CHAPTER THIRTEEN

The Death of Mrs Renate Overton

Introduction

13.1 In Phase One, the Inquiry investigated the death of Mrs Renate Overton, who died on 21st April 1995, at the age of 47. For 14 months before her death, she had lain unconscious and brain damaged in Tameside General Hospital. She had been admitted in the late evening of Friday, 18th February 1994. During that evening, Shipman had attended her home to treat her for an asthma attack. She had collapsed in his presence, in cardiac and respiratory arrest. Mrs Overton's daughter was in the house and an ambulance was called. By the time the ambulance arrived, Mrs Overton was deeply and irreversibly unconscious. The paramedics re-started her heart and took her to hospital. Shipman himself recorded in Mrs Overton's medical records that he had given her a quantity of diamorphine. My conclusion was that Shipman had deliberately given Mrs Overton an overdose of diamorphine (or possibly morphine), intending to kill her, and that this had caused her collapse, her unconsciousness and, ultimately, her death. My decision in this case is at page 283 of Volume Five of my First Report.

13.2 Consideration of this death in Phase One caused me to realise that it had many disturbing features, quite apart from Shipman's own actions. First, it became apparent to me from examination of the hospital records that the doctors at the Tameside General Hospital realised that Shipman had given Mrs Overton an intravenous bolus dose (i.e. a dose given quickly and 'in one go') of an opiate (they thought it was 20mg morphine), which had probably caused her collapse. It also appeared that they knew that such a dose, given in that way, was excessive and dangerous, especially when given to a patient suffering from asthma. Yet, it appeared that no report had been made of Shipman's conduct and no investigation into Mrs Overton's collapse was initiated. It seemed possible that an opportunity to uncover Shipman's criminality had been missed. Second, Mrs Overton's death was reported to the Coroner. The report of the death drew attention to the possibility that morphine administration with asthma had been an underlying cause of death. An autopsy had taken place but had recorded that the death was due to hypoxic cerebral degeneration and was due to 'natural causes'. No inquest was held. It appeared possible that a second opportunity to uncover Shipman's criminality had been missed.

13.3 In Phase Two of the Inquiry, I was to examine the actions of those with responsibility for the procedures and investigations following the deaths of Shipman's victims. I was also to examine the conduct of those with responsibility for the monitoring of primary care provision and the use of controlled drugs. I resolved that the circumstances of Mrs Overton's death, and the conduct of all those involved in her treatment and in reporting and enquiring into the circumstances of her death, should be fully investigated. This Chapter contains the results of that investigation.

Background

13.4 Mrs Overton was a cigarette smoker and probably drank quite heavily. She suffered from asthma, hypothyroidism, epilepsy, anxiety and depression. She was, nevertheless, active and independent. She had previously worked as a nurse.

13.5 Mrs Overton's medical records show that, until 10th February 1994, she had never complained of any symptoms suggestive of ischaemic heart disease. On that date, according to the handwritten records, Mrs Overton attended Shipman's surgery for a routine asthma check, almost certainly carried out by the practice nurse. The notes suggest that, whilst there, Mrs Overton complained of a heavy feeling in her chest, numbness in her left arm and shortness of breath. It appears that Shipman was told of this, possibly saw Mrs Overton and prescribed Tildiem, an anti-anginal and anti-hypertensive drug. There is a corresponding entry in the computerised records describing chest pain and the prescription of Tildiem. Shipman added no further details to the history, recorded no examination and arranged no investigation.

13.6 In my First Report, I found that it was not possible to determine whether or not these symptoms were in fact cardiac in origin. However, I doubt that they were. Although Mrs Overton's smoking habit put her at risk of cardiac disease, a battery of tests following her admission to hospital suggested that she did not have heart disease. The autopsy carried out in April 1995 revealed no ischaemic heart disease. I find it suspicious that, having apparently diagnosed angina, Shipman instigated no further investigations.

The Events of Friday, 18th February 1994

Mrs Overton's Collapse

13.7 In February 1994, Mrs Overton was living at 56A Green Street, Hyde, with her 22 year old daughter, Mrs Sharon Carrington.

13.8 At about 8pm on 18th February 1994, Mrs Overton returned home after having been out drinking in Hyde. Mrs Carrington thought that her mother had had too much to drink; also she was wheezing quite badly. After a short while, Mrs Overton telephoned Shipman because of her breathing problems. Mrs Carrington was not particularly concerned because the breathing difficulties did not appear to be unduly serious.

13.9 Shipman arrived within about half an hour. Mrs Carrington showed him into the front room where her mother was waiting. He had brought a nebuliser with him. A nebuliser is a portable air compressor; it delivers a drug to the patient in the form of a fine mist, which the patient inhales through a mask. This is a very effective way of giving a drug to a patient suffering an asthma attack, when co-ordination and respiratory effort are often poor. Mrs Carrington decided to go up to her room, leaving her mother, as she thought, in safe hands. She told Shipman where he could find her if he needed her. She went to her room and closed the door behind her.

13.10 Between ten and 15 minutes later, Mrs Carrington heard Shipman banging on the bannister rail and shouting for her to come downstairs quickly. She came on to the landing and saw Shipman at the foot of the stairs. She went downstairs and followed him into the front room where she saw her mother lying on her back on the floor, apparently unconscious. She sounded as though she was gasping for air.

13.11 At Shipman's request, Mrs Carrington commenced mouth-to-mouth resuscitation and, as she did so, Shipman gave external cardiac massage. They continued in this way for a

short while until Shipman reached into his bag and took out a needle and syringe. Mrs Carrington asked Shipman what he was intending to inject. She cannot recall Shipman's exact response but he said either that it was morphine or that it was adrenaline. He said that the injection was to ease Mrs Overton's breathing and he proceeded to inject the contents of the syringe into the crook of Mrs Overton's left arm. Within moments of the injection Mrs Overton seemed to stop breathing altogether.

13.12 Shipman instructed Mrs Carrington to telephone for an ambulance. She left the room to make the telephone call. She recalls that Shipman shouted to her, 'Tell them she's gone into respiratory arrest.' When she returned to the front room, Mrs Carrington continued with mouth-to-mouth resuscitation and Shipman continued with cardiac massage. According to Mrs Carrington, the ambulance arrived within a few minutes.

The Arrival of the Ambulance

13.13 The Greater Manchester Emergency and Paramedic Service Patient Report Form (PRF) reveals that the ambulance crew received the call to attend Mrs Overton's house at 9.33pm and arrived at 9.40pm. The crew members were Mr Neil Harrop, a paramedic and himself a patient of Shipman, and Mr Michael Smith, an ambulance technician. Both gave oral evidence to the Inquiry. They said that they saw Mrs Overton lying on her back on the floor and that cardiopulmonary resuscitation was in progress.

13.14 Mr Smith took over the resuscitation from Shipman while Shipman gave the history to Mr Harrop. He explained that he had been called out to see Mrs Overton because she was suffering an asthma attack. He said that, whilst he was with her, she had begun to complain of chest pain and he had suspected she was suffering a heart attack. He said that he had given morphine because of her pain. Mr Harrop recorded on the PRF that the mechanism of injury or medical history was cardiac arrest.

13.15 Mr Harrop assessed Mrs Overton's condition. He detected neither pulse nor respiration. The heart was in ventricular fibrillation. He attempted defibrillation. A first attempt met with no success, and a second, though partially successful, was not effective in restoring a proper heartbeat or sinus rhythm. It resulted in a period of electromechanical disassociation (EMD), a hybrid state of affairs in which there is discernible electrical activity within the heart but no pulse.

13.16 At about 9.50pm, Mr Harrop administered intravenous adrenaline (which was appropriate treatment) and succeeded in establishing a sinus rhythm. However, Mrs Overton remained in respiratory arrest. Mr Harrop then gave lignocaine so as to reduce the risk of refractory ventricular fibrillation. Mrs Overton was then transferred to the ambulance and taken to hospital.

13.17 Mr Harrop recorded his treatment of Mrs Overton on the PRF. When he first completed the form, he omitted to mention that the second attempt at defibrillation had resulted in EMD. The top copy of the PRF was left at the hospital with Mrs Overton. When he left the hospital, Mr Harrop realised that he had made an error and, on the carbon copy, he noted that the second attempt had resulted in EMD and that the intravenous adrenaline had then produced a sinus rhythm. The carbon copy was recovered from the file retained by the ambulance service.

13.18 Mr Harrop also recorded on the PRF that a spontaneous pulse was achieved at the scene. He explained in evidence that, by this expression, he meant that the heart was 'beating on its own with no longer having to do cardiac compressions'. Although his use of this term has been questioned, I think that his use of the word 'spontaneous' was entirely reasonable.

13.19 According to Mr Harrop, either he or Mr Smith would have contacted the hospital by radio to tell the staff that they were bringing in a patient who was 'post-VF arrest', to describe the treatment they had given and to advise of their estimated time of arrival. He said that they would not necessarily have informed the hospital of the circumstances giving rise to the collapse, prior to arrival at the hospital. Such information would usually be communicated on arrival and, as I will explain shortly, I am sure that this is what happened on this occasion.

13.20 Even at the time, it struck Mr Harrop as very unusual that Shipman should have administered morphine to a patient who was experiencing breathing difficulties. He knew that morphine depresses the central nervous system, acts as a respiratory depressant and would normally be contra-indicated for a patient suffering from asthma. Mr Harrop did not raise the issue with Shipman, partly because he would always defer to the judgement of a doctor and partly because he was too busy.

Shipman's Note of His Treatment and First Contact with the Hospital

13.21 Shipman's handwritten note for 18th February 1994 is uncharacteristically detailed. It reads as follows:

> **'V**[*visit*] **Called at 8.50.**
> **arrived 9.15 – Acute Asthma**
> **given nebuliser**
> **Pulmicort nebul. × 1**
> **Ventolin nebul × 5ml.**
> **BP 150/100. HR 120/m**
> **Resp > 30.**
> **After nebuliser A/E = BS good**
> **not cyanosed**
> **Approx 9.30 collapsed C/O chest**
> **pain sweating + pulse thready**
> **given IV diamorphine 10mg stat (only**
> **dose in bag)**
> **Settled then ?arrested**
> **Laid down ECM × 5**
> **Daughter called**
> **MTM/established patient**
> **ECM/not cyanosed**
> **pupils dilated fixed**
> **Ambulance called. pupils dilated**
> **ECM/ maintained**

MTM/
15 mins Ambulance crew IV Adrenaline
IV Lignocaine. Intubated pink
pupils fixed dilated'

Then, continued on a separate sheet:

'H/R. established output OK
[*illegible*] **No respiration established**
→TGH
CAS S/N informed of arrival
+ diagnosis + Rx'

13.22 This note suggests that, when Shipman arrived at 9.15pm, he found Mrs Overton suffering an acute asthma attack. He gave Pulmicort and Ventolin through a nebuliser. He recorded Mrs Overton's blood pressure as 150/100 and her heart rate at 120 beats per minute. The respiratory rate was said to be greater than 30 breaths per minute. The note states that, after the nebuliser, Mrs Overton's air entry was equal on both sides and the breath sounds were good. She was not cyanosed. If this were so, it would represent a good response to the nebuliser.

13.23 The note also suggests that, at about 9.30pm, Mrs Overton collapsed, complaining of chest pain. She was sweating profusely and her pulse was thready. Shipman's response was apparently to give Mrs Overton 10mg diamorphine intravenously, which, he noted, was the only dose available in his bag. If that were intended to be an excuse for giving a larger than appropriate dose, it would not be a satisfactory one. Even though the doctor might load a large dose into the syringe, he need not inject it all. When giving an opiate for the relief of cardiac pain, the injection should be given slowly, and should be stopped as soon as the desired effect has been achieved. This method of administration is known as titration against response and it should be contrasted with the administration of a 'stat' or 'bolus' dose. It appears from the handwritten record that Shipman had originally written not **'diamorphine'**, but **'morphine'**. Diamorphine is twice as potent as morphine. The note says that Mrs Overton **'settled'** but then **'?arrested'**, which would suggest that her heartbeat and respiration probably stopped. The rest of the note describes Shipman's attempts to resuscitate Mrs Overton, his calling of her daughter and the arrival of the ambulance crew. There are three references in the note to Mrs Overton's pupils being dilated or fixed and dilated.

13.24 The last two lines of the note suggest that Shipman himself contacted the casualty department of the hospital and told a staff nurse there of Mrs Overton's imminent arrival, the diagnosis he had made and the treatment he had given. It is not clear who took that message but it is likely that it contributed to the history as recorded in the hospital records.

13.25 Mrs Carrington contacted her mother's parents to tell them of Mrs Overton's collapse. They came to the house and arrived just as the ambulance was leaving. Mrs Carrington travelled in the ambulance; her grandparents followed. Mrs Carrington has no recollection of the journey, no doubt due to the extremely distressing nature of the situation in which she found herself.

Arrival at the Hospital and Triage

13.26 Mr Harrop recalled that, when the ambulance arrived at the casualty department, at about 10.10pm, Mrs Karen Taylor, the triage nurse, and other emergency staff were waiting at the entrance and Mrs Overton was taken to the resuscitation area. Mr Harrop gave the history to the casualty staff and someone told him that Shipman either was or had been on the telephone.

13.27 Mrs Taylor made the first entry in the clinical notes. It reads as follows:

> **'H/O** [*history of*] **asthma attack**
> **SB** [*seen by*] **GP at home**
> **given nebuliser**
> **Pulmicort** + **Ventolin**
> **after neb Pt** [*patient]*
> **went into cardiac**
> **arrest.**
> **O/A** [*on arrival*] **Intubated i/c** [*with cardiac*]
> **output**
> **Given morphine by**
> **GP'**

13.28 In evidence, Mrs Taylor said that she believes that she must have obtained this history from the ambulance personnel. She would have made the note after her involvement with the patient ceased, which would have been immediately after she had seen Mrs Overton safely into the resuscitation room. She was with Mrs Overton for only about 'a couple of minutes'.

13.29 Mrs Taylor said that she was struck, as Mr Harrop and Mr Smith had been, by the information that a respiratory depressant, such as morphine, had been given to someone suffering an asthma attack. This was most unusual and her immediate thought was that the doctor had made a mistake. Her evidence was similar to that of many of her medical and nursing colleagues. She knew that morphine should not normally be given to an asthmatic. If it is to be given, perhaps because of the presence of severe chest pain suggestive of a heart attack, she knew that it should be titrated against response and, had she been told that 20mg had been given, she would have known that that would be an excessive dose.

13.30 Mrs Taylor's note makes no mention of the dosage of morphine given. This suggests that she was not told the dosage. If she had been told, I think she would have noted it in the records. Also, the ambulance crew have no recollection that they were told the dosage. It appears that the information about the dosage had not yet been communicated to those in charge of Mrs Overton's care.

Assessment by the Casualty Doctor

13.31 The first hospital doctor to see Mrs Overton that night was Dr Simon Siong Sih Lee, the casualty senior house officer (SHO). He does not remember having any contact with the

family. Dr Lee's responsibility was to maintain Mrs Overton in a stable condition and, once he had done so, to pass her care on to his specialist colleagues. He was directly involved with her treatment for about ten minutes. He probably referred Mrs Overton first to the medical SHO on call, Dr Li Cher Loh. There is the possibility that he simultaneously referred Mrs Overton to the SHO in anaesthetics, Dr Ratna Mukhopadhyay, who certainly became involved in Mrs Overton's treatment within a short time. The precise sequence is of no great importance.

13.32 Dr Lee made an entry in the records at 10.30pm, which reads as follows:

'asthmatic + H/O IHD (?MI previously)
Asthmatic attack (SOB and wheezy)→
Respiratory arrest → cardiac arrest
VF → D/C Shocked into SR + Adrenaline ×
Lignocaine × 1 } **by Paramedic**
No chest pain before collapsing
given morphine 20mg IV by GP
On arrival o/e Intubated correct position
o pneumothorax AE [*illegible*]
O_2 Sat 99% on 12 l/m
P 107 BP 108/73
Rx – Naloxone
– Blood (FBC, U + E [*illegible*]**)**
– CXR, ECG – SR
Admit ITU'

13.33 This note suggests that Mrs Overton was a known asthmatic with a history of ischaemic heart disease who had possibly suffered a myocardial infarction in the past; she had suffered an asthma attack, with symptoms of shortness of breath and wheeze, which had been followed by respiratory arrest and then cardiac arrest. She had gone into ventricular fibrillation and the paramedics had then 'shocked' her into sinus rhythm. She had also been given adrenaline and lignocaine. Dr Lee noted that she had suffered no chest pain before collapsing and that she had been given 20mg morphine intravenously by her GP. This is the first reference to the dose of morphine given. The note states that the dose was given intravenously but does not say whether it had been titrated against response or given as a bolus or stat dose. On examination, Dr Lee found that Mrs Overton had been correctly intubated. There was no pneumothorax and it appears from the note that air entry was equal on both sides. Dr Lee administered naloxone, the antidote to morphine. It is clear that he thought that morphine was the cause or one of the causes of Mrs Overton's collapse and he told the police that the dosage of naloxone was 400mg. Blood samples were sent for examination. An electrocardiogram (ECG) was ordered and showed that the heart was in sinus rhythm. A chest x-ray was ordered. Mrs Overton was to be admitted to the Intensive Treatment Unit (ITU).

13.34 I cannot be sure who was the source of the information that Mrs Overton had suffered no chest pain prior to her collapse. Mrs Carrington did not believe that her mother had

suffered any chest pain and it is possible that she gave this information directly to Dr Lee. It is most unlikely that it came from Mr Harrop, who seems to have told Mrs Taylor that Mrs Overton had collapsed complaining of chest pain. It is clear that Dr Lee had not seen Mrs Taylor's note when he made his own record.

13.35 As to the dosage and mode of administration, Dr Lee told the police in February 1999 that he had some recollection that Shipman had telephoned the casualty department and told a member of staff that he had given Mrs Overton 20mg morphine. In the statement he made to the Inquiry in November 2002, which he essentially confirmed in his oral evidence, Dr Lee said that he believed that, after he had been told that morphine had been administered, he asked one of the nurses to telephone Shipman to find out exactly how much morphine Mrs Overton had been given. His recollection was that Shipman could not at first be contacted but that he later telephoned the hospital to give the information. Dr Lee explained that he would have wanted to know how much morphine had been given so that he would be able to administer an appropriate dosage of the antidote.

13.36 A second entry in Mrs Overton's general practitioner records about the events of that night also strongly suggests that Shipman was the source of the information concerning the dose. It reads as follows:

> **'18/2/94 T 10.45 CAS Rang - S/N**
> **? dose of diamorphine at time**
> **No established respiration yet.'**

13.37 This entry seems to record that the staff nurse from the casualty department of the hospital had telephoned Shipman at about 10.45pm, querying the dosage of diamorphine (or morphine) he had given. It is most likely that it was Shipman, therefore, who provided the information that he had given 20mg of morphine. He had at an earlier point in the general practitioner records written that it was 10mg diamorphine. Insofar as there is an obvious discrepancy between the two sets of notes, with the general practitioner notes implying he told the staff nurse that it was diamorphine that was given, and the nursing notes suggesting that he said that morphine was given, I prefer the latter. In other words, I believe that Shipman said in this telephone call that he had given 20mg morphine. In fact, he had given a substantial overdose of diamorphine.

Assessment by Dr Loh

13.38 Dr Loh was probably the next doctor after Dr Lee to see Mrs Overton. He probably saw her shortly before 10.40pm. He now lives in Malaysia and provided a witness statement to the Inquiry, in which he elaborated on the clinical notes that he made at the time. He did not attend to give oral evidence.

13.39 Dr Loh assessed Mrs Overton in the casualty department and decided that she should be transferred to the ITU. He contacted the SHO in anaesthetics, Dr Mukhopadhyay, through whom the necessary transfer arrangements were to be made. Dr Loh recollects that someone mentioned at some stage that Shipman had telephoned the hospital.

13.40 After seeing Mrs Overton, Dr Loh made an extensive entry in the records, beginning at about 11pm. The first part of that note is self-explanatory and concerns Mrs Overton's collapse and resuscitation:

> **'Well**
> **Went out @ 3pm today**
> **Came home ≃ 9pm.**
> **''Wheeze'' + ''SOB''**
> **Knocked on daughter's door**
> **(lives c̄ her).**
> **Called GP →**
> **Gave Nebuliser. Partially**
> **relieved. dev. ?chest pain**
> **Given IV ''Morphine'' 20mg stat.**
> **→ became unresponsive – started CPR.**
> **Called Paramedics.**
> **Noted VF.**
> **Cardio** [*illegible*] **200J**
> **then 200J → S.R. then**
> **also Adrenalin 1mg IV** **Given**
> **Lignocaine 100mg IV**
> **Intubated + Ventilated'**

13.41 I note that Dr Loh queried whether Mrs Overton had complained of chest pain. He recorded that 20mg morphine had been given as a stat dose (i.e. it had not been titrated against response).

13.42 Dr Loh then made further notes in which he recorded that Mrs Overton was not breathing spontaneously and was on a ventilator. Her heartbeat was 90, regular and in sinus rhythm and heart sounds were normal. There was no raised jugular venous pressure and her chest was found to be clear on both sides. Other findings on examination were that she had no rash or meningism. Her pupils were pinpoint and poorly reactive. She was flaccid in all four limbs.

13.43 Dr Loh went on to make detailed notes concerning Mrs Overton's previous medical and social history. He noted the history of hypothyroidism, **'asthma/bronchitis x years'** and epilepsy that was said to be well controlled. He mentioned that there was a possible history of angina but no family history of ischaemic heart disease. He believes that he obtained this history from the family, whom he described as being supportive. He also obtained information from them as to the type of regular medication that Mrs Overton was taking for these complaints, but he did not obtain any information as to the dosage.

13.44 Dr Loh then went on to record the results of a number of clinical tests that had been performed by himself or his colleagues. In particular, he noted that an ECG had excluded any acute cardiac changes, that the heart was in sinus rhythm (confirming the observation of his colleague Dr Lee) and that a chest x-ray revealed nothing abnormal. In brief, according to his witness statement, the evidence available at that time suggested to him that Mrs Overton had not suffered a heart attack.

13.45 Dr Loh recorded the following provisional assessment:

> **'47 yo lady**
> **Acute Onset SOB c̄ Wheeze**
> **followed with respiratory arrest?**
> **?ppt by morphine IV**
> **Hypoxia to cardiomyocardium**
> **c̄ VF'**

13.46 In effect, his assessment was that Mrs Overton had suffered an acute attack of shortness of breath with wheeze. An intravenous injection of morphine had then been given which Dr Loh suspected had precipitated respiratory arrest. This had resulted in the reduction or cessation of oxygenation to the heart muscle, leading in turn to ventricular fibrillation. This assessment was entirely reasonable on the basis of the information available and was, in the event, proved to be correct.

13.47 Dr Loh then went on to deal with Mrs Overton's future management. He recommended that Mrs Overton should remain ventilated. He suggested that enquiries as to her regular dosage of medication be made of her general practitioner the following day.

Transfer to the Intensive Treatment Unit

13.48 Dr Mukhopadhyay attended the casualty department at 10.40pm. She made a detailed note as follows:

> **'Attended casualty for fast bleep at 10-40P.M.**
> **47 yrs old lady asthmatic, epileptic,**
> **hypothyroid had an attack of asthma at**
> **home. GP was called in. She had**
> **ventolin nebuliser. After that (reason**
> **unknown) 20mg of Morphine (IM or IV)**
> **given by G.P. Patient had respiratory**
> **arrest. When ambulance man reached**
> **She was on** [*sic*] **ventricular fibrillation (VF)**
> **She had D.C. Shock 200J twice.**
> **She had adrenaline, lignocaine.**
> **VF turned into Sinus rhythm. Endotracheal**
> **tube was put in as she was not**
> **breathing.**
> **In casualty ventilation with**
> **100% O2 done. Naloxone 400mg given I.V.**
> **Patient is completely sedated. NO response**
> **(Dr. Wright was informed. Advised**
> **to keep on ventilator for to-night.)**
> **O/E: P-100/min (R)**
> **B.P. – 96/60**
> **Pupil – constricted (both), no reaction**
> **to light.**

Lungs – No adventitious sound.
Heart – I, II, regular heart
CNS – no reflex could be elicited.
Plantar – no response'

13.49 It would appear from this extract from Dr Mukhopadhyay's note that she saw Mrs Overton at 10.40pm. Having briefly noted the circumstances in which Mrs Overton had been attended and nebulised by her general practitioner, Dr Mukhopadhyay recorded that Mrs Overton had been given 20mg morphine either intramuscularly or intravenously by the general practitioner. She stated that the reason for his doing so was unknown. She made no mention of chest pain. She then described the circumstances of Mrs Overton's resuscitation.

13.50 Dr Mukhopadhyay knew that Mrs Overton would have to be admitted to the ITU. Before this could be done, however, she had to obtain permission from the ITU consultant anaesthetist on call, Dr John Wright. His name appears in this note. Dr Mukhopadhyay duly telephoned Dr Wright at home. There is an issue between them as to what was said. I will address this issue shortly.

13.51 Having described her findings on examination of Mrs Overton, Dr Mukhopadhyay recorded the results of the biochemical investigations that had also been noted by Dr Loh together with certain blood gas results. Having done so, she wrote that her diagnosis was:

'Asthmatic attack c̄ Hypoxia
(potentiated c̄ Morphine) leading to
VF.'

13.52 Dr Mukhopadhyay's diagnosis was thus that Mrs Overton had suffered an asthmatic attack with hypoxia, potentiated by morphine, and this had led to ventricular fibrillation. Dr Mukhopadhyay did not sign her note and it is likely that she was called away before she had time to do so. I am sure that this was a typically busy Friday evening in the casualty department. Dr Mukhopadhyay then gave certain advice as to how Mrs Overton was to be managed overnight, based on what she was told by Dr Wright.

13.53 According to Dr Mukhopadhyay, she not only told Dr Wright that she wanted Mrs Overton to be admitted to the ITU but also conveyed the relevant and important parts of the history which she had noted in Mrs Overton's medical records, including the fact that 20mg morphine had been given. She said that she would have done this, as it was her normal practice. I accept that the giving of morphine would be a relevant part of the history, particularly as the dose was very large and Dr Mukhopadhyay believed that the collapse had been potentiated by the morphine.

13.54 Dr Wright has no recollection of the events of that evening. His belief is that he was simply asked to authorise admission to the ITU. If the staff were busy, he would be provided only with the essential information. I find that hard to accept. I would expect that the consultant anaesthetist, who was in effect the 'gatekeeper' of the ITU, would wish to know something of the patient's history and any provisional diagnosis before giving permission for her to be admitted to the ITU, which had a very limited number of beds.

13.55 In one of the witness statements he made to the Inquiry, Dr Wright stated:

> **'Whether Dr Mukhopadhyay did or did not advise me of all the matters recorded on the history sheet as she says, my only concern would have been as to whether the patient needed to be ventilated or not.'**

13.56 Dr Wright said in oral evidence, however, that he would have had more than one concern. If made aware of the full circumstances, his first concern would have been to arrange treatment and his second concern would have been to investigate the circumstances of the overdose. He said that to give 20mg morphine would have been 'ludicrous', 'a gross overdose' and he would have followed up the suggestion that such a dose had been given by asking further questions of Dr Mukhopadhyay. If the information had been confirmed by her, he would have considered trying to contact Shipman and would have made it his 'business' to raise it with Dr Husaini or Dr Brown. He recollects no such discussion with either colleague. I am sure that none in fact took place. I am unconvinced by Dr Wright's claim. He had very limited responsibility for Mrs Overton. By the following morning, Dr Murtaza Husain Husaini, a consultant cardiologist and a joint director of the ITU, would be on duty and would become responsible for Mrs Overton's care. Dr Geraint Ceri Stewart Brown, a consultant anaesthetist and also joint director of the ITU, was to come on duty and assume joint care of Mrs Overton with Dr Husaini on the following Monday. There was no urgency that night to investigate the circumstances of Mrs Overton's collapse. I find it hard to believe that Dr Wright would have been so extremely conscientious that he would have made enquiries that could quite easily and more appropriately be carried out by others over the following days.

13.57 On balance, I think it likely that Dr Mukhopadhyay did mention the relevant and important parts of the history, including the fact that 20mg morphine had been given and that she thought this had caused or contributed to the collapse. However, I also think it likely that the significance of what he was told did not register with Dr Wright. This may well have been because his main concern was with the immediate future management of a patient who was admitted, not under his care, but under the care of consultant colleagues who were very shortly to be directly involved in the management of the patient. I am not critical of Dr Wright for failing to act upon the information he received about Mrs Overton. He was never directly responsible for her care and he knew that other consultants would soon be fully aware of what had happened.

13.58 At about 11pm, Mrs Overton was admitted to the ITU. A nursing note made by Nurse Susan Millward records as follows:

> **'Emergency admission via A + E.**
> **Called emergency GP this evening**
> **Extremely breathless. Had nebs × 2.**
> **daughter says felt easier. GP says Renate**
> **c/o chest pain Morphine 20 mg given**
> **IV. Paramedics arrived...**
> **... On arrival to A + E Unconscious**
> **pupils fixed and pin point ...**
> **... Sinus rhythm 68 bpm. Temp 33C axilla ...'**

13.59 These notes support the inference I have drawn that Shipman had been in contact with the hospital and had said that he had given 20mg morphine. They also mention, amongst other things, the appearance of Mrs Overton's pupils and her body temperature, matters to which I will refer again shortly.

The Involvement of Mrs Overton's Family

13.60 Having been contacted by their granddaughter, Mrs Overton's parents contacted their son, Mrs Overton's younger brother, Dr Michael Overton, who was a general practitioner. Dr Overton lived quite close to Hyde, although his practice was in Gorton, near to the centre of Manchester. In 1994, he had been fully qualified as a doctor for about 13 years and had started in general practice in August 1984. He came to Tameside General Hospital on the evening of 18th February. The family was told of the seriousness of Mrs Overton's condition. Mrs Carrington and Dr Overton recalled that there was some discussion that night about turning off Mrs Overton's life support system and the fact that her collapse appeared to have been caused by the inappropriate administration of morphine. I am satisfied that no such discussions took place that night, although they undoubtedly took place later.

Saturday, 19th February 1994

Mrs Overton Is Assessed by Dr Premraj

13.61 On the morning of Saturday, 19th February 1994, Mrs Overton suffered a number of grand mal seizures, which were brought under control by epileptic medication. Mrs Overton was seen at about 10.30am by Dr Kamudini Premraj, a registrar in anaesthetics working under Dr Brown. She made several entries in the notes and records over the weekend and on the following Monday, 21st February. The relevant parts of her clinical note read as follows:

> **'47 year old lady. Admitted last night. Known Asthmatic.**
> **Severe asthmatic attack. –Recieved** [*sic*] **ventolin**
> **nebuliser and morphine 20mg ?IM or IV given by GP**
> **Resp. arrest thereafter. Resuscitated by GP**
> **until arrival of ambulance crew.**
> **Seems to have had a cardiac arrest too**
> **as there was no output without cardiac**
> **massage ...**
> **... As this lady seems to have been hypoxic**
> **prior to arrest and for ? how long after'**
> **She needs to be ventilated for 24-48 hours'**

13.62 Dr Premraj told the Inquiry that she has no recollection of her involvement. However, she accepted that it was obvious that the 20mg morphine had caused the respiratory arrest and that it must also have been obvious that to give 20mg morphine was excessive and a mistake by whoever had given it. Her note makes no reference to chest pain. She would have discussed the sequence of events with Dr Husaini when he came on duty.

Mrs Overton Is Seen by Dr Husaini

13.63 Mrs Overton was seen, later that day, for the first time by the consultant cardiologist under whom she was to remain until her death, Dr Husaini. As I have already said, during Mrs Overton's stay in the unit (until 1st March 1994, when she was transferred to ward 17), he and his consultant anaesthetist colleague and fellow ITU director, Dr Brown, were jointly responsible for her care.

13.64 Dr Simon Rushton was Dr Husaini's SHO, a position he had held since his transfer to ward 17 from the casualty department earlier that month. He accompanied Dr Husaini on his ward round that day and was thereafter intermittently involved in Mrs Overton's treatment on ward 17. Dr Rushton told the Inquiry that he had no recollection of his initial reaction to the circumstances of Mrs Overton's collapse, although he explained that he would have read the notes and would have been aware that the giving of 20mg morphine in the circumstances noted would be wholly wrong. Had he thought that his consultant was unaware of the problem, he would have reported the circumstances to him. Dr Rushton knew, however, that Dr Husaini knew of the circumstances of Mrs Overton's collapse and so the need to report did not arise, so far as he was concerned.

13.65 In evidence, Dr Husaini said that he realised from the hospital notes made by the junior staff that Mrs Overton had suffered a respiratory arrest resulting from the administration of morphine by her general practitioner. Basing his opinion on the facts as then known to him, this mechanism of injury was logical. On his 'post-take' ward round, when he saw the recently admitted patients, Dr Husaini made the following brief entry in the clinical notes:

> **'- Respiratory arrest**
> **-known epileptic**
> **-known asthmatic?**
> **-known alcoholism.'**

13.66 Dr Husaini explained that he did not mention ischaemic heart disease because he did not think that there was anything wrong with Mrs Overton's heart. He based this opinion on the clinical findings that the ECG results were normal, heart sounds were normal, there was no evidence of cardiac failure and the lungs were clear. He considered that the administration of morphine to an asthmatic patient was wrong; he would not do it under any circumstances. He knew that 20mg morphine would be a grossly excessive dose and that, in whatever dosage it was given, it should always be titrated against the patient's response. Dr Husaini said that he was distressed to realise that a fellow doctor had caused Mrs Overton to be in this terrible condition. At an early stage, according to his evidence, he resolved to ensure that his concerns were conveyed to the authorities. However, I note that Dr Husaini did not anywhere record his opinion that 20mg morphine administered intravenously in a bolus dose was grossly excessive and nor did he record his intention to convey his concerns to the authorities.

The Involvement of Dr Brown

Dr Brown Sees Mrs Overton

13.67 Dr Brown was on holiday at the time of Mrs Overton's admission to hospital and returned to work on Monday, 21st February. From that day until her transfer to ward 17 on 1st March

1994, Dr Brown shared responsibility for Mrs Overton's care with Dr Husaini. During her stay in the ITU, it became increasingly clear that Mrs Overton's prognosis was extremely poor.

13.68 Dr Chithambaram Veerappan was in a staff or 'middle' grade position, responsible to Dr Brown. He saw Mrs Overton with Dr Brown on 21st February and on several occasions thereafter until her transfer to ward 17. He realised that an excessive dose of morphine given in an inappropriate way had caused Mrs Overton's collapse and he told the Inquiry that he would probably have discussed this with Dr Brown and some of the nursing staff.

13.69 Dr Brown told the Inquiry that, although the clinical notes suggested that Mrs Overton's collapse had been caused by the administration of morphine, he was not by any means convinced that morphine was the cause of her collapse or that the dosage given was as high as had been recorded. Dr Brown said that he thought the history recorded in the notes was confusing; there were a number of inconsistencies in the accounts given. These led him to consider that Mrs Overton's condition had not been properly understood. Dr Brown relied on a number of factors.

The Ambulance Patient Report Form

13.70 According to Dr Brown, the PRF (as well as Dr Lee's notes) left it unclear why adrenaline was given by the paramedics if there was a sinus rhythm. In fact, it was given, as it often is, to treat EMD. I accept that this was not apparent from the top copy of the form left at the hospital but I cannot accept that Dr Brown regarded it as important at the time, if indeed he considered it at all. Certainly, he did not suggest that the mention of adrenaline implied, for example, that morphine had not been given in the dosage suggested.

13.71 Dr Brown also said that he could not understand why the pulse was said to be spontaneous. As I have said, Mr Harrop explained that he meant that the heart was 'beating on its own with no longer having to do cardiac compressions', a meaning which I accept as reflecting a normal and natural meaning of those words and a meaning accepted as legitimate by Dr Brown. Dr Brown pointed out that the PRF does not indicate what was the cause of the cardiac arrest. This is so, but I would not necessarily expect paramedics to be able to provide such information unless they were told by a doctor. In any event, I do not accept that Dr Brown regarded this as important and I reject the suggestion that these matters had any effect on his thinking.

Dr Lee's Note

13.72 In evidence, Dr Brown said that the notes made by Dr Lee suggested that the cause of the collapse was Mrs Overton's asthma with 'possibly a significant contribution from a pre-existing heart problem ... sufficient to have possibly given the patient an MI in the past'. Dr Brown knew the results of all the tests carried out on Mrs Overton's heart and should have known that his consultant cardiologist colleague thought there was nothing wrong with Mrs Overton's heart. However, I accept that a cardiac event could not be excluded.

13.73 The same notes recorded the giving of 20mg morphine, which Dr Brown accepted was a grossly excessive dose. He said in evidence: '20mg morphine is a grossly excessive dose of morphine to give to somebody who has an asthmatic attack. In fact, one should probably not give it in an asthmatic attack. But if you have chest pain, 20mg is certainly far too much. It should be given in small doses incrementally.'

Dr Loh's Note

13.74 Dr Brown knew of Dr Loh's note and provisional assessment of Mrs Overton's condition. His reaction was to dismiss the content of this note as revealing only that Mrs Overton: '... had had a degree of pathology which was associated with the respiratory arrest with a possibility of it having been precipitated by morphine intravenously but no indication of when the morphine was given in relation to the respiratory arrest'.

13.75 In support of the contention that Mrs Overton had had a heart problem, Dr Brown noted that, in addition to Dr Loh's note, **'? chest pain'**, a high blood sugar level had been found and this might suggest that Mrs Overton was suffering from diabetes mellitus, which is often associated with ischaemic heart disease. Dr Brown contended that the absence of signs of a heart attack on the ECG did not exclude the possibility of chest pain resulting from ischaemic heart disease. I have said that I accept that the possibility of a cardiac problem could not be completely excluded.

13.76 Dr Brown also mentioned that Dr Loh had recorded that Mrs Overton's chest was clear; this suggested that there was no ongoing asthma and cast doubt on the cause of the initial complaint. In fact, if Mrs Overton had not had an asthma attack at all but had complained of chest pain, morphine would have been appropriate treatment, but there would still be concern about the giving of 20mg morphine as a bolus dose.

Nurse Millward's Note

13.77 Nurse Millward's note recorded that Mrs Overton's general practitioner said she had had chest pain and had been given 20mg morphine. It also recorded that on arrival at the hospital, Mrs Overton had been unconscious and her pupils fixed and pinpoint. Dr Brown said that this last observation suggested to him that morphine had been given, although the fact that she had obviously also suffered some hypoxic brain injury made it more difficult to say that the morphine was the cause of the pinpoint pupils.

13.78 Dr Brown postulated that the mechanism of the hypoxic brain injury might have been the slowing of her metabolic rate. He suggested that the low body temperature recorded (33 degrees C) might indicate the possible presence of some other pathological process and, if this was not asthma or ischaemic heart disease, 'the probability was a hypothyroidism leading to a decreased basal metabolic rate'. By 5.30am next day, Mrs Overton's body temperature was restored nearly to normal by giving her extra blankets. In the presence of the other more obvious explanation for the collapse suggested by Dr Loh and Dr Mukhopadhyay, I do not believe that Dr Brown ever seriously considered that a decrease in metabolic rate had caused Mrs Overton's collapse.

Dr Mukhopadhyay's Note

13.79 Dr Mukhopadhyay had noted that there were no adventitious sounds in the lungs when she examined Mrs Overton at about 10.40pm. To Dr Brown, this suggested that Mrs Overton might not have had an asthma attack. However, I do not think anyone could attach much weight to this argument, as, if the asthma had been stabilised by the use of a nebuliser, one would not expect to hear sounds two hours later.

Dr Brown Accepts that the Likely Cause of the Arrest Was a Combination of Asthma, Chest Pain and the Giving of Morphine

13.80 Despite the inconsistencies referred to, Dr Brown accepted in evidence that the view of Dr Loh and Dr Mukhopadhyay, that Mrs Overton had suffered a respiratory arrest precipitated by the administration of morphine, was sensible and was justifiable on the basis of the evidence available. He also accepted that the administration of morphine had played a part in Mrs Overton's collapse; in oral evidence, he said the most likely cause of the arrest was a combination of asthma, chest pain and the giving of morphine.

Dr Brown's Understanding as to the Dose of Morphine Given

13.81 Dr Brown said in evidence that he doubted the accuracy of the entries recording that 20mg morphine had been given. The dose was so large that he could not accept that it had been given. He said that he thought 20mg must have been a mistake, and that possibly 2mg, 5mg or 10 mg had been given. At the Inquiry, he was asked what steps he had taken to verify the information that the dose had been 20mg. He agreed that he had taken no steps. He said that he had in mind, at the time, that there was no good evidence as to the dose but that enquiry of, for example, Dr Lee would have produced only hearsay evidence, which would not have been good enough. I cannot accept that Dr Brown did go through this thought process, weighing up the potential value of such evidence, without taking any steps to establish how reliable the evidence was as to dosage. Enquiry of staff in the casualty department would have allowed him to ascertain where the information had come from. He might well have been able to speak to the person who had spoken to Shipman and to assess how confident that person was that Shipman had said that the dose was 20mg.

13.82 Dr Brown claimed that he had thought of telephoning Shipman to ask him what dose of morphine had been given but had decided against it. He said that he had it in mind that, even if Shipman were to admit having given 20mg morphine, and even if Dr Brown were to make a written note of this, Shipman could always later deny what he had said. I am afraid that I wholly reject Dr Brown's suggestion that these factors operated on his mind at all at that time.

13.83 I observe finally on this issue that the evidence suggesting that 20mg morphine had been given is consistently recorded throughout the notes, which mention no other dosage (except that Dr John Peters, who was Dr Husaini's registrar, once referred to diamorphine rather than morphine having been given).

13.84 If Dr Brown had been in doubt about the accuracy of the information within the notes, I would have expected him to discuss his doubts with Dr Husaini, who did not apparently share them. He did not do so. If his doubts persisted, I would have expected Dr Brown to try to find out who in the casualty department had supposedly received information from Shipman about the dosage. He did not make this attempt. If he were still unsatisfied, I would have expected him to speak to Shipman. If he were in genuine doubt about the dose given, it would be important to find out the true dose and to give Shipman the opportunity to correct the misapprehension that was current in the hospital.

13.85 I can accept that Dr Brown might have hesitated to do that because he might have thought that Shipman would have a motive to understate the dose. I also accept that, with the benefit of hindsight, we know that Shipman would almost certainly have lied to Dr Brown. But the fact that Dr Brown did not voice his doubts or make any of the enquiries I have mentioned suggests to me that he was not then in the state of doubt that he now claims he was in. It appeared to me that, at this stage of his evidence, Dr Brown was 'clutching at straws' in his attempts to justify his supposed doubts about the history and the cause of Mrs Overton's collapse. However, the evidence which satisfied me completely that Dr Brown never thought that the dose had been mistakenly recorded and had never doubted that morphine was the cause of that collapse was the content of his police statement.

Dr Brown's Police Statement

13.86 After Shipman's arrest but before his conviction, the police were investigating Mrs Overton's death. Dr Brown was asked to provide a statement. Before doing so, on 9th March 1999, Dr Brown telephoned the Medical Defence Union (MDU) for advice. Dr Brown explained that Mrs Overton was thought to have collapsed following a possible asthma attack or myocardial infarction. She had then been nebulised and given morphine by her general practitioner, following which she had gone into cardiac arrest. She had been taken to hospital where she had survived in a persistent vegetative state. Dr Brown went on to explain that he would be critical of the dose of morphine given and wanted to know whether he needed to instruct his own solicitor. He was told that he did not.

13.87 On 15th March, Dr Brown wrote to the MDU, enclosing the statement that he proposed to send to the Greater Manchester Police (GMP). He said that he would particularly welcome advice from the MDU on his concluding comments in which he stated his opinion as to the actions of another doctor. That statement was approved by the MDU. The advice given to Dr Brown was that, so long as his concluding comments amounted to **'fair comment'**, they could reasonably remain in the statement.

13.88 The statement contains a clear and concise narrative of the circumstances surrounding Mrs Overton's collapse and admission to hospital. It also contains logical and unequivocal criticism of the treatment given by Shipman, unqualified by any of the reservations Dr Brown was later to say he had felt about the accuracy of the information contained in the hospital records. Dr Brown wrote:

> **'If the initial diagnosis of an asthmatic attack was correct, it was treated appropriately with the nebulisers. Intravenous Morphine plays no part in**

the management of patients with asthma outside the hospital. There is a statement in the notes by the admitting physician that she may have had chest pain, although this contradicts the clear statement of the casualty officer that she had no chest pain prior to her collapse. While intravenous Morphine has a place in the management of acute myocardial infarction (heart attack) I have always understood that it should be given intravenously, in small amounts, with time between doses to assess the affect [*sic*] **of the drug. In addition, it would be essential to monitor the heart rate and blood pressure of the patient in order to detect any signs of a cardiovascular collapse. In my experience of managing patients who have developed wheeze following a heart attack, I have never seen a dose of 20mg of Morphine used. I should add that I am familiar with the administration and effects of Morphine because in my work as an anaesthetist I regularly administer Morphine intravenously to patients undergoing surgery. I am also familiar with the use of Morphine post-operatively in patient controlled analgesia pumps and it is common for these pumps only to allow 1mg of Morphine to be given at a time with five minutes elapsing between doses of Morphine.'**

His considered opinion was expressed as follows:

'It was my opinion at the time that the patient's initial management by the general practitioner was highly unusual even dangerous.'

13.89 I cannot believe that Dr Brown would have made such a statement to the police if he had harboured any doubts about the dose of morphine Shipman had given or the cause of Mrs Overton's collapse. It is quite clear that he is describing there what had been his opinion at the time when he was treating Mrs Overton, and not any opinion informed by later events, such as Shipman's arrest. I am satisfied that, in common with many other hospital staff, Dr Brown believed in 1994 that Mrs Overton's collapse had been caused by the highly unusual and dangerous administration of a bolus dose of 20mg morphine.

Dr Brown Speaks to Mrs Overton's Family

13.90 Dr Brown recalled that his first conversation with Mrs Overton's family took place on 21st February and I am sure this is correct. He said that he thought it important for him to speak to the family to see what they knew about the prognosis. He told them that it was grim. An entry in the nursing notes for that day confirms that such a discussion took place:

'Parents and daughter interviewed
by Dr Brown and given poorest possible
prognosis. No further visitors since.'

13.91 Dr Brown had learned earlier that day that Mrs Overton's brother was a general practitioner. That evening, he spoke to Dr Overton alone. Again, an entry in the nursing notes confirms that such a discussion took place. Dr Brown told the Inquiry that he spoke to Dr Overton as he wanted to raise his concerns about the fact that Mrs Overton had been given morphine, which would not normally be given to an asthmatic. When asked by his

own counsel what had been his purpose in speaking to Dr Overton, he replied: 'To tell Dr Overton that as well as the bleak prognosis that his sister had, that a dose of morphine had been administered by the general practitioner and for him to consider whether he felt the matter should be taken further.' Dr Brown said that, had Dr Overton not been medically qualified, he would have told the family that the matter had to be taken further but that – out of respect for his professional colleague – he could not, in Dr Overton's case, be so 'directive'.

13.92 Dr Overton recalled that his conversation with Dr Brown took place on the evening of 18th February. I am sure he is mistaken, as he accepted may well be the case. Dr Overton agreed that Dr Brown told him that his sister had been given morphine and that she was known to be an asthmatic. Dr Overton's recollection was that Dr Brown asked him whether he understood the significance of what he was being told. Dr Overton said that he did. He realised that morphine should not usually be given to an asthmatic patient. He also realised that Dr Brown was giving him this information so that he and the rest of the family could consider whether or not to take any further steps. Dr Brown and Dr Overton agreed that Dr Brown did not tell Dr Overton either that the dosage given was 20mg or that it had been given as a bolus dose. Dr Overton learned this important further information only when supplied with the relevant papers by this Inquiry. This is a very surprising and disturbing omission on the part of Dr Brown.

13.93 There are two reasons why I find this omission disturbing. First, there is a world of difference between the information given to Dr Overton and the picture as Dr Brown knew it to be. It might well be understandable for a doctor, in the heat of the moment, to give a small titrated dose of morphine to an asthmatic who began to complain of chest pain. But the administration of a 20mg bolus dose could not be so readily understood. If Dr Brown had been in genuine doubt about the dose given and had genuinely had in mind that further enquiry of Shipman or the person at the hospital who had spoken to him would be fruitless, he should at least have given Dr Overton the option of having the information clarified. Second, although Dr Brown said that his intention was to alert Dr Overton to the possibility of making a complaint, I am not convinced that is correct or, at least, that it tells the whole story. Dr Brown must have expected that Mrs Overton's brother, being a doctor, would be bound to ask what had caused the collapse. In speaking to Dr Overton, Dr Brown was supplying some of the information that Dr Overton would be expected to seek. However, Dr Brown must have recognised that, by giving only part of the picture, and presenting it in a relatively innocuous way, there was a very real danger that Dr Overton might be put off further enquiry.

13.94 Dr Overton was about nine years younger than his sister. They were not close. They saw one another every month or two, at Christmas and on family occasions. I formed the impression that Dr Overton probably thought that his sister would have been a very demanding patient for Shipman to have on his list. In a statement he made to the Inquiry, he described her as a **'heartsink'** patient, meaning that she was the kind of patient who would cause her doctor's heart to sink when she attended for an appointment. He confirmed to me, however, that Mrs Overton shared the widely held view that Shipman was an excellent doctor. She had nothing but praise for him. Dr Overton told me that he knew that Shipman also enjoyed a good professional reputation locally.

13.95 Dr Overton explained to his family that there was the possibility of bringing a claim against Shipman. He had, as I have said, only incomplete information. His understanding was that his sister had developed chest pains after being successfully treated for an asthma attack. He believed that Shipman had thought these pains were cardiac in origin. He felt that Shipman had made an honest mistake in stressful, chaotic circumstances. He did not believe that the mistake had arisen from lack of knowledge. In oral evidence, he said: 'Morphine can certainly be used for cardiac pain. So in that way it would not have been a surprise that he may have felt it necessary to give it her but unfortunately with the asthma it is not appropriate ... I realise that it is not considered normal practice. In the heat of the moment in an emergency situation, I felt he would have made a clinical judgement – not a judgement I would have made but that is how it seemed at the time, that he made that clinical judgement.'

13.96 The family decided that they did not wish to pursue any complaint or claim. They trusted Shipman and believed that he had made a genuine mistake. Mrs Carrington was also a patient of Shipman and she held him in very high regard because of the way in which he had cared for her. Mrs Overton's parents were strongly opposed to the idea of making any complaint or claim. This was obviously an extremely distressing time for the family. I entirely understand the decision not to take things further, especially as it was founded on the incomplete information provided by Dr Brown.

13.97 Dr Overton can have had no reason to doubt the accuracy of the information he had been given. Dr Brown had ostensibly made a special effort to ensure that the family was informed of his concern over the administration of morphine and Dr Overton could not have suspected that important information was being withheld. Unless told otherwise, his expectation would be that the morphine had been administered in the usual way and in the usual dose. When asked at the Inquiry what the decision of the family would have been if he had been told that Shipman had given 20mg morphine as a bolus dose, Dr Overton thought that this might have altered the course that the family decided to take. He emphasised, however, that his father was vehemently opposed to any complaint being made. It seems to me that, if all the relevant information had been furnished by Dr Brown and if Dr Brown had expressed his view that the declared dosage, if given, was **'highly unusual even dangerous'**, Dr Overton would have been very shocked and would probably have advised the family to make a complaint. I can understand that he would wish to protect his parents and niece from further distress but I think he would have felt it right to take some action.

13.98 On the afternoon of Friday, 25th February, Dr Overton and Dr Brown spoke again. The nursing notes record a conversation in which Dr Brown is said to have informed Dr Overton of the lack of progress and the bleak prognosis. Dr Brown recalls that it was on this occasion that he was told that the family did not want to take the matter further and Dr Overton accepted that this might have been the case. There is no doubt that Dr Overton told Dr Brown of the family's decision. The timing is not important. I am satisfied that, by about 25th February, Dr Brown knew that, if any concerns about Shipman's treatment of Mrs Overton were to be pursued at all, the initiative would have to come from the senior staff at the hospital, in effect, himself, Dr Husaini or both.

Dr Brown Decides to Take No Further Action

13.99 Dr Brown told the Inquiry that he was informed that the family did not want to take the matter further because Shipman was a good doctor, a judgement which Dr Brown had no reason to doubt. He said that he felt that, without the support of the family, he could not initiate the enquiries necessary to gain more evidence of the quantity of morphine given. He said that the first step he would have taken would have been to obtain a letter of referral from Shipman, something which, if Shipman refused, he could not have insisted upon without the authority of the family. I am wholly unpersuaded by this piece of evidence. In my view, if Dr Brown had wished to put Dr Overton in the picture so that he could consider what, if any, steps the family should take, the first thing he would have wished to tell Dr Overton was that it appeared that Shipman had given a bolus dose of 20mg morphine. If Dr Brown had felt that this required verification, he would have explained that to Dr Overton. That Dr Brown did not do so persuades me that he did not intend to enable the family to make an informed choice as to how to proceed.

13.100 Dr Brown said that he decided that it would not be appropriate for him to initiate any complaint against Shipman or precipitate any investigation of Shipman's treatment of Mrs Overton. He advanced several reasons for this decision. It is only fair that, before giving my final view about these reasons, I should know more about what, in terms of reporting concerns, was generally regarded as appropriate at that time. The Inquiry will hear evidence about these matters in late 2003 and I shall address them in my final Report.

13.101 Dr Brown's first reason was that he felt he ought to honour the family's wish that no complaint should be made about Shipman. He said that, in such circumstances, as with situations where important decisions about treatment are made, the wishes of the family must be paramount. I accept that in decisions about whether a complaint is to be made, the patient or the patient's family have an important voice. However, my provisional view is that, where there is a possible danger that the apparent error made by a doctor might be repeated and harm other patients, the safety of other patients must override the wish of the family to do nothing.

13.102 Second, Dr Brown said that he was unaware of any local procedure or mechanism that would have enabled him to pursue a complaint against a general practitioner. He believed, correctly, that it would not be appropriate to do this through the 'Three Wise Men' procedure, which was available only to investigate concerns about hospital doctors. In fact, there was a procedure available by which a complaint against Shipman could have been pursued. If a report had been made to the local Family Health Services Authority, it could have referred the report to the local Medical Services Committee, which could investigate and hold a hearing. The simplest way for a doctor in Dr Brown's position to initiate this procedure would have been to inform either the Chief Executive designate or the Medical Director designate of the Trust which was to be responsible for running Tameside General Hospital, and which was due to come into being on 1st April 1994.

13.103 Third, Dr Brown said that he believed that the only route to follow was to make an individual complaint to the General Medical Council (GMC). He did not think that he had sufficient information to found such a complaint. He was concerned to strike the correct balance between the need to report a colleague's misconduct or mistake and the need to avoid

making false accusations against a colleague, and was worried that he might, by pursuing the complaint, be considered by the GMC to be acting improperly. In a supplemental statement made by Dr Brown, he said:

> **'In general I would not consider making an allegation of malpractice against another doctor unless the evidence was based on direct observation of behaviour or supported by clinical measurements.'**

13.104 Dr Brown told the Inquiry that professional etiquette had a bearing on his decision not to pursue the matter further. He said that, as part of doctors' training, they are told to be very reluctant to criticise other doctors or to pass opinions on them. In fact, when doctors not involved in the treatment of a patient are asked about that treatment by patients or others who are concerned, it is usual for them to say, 'I am sorry, I cannot say anything. I was not there to judge.' I accept that Dr Brown was genuinely influenced by this consideration. His decision to telephone the MDU for advice before giving the police a statement about Mrs Overton confirms that, as recently as 1999, he was hesitant about criticising a fellow practitioner, even one who had been arrested for murder.

13.105 Fourth, as to raising his concerns with the Chief Executive or any other individual or body, Dr Brown claimed that he knew that, before making any allegations, he had to have firm evidence and he considered that the clinical notes were insufficient for this purpose. I shall consider Dr Brown's position further, later in this Chapter and will now continue my account of Mrs Overton's history.

Mrs Overton's Transfer to Ward 17

13.106 Mrs Overton's condition did not alter significantly during her stay in the ITU but it was possible to wean her from the ventilator on 27th February. She was transferred to ward 17 on 1st March. The prognosis remained very poor. I am satisfied that, by this time, it was common knowledge in the ITU, and was soon to become common knowledge on ward 17, that the reason for Mrs Overton's collapse was that she had been given an overdose of morphine by her general practitioner.

The Issue of Withdrawal of Treatment

13.107 Some time before her collapse, Mrs Overton had told her daughter that, if ever she were to be in a vegetative state, she would not wish her life to be prolonged by artificial means. The two women had been discussing the case of Mr Anthony Bland, the Hillsborough victim. Mr Bland's parents had sought the permission of the High Court to withdraw life-sustaining treatment from their son, who was in a persistent vegetative state and the case was much in the news in the early 1990s. The case was heard in the Family Division of the High Court in November 1992 and in the Court of Appeal and the House of Lords in December 1992. Their Lordships' opinions were delivered on 4th February 1993.

13.108 In the light of this expressed wish, and provided they were satisfied that Mrs Overton's prognosis was hopeless, her close relations had no desire for her life in a vegetative state to be prolonged by medical intervention.

13.109 On 3rd March, Dr Peters, Dr Husaini's registrar, was involved in a discussion with the family, in the course of which they communicated their views to him. Dr Peters made a note of their wishes in the hospital records and decided that he should discuss the matter with Dr Husaini.

13.110 That discussion with Dr Husaini apparently took place at 3.30pm on Friday, 4th March. Dr Husaini agreed that Mrs Overton should not be resuscitated in the event that she stopped breathing. She was to continue with full nursing and medical care, at least until Dr Husaini had reviewed the latest electroencephalograph (EEG), which was not at that time available. Dr Peters made a note of this discussion.

Dr Husaini Contacts the Coroner

13.111 Three days later, on Monday, 7th March, Dr Husaini contacted the Coroner for Greater Manchester South, then Mr Peter Revington. According to Dr Husaini, he was seeking advice on two issues. First, he was concerned that Shipman had given morphine, which had caused a respiratory arrest and brain death, and that its administration had been a mistake. He wanted advice from Mr Revington about how he should pursue his concerns. Second, he wanted to know whether the withdrawal of treatment was legally possible.

13.112 I am unable to accept that Dr Husaini sought advice from the Coroner about his concerns over the administration of morphine. The evidence suggests irresistibly that his only purpose was to seek advice about Mrs Overton's future management. There are a number of reasons for this conclusion.

13.113 First, in Dr Husaini's clinical note of 7th March, there is no reference to his concerns about Shipman's treatment. On the contrary, the note deals explicitly and exclusively with future treatment issues noted by Dr Peters on 3rd and 4th March. The note reads:

> **'Mr Rivington** [*sic*] **Coroner consulted.**
> **He says that the patient is not legally dead** ∴
> **do not** [*illegible*] **withhold food**
> **or antibiotics or any**
> **other medical or nursing treatment required**
> **SEEK COURT ORDER IF**
> **WE WISH.'**

The advice from Mr Revington in connection with the seeking of a court order can have referred only to an application to withdraw life-sustaining treatment.

13.114 Second, the nursing note for 7th March records that the EEG report had been received and revealed no cerebral activity. It continued to the effect that, after review of the EEG, Dr Husaini had contacted the Coroner **'re: further management'** and made no mention of any expression of concern.

13.115 Third, the timing of the contact with the Coroner points towards its having been prompted by the recent discussion about the withdrawal of treatment.

13.116 Fourth, the Coroner would have been an improbable person to contact for advice about how to pursue concerns about treatment. As I have already suggested, one obvious first

port of call would have been someone within the hospital administration, such as the Chief Executive designate, Mr Roger Butterworth.

13.117 Finally, when Dr Husaini wrote to his defence body following Shipman's arrest, asking how he should respond to a request by the police for a statement, he did not suggest that he spoke to the Coroner about the concerns he had but wrote:

'I did speak to the Coroner regarding ... withholding treatment.'

13.118 After speaking with the Coroner, Dr Husaini spoke to Mr Butterworth later that same day.

Dr Husaini's Contact with Mr Butterworth, Mrs Nuttall and Mr Howorth

13.119 Dr Husaini told the Inquiry that, when speaking with Mr Butterworth that day, he informed him of the two issues he had raised with the Coroner. His evidence as to the concern he expressed about the treatment given was inconsistent. At one stage in his evidence, he said that he told Mr Butterworth that the treatment given had been incorrect but, at other times, he explained that he had not said that he thought the general practitioner was to blame because he did not want to pass judgement on his conduct in that way. He said that he contemplated that there would be a meeting about the issue of treatment by the general practitioner, attended by those members of the hospital staff who had understood that morphine had been given. According to Dr Husaini, Mr Butterworth said he would ask Mrs Lynn Nuttall, the Hospital's Business Manager, to contact Dr Husaini.

13.120 In evidence, Mr Butterworth denied that Dr Husaini had mentioned the circumstances in which the collapse had occurred. I accept his evidence. Again, I rely on a note made by Dr Husaini at the time, the emphasis of which is the same as the emphasis of the note of his contact with the Coroner. It makes no mention of concerns about past treatment but focusses on withdrawal of treatment issues. It reads as follows:

'Mr Butterworth chief executive informed
Father and Mother informed
re E.E.G. flat
& will be repeated
day after tomorrow
after withdrawal of
Epilim
We need a court order
to stop treatment.'

13.121 At some stage during the following fortnight, Mrs Nuttall also contacted Dr Husaini. According to Dr Husaini's oral evidence to the Inquiry, he told Mrs Nuttall also of his concerns about the treatment given. He said: '... I spoke to her about what I spoke to Mr Revington and to Mr Butterworth and that is although the patient was under my care, I was not satisfied with all the aspects of her illness and what led to her illness as well as for her future care.' For her part, Mrs Nuttall says that Dr Husaini raised only one matter with her, that of the possibility of withdrawing Mrs Overton's treatment.

13.122 In a memorandum dated 21st March, Mrs Nuttall asked Dr Husaini to write to Mr Charles Howorth, legal adviser to the then North West Regional Health Authority, with

Mrs Overton's full medical history and other relevant details. She did not ask him to articulate any concerns he had about the treatment Mrs Overton had received, as I would have expected her to do, if Dr Husaini had mentioned them to her. She informed Dr Husaini that Mr Howorth would advise him of the steps to take and that she was available to give further help if this was required.

13.123 The contents of this memorandum suggest strongly that Mrs Nuttall had in mind only the future treatment of the patient and not an investigation of concerns about past treatment. Her oral evidence was that, had Dr Husaini told her that he was concerned about Mrs Overton's treatment at the hands of her general practitioner, she would have remembered it. She said that she would have returned to Mr Butterworth to convey those concerns to him and that, as she did not do so, she cannot have been told of such concerns. I accept her evidence and reject that of Dr Husaini.

13.124 Dr Husaini wrote to Mr Howorth on 24th March. The letter is very clear. It explicitly seeks advice about Mrs Overton's future management but does not even obliquely seek advice about how Dr Husaini might pursue his concerns about past treatment. The only reference to the administration of morphine is couched in rather reassuring terms. The suggestion is that it might have been given for **'restlessness'**, but it does not say (as is the case) that it would be wholly inappropriate for it to be given for that condition. There is no suggestion in the clinical notes that morphine had been given for that reason. The letter mentions that Mrs Overton had a history of asthma but does not say that morphine should not be given to an asthmatic. Nor does the letter say that the dosage of morphine was dangerously high or that it was the administration of morphine that led to the collapse. It only implies that morphine might have been the cause by referring to the reversal of the respiratory arrest by the giving of naloxone, the antidote to morphine. Nor did Dr Husaini state who had given the morphine. If he intended to raise concerns, it is surprising that he did not identify the object of his concerns.

13.125 In oral evidence, Dr Husaini said that, when writing this letter, he thought that the circumstances of Mrs Overton's collapse would be investigated. He wanted to know what he should do next and believed that Mr Howorth would take into account not only the contents of the letter, but also the contents of the conversations that he had had with Mr Butterworth and Mrs Nuttall.

13.126 I regret to say that I am firmly of the view that, when writing this letter, Dr Husaini did not intend to communicate his concerns about past treatment to Mr Howorth. In evidence, he acknowledged that his letter, looked at carefully, did not communicate his concerns. It appears to me that Dr Husaini probably deliberately avoided mentioning his concerns. His reference to the giving of morphine for restlessness seems designed to explain away its administration rather than to raise any concern about it.

13.127 By 14th April, Mrs Nuttall had spoken to Mr Howorth. In a memorandum to Dr Husaini of that date, she mentioned the case of Mr Bland and another case concerning the withdrawal of treatment from a patient in a persistent vegetative state. Judgement in the Bland case had been delivered in February 1993 and the other case had been heard by the Court of Appeal in January 1994. She told Dr Husaini that she was awaiting copies of the judgements in those cases. She would then arrange for them to meet to discuss **'what**

the next steps will be'. Mrs Nuttall believes that, a short time later, she passed copies of the court transcripts to Dr Husaini and then left matters in his hands.

13.128 The memorandum of 14th April represents yet further contemporaneous evidence that Dr Husaini and the hospital administrators were concerned only with the issue of withdrawal of treatment. I am satisfied that neither Mr Butterworth nor Mrs Nuttall were ever aware of the concern that had been felt about the circumstances of Mrs Overton's collapse. I am also quite satisfied that Mr Howorth, who is a lawyer and not a doctor, believed that his opinion was being sought only in connection with the question of Mrs Overton's future management.

13.129 On 15th April, Mr Howorth wrote a letter, responding to Dr Husaini, saying that he had discussed the situation with Mrs Nuttall, that he had written to her with information **'relating to the legal position'** and suggesting that Dr Husaini liaise further with her.

13.130 Dr Husaini remembers being told that, before any application could be made to the court for permission to withdraw treatment, the patient had to be in a persistent vegetative state for 12 months from the time of the collapse. This is consistent with the medical evidence in the Bland case, which was to the effect that, if a patient in such a state shows no signs of recovery after six months, or at most a year, there is no prospect of recovery. It may be that Dr Husaini read this in the transcripts with which he was provided. Alternatively, he may have become aware of it following the involvement of Dr David Shepherd.

The Involvement of Dr Shepherd

13.131 Dr Shepherd was a visiting consultant neurologist to Tameside General Hospital, based at North Manchester General Hospital. He retired on health grounds in December 1998 and was unfit to attend the Inquiry to give oral evidence. In April 1994, he was asked to see Mrs Overton, with a view to advising on her future treatment, and he saw her on 25th May. It is unlikely that he spoke directly to Dr Husaini about Mrs Overton. After examining her, Dr Shepherd recorded his opinion that, three months post-collapse, the likelihood of recovery was remote but that her persistent vegetative state or coma vigil state could not be said to be unequivocal and, therefore, permanent until 12 months had elapsed. According to him, Mrs Overton was not **'brain stem dead'** because she was breathing spontaneously.

13.132 I accept Dr Shepherd's written evidence that he had no concerns about the circumstances of Mrs Overton's admission to hospital. His knowledge of morphine was very limited; he had not prescribed it for about 30 years. The effect of a 20mg dose of morphine would have been outside his area of expertise. His concern and the sole purpose of his visit was to advise on Mrs Overton's current condition and prognosis.

Mrs Overton Remains on Ward 17

13.133 Mrs Overton remained on ward 17. She received a very high standard of nursing and medical care, although an acute medical ward, such as ward 17, was not an ideal environment for a long-term patient. The staff became attached to her. She was a fixture on the ward, an unconscious human presence, who nonetheless inspired affection. Her

family appreciated the treatment that Mrs Overton received at the hospital and were very keen for her to remain there.

13.134 For much of the duration of her stay, however, there loomed on the horizon the prospect that she would be removed to an alternative placement, in a nursing home or similar establishment. In early May 1994, even before Dr Shepherd visited her, it was mooted that she might be transferred to a local long-stay facility in Chadderton. Later in the year, the possibility was raised that she might be transferred to the Royal Hospital and Home, Putney, London. This was a specialist unit with experience of managing persistent vegetative state patients. The family were unhappy at the prospect of a move but the possibility remained open into the New Year.

13.135 Quite apart from the fact that the family wanted Mrs Overton to stay on ward 17 because of the high quality of care she was receiving, there was another good reason for opposition to a move. Such a move could well have had severe financial and social consequences for Mrs Carrington, who had paid many of her mother's debts and had maintained the mortgage repayments on their home. If Mrs Overton were to be transferred to a nursing home, it appeared that charges would be payable and these would have to be defrayed from Mrs Overton's capital. The equity in her home represented her only capital and, if that had to be realised, her daughter would be rendered homeless. Such a possibility was to be avoided at all costs. Dr Overton represented the family in correspondence and meetings with the hospital staff and sought to ensure that his sister was not transferred from the hospital.

13.136 In early 1995, there were further discussions between the hospital and the family about Mrs Overton's future. An entry in the clinical records at this time recorded improved cerebral activity; a transfer to Putney was to be reconsidered. At a meeting on 20th January, it was decided that Dr Shepherd should be instructed again, with a view to his advising on future management and also as to whether there were any suitable specialist units in the North West. On 25th January, Dr Shepherd advised that Mrs Overton's clinical condition had not changed, although the signs on her EEG had improved. He advised that the hospital should contact Dr Krystyna Walton, who ran a local rehabilitation unit in Rochdale. He also mentioned the possibility of an assessment at the Royal Hospital and Home and said that Dr Keith Andrews, who was based there, was **'the main expert'** on persistent vegetative state in the United Kingdom and might be able to offer some help with regard to withdrawal of treatment.

13.137 Dr Walton is a consultant physician in rehabilitation medicine and the Head of the Floyd Unit for Neurological Rehabilitation at Birch Hill Hospital, Rochdale. She was asked to assess Mrs Overton's suitability for admission to her unit and examined her on 30th January 1995. Dr Walton's recollection of her conversation with the nursing staff on ward 17 was that consideration was being given to withdrawal of treatment and that, since this could not be done on the ward, the Floyd Unit was seen as a possible alternative place for this to be done. I am satisfied this was not the intention of the medical staff and that there was a misunderstanding between the nursing staff and Dr Walton. In any event, Dr Walton quickly realised that Mrs Overton was not suitable for rehabilitation in her unit. She made an entry in the notes, recommending a nursing home placement at Chadderton Total Care

(which had been discussed nine months earlier). However, Mrs Overton remained on ward 17 and no further steps of any significance were taken with a view to her transfer.

The Weeks Leading up to Mrs Overton's Death

13.138 I am slightly disadvantaged in describing Mrs Overton's clinical course during the weeks leading up to her death because no clinical records are available for the period beginning on 7th March and ending on 20th April. I am quite satisfied that some such records must have been made and I was for some time worried about the possible circumstances in which they had gone astray. However, having seen and heard the evidence of those treating Mrs Overton, having seen the nursing notes (which are available) and having read an account of the attempts that have been made to locate the missing notes, I am satisfied that there is no sinister explanation for their disappearance.

13.139 The evidence from the nursing notes, supported in many respects by the evidence of the witnesses, reveals that, at the beginning of March 1995, Mrs Overton developed an infection around the site of her gastrostomy feeding tube. This was treated with antibiotics. She was also suffering from symptoms of acid reflux and related gastric problems. She seemed to recover from these ailments in about the middle of March.

13.140 On 22nd March, just over 13 months after Mrs Overton's original admission, Dr Husaini again sought Dr Shepherd's advice. He wanted to know whether the presence of cortical activity in the brain excluded a diagnosis of persistent vegetative state. Dr Shepherd advised that it did not but that an EEG suggesting that there was a response to external stimuli would exclude such diagnosis. On 11th April, almost certainly as a result of this advice, a further EEG was ordered, but there was some uncertainty about precisely what was required and the EEG was cancelled on 20th April.

Mrs Overton's Death

13.141 Early in the morning of Friday, 21st April, a nurse, Mr Michael Berrisford, was on duty on ward 17. He remembers checking on Mrs Overton at about 5.15am and finding that she was not breathing. He listened to her chest and heard no heartbeat. He made the following note:

> **'0515 hrs Checked to see if alright, found Renata not to be breathing with no pulse. Sr on block phoned. Dr Davies contacted. No warnings, noises prior to this routine check.'**

13.142 Mr Berrisford called the nursing sister on duty, Sister Mariko Tazaki (now Sharples), and the on-call doctor, Dr Jacqueline Davies (now Shaw). According to Sister Tazaki's note, Dr Davies attended at 6.20am and confirmed that Mrs Overton was dead. Dr Davies' note records that she was asked to see Mrs Overton and confirmed that she was dead, finding

neither breath sounds nor heart sounds. An entry written in the margin of the notes, recording the time as 5.30am, was probably made by Dr Rachel Pyburn, to whose involvement I shall turn shortly. It is unclear to what precise event this time is intended to refer.

13.143 It is clear that Mrs Overton's death came as a shock to those who were involved in her care. It came as an emotional shock because they were fond of her. It also came somewhat unexpectedly, as Mrs Overton had not been suffering any acute illness that led those about her to believe that her death was imminent. Everyone recognised, however, that the nature of her chronic condition was such that she might die at any time.

The Report of the Death to the Coroner

The Evidence of Dr Pyburn

13.144 Dr Pyburn graduated from Newcastle University in 1989. She is now a consultant geriatrician at Hope Hospital, Salford. She arrived at Tameside General Hospital in July 1994 and was initially assigned to work as a medical registrar on ward 17. She left ward 17 during the same month, but returned there in February 1995.

13.145 In late July 1994, just before they both left ward 17, Dr Rushton told Dr Pyburn about the circumstances of Mrs Overton's collapse and admission. Dr Pyburn told the Inquiry that she shared Dr Rushton's concern that the collapse had been caused by morphine being given following an asthma attack. She was told, probably by both Dr Rushton and Dr Husaini on her first ward round on ward 17, that the circumstances had been 'gone into' following Mrs Overton's admission to hospital. She was made aware that the matter had been discussed by Dr Brown with Mrs Overton's family following her admission and that one member of the family was a doctor. She could not remember being told that the matter had been referred to the Coroner or the GMC. Nor could she remember the detail of what Dr Husaini had said about any enquiry or investigation that had taken place. Dr Pyburn then had no involvement with Mrs Overton until her return to ward 17 the following February.

13.146 Dr Pyburn has no recollection of Mrs Overton's condition in the days and weeks leading up to her death. Whilst she was not expecting Mrs Overton to die, the death was not, in Dr Pyburn's words, 'a total surprise'. She told me that she was saddened by it. Dr Pyburn probably learned of the death at some time before 9am on 21st April. She immediately felt that she had a responsibility to report the death to the coroner. That sense of responsibility was also tinged by concern that the general practitioner in question (whom she did not at that stage know by name) was bound to be affected and possibly upset by the investigation into the death that she expected would follow. She told the Inquiry that she believed that Mrs Overton's case was 'a complete tragedy' that had resulted from 'medical error'. It was the circumstances of the original collapse that caused her to report the death and not the fact that she could not confidently state what specific condition had caused Mrs Overton to die when she did.

13.147 Dr Pyburn described personal circumstances that strengthened her resolve to ensure that the case was properly reported. Her grandmother had died following an asthma attack

and her grandfather had believed that more might have been done at the time to save her life. Dr Pyburn had only learned of this some years later when she became medically qualified. Moreover, her personal experience that coroner's officers were sometimes keen to persuade junior doctors to suggest a natural cause of death meant that she decided not to delegate the task of telephoning the coroner's office.

13.148 Dr Pyburn said that she telephoned Dr Husaini to ask whether he wished to report the death to the coroner or whether she should do so. He agreed that it should be done and said that she should do it. She telephoned the coroner's office in the mid-morning. There is a sharp conflict of evidence between Dr Pyburn and Mrs Mary Evans, the coroner's first officer at that time, as to what was said by Dr Pyburn.

13.149 Dr Pyburn's evidence was that her conversation with Mrs Evans lasted about ten minutes. She told the Inquiry that she sought to explain that Mrs Overton's respiratory arrest and death had been caused by the giving of morphine in circumstances in which morphine would not normally be expected to be given. However, because she had not been present at the time of the collapse, she said that she wanted to avoid giving the impression that she was judging the issue and she avoided using the word 'negligence'. She said: 'I would have quite a clear recollection of my intentions in ringing the Coroner's office and also in struggling with words at various times to try and convey what had happened without using the word '*negligence*'. I would not have wished to use the word '*negligence*' because I had not been present at the time and that would seem to be a judgement that somebody ought to make after an appropriate investigation.'

13.150 Dr Pyburn said that she believed that she was quite clear in saying that there had been a 'medical mishap' and that she told Mrs Evans so. However, in the light of what she said in the above extract, I doubt that Dr Pyburn used any expression as clear as that. This was unfortunate because, as Dr Pyburn realised, Mrs Evans was not medically qualified and could not be expected to understand the significance of the giving of morphine unless it were spelled out to her.

13.151 Dr Pyburn said that she was sure that she had said enough to satisfy Mrs Evans that the death ought to be investigated. She said that she did not seek to put forward any provisional causes of death and that she never contemplated that the coroner might 'accept' any cause of death that she proposed. She always believed that there would have to be an inquest.

13.152 I am puzzled by Dr Pyburn's reluctance to mention the word 'negligence' or otherwise to spell out her concerns in clear terms. She acknowledged that she felt a degree of concern for the doctor, who was unknown to her, upon whose head she would bring trouble by making the report. I cannot understand why, if she had decided to make a report because of her concern about the circumstances of Mrs Overton's collapse, she felt unable to say that, although she had not directly observed the circumstances of Mrs Overton's collapse, the clinical notes made at the time suggested that the general practitioner had made a serious mistake and had given a gross overdose of morphine with terrible consequences. It may be that Dr Pyburn's unwillingness to use clear words reflects an attitude that is widespread among doctors, namely a reluctance to comment, even hypothetically, on the conduct of colleagues.

13.153 Following her conversation with Mrs Evans, Dr Pyburn made a note in Mrs Overton's clinical records, as follows:

> **'D/W Dr Husaini, to D/W Coroner's Officer.**
> **HM Coroner's officer feels post mortem is required.**
> **No DC** [*death certificate*] **to be issued.'**

The second line of this entry suggests that Dr Pyburn might have been less determined that the case should be fully investigated than she claimed. The words suggest either that Dr Pyburn was enquiring of the officer whether or not an autopsy was required or that she was actively suggesting to the officer that an autopsy was not necessary but that the officer felt that it was. Dr Pyburn strongly denied that this was the case when it was put to her by Senior Counsel to the Inquiry. She said that she was recording that Mrs Evans had agreed that an autopsy was required and that a death certificate was not to be issued. I find that assertion hard to accept, as it is not really consistent with the words used. I think that expressions such as 'HM Coroner's officer agrees' or 'HM Coroner's officer also feels' would have been far more appropriate to convey what Dr Pyburn told the Inquiry was said and would quite readily have come to her mind.

The Evidence of Dr Husaini

13.154 In his witness statement, Dr Husaini said that he agreed that Mrs Overton's death must be reported. This was partly because the death was sudden and of unknown cause. In oral evidence, he said that the only reason for making the report was on account of the concern over the administration of morphine. I am uncertain as to what was in Dr Husaini's mind, or even that he applied his mind to the point at the time. It is possible that he simply agreed with Dr Pyburn's proposal that the death should be reported and believed her to be a suitable person to make the report. That Dr Husaini did not speak to the Coroner himself tends to confirm my view that he had not mentioned his concerns about the circumstances of Mrs Overton's original collapse when he had spoken to the Coroner in March 1994. Had he done so, I would have expected him to wish to remind the Coroner that the person to whom he had earlier referred had now died and he remained concerned about the circumstances of her collapse which were directly related to her death. At the very least, I would have expected him to tell Dr Pyburn that he had explained his concerns about Mrs Overton to the Coroner. Dr Husaini said that he told Dr Pyburn but Dr Pyburn had no recollection of being told this.

13.155 The fact that Dr Husaini delegated to Dr Pyburn the task of reporting the death to the Coroner casts doubt on his determination that the matter be fully investigated, as does his subsequent inactivity when there was no inquest. Moreover, it is unlikely that he told Dr Pyburn about the earlier referral to the Coroner. Had he done so, I think Dr Pyburn would have mentioned it to Mrs Evans and it appears that she did not.

The Evidence of Mrs Evans

13.156 In 1995, Mrs Evans was the first coroner's officer. She had begun working in a clerical/typing/secretarial role in 1974. In about 1984, she had become the coroner's second

officer and in 1985 she became first officer. In giving evidence, she had no independent recollection of her involvement in the reporting of Mrs Overton's death but recognised her writing on the report of the death, which must have been completed during her conversation with Dr Pyburn. She said that the extent of her involvement was to receive the report and then (after consultation with Mr Revington) to arrange an autopsy.

13.157 Mrs Evans' account is necessarily a reconstruction of events based on what she recorded at the time. She completed the heading of the form and recorded Mrs Overton's name, age, address and date and place of death. She then recorded, in the section described as **'Brief Report'**:

> **'Admitted 18.2.94 after a respiratory arrest.**
> **Had been in a coma for over a year.'**

This information is written in black ballpoint pen, but certain additional information, concerning details of Mrs Overton's next of kin (her brother) and the causes of death I(a)–(c), are written in pencil. Mrs Evans explained that she would use the ballpoint pen to record the account taken from Dr Pyburn. She said that she would then have changed to pencil to record Dr Pyburn's suggested causes of death, as these could only be provisional, until 'accepted' by Mr Revington. After recording the provisional causes of death, she would have continued to use a pencil to record the details of the next of kin. In the **'Cause of Death'** section, she wrote:

> **'I(a) Persistent vegetative state**
> **(b) Respiratory arrest**
> **(c) Asthma + morphine administration.'**

13.158 According to Mrs Evans, the conversation with Dr Pyburn cannot have been as Dr Pyburn claimed. First, it must have lasted less than ten minutes. Second, Dr Pyburn can only have given a brief account of the death and cannot have mentioned morphine until she provided the provisional causes of death. Third, Mrs Evans maintained that Dr Pyburn was seeking to provide provisional causes of death, which, if Mr Revington had been prepared to accept them, would have become the registered causes.

13.159 Mrs Evans' evidence as to whether she had or had not been told that the morphine had been given in inappropriate circumstances was inconsistent. In her written statement, she seemed to suggest that she had not been told this. However, when questioned by counsel for Dr Pyburn, she at times seemed to agree that she had. As she had no direct recollection of this event, I infer that this evidence shows that Mrs Evans does not know whether or not Dr Pyburn said that. Mrs Evans denied that she had been told that there was any causal connection between any medical treatment given to Mrs Overton and her death, even though, of course, she wrote that the underlying causes of death were **'Asthma + morphine administration'**. Mrs Evans said that she recognised that morphine administration was being put forward as a cause of the death and was not just mentioned incidentally as being the treatment for the primary pathological cause.

13.160 According to Mrs Evans, after she had taken down the report of the death, she would have discussed it with Mr Revington, who must have said that there should be an autopsy. She would then have spoken again to Dr Pyburn to inform her of this decision. Dr Pyburn did

not accept this; she said that she spoke only once to the coroner's officer and that there was never any doubt or discussion as to whether an autopsy was needed.

13.161 When questioned, Mrs Evans accepted that she herself sometimes authorised an autopsy in cases in which it was plain to her that the doctor was not in a position to certify the cause of death. She said that she would not have done so in this case because the mention of morphine 'rang warning bells'. I do not accept the reasoning behind this remark. If morphine rang warning bells in Mrs Evans' mind, it would surely be to convince her that the Coroner must accept jurisdiction and it would follow that there would have to be an autopsy. If she was in no doubt about the Coroner 'taking a case on', she was accustomed to order an autopsy without consulting the Coroner. I am unable to decide whether Mr Revington was or was not involved in the decision to order an autopsy. However, the point is not of great importance.

13.162 I have to resolve the conflict of evidence between Dr Pyburn and Mrs Evans. Before attempting to do so, I must examine the evidence of what happened after the report of the death was received at the coroner's office. The way in which the report was handled in the coroner's office throws some light on the conflict of evidence.

The Involvement of Mrs Collins

13.163 In 1995, Mrs Joan Collins worked as Mr Revington's second coroner's officer, placing her one rung below Mrs Evans. She was involved in dealing with Mrs Overton's death at some time after Mrs Evans had taken the initial report. She had no independent recollection of her involvement but recognised marks and writing she had made on the form. She said that she had made the red ticks on the first few lines and had written the following entries, in the order in which they appear on the form:

> **'Ask Terry to check'** [*in pencil*]
> **Robinson + Jordan, Hyde.** [*in red ink*] **Funeral fixed for Friday 28.4.95'** [*in pencil*]
> **'Dr D L Bee**
> **Ia Hypoxic cerebral degeneration'** [*in red ink*]

13.164 The last two lines of that record were plainly made after the autopsy had been carried out on 26th April. Dr Bee was the pathologist responsible. Of more immediate interest is the entry **'Ask Terry to check'**. **'Terry'** must be a reference to Police Constable (PC) Theresa King, then Tameside Division police coroner's officer. She was based at Ashton-under-Lyne police station and the mortuary at Tameside General Hospital. She was accustomed to undertake enquiries for the Coroner. Mrs Collins could not remember when or in what circumstances she came to make this entry; nor could she remember speaking to PC King or even what it was that PC King had to check. She postulated that Mr Revington had been in court when the report of the death was initially taken and that, on his return, he saw it and asked Mrs Collins to pass a message to PC King. Mrs Collins now believes that Mr Revington must have wanted to know whether morphine had been given 14 months earlier, and by whom and in what circumstances. I think she is probably correct.

The Involvement of Police Constable King

13.165 PC King came to the Inquiry voluntarily from the Republic of Ireland, where she has lived since her retirement from the police force. Although Mrs King is no longer a police officer, I shall refer to her as PC King throughout this Chapter. In 1995, she was experienced in police work and had been the police coroner's officer since 1985. However, she had no medical training or knowledge, save what she had picked up in the course of her work.

13.166 The usual procedure, in the case of a hospital death that had been reported to the coroner, was for one of the coroner's officers to ask PC King to complete Forms 751 and 751A, the functions of which I have explained in Chapter Four. PC King would receive information from the report of the death to the coroner's office and would then ask the next of kin or a member of the deceased's family to attend the mortuary to identify the body. PC King would check the information given to the coroner's office with the next of kin and would complete the forms. The information on the forms is duplicated to a large extent. Both contain some limited information about the medical history and circumstances of the death. Form 751 is returned to the coroner's office; Form 751A is left at the mortuary for the pathologist. This form contains a specific request for **'Any other information which may assist the Pathologist to determine cause of death'**.

13.167 PC King arranged for Dr Overton to attend her office, situated in the Tameside General Hospital mortuary complex, probably on 24th April. She completed Form 751 on the basis of information supplied by Dr Overton, the Coroner's staff and, in relation to the time of death, information probably obtained from the ward. The important evidence as to the medical history and the circumstances of the collapse and of the death was, I am sure, provided by the Coroner's staff and not by Dr Pyburn. It was not usual for PC King to speak to the doctor who had made the report. PC King did not seek from Dr Overton, and nor did Dr Overton offer, any elucidation as to the circumstances of Mrs Overton's original collapse. PC King said that she would not normally do so, even when the next of kin was a doctor. Dr Overton and the rest of the family had, of course, long since decided to 'let sleeping dogs lie'.

13.168 On Form 751, PC King stated that Mrs Overton had suffered from asthma and was hypothyroid. She recorded that Mrs Overton had been admitted on 18th February 1994, after a respiratory arrest. She had been in a coma for over a year.

13.169 Form 751A contains essentially the same information. Responding to the specific request for any other information which might assist the pathologist to determine the cause of death, PC King wrote:

> **'Dr. states possible cause of death as: Persistant** [*sic*] **vegetative state, due to resp. arrest, due to asthma, Also morphine administration.'**

It is likely that the **'possible cause of death'** was based on what Dr Pyburn had told Mrs Evans. PC King wrote Dr Pyburn's name at the top of Form 751A. When Forms 751 and 751A were complete, PC King followed her usual practice and sent Form 751 back to the coroner's office and left Form 751A for the attention of the pathologist.

13.170 I observe in passing that the process of completion of Form 751A involved two medically unqualified people (a coroner's officer and a police coroner's officer) being used as conduits for information passing between a doctor who had treated the deceased and reported the death and a pathologist who was to decide (when the doctor could not) what was the cause of death. This is not a satisfactory way of communicating information which might be of a technical nature.

13.171 The autopsy was to take place on Wednesday, 26th April. PC King was not usually expected to carry out any further investigations until after the autopsy, when the coroner would decide whether or not to hold an inquest. If there were to be an inquest, PC King might then undertake some further investigations. However, it is clear that, on this occasion, PC King was asked to undertake an enquiry before the autopsy. Unfortunately, there is no record of the nature of the enquiry, and this is consistent with the poor quality of record keeping in the coroner's office at that time. It is only possible to work out what the request must have been from a note made on 25th April by Mrs Margaret Blake, the third coroner's officer (and the third person in the office to have been involved with Mrs Overton's death). It is plainly a note of PC King's report to the office of what she had found out in response to the request for her **'to check'**.

13.172 This note clearly shows that PC King must have been asked to find out from Shipman what had happened when he had attended upon Mrs Overton on 18th February 1994. PC King was at pains to point out that, had she been told that there was a suggestion that poor practice by Shipman had caused or contributed to Mrs Overton's death, she would not have spoken to him. I accept her evidence on this point. It would have been quite inappropriate for a police officer of her rank to undertake any investigation of an allegation of potential negligence or misconduct by a doctor. Moreover, I do not think the Coroner would have asked her to make such an enquiry if he had realised that there was any suggestion that Shipman might have been at fault in the treatment he had given Mrs Overton. I am satisfied that PC King had been given no warning that Shipman might be at fault. Indeed, in view of the fact that the request that she should speak to Shipman probably came from Mrs Collins, who had not taken the original report and would have had before her only the written report form, there does not seem to have been any opportunity for PC King to be told of Dr Pyburn's concerns, assuming that she had expressed them. However, PC King knew that the administration of morphine was said to be an underlying cause of death and that it was a potentially dangerous drug. Had she thought the matter through, she might have realised that malpractice by Shipman was a possible explanation for what had occurred. However, she did not.

13.173 Mrs Blake's note confirms that Shipman accepted that he had been called out to see Mrs Overton; she was suffering an asthma attack and he had stabilised her. He had then gone upstairs to tell Mrs Carrington that her mother would need some hydrocortisone. When he returned, he had found Mrs Overton flat on the floor. There is no record that he mentioned chest pain. Nor did he apparently tell PC King why Mrs Overton had collapsed. The note records that Shipman then commenced resuscitation. The ambulance crew arrived. Although they had **'managed to get a beat'**, Shipman took the view that Mrs Overton was **'brain dead'**. She had been in a coma ever since. The penultimate sentence of Mrs Blake's note of PC King's report reads:

'Dr Shipman does not feel there was anything perculiar [*sic*]**. She had some emotional problems in the past but everything seemed to be ok at the time.'**

13.174 When PC King was asked how she could have failed to ask Shipman what part, if any, morphine had played in Mrs Overton's death, she replied, with commendable frankness, that she had 'absolutely no idea.' She conceded that it really had been up to her to ask him that question. PC King agreed also that it appears that she had not asked Shipman what had caused Mrs Overton's sudden collapse. She explained that, because she used to work across two sites, at the mortuary and at the police station, she may have had neither her notes nor Forms 751 or 751A in front of her, when speaking to Shipman. This would be quite unsatisfactory but may explain, though it could not excuse, her failure to raise those matters with him.

13.175 It is clear that PC King did not appreciate that this death was in any way problematical and did not have any clear idea of what she was trying to find out. She cannot have been told that there was any suspicion that a medical error had been made. I think she approached Shipman asking for a purely factual account of what had happened. I think she would then have accepted his account without question and without considering whether he had provided the answers she needed. I think it likely that, in common with many people in Hyde at the time, she was taken in by Shipman's confident manner and possibly cowed by his condescending attitude. I think that, having only an imperfect understanding of what she was supposed to be finding out, she did not stop to think for long about what she had (and had not) been told. I bear in mind that PC King had no medical background or training, and was ill equipped to question Shipman or to go behind his assertion that there was nothing peculiar about the death.

13.176 Mrs Blake said that she took the message without knowing what PC King had been asked to find out or why she had been asked. She said that, even if she had seen the original report at the time of taking the message, she would not have realised that the issue of the administration of morphine had not been addressed because her role was simply to take down the message. There is no evidence as to whether the Coroner ever saw the note of PC King's enquiry of Shipman. He should have done and it should have been clear to him that Shipman had not confirmed or denied the administration of morphine. Nor had he explained why Mrs Overton had collapsed so suddenly in his absence. Even if Mr Revington had not previously been alerted to the possibility that Shipman had given an overdose, he should have recognised the need to find out if, when and why morphine had been given and what reason Shipman was giving for the collapse. As Mr Revington is not able to answer questions from the Inquiry owing to ill health, it will never be known what was in his mind at this stage of the investigation into Mrs Overton's death.

13.177 I conclude that Mrs King did fail properly to investigate and report upon the circumstances of Mrs Overton's collapse. In particular, she failed to ask Shipman whether he had given any morphine and why he thought Mrs Overton had collapsed in his absence. I am quite sure that Shipman was very persuasive and authoritative when they spoke and I accept that she had no prior suspicion that his treatment of Mrs Overton might have been incorrect. It is to her considerable credit that she acknowledged her fault when she gave

her oral evidence. It is also to her credit, and for this I am very grateful, that she attended the oral hearings from the Republic of Ireland, when she could not have been compelled to attend.

Resolving the Conflict of Evidence between Dr Pyburn and Mrs Evans

13.178 I found Dr Pyburn a most persuasive witness. She is intelligent, quietly articulate and obviously sincere. Whether or not her evidence is true and accurate is a different question. Listening to her, I felt convinced by her claim that she was determined to ensure that the circumstances of Mrs Overton's respiratory arrest in February 1994 were fully investigated. I went so far as to express that view during oral submissions. Yet, careful analysis of the whole of the relevant evidence has made me aware that there are several factors that point against this conclusion.

13.179 First, the fact that Dr Pyburn said that she was reluctant to use plain language critical of Shipman when making the report suggests to me that she was also ambivalent about conveying the message that Mrs Overton was the victim of a 'medical mishap'. It may well be that Dr Pyburn mentioned the administration of morphine in its natural position in a narrative explanation of the course of events. It may well be that she also said that morphine had been given by a doctor in circumstances in which it would not normally be given. If she did, I do not think that those expressions would necessarily have made Mrs Evans realise that Dr Pyburn was concerned about the treatment. I am quite satisfied that Dr Pyburn did not criticise the treatment directly. As I have already said, I find it hard to understand why, if she were anxious to report her concerns about the treatment, she could not bring herself to do so in clear language, without prejudging any issue.

13.180 Second, the extremely scanty details of the death recorded by Mrs Evans suggest that Dr Pyburn may not have given as full an account of the circumstances as she claims. I am satisfied that neither Mrs Evans nor anyone in the coroner's office realised that it was being suggested that Shipman had done anything wrong. PC King would not have been sent to make enquiry of Shipman if it had been realised that there was a possibility that his treatment of Mrs Overton might be called into question at an inquest. I observe, in passing, that the report of death, as recorded by Mrs Evans, was not adequate, either to allow the Coroner to decide whether or not an inquest into the circumstances of the respiratory arrest was necessary or for him to consider whether or not to approve the provisional causes of death. Whatever she believed the purpose of the report to be, Mrs Evans should have asked far more questions about the circumstances than she did. I do not criticise her personally for this, as I am satisfied that, at any rate at this period, decisions were often made in the coroner's office on inadequate material.

13.181 Third, there is the fact that the proposed causes of death were written down in pencil, which was, I accept, the usual practice in the office where a doctor was seeking the Coroner's approval to issue an MCCD. Dr Pyburn said that she had no recollection of providing any causes of death and, indeed, on the first day of her evidence, asserted that she had not done so. However, on reflection, she accepted that she must have done. There was no one else who could have formulated them. Mrs Evans did not have the medical knowledge to do so. Dr Pyburn was unable to suggest how this might have come

about. I think it is not impossible to imagine circumstances in which Mrs Evans might have encouraged Dr Pyburn to provide provisional causes of death, even though she was reporting her concerns about the circumstances of the death. However, a far more simple and obvious explanation for the proffering of the provisional causes is that Dr Pyburn was seeking approval for the causes of death but, when Mrs Evans heard and wrote the words 'morphine administration', they rang warning bells and she (or the Coroner) decided that there would have to be an autopsy.

13.182 Fourth, Dr Pyburn's own note in the clinical records of her conversation with Mrs Evans suggests either that Dr Pyburn had telephoned the office to seek approval for the proposed causes of death and permission to issue an MCCD (which had been refused) or that her report had been 'neutral' in that she was just putting the case before the Coroner in case he wanted to investigate it.

13.183 I have found this a difficult issue to resolve. In the end I have been driven to doubt my own reaction to Dr Pyburn's evidence. I have concluded that it is more likely that Dr Pyburn telephoned the coroner's office to seek approval for her proposed causes of death than that she reported the death because she wished her concerns to be investigated. I think it likely that, since Shipman's exposure, Dr Pyburn has come to believe that she reported this death for investigation, when the truth is that she did not. I think it likely that, following her realisation that Shipman was a mass murderer, she became far more concerned about Mrs Overton's death than she had been at the time of the death. With the passage of time, she has, I think, come to believe that she was deeply concerned. As she knows that it was she who reported the death to the Coroner, I think she has become convinced that she did so only because she was determined that the circumstances of Mrs Overton's original collapse should be investigated. I think she had been concerned about the reasons for Mrs Overton's collapse but that she had put her concerns to the back of her mind because Dr Husaini and Dr Rushton had told her that the case had been 'looked into' around the time of her first admission to hospital. In those circumstances, being still somewhat concerned, Dr Pyburn decided that the death should be reported to the Coroner so that he would have the opportunity to look into the death if he thought it appropriate. I think that she was willing to certify the causes of death, if the Coroner gave his approval. Although I reject her evidence as inaccurate, I do not think Dr Pyburn deliberately misled the Inquiry. Nor do I criticise her conduct. Considering her state of mind, as I have found it to have been, I consider that her decision to report the death in a neutral way was not unreasonable.

The Autopsy

Dr Bee

13.184 Dr David Lyle Bee was a consultant pathologist for 26 years from 1969 until his retirement in October 1995. He used to perform about 20 autopsies a week. On some days he might carry out as many as eight. The most usual number was three or four. Eighty per cent of those autopsies were for the Coroner. He said that the performance of an autopsy could last anything between 15 minutes and 2 hours, depending on its complexity. He told the Inquiry that coroners' autopsies were usually less complex than hospital autopsies. He

thought that the autopsy performed in Mrs Overton's case was straightforward and would have lasted about 20 minutes. Not surprisingly, he had no recollection of the case and relied on his limited contemporaneous records, combined with his recollection as to what was then his usual practice.

13.185 According to Dr Bee, he felt under some kind of self-imposed pressure to find a natural cause of death in order to avoid an inquest. If he was satisfied that the cause was natural, but the evidence revealed only a possible cause, he would nevertheless record that that was the actual cause of death if there was no other obvious competing cause. I understand that this is not an uncommon practice. Dr Bee said that there were very few cases in which he reported that no definite cause of death could be found; in evidence, he said that this would happen in about one case in 40 or perhaps once a month (which would amount to about one case in 85).

13.186 I find it disappointing that a consultant pathologist should have so lax an approach to a scientific examination. Dr Bee did not explain why he felt under such self-imposed pressure. It seems likely that he felt that he would be doing the Coroner, the deceased's relatives and himself a favour if he were able to avoid an inquest.

Professor Whitwell

13.187 Professor Helen Whitwell gave evidence to the Inquiry on several occasions. She is Professor of Forensic Pathology and Head of the Department of Forensic Pathology at the University of Sheffield. I have dealt with some of her evidence in Chapters Nine and Ten. She provided written and oral evidence dealing with Dr Bee's involvement in Mrs Overton's case. I found her evidence very helpful. I remind myself that I should not expect the same level of forensic skill in a consultant pathologist in a general hospital (as Dr Bee was) as that of a forensic pathologist, particularly one of Professor Whitwell's experience and ability.

Dr Bee's Report

13.188 Dr Bee said that, when conducting the autopsy on Mrs Overton, he had available the medical notes and records and Form 751A. The information on Form 751A was, as I have said, very limited. In particular, Dr Bee had not been alerted to any concerns felt by the hospital staff as to the propriety of the morphine administered. However, if he had read the medical notes, he should have seen the dosage of morphine and the opinions of the junior doctors that the morphine given by the general practitioner had caused or contributed to Mrs Overton's initial collapse and precipitated her persistent vegetative state. It is worth noting, however, that neither Dr Brown nor Dr Husaini had recorded in the clinical notes any opinion as to the conduct of the general practitioner. Had they done so, the post-death investigations might well have followed a very different course.

13.189 The autopsy was performed at 10am on Wednesday, 26th April. The signed typewritten autopsy report (or **'POST MORTEM EXAMINATION REPORT'**) itself is extremely brief. It records that the brain was small with dilated ventricles. It was generally soft, especially in the parietal regions. There was a little atheroma of the cerebral circulation. The bronchi

were clear although there was a little congestion and oedema of the lungs. The heart weighed 254g and there was mild atheroma of the coronary circulation. The liver and kidneys were said to be congested.

13.190 The report form invites the pathologist to provide an opinion as to the causes of death. It explains that the pathologist should list, first, the disease or condition directly leading to death, next, any morbid conditions giving rise to the direct cause, and, last, any other significant conditions contributing to the death but not related to the disease or condition causing it. An explanatory note states that what is sought is the disease, injury or complication which caused the death and not the mode of dying.

13.191 Dr Bee gave the opinion that the cause of Mrs Overton's death was hypoxic cerebral degeneration. Whilst this may accurately explain that shortage of oxygen had caused degeneration of Mrs Overton's brain and that this had caused her death, it does not explain what had caused the oxygen deprivation. It may seem trite to say so but the human brain is normally well perfused with oxygen. It is obvious, and must at the time have been obvious to Dr Bee, that there must have been some mechanism to cause that position to alter and yet he seems not to have realised this. Without apparently determining what had caused Mrs Overton's brain to be deprived of oxygen, Dr Bee went on to state:

'In my opinion death was due to natural causes.'

13.192 It must have been clear to Dr Bee that, since 14 months had passed since Mrs Overton's original collapse, pathological examination was unlikely to reveal a great deal about the circumstances of the collapse. In fact, as Dr Bee accepted, it revealed absolutely nothing about them. It might have been expected to reveal (as it did) something about Mrs Overton's cardiac condition and it would have been expected (as it did) to reveal severe cerebral atrophy. So, all that the autopsy could tell Dr Bee was that the immediate cause of Mrs Overton's death was hypoxic cerebral degeneration. If he accepted that the degeneration had followed a cardiac arrest (which was mentioned as a possibility in the notes), he would be able to say, from the autopsy, that it was unlikely that the cardiac arrest had been caused by ischaemic heart disease. But, from the autopsy, he could not form any view whatever as to what had caused the cardiac arrest. As Professor Whitwell explained, the appearance of the brain some months after a severe hypoxic episode would be the same however the hypoxic episode had occurred. For example, there would be no way of telling from the brain whether the hypoxia had been caused by near drowning, by near suffocation, by a naturally occurring cardiac arrest or by a cardiac arrest induced by the administration of an overdose of a respiratory depressant such as morphine. Dr Bee did not disagree with that proposition. It is clear that his conclusion that the death was due to natural causes could not properly have been based upon his autopsy findings.

13.193 Dr Bee claimed that he had reached his conclusion that the death was due to natural causes after perusing the hospital notes. He could not remember exactly what he had read but said that he would have looked only at the casualty notes and the other notes at the beginning of the file, as the whole file was **'rather substantial'**.

13.194 Dr Bee said that his examination of the notes drew him to the conclusion that ventricular fibrillation had led to cardiac arrest and was the principal cause of death. This ventricular

fibrillation could have resulted from 'spasm of the coronary artery or something like that rather than the morphia'. Dr Bee was 'inclined to think that ventricular fibrillation came before the respiratory arrest'. For many reasons, I find it impossible to accept that Dr Bee reached any such conclusions.

13.195 First, I observe that he did not enter ventricular fibrillation as the underlying cause of death on the autopsy report, as he should have done, had that been his opinion. Second, Dr Bee did not mention this conclusion in his written statements to the Inquiry. He revealed it for the first time in his oral evidence. By that time, Dr Bee was aware that he was open to criticism for having certified that the death was due to natural causes without having any proper basis to do so. In oral evidence, Dr Bee sought to reconstruct what had been in his mind at the time of reporting on the autopsy examination. I cannot accept that the reasons and explanations he gave were in fact operating on his mind at the time. I am afraid that by the end of his evidence, I was quite satisfied that Dr Bee's endeavours were directed far more towards creating a picture that would result in his being absolved from blame than towards genuinely working out what had been in his mind at the time.

13.196 Third, Dr Bee's conclusion that the cause of Mrs Overton's death was ventricular fibrillation was not soundly based. There was no pathological evidence to explain why the patient might have gone into ventricular fibrillation and Dr Bee was forced to speculate that this might have happened as the result of some coronary artery spasm. Dr Bee drew attention to the entries in the early clinical notes suggesting the possibility of ischaemic heart disease but apparently chose to ignore the fact that Mrs Overton's heart was revealed to be normal, both in the clinical assessments following her admission to hospital and as part of his own autopsy examination. Ventricular fibrillation was one possible cause of the death but there was nothing to suggest that it was a more likely cause than any other.

13.197 Fourth, if Dr Bee did think that the death was due to ventricular fibrillation and was prepared to certify the death as being due to natural causes for that reason, he must have known that, in so concluding, he was in disagreement with the views expressed by the treating doctors in the clinical notes. Those notes make it clear that those treating doctors who expressed an opinion had reached the view that the administration of morphine had played a part in Mrs Overton's respiratory arrest. Although the notes contain conflicting information as to whether Mrs Overton had or had not suffered chest pain before her collapse, there was abundant material to suggest that the collapse had been caused by the administration of 20mg of morphine, given intravenously in a bolus dose. In addition, Form 751A flagged up the belief of the reporting doctor that morphine had been an underlying cause of death. Professor Whitwell said that the mention of morphine as a potential contributory cause of death should have sounded warning bells in the mind of any pathologist.

13.198 Dr Bee had little knowledge (and certainly far less experience than the treating doctors) of the circumstances in which it might or might not be appropriate to give morphine to a patient. This is not surprising and he should not be blamed for it, because it is likely that many pathologists would be similarly unaware. Further, he did not know what dosages of morphine would be appropriate. Yet, he did not speak to any member of the clinical team from ward 17, such as Dr Pyburn, whose name was mentioned on Form 751A. The reason

Dr Bee gave for this omission was that Dr Pyburn would have been able to say no more than the notes said. That explanation is not acceptable. What Dr Bee needed was advice about whether it would have been reasonable for the general practitioner treating Mrs Overton to give 20mg morphine as a bolus dose, and whether such a dose given in that way might be expected to cause respiratory depression or arrest. There can be no doubt what advice he would have received had he made such an enquiry. I agree with Professor Whitwell that, before he reached any conclusion about whether the death was natural, Dr Bee should have discussed the case with the treating clinicians. In evidence, Dr Bee said that he considered that, if a patient suffering from an asthma attack was suffering from the 'psychological overlay' that sometimes increases pain, it might be legitimate to give morphine. The notion that any doctor who knew anything about the effects of morphine would think it reasonable to give a 20mg bolus dose for 'psychological overlay' enters the realm of fantasy. Dr Bee said that it did not appear to him that the administration of morphine had been inappropriate. He said he would on that issue rely on the judgement of the clinician who administered it. He did not think of checking the British National Formulary to ascertain what was said about dosage and mode of administration.

13.199 In short, I cannot believe that Dr Bee actually went through so deeply flawed a process of reasoning as could have resulted in an honest conclusion that the death had been caused by ventricular fibrillation leading to cardiac arrest and had not been caused or contributed to by the inappropriate administration of morphine. He admitted in evidence that his conclusion involved a significant degree of speculation. In my view, his opinion that the death had been due to natural causes can be explained only by his misplaced desire to avoid the need for an inquest. It is possible that he concluded, after brief and superficial thought, that the collapse might have been due to an asthma attack. Whatever he thought, his reported conclusion that this death was due to natural causes was untenable and his performance inadequate. I recognise that he had not been alerted, as explicitly as he might have been, to the possibility that Shipman had made a serious error in treatment. However, knowing, as he did, that there was a possibility that morphine had caused or contributed to the death, it was quite wrong of him to discount that possibility and certify that the death was due to natural causes, without even making the enquiries I have mentioned.

13.200 When Dr Bee came to communicate his findings to the coroner's office he should have made it plain that, although he had found an immediate cause of death, cerebral hypoxic degeneration, and believed that the underlying cause of that was a cardiac arrest some 14 months earlier, he was unable to establish the underlying cause of the cardiac arrest. It would then follow that he was unable to say whether the death had been due to natural causes. That should have been the gist of the oral report that Dr Bee gave to the coroner's office as soon as he had completed the autopsy. If he had said that or something like that, the Coroner would have ordered an inquest. The same message should also have been reflected in Dr Bee's written report which was to follow. In the event, as I shall shortly explain, it seems likely that, when reporting orally, Dr Bee mentioned only the immediate cause of death, cerebral hypoxic degeneration, and said nothing more.

13.201 A particularly unattractive feature of Dr Bee's evidence was his attempt to justify his opinion that the death had been the result of natural causes by saying that there had been

no way of proving otherwise, and that, at any inquest that might have taken place, Shipman would have given an account to justify the administration of morphine, and that that account would have been believed at the time. That may be so; much would have depended upon the thoroughness of the investigation carried out by the Coroner before the inquest and the willingness of doctors such as Dr Husaini, Dr Brown and Dr Pyburn (any of whom might have been called to give evidence) openly to criticise Shipman's treatment. Whatever difficulties there might have been at inquest, there is no excuse for the serious deficiencies of Dr Bee's work.

Mr Revington Decides that No Inquest Is Necessary

13.202 Mr Revington was 74 years old when Mrs Overton died. He was to retire at the age of 75. Although he did not enjoy the best of physical health, having suffered from polio as a child, he still retained all his mental faculties.

13.203 As I have already explained, I am unable to decide whether Mr Revington was personally involved in the decision to order an autopsy, although I suspect that he may not have been. I am satisfied, however, that he was behind the decision to **'Ask Terry to check'**. By the time that instruction was given, he was clearly aware in general terms that it had been suggested that one of the underlying causes of Mrs Overton's death was the administration of morphine. I infer, from the terms of Mrs Blake's report of PC King's conversation with Shipman, that Mr Revington had asked for clarification of the circumstances of Mrs Overton's collapse, including the possible involvement of morphine.

13.204 When Mr Revington received the report of PC King's enquiry, probably on 25th April, he should have realised that it did not provide answers to two obviously important questions. Had Shipman given Mrs Overton any morphine? Why had she collapsed? It appears that Mr Revington did not ask for any further enquiry to be made. It seems likely that he was generally reassured by the final sentence of the report, that there was nothing peculiar about the death.

13.205 The result of the autopsy was almost certainly telephoned through to the coroner's office by Dr Bee or someone acting on his behalf, at some time during the late morning or afternoon of Wednesday, 26th April. Mrs Collins wrote on the report of death form that the cause of death was hypoxic cerebral degeneration. She did not write **'natural causes'**. I think that she would have done, if she had been told that that was Dr Bee's opinion.

13.206 Mr Revington's task was then to decide whether or not to hold an inquest. He made that decision on Wednesday, 26th April. If he was satisfied that the death was due to natural causes and that the cause of death was known, he would decide that an inquest was not necessary and he would send a Form 100B to the register office, confirming that he did not consider it necessary to hold an inquest and stating the cause(s) of death found at autopsy. The bundle of papers on which Mr Revington was to base his decision included Mrs Evans' initial report of the death, Form 751, and Mrs Blake's file note of PC King's report. It is not clear whether or not the written autopsy report was by then available. Usually, there would be a little delay between the completion of the autopsy and delivery

of the written report; that is why the result was usually communicated informally by telephone. As Mr Revington made his decision on the same day as the autopsy took place, I think it likely that he considered his decision before receiving the written report.

13.207 On examination of the papers, it should have been apparent to Mr Revington that the autopsy had confirmed the immediate cause of death proposed by the reporting doctor from the hospital but had not confirmed the proposed underlying causes. He should have realised that he did not know the underlying causes of the cerebral degeneration or whether the death was due to natural causes. He must have known that cerebral hypoxic degeneration can result from a great number of different causes, some natural and some unnatural. He must, for example, have been aware of the case of Mr Bland, to which I referred earlier. The decision of the House of Lords in that case was a landmark of which all coroners should have been aware. The mention in Mrs Evans' note of Mrs Overton's persistent vegetative state, combined with the reference to her having been in a coma for over a year, probably would, in my view, have struck Mr Revington as resonant of Mr Bland's case. Mr Bland had suffered his injuries in the Hillsborough disaster, as I have already stated.

13.208 In my view, Mr Revington could not properly have reached a decision not to hold an inquest on the basis of the information in the papers before him, unless those papers included Dr Bee's written report, which seems very unlikely. It is possible that Mr Revington spoke to Dr Bee on the telephone and asked him if he thought the death was due to natural causes. Dr Bee has no recollection of such a conversation but that does not mean it did not happen. However, Mr Revington did not make a note on the file to say that he had spoken to Dr Bee. As it was his usual practice to make a note of any such conversations, I infer that it is unlikely that he did so in this case. In any event, Mr Revington decided that no inquest was necessary and he issued Form 100B, giving the cause of death as cerebral hypoxic degeneration. He also issued Coroner's Certificate 'E' for Cremation (Form E) in which he said that he was satisfied that there were no circumstances likely to call for further examination of Mrs Overton's body. That would permit the medical referee to authorise cremation of her body. With the signing of these forms, Mr Revington effectively closed the enquiry into the circumstances of Mrs Overton's death. Yet the question as to the role played by morphine in the death remained unanswered.

13.209 Mrs Collins said that she was surprised that no inquest took place because the autopsy report did not say what had caused the coma. She agreed that the circumstances would cry out for an inquest. She was also surprised that hypoxic cerebral degeneration was given as the cause of death with no underlying cause stated.

13.210 Why did Mr Revington decide not to hold an inquest? I think that the answer is that Mr Revington did not think through the issues in the case with sufficient thoroughness or clarity. I have said that the mention of morphine in the written report of the death undoubtedly prompted the involvement of PC King. However, I am satisfied that Mr Revington did not realise, when he suggested that PC King make that further enquiry, that it was being suggested that Shipman had made a gross error of judgement in his administration of morphine and that this had led to Mrs Overton's original collapse. Had

he done so, he would not have suggested so informal an enquiry. Had he known of that suggestion, he would have been less willing to close the investigation without an inquest. I think that Mr Revington understood no more than that it was being suggested that one of the underlying causes of death was the administration of morphine and that he wanted to know more.

13.211 I think that Mr Revington also fell prey to two pieces of misinformation with which he was provided. First, he relied uncritically on the passage in the note of PC King's report that Shipman had not felt that there was anything peculiar about the death. He plainly should not have done so and he should have made further enquiries as to the administration of morphine. Second, he accepted the cause of death stated by Dr Bee, although, as I have already said, that did not explain what had caused the cardiac arrest and coma; nor did it suggest that Dr Bee had considered and discounted the role played by morphine in the death. Again, Mr Revington should not have done so. He could, had he been reluctant to order an inquest, have spoken to one of the doctors on ward 17 (Dr Pyburn's name was available to him) and enquired what information was available about the use of morphine. I am sure Dr Pyburn would have told him that the notes suggested a 20mg bolus dose, which was extremely large.

The Registration of the Death

13.212 On the basis of Mr Revington's Form 100B, Miss Marilyn Partoon, registrar at the Tameside register office, recorded that the cause of death was hypoxic cerebral degeneration and the death was duly registered.

The Reaction of Dr Husaini and Dr Pyburn

13.213 Dr Husaini says he was worried when he realised that there was to be no inquest, but did nothing. He had expected that the Coroner would have looked into the death and would have spoken to Shipman. He said that he cried when time passed and he had not been asked to provide a report and realised that there had been no inquest and that the death must have been registered.

13.214 If Dr Husaini really was so concerned, it is very surprising that he did not then pursue the matter with the Coroner, Chief Executive or any other person or body, especially when he knew that there had been no investigation immediately following the initial collapse. I do not accept that Dr Husaini was at all concerned about the fact that there had been no inquest.

13.215 Dr Pyburn said that she believed that her report of the death would lead to a discussion with the family, followed by an autopsy and inquest. In her previous experience of coroners' cases, there had been no communication back from the coroner following the initial report. On one occasion, Dr Pyburn had been told that she was not even entitled to the result of the autopsy. She told me that she would not have expected to be contacted about any information that she could give because she had not been present at the time of Mrs Overton's admission to hospital.

The Actions of the Doctors following Shipman's Arrest

13.216 In the course of the police enquiries following Shipman's arrest, investigating officers sought witness statements from Dr Husaini and Dr Brown, in relation to Mrs Overton's case. As I have already said, both sought advice from the MDU. For the purposes of the Inquiry, both waived any privilege that might have attached to relevant communications. I have already dealt with Dr Brown's communications and his police statement in paragraphs 13.86 to 13.89.

13.217 Dr Husaini telephoned the MDU on 24th November 1998. Having explained the background to the MDU adviser, Mr Kuncewicz, Dr Husaini apparently said that he felt vulnerable because he had been aware that Mrs Overton had been treated with morphine. He was unsure whether this was substantiated in the notes but he thought it might have contributed to the death. He was advised to obtain a copy of the medical notes and records and to send a draft statement to the MDU for approval. He was advised that the statement was to be factual and had not to contain assumptions.

13.218 There then followed some correspondence and, on 11th December, Dr Husaini wrote to the MDU advisers, giving an account of the relevant history and enclosing Mrs Overton's hospital notes. The letter refers to the circumstances surrounding the original admission to hospital. Dr Husaini expressed no reservations about the accuracy of the history that he described which was, in summary, that Shipman had first nebulised Mrs Overton for an asthma attack and had then given 20mg morphine, which had caused respiratory arrest. The letter goes on to describe the contact that he had had with the Coroner and Mr Charles Howorth, the Health Authority's legal adviser. His previous contact with Mr Revington was said to have been **'regarding ... withholding treatment'**. This was, as I have explained, inconsistent with the account he gave to the Inquiry, in which he said that he also voiced his concerns about the treatment initially given.

13.219 Further, Dr Husaini told the MDU that he had reported his concerns to Mr Howorth and had:

> **'... clearly mentioned that the patient had received I.V. morphine following which she became unresponsive'**.

He continued by saying that, after the patient's death, the case was reported to the coroner. He did not say why or with what effect. He then added:

> **'There is no doubt that ventolin nebulisers can induce ventricular fibrillation. There is also no doubt that morphine, by suppressing respiration in a patient who is already anoxic can induce ventricular fibrillation.'**

13.220 Dr Husaini went on to explain that he had at no stage spoken to Shipman and asked whether he should have done. He added:

> **'Family Practitioners do sometimes use morphine to sedate patients who are restless.'**

13.221 Finally he said:

> **'I do not think I am in any way responsible for her death.'**

It seems to me that, at this time, Dr Husaini was feeling vulnerable. He was concerned that he had not investigated what Shipman had done by speaking to him. Also, he was seeking to imply, without actually saying so, that he had reported his concerns to Mr Howorth. I have already found that Dr Husaini did not report his concerns to Mr Howorth. He was also seeking to suggest that Mrs Overton's respiratory arrest might have been caused by ventricular fibrillation, due to the use of a ventolin nebuliser, a suggestion that he did not advance before the Inquiry. He also suggested that the general practitioner might have been justified in giving morphine if he believed the patient was restless and in need of sedation. He did not make it plain that the dosage given could never be justified for such a purpose.

13.222 On 18th December 1998, he wrote to the coroner's office for the first time on the subject of Mrs Overton's case. He asked Mr John Pollard (Mr Revington's successor) what had been Mr Revington's conclusion as to the **'mechanism of this patient's death'**. I observe again that it would be most surprising, if Dr Husaini was as upset as he said he was when he realised there would be no inquest, that he did not contact the Coroner until December 1998. He did so only when he was feeling vulnerable to criticism for not having done more to bring about an investigation of the circumstances of Mrs Overton's collapse.

13.223 The MDU replied to Dr Husaini on 22nd December, offering to review any statement made and explaining that it was not possible to give a specific answer as to what Dr Husaini ought to have done. He was told that, where he thought that another doctor was causing harm to patients by inappropriate treatment, he had an ethical duty to point this out to the doctor. In the event, Dr Husaini was not required to furnish the police with an account of his involvement in Mrs Overton's treatment.

Responsibility

13.224 It follows from what I have said that, despite the fact that it was widely known at Tameside General Hospital, within a short time after Mrs Overton's admission, that her collapse had been caused by the inappropriate administration of a large bolus dose of morphine, no steps were taken during her lifetime to ensure that the cause of her collapse (which had devastating consequences) was properly investigated. Moreover, after Mrs Overton died, and when the opportunity arose for a coroner's investigation into her death, there was never any proper enquiry into the circumstances.

13.225 I do not blame any of the junior doctors for their failure to act. In my view, the responsibility, if any, for ensuring that the circumstances were reported fell squarely on the shoulders of Dr Brown and Dr Husaini. I should deal briefly, however, with the state of knowledge of the doctors and nurses who treated Mrs Overton.

The State of Knowledge of the Nurses and Junior Doctors Treating Mrs Overton

13.226 Dr Husaini said that the doctors who treated Mrs Overton knew the reason for her collapse. He said:

> **'Whenever I would come to the ward I would have mentioned the fact that this is not right what has been done to her. I freely admit it. I admit**

because you might ask me some further questions as to what I do but I think it would be unusual or unthinkable of me not to have mentioned that morphine administered has resulted in unnecessary suffering to a patient.'

13.227 I accept that Dr Husaini probably did speak openly with his junior colleagues about his view of the circumstances of Mrs Overton's collapse. I also think that many of those treating Mrs Overton independently reached the view that the reason for her collapse was the inappropriate intravenous injection of a 20mg bolus dose of morphine.

13.228 Dr Lee admitted that both he and Dr Loh thought it unconventional that morphine had been given to someone who was suffering an asthma attack and they discussed the issue together. Dr Loh readily admitted that it was clear to him at the time that the dose of morphine given was excessive. Even in the situation of a concurrent heart attack and asthma attack, he acknowledged that the maximum dose given would be about 5mg diamorphine and that this would have to be titrated against response. To his credit, Dr Loh said, **'It is right to say that with hindsight I feel upset about the matter and wish that more had been done.'** I have no reason to doubt the truth of that comment. I think that Dr Mukhopadhyay must have realised the serious mistake that had been made and its consequences. Dr Premraj accepted that it was obvious that to have given 20mg morphine was excessive, represented a mistake by whoever had given it and had caused the respiratory arrest. Dr Rushton acknowledged as much and agreed that all the junior staff would have felt that what had happened was not right and would have talked about it. Dr Veerappan realised that an excessive dose of morphine given in an inappropriate way had caused Mrs Overton's collapse. He said he would have discussed this with Dr Brown and the nursing staff. Dr Peters took the view that 20mg was a huge dose to give. He had no recollection of discussions at the time. I have explained the reaction of Dr Pyburn when Dr Rushton informed her, in the summer of 1994, of the circumstances leading up to the collapse.

13.229 Statements were taken from 16 nurses who were responsible for Mrs Overton at various times. Some worked in the ITU and others on ward 17. Five nurses gave oral evidence. According to almost all of the nurses, it was common knowledge in the ITU and on ward 17 that the reason for Mrs Overton's condition was that she had been the victim of a serious mistake by her general practitioner, who had given her an excessive dose of morphine. After the individual nurses first became aware of the circumstances, which would normally have been on handover, I am sure that that knowledge slowly receded to the back of their minds as they concentrated on treating Mrs Overton, although I am sure they did not forget about it. I am sure that it was the subject of discussion between the nurses, although again this will have been more the case in February and March 1994 than later. I am quite satisfied from the evidence I heard that the nursing staff were fully aware that their consultants knew of the circumstances. I am also satisfied that they believed that some steps at least had been taken to enquire into the circumstances.

The Absence of Criticism in the Medical Records

13.230 I note that, despite what was known on the ITU and on ward 17, no expression of anxiety about or criticism of the general practitioner's treatment of Mrs Overton was entered in

the notes and records. Dr Brown said in his written statement that there is a reluctance to put in writing any adverse comments about the conduct of colleagues for fear that they could be used in legal cases brought by patients. If this were correct, I would deprecate such an attitude, which seems to be motivated by a desire to protect doctors rather than to support patients. I will consider this issue in detail in Stage Four.

The Responsibility of Individuals

13.231 I have made it plain that I am quite satisfied that many among the nursing and medical staff at Tameside General Hospital were aware of the circumstances that had led up to Mrs Overton's collapse. I have also said that I think that the responsibility, if any, for ensuring that those circumstances were reported and investigated lay on the shoulders of the two consultants who treated her, Dr Brown and Dr Husaini. I shall postpone my consideration of whether they should be criticised for their failure to report the circumstances until I have heard further evidence during Stage Four of Phase Two of the Inquiry, dealing with the climate or culture surrounding the making of an adverse report by one doctor about another.

13.232 I can say at this stage, however, that I am left in no doubt that Dr Husaini did not at any stage report to Mr Revington, Mr Butterworth, Mrs Nuttall or Mr Howorth any concerns that he may have harboured about the role of Mrs Overton's general practitioner in her collapse. It is, I am afraid, to his great discredit that he sought to persuade me otherwise. I believe that Dr Husaini realised, when preparing his evidence for the Inquiry, that his initial contact with the Coroner in March 1994 afforded him the opportunity to claim that what was being discussed around that time was not only Mrs Overton's future management but also his concerns over her past treatment. I have rejected that claim.

13.233 So far as Dr Brown is concerned, he did not claim to have reported his concerns to anyone in authority. Whilst I shall defer consideration of whether he should be criticised in that respect until after the Stage Four evidence has been heard, I should say at this stage that I have had no hesitation in rejecting as untrue Dr Brown's assertion that his state of mind in 1994 was that the circumstances of Mrs Overton's collapse were so uncertain that he could not reasonably act upon them. I think that his state of mind was neatly encapsulated in the witness statement that he made to the police at the beginning of 1999 when he said that he had been of the view in 1994 that Shipman's treatment of Mrs Overton had been **'highly unusual even dangerous'**.

The Handling of the Report of Death by the Coroner's Office

13.234 I have explained in detail why I have concluded that neither Dr Pyburn nor Mrs Evans should be the subject of individual criticism in relation to their respective duties to report and record the circumstances of Mrs Overton's death.

13.235 However, this case has illustrated the shortcomings of the systems in operation in the office of the Greater Manchester South Coroner at the material time. First, the report of the death was taken over the telephone by a coroner's officer who had no training whatsoever, other than what she had picked up from colleagues over the years of her

employment. Mrs Evans followed procedures that I think had probably been in operation for years. As I have explained in Chapter Seven, coroner's officers working in the office of the Greater Manchester South Coroner were permitted to make decisions about whether or not the Coroner would accept jurisdiction in respect of a death without reference to the Coroner and on the basis of scanty information. I have said that Mrs Evans should have obtained far more information from Dr Pyburn before bringing the conversation to an end. I think that, as soon as she heard of a factor which told her that jurisdiction must be accepted and that there would therefore have to be an autopsy, she was content to end the conversation. I think that would be standard procedure.

13.236 Second, no record was kept of the important instruction that Mr Revington must have given in connection with PC King's enquiry of Shipman. Record keeping was poor in the office at that time and at all times until relatively recently.

13.237 Third, a system in which no fewer than three coroner's officers took and passed messages about the same case, without any understanding of why the death had been reported, is not satisfactory. Mrs Evans spoke to Dr Pyburn and she came away from that conversation with an imperfect understanding of why Dr Pyburn had reported the death. She either spoke to the Coroner or put her report before him. Thereafter, she had no further dealings with the case. Mrs Collins seems to have spoken to the Coroner and conveyed a message to PC King that she was to check with Shipman. But she did not know the background to the death and would have been unable to explain in detail what was wanted and why. When PC King had seen Shipman, her report was passed to yet another coroner's officer, Mrs Blake, who had no knowledge of the case and who was, like Mrs Collins, no more than a carrier of messages.

13.238 I have explained why I must also criticise PC King, although there exists substantial mitigation for her failure to enquire fully of Shipman about the circumstances of Mrs Overton's collapse and the possible role of morphine.

13.239 I have explained in detail why I am critical of the work of Dr Bee. He failed to provide an adequate report (oral or written) stating the extent of the findings he had been able to make as a result of the autopsy and his examination of the clinical records. Instead, he provided an incomplete oral report and a written report containing a conclusion that went far beyond that which he could properly have advised. Neither his oral nor his written reports addressed the issue of the administration of morphine.

13.240 I bear in mind when criticising Mr Revington that he has been unable to attend the Inquiry due to ill health and has not been able to provide a detailed account of events in writing. Even bearing that in mind, I feel compelled to criticise him for his failure to realise that PC King's report did not say whether Shipman had given any morphine and provided no explanation for Mrs Overton's collapse.

13.241 I must also criticise Mr Revington for his decision, on the manifestly inadequate information available to him, not to hold an inquest. He had to consider whether there were reasonable grounds to suspect that the death might not have been due to natural causes. He could not rationally have reached the conclusion that there was no such suspicion and that an inquest was not necessary.

General Conclusions

13.242 I shall say nothing at this stage about the lessons that may be learned from this case about the duty of doctors and other health professionals to report concerns or allegations of misconduct or incompetence by a fellow professional.

13.243 The investigation undertaken by and on behalf of the Coroner in this case vividly illustrates many of the shortcomings I have previously identified and lends support to the conclusions I expressed in Chapters Seven, Eight and Nine.

13.244 The initial gathering of information was inadequate. The coroner's officer who took the report did not fully understand what had happened and why the death had to be investigated. She had long experience in the job but no formal training and no medical knowledge. She passed a very brief report to the Coroner, so his understanding was also limited. Unusually, he gave an instruction for a further enquiry to be made but the instruction was transmitted by a different coroner's officer with no knowledge of the facts. It is small wonder that PC King did not understand what she was enquiring about and failed to ask vital questions of Shipman. No one obtained the medical records or returned to Dr Pyburn for a better understanding of the background. No one in the coroner's office had the medical knowledge to appreciate the significance of the information which could have been obtained. In short, the investigation from within the coroner's office was fragmented, uninformed and superficial.

13.245 The provision of the pathologist's opinion illustrates the shortcomings I have mentioned in Chapter Nine. I have no reason to think that Dr Bee's conduct of the autopsy itself was in any material respect inadequate. However, his report was manifestly inadequate. He provided no underlying cause of death and should have said that he was unable to do so. Instead, he gave an unfounded opinion that the death was due to natural causes, thereby giving the Coroner a way of avoiding an inquest. In Chapter Nine, I observed that there appeared to be an expectation on the part of some pathologists and coroners that a death would be 'natural' and that an inquest would be avoided. This is an example of a case where such an expectation was clearly present.

13.246 The Coroner's decision not to hold an inquest appears to have been based on the pathologist's oral report and the manifestly inadequate report of PC King's enquiry. The Coroner's understanding of the background circumstances cannot have been other than superficial. Nor can he have had any understanding of the medical issues involved. A more thorough investigation was required but, even on the basis of the limited information available, an inquest was plainly necessary.