asked for their response to this suggestion, a number of other witnesses agreed that Shipman might well have done this.
- 5.28 Dr Brian Gallagher, surgical registrar during Shipman's time on the surgical wards, said that he would occasionally write **'self'** in response to the question about presence at the time of death even when other persons had been present. He said that he would not have seen the point of writing down the names of everyone who had been present at the death. He thought that he interpreted the question as **'just requiring the doctor to state the name of someone who had been present at the time the patient died'**. He thought that approach would have been **'quite common'**. However, it cannot have been very common, as Professor Baker's analysis showed that Shipman recorded only himself as having been present at death much more frequently than did other doctors.
- 5.29 An examination of Shipman's Forms B reveals that, sometimes, when he recorded that he had been present at a death, he recorded that a named member of the medical or nursing staff had also been present. At other times, he recorded that **'self and night staff'**, **'self and Staff Nurse'**, **'self and Sister'** or **'self and nurses'** were present. It might well be that,

on those occasions when he did not mention a person by name, Shipman did not recall the identity of the relevant person (or did not think it necessary to state their identity). However, it is clear that he did not always resolve this problem by writing merely **'self'**.

- 5.30 I shall deal with the issue of the degree of significance to be placed on Shipman's claims to have been present at death in Chapter Seven.

### ***Period of Attendance on Deceased Patient***

- 5.31 Form B contains a question asking whether the doctor completing the form attended the deceased during his/her last illness and, if so, for how long. Shipman seems to have treated the start of his 'attendance' on the deceased patient as the time when the patient came under the care of the medical team of which he was a member. I suspect that this would have been the usual approach. The start of the period of his attendance would therefore generally be the time when the patient was admitted to PGI.
- 5.32 On seven of the 66 Forms B that he completed, Shipman recorded that he had attended the deceased patient for less than 24 hours before death; this would mean that the patient had been admitted to PGI less than 24 hours before his/her death and that the death should therefore have been reported to the coroner, in accordance with the 'local rule' to which I have already referred. Six out of the seven deaths in question occurred in April and May 1972. In one of the seven cases, that of Mr John Brewster, Shipman wrote in the clinical notes **'no need to report to the coroner'**. The assertion that there was **'no need'** to report this death to the coroner was plainly unfounded. The death was sudden and there is contemporaneous documentary evidence suggesting that it occurred within about seven or eight hours of the patient's admission to hospital; Shipman claimed on Form B that he had been attending the patient for 18 hours prior to his death. It is clear that this was not so. Even if it had been, there would still have been an obligation to report the death.
- 5.33 Of the remaining six cases, relevant medical records are available in respect of only one, that of Mrs Agnes Scott. The evidence gathered by the Inquiry shows that the death occurred within about four hours of Mrs Scott's admission to hospital. Shipman said on Form B that he had been attending the patient for 12 hours. Despite the fact that, even on Shipman's account, the period was less than 24 hours, Shipman noted in the medical records **'not reported to coroner'**. No reason was given for the failure to report. In the other five cases in which Shipman recorded on Form B that he had attended the patient for less than 24 hours (and where no relevant medical records survive), it is possible that he had discussed the death with the coroner's office and had completed the MCCDs in those cases with the permission of the coroner. Unfortunately, the Inquiry has no way of knowing for certain. Form B requires the certifying doctor, if the MCCD was completed by authority of the coroner, to state this fact. No such statement appears on the Forms B in the cases in question. This would tend to suggest that Shipman had not in fact discussed those cases with the coroner, although I do not regard it as conclusive of the issue. However, in my view, it is highly unlikely that he reported those deaths to the coroner as he should have done.
- 5.34 In addition to the seven cases I have already mentioned, there are four other cases in which Shipman claimed on Form B that he had attended the deceased patient for 24 hours

before death, but where the witness evidence suggests that the period was much shorter than that. In those four cases, it seems likely that Shipman deliberately exaggerated the period for which he had been attending the patient in order to conceal the fact that the death should be reported to the coroner. All four deaths occurred in the period from March to May 1972. I shall discuss the possible significance of Shipman's actions in attempting to avoid reporting deaths to the coroner in Chapter Seven.

### **The Person by Whom the Patient Was Nursed**

- 5.35 One of the questions on Form B asks by whom the deceased person was nursed during his/her last illness. When answering that question, Shipman would often insert the name of the senior nursing sister on the ward, even if that sister had not been present on the ward at the time of the death and even though most of the patient's contact had been with other nurses. Mrs Kathleen Naylor (ward sister, Ward 1, during Shipman's two six-month periods on the medical wards) said that it **'would make sense'** for doctors to do this, as it would be the ward sister who communicated with them about the patients' conditions. Dr Jeremy Belk, a contemporary of Shipman, also usually named the ward sister on Form B as the person who had nursed the deceased patient. He said that he thought of the nursing staff as a single unit identified by their senior sister. It seems to me to be understandable that doctors should regard the senior sister on the ward as responsible for nursing a patient. Her name would be familiar to them and most of their dealings would have been with her. In any event, she was in charge of the nursing staff on the ward and would take ultimate responsibility for the patients there.

### **The Completion of Forms C**

- 5.36 During Shipman's time in Pontefract, he completed 66 Forms B. In 43 of those cases, the Form C was completed by Dr Rizvi Hasnain, resident surgical officer. In eight cases, the Form C was completed by Dr Surinder Ahuja, medical registrar. Nine doctors between them completed the remaining 15 Forms C.
- 5.37 The Inquiry has examined the position of Dr Hasnain, who, as I have explained, completed the Forms C in the majority of cases in which Shipman had completed the Form B. Dr Hasnain did not, of course, complete Forms C only in cases in which Shipman had been involved. In total, Dr Hasnain completed 109 Forms C between 1<sup>st</sup> February 1971 and the end of August 1973.
- 5.38 Dr Hasnain obtained his medical qualification in Pakistan in 1958. He entered practice in the UK in 1960 and worked on the surgical wards at two hospitals before being appointed as a resident surgical officer at PGI in 1968. He provided three witness statements to the Inquiry, in which he described his practice when completing Forms C. He said that he would be notified by the records office that there was a Form C for him to sign. He would then attend the office to collect the documentation, which would consist of the medical records of the deceased patient and cremation Forms B and C. Dr Hasnain said that he would look through the medical records. He said that he would also view the body. He would always speak to the doctor who had completed Form B, either in person or by telephone. He said that the conversation would be fairly general and would have involved

asking the Form B doctor to confirm what s/he had written on Form B. Dr Hasnain said that he would have taken the Form B doctor's word as he would have had no reason to suspect that s/he was not telling the truth. He did not know Shipman well. He said that Shipman struck him as a person who **'kept himself to himself'** and that Shipman was not particularly friendly towards him.

- 5.39 Dr Hasnain was asked about the number of deaths where Shipman had signed Form B and he had signed Form C. In the six months from 1<sup>st</sup> February 1972, Dr Hasnain signed 31 Forms C in cases where Shipman had completed Form B and 12 in cases where other doctors had done so. He was asked whether he had noticed that the number of deaths certified by Shipman during this period was unusually high. Dr Hasnain said that his only experience of working on a medical ward had been in the course of his training in Pakistan, which had been in the late 1950s. All his hospital experience in the UK had been in surgery. He believed (correctly) that the death rates on the medical wards would be significantly higher than on the surgical wards where he worked. Consequently, the fact that he dealt with a high number of cremations in the medical wards would not have surprised him. He pointed out that the death rates at PGI did fluctuate from time to time. Of course, Dr Hasnain did not become aware of all the deaths that occurred in the hospital or on the medical wards and would not, therefore, have known whether the number of cremation forms that he was signing was indicative of the overall death rate.
- 5.40 Dr Hasnain was also asked about the fact that, on 13 occasions during the six-month period from 1<sup>st</sup> February 1972, Shipman had recorded on Form B that only he had been present at the death. Dr Hasnain agreed with other witnesses who had said that it would be very unusual for a doctor to be present alone at a death. However, he said that he would not have interpreted literally Shipman's statement that only he had been present at a death. He would have assumed that, when Shipman said that he was present at a death, members of the nursing staff would have been present too. He would have attributed the fact that Shipman referred only to his own presence to a lack of accuracy on Shipman's part when filling in Forms B. Dr Hasnain cited as an example one of his own Forms B where he had recorded, in answer to the question about who was present at the death, that a member of nursing staff had been present. He had not mentioned in answer to that question that he himself had been present, although it was evident from his answer to another question that he had. He said that it was not his practice to provide an exhaustive list of everyone who had been present at a death and he would not have automatically assumed that other doctors would do so either.
- 5.41 Dr Hasnain completed Forms C in six of the seven cases in which Shipman had recorded on Form B that he had attended the patient for less than 24 hours prior to death. As I have said, Shipman's practice was to assume that his 'attendance' on the patient had started at the time when the patient came under the care of the medical team of which he was a member. Thus, if he recorded that he had attended the patient for less than 24 hours, that would have meant that the patient had been admitted to PGI less than 24 hours before death and the death should therefore have been reported to the coroner. Dr Hasnain was aware of the fact that such deaths should be reported. However, he explained to the Inquiry that, if he had become aware from the contents of a Form B that the death had occurred within 24 hours of a patient's admission to PGI, he would not have queried the

fact that the death did not appear to have been reported to the coroner. He said that he understood that it was the responsibility of the Form B doctor to decide whether the coroner needed to be involved. He did not see it as the role of the Form C doctor to check whether a case had been (or should have been) reported. If he had become aware from the entries on a Form B that the death had occurred within 24 hours of admission, he would have assumed that the patient was well known to the medical team which had been caring for him/her and that the cause of death had been satisfactorily ascertained so that there was no need for the coroner to be involved. Alternatively, he would have assumed that the Form B doctor had received authorisation from the coroner to issue the MCCD.

- 5.42 Dr Hasnain told the Inquiry that he might not even have picked up the fact that the death had occurred within 24 hours of admission to PGI. He said that time constraints sometimes prevented him from reading through Form B and the medical records in any great detail so that he might not have noticed the timings. Dr Hasnain added that, when he was asked to sign a Form C, he would have **'assumed that all was in order'**. He regarded it as his role to **'confirm what the Form B doctor had said'**. He said that it would never have occurred to him that Shipman might have completed Form B if he was not in a position properly to do so. Neither would it have occurred to him to check that this was the case.
- 5.43 I have already explained that the medical referees at the Pontefract Crematorium imposed no requirement that, if authority to cremate was to be given, a doctor completing Form C must indicate on the form that s/he had obtained information from a person independent of the Form B doctor. Some doctors who completed Forms C at PGI indicated on the form that they had made no enquiries of anyone other than the Form B doctor. Others invariably stated that they had spoken to a person or persons other than the Form B doctor. Dr Hasnain was one of the latter group. In most cases in which he completed a Form C (and in all those in which Shipman had completed the Form B), Dr Hasnain stated on the form that he had questioned the **'nursing staff'** on the ward on which the patient had died. In a few cases where other doctors had completed Form B, he named on Form C an individual member of the nursing staff to whom he had spoken.
- 5.44 Dr Hasnain told the Inquiry that, if Shipman (or, presumably, any other doctor) had named a member of staff as either having been present at the patient's death or having nursed the patient during his/her last illness, he would telephone the sister's office on the relevant ward and would ask to speak to the member of staff concerned. He would usually telephone rather than visit the ward in person. If the named member of staff was not available, he would have a **'general conversation'** with the sister and would check that the patient had indeed died on the ward. He said that he would **'verify when the death had occurred and whether anybody had been present'**. He said that the sister to whom he spoke was usually able to verify the information for him. He regarded it as sufficient to speak to the sister, since she was in charge of the nursing staff on the ward.
- 5.45 Members of the nursing staff were asked by the Inquiry about their experiences of being questioned about the circumstances of a death by a doctor at PGI for the purposes of the completion of Form C. None of them ever remembered this happening. Mrs Lightowler said that she did not remember having been asked such questions except when she worked at Ackton Hospital and the medical officer there, Dr Robert Forster, had done so.

She described him as a **'by-the-book doctor and very conscientious'**. Mrs Lightowler's successor on Ward 2, Mrs Calverley, said that she had never been approached by a Form C doctor about a patient's death. She explained that the requirement that the Form C doctor should find and speak to the nurse who had attended the deceased patient was **'just not practicable and too difficult to be complied with'**. She said that her experience was that doctors never attempted to comply with the requirement.

- 5.46 Members of the medical staff were asked about their experience of cremation certification. Dr Nicholas Kounis said that, on only one or two occasions when he had completed a Form B, had the Form C doctor contacted him to discuss the death; this was despite the fact that it was a requirement of the Pontefract Crematorium, if authority to cremate were to be given, that the Form C doctor should state on the form that s/he had questioned the Form B doctor. It seems, therefore, that some Form C doctors must have been claiming on the form that they had questioned the Form B doctor when they had not in fact done so. Dr Brian Gallagher, surgical registrar in 1970, said that, when completing a Form C relating to a death which had occurred in hospital, he would not have sought information from anyone other than the Form B doctor and that he would have indicated this when completing the form. He said that his approach would have been entirely different if the death had occurred in the community. In that event, it would have been **'inappropriate'** to complete Form C without questioning the person who had nursed or treated the patient during his/her last illness. He said that there would have been an **'assumption'** that hospital deaths did not require the same degree of checking. By contrast, Dr Forster described how he would question the member of the nursing staff named on Form B. He would ascertain that the nurse had personal experience of nursing the deceased patient and, if so, would go on to ask if the death was expected. If the answer was that the death was not expected, he would go on to make further enquiries. Dr Forster, who is now a medical referee, told the Inquiry that he doubted whether many Form C doctors bothered even to read through cremation Form B. He said that most Form C doctors were only interested in looking at the causes of death given on Form B and replicating them on Form C. That was the case in the early 1970s and he believes that the position has not changed much today.
- 5.47 Dr Hasnain was asked about the evidence of the nursing staff to the effect that they had no recollection of ever being questioned by a Form C doctor. He said that he was aware that there was no requirement that he should speak to a member of the nursing staff before completing Form C. However, he was adamant that he always did so. He said that he did not always manage to speak to the nurse named on Form B (although he tried to do so wherever possible), nor did he always speak face to face. He said that, if he could not speak to the named nurse, he would speak to the sister or staff nurse in charge of the ward **'to ascertain who else nursed the patient during his/her last illness'** and, as he put it, **'to satisfy myself accordingly'**.
- 5.48 It is evident that there is a conflict of evidence between Dr Hasnain, who says that he always spoke to a member of the nursing staff before completing a Form C, and the nursing staff, whose evidence is that they cannot recall ever being questioned by a Form C doctor. In fact, the conflict goes rather wider, since other Form C doctors (including Dr Ahuja) also stated on Forms C that they had questioned the nursing staff. I cannot



resolve that conflict of evidence on the basis of the documents alone, nor do I consider that it is necessary, for the purposes of this Report, for me to do so. It is clear to me that, if some Form C doctors at PGI did question members of the nursing staff, their questioning would have been of a very general nature. They would no doubt have wanted to confirm that the patient had been nursed on the ward and (possibly) the nature of his/her illness. However, they are unlikely to have asked any searching questions about the circumstances of the death such as would have been likely to have revealed any possible misconduct by Shipman. They would not have regarded it as the purpose of their discussion to check the details recorded on Form B or to discover details that might not have been recorded. Often, they would be speaking to a member of the nursing staff who would have no personal knowledge of the circumstances of the death and who would, therefore, be in no position to answer detailed questions even if such questions were asked. In those circumstances, the Form C doctor would glean little additional information as a result of such a discussion.

## Conclusions

- 5.49 Three conclusions emerge from this examination of the procedures of death and cremation certification at PGI.
- 5.50 First, the practice at PGI was for HOs and SHOs to undertake the completion of MCCDs without any supervision by more senior doctors. It appears that no one would have queried Shipman's decisions to certify a cause of death rather than to report it to the coroner. Nor would anyone have questioned the accuracy of the causes of death he certified. I am not critical of the senior medical staff at PGI because I believe that the practice at PGI was and still is standard practice in hospitals throughout the country.
- 5.51 Second, it appears from the evidence of the medical staff that, although most doctors at PGI took their duty of completing Form B seriously, there was no clarity of understanding as to the correct practice when doing so. Different doctors would complete parts of the form in different ways. Again, I am not critical of the staff at PGI because I am quite satisfied that, even today, there is no uniform understanding of what is required of the doctor who completes Form B. The effect is that any one who examines Shipman's Forms B is on very uncertain ground when considering what meaning can be attributed to his various statements.
- 5.52 Third, it is clear too that the standard of completion of Forms C at PGI was poor. It appears that the completion of Form C was, for most doctors, little more than the application of a 'rubber stamp'. In saying that, I do not intend to be critical of the individual doctors involved. It is quite clear to me, from evidence that I heard during Phase Two, Stage One (and indeed from that recorded in the Brodrick Report in 1971), that the approach to the completion of Forms C at PGI was entirely typical of that which prevailed generally. It is not the purpose of this Report to apportion blame or responsibility for that state of affairs. I have already dealt with those issues in the Third Report. However, the fact that the completion of Forms C at PGI was generally no more than the application of a

'rubber stamp' means that, when considering the evidence in any individual death, I cannot regard the contents of a Form C as constituting independent confirmation of the facts stated by Shipman on Form B. Accordingly, in the individual decisions for which cremation forms are available, I have identified the doctor who completed Form C and briefly summarised its contents. But I have regarded the contents as having no evidential value.

## CHAPTER SIX

### Review of Deaths at the Hospital by Professor Richard Baker

#### Introduction

- 6.1 The Inquiry requested Professor Richard Baker, Director, Clinical Governance Research and Development Unit, University of Leicester, to carry out a review of the deaths of patients at Pontefract General Infirmary (PGI) which had occurred during Shipman's time there. Professor Baker had previously conducted a clinical audit of Shipman's practice in Todmorden and Hyde, a full account of which appears in my First Report.
- 6.2 Professor Baker provided a report of the results of his review, dated July 2004, together with an addendum, dated December 2004, dealing with specific questions raised by the Inquiry. Both the report and the addendum are at Appendix A to this Report. Professor Baker also provided additional information relating to certain specific deaths and I have taken that information into account when considering those deaths.

#### Review of Medical Records

- 6.3 Professor Baker first reviewed the surviving medical records relating to patients whose cause of death had been certified by Shipman. Only 28 sets of records survived. Professor Baker considered the medical records in conjunction with the information contained in the copy entry in the register of deaths (the 'death certificate') in respect of each death and, in those cases where cremation forms (also known as cremation certificates) were available, the information on the cremation forms. In his report, Professor Baker emphasised the need for caution when considering the results of his review of the medical records. Clinical practice has changed greatly over the last 30 to 35 years. Professor Baker worked as a junior doctor in general hospitals in the mid-1970s, so felt reasonably well equipped to make an assessment based on the medical records. Nevertheless, he warned that there were considerable difficulties in making judgements about clinical decisions taken, and care given, so long ago.
- 6.4 Professor Baker also pointed out that, in many cases, the medical records were not complete. Copies of drug charts and nursing records were often not available. Moreover, it seemed clear to him that the medical staff did not always note their clinical findings or management decisions in patients' medical records. This would not have been unusual for the time. As a result, however, it was often not possible to gain a clear and coherent picture of a patient's care and progress during the period of his/her stay in PGI.
- 6.5 In six of the 28 sets of medical records, there was insufficient information to enable any assessment to be made. In 14 of the remaining cases, Professor Baker found no cause for concern on the basis of the medical records. In five cases, he found some cause for concern and, in three cases, cause for substantial concern. Professor Baker's detailed comments on the individual cases which he reviewed are set out in the Appendix to his report and I shall not rehearse them here. In general, however, cases about which Professor Baker expressed concern were those which exhibited features such as Shipman's presence at the time of death, a lack of information in the medical records

about the patient's deterioration before death or about attempts at resuscitation, a lack of corroboration in the nursing records of the details recorded by Shipman, the administration of drugs shortly before death, or the fact that a death was apparently sudden or unexpected or difficult readily to explain from the recorded history or clinical management. Professor Baker concluded that the cases which he had identified from the medical records as causing concern raised the possibility – particularly in view of what is now known of Shipman's subsequent criminal behaviour – that Shipman did unlawfully kill some patients during his time at PGI.

## Analysis of Death Certificates

- 6.6 Shipman was at PGI from 1<sup>st</sup> August 1970 until 28<sup>th</sup> February 1974. The Inquiry's investigation into deaths at PGI covered the five-year period from 1<sup>st</sup> August 1969 to 31<sup>st</sup> July 1974. During that time, 1637 Medical Certificates of Cause of Death (MCCDs) were issued in respect of deaths of patients at PGI. Most of those MCCDs were issued by doctors working at the hospital. A few were issued by the general practitioners (GPs) of the patients concerned; this would happen where the death had occurred within a short time of admission to hospital and the deceased patient had been attended by his/her GP recently before admission. In addition to the deaths in respect of which MCCDs were issued, there were 1045 deaths at PGI during the same period, the cause of which had been certified by the local coroner after a post-mortem examination and/or inquest. Professor Baker analysed the information contained in the entries in the registers of deaths ('death certificates') which had been issued on the basis of the information contained in the 1637 MCCDs.
- 6.7 I have already described in Chapter Two how junior doctors rotated between posts in different specialties within the hospital. Usually, each placement was for a period of six months. In general, the dates when junior doctors moved from one placement to another were 1<sup>st</sup> February and 1<sup>st</sup> August each year. Professor Baker started by examining the number of MCCDs completed by Shipman and by other doctors within each six-month period over the five years under examination, starting on 1<sup>st</sup> August 1969. That exercise revealed that, during his two six-month periods working on the two adult medical wards, Shipman issued a total of 99 MCCDs in respect of deaths occurring at PGI, 23 in the first period (between February and July 1971, when he was a house officer (HO)), and 76 in the second period (between February and July 1972, when he was a senior house officer (SHO)). During his other placements, covering a period of 31 months in all, he certified the cause of a total of 28 deaths at PGI. The proportions of male and female deaths in respect of which Shipman issued a MCCD (51.2% male, 48.8% female) was not significantly different from that certified by other doctors.

### Deaths on the Medical Wards

- 6.8 Because of the high number of MCCDs issued by Shipman while working on the medical wards, Professor Baker focussed his analysis of the death certificates on deaths which occurred on those wards. It is clear that (with the possible exception of the accident and emergency department, for which the Inquiry has no information) the medical wards

consistently had the highest number of deaths of any specialty at PGI. This was no doubt due to the severity of the clinical conditions from which patients admitted to the medical wards were often suffering. During the ten six-month periods between August 1969 and July 1974, the number of MCCDs issued in relation to deaths on the medical wards varied between 49 and 126; the number of deaths in respect of which MCCDs were issued on the surgical wards (which had the second highest death rate) varied between 32 and 58. These figures must be regarded as approximate only, since Professor Baker could not always establish on which ward a death had occurred. The six-month period when the highest number of MCCDs (126) was issued in respect of deaths on the medical wards was that between February and July 1972, i.e. Shipman's second period on the medical wards. The only other period for which the number of MCCDs issued on the medical wards reached three figures was the period from February to July 1974, when 103 MCCDs were issued. Shipman was not working on the medical wards at that time; indeed, as I have explained, he left PGI at the end of February 1974.

- 6.9 Professor Baker also analysed the causes of death recorded on the MCCDs. He found that, taking Shipman's two six-month periods on the medical wards together, an analysis of the causes of death certified by Shipman compared with those certified by other doctors working on the medical wards showed that Shipman certified the cause of death as cerebrovascular more frequently (in 24.5% of cases, compared with 15%) than did other doctors. By contrast, Shipman certified the cause of death as cardiovascular slightly less frequently (42.9% compared with 44.7%) than did other doctors.
- 6.10 When Shipman's second six-month period on the medical wards (i.e. the period from February to July 1972) was considered alone, the difference between the proportions of deaths certified by Shipman and by other doctors as being attributable to a cerebrovascular cause increased. Shipman gave this cause in 25% of cases, exactly twice the proportion given by the other doctors. During that period, he also certified a greater proportion of deaths as attributable to a cardiovascular cause than did other doctors (44.7% compared with 37.5%). He attributed fewer deaths to cancer than did other doctors (2.6% compared with 9.6%). These features gave rise to potential concern because they were reminiscent of the later pattern of deaths where Shipman had killed; when at Hyde, he frequently attributed such deaths to sudden causes such as cerebrovascular accident or coronary thrombosis. As a consequence, Professor Baker's previous clinical audit had shown that the proportion of deaths which Shipman attributed to those causes was significantly higher than the proportion attributed to the same causes by the other GPs with whom he was compared.
- 6.11 While cautioning against placing undue weight on the findings of his analysis, on account of the limited information contained in the death certificates and the fact that the passage of time might have obscured the true and innocent explanations for the differences between Shipman's cases and those of the other doctors, Professor Baker observed that the results of the analysis did give rise to grounds for concern. The first cause for concern was the high number of deaths which occurred during Shipman's second period on the medical wards while he was working as a SHO. The second was the difference between

the causes of death given by Shipman and those given by other doctors, and Shipman's greater tendency to attribute death to sudden causes.

## Analysis of Cremation Certificates

### Analysis of All Cremation Certificates Completed During the Five-Year Period

- 6.12 Professor Baker examined the sets of cremation certificates relating to 766 deaths which had occurred at PGI during the five-year period from 1<sup>st</sup> August 1969 to 31<sup>st</sup> July 1974. He noted that Shipman had been responsible for completing Form B in 65 out of the 766 cases. (In fact, Shipman completed 66 Forms B, one of which related to a death which occurred at Ackton Hospital.).
- 6.13 Professor Baker analysed the information contained on the Forms B. He first analysed the Forms B completed by Shipman and by other doctors throughout the five-year period. This analysis showed certain differences between the Forms B completed by Shipman and those completed by other doctors. All these differences were statistically significant, i.e. unlikely to be due to chance. First, an examination of the cremation certificates for the whole of the five-year period showed that Shipman was more likely to attribute a death to a cerebrovascular or cardiovascular cause (and less likely to attribute it to cancer) than were other doctors.
- 6.14 In addition, Shipman tended to report on Forms B that he had seen the deceased person alive more recently before death than did other doctors. Professor Baker pointed out that this could have been innocently explained by the type of patient under Shipman's care. Another possible innocent explanation could be that Shipman was present on the wards seeing his patients more frequently than were other doctors.
- 6.15 Professor Baker found that Shipman also recorded himself as present at death much more often than did other doctors. He recorded only himself as the person present at 20 deaths (i.e. 30.8% of deaths, as against 2% of deaths in the case of the other doctors who completed Forms B). He recorded that he had been present at death with a nurse or relative in 23.1% of cases, whereas other doctors recorded this in only 7.6% of cases. Shipman's statement that he had been present (in particular, the only person present) at death on so many occasions was especially worrying since, in later years, he frequently stated that this was the case when he had indeed been the only person present at the death of a patient and had been responsible for causing the death. Shipman also reported in 26.2% of cases for which he completed Forms B that a patient had died with no one present, whereas other doctors had stated that this was the case in only 12.8% of cases. Other doctors recorded on Forms B that, in the case of 61.2% of deaths, nurses only had been present at death. Shipman stated this in only 16.9% of cases.
- 6.16 Two of the questions on Form B relate to the mode of death and its duration. In general, the patients in respect of whom Shipman had completed Forms B were recorded as having taken a shorter time to die than those where other doctors had completed Forms B; just over 50% of patients were said by Shipman to have taken two hours or less to die, as compared with less than 36% of the patients of other doctors who completed Forms B.

Moreover, Shipman was more than twice as likely as other doctors to record the mode of dying as 'coma'.

### **Analysis of Cremation Certificates Relating to Deaths on the Medical Wards**

- 6.17 When the analysis of cremation certificates was confined to cases in which Forms B had been signed by Shipman and other doctors solely while they were working on the medical wards, the difference in the causes of death recorded by Shipman when compared with those recorded by other doctors was not statistically significant. The fact that there was no statistically significant difference was most likely because of the small numbers of deaths under consideration. However, there were statistically significant differences between the information recorded on Forms B by Shipman and that recorded by other doctors. Shipman again tended to report having seen patients more recently before death than did other doctors; he recorded that he had seen deceased patients on the day of death or within hours (or a shorter period) of death in 94% of cases, as against just over 72% in the case of other doctors. Moreover, he was much more likely than other doctors to have recorded that he had been the only person present at death (in 33.3% of cases, compared with 1.6%) or present at death with nurses or relatives (19.6%, compared with 5.7%). Professor Baker observed that the fact that Shipman reported being present at the deaths of over 50% of patients in respect of whom he completed Forms B must be a cause for concern.
- 6.18 In the case of Forms B completed when Shipman was on the medical wards, Shipman was also much more likely than other doctors to record that the mode of dying was 'coma' (64.7%, compared with 29.1%) and less likely (3.9% as against 29.6%) to record the mode of dying as 'exhaustion'. He reported the duration of the period of dying as being within two hours more frequently than did other doctors (in 52.9% of cases compared with 32.9%). He also tended to report having examined patients within a shorter time after death than did other doctors. Again, these differences were statistically significant.
- 6.19 One very striking feature revealed by the analysis of Forms B completed in respect of patients who had died on the medical wards was the difference (also statistically significant) between the timing of the deaths as recorded by Shipman and that recorded by other doctors. Professor Baker explained that deaths occurring naturally could be expected to be evenly distributed throughout the day, so that one would expect the mean time of death to be around midday. This was the case with the deaths in respect of which Forms B had been completed by other doctors; the mean time was 11.8 hours after midnight (i.e. 12 minutes to noon). However, the mean time of day of the deaths for which Shipman had completed Forms B was 15.2 hours (i.e. 12 minutes past three in the afternoon).
- 6.20 In his analysis, Professor Baker divided the day into four six-hour quarters. Around 25% of natural deaths could be expected to occur in each quarter of the day and, with the other doctors, that expectation was borne out. However, 24 out of 51 deaths (i.e. 47.1% of the deaths in respect of which Shipman completed Forms B) occurred in the final quarter of the day (i.e. from 6pm to 11.59pm), whereas very few deaths (3, i.e. 5.9%) were recorded by Shipman as having occurred in the first quarter of the day (i.e. from midnight to 5.59 a.m).

### **Analysis of Cremation Certificates Relating to Deaths During Shipman's Second Period on the Medical Wards**

6.21 Professor Baker then repeated the analysis, this time confining it to Forms B completed by Shipman during his second period of employment on the medical wards only and those completed by other doctors employed on the medical wards during the same period. Professor Baker said that the reason for this was to eliminate the **'potentially confounding variables'** (e.g. variation of the conditions from which patients admitted to the wards were suffering due to the season, changes in admissions policy, variation in the availability of beds in alternative establishments, etc.) that might affect the mix of patients over a longer period. The disadvantage of looking at only one short period was the reduction in the number of patient deaths in the comparison group. The result of this analysis revealed features very similar to the wider analysis covering the periods when Shipman was working on the medical wards. In particular, Shipman recorded having been present at death, alone or with another person, much more frequently than did other doctors on the medical wards at the same time. Eighteen out of 40 deaths (i.e. 45%) for which he completed Forms B occurred in the last quarter of the day; only 17.4% of deaths for which other doctors completed Forms B occurred during that period.

### **Subsequent Analysis of Distribution of Times of Death**

6.22 After receipt of Professor Baker's initial report, the Inquiry asked him to explore further the variation between doctors in the proportion of deaths reported as occurring at different times of day. Professor Baker's initial report had shown that, when compared with the mean results for all the other doctors responsible for completing cremation certificates, the distribution of the times of death recorded by Shipman was unusual. The other doctors were considered collectively, not individually. The Inquiry wished to discover whether there were other doctors whose cremation certificates would have shown an unusual distribution of times of death had they been examined individually.

6.23 Professor Baker, therefore, carried out an analysis of the distribution of times of death recorded on Forms B completed by 110 doctors at PGI who had issued any cremation certificates during the five-year period under examination. The number of cremation certificates issued by each doctor varied between one and 66 certificates. Shipman completed the highest number (66); the next highest number of certificates completed was 42. Professor Baker said that it was difficult to draw any meaningful conclusions from the data because of the fact that some doctors had completed such a small number of certificates. The differences between the doctors in the times of death reported were not statistically significant. Professor Baker next carried out an analysis of the distribution of times of death recorded on cremation certificates completed by all those doctors at PGI who had issued a total of 20 or more cremation certificates during the five-year period under examination. That analysis revealed that Shipman had the highest percentage (42.4%) of deaths occurring in the fourth quarter of the day and the largest differential between the percentage of deaths occurring in two quarters of the day (i.e. 42.4% in the fourth quarter and 12.1% in the first quarter). However, the difference between Shipman and the other doctors was not statistically significant. Professor Baker pointed out that



Shipman issued more cremation certificates than any of the other doctors and that the smaller the number of certificates completed, the greater the risk of chance variation.

- 6.24 Professor Baker repeated the analysis, this time restricting it to doctors who had completed 20 or more cremation certificates while working on the medical wards. This time, Shipman's distribution of times of death appeared more noticeably different and the difference almost reached statistical significance.
- 6.25 Professor Baker concluded that his original finding, i.e. that the distribution of the times of death of Shipman's patients was unusual when compared with all other doctors, still stood. Shipman's pattern was unusual. Professor Baker acknowledged that it was possible that the pattern of some other doctors was also unusual but pointed out that it was clear from his analyses that no other doctor was as unusual as Shipman. Nevertheless, the relatively small number of cremation certificates issued by many of the doctors necessitated caution in drawing conclusions about those doctors.

#### **Analysis of Cremation Certificates Relating to Deaths on the Paediatric Wards**

- 6.26 Professor Baker also analysed the cremation certificates issued by Shipman and other doctors when working in paediatric posts. Fourteen sets of cremation certificates were available, four of which related to adults, rather than to children. The doctors who completed these certificates must have been providing cover for other wards on which the deaths occurred at the same time as working on the paediatric wards. Of the remaining ten sets of cremation certificates, Shipman completed Forms B in six of them and other doctors completed four. The concerning feature of these deaths was that Shipman recorded only himself as having been present at the deaths of three of the children and present with a nurse or nurses at the other three. The other doctors reported having been present with nurses and relatives at only one of the four deaths. Nurses alone were said to have been present at the other three.

#### **Professor Baker's Observations on the Contents of the Cremation Certificates**

- 6.27 Professor Baker pointed out that cremation certificates were available for less than half of the 1637 deaths examined. He warned that it may be that the contents of these certificates were not representative of all the deaths. There was the possibility of an **'unrecognised difference'** between those patients who were cremated and those who were buried. It is, however, difficult to see why such a difference should exist.
- 6.28 Professor Baker observed that the cremation forms presented a **'consistent pattern'** that bore **'alarming similarities'** to the pattern of the cremation certificates completed by Shipman in later years when he was a GP in Hyde and was, as is now known, regularly killing his patients. The cremation certificates showed that Shipman reported having been present alone or with others at half the deaths in respect of which he completed Forms B. Particularly concerning was the fact that he claimed to have been present at all the paediatric deaths. Moreover, the patients for whom he completed Forms B appeared to have died more quickly than the patients of other doctors, including the patients of doctors working on the medical wards at the same time as Shipman. Professor Baker observed

that the distribution of the times of day of the deaths of Shipman's patients was unusual and could not be explained clinically. He suggested that it was compatible with the unlawful killing of patients in the evening.

## Conclusions

- 6.29 In my view, the unusual pattern of features disclosed by Professor Baker's analysis of the cremation certificates gives rise to some concern that Shipman might have been killing patients while working at PGI. A similar unusual pattern was present in Shipman's Forms B during this early period to that which was later to appear during the period in which it is now known that he was killing patients. However, it must not be assumed that this unusual pattern of features necessarily indicates that Shipman was acting unlawfully. Some of the features might be explained simply as the result of Shipman's practice or 'style' of completing the forms. When the Inquiry received evidence about the completion of cremation forms during Phase Two, Stage One, I found that doctors did have different styles or practices. For example, doctors seemed to have different preferred ways of describing the mode of death. Also, doctors would mean different things when they said that someone was 'present at the death'. Some doctors would not say that a person had been present unless s/he had been at the bedside at the moment of death; others would say that a person was present if s/he was in the house at that moment.
- 6.30 Another possible explanation for the unusual pattern in Shipman's forms could be that he was particularly cavalier about his duties of certification and tended to fill in his forms along similar lines regardless of what had actually happened. However, this is all speculation; I do not know the reason why Shipman's cremation forms were different and unusual. The fact remains that the unusual features were present both during the early period at PGI and during the later period when he was killing patients.
- 6.31 The abnormality of the distribution of the times of death is, in my view, difficult to explain. An abnormally large number of deaths in respect of which Shipman completed Form B occurred in the evening and an abnormally small number of deaths occurred during the early hours of the morning. These abnormalities, taken together, do not suggest that Shipman was killing patients who would not otherwise have died, but they do suggest that he may have been hastening the deaths of patients whose deaths were inevitable. Indeed, the figures could be explained by the theory that Shipman killed patients who were very close to death and who might otherwise have died a few hours later. The abnormally high proportion of deaths occurring between 6pm and midnight raises a degree of suspicion in respect of any death occurring during that period. Of course, some deaths will have occurred naturally during that period, so the significance of the time of death must not be overstated. It is, however, a factor to be taken into consideration when examining the evidence in relation to any individual death which happened in the evening.

## The Number of Deaths

### Deaths on the Medical Wards

- 6.32 In his report, Professor Baker explained that it was not possible to establish, from an analysis of the MCCDs issued at PGI, whether there had been an excess of deaths

attributable to Shipman and, if so, how great that excess might be. In order to carry out that exercise, it would be necessary to have reliable information about the number of deaths that could be expected at the hospital during any given period. No such information is available. The number of deaths to be expected at a hospital would be heavily influenced by case mix factors, e.g. the nature and severity of the conditions from which patients admitted to the hospital were suffering and the age of those patients. No reliable information about these factors is available. Nor is there any information about the numbers and characteristics of patients whom Shipman was caring for at any one time. There are also difficulties in reconstructing the data on hospital mortality rates and the numbers of deaths certified by different doctors. For all these reasons, Professor Baker did not attempt, on the basis of the available figures, to determine whether there was an excess of deaths or, if so, how great that excess might be.

- 6.33 While it is clear that no conclusions can be drawn from the figures alone, it is perhaps worthwhile looking at the general picture created by the figures in the possession of the Inquiry. I have already referred to the fact that, during the period from February to July 1972, the number of deaths on the medical wards for which MCCDs were completed was 126, the highest for any of the ten six-month periods examined by Professor Baker. An increase in deaths for which MCCDs were completed during this period might have occurred by chance or as a result of factors of which we are unaware. Dr John Turner, formerly consultant physician on the medical wards, made this point in his witness statement. However, he acknowledged that the fact that such a high number of deaths had occurred on the medical wards during Shipman's time there was **'worrying'**. In my view, it is particularly worrying because the highest number of deaths occurred in the period when Shipman was described by at least one witness as **'running'** the medical wards. Dr Turner was able to offer no explanation for the high number. In the early 1970s, there was no system of reviewing the number of deaths that occurred on the wards, or of comparing the number of deaths occurring in one period with those which occurred in other periods. Thus, Dr Turner would have been unaware at the time that so many deaths had happened. Patients on the medical wards were under the care of four different consultants, so that no one consultant would have a complete overview of the deaths occurring on the wards. I shall return to consider this apparent excess of deaths later in this Chapter.

#### **Deaths Certified by Shipman and Other Junior Doctors**

- 6.34 During Shipman's first period on the medical wards, between February and July 1971, the SHO was Dr Husain Abbas. He issued 31 MCCDs. Shipman and Dr Jeremy Belk, the two HOs, issued 23 and 21 MCCDs respectively. Dr Surinder Ahuja, the medical registrar, issued one MCCD.
- 6.35 During Shipman's second six-month period on the medical wards, between February and July 1972, he issued 76 MCCDs in respect of deaths that occurred at PGI. The late Dr Simon Bowden and Dr Nicholas Kounis, HOs on the medical wards, issued 22 and 18 MCCDs respectively. Dr Ahuja, registrar, issued one MCCD. A number of witnesses expressed surprise at this distribution of deaths as between Shipman and the HOs. They said that it would be usual for the two HOs together to issue more MCCDs than the SHO.

Some witnesses suggested that Shipman might have been issuing MCCDs that would ordinarily have been issued by HOs. I shall return to that suggestion shortly.

- 6.36 During the six-month period from August 1971 to January 1972, Dr Belk was the SHO on the medical wards. He issued 42 MCCDs. During that period, the HOs were Dr Charles Cook, who issued 31 MCCDs and Dr Raj Rani Pawa, who issued ten MCCDs. Dr Ahuja, registrar, also issued one MCCD. Thus, during this period, Dr Belk, the SHO, issued one more MCCD than the total issued by the two HOs.
- 6.37 In the six-month period from August 1972 to January 1973, Dr Robert Pugh was SHO on the medical wards. He issued 41 MCCDs. The HOs were Dr Stuart Child and Dr Abdool Rajack Sooltan, who issued 21 and 29 MCCDs respectively. The registrar at that time, Dr Mohammed Ali Sooltan, issued two MCCDs.
- 6.38 In two of the four periods referred to above, the two HOs together issued more MCCDs than did the SHO. According to the witnesses, this was the usual pattern. In one period, the SHO issued just one more MCCD than did the two HOs. However, during Shipman's second period on the medical wards, the number of MCCDs issued by him was markedly higher than the numbers issued by any of the SHOs in post on the medical wards during the three other six-month periods. It was also significantly higher than the total number issued by the two HOs in post at the time. Indeed, the total number of MCCDs issued by those two HOs was fewer (by between one and ten) than the number issued by the two HOs in post during all the other periods examined. It may be, therefore, that Shipman was, for some reason, issuing some MCCDs that would ordinarily have been signed by the HOs. One possible reason was that he was killing some patients who were in any event going to die fairly soon and certifying their deaths, thereby reducing the number of deaths that occurred during the following day or night, when one of the HOs would have been on duty and would have been responsible for certification.
- 6.39 However, there are other explanations that could account for these apparent disparities and some were put forward by witnesses. It was suggested that, for financial reasons, Shipman might have sought to ensure that he issued as many MCCDs as possible. Although completion of a MCCD attracted no payment, it might lead to a request to complete a Form B, which did carry a payment. Shipman had a wife and young family and no doubt welcomed any addition to his income. There was a suggestion that the nurses (with whom he was generally popular) might have assisted by ensuring that Shipman was called when a patient died and was thus in a position to issue the MCCD. He could have instructed the nurses to call him, rather than one of the HOs, in the event of a death. There is, however, no evidence that Shipman did this or that the nursing staff assisted him by ensuring that he was called whenever a death occurred. Nor did Dr Kounis, HO on the medical wards at the time, have any recollection of Shipman completing MCCDs in cases where Dr Kounis felt that he himself should have been requested to do so.
- 6.40 Another possibility is that, during this period, Shipman was called out by the HOs, or by the nursing staff, more than would have been usual (at least during the day) in order to give a 'second opinion' about a patient's condition or treatment. If that was done, if Shipman

then assumed responsibility for the patient's treatment and if the patient then died, it might have been considered appropriate for Shipman, rather than one of the HOs, to issue the MCCD. The evidence suggests that, during the day, Mrs Anne Calverley (formerly Miss Anne Paley, ward sister, Ward 2) might well have tended to call Shipman out to give a second opinion and that she might also have called out Shipman, whether or not he was officially on duty, in preference to the HOs. According to her, he had made it clear that he did not mind coming out in these circumstances. However, Mrs Calverley would not have called Shipman out at night and, in any event, this explanation would not account for deaths which were certified on Ward 1, the female medical ward. A further factor is the extent to which Shipman was present on the wards. Dr Kounis' recollection is that Shipman was **'always on the wards'**. Clearly, if he were constantly at hand, he would be the person most available to treat a patient who deteriorated suddenly and to certify the cause of death if a death occurred. After leaving the ward in the early evening, however, he would have no occasion to be on the wards unless he was on duty on the night in question. The Inquiry has been told that the night staff would not have called a junior doctor out at night when s/he was not officially on call.

- 6.41 Thus, the unusual pattern of distribution of the issue of MCCDs during the period February to July 1972 may be sinister or it may have an innocent explanation. However, I have already drawn attention to the high proportion of deaths certified by Shipman that occurred during the evening. The two factors are consistent with each other. The hypothesis that Shipman was killing seriously ill patients during the evening would explain not only the high proportion of deaths in the evening but also the shortfall of deaths certified by the HOs.
- 6.42 There remains the question of whether or not there was an actual excess of deaths on the medical wards during this period. The fact that Shipman was certifying more than his expected share of deaths does not necessarily suggest that there was an overall excess of deaths. Although the number of medical ward deaths for which MCCDs were issued was higher in the period in which Shipman was SHO than in any other period examined, it cannot be said with confidence that the actual number of deaths occurring on the medical wards in that period was higher than in any other. It is instructive to compare the period when Shipman was SHO on the medical wards with the following period, when he had moved to paediatrics. In the six-month period from August 1972 to the end of January 1973, the overall number of deaths in the hospital (327) was higher than the overall number (310) in the previous six months. Although the number of medical ward deaths for which MCCDs were issued was lower (at 92) in this later period than it had been in the period when Shipman was SHO (126), it cannot be said that the number of actual deaths occurring on the medical wards was at its highest during Shipman's period. That is because, in the later period, a large number of deaths were referred to the coroner and were not certified by any doctor at the hospital. Thus, it may be that there were more deaths on the medical wards in the later period than there were in Shipman's period and that the fact that more deaths were certified on the wards in Shipman's period than in the later period might be attributable to the fact that Shipman certified the cause of death himself in cases where other doctors would have referred the death to the coroner. We simply do not know and it is not possible to find out. I shall discuss Shipman's practice in relation to reporting cases to the coroner in Chapter Seven.

## Conclusions

6.43 It is evident from Professor Baker's analysis that there is no reliable evidence that there was an overall excess of deaths that might be connected to Shipman. There is no statistical evidence that Shipman was killing patients who would otherwise have recovered and left the hospital. However, in my view, Professor Baker's analysis does strongly suggest that, in some cases, Shipman was interfering with the ordinary processes of death and was hastening the deaths of patients who would have died quite soon in any event. The fact that this is all that can be deduced from the figures does not mean that Shipman was not killing other patients besides those who were about to die. He might have killed patients who would otherwise have survived. Indeed, the other disparities revealed by Professor Baker's analysis of the causes of death Shipman gave on MCCDs and the unusual pattern of features seen on his cremation certificates, particularly the unusual number of deaths at which he claimed to be present, suggest that something abnormal was happening in quite a large number of cases. The imbalance in the distribution of the times at which deaths occurred and the imbalance in the distribution of death certification between Shipman and the HOs could be created by a relatively small number of accelerated deaths, something of the order of 10 to 15. However, the unusual pattern of cremation certification (in particular, the frequency with which Shipman claimed to have been present at the death) was present on a wider scale than that. That pattern is sinister because it was replicated later when Shipman was an established killer.

## CHAPTER SEVEN

### Shipman's Unlawful Activities: the Pontefract Years

#### Introduction

- 7.1 My objective at this Stage of the Inquiry has been to find out whether or not Shipman began killing patients during the first part of his professional career. I have examined the available evidence relating to 137 deaths that occurred between August 1970 and February 1974. In this Chapter, I shall set out my findings in relation to these deaths. Of the 137 deaths, 134 occurred at Pontefract General Infirmary (PGI) or its annexe, Ackton Hospital. The other three deaths were of patients of the general practitioners (GPs), Dr Michael Hessel and Dr Gwendolen Hessel, for whom Shipman worked as a locum. Those deaths occurred at the patients' homes or, in one case, in a residential care home.

#### The Background Evidence

- 7.2 My examination of the evidence relating to this period has been set against the background of what I have already discovered about Shipman, namely that, while working as a GP in Todmorden and Hyde, he was an habitual killer. In the First Report, I found that he had killed at least 215 patients during the period 1975 to 1998 and I have suspicions about 45 more deaths. Each of the patients whom he killed was Shipman's own patient and not the patient of another doctor. I have borne that in mind when considering the three deaths that Shipman certified while working as a locum. The other important finding made in the First Report was that Shipman was deeply dishonest and an inveterate liar. Because of the findings in the First Report, I have approached Shipman's words and actions while in Pontefract with a high degree of suspicion.
- 7.3 Another background feature to my consideration of these deaths is the possibility that Shipman certified the cause of (and was therefore involved in) an excessive number of deaths, particularly during the period in which he worked as a senior house officer (SHO) on the medical wards between February and July 1972. At first glance, the figures (which I set out in Chapter Six) suggest an excess but Professor Richard Baker is firmly of the view that no clear conclusions can be drawn. However, the figures do show that, during this period at least, Shipman was involved in the certification of the cause of more deaths than any other doctor in a comparable position during the five-year period for which figures have been examined. In the light of Shipman's later history, that must arouse some suspicion in my mind. However, the comparatively high number of deaths Shipman certified may be explained, at least to some extent, by the fact that he may have referred fewer deaths to the coroner than other doctors did. I have found that he certified some deaths that should have been reported to the coroner. He may have done that because he was responsible for the death and he wished to avoid a coroner's investigation which might have cast suspicion upon his actions. On the other hand, he may have avoided referring deaths to the coroner for other reasons, for example so that he could certify them himself and have the chance of receiving the fee for completing cremation Form B. In short, although the comparatively high number of deaths Shipman certified gives rise to some suspicion that he might have been killing patients, it does not point clearly to that conclusion.

- 7.4 I have considered the evidence relating to each individual death in the context of the evidence received about the arrangements at PGI, which I have described in Chapter Two, and of the recollections of the medical and nursing staff of Shipman's personality, abilities and working practices. It is clear that, although he was not universally liked, Shipman was well thought of by the majority of the medical and nursing staff. He was regarded as able and hardworking. He was seen to be enthusiastic and always willing to be called out to attend to patients when he was on 'out of hours' duty. He was trusted and respected and, of course, no one for a moment entertained any suspicion that he might ever have deliberately harmed a patient. There is evidence that, by the time he was a SHO, he was authoritative and, while working on the medical wards, was effectively in charge of the day-to-day running of the wards.
- 7.5 There is some evidence that Shipman was over-confident, even to the point of recklessness. Mrs Margaret Calvert, formerly a night sister at PGI, described an occasion in the accident and emergency department when he administered 40mg Valium to a young woman with an injured leg. That was four times the usual recommended dose. The young woman suffered no apparent ill effects. Mrs Jennifer Bratley (formerly Miss Jennifer Buckley, day sister on Ward 2 from about July 1971) recalled an occasion when Mrs Anne Calverley (then Sister Paley) told her that Shipman had administered a drug too quickly and the patient had collapsed. Another episode was recounted by Dr Surinder Ahuja, who in 1971/72 was the registrar on the medical wards. He described how, as a junior house officer (HO), Shipman carried out a quite difficult and slightly risky procedure on his own which the consultant in charge, Dr Leslie Watson, had intended to carry out himself with the assistance of the registrar. In fact, no harm was done, but the incident demonstrates in Shipman a degree of over-confidence or, possibly, recklessness.

### Factors Giving Rise to Suspicion

- 7.6 There are a number of features in the evidence relating to individual deaths which give rise to a degree of suspicion that Shipman may have killed the patient. None of these features is, of itself, probative of criminal conduct but, where several such features arise in the same case, the degree of suspicion that he was acting unlawfully is obviously greater.

### Certification of Deaths That Ought to Have Been Reported to the Coroner

- 7.7 There are a number of cases in which Shipman certified the cause of death despite the fact that the death ought to have been reported to the coroner. Most of these were cases in which the patient had been admitted to the hospital less than 24 hours before the death. The local coroner had made a rule that such cases should be reported. Therefore, a doctor who was thinking of certifying the cause of death of a recently admitted patient should at least have spoken to the coroner or his officer before so doing. The coroner might have given permission for the doctor to certify the death after discussing the circumstances. Alternatively, the coroner might have decided to order a post-mortem examination or he might have allowed the patient's GP to certify the cause of death, if he judged that the GP had sufficient knowledge of the deceased's condition before death.
- 7.8 During the later stages of Shipman's career, when he was killing patients regularly, it was only on the most rare occasion that he reported a death to the coroner, despite the fact



that many of his patients' deaths were very sudden. On a few occasions, he spoke to the coroner's officer and obtained approval for the cause of death he proposed to certify. Thus, the fact that Shipman sometimes failed to report a death that ought to have been reported is an obvious cause for concern. He would be unlikely to wish to report a death when he had just killed the patient. However, as I have already said, there are other reasons, not related to any unlawful conduct, why Shipman might have decided not to report a death that ought to have been reported. Evidence received during Phase Two, Stage One of the Inquiry suggests that compliance by doctors with the coroners' reporting rules is not generally good. Thus, it is not possible to draw the inference that Shipman killed the patient merely from his failure to report a death which ought to have been reported.

- 7.9 However, there are some cases involving deaths at PGI, which the Inquiry discovered by chance (because Shipman was recorded, on a Form B completed by another doctor, as having been present at the death), where the death occurred shortly after the patient's admission to hospital and in which Shipman did make a report to the coroner. These resulted in the coroner inviting the patient's former GP to certify the cause of death. The Inquiry has examined these deaths. There will almost certainly have been other patients treated by Shipman at PGI whose deaths were reported to the coroner and where the coroner ordered a post-mortem examination to determine the cause of death. The Inquiry has not examined those deaths. I took the view that they should not be regarded as suspicious. I consider that it is most unlikely that Shipman will have acted unlawfully in respect of any patient whose death he reported to the coroner.

### **Deaths Occurring Between 6pm and Midnight**

- 7.10 As I explained in Chapter Six, Professor Baker found that an abnormal proportion of deaths certified by Shipman occurred between 6pm and midnight. Of course, some deaths will have occurred naturally during the evening; one would expect about 25% of all natural deaths to occur in each six-hour period of the day. However, during Shipman's first period on the medical wards, six of the 11 deaths (54%) for which he completed cremation Form B occurred between 6pm and midnight. In his second six-month period on the medical wards, 18 of the 40 deaths (45%) for which he completed Form B occurred during that six-hour period. As I have explained, those figures give rise to the suspicion that Shipman was killing patients in the evening. In both six-month periods, very few deaths for which he completed Form B occurred in the six hours between midnight and 6am. These two features suggest that, during the evening, Shipman may have been hastening the deaths of patients who were expected to die very soon. If Shipman were minded to kill a patient, the evening would provide him with the best and safest opportunity. It would be much easier for him to be alone with a patient during the evening. There were fewer staff on duty at that time, especially after about 9pm. There is some evidence that Shipman used to spend time on the wards during the evening, when he was not required to be present. It is relevant in this context that, in his statistical analysis of the deaths that took place in Hyde, Professor Baker found that an abnormal proportion of deaths certified by Shipman had occurred during the afternoon, the period in which Shipman undertook his home visits and had the greatest opportunity to kill his patients.

### **Unusual Entries in the Medical Records**

- 7.11 Unfortunately, very few sets of medical records relating to patients who died at PGI in the early 1970s, and whose causes of death were certified by Shipman, have survived. Those that remain contain two types of entry that give rise to particular suspicion that Shipman was unlawfully involved. Those are entries (directly relating to the period shortly before a death) that either are very short or are elaborate, with deletions and alterations and sometimes underlinings for emphasis. The very short entries are suspicious because one would usually expect to see recorded in the notes some evidence of deterioration in the patient's condition, followed by the death. Sometimes, with Shipman, the penultimate entry is a record of a routine examination where the patient appears to be making normal progress or, at least, is not giving cause for special concern. Then, there is a final entry in Shipman's hand, which is very brief and does not give any information about the deterioration prior to death or treatment given in the final stages. I recognise that the standard of medical records in the 1970s should not be judged by the standards of good practice expected today. However, these very short entries raise suspicion in my mind because they are so similar to entries I saw in the records of patients whom Shipman had killed in Hyde.
- 7.12 An elaborate entry with alterations also gives rise to suspicion because it suggests that Shipman has been trying to create a plausible account of the death. I came across examples of this type of entry in several of the Hyde cases in which he had killed the patient.

### **Unusual Pattern of Entries on Cremation Forms B**

- 7.13 Professor Baker has also identified an unusual pattern in the contents of the cremation Forms B completed by Shipman at PGI, which is similar to the pattern observed later in Shipman's career. The unusual pattern included such features as Shipman's presence at death, Shipman's having seen a patient shortly before death, the death being of short duration and/or the death being due to cardiovascular or cerebrovascular cause. This pattern gives rise to suspicion, not only because it is not seen in the cremation forms completed by other doctors, but also because it reflects the circumstances that would be expected to exist if Shipman had killed the patient. He would have seen the patient shortly before the death, the death would have been of short duration and Shipman might well still have been present at the moment of death. Moreover, a cerebrovascular or cardiovascular event could cause death to occur suddenly. If Shipman were to certify a sudden cause of death (when the death had in fact been caused by his criminal activity), this would provide a degree of medical plausibility.

### **Presence at Death**

- 7.14 One very unusual feature of the Forms B completed by Shipman at PGI is the frequency with which Shipman stated that he was present at the death, either apparently alone or with others. Professor Baker regarded Shipman's presence at death as suspicious. He said that it is unusual for a hospital doctor to be present at the moment of a patient's death, even in company with nurses, other doctors or relatives. It is especially unusual for the doctor

to be alone with the patient at the moment of death. Professor Baker's opinion is borne out by his analysis of the frequency with which Shipman recorded himself as having been present at death compared with the other doctors working at PGI. On 33.3% of the Forms B completed by Shipman during his two periods on the medical wards, he stated that he was present at the moment of death and did not mention any other person as being present, thereby implying that he was alone with the patient. For other doctors working on the medical wards, that was stated on Form B in only 1.6% of cases. During the same two periods on the medical wards, Shipman said that he had been present at the death with a nurse or relative in 19.6% of cases, whereas other doctors stated that they were present with a nurse or relative at only 5.7% of deaths. Putting the two sets of figures together, Shipman stated that he was present at about 53% of the deaths for which he completed cremation Form B while working on the medical wards, whereas the other doctors stated they had been present at only 7.3%. As Professor Baker observed, when Shipman was killing patients as a GP in Hyde, an unusually high proportion of cremation Forms B showed that he had been alone with the patient at the moment of death. Professor Baker has expressed his concern that these figures suggest that Shipman may have been killing patients at PGI.

- 7.15 I share Professor Baker's concern. However, I do not think that presence at death is as suspicious for a hospital doctor as for a GP. For a GP to be present with a patient at the moment of death is rare. To be alone with the patient at death is so rare that it is, for most GPs, a once-in-a-lifetime experience. It can arise only as a remarkable coincidence. However, the opportunities for a hospital doctor to be present at a death are much greater. That said, Shipman's figures are abnormal and quite out of line with those of the other doctors at PGI. They indicate that Shipman was doing something different from the other doctors.
- 7.16 There is another respect in which Shipman's Forms B completed during his two periods on the medical wards are strikingly different from those of other doctors. Nurses alone were said to be present at a very large proportion (58.7%) of the deaths for which other doctors completed Form B, whereas only 15.7% of Shipman's Forms B show that the death took place in the presence of nurses alone. Here again, Shipman was saying or doing something different from the other doctors.
- 7.17 What was this difference? There are two possibilities. Either Shipman was actually present at a far greater proportion of deaths than the other doctors were or he was saying that he was present when in fact he was not. If he was actually present more frequently than the other doctors, that would be a cause for concern and suspicion. Of course, the explanation for his presence might be that he was more caring, conscientious and enthusiastic than other doctors. However, in the light of his later conduct, it seems likely that the explanation would be sinister rather than innocent. Presence at death on an abnormal number of occasions might well suggest that he was killing his patients. Even if he was not killing his patients, it might at least suggest an abnormal interest in death.
- 7.18 The second possibility is that Shipman was not actually present at all the deaths that he claimed to have attended. It is possible that he might sometimes have claimed to have been present in an attempt to make it appear that he was justified in certifying the cause

of death and completing cremation Form B (if the deceased's body was to be cremated) in cases where the death ought really to have been reported to the coroner. Why would he wish to do that? I can think of at least four possible reasons, only one of which would be to conceal criminal activity. Shipman might have wanted to avoid reporting deaths to the coroner because he had killed the patient and he did not wish there to be a post-mortem examination or the possibility of an inquest, when his unlawful role in the death might have come under scrutiny. On the other hand, he might have falsely claimed to have been present at deaths so that he could certify the cause of death and save the family the trouble and worry of a coroner's investigation. He might have wanted to avoid for himself the possible inconvenience of having to communicate with the coroner's office or (possibly) attend an inquest. He might have claimed to have been present so that he could certify the cause of death and increase the chances of earning a fee for completing Form B. I do not think Shipman would have hesitated to lie on official forms if it suited him. He certainly did so later in life.

- 7.19 Another conundrum arises from the fact that, in some cases, Shipman implied that he was alone with a patient at the moment of death when it is clear beyond doubt from the evidence that he was not. For example, on cremation Form B in the case of Mr William Turner, Shipman implied that he alone had been present with the patient at the moment of death. Yet, in the medical records, he described an attempt at resuscitation of Mr Turner which would plainly have involved other people besides himself. These other people would not have left until it was apparent that the attempt had failed and the patient was dead. The nursing records corroborated the account given by Shipman in the medical records. I have concluded that Shipman was not alone with Mr Turner at the moment of death. So why, on Form B, did he imply that he had been? There are a number of possibilities. One possibility is that Shipman honestly thought that, if he had been there, that was all that he needed to state on the form. But that cannot be right because, sometimes, he stated that he had been present with members of the nursing staff, whom he would either name or describe generically as **'Sister'** or **'Nurses'**. Another real possibility is that, sometimes, he could not be bothered to mention that other people had been present besides himself. It is possible that Shipman was so completely cavalier about his duties of certification and record keeping that he simply did not care whether what he wrote was true or false. On the other hand, it is quite possible that the explanation for his certification practices was that he was acting illegally and was seeking to cover his tracks by completing the forms in various different ways.
- 7.20 The only conclusion that I feel able to draw from Shipman's claim that he was present at a death (either with others or apparently alone) is that it gives rise to a general sense of suspicion and unease about the case. That is because it is unusual for a doctor to be present or to say that s/he was present at a death; Shipman was saying or doing something that most doctors do not say or do. As Shipman is now known to have been a serial murderer and as one of the possible explanations for his claims of presence is that he was present and was acting illegally, a claim of presence gives rise to suspicion. That is as far as I can go. I do not think that a claim of presence is necessarily true; if other evidence suggests that Shipman was not present (or not present alone), even though he claims to have been, then I am quite prepared to accept that he was not present (or not present alone) and his statement that he was present (or present alone) was false.

- 7.21 Although a claim that Shipman was present at a death gives rise to some suspicion, the converse is not true. The fact that Shipman said that he was not present, that only nurses were present or that no one was present does not remove all suspicion. When killing patients in Hyde, Shipman often left the scene, allowing others to find the patient dead. There is no reason to think that he would not have followed a similar practice if he decided to kill a patient at PGI. He might well have administered a lethal dose of a drug and then have left the patient to be found by a nurse. If he was on the ward or on call, he could be confident that it would be he who would be summoned to examine the patient, to declare him/her dead and to certify the cause of death. Alternatively, after administering a lethal dose, Shipman might have alerted a nurse to the fact that the patient looked very unwell or appeared to be unconscious and might then have returned to the bedside with the nurse. It would then appear that both had been present at the moment of death.

### **Shipman's Claim to Describe the Mode and Duration of Death as the Result of His Own Observations**

- 7.22 The possibility of suspicion arises also where Shipman claimed that he could describe the mode and duration of death on the basis of his own observations, at least if the duration of death was said to be short. That would imply that he had been present shortly before the death. If Shipman had been summoned to attend the patient shortly before the death, it would be usual for a nurse to stay with him while he examined the patient. Presence shortly before the death, especially if apparently coupled with presence alone at the death, is a feature which gives rise to concern.
- 7.23 Suspicion also arises where Shipman stated or implied that he was present shortly before the death (and was able to observe the mode and duration of death) and either that no one at all was present at the moment of death or that he and nurses were together present at the death. In those cases, my suspicion is that he might have been present alone with the patient shortly before the death, that he did something to cause or hasten death and that he then either went away altogether, leaving the nurses to find the body, or went away to find a nurse to bring her back so that they would be together when the death occurred or was discovered.

### **My Approach to the Individual Cases**

- 7.24 My approach to the evidence in each case was, first, to consider the witness statements of the members of the family or friends of the deceased. These would often provide me with background information about the deceased's medical and social history and the circumstances leading to the final admission to hospital. However, in many cases, the family witnesses were very young at the time of the death and their knowledge of events was very limited. The recollection of others is now faded and vague although some still have vivid memories of the events surrounding the death. In cases where the medical records are available, I sometimes found corroboration of the relatives' accounts.
- 7.25 Sometimes, family members were able to describe the deceased's condition during his/her stay in hospital and even at the moment of death. It is noticeable that very few families were given much information by the staff and most never saw a doctor at all during

their visits to the hospital. Visiting was strictly regulated and the doctors were not usually on the wards at visiting times. Most relatives were not given a clear explanation of the patient's condition. In some cases, a nurse might warn the relatives that the patient was very ill and might suggest that a family member should stay at the bedside after visiting time was over. Sometimes, a nurse would telephone the patient's family to warn of a deterioration, and a relative would then be at the bedside at the time of the death. In such cases, if the family member is still alive, s/he has usually been able to give a clear account of the death which has enabled me to say with confidence that the death was completely natural. If no family member was present at the death (as in the great majority of cases), I have had to rely on medical and nursing records (if available) and cremation Forms B (if any) for information about the circumstances of the death. Unfortunately, members of the nursing staff have been unable to remember the circumstances of all but a very few of the deaths of individual patients. This is not surprising, after such a passage of time. If there are neither medical records nor cremation certificates, it has usually been impossible for me to reach any conclusion at all as to whether or not Shipman was responsible for the death.

- 7.26 There are medical records available in only a small minority of cases and, even in those cases, the records are often not complete. In a few cases, the medical and nursing records have provided detailed and reliable evidence. In general, I have approached any record made by Shipman with caution because I know that, later, he frequently made false entries in his patients' records. However, in the PGI records, there are some entries made by Shipman, particularly those made immediately after the patient's admission, that have every appearance of being a genuine record. It is the entries made around the time of death which I have had to approach with the greatest reserve. As I have explained, two types of record (the very brief and the over-elaborate) cause me particular concern. In considering the individual cases, I have also taken into account Professor Baker's comments on the medical records and the advice I have received from Dr Aneez Esmail, Medical Advisor to the Inquiry.
- 7.27 I have also had to approach Shipman's entries on cremation Forms B with circumspection. While working in Hyde, Shipman frequently made false entries on Forms B, thereby creating a plausible story about the circumstances of the death. It is possible that he had already begun to do that while in Pontefract. As I have said, Shipman was a deeply dishonest man and I think it entirely possible that he might have made false entries in records and certificates even at this early stage of his career.

## My Findings in Summary

- 7.28 In each individual case, I have sought to decide whether the death was natural or whether the evidence showed that Shipman caused or might have caused it. As I explained in Chapter One, it was apparent from an early stage that, in quite a large proportion of cases, there would be insufficient evidence for me to reach a firm conclusion. It appeared to me that, if I would be unable to report anything of significance, some of the families might prefer not to receive a full individual decision. I thought also that there would be a significant proportion of cases in which the death was natural and where the relatives were quite satisfied in their own minds that Shipman could not have played any sinister part in

it. In such cases, if the family concerned did not wish to receive a full decision, it seemed that nothing would be gained by writing one. However, each and every death has been considered and, if any family has expressed a wish to receive a full decision, I have written one, even in cases where I am unable to reach a conclusion.

- 7.29 In the First Report, I was able to reach a definite conclusion in the great majority of cases. I was usually able to say that the death was either natural or that Shipman had unlawfully killed the patient. In 45 cases out of 493, I had suspicions that Shipman might have killed the patient but the evidence was not sufficiently clear for me to reach a positive conclusion, and, in 38 cases, there was so little evidence, or evidence of such poor quality, that I was unable to form any view at all. In this group of 137 deaths from Pontefract, there are 45 cases in which I have been unable to reach any conclusion. This is not surprising, bearing in mind the passage of time and the fact that so few medical records have survived. Sometimes, I have been unable to reach a conclusion because there is hardly any information available. In other cases, there is some information but it is unclear. However, in none of the cases where I have been unable to reach a conclusion is there any reason positively to suspect Shipman's involvement, and the likelihood is that the death was natural. It is unfortunate that the evidence is not sufficiently clear to enable me to reassure the families as I would wish to do.
- 7.30 There are 68 of the 137 Pontefract deaths in which the evidence is sufficiently clear to enable me to say that the death was almost certainly natural. I must confess that it has sometimes been difficult to draw the line between a death in which I cannot reach any conclusion and one in which I am satisfied that it was almost certainly natural. To some extent, I am relying on my background knowledge of Shipman, his methods and his motivation.
- 7.31 There are 14 deaths about which I entertain some suspicion that Shipman might have been involved in causing the death, although, in these cases, my suspicions are not grave. These deaths were probably natural but there are one or more features in the evidence which give rise to some suspicion or unease. Again, it has sometimes been difficult to draw the line between saying that I could not reach any conclusion at all and finding that the death was, to some extent, suspicious. Again, my background knowledge has played some part in the decision. The process of decision making has not been easy so long after the events occurred.
- 7.32 There are four cases in which I have quite serious suspicions about Shipman's involvement in the death and there are three in which my suspicions are such that I have concluded that Shipman probably caused or hastened the death. I shall discuss those cases in more detail below.
- 7.33 There are three cases (those of Mrs Edith Swift, Mr Butterfield Hammill and Mrs Cissie Macfarlane) in which Shipman's treatment of the patient was inappropriate. He either prescribed or administered inappropriate and/or dangerously large doses of a sedative drug, which would have had an adverse effect and which probably caused or contributed to the patient's death. I cannot say whether Shipman prescribed these drugs intending to kill the patient or being reckless as to their effects or whether he was unaware that the drugs in question or the doses given were potentially dangerous for these patients. It is

possible that he might have been ignorant of the danger, although my view is that it is quite likely that he was reckless as to their effect. In each case, I have some suspicion that Shipman acted unlawfully in that he was reckless as to the effect that the drugs would have. When these three cases are added to the 14 cases to which I referred at paragraph 7.31, that makes a total of 17 cases in which I have some suspicion that Shipman might have been involved in causing the death.

- 7.34 In each case in which I have found that Shipman caused the death or in which there is any cause for suspicion, I have written a full reasoned decision. That accounts for 24 decisions. In a further 27 cases, I have written a full decision at the request of a family member, even though I have found that the death was natural or I have been unable to reach any conclusion at all.
- 7.35 The individual decisions appear in Appendix D. The Inquiry team has also prepared an alphabetical and a chronological list of every death that I have considered and against each name appears my finding about Shipman's possible involvement. These lists are at Appendices B and C respectively.

## A Chronological Account

- 7.36 I now propose to set my conclusions about the individual deaths into the context of Shipman's working history.

### **The Period from August 1970 to January 1971: Shipman as a Pre-Registration House Officer on the Surgical Wards**

- 7.37 Shipman's first period as a HO in surgery, from August 1970 until the end of January 1971, gives rise to no cause for concern. He signed 14 Medical Certificates of Cause of Death (MCCDs). Most of the patients who died had undergone surgery and were very ill indeed immediately before their deaths. In all but two of those cases there is sufficient information for me to say that I am almost certain that the death was natural and due to the cause as certified. In two cases, I have been unable to reach a conclusion but that does not mean that there is any cause for suspicion. In respect of this period, I have taken into account the fact that Shipman was not yet fully qualified and would have been under quite close supervision by the more senior medical staff and also, to some extent, by the nursing staff. I have also taken into account the fact that Professor Baker's analysis has not detected any abnormalities during this period. My overall conclusion is that it is very unlikely that Shipman did anything unlawful at PGI during this period.

### **The Period from February 1971 to July 1971: Shipman as a Pre-Registration House Officer on the Medical Wards**

- 7.38 During this six-month period, Shipman signed 24 MCCDs. All except one related to deaths of patients at PGI. He was working on the wards in which most of the deaths in the hospital took place. This was usual and inevitable as the patients on the medical wards were often quite old and very ill. I note that Shipman did not sign any MCCDs during July. I think he



must have been on holiday for some, if not all, of that month. Even so, there is no reason to suspect him of criminality on account of the number of MCCDs signed.

- 7.39 In this period, there is some evidence of imbalance in the times at which the deaths occurred. Usually, it has been possible to establish the time of death only in cases in which Shipman completed cremation Form B and/or where there are medical records, although there are some cases in which a witness is able to provide the approximate time of death. In this period, Shipman completed 11 Forms B. In general, one would expect about three or four natural deaths to occur in each six-hour period of the day, although with such small numbers, that cannot confidently be expected. However, the fact that six of the 11 deaths occurred in the period between 6pm and midnight and none of the 11 occurred between midnight and 6am does seem slightly strange. It suggests the possibility that, during the evening, Shipman might have hastened the deaths of one or two patients who would otherwise have been expected to die during the early hours of the morning.
- 7.40 Of the 24 deaths, I am satisfied in 13 cases that the death was due to natural causes. In seven cases, I feel unable to reach any conclusion. In four cases, those of Mrs Margaret Thompson, Mr Wilfred Sanderson, Mrs Ethel Follon and Mrs Edith Swift, I feel some degree of suspicion that Shipman might have done something to hasten the death. Mr Sanderson and Mrs Follon died late in the evening and the time of their deaths is one of the causes for suspicion. Mrs Thompson died during the day; however, there are other causes for suspicion in her case. Mrs Swift died in the early morning.
- 7.41 During this period, Shipman certified the deaths of two children on the Hydes Medical Ward. These were David Chew and Ian Dunnington. In both cases, I have concluded that the deaths were almost certainly natural.

#### **The Period from August 1971 to January 1972: Shipman as Senior House Officer on the Paediatric Wards**

- 7.42 During this six-month period, Shipman signed five MCCDs. Of those, four related to the deaths of young babies. I have considered these four deaths very carefully and have concluded that, in each case, there is reason to believe that the death was natural and no reason to suspect otherwise.
- 7.43 The fifth death was that of Mr Tom Goodliffe, who was aged 62 and died on the male medical ward. Shipman would not normally have been present on the medical wards during this period. However, this death took place at 4.45am and it seems reasonable to infer that Shipman must have been on call at the time and must have been covering the medical, as well as the paediatric, wards. Mr Goodliffe's relatives had been summoned to the hospital in the early hours of the morning and were at his bedside. They noticed that his breathing had changed and went to find a doctor. Shipman attended with a nurse. There is no evidence that Shipman could have had sole access to Mr Goodliffe before his death. I have concluded that there is no reason to suspect that this death was not natural.

#### **The Period from February to July 1972: Shipman as Senior House Officer on the Medical Wards**

- 7.44 This is the period of time which gives rise to the greatest degree of concern about Shipman's activities. Although I have considered 81 deaths that occurred during this

period, only 79 of those deaths were certified by Shipman. Seventy six deaths certified by Shipman took place on the medical wards at PGI and three took place elsewhere. Of the 76 deaths that took place on the medical wards at PGI, in only 24 cases have I felt able to say that the death was natural. In 34 cases, I have felt unable to reach any conclusion but I stress that, in those cases, there is no positive reason to suspect Shipman of wrongdoing. In 12 cases, I have some suspicion that Shipman might have been involved in the death. In three cases, I have quite strong suspicions about Shipman's actions and, in three other cases, I have concluded that he probably did kill the patient. Of the three cases which took place elsewhere and were certified by Shipman, I have some suspicion about Shipman's involvement in one. I am satisfied that the other two deaths were natural. Almost all the deaths that give rise to concern occurred during the three-month period from March to May 1972.

- 7.45 I have already explained the principal grounds for suspicion arising out of Shipman's conduct. A significant cause for concern arises in respect of this six-month period because of the unusual distribution of the times at which the deaths took place. As I have said, the time of death can be reliably established only from cremation certificates and medical records. There is no reason to suppose that Shipman would lie about the time of death and, indeed, where medical records exist, they confirm the time of death given by Shipman on Form B. Shipman completed 40 cremation Forms B during this period. One of the 40 related to a death at a residential home which Shipman certified while working as a locum for the patient's GP. I shall leave that death out of account. Of the 39 remaining deaths, 17 took place between the hours of 6pm and midnight. Only three took place in the early hours of the morning, between midnight and 6am. This imbalance suggests that Shipman might have been hastening the deaths of patients who would otherwise have died within a few hours.
- 7.46 I am particularly suspicious of deaths that occurred between 8pm and midnight. Visiting time was from 7pm until 8pm. From 8pm until about 9pm, the nurses would be very busy settling the patients down for the night. Then, there would be a period of changeover to the night staff. After that, there would be fewer nursing staff on duty. After about 8pm, it would be fairly unusual for a doctor to be on the ward unless s/he had been sent for, although some doctors would check on their patients in the evening and some would spend time with the nursing staff. However, there is some evidence that Shipman was sometimes to be seen on the ward after this time. His presence was attributed to his hardworking and caring nature. However, later in life, he cultivated a reputation for being hardworking and caring as a guise for his unlawful activities. I cannot ignore the possibility that he was already doing that at Pontefract. Another factor is that, during this period, Shipman was, to all intents and purposes, running the wards, although he was only a SHO. That being so, his presence on the wards in the evening would not excite surprise. Nor, as he was a trusted and highly regarded doctor, would it be surprising if the nurses were prepared to leave him alone with a patient if he suggested that they should do so. Being in charge of the ward would enable Shipman to decide which patients should be accommodated in cubicles and which on the main wards. It would be very easy for Shipman to arrange to have a patient transferred into a cubicle. It appears to me that his position and habits made it easy for him to be alone at the bedside of a patient during the

late evening. This would provide him with the opportunity to give a patient something to hasten his/her death if he decided to do so.

### ***The Three Unlawful Killings***

- 7.47 All three of the deaths which I have found Shipman caused took place in the late evening. Mr Thomas Cullumbine, who died on 12<sup>th</sup> April 1972, was suffering from chronic bronchitis and emphysema. I am satisfied that, despite his young age (he was 54), his state of health was such that he had not long to live. He was a difficult patient and had discharged himself from the hospital against medical advice on two occasions in the recent past. My conclusion in this case is based mainly on the content of the medical records and the conflict between the medical and nursing records. There are no cremation certificates. Nonetheless, I have concluded that Shipman was alone with Mr Cullumbine in the late evening and that he probably administered 10mg morphine, which Shipman would have known to be dangerous for a patient with severely impaired lung function.
- 7.48 The second death that I have concluded was caused by Shipman was that of Mr John Brewster, who died at about 8.55pm on 28<sup>th</sup> April 1972. Mr Brewster had almost certainly had a heart attack on the day on which he died and, although he had survived that attack, he was at considerable risk of suffering another attack which might well prove fatal. My conclusion that Shipman probably killed him is based upon the evidence contained in the medical records and cremation forms, both of which are available. Members of Mr Brewster's family were with him until about 6pm on the day of the death. They left him conscious and comfortable. The medical notes do not record any deterioration in his condition, only his death. The relevant entry is suspiciously brief. Yet cremation Form B, completed by Shipman, states that Mr Brewster was in a coma for 40 to 50 minutes before his death and that Shipman was with him for at least part of that time – facts that he did not record in the medical notes. Cremation Form B also records that Shipman was present – apparently alone – with Mr Brewster at the moment of death. That is most unlikely if, in fact, Mr Brewster had been in a coma for 40 to 50 minutes. It is likely that a nurse would have stayed close by to keep an eye on him and that Shipman would have left the bedside; there would have been nothing that he could usefully do. In short, cremation Form B presents an unlikely story and gives rise to the real suspicion that Shipman gave Mr Brewster something that caused his death, and then stayed at the bedside while it happened. What the drug or substance was I do not know. It might have been potassium, which, if injected in sufficient concentration, will cause cardiac arrest and death very quickly. It might have been a drug, such as digoxin, which could have been given legitimately but which would be dangerous if too much were given. Another possibility is that Shipman administered aminophylline and gave it too quickly, intending to kill or possibly being reckless as to the consequences.
- 7.49 My suspicion was heightened in the case of Mr Brewster because Shipman recorded in the medical notes that there was no need to report the death to the coroner. There was such a need, as Mr Brewster had been in hospital for only about eight or nine hours at the time of the death. Yet Shipman avoided referring the case to the coroner. My suspicions are further raised because Shipman's letter to Mr Brewster's GP, written after the death, contained what I believe to be an untruth. Mr Brewster's GP had seen him at midday on

the day of his death; he arranged the admission. Shipman later informed the GP that Mr Brewster's condition had deteriorated on the way to hospital. There is no evidence that it had; indeed, such evidence as there is suggests that it had not. I consider it likely that Shipman told the GP that the patient had deteriorated in order more readily to explain what might otherwise have been a rather surprising death.

- 7.50 The third death which I have concluded was caused by Shipman was that of Mr James Rhodes, who died during the evening of 22<sup>nd</sup> May 1972. Mr Rhodes had almost certainly had a heart attack shortly before his admission to hospital in the early hours of the morning on the day of his death. He may well have had another attack shortly after his admission. He was at risk of having yet another attack, which might well prove fatal. It is quite possible that this was a natural death. However, I have concluded that it was probably not natural because of the circumstances prevailing around the time of the death, as revealed by the medical and nursing records and the cremation certificates, all of which are available. Mr Rhodes was seen by members of his family about three hours before his death. He was conscious and comfortable. It appears from the cremation Form B that Mr Rhodes fell into a coma about 20 to 30 minutes before his death and that Shipman was aware of that fact from his own observation. That implies that Shipman was with Mr Rhodes during that time. Yet he did not make any entry in the medical records. Nor does it appear that he called a nurse, as would be normal practice both at PGI and generally. The nursing records contain no note of this important change in Mr Rhodes' condition. Shipman claimed on cremation Form B that Mr Rhodes was found dead by the nurses at 9.25pm. I infer that it is likely that Shipman was with Mr Rhodes at about 9pm but chose not to make an entry in the records and not to summon a nurse because he was, in fact, administering to Mr Rhodes something which caused his death. He might well have then left Mr Rhodes' body to be found later by a nurse. I do not know what drug Shipman used.

### ***Deaths Which Arouse Suspicion***

- 7.51 In addition to the three cases in which I have found that Shipman probably killed the patient, there are, in this six-month period, three other deaths about which I feel significant suspicion and thirteen other deaths that give rise to some suspicion. All these deaths occurred in a period of three months between 29<sup>th</sup> February and 1<sup>st</sup> June 1972. It appears to me that, for the first month after his return to the medical wards, Shipman conducted himself properly but that, as his authority on the wards increased and as the nursing staff came to repose more confidence in him, his conduct began to change. The death of Mrs Macfarlane on 29<sup>th</sup> February 1972 is the first in this period about which I have expressed concern. Shipman prescribed an excessive dose of Valium for Mrs Macfarlane. She was given this dose (either by Shipman or possibly by a nurse on Shipman's instructions) some hours before her death. I am unsure of Shipman's intentions although there must be a real possibility that he was at least reckless as to the consequences of giving so much of this drug.
- 7.52 During the following three months, there are a number of cases where I suspect him of deliberately killing the patient or at the very least of administering a drug being reckless as to the consequences, not caring whether the patient lived or died. As I have said, Shipman's best opportunities for killing arose during the evening when the wards were

quiet, there would probably have been no other doctor about and there would have been a reduced level of nursing staff on duty.

- 7.53 There are some specific periods about which I have particular concern. The first is the period from 12<sup>th</sup> to 14<sup>th</sup> April. On 12<sup>th</sup> April, Shipman certified the cause of three deaths. In one, that of Mrs Kathleen Nicholson, there is insufficient evidence for me to reach a conclusion. However, I have concluded that Shipman probably killed Mr Cullumbine on that day and I have some suspicion about the death of Mrs Ada Wandless. My concern is increased by the deaths that occurred two days later on 14<sup>th</sup> April. Three deaths occurred on that day, all on Ward 1, the female medical ward. Two of them (those of Mrs Agnes Davidson and Mrs Elizabeth Thwaites) occurred late at night, at about 10.30pm. The time of the third death, that of Mrs Alice Smith, is not precisely known but her family was advised of the death at about 11pm. I infer that the death also occurred in the late evening. There is cause for suspicion about all three of these deaths. Thus, within three days, there are five worrying deaths. Indeed, if 16<sup>th</sup> April is included, there is another suspicious death, that of Mr George Fisher. He died at about 11pm.
- 7.54 On 8<sup>th</sup> May 1972, Shipman certified the deaths of two men. Mr John Harrison died at about 8.30pm and Mr Thomas Ridge about ten minutes later. I have suspicions about both deaths, more significant in the case of Mr Harrison than in that of Mr Ridge. The proximity of these deaths gives rise to additional concern.
- 7.55 Another small, but worrying, cluster of deaths occurred on 22<sup>nd</sup> May. Shipman certified four deaths on that day. In the cases of two of them, those of Mr Ernest Sheard and Mrs Lucy Houston, there is insufficient evidence for me to reach a conclusion. However, I have found that Shipman probably killed Mr Rhodes at about 9pm that evening and I have significant suspicions about the death of Mr Louis Bastow, who died at about 8.40pm. Both men died on Ward 2. The proximity of the time and place of these deaths again gives rise to additional concern.
- 7.56 The fact that I have drawn attention to particular clusters of deaths does not mean that there is no suspicion about Shipman at other times during this three-month period. There is. It seems to me that there are strong grounds to believe that Shipman embarked upon a course of conduct during this time which resulted in a significant number of premature deaths. There are common threads running through these suspicious cases which allow me to draw some general conclusions. I think his most likely victims were patients who were very poorly and whose deaths were likely to take place in the very near future. I think he might well have killed patients in the late evening in order to avoid being called out in the middle of the night. I think that he might well have killed patients who would soon die but who were occupying beds that were urgently needed for other patients. I think also that he might well have killed because he was annoyed with a patient or regarded him/her as in some way 'unworthy'.
- 7.57 I have observed that the greatest suspicion arises during a period of only three months. After 1<sup>st</sup> June 1972, there are no suspicious deaths during Shipman's remaining period on the medical wards. In fact, in June 1972, Shipman certified only five deaths but that is probably because he was away from PGI and working as a locum for the Drs Hessel. He was probably away from the wards for two weeks between about 9<sup>th</sup> June and 26<sup>th</sup> June.

The only death he certified during this period was that of a patient of the Hessels' practice. In July, he certified 14 deaths, none of which is suspicious. Moreover, during that month, he appears to have reported two deaths to the coroner, apparently because the patients had been in hospital for less than 24 hours. This suggests that he may have been obeying the rules in July in a way that he had not obeyed them earlier.

- 7.58 I suggest an explanation for this apparent change in Shipman's behaviour. On 1<sup>st</sup> June 1972, Mrs Phyllis Cooling died. At least one member of the medical staff (and probably members of the nursing staff too) knew that the death was closely associated with an injection administered by Shipman. I do not know what drug had been administered. Nor do I know whether Shipman intended to kill Mrs Cooling. There are some reasons to suspect that he did. Whether or not he intended to kill her, it seems to me quite likely that Shipman was shocked and worried by the fact that he was known to be associated with a sudden death. It appears that he was able to 'talk his way out of' any suspicion of malpractice or negligence. He was adept at that later in life. However, he may well have been subject to some criticism, either officially or in ward gossip. Later in life, whenever Shipman had narrowly escaped detection, he gave up unlawful killing for a time. It seems to me quite likely that the absence of suspicious deaths after 1<sup>st</sup> June might be explained by the fact that he had been criticised in some way over Mrs Cooling's death and was 'watching his step'.

### ***The Recollections of Nurses Working on the Medical Wards in the Spring of 1972***

- 7.59 Whether or not I am right about the reason for the change in Shipman's conduct after 1<sup>st</sup> June, there is little doubt in my mind that his conduct did change at about that time. I am satisfied that he had killed a number of patients during the previous three months and that he then stopped doing so. It seems worth observing that, when Mrs Sandra Whitehead first raised her concerns with the Inquiry, she did so in respect of this very period in the spring of 1972. In the course of the investigation, the Inquiry received evidence from three nurses (including Mrs Whitehead), who all recalled clusters of deaths on particular days during this period. These memories had stayed with them over the years as being unusual or striking in their experience. Each of these witnesses did her best to recall the details of those unusual clusters, as the Inquiry was anxious, if possible, to identify the dates on which they had occurred. In the event, it has proved impossible to identify clusters of deaths which fit exactly with the witnesses' recollections. However, there is no doubt that there were clusters of deaths on some days and I am suspicious about Shipman's involvement in some of those deaths. In my view, the fact that these three nurses should have carried with them, for over 30 years, the memory of these events suggests that there was something very unusual going on at that time.

### **The Period from August 1972 to September 1973: Shipman as a Registrar in Paediatrics**

- 7.60 During this period of 13 months, Shipman certified the causes of death of seven babies and young children. Only one death gives rise to any concern, that of Susan (Susie) Garfitt. In each of the other six cases, I am satisfied, on the evidence available, that the death was almost certainly natural.

- 7.61 I have given the deaths of these children particularly anxious consideration because Professor Baker has expressed concern about the number of times Shipman stated on cremation Form B that he was present at the death of a child under ten years. Professor Baker considered all the children's deaths that were certified by Shipman. Of the six Forms B Shipman completed in respect of the death of a child during his time at PGI, he stated on three that he had been present alone with the child at the moment of death and, on the other three forms, he said that he had been present with members of the nursing staff. On the face of it, it appears worrying that Shipman should have been present at every death of a child for which a Form B exists. However, I have reached the conclusion that each death (save that of Susie Garfitt) was natural.
- 7.62 Fortunately, deaths on a paediatric ward are rare events. In general, it will be known that a child is very ill and there will be a high level of attention from both the medical and nursing staff. That makes it much less surprising that a doctor should be present at the death. I am sure that there are many doctors who regard it as more appropriate to leave the parents alone with the child when s/he is close to death but I do not think that would have been Shipman's approach. Nor do I think that Shipman would have been content to leave the child with the nursing staff. I think he would have wanted to be there; he always liked to be the centre of attention and I find it wholly explicable that he would have wished to be present at the death of a young child for whom he had been responsible.
- 7.63 The high level of attention that a gravely ill child will usually receive also makes it most unlikely that a doctor would be present alone with the child at the moment of death. It is far more likely that there would also be a nurse in attendance and, unless the final deterioration were very rapid, parents also. If Shipman was in fact alone with a child at the moment of death, that would be a cause for real concern. However, I think it unlikely that he was alone with any of these children at the moment of death. Elsewhere in this Report, I have said that there are occasions when Shipman has implied that he was alone with the patient at death and yet, from other evidence, I am satisfied that that was not so. Why Shipman made these false or inaccurate entries on Forms B, I cannot say; but I am satisfied that, sometimes, he did. I can only say that he was cavalier about his duties of certification and sometimes made misleading entries. For that reason, I have had to approach Shipman's assertions on the Forms B in these children's cases on the basis that they may or may not be true. I have sought to put the implication of 'presence alone' into the context of the other evidence available and the general impression I have of the way in which the paediatric wards were staffed and run. I am very doubtful of his implication that he was alone with any of these children and, in the end, I am satisfied that these young children died as the result of the grave illnesses from which they suffered and not on account of any wrongful intervention by Shipman.
- 7.64 I have written a full decision about the death of Susie Garfitt. There are no medical records or cremation certificates and my decision is based upon the account given by Susie's mother. It is a clear account, supported by the friend who was with her at the time, and I have no reason to doubt it. Susie suffered from cerebral palsy; she was quadriplegic and suffered from severe epilepsy. At the time of her last admission to hospital, she was suffering from a severe chest infection. Mrs Ann Garfitt describes how a doctor (who was almost certainly Shipman) explained to her, in a gentle and kindly way, how ill her daughter

was, and how poor her prognosis. He told Mrs Garfitt that it might be possible to keep Susie alive by the administration of strong medication. He seemed to Mrs Garfitt to be suggesting that to do that would be unkind, as it would only prolong her suffering. Mrs Garfitt realised that Susie was dying and did not insist that she should be given the medication required to prolong her life. She told Shipman to **'be kind'** to Susie. She certainly did not give permission for Shipman to do anything to hasten Susie's death and did not understand Shipman to be telling her that death was imminent. She went away to have a cup of tea and when she returned – she estimates about ten minutes later – Susie was dead. That the death should have occurred so soon after the conversation between Shipman and Mrs Garfitt gives rise to the strong suspicion that Shipman did not simply withhold medication but actually administered something that precipitated the death. I have limited myself to saying that I am suspicious about this death because there is no contemporaneous documentary evidence available to confirm Mrs Garfitt's recollection. A failure of recollection is possible. It is also possible that, in the conversation, Shipman was trying to tell Mrs Garfitt that Susie's death was indeed imminent. Nonetheless, I am bound to feel suspicion, especially when I take into account Shipman's attitude towards death, of which I wrote in Chapter Thirteen of my First Report. I said there that Shipman seemed to think that he knew when the right time had come for some patients to die. It is entirely possible that he had taken that view with Susie Garfitt.

### **The Period between September 1973 and February 1974: Shipman as a Senior House Officer in Obstetrics and Gynaecology**

- 7.65 Shipman certified the deaths of only two patients during this period. So little is known about these two deaths that I have been unable to reach any conclusions. However, I stress that there is no reason to suspect that Shipman was unlawfully involved in either case.
- 7.66 This period of Shipman's career is of some interest for a different reason. It was the period immediately preceding his entry to general practice at the Abraham Ormerod Medical Centre in Todmorden. Within a few weeks of moving to Todmorden, Shipman had begun obtaining quite large quantities of pethidine from the pharmacy at Boots the Chemists. Initially, he obtained the drug on requisition (signed order), ostensibly on behalf of the practice. He told the pharmacist that the drug was needed by the midwives who worked in association with the practice. In fact, he wanted it for his own use. The amounts that he obtained from April 1974 onwards suggest that he was already habituated to pethidine by the time he arrived in Todmorden. If he was, the question arises as to when he became habituated to the drug.
- 7.67 The evidence relating to the use of pethidine at PGI is to some extent conflicting. Some witnesses suggest that it was in general use as an analgesic on all wards. Other witnesses say that that was not so and that other drugs, particularly morphine and diamorphine, were in more regular use on the medical and surgical wards. However, it is clear beyond doubt that pethidine was in very regular use in the obstetric unit, which opened in September 1973.
- 7.68 The evidence suggests that the use of controlled drugs was very strictly regulated at PGI and I am satisfied that, in general, it would not have been easy for Shipman to obtain



pethidine for his own use. However, the evidence also suggests that, because pethidine was so frequently used during childbirth, it would have been much easier and quite practicable for Shipman to obtain supplies of pethidine for himself during this final period in 1973/74. Bearing in mind the rapidity with which Shipman began to obtain supplies illicitly on arrival in Todmorden, I have come to the conclusion that, in all probability, he commenced his abuse of pethidine during his last few months or weeks at PGI.

## Conclusions

- 7.69 My conclusions about Shipman's activities at PGI are necessarily imprecise. It is quite likely that he killed one or two patients while working on the medical wards in 1971. It is, I believe, very likely that he killed patients while working as a SHO on the medical wards in 1972. I do not think that he killed anyone while working on the surgical or gynaecological wards and I have concerns about only one death that occurred while he was working on the paediatric wards.
- 7.70 Exactly how many patients he killed, I am unable to say. I feel reasonably confident that I have correctly identified three victims, Mr Cullumbine, Mr Brewster and Mr Rhodes. However, I think it likely that there were other victims besides these three whom I have been unable positively to identify. The patients about whose deaths I have expressed significant suspicion are the most obvious candidates but it is also possible that some of those about whose deaths I have only some suspicion were in fact victims. I cannot rule out the possibility that some of the deaths about which there is so little evidence that I have not been able to reach a conclusion were in fact unlawful killings. I regret that I am not able to be more definite. I am deeply conscious of the fact that many families have co-operated with the Inquiry in the expectation that they will find out the truth about their relatives' deaths and that that expectation has not been fulfilled in many cases.
- 7.71 I am unable to say with any degree of confidence how Shipman killed patients in PGI. I think it unlikely that he usually used opiate drugs, as he did later in his career. The use of controlled drugs was very strictly regulated at PGI and it would not have been easy for Shipman to obtain such drugs, unless they were officially prescribed. I think it likely that he used morphine to kill Mr Cullumbine. Shipman had prescribed morphine for him to be given if necessary. He claimed he had not administered it but I am satisfied that he did and that he knew that the dose given (10mg) would be dangerous for a man with severely compromised respiratory function. There may have been other cases in which Shipman used an opiate drug but, if so, I have not been able to identify them. As I explained in Chapter Four, there were other drugs that were readily available on the wards and which Shipman could have used to lethal effect.
- 7.72 I have formed the view that, while he was working at PGI, Shipman's most likely victims were patients who were very ill and were likely to die in the near future in any event. I cannot say that with certainty but that is my impression. Bearing in mind the characteristics that I discussed in Chapter Thirteen of my First Report, it seems likely that Shipman would have started by hastening the deaths of people who would inevitably die soon. He seemed to think that he always knew when the time to die had come. It is clear that, in later years, he killed healthy patients too but it 'makes sense' that he would have started with the very sick,

whose quality of life was severely impaired. I am quite satisfied that, in the only case in which I think he might have killed a child (Susie Garfitt), he was convinced that she was very ill and that she would never have any reasonable quality of life. By saying this, I do not seek to excuse his actions. However, it does seem to me that his later actions become more explicable if it is understood that he began by killing the terminally ill.

- 7.73 I think also that, in the early days, one of Shipman's motivations may well have been a desire to experiment with drugs. There is some evidence that he liked to 'test the boundaries' of certain forms of treatment. He openly gave 40mg Valium to a young woman in the accident and emergency department. He is known to have caused a patient's collapse by administering a drug (probably aminophylline) too quickly. He himself was to become addicted to or dependent on pethidine. I think he was fascinated by drugs and liked to experiment with them. Another example of that is seen in his treatment of Mrs (later Professor) Elaine Oswald in August 1974. I wrote about that incident in the First Report. Shipman gave her an injection of pethidine soon after she had taken two diconal tablets (on his instruction). She collapsed and went into respiratory arrest. I do not claim to understand his motivation on that occasion, save that I am sure he did not intend to kill Mrs Oswald. However, his behaviour is consistent with a fascination with drugs.
- 7.74 I think it is quite likely that some of the deaths Shipman caused resulted from experimentation with drugs. I think it quite likely that he would have tried out larger than usual doses of drugs being reckless as to the consequences for his patients who were often elderly and very ill. I have identified three cases where Shipman is recorded as having given or prescribed inappropriate or larger than usual amounts of a sedative drug. I suspect in each case that Shipman might have intended to hasten the patient's death or was reckless as to whether or not death would be hastened. However, it is quite possible that other deaths were caused as the result of reckless experimentation with drugs, rather than as a result of a positive intent to kill.
- 7.75 I realise that the public wishes to know how many patients Shipman killed while working in Pontefract. Professor Baker's statistical analysis is not able to provide an answer and, if I am to make an estimate, it must be based upon impression rather than analysis. Doing my best, on the basis of everything I know, I estimate that, while at Pontefract, Shipman probably caused the deaths of between ten and fifteen patients.
- 7.76 In the light of my conclusion that Shipman did indeed begin killing patients while working at PGI, I felt it necessary to reconsider those deaths that occurred at Todmorden about which I was suspicious, but which I was not persuaded that he had caused. The fact that, when he arrived in Todmorden, Shipman was already an established killer inevitably raises the general level of suspicion about his activities there. I was particularly anxious to reconsider my decisions in relation to the three deaths that occurred on the same day, 21<sup>st</sup> January 1975. However, reconsideration of all these suspicious deaths has not caused me to alter any of my decisions. I still regard each of those cases as suspicious but the evidence is not such that I could make a finding of unlawful killing. I think it is likely that Shipman did kill some of the patients about whose deaths I am suspicious but I cannot identify how many or which ones.

- 7.77 There were a number of suspicious deaths during the early years of Shipman's practice in Hyde. I have reconsidered them in the light of my belief that Shipman began killing earlier than I had previously thought. However, I do not wish to alter my decision in any of those early cases.
- 7.78 Since the publication of my First Report, in which I identified 215 deaths for which Shipman was responsible, there has been speculation in the press about the total number for which he was responsible. I accept of course that some of the deaths that I said were suspicious must in fact have been unlawful killings. Professor Baker's statistical analysis suggested that the total number of unlawful killings was of the order of 236. If I were to assume that 50% of the deaths that I regarded as suspicious were in fact unlawful killings, my estimate for the Todmorden and Hyde years would come to 237 or 238, very close indeed to Professor Baker's estimate. That being so, it seems to me not unreasonable to take Professor Baker's figure as the most reliable estimate of the number of unlawful killings during these two periods. If I then add in my estimate of unlawful killings in Pontefract, I arrive at a total of about 250 deaths. My overall conclusion is that Shipman killed about 250 patients between 1971 and 1998, of whom I have been able positively to identify 218.

