

# **Report of the Independent Inquiry into the Colin Norris Incidents at Leeds Teaching Hospitals NHS Trust in 2002**

**Produced for Yorkshire and the Humber Strategic Health Authority  
based on evidence gathered up to December 2008**

**The Independent Inquiry Team**

**Professor Pat Cantrill - Chair  
Mrs Eileen Foster  
Professor Pat Lane  
Mr Ronald Pate**

**To be presented to the Strategic Health Authority Board  
on 26 January 2010**

## **Acknowledgments**

### **Relatives**

The Independent Inquiry Team would like to thank the relatives of the patients killed by Colin Norris (CN) for sharing their personal experiences with us. The outcome of Colin Norris' actions for the families must not be lost. They have been at the centre of our thoughts as we have undertaken this review and we hope that it will answer some of the questions that remain for them. The Independent Inquiry Team cannot, of course, answer why Colin Norris did what he did or why he selected their relatives. The Independent Inquiry Team can, however, make sure that the experiences they have shared help to inform those who plan and provide health services.

Throughout the report, we have made reference to the women Colin Norris murdered:- Ethel Hall, Bridget Bourke, Doris Ludlam and Irene Crookes and in the case of Vera Wilby, attempted to murder. The Independent Inquiry Team has used their names at the families' request.

### **Staff of Leeds Teaching Hospitals NHS Trust**

The Independent Inquiry Team would like to express our gratitude to staff, senior managers and their teams at Leeds Teaching Hospitals NHS Trust (LTHT) for the way they have shared information with us. They faced a challenging time from the arrest of Colin Norris, through the extensive police investigation, which involved taking 7000 statements and seizing 3000 exhibits, to the criminal trial and beyond. Their commitment and loyalty should not be underestimated.

### **West Yorkshire Police**

The Independent Inquiry Team would also like to thank the police officers who have been involved with the families and staff for the support they have given to this inquiry.

## Contents

Executive Summary	1
1 The Independent Inquiry	7
2 Serious Untoward Incidents	10
3 Clinical Governance at Leeds Teaching Hospitals NHS Trust	19
4 Training and Human resource (HR) Issues	24
5 The Professional Standards of Nursing and Nursing Management	30
6 The Professional Standards of Doctors and Medical Management	34
7 Medicines Management	40
8 Listening to and Supporting Relatives	49
9 Listening to and Supporting Staff	52
10 Hospital Security	53
11 Independent Inquiry Conclusions	56
12 Recommendations	57
Appendix 1 Glossary	61
Appendix 2 Documents used in preparing the report	65
Appendix 3 The Independent Inquiry Team	70

# Executive Summary

## Background

On 4 March 2008, staff nurse Colin Norris was convicted of the murder of four patients and the attempted murder of a fifth in 2002 at Leeds Teaching Hospitals NHS Trust and received a prison sentence of a minimum term of thirty years.

During a period of six months from May until the 20th of November 2002, five elderly female patients who were all non-diabetic and had undergone surgery to repair a hip fracture, suddenly suffered severe hypoglycaemia resulting in brain damage being either the cause of their deaths or a significant contribution to their deaths.

An independent inquiry was commissioned by Yorkshire and the Humber Strategic Health Authority (SHA) in August 2008 and the families of Norris's victims were consulted about its terms of reference. **This report is based on evidence gathered up to December 2008 and therefore does not take into account developments since that time. The publication of the report was delayed for legal reasons.** However, since being given feedback on the recommendations from the Independent Inquiry Team, LTHT and other relevant organisations have developed an action plan and commenced implementation of the recommended changes.

This report is not a judicial opinion based on rigorous investigation of evidence as required in Civil or Criminal Courts. Any issues or concerns identified are a reflection of the evidence made available to us with benefit of hindsight and the application of foresight. The Independent Inquiry Team have however evaluated the decisions or action taken at the time it was taken on the basis of what was known or going on at that time, irrespective of the success or failure of the outcome.

## Conclusion

**Overall, it is the Independent Inquiry Team's view that a combination of factors, including organisational, systems and cultural factors, provided an opportunity for Colin Norris to carry out his intent to harm patients in 2002. Building on action taken by the Trust since that time, the recommendations of this inquiry are designed to improve the safeguarding of patients and improve the quality of services.**

**The responsibility for the intentional harming and subsequent death of patients rests with Colin Norris. It is difficult for an organisation to design and implement systems and processes that will totally eradicate the risks posed by an individual with that intent.**

## **Recognition of the incidents**

The provision of healthcare is built on trust and cases of deliberate and malicious harm to patients by healthcare professionals are extremely rare. The independent inquiry team recognises the difficulties in identifying individuals who have the intent to harm as they take conscious and deliberate steps not to be detected. Colin Norris was a trained nurse who had access to drug cupboard keys and the means to administer lethal injections to elderly and vulnerable patients.

There is evidence to suggest that the systems in place at the Trust to monitor the supply and administration of drugs at the time of the incidents were not robust enough to identify and prevent malpractice.

The Independent Inquiry Team believes that the action taken by the attending Consultant and the Trust Medical Director following the collapse of Ethel Hall was prompt and effective. However, had the earlier unexpected and unexplained deaths and incidence of hypoglycaemia been reviewed effectively and investigated and if death certificates had been accurately completed, Colin Norris' actions may have been identified earlier.

## **Internal investigations and subsequent action**

The Independent Inquiry Team assessed two serious untoward incidents (SUIs) that occurred during 2001 and 2002. The first of these involved the theft of pethidine by an agency nurse and is referred to in this report as the Pethidine SUI. The second SUI is referred to as the Colin Norris SUI and is an amalgamation of five separate incidents.

The handling of the SUIs reflects the clinical governance, risk management and patient safety systems at that time. That the incidents occurred and that the culture and systems in place did not identify problems earlier reflects the fact that clinical governance was not embedded throughout the Trust.

The Trust made an informed decision after reviewing internal evidence to amalgamate the two SUIs at an early stage of investigation. The Trust took a conscious decision to do this in order to review wider clinical governance arrangements. The Independent Inquiry Team believes that this was a mistake which has prevented effective learning following the two SUIs. Whilst there are areas of similarity there are significant areas of difference between the two SUIs. The fact that there were 77 recommendations in each report leading to the development of an action plan with 147 actions resulted in the really significant changes required to address deep-rooted issues being lost in a mass of small changes.

There is no doubt that the complexity of the police investigations in the case of Colin Norris resulted in the Trust having to undertake any internal investigation with great care and this influenced the pace in which they were able to be completed. The Independent Inquiry Team however believes that it is undesirable that it took two years for the Trust's internal team to complete their investigations and that a detailed action plan to respond to the

recommendations of those investigations was not established until four years after the Pethidine SUI and three years after the Colin Norris SUI. Actions identified in the plan were not always specific, measurable, achievable and realistic or time bound, and the responsibility for actions was not always clear. The action plan did not identify methods by which the Directors, Senior Managers and the Board could be assured that the required change had been achieved.

Some of the required changes however were made and not delayed by the development of the action plan, notably in relation to medicines management, but a coordinated, coherent strategy was not in place to assure the Board. Even after the major internal investigations, the subsequent action plan did not provide the overall direction, focus and momentum that was required.

It appears that for significant periods, little action was taken in reviewing performance against the action plans developed to address the two SUIs until a key point was approaching, such as the trial of Colin Norris. The action plan that was provided by the Trust to the Independent Inquiry Team identified that there are still outstanding actions. The Independent Inquiry Team was unable to gain evidence in some areas that actions had been fully and successfully implemented, for example audit of clinical records.

## **Key issues**

### **Listening to and supporting relatives**

The Independent Inquiry Team found that there were issues around relatives' complaints and concerns (both written and verbal) not being responded to at the time of the incidents. There have been changes in this area with the development of the the role of the Matron, Patient Advice and Liaison Service and a new complaints system for the NHS and social care. The Trust accepts that it did not communicate adequately with relatives or provide support for them following the incidents (as with staff). It is to be anticipated that this should not be the case now with the application of the 2006 Memorandum of Understanding regarding 'Patient safety incidents involving unexpected death or serious untoward harm'. This has been agreed between the NHS, the Association of Chief Police Officers and the Health and Safety Executive and one of its key tenets is that the organisations should work together *'to keep patients, relatives, injured parties and staff informed and to provide support as appropriate.'*

### **Clinical governance**

What is clear from reports, reviews and discussions with staff in the Trust, is that there remain issues associated with:- staff knowledge and understanding of clinical governance policies, structures, systems and processes. There has been a lack of a clear line of accountability at all levels, with ambiguity about who is responsible for the delivery of quality services and patient safety. Whilst there are pockets of good practice and areas where developments are

taking place within the Trust, there is inconsistency, which the Trust acknowledges and is acting on.

As part of the changes to overall Trust management a new integrated governance system has been introduced this should address the issues identified in this report. These arrangements need to be embedded in the new structure of the Trust and understood by staff at all levels of the organisation. The key challenge for the Trust is to ensure that the new framework is working effectively and that the required outcomes are clear and achieved. This has been a focus for discussions at the Trust Clinical Governance Committee, which was established in October 2008.

### **Clinical records**

Poor quality record keeping was identified as an issue as part of the police inquiries and the internal review of SUI 2001/55 and 2002/1655. The Trust still does not assure itself of directorate and ward performance. The Independent Inquiry Team found that there are still issues about the lack of recorded timings, signatures and legible notes in the medical records.

### **Training and HR (Human Resources) issues**

The Independent Inquiry Team identified a number of issues in relation to Colin Norris's training and employment. These included:- his behaviour during training, the quality of employment references, ill-health and attendance, record-keeping within personnel files and communications between Leeds Teaching Hospitals NHS Trust and the University of Leeds (where Norris studied for a BSc in Acute Healthcare). The Independent Inquiry Team found evidence of considerable work by the Trust to improve recruitment and management practice, notably in respect of protocols regarding the employment of agency and bank nurses. A key outstanding issue is the lack of audit of personnel files.

### **Professional standards of nursing and nursing management**

The Independent Inquiry Team found evidence of progress in this area, notably with the development of a Nursing and Midwifery Strategy which was launched in May 2007. However, the team felt that this strategy was not fully embedded and identified pressures on ward leaders and other senior nurses and variation in clinical supervision and the extent of multidisciplinary team working.

### **Professional standards of doctors**

The Independent Inquiry Team identified progress in relation to the development of the orthogeriatric service, reviewing crash calls, prescribing and systems to confirm shift changes between junior doctors. However, there are some unresolved workforce issues and the team highlighted to the Trust the need to develop a standard approach to mortality review across the Trust. This work is being progressed. The key outstanding issues are around confirmation and certification of death, communication with relatives,

escalating concerns to senior colleagues and reporting to the Coroner's office. The issue of certification of death is also a national issue and it is recommended that this requires a national response.

### **Supporting staff**

The Trust acknowledges that it did not provide sufficient support to staff during and following the criminal investigation and then at the trial of Colin Norris. Advice at the time was to restrict communications because of the criminal investigation and trial. Application of the Memorandum of Understanding previously described should address support for staff much more effectively in future.

### **Medicines management**

Leeds Teaching Hospitals NHS Trust medicines management services have made much progress following the two SUIs. The Independent Inquiry Team gained the impression that risk reduction with respect to medicines use was now fully embedded in the culture of the pharmacy and judged that many systems, procedures, policies and practices were better than in most other trusts. The notable exception to this was the lack of progress and priority given to automated solutions in medicines management which can significantly reduce risk to patients. This is particularly surprising given that most other hospital trusts have made much progress. Leeds Teaching Hospitals NHS Trust is clearly falling behind what is becoming the national norm in this respect. The Trust also needs to place greater priority on carrying out its three monthly checks of controlled drug and other drug storage areas and these need to be reported regularly to the Medicines Risk Management Sub-Committee (MRMSC) of the Trust Drugs and Therapeutics Committee.

### **Security**

The Trust has undertaken a considerable amount of work and invested substantial resources in the development of a modern, fit for purpose security system. It has also developed a close working partnership with West Yorkshire Police. The Trust must ensure that the work of the security service is understood and supported by staff, as without information from staff, the service will not be as effective as it could be in safeguarding patients and staff.

## **Recommendations**

This inquiry makes recommendations for the Trust, covering the wide range of issues outlined. In addition, there are national and regional recommendations, notably in respect of references for healthcare professionals from education providers, medical training and and certification of death.

# 1. The Independent Inquiry

## Background

On 4 March 2008, a 32 year old staff nurse, Colin Norris received a prison sentence of a minimum term of thirty years. This followed his conviction for the murder of four patients and the attempted murder of a fifth in 2002 at Leeds Teaching Hospitals NHS Trust (LTHT). During a period of six months from May to November 2002, five elderly female patients who were all non-diabetic and had undergone surgery to repair a hip fracture, suddenly suffered severe hypoglycaemia resulting in brain damage being either the cause of their deaths or a significant contribution to their deaths. The actions of Colin Norris have been subject to extensive criminal investigation by the Police, Coroner and internal investigations by the Trust.

Yorkshire and the Humber Strategic Health Authority (SHA) commissioned an independent inquiry in August 2008. The SHA will work with NHS Leeds, the lead commissioning Primary Care Trust, to manage the implementation of the recommendations with Leeds Teaching Hospitals NHS Trust (LTHT). It is anticipated that the report will also be used as a means of sharing learning and experiences across the wider health community.

This report should not be considered as a judicial opinion based on rigorous investigation of evidence as required in Civil or Criminal Courts. Any issues or concerns identified are a reflection of the evidence made available to the Independent Inquiry Team with the benefit of hindsight and the application of foresight.

## Terms of reference

In dialogue with the families of Colin Norris' victims, the panel chair, LTHT and NHS Leeds, the SHA set the following terms of reference:

- Review current systems and processes at Leeds Teaching Hospitals NHS Trust, with specific reference to the Orthopaedic Department, and identify key changes since 2002 in:
  - the professional standards of nursing and nursing management.
  - recruitment and selection.
  - training and links with education providers.
  - medicines management.
  - clinical record keeping, in particular the documentation of prescribed and administered medication.
  - multidisciplinary team working.
  - the certification of deaths.
  - the ability of staff to raise concerns regarding the care and treatment of patients.
  - the handling of informal complaints.

- Review the internal investigation reports and action plans produced by the Trust, including issues of security, and comment on the robustness of these.
- Comment on implementation of the action plans, identifying the extent to which the actions taken were compliant with NHS policies, guidance and best practice.
- Review the information and support provided to the relatives of the victims and to Trust staff once the SUI had been identified.
- Report findings and make any recommendations as necessary for service improvements to the Board of Yorkshire and the Humber Strategic Health Authority.

### **Independent Inquiry Team**

The Independent Inquiry Team members are:<sup>1</sup>

- Professor Pat Cantrill, Chair
- Mrs Eileen Foster
- Professor Pat Lane
- Mr Ron Pate

### **Period covered by the independent inquiry**

The period covered is from July 2001 when Colin Norris commenced working for LTHT until December 2008. The publication of the report was delayed for legal reasons. However, since being given feedback on the recommendations from the Independent Inquiry Team, LTHT and other relevant organisations have developed an action plan and progressed towards full implementation.

### **Methodology**

The Independent Inquiry Team:

- Met with all the immediate relatives of the patients Colin Norris murdered.
- Reviewed national policy documents of significance to this case
- Analysed documentation provided by LTHT including management reviews of the performance of services.<sup>2</sup>
- Reviewed court proceedings and Police documentation
- Conducted one to one interviews of key members of staff at the Trust
- Made site visits to review developments and assess systems in place and the environment of care.

---

<sup>1</sup> For biographical details see Appendix Three

<sup>2</sup> See Appendix Two for a list of documents and reports used as part of the review.

The development of the report has been challenging for the Independent Inquiry Team, primarily due to the time elapsed since the events took place. Many of the key staff employed at the Trust at the same time as Colin Norris have left or retired and it has not been easy to ensure that the required evidence supports all findings. There was not a filing system in place within the Trust that presented a complete audit trail from the identification of the incident to the present day. The Independent Inquiry Team has attempted to develop a complete record of events at the Trust. Where possible, triangulation of sources of evidence has been used to increase confidence in the findings.

All of the information supplied helped the Independent Inquiry Team to identify key issues and make recommendations to support the provision of best practice by services in the future. Analysis of the data also helped to identify areas of concern needing to be reviewed during site visits to Leeds General Infirmary.

## **2. Serious Untoward Incidents**

### **Background**

A serious untoward incident is defined as:

‘An accident or incident when a patient, member of staff, (including those working in the community), or member of the public suffers injury or unexpected death, or the risk of death or injury on hospital, or other health service premises or other premises where health care is provided or where actions of health service staff are likely to cause significant public concern.’

(Northern & Yorkshire Regional Office, 2002)

During this inquiry, the Independent Inquiry Team was informed about a serious untoward incident (SUI) that occurred on Wards 34 and 36 of the Orthopaedic Unit in December 2001. The Independent Inquiry Team believes this SUI identifies key issues about systems and processes that were in place around the time of the Colin Norris SUI.

### **The Pethidine SUI**

The incident began in July 2001 with the appointment of an agency nurse on the Orthopaedic Unit (wards 34 and 36 at Leeds General Infirmary) and was reported in December 2003. The agency nurse took charge of the ward and held the drug keys (against policy). Following the incident, a number of internal investigations took place and LTHT concluded that the agency nurse had been misappropriating large quantities of the controlled drug Pethidine from Ward 34 and 36.

In the early hours of 30 December 2001, a staff nurse from Ward 36 at Leeds General Infirmary (LGI) found part of a broken vial of the controlled drug pethidine in the staff toilets. This was immediately reported and a routine check of the controlled drug book made. The check showed that the book had been defaced and three vials of pethidine could not be accounted for.

A detailed analysis of the drug book highlighted ten irregular entries involving one particular agency nurse. Further reviews indicated that some patients on the wards appeared to have received a significant number of doses of pethidine; one patient's chart in particular suggested the patient had received 75 doses of pethidine. A second signature for some of these incidents was provided by Colin Norris.

The unit at the time did not advocate the use of pethidine for pain relief and the Trust had a policy that agency nurses should not take charge of wards or hold the drug cupboard keys.

The Trust began an informal internal review and the police were contacted in February 2002 but they took no action. In June 2002, the police renewed their

---

<sup>3</sup> Colin Norris commenced working on Ward 36 of the Orthopaedic unit on 08.10.2001

interest in the case and asked for access to the Trust's investigation reports on the incident. At this point it became apparent that there had been no formal investigation report. There had been a number of interim investigations and reports developed by Nursing and the Medical Directorates and Pharmacy, which resulted in a short report and recommendations for actions to prevent similar occurrences. These findings were not shared at the time with the remainder of the organisation.

The Trust also commissioned an investigation by an independent expert in 2002 to examine the use of pethidine on Wards 34 and 36 between July and December 2001.

A final report on the Pethidine SUI went to the Trust Board in September 2002. The report concluded that there was a lack of overall management control which allowed for continued poor management of ward areas, allowing the agency nurse to ignore Trust policies and procedures in relation to the use of pethidine.

The nurse involved in the Pethidine SUI was suspended and the agency that employed her informed. As Colin Norris worked closely with this agency nurse, the Independent Inquiry team believes that he would have been aware of the SUI.

### **The Colin Norris SUI**

The table below provides a summary chronology of Colin Norris's training and early career, leading up to and including the five incidents which constitute the SUI and what happened subsequently. Further detail of key aspects follows this table.

Date	What happened
September 1998	Colin Norris commenced nurse training (Higher Nursing Diploma) at the University of Dundee. The course included clinical placements in a variety of health and social care settings. From the evidence given at Norris' trial and from information supplied by lecturers, he was frequently absent from clinical placements and had to repeat a placement at the end of training because of absences. There was evidence presented at his trial to suggest that he did not enjoy working with elderly patients. He also had difficulties dealing with authority. His sickness record during training was 73.5 days during a three year period which is considered high.
October 2001	Colin Norris completed his Diploma and registers as a nurse.
October 2001	Colin Norris joined Leeds General Infirmary Ward 36 as a staff nurse. During the next 14 months he also worked on the orthopaedic ward at St James' Hospital. As well as working for the Trust, he also undertook agency nursing at the Trust and was employed by NHS Professionals and the British Nursing Association.

Date	What happened
April 2002	Colin Norris completed a period of preceptorship.
May 2 2002	Vera Wilby, 90, was admitted to Ward 36 at Leeds General Infirmary with a fractured hip after a fall. Her condition deteriorated as she recovered from surgery.
May 17 2002	Colin Norris administered morphine to Vera Wilby to make her drowsy and then administered insulin. She was found semi-conscious with a sudden hypoglycaemic attack but survived.
June 12 2002	Doris Ludlam, 80, fell and broke her hip at Chapel Allerton Hospital in Leeds where she was receiving treatment for a heart complaint. She was transferred to Ward 36 at Leeds General Infirmary for surgery.
June 16 2002	Bridget Bourke, 88, was admitted to Ward 36 at Leeds General Infirmary with a fractured hip.
June 17 2002	Surgeons operated to repair Bridget Bourke's hip. She was frail and confused, and her general condition was poor.
June 25 2002	Colin Norris gave Doris Ludlam a dose of the painkiller diamorphine, which was double the prescribed dose and then injected insulin which reduced her blood sugar level. She was discovered in a coma.
June 27 2002	Doris Ludlam died.
July 21 2002	Colin Norris, who was working the night shift, was said to have discovered Bridget Bourke slumped in bed at 3.10am. Doctors were called and she was found to be deeply unconscious after a hypoglaecaemic attack, despite not being diabetic.
July 22 2002	Bridget Bourke did not recover and died shortly after midnight.
October 2002:	Vera Wilby was discharged from hospital and went to live in a nursing home. She died the following year from unrelated causes.
October 10 2002	Colin Norris transferred to Ward 23.
October 10 2002	Irene Crookes, 79, fell and fractured her hip and was treated on Ward 23 at St James' Hospital.
October 19 2002	Colin Norris reported finding Irene Crookes "totally unresponsive" shortly before 6am. She suffered a hypoglaecaemic attack but was not diabetic.
October 20 2002	Irene Crookes died.
November 2002	Ethel Hall was admitted to Ward 36 at Leeds General Infirmary with a fracture to her hip. She had surgery to

Date	What happened
	repair it.
November 20 2002	Colin Norris was working on night duty on Ward 36 for an agency. Ethel Hall's condition deteriorated in the early hours of the morning. Her blood sugar levels were found to be very low and blood tests showed abnormally high levels of insulin. The attending consultant, who was a geriatrician, raised concerns about her collapse. The Trust Medical Director was informed of the suspicious nature of the incident.
November 29 2002	Medical results indicated that the cause of the hypoglycaemia was the administration of insulin. This had not been prescribed and there was no record of who had administered it.
December 6 2002	West Yorkshire Police were called in to investigate. The incident was reported to the Strategic Health Authority on 2nd.
December 11 2002	Ethel Hall died of irreversible brain damage without regaining consciousness. The police met with the Trust Medical Director and other senior managers. There followed a detailed review of patient notes by internal and external experts and four other elderly patients' deaths were linked with suspicious hypoglycaemia. A common denominator between the deaths was found to be Colin Norris, a "D" grade staff nurse who had either directly cared for or been directly involved with the care of all the patients
December 12 2002	Colin Norris was arrested for questioning and suspended from duty by the Trust following advice from the Police. The Nursing and Midwifery Council (NMC) was notified and an alert letter circulated to NHS organisations to contact the Trust if he attempted to gain employment with them. The two agencies he worked for, NHS Professionals and the British Nursing Agency, were also notified. During his period of suspension, Colin Norris attended a disciplinary hearing for undertaking bank nursing shifts when he should have been attending a BSc Acute Healthcare course at the University of Leeds. He received a written warning for working as an agency nurse whilst being paid by the Trust to attend the University. He was absent 4 weeks from the course out of a total of ten and he failed to attend two personal tutorials.
December 13 2002	Trust Incident Coordination Group (ICG) was established.

December 20 2002	ICG identified areas that required review and terms of reference were agreed.
March 2003	Colin Norris was suspended by the Nursing and Midwifery Council from practising as a nurse while investigations continued.
March 2003	An interim report by the ICG was submitted to the Trust Board.
January 2004	Colin Norris' current employment was reviewed and his employment was terminated.
April 19 2005	Colin Norris was dismissed from employment.
October 2005	Colin Norris was charged with four counts of murder and one of attempted murder.
October 2007	Colin Norris went on trial at Newcastle Crown Court.
March 2008	Colin Norris was found guilty of murdering Ethel Hall, Doris Ludlam, Irene Crookes and Bridget Bourke. He was also convicted of the attempted murder of Vera Wilby.
April 2009	The NMC Professional Conduct Committee removed Colin Norris from the NMC register.

### **Investigations and Action**

A major issue for any Trust finding itself in the situation where an incident is subject to police investigation is the need to ensure that they do not impede the police investigation and this can lead to a period of inertia.

In 2002, it was difficult for the Trust to proceed with internal investigations, but clarity was sought from the police and the establishment of the incident co-ordination group resulted in a review of immediate issues to ensure that patients were safeguarded.

By 20 December 2002 the Trust had set the following terms of reference for an internal review group:

- To review implementation of the Clothier recommendations
- To review nursing issues
- To review medical issues
- To review pharmacy issues

The police inquiry into the events associated with Colin Norris proceeded in close liaison with the Trust. There were examples of good joint working, for example a senior Trust nurse was seconded to work with the police as part of the investigation team.

At the request of the police, a detailed review of patients' case notes took place on all deaths on Ward 36 between 1 January 2001 and 31 December

2002 and as part of the ongoing investigation, police contacted the families of 415 patients. The notes were reduced to a final cohort of patients who were then reviewed by a panel of internal and external experts. Their findings concurred with that of the police in relation to the number of suspicious deaths.

The Trust believed that there were some factors that may have linked the Pethidine SUI with the Colin Norris SUI. The incidents occurred over an overlapping timeframe and in the same part of the Trust (specifically Ward 36 at LGI). Both staff worked for a short period on Ward 36. These factors were investigated by the police and subsequently discounted.

At the end of 2002, the Trust Board asked for assurance that the required actions relating to both the Pethidine SUI and the Colin Norris SUI had been identified and appropriately resolved. In March 2003, an interim report on the Colin Norris SUI in relation to the four key areas listed above was produced and reported to the Trust Board.

At the October 2003 Trust Board, a formal investigative review was ordered into the Pethidine and Colin Norris SUIs. Due to the ongoing police investigation, a subgroup of the Trust Board known as the Oversight Committee was set up and an internal review team was established, consisting of senior Trust staff.

The Oversight Committee asked the internal review team to review the national literature around incident investigation. It was decided that, based on the draft nature of national literature available and because the Committee did not want to prejudice the ongoing police investigation, they would not conduct a further primary investigation of the SUIs. Instead, the Trust Board took a conscious decision to amalgamate the two SUIs to review the wider clinical governance system.

The internal review team put out a formal call for evidence to all members of Trust staff who had any involvement in the Colin Norris SUI. They were asked to provide electronic or paper documents. In response, 243 documents were received and logged onto a database and were subsequently analysed by the internal review team. Following discussions, further questions were raised, considered and recommendations then made which were grouped into themes.

Key findings of the Internal Review reported to the Trust Board in April 2005:

- There was a culture of “a quiet word”, an informal culture where issues of concern were discussed but not documented. Problems were addressed within professions and not via management structures. There was a lack of a clear, widely understood process for staff to raise concerns about patient care. There was a culture of dealing with poor performance issues by education rather than direction to staff that persisted in behaving inappropriately and a lack of recognition that documentation of performance was required.

- Management structures and functions within the Trust were in flux because of transition to a new structure which was being introduced. This resulted in a lack of clarity of roles and responsibilities, specifically between the G grade ward managers, clinical service managers, clinical educators and ward pharmacists. There were obvious failures to adhere to Trust policies regarding the use of agency staff and out-of-hours management arrangements.
- The patient record system showed major weaknesses. The quality of record keeping varied greatly with no standard approach regarding what needed to be documented.
- The internal review team questioned whether there was an effective interface of professional and clinical governance committees with operational committees.
- Patient care was found to be an issue. There was poor pain management practice and the role of the pain management team was found to be unclear. Postoperative monitoring of the patients on Ward 36 was deemed to be of variable quality.
- There was a wide range of concerns regarding the management of medicines relating to supply, transport, storage, prescription, administration and disposal. The systems in place to identify problems were found to be inadequate.
- In response to these findings, the internal review team developed two separate reports, each with broadly the same 77 recommendations which were commended to the Oversight Committee for approval. They were approved and subsequently converted into an action plan for delivery by the Trust. This action plan had 147 actions, which resulted in the significant changes required being lost in a mass of small changes.

### **Findings of the Independent Inquiry Team**

The two serious untoward incidents and their handling reflect the clinical governance, risk management and patient safety systems at that time. That the incidents occurred and that systems in place, whether medicines management or audit, did not identify problems earlier reflects the fact that clinical governance was not embedded throughout the Trust. There was no risk management and/or clinical governance committee as a subcommittee of the Board and this may have contributed to the lack of a coordinated, corporately assured system.

The Independent Inquiry Team identified in 2008 that the recording of adverse incidents onto Datix (the Trust's internal risk management IT system) was significantly behind in many Divisions some up to eighteen months. Contemporary information that could inform patient safety, learning and effective change is not available to Directors or the Trust Board. This also

leads to a lack of timely feedback for staff reporting the risk issue. The Trust does have a newsletter, "Lessons learned" that is circulated regularly to staff.

Some junior doctors who the Independent Inquiry Team spoke to in 2008 expressed a view that risk management was an issue for nurses rather than themselves and that they were not aware of IR1s (incident reporting forms) or SUI reports. Whilst risk management is an issue for all staff, there are particular issues associated with junior doctors.

The Independent Inquiry Team could not find any evidence that an ongoing system has been set up to manage the information pertaining to the Colin Norris SUI. The documentation that was available:

- Was not in any chronological order.
- Did not have identification headers or footers
- Did not always identify ownership and responsibilities of ongoing risks
- Did not provide the Independent Inquiry Team with any assurance that risks, adverse incidents or action plans were being effectively completed
- Contained numerous mistakes in the detail of the information provided in minutes of meetings relating to the case which has called into question the validity of the documentation.

The Independent Inquiry Team believes that the amalgamation of the two SUIs was a fundamental mistake which has prevented effective learning.

The Independent Inquiry Team could not establish why it took the Trust two years for the internal team to complete their investigation and why a detailed action plan was not established for four years after the Pethidine SUI and three years after the Colin Norris SUI. Progress to address some of the key issues was being made, but a coordinated, coherent strategy to provide Board assurance was not in place. This was not acceptable practice. Even after the major internal review, the subsequent action plan did not provide the overall direction, focus and momentum required.

Changes in structures and staff at a senior level have resulted in some of the energy for change being lost as the Trust's agenda has moved on considerably. The action plan was periodically reviewed by the Trust Board but was not reduced and updated in line with changing clinical and organisational practice, nor integrated into everyday business.

Gaining the support and cooperation of key people at different levels within the organisation is an important factor for LTHT to successfully implement any action plan. Reaching the required outcomes depends on the awareness, commitment and capability of the people who will implement the projects and effective communication throughout the organisation. It is clear that support and cooperation was not always available because of the changes taking place within the Trust and the firm belief that both SUIs resulted from the actions of rogue individuals.

Crucially, the action plan developed as a result of the two SUIs needed to identify key assurance mechanisms. Maintaining a tracking system enables the assessment of necessary steps, corrective actions, and identifies successes. Periodic review of the activities outlined in the action plan is critical to meet performance goals.

The Independent Inquiry Team was concerned about the pace of change within the Trust. It appears that for significant periods, little action was taken in reviewing performance against the action plan until a key point was approaching like the trial of Colin Norris. The action plan that was provided to the Independent Inquiry Team in 2008 identified that there were still outstanding actions and the Team was unable to gain evidence based assurance in some areas that actions from the plan had been fully and successfully implemented, for example by auditing clinical records. Actions identified in the plan were not always specific, measurable, achievable or time bound and the responsibility for actions was not always clear. The action plan did not identify methods by which the Directors, Senior Managers and Board could be assured that the required change have been achieved.

### **3. Clinical governance at Leeds Teaching Hospitals NHS Trust**

The Independent Inquiry Team has focused on clinical governance to review current systems and processes at LTHT and identify key changes since 2002. Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.

An effective clinical governance system helps to answer the following:

- What is it like to be a patient/service user here?
- How good are the Trust systems for safeguarding and improving the quality of care?

LTHT, like all NHS organisations, is assessed regarding the quality of their services by external bodies, notably the Healthcare Commission.

The Healthcare Commission's assessment of Trusts covers a wide range of areas, including standards concerned with safety and cleanliness, safeguarding children, infection control, dignity, respect, privacy and confidentiality. LTHT's performance as assessed by the Healthcare Commission since 2002 was as follows:-

- 2002/2003 - 2 stars (out of a possible 3)
- 2003/04 - 1 star
- 2005/06<sup>4</sup> - weak for quality, fair for use of resources
- 2006/07 - weak for quality, fair for use of resources
- 2007/08 - weak for quality, fair for use of resources

Healthcare research specialists known as 'Dr Foster Intelligence' produce an annual Hospital Guide which uses specific criteria to reveal the 'health' of hospitals. Dr Foster's 2008 report focuses on three dimensions of quality:- patient safety, effectiveness of care and patient experience. The Independent Inquiry Team has looked at Leeds General Infirmary's performance in relation to hip replacement as the nearest procedure to that undertaken on the patients involved in this inquiry. For Leeds General Infirmary, post operative mortality rates were better than any other West and North Yorkshire hospitals and overall, the Trust was in the top ten performers in the country in relation to mortality rates.

---

<sup>4</sup> The Healthcare Commission introduced the annual health check, a risk-based system of assessing performance in the NHS, in 2005/06

## Findings of the Independent Inquiry Team

The merger of the United Leeds Teaching Hospitals NHS Trust and St James' University Hospitals NHS Trust in 1998 created the largest Trust in the country, LTHT. There were difficulties experienced not only in merging two hospitals with very different cultures but also in establishing policies, systems and processes, communicating them effectively throughout the Trust and changing practice. The view of staff who were interviewed by the Independent Inquiry Team and who had worked at the Trust in 2001/2002 was that the two main hospitals (Leeds General Infirmary and St James') worked separately. A period of restructuring resulted in staff leaving and a freeze on staff replacement. For some it created job opportunities, but others felt bitter about the change.

A major risk issue for any Trust is ensuring that vulnerable patients, particularly the elderly, are assessed effectively to ensure that the plan of care developed meets their needs whilst they are in hospital. Recognising the challenge for the NHS to meet the needs of vulnerable people in 2000, the Government produced guidance '*No Secrets*' which provides a template for health providers to assess their services and the individuals who use them. LTHT, in common, with many other Trusts did not use the framework in 2001. Safeguarding procedures for the city of Leeds were established in 2002.

Key personnel changes at senior management level during a seven to eight year period are not unusual. Since 2001/2002 changes have included the Chief Executive, Director of Nursing, Director of Quality and Director of Human Resources.

In 2002, clinical governance systems were said by staff who the Independent Inquiry Team interviewed to have been embryonic, with staff having a lack of knowledge and understanding of the systems in place.

In 2003, the Trust established its revised management arrangements, which consisted of a number of Clinical Management Teams (CMTs). Clinical governance arrangements were discharged through the Head of each CMT, who was either a clinician or a senior manager (most of these were senior managers). Safety and governance were managed through the clinical director, matron and manager in each of these specialty areas. Assurance was to be provided through monthly performance review meetings, chaired by the Head of each CMT and reporting to the Director of Operations. Whilst structures were said to be in place they were not applied consistently in all areas.

The Medical Director has overall responsibility for the integrated approach to quality within the Trust and an appointment was made to a new post of Director of Quality in June 2003. Proposals for a new integrated approach to the management of quality were approved by the Trust Board in November 2003. The proposals included changes to the Executive Directors' responsibilities relating to the corporate functions that feed into and support the quality agenda. It also included a new committee structure, with a new

Trust Board Quality Sub-committee replacing the existing Clinical Governance Sub-committee and Risk Management Sub-committee.

In June 2004, it was reported that the development of the Quality Strategy had been delayed due to the publication of the NHS Standards for Better Health and the importance of ensuring that these standards were reflected in the strategy. The strategy was launched in December 2004.

The Trust's Clinical Governance Action Plan was transformed into an Integrated Quality Development Plan for 2004/5. There was also recognition that a key challenge was to embed clinical quality into routine performance management processes. Clinical quality was one of the Trust's top short to medium-term objectives.

In 2004, a range of corporate functions were devolved to clinical management teams to facilitate more local ownership. This had an impact on the way that resources were deployed corporately and through CMTs (and more recently directorates).

LTHT has taken steps to address the requirements of the '*No secrets*' guidance on adult safeguarding. Significant progress was made with the establishment of Trust procedures and a steering group in 2006 and at this time the procedures were reflective of the 2000 guidance. The procedures were further updated in 2007. There has also been the appointment of a Nurse Consultant and Lead Nurse with the responsibility to lead on safeguarding for the Trust.

From April 2008, it was planned to embed an 'Organisational Development' Strategy into governance more generally, in line with the action plan developed from the Trust's internal review of the Colin Norris SUI. The Independent Inquiry Team was not able to establish the existence of this strategy.

In May 2008, new Trust management arrangements were put in place, with the establishment of five divisions:-

- Diagnostic and Therapeutic Services
- Medicine
- Oncology and Surgery
- Specialist Surgery
- Women's and Children's and Head, Neck and Dental

The clinical governance arrangements were strengthened through this model. This included the appointment of a Divisional Medical Manager and a Divisional Nurse Manager, senior individuals with specific responsibility for safety and governance for the division as delegated by the Divisional General Manager, who is the nominated lead of each division.

The Trust approved and launched its patient safety strategy in September 2008 and signed up to the 'Patient Safety First' campaign, including a programme of work to improve the quality of care delivered to patients. In September 2008 the Trust Board commenced weekly patient safety walk rounds in order to provide an opportunity for staff to discuss patient safety issues directly with Board members.

In October 2008 the Trust established its Clinical Governance Committee, chaired by the Chief Executive, with membership including the Medical Director and Chief Nurse. The committee includes representation from each of the five divisions, consisting of a combination of Divisional Medical Manager, Divisional Nurse Manager and Divisional General Manager.

The Trust Clinical Governance Committee has agreed a programme of work for the first year, working in conjunction with the established Trust Audit Committee, which meets quarterly. Divisional General Managers have established monthly clinical governance forums in their areas, led by the Divisional Medical Manager and Divisional Nurse. These individuals support the matrons, clinical directors and managers who were the lead officers in the previous structure. This provides more senior support and leadership for safety and governance and there is greater accountability and clarity of individual roles relating to this.

Whilst Divisions are responsible for their own clinical audits and subsequent development and implementation of action plans, there is not a coherent Trust audit programme and mechanism for sharing results and learning.

An example of the lack of audit coordination by the Trust is the auditing of record keeping. Clinicians and managers have a responsibility to demonstrate that the quality of record keeping conforms to legal requirements and best practice and, as part of their professional codes of conduct, health professionals are encouraged to audit clinical records to assess the standard of record keeping and identify areas for improvement and development.

Poor quality record keeping was identified as an issue in the internal investigations into the Pethidine and Colin Norris SUIs and in the police inquiry into the latter. In 2008, the Independent Investigation Team found no central analysis and therefore assurance of record keeping. Whilst some Divisions appear to have completed an audit of records, the outcomes were not available at the time of the inquiry. Specifically in relation to the orthopaedic wards at Leeds General Infirmary, the last record audit was in 2004. The outcome of this was also not available.

Of concern to the Independent Inquiry Team was the lack of recorded timings, signatures and legible notes in the medical records. The Independent Inquiry Team has been informed that there are still difficulties in relation to the completion of legible medical records.

The challenge for a Trust like LTHT is for risk management to be consistent throughout the organisation's culture, its strategy and the implementation of

that strategy. The Independent Inquiry Team did not gain the impression that this challenge was well met at LTHT.

In 2008, the size of LTHT still creates difficulties for the Trust Board and Directors to ensure that the vision and values of the Trust are communicated effectively throughout the organisation and for them to assure themselves that the quality of care and services across the trust meet required levels. It has not been easy for the two previous Trusts to come together and develop a corporate identity. Embedding a new culture within an existing organisational fabric is not an easy task and there appears to be a dislocation within the Trust between the development of organisational policies and their implementation.

What is clear from reports, reviews and discussions with staff at LTHT is that there remain issues associated with clinical governance policies, structures, systems and processes which need to be strengthened. There is a lack of a clear line of accountability at all levels, with ambiguity about who is responsible for the delivery of quality services. There are pockets of good practice and areas where developments are taking place, but also areas where the required activity is not happening.

The Independent Inquiry Team remained unclear from discussions with key clinical leads and with operational staff how the clinical quality structure provides the Trust Board with effective assurance not only that the required systems and processes are in place, but most importantly, that the required quality of care is being delivered.

Approaches utilising the NHS Leadership Qualities Framework in the training and development of leaders to support leadership development, such as 360° feedback are in place. LTHT has been acknowledged as a centre of good practice for 360° feedback. The Trust actively promotes uptake by managers and it is now a requirement for consultant appraisal. The Independent Inquiry Team has been advised that further work is to be undertaken which includes the development of an in-house leadership programme due for launch in 2008/9.

## **4. Training and HR (Human Resources) Issues**

### **Background**

The Clothier Report, the outcome of an independent inquiry into the deaths and injuries caused by children's nurse Beverly Allitt, recommended stricter criteria for selection to and progress in nurse training (Clothier *et al*, 1994). Eight of the report's twelve recommendations relate to tougher screening procedures. Each Trust was asked to compare their recruitment practices against those identified in the Clothier report and to address any inadequacies or gaps. Following an inquiry into the actions of another nurse, Amanda Jenkinson, the Bullock Report advocated that the recommendations of the Clothier Report be extended to cover all health care professions (Bullock, 1997).

In 2002, the Department of Health produced circular HSC 2002/008 'Pre and Post Appointment Checks for All Persons Working in the NHS in England'. The Circular covers all procedures and checks required before the appointment of anyone (employees, volunteers, students and trainees) in the NHS. It applies to all NHS settings, including primary care. This was superseded in May 2005 by 'Safer recruitment: a guide for NHS employers'. It brings together various elements of good practice relating to the checks required before an NHS organisation appoints a person, whether as an employee, volunteer or by hiring a person's services.

### **Findings of the Independent Inquiry Team**

The Independent Inquiry Team has spent time reading the evidence that was given during the trial of Colin Norris and other available documentation. The team are concerned that evidence provided by University of Dundee lecturers and Scottish hospital staff at the time of the trial indicated that as a student, Colin Norris had poor attendance at clinical placements and that his behaviour and communication with some of the lecturers was unacceptable. Mr Justice Griffiths William's 'Summing up to verdict' identifies that Colin Norris' attendance at clinical placements (caring for elderly people) was an ongoing problem and some placements refused to allow him to return. The result was that his training had to be extended. Witness statements also identify concern about his aggressive behaviour towards lecturers and the fact that on occasions he was found not to be telling the truth.

There were a number of incidents during Colin Norris' training which leave the Independent Inquiry Team with questions about his suitability to have been supported to register as a nurse and why he was provided with a reference that did not indicate any difficulties during training, particularly in relation to working with older people.

The reference from the University indicated that Colin Norris was an average student who had communicated well, was polite and capable of coordinating and prioritising nursing practice.

It is the view of the Independent Inquiry Team that the reference provided by the University of Dundee, whilst consistent with the practice of most universities, does not clearly identify the fact that Colin Norris had difficulties during training as a First Level Nurse. The content of the reference did not support the recruitment decision-making processes.

The decision made by the senior nursing team in 2001 to short list and employ Colin Norris as a staff nurse on the orthopaedic wards at Leeds General Infirmary was made on the basis of his educational qualifications, satisfactory occupational health checks, satisfactory references and, finally, his performance at interview.

The two references reviewed as part of the recruitment process were from Colin Norris' colleagues and not from an employer (as he had not been employed as a nurse) or senior manager. An additional approach for an additional reference from a Sister or Charge nurse was made but not followed up. However, a third reference was obtained from the University.

The Trust was under pressure to recruit because of a shortage of nurses and the information in the third reference, from the university, was supportive of Colin Norris' appointment. However, if there had been a detailed review of its content the difference between the 22 days sickness declared by Colin Norris and the 73.5 days identified in the University reference should have resulted in further information being sought and an occupational health review.

It is the university that has the overview of a student nurse's performance during their three-year training. The reference from the university is crucial to employing Trusts as it provides an overview of an individual's clinical and theoretical performance as well as their personality and integrity over the period of their training.

As part of the internal review of the Colin Norris SUI, the Trust assessed itself against circular HSC 2002/008 and found that:

- There were robust policies, procedures and guidance available and in use across the Trust.
- Recruitment processes operated across the Trust but were variable in terms of ownership.
- Recruitment and selection training covered pre employment checks and Occupational Health screenings were carried out via questionnaires and if problems identified further screening would take place.
- The HR directorate audited ten sets of personnel files, which highlighted concerns regarding the standard of administration in recruitment.
- Because of organisational restructuring, a review of variations in HR procedures across the organisation divisions did not take place.
- It was not possible to collate an audit trail of the documentation to show that the Clothier recommendations had been implemented across the

Trust, as documentary evidence for St James' Hospital was not available.

- Recruitment policies were on the intranet in draft form.
- Specific recruitment processes were examined and it was found that:
- Colin Norris had been interviewed by two senior nursing staff who had received some training by the Trust.
- Colin Norris received satisfactory health clearance based on what he had written in his health questionnaire. As he did not identify any health issues and his true level of sickness in training was not declared, he did not require further assessment.
- It is LTHT policy that references are obtained from previous employers and in the first instance references had been provided by colleagues of Colin Norris.
- HR staff had put a note in his personnel file to follow up references but this did not take place. There were staff shortages in HR at the time and this might have resulted in the action not being taken.
- Colin Norris' records showed a sickness absence on his application form of 22 days but subsequently the University advised that it had recorded 73.5 days of absence.

A review of Colin Norris' preceptorship period (first six months, completed in April 2002) took place and the conclusions were that there were no concerns in terms of his capability, conduct, or attendance at any time. Preceptorship is a structured, supportive programme recommended by the NMC, which intends to support a newly qualified nurse to make the transition from student nurse to practitioner. It also aims to produce competent, professional nurses.

From evidence at the trial of Colin Norris and from subsequent letters of complaint, it is apparent that during his employment at the Trust, Colin Norris was involved in a number of incidents with patients, relatives and staff that should have resulted in investigation, action and a notation on his personnel file. This included verbal hostility and unacceptable treatment of elderly patients and junior staff.

Colin Norris undertook bank and agency nursing shifts when he was being paid by LTHT to attend a BSc Acute Healthcare course at the University of Leeds. He later (during his period of suspension) attended a disciplinary hearing and received a written warning for this. He was absent from the course for four weeks out of a total of ten and he failed to attend two personal tutorials. In 2002, the university contract was with the individual registered for the course and not with the Trust. There was therefore no obligation to inform the Trust that Colin Norris was absent for significant periods of the course. The relationship between the Trust and the university is said to be much stronger now and Trust employees funded to attend a course at the university are asked to sign a form that supports release of information to the Trust

regarding lack of attendance. Whilst this is in place, the Independent Inquiry Team was told by the university that there is still reluctance to release the information to the Trust.

### **Developments in Trust training and HR**

In 2004/05, there was a major review of HR and other services, primarily as a result of the financial position of the Trust. The result was the devolvement of key administrative HR processes to Divisional level and a small strategic specialist support service maintained centrally. HR staffing levels were reduced from 96 to 36. The Independent Inquiry Team was told by a number of staff that the function was delegated without the development of expertise within the Divisions, although the HR Department developed a number of toolkits to assist managers.

Following the 2004/05 restructuring, HR developed and delivered its own training (previously training had been delivered by the Education and Training Department).

In 2008, the HR (including recruitment) function sits with the Divisions but the Trust has maintained a strong central HR function in order to check that its corporate HR policies and processes are being followed. The recruitment process will not be completed and a post offered until the instigating manager completes the required actions. However, there is no central audit of the recruitment process and the Independent Inquiry Team was informed that staff are still interviewing job applicants without having completed relevant HR training. It has been reported to us that there is concern about the lack of involvement of ward sisters in recruiting staff to work in their area. This was found to be the case in relation to the clinical areas that provide medical and elderly care where 75% of the team have not been recruited or redeployed with the ward leader's involvement.

The Trust's internal review team identified the culture of a 'quiet word'. Whilst the view of the Trust is that this has changed, other than in pharmacy, it is difficult to support this with evidence. The police found a lack of recorded information on personnel files regarding Colin Norris' performance. The action to address this in the SUI action plan states that '*the thresholds for the consistent application of the disciplinary process should be better defined*'. In March 2008, the requirement for poor performance to be recorded on personnel files was incorporated in the review of the Disciplinary and Grievance Toolkit.

The Independent Inquiry Team found that there are still difficulties with openness and the willingness to 'whistleblow'. The Trust is developing a new whistleblowing policy, but that on its own will not address a culture where 'a quiet word' has been the preferred style of practice.

There are 1.338 million (or 1.095 million full time equivalents) staff working in the NHS and a member of staff being charged with harming patients is extremely rare. That is why when such incidents occur they attract considerable interest.

Whilst properly performing health services cannot be held accountable for the actions of rogue nurses who murder there is a responsibility to understand how hospitals form a crucible in which murders can take place. Health service organisations and the professional groups within them can reduce the possibility of the workplace providing opportunity for the murder of a patient.

For a nurse to murder, they require the motivation to kill, access to vulnerable patients, access to the means of murder and they need the opportunity to kill by having time alone with the patient.

The core enablers are available to all nurses; however, for a nurse to continue to murder patients in their workplace for any length of time, some additional elements are required. They need to avoid arousing the suspicions of colleagues or if they do, that they keep silent. The murderer must also ensure that a pattern of unusual death does not develop or they run the risk of being identified, usually by a health care professional.

Nurses who murder usually do so with lethal injection, a fact that healthcare organisations need to consider when developing medicine management and patient safety systems.

Inadequate systems for managing human resource issues e.g. inadequately trained or prepared staff, inadequate risk and clinical governance systems and a culture of silence all support the space for such activity.

The Trust and wider NHS need to raise awareness amongst staff of the potential for malicious action against patients by healthcare professionals. There is a need to develop services that protect vulnerable patients and staff should be made aware of the mechanisms in place to report any suspicions about colleagues so that these can be investigated as appropriate.

Appraisal is an important mechanism for reviewing performance, both for individuals and teams. In 2002, an appraisal was not completed on Colin Norris. Across the organisation in 2007/2008, according to the latest staff survey only 50 to 60% of staff appraisals were completed. The staff survey action plan identified that *'Trust Directors should be set the objective of ensuring all of the staff members in their area participate in annual appraisal.'*

In 2008, the Trust was found not to undertake an audit of personnel files. This is delegated to divisional level and there is no central process to assure that this takes place and the outcome checked. The Independent Inquiry Team has found no evidence that this audit takes place. It is therefore difficult for the Trust to assure itself that accurate records are being maintained, HR practice is in line with corporate policy, notably with respect to recruitment, performance review and significant incidents being recorded in personnel files. The Trust acknowledges that compliance needs to be monitored consistently and this will form part of the divisional clinical governance review forums.

The Trust has undertaken a considerable amount of work since the Pethidine and Colin Norris SUIs to improve the recruitment, management and

adherence to Trust protocols regarding the employment of agency or bank nurses. The action plan following the SUIs stated that the Trust should set standards for the pre-recruitment screening of all agency staff and enforce them through contracts with staff agencies. Agency nurses were also not to be in charge of wards or hold drug cupboard keys. The nurse in charge of a ward is now required to be a Trust substantive post holder, supported by agency staff when required. Matrons now coordinate staff redeployment from other areas to take charge when this is required.

There was also an issue at the time of the Colin Norris incident of identifying Trust staff who worked additional hours at the Trust for agencies. The internal review team found examples of Trust nurses breaching working time directives and also wearing the Trust uniform whilst working for nursing agencies. The Independent Inquiry Team has been informed that all these issues have now been addressed and that standards have been incorporated in the NHS Purchasing and Supply Agency contracts for provision of bank and agency staff.

The Independent Inquiry Team was informed that an improved record has been established to identify Trust staff working additional hours within the Trust for the nursing bank or an agency.

The Independent Inquiry Team also examined the issue of multidisciplinary working and was informed that there was a wide variation in practice in 2008. Practice differs from ward to ward and between hospitals, ranging from excellent team working to limited contact between team members.

## **5. The Professional Standards of nursing and nursing management**

### **Background**

The Nursing and Midwifery Order 2001 (SI 2002/253)<sup>11</sup> prescribes the function of the Nursing and Midwifery Council (NMC). The NMC maintains a register of qualified nurses, midwives and specialist community public health nurses and sets standards for conduct, performance and ethics. It provides advice for nurses and midwives and considers allegations of misconduct, lack of competence or fitness to practise due to ill health.

### **Findings of the Independent Inquiry Team**

The Independent Review Team has attempted to develop a picture of nursing at the Trust from 2001 when Colin Norris began work on Ward 36 to compare with the position to date. The Independent Review Team has talked with staff, relatives and reviewed the documentation that is available. The Independent Review Team has drawn heavily on perceptions of nursing practice at that time and have attempted to triangulate the information supplied by staff with that of relatives and internal and external indicators.

The nursing staff working on Wards 23 and 36 were required to undertake a variety of assessments and utilise technical skills in caring for elderly orthopaedic patients who had a wide spectrum of additional illnesses.

Concerns and issues raised by families and staff relating to the care provision on Ward 36 in 2002 reflect some of the areas of weakness identified in the internal reviews of both the Pethidine and Colin Norris SUIs. For example:

- General care being poor, medications being left on lockers, requests for help with toileting or other care needs being ignored or delayed
- Poor communication with patients and relatives
- Preceptorship of new staff being embryonic
- Little preparation for the Sisters to develop management skills
- Shortage of staff with shifts filled by agency nurses, some of whom were existing Trust staff
- Agency staff wearing the same uniform as Trust staff and being in charge of wards and drug keys
- The skill mix of staff not meeting need. The Trust was starting to train health care assistants to develop their role but this was embryonic
- Very different cultures between doctors and nurses, impacting on care delivery

---

<sup>11</sup> The Nursing and Midwifery Order 2001(SI 2002/253)

- Lack of clinical supervision and appraisal
- A lack of assessment tools to inform the development of clinical care for patients

A fundamental factor in delivering high quality care is having the correct establishment (number) and skill mix of nurses in post. At the time of the Pethidine and Colin Norris SUIs, above average rates of staff vacancies and sickness and absence rates put staff under pressure and would have impacted on the quality of care provided.

The Independent Inquiry Team found that the Trust does not keep “in post” figures and sickness and absence rates for nurses at ward and division level. Only overall Trust nursing workforce figures are provided to the Board. The Independent Inquiry Team was informed that the most recent figure for nursing vacancies was calculated in October 2007 where the position at March 2007 was calculated for a staff survey. The vacancy rate at that time for qualified nursing staff was 1.77%. The present figures for the Directorate of Musculoskeletal Services identify that the staffing position is good.

In May 2007, the Trust launched its ‘Nursing and Midwifery Strategy 2007 to 2012’ following a consultation process. The strategy provides the Trust’s vision for nursing and midwifery and is divided into nine themes which describe what is to be achieved and how it will be achieved.

Detailed action plans in relation to each of the nine themes are accessible to all nurses and midwives on the Trust intranet.

A Trust Annual Nursing and Midwifery Report was produced in September 2008 to inform the Board of progress. Whilst the report provides examples of improved practice and performance, there is no quantitative data against agreed indicators to indicate overall improvement.

The introduction of Divisional Nurses (4), Matrons (32) and Lead Nurses (4) who focus on midwifery, patient safety, cancer and medicines management, provides the leadership, management and support structure required to ensure that nurses and midwives are delivering the required quality of care. Good practice is shared using the good practice database that the Trust has developed.

The Trust is also now implementing the ‘Releasing Time to Care’ programme, a modular development programme for ward teams that is leading to significant improvements in patient care, enabling ward staff to increase the time spent on direct patient care. ‘Releasing Time to Care’ focuses on improving ward processes and environments to help nurses and therapists spend more time on patient care, thereby improving safety, quality and efficiency. This demonstrates a significant commitment from the Trust to empower ward teams to make improvements locally.

The development of an orthogeriatric model of care on the three trauma wards at Leeds General Infirmary was supported by the recruitment of two older

people's nurse specialists. Their role was to educate staff and to develop and implement a patient pathway. Liaison services were also extended to patients with dementia. This was felt by the orthogeriatric and nursing teams to be a great success but when the funding ended, the posts were removed. The trust has, however, appointed a nurse consultant also recently appointed a senior nurse for adult safeguarding.

Until recently, leadership programmes have tended to focus on philosophical models rather than the skills and behaviours required to manage effectively changes that are taking place to develop ward leaders and managers at LTHT. However, the Division of Specialist Surgery has established a structured development programme for Band 6 Sisters. Clinical Nurse Specialists are also undertaking a leadership programme to increase their political understanding and awareness and to develop skills to support future progress in nursing practice.

Whilst considerable progress has been made and the strategy provides the vision and values for nursing, there are a number of areas that the Independent Inquiry Team identified as requiring further development. There is still work to do in relation to ensuring that staff are aware of and understand the vision and values identified in the Strategy. Some nurses the Independent Inquiry Team spoke to did not know there was a strategy.

There is an opinion held by a number of staff interviewed in 2008 that establishments for nursing are not correct and this is leading to ward leaders and other senior nurses not being able to lead and manage clinical practice effectively. The Trust has undertaken a series of nursing workforce and establishment reviews since 2002. Further benchmarking occurred in 2007, and in 2008 the Trust implemented the Acuity and Dependency Tool which is now used on a regular basis to inform workforce planning and staff deployment in adult inpatient areas. The Acuity and Dependency Tool (AUKUH) has been developed to help NHS hospitals measure the number of nursing hours required to care for patients. However, the perception of some of the staff interviewed by the Independent Inquiry Team was that the review of clinical nurse specialist and clinical educator involvement has resulted in inconsistency in across the Trust in relation to their contribution to patient care and education and training. The pressure on ward leaders is said to have increased as a result of a growing amount of paperwork to be completed.

There is evidence to suggest there is a lack of coordinated education and training in the Trust. Nurses reported that they are finding it harder to obtain study leave. The Independent Inquiry Team was informed that there had not been a Head of Education and Training for over a year. A senior HR manager has been seconded to undertake this role whilst the post is reviewed and a substantive appointment is made. This has been out to advert on two occasions without success and this has continued to be pursued.

Clinical supervision is the term used to describe planned regular periods of time that supervisor and supervisee spend together discussing the

supervisee's work and learning progress. In 2001/2002 the process was not well developed across the Trust and this position remains the same in 2008.

## **6. The Professional Standards of doctors and medical management**

### **Background**

The professional standards of doctors are set and regulated by the General Medical Council (GMC), which has undergone radical reforms in recent years following the Shipman Inquiry.

### **Independent Inquiry Team findings**

The Independent Inquiry Team recognises that the response of the consultant geriatrician and the Trust Medical Director to Ethel Hall's collapse was appropriate and timely and the involvement of senior doctors in reviewing the clinical records of patients helped the police with their investigations. However, the Independent Inquiry Team examination of the Pethidine and Colin Norris SUIs indicates a lack of medical ownership of these incidents in 2001/02.

The Pethidine SUI was raised at the Orthomedical meeting three weeks after it was identified. Doctors were reminded at that meeting to review prescriptions and a discussion took place about undertaking prospective audits of postoperative analgesia. Further reviews indicated that some patients on the wards appeared to have received a significant number of doses of pethidine but this was never queried by doctors, although pethidine was not routinely given to this group of patients postoperatively.

The Independent Inquiry Team believes that in the case of the Norris SUI, the apparent lack of medical ownership is partly attributable to the fact that Colin Norris was a nurse and that his actions were perceived to be those of a rogue practitioner. It was also as a result of the general manager at the time not undertaking a formal investigation of the incident in line with SUI policy and guidelines. As a result; the implications for systems change in medical practice were not readily identified until a formal investigation occurred.

The Trust informal review of the Pethidine SUI found the following medical issues:-

- Interfaces between doctors, nurses and other health professionals.
- Informal processes were in place but there was a lack of formal records.
- No process to record anticipated actions from clinical rounds.
- Separate records for different professional groups e.g. medical, nursing, physiotherapy.
- No approach to discussing deaths of patients and therefore no identification of clusters.
- Medical handover.

Key issues identified in the second review, which addressed both SUIs were:

- The model of medical practice that operated between orthopaedic surgeons and geriatricians (orthogeriatric model) at that time
- Communication between doctors and nurses
- Arrangements for reporting clinical incidents
- Consistency of the surgical care plans
- Lack of process for discussing deaths and untoward incidents
- Rotation/allocation of the medical staff
- Silo working.

The Independent Inquiry Team has focussed in this section on four major areas to identify whether changes have taken place in the provision of medical care. These are:

- Development of the orthogeriatric service
- Audit of resuscitation calls and review of unexpected deaths
- Identification of doctors on duty
- Certification of death

### **Development of an orthogeriatric service**

The requirement for an orthogeriatric service has been recognised by the Trust but the resource allocated was not sufficient to meet requirements.

In 2001/2002, Wards 23 and 36 provided care for patients who had experienced a traumatic injury and for elective patients. There was a mixture of fit younger patients without additional health problems and extremely frail elderly patients with multiple health problems. There was a limited service provided by a geriatrician. Research has identified that a service provided in this way can lead to disparate and compartmentalised care, with poorer overall outcomes. In 1999/2000 LTHT had one of the worst UK mortality rates after hip fractures – 11%. (The Trust Board responded to the mortality rates by establishing an orthogeriatric service).

Ward 36 at Leeds General Infirmary and Ward 23 at St James' Hospital, where Colin Norris practiced, provided care for patients who had experienced trauma or conditions associated with bones, joints and muscles. They also provide care before and after orthopaedic surgery. In 2001/02, the wards had a mixture of fit younger patients without additional health problems and extremely frail elderly patients with multiple health problems.

The approach to the provision of orthopaedic services across the UK at that time was a 'one size fits all' model. In discussion with staff working on the wards at that time, the problem of meeting the needs of both groups was identified as difficult and it was said to be frequently the care of the older patients that was adversely affected.

In November 2006, the care of patients who had experienced a traumatic injury was centralised at Leeds General Infirmary. There are now three wards designated as 'orthogeriatric' to more effectively meet the needs of older patients requiring orthopaedic care. The clinical responsibility for patients is divided, with orthopaedic surgeons being initially responsible for the acute phase of care before transferring care on a named patient basis to geriatricians. Details of the handover are entered into the Patient Administration System.

Services are provided to the orthopaedic wards by three half time consultant geriatricians; two of these posts being at St James' University Hospital and the other at Leeds General Infirmary. This level of service has been provided for a number of years. The patients remain under the responsibility of orthopaedic surgeons.

The orthogeriatricians remain of the view that it would take four half time posts to provide the service required from the point of centralisation. Resourcing of the fourth post remains unresolved and the Trust is currently considering the options. There is also a view held by some medical staff that the workforce position regarding junior and middle grade doctors requires review.

### **Audit of resuscitation calls and review of unexpected deaths**

One of the recommendations of the internal review of the Colin Norris SUI was that the Trust should establish a system for centralised recording of crash calls in order to monitor trends. This has been in place since 2007. A review of current arrangements, practice, policies and procedures within the resuscitation service was stated as 'ongoing' in the action plan review of March 2008.

The Independent Inquiry Team was told that monitoring is being undertaken by the Trust's Resuscitation Board, chaired by the Deputy Medical Director. This includes the recording of crash calls. The Independent Inquiry Team has been informed that interim arrangements to commence data collection are in place. This involves the resuscitation administration officers collecting information from both main site switchboards for the last twelve months to enable trend analysis to commence. Data items include:- date of call, site, time of call and ward/department requesting the crash team attendance. The information gathering covers the adult, paediatric and neonatal crash teams Trust-wide and will be kept on a central database.

A business case was submitted and approved in December 2008 to develop a new computer programme for cardiac arrest audit. This development and the appointment of a Resuscitation Officer will enable the NHS Litigation Authority standard to be met, including establishing effective reporting and monitoring systems and robust audit processes to record attendance at crash calls and outcomes.

The Independent Inquiry Team has been advised of a number of other developments that have improved medical practice since the Pethidine and Colin Norris SUIs, as follows:

- Quarterly meetings between orthogeriatricians and pharmacy staff to discuss any issues associated with prescribing and to identify 'top tips' for junior doctors
- Monitoring prescribing by junior doctors
- Multidisciplinary meetings prior to ward rounds
- Monthly meetings regarding mortality rates including sudden deaths alerts to geriatrician with peer reviews of deaths selected at random
- Building on a specific alert which was sent out Trust-wide after the Colin Norris SUI came to light advising staff of the reporting procedures in the event of an unexplained hypoglycaemic episode, a protocol has been developed for the management of hypoglycaemia. The relevant guidelines (Hypoglycaemia in Adults - Detection and Management) were approved by the Clinical Guidelines Committee and placed on the Leeds Health Pathways site in November 2004. The Clinical Guidelines Committee are said to ensure regular review.

The Independent Inquiry Team was not able to determine if a standard approach to mortality review had been established and applied to all patient deaths in the Trust but this is in place in the orthogeriatric services. The Trust recognises that this needs to be strengthened. This is included in the Trust's revised clinical governance framework and has been subject to recent review and discussion at the Trust's Clinical Governance Committee.

### **Identification of doctors on duty**

As part of police investigations and the internal review of the Colin Norris SUI, issues were raised about the difficulty of identifying doctors who had been on duty. The action plan following from the SUIs identified that a Trust based system for communicating with junior doctors should be implemented. The Independent Inquiry Team was advised that a number of developments have taken place to strengthen contact with junior doctors, which include:

- New starters are asked to give email addresses to the post graduate department to enable more effective communication
- A rota being developed by the administrative department and any changes made have to be notified to the department in writing. Confirmation of doctors changing shifts have to be reported to this department.

### **Death Certification**

Mr Justice Griffiths William's 'Summing up to verdict' at the trial of Colin Norris in 2008 identifies that:

- *Several expert witnesses stated that hypoglycaemia, whilst not uncommon in diabetics, is a rare condition in non-diabetics. Severe hypoglycaemia in non-diabetics, ie serious enough to result in death, is very rare.*
- *One witness stated, 'In hindsight I believe a screen should have been taken for insulin levels and c-peptide levels as later suggested by me. This would have provided information with regard to what in my opinion were two of the most likely cause of the low blood glucose levels in the patients.'*

In the three deaths prior to that of Ethel Hall, relatively junior medical staff completed all certificates and the patients' deaths were certified as resulting from natural causes. The fact that they were severely hypoglycaemic and that this had been noted at the time was not recorded on the death certificate. Two of the deaths were reported to the Coroner but hypoglycaemia was not on the death certificate and it is impossible to determine if the notifying doctor discussed this with the Coroner's Office. There was no follow up of what the Independent Inquiry Team believes should have been identified as suspicious deaths.

In the case of Ethel Hall, her sudden deterioration was noted to be suspicious and triggered the police investigation. Before her death, the Trust did not identify that in the deaths of three other elderly women and in the collapse of a fourth (Vera Wilby), there was unexplained hypoglycaemia.

The Independent Inquiry Team believes that if unexpected/unexplained deaths and incidence of hypoglycaemia had been assessed and investigated and if death certificates had been accurately completed, Colin Norris' actions might have been identified earlier.

It was stated at the trial of Colin Norris that it is not unusual for stroke to be given as a cause of death in elderly people even though there may not be evidence for it.

The Independent Inquiry Team was informed that since the Colin Norris SUI, geriatricians are alerted when sudden deaths occur and that there is a peer review of deaths selected at random.

Dame Janet Smith and Dame Caroline Swift, Chairman and Leading Counsel to the Shipman Inquiry highlighted to the Independent Inquiry Team similarities between the offences of which Colin Norris was convicted and those of Harold Shipman. Both cases relate to death and cremation certification. The judge at Colin Norris' trial, Mr Justice Griffiths Williams expressed his concerns about the evidence given regarding the role of junior doctors in completing and signing death certificates. He described it as 'very disturbing indeed'.

Following the Shipman Inquiry, six inquiry reports were published between 2005 and 2006. Recommendations made in the reports included measures to strengthen the systems for death and cremation certification. However,

despite a number of papers and consultation processes to address the concerns expressed after the Shipman Inquiry (including a Pathfinder Pilot at Sheffield Teaching Hospitals NHS Trust), in December 2008, the systems remain unchanged from the period when Harold Shipman and Colin Norris practised.<sup>5</sup>

Under current arrangements, the doctor responsible for a patient's care prior to their death completes a 'medical certificate of the cause of death' (MCCD), and this forms the basis for registration of the death. The registrar of births and deaths checks the MCCD to ensure that it is correctly completed and they must report any cases to the coroner where the MCCD or information from the family of the deceased suggests that further investigation is needed, for instance, if there was an unexplained injury or uncertainty over the cause of death. If they have any suspicions over the cause of death or in other specified circumstances, doctors can refer the case to the coroner.

Where the bereaved family choose a burial, there are no further checks on the MCCD. For cremations, statutory forms are completed by three doctors, namely the treating doctor, an independent experienced doctor who makes enquiries and examines the body and an Appointed Medical Referee. The applicant for cremation (usually the next of kin) also completes a form. The Medical Referee at the crematorium authorises cremation in the light of the information on the forms completed by the applicant and the two doctors but does not examine the MCCD; nor does the medical referee have access to the medical records of the deceased. Any of the three doctors may refer the case to the Coroner in cases of doubt. The medical referee is entitled to refuse to authorise the cremation if these doubts are not resolved but must give reasons for such a refusal.

The Independent Inquiry Team has established from conversations with junior doctors at LTHT that they do not feel adequately prepared to certify death. Whilst at medical school, they may have been prepared to assess a patient for vital signs but the process of completing the death certificate, dealing with relatives and reporting to the coroner's office are not covered. The Independent Inquiry Team was informed by some of the doctors that the deanery is addressing this by covering this issue as part of six development days. Junior doctors are required to check completed death certificates with a consultant. However, in conversation with junior doctors, the Independent Inquiry Team found that they are still signing death certificates without supervision. They felt that they can contact senior colleagues for support but recognise the difficulty for deaths at night. They also identified that they lack the confidence to refer a situation to the coroner if they suspected poor practice.

There has been little change to the system of death confirmation and certification since the Colin Norris SUI. The majority of Trusts in England will

---

<sup>5</sup> Learning from tragedy, keeping patients safe DoH 2007

operate in the same way. This is an issue that requires legislative and national change.

## **7. Medicines management**

### **Background**

The Audit Commission, in 2001<sup>6</sup>, defined medicines management as encompassing the entire way that medicines are selected, procured, delivered, prescribed, administered and reviewed to optimise the contribution that medicines make to producing informed and desired outcomes of patient care. Medicines governance more specifically focuses upon the safety and risk management issues concerned with medicines and importantly, systems risks that can lead to error and resultant adverse incidents.

### **Governance arrangements**

At the time of this inquiry in 2008, LTHT governance structure was being revised to bring together both clinical and non-clinical risk. The governance structure organogram seen was dated February 2007 and did not include the Drugs and Therapeutics Committee (DTC), as the DTC reported directly to the Medical Director, Trust Board and Chief Executive. Subsequently, under new management arrangements, the DTC reports to the Board through the Clinical Governance Committee, as shown in this Committee's terms of reference and minutes of meetings.

As part of Leeds Teaching Hospitals Trust governance accountability framework, the Clinical Governance Committee draft work programme which the Independent Inquiry Team saw requires a bi-monthly report to be received from the DTC.

The Trust Medicines Risk Management Sub Committee (MRMSC) is a subcommittee of the DTC and has a wide-ranging membership that includes the Leeds Teaching Hospitals Trust Director of Quality, a good range of consultant medical staff, senior/middle grade pharmacists and nurses but doesn't include any junior/middle grade doctors. The work of this committee may benefit from the experiences of a junior/middle grade doctor.

The work of the MRMSC is wide ranging and the Independent Inquiry Team was advised that in order to get through the very full agenda, much background and preparatory work takes place. Although the Independent Inquiry Team were told that the MRMSC has a good profile in the Trust, reporting to the DTC means it does not have the same status as other key Trust risk committees e.g. transfusion committee and the link and connectivity of the MRMSC with other trust risk committees was not apparent other than for the LTHT Risk Assessment Committee. This should be reviewed though care will need to be taken to ensure continuity with and maintenance of the successes the MRMSC is achieving within the LTHT risk reduction strategy.

---

<sup>6</sup> Spoonful of Sugar, Audit Commission , Dec 18<sup>th</sup> 2001, ISBN: 1 86240 321 X

From the minutes of the MRMSC and annual reports of the DTC and MRMSC it was clear that there was much overlap with the work of the DTC. Whilst the Terms of Reference that the Independent Inquiry Team were provided with set out the work remit for the MRMSC there was no constitution for this committee similar to that of the DTC. This may be because the MRMSC reports to the DTC but given the depth and breadth of work undertaken plus the committee's wide membership and the fact that medicines are the most common patient intervention that occurs in the hospital, this is in need of review.

The Medicines Management and Pharmacy Services Directorate has a full time lead pharmacist for clinical governance who has within her portfolio a small medicines risk management team. This includes a Pharmacy Medicines Risk Manager (PMRM), who co-manages a pharmacist who works for the LTHT Internal Audit department. The Independent Inquiry Team was informed that this management structure was developed to ensure a robust, independent infrastructure for the medicines governance assurance programme led by Trust Medicines Risk Management Subcommittee (MRMSC) of the DTC.

The Medicines Management and Pharmacy Senior Management Team also consists of a part time Lead Nurse for Medicines Management and, more recently, a team of two part time nurse 'educators' for medicines management. In addition, the Medicines Management and Pharmacy Services directorate has, for approximately two years to date, received the services of an associate medical director for three sessions per week. Having dedicated non-pharmacy personnel as part of the pharmacy resource to support good governance in medicines management is both unusual and most commendable.

The LTHT Clinical Director for Medicines Management and Pharmacy Services is responsible for the Trust assessment of compliance with the Healthcare Commission Standards for Better Health Medicines Management Criteria (C4d). The Independent Inquiry Team learned that under 'Business Planning Requirements' which form part of the Trust performance management framework, each directorate has to identify a series of audits they will undertake to assess their compliance with specific areas of the Trust Medicines Code and to reduce risk relating to medicines use. Of particular relevance to this inquiry is that audits should include at least one relating to security/ storage/ transport/ administration of medicines (especially parenterals) plus an annual audit and review of controlled drug use. The Independent Inquiry Team was able to review examples of C4d Medicines Management compliance reports and these were most impressive. The LTHT Clinical Director for Medicines Management uses this information and Pharmacy Services to inform her report to the Trust Board in compliance with the Healthcare Commission core standard C4d relating to medicines management.

LTHT Pharmacy service has a good procedure for reviewing stock drugs held on wards and departments and this is linked to a Quarterly Medicines Management Assurance check against a list of key issues in the Trust's Medicines Code and other related documents. The Independent Inquiry Team

noted that this had been reviewed in November 2008, when it was also decided to link this to a wider medicines management assurance review process conducted by pharmacists and sisters/charge nurses.

The Independent Inquiry Team was told that all pharmacists have to provide evidence on an annual basis of their continued registration with the Royal Pharmaceutical Society and that all appointments to pharmacy posts are only made following provision of suitable references and approval through a Criminal Records Bureau check.

The Independent Inquiry Team was told that agency staff employed by LTHT are required to undertake a competency based assessment of their knowledge of relevant drug policies before they are allowed to be involved in duties related to these policies. This includes a drug calculation test.

### **Incident reporting and risk management**

The 'Pharmacy Incident Reporting and Documentation Procedure' gives clear guidance to staff on how to report an incident in terms of its severity and importance, suspicions to raise and how to escalate such issues to involve the PMRM and senior medicines management staff.

To help address "the culture of the quiet word"<sup>7</sup>, when pharmacy staff identify a medicines management issue about which they have a concern, this is now raised through the pharmacy management line. Concerns are then taken up via the Trust Medicines Risk Management Subcommittee of the DTC and/or by the Deputy Medical Director who liaises with the appropriate Clinical Director or Deputy Chief Nurse to address/resolve the issue. If no improvement occurs, this is escalated through the appropriate Leeds Teaching Hospitals Trust management line. This is in marked contrast to the system prior to SUIs 2001/55 and 2002/1655 whereby the Chief Pharmacist would write to the appropriate clinical director. The system now allows doctor to doctor or nurse to nurse communication and the Independent Inquiry Team was told that this has proved much more effective.

Where medicines related incidents are suspected, these are promptly raised, usually in a telephone conversation, often by pharmacy staff, but also by other healthcare professionals, with one of the senior Pharmacy and Medicines Management team. Whenever possible, this also involves the LTHT Clinical Governance Lead Pharmacist. Nursing staff act in a similar way, usually by contacting their ward manager or matron though often the issue is raised with a member of the pharmacy team (who then passes it onto the LTHT Clinical Governance Lead Pharmacist). The fact that staff can raise concerns in an open way aids the incidence of reporting. This system appears to work well and is greatly assisted by the fact that the LTHT Clinical Governance Lead

---

<sup>7</sup> April 2005 Final Report of the investigative review into the misuse of pethidine on wards 34 and 36 at the LGI in 2001

Pharmacist and her team, plus the pharmacy and medicines management teams, generally are all seen as approachable and helpful.

The Independent Inquiry Team noted that LTHT has a wide range of policies and clinical guidelines for the prescribing, administration and monitoring of opioid use. These are listed on the Trust intranet along with various guidelines for the management of acute pain, which is also accompanied by a simple, easy to follow, analgesic ladder. The Independent Inquiry Team noted that a number of other associated documents were also being developed e.g. irregular pain assessment chart and these need to be concluded.

A pharmacy procedure titled 'Scheduled visits by pharmacists to wards' sets out the key responsibilities of the pharmacist or ward support technician undertaking such visits. Whilst it is reasonable for these responsibilities to focus on direct clinical care of patients, the opportunity should not be lost to ensure compliance with the Leeds Teaching Hospital Trust Medicines Code and other key policies that reduce medicines risk. This needs to be considered in the review of this procedure and the Policy on Clinical Pharmacy Practice.

### **Medicines Code**

The Leeds Teaching Hospital Trusts Medicines Code is good and wide ranging and available to all staff via the Trust's intranet. Of particular note was the fact that borrowing of drugs from other wards/departments is not allowed. It is reported that any borrowing of drugs that occurs is authorised only by the on call resident pharmacist who then provides a report electronically for pharmacy to follow up the next day.

Outside of normal pharmacy opening hours, drugs may also be accessed via an 'out of hours drug cupboard'. Staff wishing to access the contents of this cupboard firstly have to access the key via the hospital security service. A record is kept of who has accessed the key and the person accessing the key is required to record the stock they have taken in an 'honesty' book in the cupboard. A guide relating to this process and the contents of the cupboards is available on the Trust intranet. Whilst the system can provide an audit trail of access, it is somewhat outdated and labour intensive. It is also open to abuse. Automated solutions exist, including finger print technology and these are in use or being introduced in hospital A and E departments e.g. Royal Wolverhampton Hospital, where they have proved to be labour saving as well as improving drug security. Pending development and consideration of the associated business case to deliver the introduction of an automated solution the current arrangement could be made more robust by having two nurses present when stock is removed from the 'out of hours' drug cupboard" with both nurses signing the 'honesty' book (one as witness/checker to the other). Whilst it is acknowledged that this arrangement is more labour intensive than before, it is more secure and should be seen as an interim measure pending the introduction of the more cost effective and secure automated solution.

In common with most hospitals, LTHT Medicines Code has grown to be a somewhat bulky document. To assist with this, the Trust has produced

booklets, which cover specific sections of the Code only (e.g. controlled drugs, borrowing of medicines, prescribing for patients, prescribing for individuals who are not Trust patients, What Nurses Need to Know, Medicines Supply, Storage, and Transportation). These are excellent documents and designed to support implementation and application of the Medicines Code.

To reduce the risk of misappropriation of drugs, LTHT's Medicines Code requires nurses to record on the drug treatment chart actions they have taken to prevent missed doses. The Independent Inquiry Team was informed that such records will be subject to audit. Substantial progress has been made in this area since the time of the incidents.

LTHT has a good procedure for the management (use during in patient stay and re-labelling where necessary at discharge) of patients own medicines.

### **Medicines security**

LTHT does not use automation for drug storage and access which would improve drug security. The Independent Inquiry Team understands this has been proposed as a solution by pharmacy. The Independent Inquiry Team is also aware that when such systems were introduced in other Trusts, efficiency was significantly improved and nurse time released as a result of being 'key free'.

Controlled drug order stationary was locked away on all wards that the Independent Inquiry Team visited and drug storage areas were locked, with the exception of the orthopaedic ward. This environment is poor as a drug storage facility and the current lock and key security arrangements to the room were inadequate. This was raised with ward staff on the day of the visit and the Independent Inquiry Team has learned since that action was finally taken on 1 May 2009 to address the problem.

Non-controlled drug stationary was not always found to be locked away by the Independent Inquiry Team. However, the LTHT pharmacy system for supply of drugs incorporates a number of safeguards that reduce the risk of unauthorised ordering of stock using this stationary to a minimum. For example, there is a requirement for the supply of drugs against stock requisitions to be accompanied by the patient drug treatment chart. Such instances are also picked up on three monthly supply exception reports and the Independent Inquiry Team was able to confirm that requests for drug stock supplies outside the pharmacy-managed system are unusual, reducing disruption to the department's work flow and systems.

### **Insulin**

The Independent Inquiry Team was provided with a report "Summary issues discussed by the Trust Medicines Risk Management Subcommittee between 2003 and December 2007" relating to insulin storage and safe handling in clinical areas. It was clear from this that a robust attitude is taken to maintaining good security of insulin stock and this was supported by audit reports.

The following lists the key issues that the Trust MRMSC has considered with respect to insulin:

- A survey of insulin in clinical areas (audit of storage and staff questionnaire) together with recommendations arising from the analysis of this audit. Change implemented was re-audited twice
- Consideration of requests from some clinical areas for amendments to refrigerator security. N.B. The MRMSC was able to agree changes that did not compromise the requirement for insulin to be held only in locked refrigerators.
- Removal of insulin from the out-of-hours drug cupboards.
- An Internal Audit Service report on the storage and handling of insulin.

### **Controlled drugs**

Following the Shipman Inquiry and the reports produced by its chair, Dame Janet Smith, there was widespread national concern about the way in which Harold Shipman had been able to obtain controlled drugs such as diamorphine and kill patients over a long period of time. In response, the Government agreed a new legislative structure for control of narcotics (such as diamorphine) and other drugs that were liable to abuse (collectively known as 'controlled drugs').

The Shipman Inquiry produced its Fourth Report in July 2004. It made a number of recommendations to strengthen the prescribing of controlled drugs and for monitoring their movement from prescriber to dispenser to patient. In December 2004, the Government's response 'Safer Management of Controlled Drugs'<sup>8</sup> was published. The response accepted that current systems could be strengthened provided that this does not hinder the use of controlled drugs to meet patients' needs. In 2007, the Department of Health published a further document entitled 'Safer Management of Controlled Drugs *A guide to good practice in secondary care (England)*'.

The Trust Clinical Director for Medicines Management and Pharmacy Services is designated as the Accountable Officer (AO) in accordance with regulations that came into force following the Shipman Inquiry. In this capacity, she reports to the Leeds Local Intelligence Network (LIN) for controlled drugs.

The Independent Inquiry Team noted from minutes seen that the LIN is an active group and that the Trust AO provides regular Occurrence Reports to the LIN.

---

<sup>8</sup> Safer management of controlled drugs: (1) Guidance on strengthened governance arrangements DoH March 2006

14 NMC Code of Professional Conduct : standards for conduct ,performance and ethics

The pharmacy department maintains an authorised signatory list for Trust staff authorised to order controlled drugs. At the time of our visit, this was seen to be up-to-date though the maintenance of this is very labour intensive.

The pharmacist member of the Independent Inquiry Team visited the Intensive Therapy Unit, one surgical ward and one medical ward and controlled drug order and register of administration books were examined. In all cases, administration registers were in good order though for controlled drug requisition books the ward duplicate copy for receipt was not always signed. This did not mean that there wasn't an audit trail for receipt of these controlled drugs since the ward based controlled drug administration register recorded the name of the person receiving the controlled drug into stock. However, national guidance on 'The Safe and Secure Handling of Medicines: a team approach' published by the Royal Pharmaceutical Society in 2005 stated: 'Controlled Drugs coming on to the ward, theatre or other department should be received by a Designated Person who should check them against the requisition and record that a check has been made'. The requirement for a record that the check has been made therefore remains.

Controlled drug cupboards were examined on wards visited and the Independent Inquiry Team can confirm that these were used solely for controlled drugs and that controlled drug cupboard keys were held separately from other keys by the nurse in charge. In addition, controlled drug order stationary was locked inside these cupboards to prevent unauthorised use.

Patients' own controlled drugs are stored in ward controlled drug cupboards and a record made in the ward controlled drug register.

LTHT has a range of good policies and procedures relating to the management of controlled drugs including disposal of controlled drug waste and expired stock.

### **Medicines Management Audits**

The pharmacy carries out a three monthly check of all controlled drug storage areas and associated records. Whilst it was clear these checks were being carried out, many were not up to date. The Independent Inquiry Team was told that the reason these were behind was staff recruitment difficulties. However, on wards visited, the Independent Inquiry Team noted that regular checks of controlled drug stock balances are carried out and this was in accordance with the Medicines Code i.e. at least every seven days though in some areas where use is high this can occur as frequently as daily.

The Independent Inquiry Team was provided with an example of the medicines management monitoring report detailing discrepancies identified by the three monthly controlled drug check and associated review process together with action taken. This report is reviewed quarterly by the Pharmacy Services and Medicines Management Group, with actions being agreed either on a Trust wide basis or in relation to local area or clinical team basis. The action plan for this meeting is managed and monitored by the Medicines Management and Pharmacy Service Business Manager.

The pharmacy undertakes a three monthly audit of ward and department stock lists though again many of these were not up to date. However, in contrast to the controlled drug check, the Independent Inquiry Team would question whether it is necessary for the stock list check to be carried out every three months. This may help with resource availability to ensure that the audit of all areas is carried out regularly e.g. every six months.

The Trust's Internal Audit Service has carried out a wide-ranging review of progress against the Pethidine and Colin Norris SUIs action plan... This report was dated 2004 and was followed by regular reviews (approximately three per year up to and including 2008) of specific components of the action plans relating to compliance with the LTHT Medicines Code.

The Trust's Internal Audit Service has conducted regular supply chain audits since 2002 and these have included controlled drug transactions and associated controls.

The Trust's Internal Audit Service has carried out an audit of the "Quality of Pharmacist' Chart Endorsements" and the "Non-Administration of Prescribed Doses on Inpatient Medication Charts".

The Independent Inquiry Team understands that all Internal Audit Reports are subject to consideration by the Trust's Audit Committee before being provided to the Trust Board. These reports and the report provided from the Clinical Director for Medicines Management and Pharmacy Services relating to compliance with the Healthcare Commission Standards for Better Health Medicines Management Criteria (C4d) are the main mechanisms for ensuring the Board is aware of the status of medicines security at LTHT.

### **Communications and training**

The pharmacy produces a number of newsletters and bulletins related to medicines management. Where these are designated as important e.g. all editions of 'The Tablet', a signature is required to confirm delivery has taken place into clinical areas. 'The Tablet' is produced monthly and is delivered to all wards and departments. Another bulletin "On the Ball with Medicines" is produced mainly for pharmacy staff and focuses around the potential for medication errors. A 'Medication Safety Alert' is also produced by pharmacy and this relates to safe medicines practice for doctors and nurses. In the opinion of the Independent Inquiry Team, the proactive approach taken in producing these bulletins is impressive and the process for their circulation is robust.

Medicines management forms part of mandatory training for all doctors and nurses. With respect to safe use/prescribing of medicines, this is repeated every two years. Attendance at such training sessions is recorded and non attendance identified and reported back to matrons and managers. Attendance records seen during this review reflected a very high attendance rate (in excess of 90%). Examples seen of presentations used in training sessions were excellent.

At induction, all doctors and nurses receive a 5–10 minute summary presentation of key issues relating to medicines management. Junior doctors in training receive two half day training sessions in addition to this. Nurses also receive a half day training session on basic aspects of medicines management and this extends to a full day if staff are involved with intravenous drug administration. At the end of the half day training session there is an assessment of trainees.

For pharmacists there is a mandatory medicines management training pack with an associated workbook. This training is repeated annually.

The panel gained the impression that risk reduction with respect to medicines use was fully embedded in the culture of the pharmacy. This was evidenced in the annual training work book for pharmacists, the focus on safety in the training of clinical staff, the newsletters/bulletins produced by pharmacy, the regular audit programme and the team (which includes pharmacy based medical and nursing staff) within pharmacy dedicated to the delivery of good governance with respect to medicines.

### **Pharmacy staffing**

The Independent Inquiry Team was informed that the current pharmacy establishment does not support all wards/departments having their own designated pharmacy technician.

### **Pharmacy environment**

The pharmacy environment is poor and in need of upgrade. Of particular note is the very limited progress with automating drug supply. Use of such modern technology is now widespread amongst many hospital pharmacy departments, having featured in the 2002 Audit Commission report 'Spoonful of Sugar' as a recommendation and having formed part of the Healthcare Commission assessment of Medicines Management Services in its 2007 report 'The Best Medicine'.

Progress with automating medicines provision (including dispensing) will significantly reduce patient risk from medicines supply and improve stock security. Opportunities also exist to improve medicines security by use of technology and gain a key free secure drug access system e.g. using swipe cards for locks and finger print technology.

## **8. Listening to and supporting relatives**

### **Findings of the Independent Inquiry Team**

During the Independent Inquiry Team's discussions with the relatives of Colin Norris's victims, a number of significant issues were raised which provide an additional perspective on the care provided on Wards 23 and 36 at LTHT at the time their relatives were patients.

The first issue was the lack of and delay in providing information to relatives whilst patients were being treated in the hospital. Family members found it difficult to obtain information about the condition of their relatives. They were not informed when incidents had taken place such as falls. Their main source of information was other patients.

On one occasion the daughters of one patient had spent time with staff discussing who to inform if their mother's condition deteriorated or if she died. When she died, staff ignored this conversation and informed the patient's husband who had dementia, creating the problem the daughters had tried to avoid.

A number of relatives expressed concern that they had attempted to draw attention to dramatic and unexpected changes in their relative's condition. This included expressing concern about them having hypoglycaemia when they were not diabetics. At the time, they wondered if the wrong dose or drug had been given and they felt that staff had not taken their concerns seriously.

Whilst relatives did not express concerns about the care and information provided on Ward 23 at St James' Hospital some relatives expressed their dissatisfaction with the quality of care given on Ward 36. This particularly related to the care of older people. This has been reinforced by evidence given at the trial and letters of complaint received about the care of other patients who were patients on Ward 36 at the same time that Colin Norris was a Staff Nurse. Some of the complaints made at the time were never subject to formal investigation or recorded on an incident report form (IR1) although they were serious enough to have resulted in both actions.

Matrons now provide the first point of contact for patients and relatives to express their concerns or complaints about care and see all of the IR1s. There is also a central Trust team with a Head of Patient and Public Support Services which handles patient and public involvement (PPI) and complaints. They run initiatives such as a complaints awareness week. There is also a PPI Trust website and database on the Trust's intranet. The Independent Inquiry Team was informed that there are issues associated with the effective coordination of the roles of matrons and the Patient and Public Support Services.

A further issue identified was the lack of assurance that required actions have been taken to address complaints and the issues that caused them. This is compounded by the lack of independent involvement by individuals outside the directorates when investigating complaints.

In 2002, as part of the application of the Serious Untoward Incident process, discussions took place regarding the handling of communication with the media and with relatives. The Trust established a telephone advice line for access by patients and relatives who had been in hospital during the period that Colin Norris had worked on Ward 23 and 36.

There is a difference of opinion regarding the advice the Trust was given about contact with the relatives of Colin Norris's victims. The Trust informed the Independent Inquiry Team that it was advised explicitly by the West Yorkshire Police not to make contact with the families once their investigation had started. West Yorkshire Police believe that they did not provide this advice. It was reasonable that the intention of the Trust was to ensure that they had a better understanding of the situation before communicating with relatives and that once the police were involved they had to be guided by them. The relatives understand the constraints experienced by the Trust in relation to communicating with them, however, it was felt that it would have been possible for the Trust to write to express their sorrow and to explain that as a result of the police investigation contact would be restricted.

It is Independent Inquiry Team's view that the Trust needed to have in place a communications strategy that went further than simply covering the response to the media at key points during the case. An important part of the strategy should have been to establish a well thought through approach for working with relatives.

Relatives did not receive a letter from the Trust until after Colin Norris' trial. The Trust also met with relatives of those murdered by Colin Norris following his conviction in 2008. Relatives reported to the Independent Inquiry Team that they felt unsupported by the Trust. The Trust accepts that it did not provide as much support to the families as was needed and this was discussed directly at the meeting with them.

In the opinion of the Independent Inquiry Team, the Trust should also have recognised the potential difficulty created for relatives in having confidence in using hospital services following the incident. It would have been beneficial for the Trust to identify a named contact to support the relatives. As this was not available, relatives turned to police liaison services to help them. Without exception, the families expressed their gratitude to the West Yorkshire Police and the liaison officers who have kept them fully informed and supported from the point that their relative was identified as a victim of Colin Norris to date.

The Trust recognises the distress that the lack of contact caused to the relatives. This is a key learning point for the organisation and has been discussed directly with the West Yorkshire Police. Arrangements have now been put in place to meet with representatives from the West Yorkshire Police in any incident where they are involved in order to establish the ToR for an investigation and agree the key named point of contact, including how communications will be handled with relatives. The Trust has made reference in its 2008 SUI Procedure to the February 2006 Memorandum of Understanding agreed nationally between the National Health Service,

Association of Chief Police Officers and Health and Safety Executive (HSE).  
This protocol states that:

*'In the event of a patient safety incident it is important that the NHS, Police and/or HSE work together to keep patients, relatives, injured parties and NHS staff informed and to provide support as appropriate.'*

## **9. Listening to and supporting staff**

Staff who worked with Colin Norris, some of whom went to court to give evidence, were also significantly affected by Colin Norris' actions. People worked with him as a colleague, team member and some had shared their social life with him. Suddenly they had to think the unthinkable and question if they should and could have identified what he was doing. For some there is a feeling of guilt about not identifying Colin Norris' actions, a questioning of their own practice, coupled with the disbelief and anger that a nurse could do this to patients they were supposed to protect. Some of the staff interviewed by the Independent Inquiry Team were obviously still distressed by the experience.

The staff received some support from the Trust during the period of the police investigation, but they did not feel it was enough. The feeling reported to the Independent Inquiry Team is that the Trust focused on addressing media issues rather understanding and meeting the needs of staff. As in the case of the relatives, the Trust's senior management team had to consider the implications of adversely affecting police investigations and any potential impact on the court case if inappropriate communications occurred.

Staff do not feel that senior managers supported them during the whole experience, either emotionally or practically. Whilst the Trust informed staff of the opportunity to self refer to Occupational Health, it was not considered the right approach and people needed a more proactive intervention. A meeting was held two months after the trial which staff felt was not particularly helpful. Whilst Trust managers were unable for legal reasons to discuss the details of the case with staff, it would have been helpful for them to have prepared staff for the experience of giving evidence in a criminal trial. This was not done. In addition, there was some evidence of a lack of consideration of the personal impact on staff, for example they were asked to work shifts after travelling to Newcastle Crown Court to give evidence.

Staff valued the supportive role of the matron and the police during the trial.

As with the relatives, the Trust acknowledges the shortcomings identified in its communications and support to staff and has subsequently discussed the issues with those affected. The issues have been addressed through inclusion of reference to the 2006 Memorandum of Understanding between the NHS, police and HSE within the Trust's SUI management procedure.

## **10. Hospital Security**

### **Background**

At the trial of Colin Norris, the issue of hospital security was raised. There have also been concerns raised by relatives of the patients harmed. The major issues relate to access by unauthorised people to the hospital and wards at night as a result of a lack of a security presence and security of the building and wards.

The Independent Inquiry Team examined the above issues to determine the situation in 2002 and the developments that have taken place since.

LTHT has to address a number of issues to establish effective security of the buildings that form its estate. It includes:

- Leeds General Infirmary covering a 29 acre site and St James' a 57 acre site.
- 4.5 million (16,000 people daily) people enter the buildings every year plus 12,000 cars.
- There are 27 entrances at Leeds General Infirmary.

### **Staffing**

In 2002 there were 44 whole time equivalent security staff which resulted in four people plus one control room operator on duty at night at Leeds General Infirmary and an average of three people on duty at St James' Hospital.

### **Control Room**

In 2002 there was one control room at Leeds General Infirmary which was staffed twenty four hours a day and a part funded control room at St James' open eight hour per day for five days a week.

### **Card Access**

In 2002 there were approximately 126 swipe card access areas across the Trust with 55 of these at Leeds General Infirmary. There were also 250 Trust wide stand alone card access readers.

### **Secured night time entrances**

In 2002 the policy was that the 29 entrances to Leeds General Infirmary were secured at 22.00 and reopened at 06.00 and ten blocks at St James' Hospital followed the same pattern.

### **Partnership with West Yorkshire Police**

In 2001/02 there was early partnership working taking place between the trust and West Yorkshire Police and this has been further developed as part of the implementation of the Government directive to support Section 17 of the Crime and Disorder Act 1998<sup>9</sup>.

---

<sup>9</sup> Guidance on Statutory Crime and Disorder Partnerships. Crown Copyright 1999

## Findings of the Independent Inquiry Team

In 2008 there are now eight people on duty with support from a rapid response team and the security control room.

There is now a state of art control room which provides a central monitoring facility for security systems and building alarms. The control room operators monitor the CCTV, access control, intruder detection, car parking and building alarms using a central management system which has graphical mapping to help the operators identify the locality of problems.

There is now a Trust wide control room which monitors and controls:

- 750 building public access points
- 206 CCTV cameras have been increased to 678 which include digital recording. This is being increased further.
- 500 intruder and panic alarm points
- 125 intercom handsets.

The Trust now has 687 swipe card access areas of which 156 are at Leeds General Infirmary. The Independent Inquiry Team was informed that this is going to be developed to 1,000 across the Trust and include 400 stand alone card access readers.

The Independent Inquiry Team was informed that in 2008 access at night was reduced to two staffed entrances at the Jubilee Wing main entrance and the Emergency Department at Leeds General Infirmary. The Independent Inquiry Team was also told that locking of the other 27 entrances commences at 17.00 and they are all secured by 21.00 and reopened at 06.00. At St James' Hospital, the buildings are stand alone and are therefore difficult to move to a single site entrance though the Independent Inquiry Team learned that the perimeter is secured and has only one entrance.

The early partnership working taking place between the Trust and West Yorkshire Police and has been further developed as part of the implementation of the Government directive to support Section 17 of the Crime and Disorder Act 1998<sup>10</sup>.

The Independent Inquiry Team learnt that there are now four jointly funded Community Support Officers working with the security team and two dedicated Police officers are based in the emergency departments at the Leeds General Infirmary and St James'.

The Trust has undertaken a considerable amount of work and has invested a substantial amount of resource in the development of a modern, fit for

---

<sup>10</sup> Guidance on Statutory Crime and Disorder Partnerships. Crown Copyright 1999

purpose security system. There is a good management structure in place and a close working relationship with West Yorkshire Police. The Trust must ensure that the work of the security department is understood and supported by the staff of the Trust, as without their input, the Trust's security service will not be as effective as it otherwise might be in safeguarding patients and staff.

## **11. Independent Inquiry Conclusions**

This report has attempted to capture the key findings and issues associated with the provision of services at LTHT before, during and since the incidents associated with Colin Norris. It is not about blaming individuals or services for what happened but identifying the lessons to be learnt to improve the safety and quality of health services in the future.

**Overall, it is the Independent Inquiry Team's view that a combination of factors, including organisational, systems and cultural factors, provided an opportunity for Colin Norris to carry out his intent to harm patients in 2002.**

Building on the work that has been undertaken within the Trust since 2002, the Independent Inquiry Team has made a number of recommendations to address the outstanding issues identified.

## 12. Recommendations

### National

1. The Department of Health should work with the NMC and Council of Deans and Heads of UK University Faculties for Nursing and Health Professions to establish a national reference template to be completed by Universities which identifies the clinical and theoretical performance as well as personality and integrity of a student nurse during the period of their training.
2. The Department of Health should work with Deaneries to strengthen the training of junior doctors with respect to:
  - Certification of death.
  - The importance of managing risk and the associated processes as a key facet of clinical practice.

### Yorkshire and the Humber Strategic Health Authority

The Health Authority should:

3. Review the training of junior doctors to improve their knowledge and understanding of certification of death and equip them to understand the importance of managing risk and the associated processes as a key facet of clinical practice.
4. Use the contracting process to address the issue of Universities providing information to NHS organisations about NHS sponsored staff non attendance at courses.

### Leeds Teaching Hospitals NHS Trust

#### Governance

The Trust should:

5. Embed the new approach to governance across the Trust, ensuring that this is effective in meeting the needs of both the Trust as a whole and individual clinical area such as the orthogeriatric service.
6. Develop and actively use consistent Trust-wide evidence-based measures of the quality and safety of patient care, focussing specifically on the Releasing Time to Care and patient safety programmes that are being implemented throughout the Trust.
7. Review the effectiveness of the Trust's assurance framework and other mechanisms for the Board to evaluate Trust performance in relation to clinical quality.

8. Address the gap between the development of policies and their implementation, ensuring that policies are regularly reviewed and that they are audited to check that they are working in practice.
9. Establish an effective, standardised system of audit where directorates feed into a coherent Trust audit programme, resulting in consistent collection of information, action in response to recommendations and assurance mechanisms. The audit programme should include a specific audit of clinical records to assure the Board that the quality of record keeping meets clinical and legal requirements.
10. Review how the central risk team is formally coordinated with and supports the devolved directorate structures as the team has a wealth of experience and knowledge that could be used more effectively.
11. Ensure the timely input of incident data onto Datix and the sharing of lessons learned.
12. Review and update as necessary the Trust policy on safeguarding vulnerable adults in the light of the latest guidance following the “No Secrets” consultation process.
13. Actively promote the new whistleblowing policy through communication and training, thus supporting development of a culture of openness.

#### **HR, training and clinical practice issues**

14. Establish a process for auditing personnel files in order to ensure that (a) the Trust's recruitment processes are complied with; (b) the performance of staff is effectively assessed through appraisal; and (c) individual and collective training needs are identified from the appraisal process.
15. Develop a coordinated education and training programme for staff to respond to the training needs identified through staff appraisal and the development of clinical supervision.
16. Establish effective workforce information e.g. on establishments, vacancies, sickness and absence levels and actively use this to support management at both Trust and Divisional level.
17. Review the effectiveness of the current model for the supervision of nursing and other clinical staff.
18. Introduce a policy and standards for multidisciplinary working throughout the Trust and to audit practice against these.
19. Raise awareness as part of patient safety training amongst staff of the potential for malicious action against patients by healthcare professionals.

### **Certification of death**

20. Review the internal processes and practices for certification of death in line with best practice with reference to the Pathfinder Pilot established at the Sheffield Teaching Hospitals NHS Foundation Trust.

### **Medicines management**

21. Review the terms of reference for the Medicines Risk Management Sub Committee, including membership and accountability/reporting arrangements within the Trust's overall governance structure.

22. Complete outstanding documents relating to pain management guidance, in particular the assessment and management of irregular pain.

23. Review the pharmacy procedure titled 'Scheduled visits by pharmacists to wards' and the "Policy on Clinical Pharmacy Practice" and incorporate the role of the visiting pharmacist and monitoring of compliance with the Trust Medicines Code as a key component of the visit.

24. Review clinical pharmacy support to the wards and ensure that provision is sufficient to meet ward needs.

25. Place a higher priority on the implementation of technological solutions to improve the audit trail of drug use and reduce patient risk. This should include:

- Automated dispensing system for access of drugs from the out of hours drug cupboard (this should also be considered for the A+E department)
- Automated dispensing in pharmacy
- Swipe card technology for access to drug cupboards instead of keys
- Electronic prescribing and administration of drugs.

26. Undertake an audit of the omission of administration of drugs prescribed including the reasons why the drug has been omitted, what nursing staff involved have done to obtain the drugs required and who authorised the non-administration.

27. Ensure that controlled drug audits are up-to-date with copies of completed audit reports provided to the Medicines Risk Management Sub Committee as part of the Accountable Officer's report. Where it is not possible to undertake these audits due to difficulties in recruiting staff, the associated risk needs to be recorded on the Trust risk register. The three monthly audit of controlled drug records should include an audit of compliance of the receipt section of the controlled drug order book bearing a signature to verify receipt has occurred and by whom.

28. Raise the profile of the need to sign the receipt section of the controlled drug order book possibly by emphasising this as part of the three monthly audit of controlled drug records.

### **Listening to relatives**

29. Raise awareness of the Trust policy for listening to, formally recording and acting on information and concerns expressed by relatives so that relatives' views may be taken into account in care planning and review.

30. Undertake further work to clarify the roles of and communication between Matrons and the Patient and Public Liaison Service (PALS).

31. Review complaints handling to ensure that there is sufficient independence in investigations and that action is taken in response to issues raised.

### **Follow-up to serious untoward incidents**

32. Should audit compliance with the Trust's serious untoward incident policy to ensure that following incidents, there is effective communication with and support to patients, their relatives and staff.

## Appendix 1 – Glossary

<b>360° feedback</b>	<b>Feedback is provided about an individuals performance by subordinates, peers, and supervisors. It also includes a self-assessment and, in some cases, feedback from external sources such as customers and suppliers or other interested stakeholders.</b>
<b>Attending consultant</b>	Consultant responsible for the care of the patient
<b>AUKUH tool</b>	The AUKUH Acuity and Dependency Tool has been developed to help NHS hospitals measure the number of nursing hours required to care for patients and/or dependency to inform evidence-based decision making on staffing and workforce.
<b>Clinical audit</b>	Comparison of measured performance against agreed standards in order to identify where improvements in patient care can or have been made and how they can be achieved
<b>Clinical Governance</b>	Clinical governance is the system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish.
<b>Datix</b>	The Datix Common Classification System for Incidents in Healthcare (CCS) enables Trusts to identify shortcomings in the healthcare system from the evidence of incidents accumulating their database.
<b>Division of Specialist Surgery</b>	Provides theatre and anaesthetic services and associated with musculoskeletal and neurological surgery
<b>Drugs and Therapeutics Committee (DTC)</b>	Takes a strategic and advisory, evidence based approach, to medicines management issues, advice, policies and regulations which will be supported at Trust Management and Directorate level to allow practical implementation
<b>Elective patients</b>	Patients who require a planned ,not emergency,admission to hospital for surgical or medical treatment.
<b>FY1 and FY2 training</b>	New training for doctors consists of a Foundation Programme first 2 years of NHS medical post-graduate training for junior doctors. FY1 replaces the PRHO year and FY2 follows on before Specialty Training begins.
<b>Geriatrician</b>	Geriatrics is the branch of medicine that focuses on health care of the elderly. It aims to promote health and to prevent and treat diseases and disabilities in older adults.
<b>Modern Matron</b>	Modern matrons are senior sisters and charge nurses who

---

are easily identifiable to patients and who have the authority and support they need to make sure the fundamentals of care are right.

---

<b>NHS Leeds</b>	NHS Leeds is the organisation responsible for making sure everyone in Leeds has access to the health services they need.
<b>Nursing and Midwifery Council (NMC)</b>	A UK organisation set up by Parliament to ensure that nurses, midwives and health visitors deliver a high standard of care through professional standards
<b>Orthogeriatrics</b>	Orthogeriatrics is a sub-speciality area that originally developed from liaison services with orthopaedic and trauma services.
<b>Pathfinder Pilot</b>	When a NHS organisation implements a new development to identify issues for other organisations
<b>Preceptorship</b>	A structured, supportive programme to enable newly qualified nurses to make the transition from student nurse to practitioner. It also aims to produce competent professional nurses.
<b>Releasing Time to Care and patient safety programme</b>	The 'Releasing time to care: productive ward' programme is an innovative and practical programme of work which aims to help front-line teams focus more on directly caring for their patients
<b>Risk management</b>	A tool for improving the quality of care and is not simply the reporting of patient safety incidents. Whether the patient suffers harm as a result of a medication error (clinical risk) or as a result of falling in a ward (non clinical risk), the factors, such as organisational culture or poor staffing levels that allowed this incident to happen may be the same.
<b>Serious Untoward Incident (SUI)</b>	An incident that is very serious, out of the ordinary or unexpected, with the potential to cause serious harm, and/or likely to attract public and media interest that occurs on NHS premises or in the provision of an NHS or a commissioned service.
<b>Standard for Better Health</b>	Published by the Department of Health in 2005. The Standards describe the level of quality that healthcare organisations are expected to meet in terms of safety; clinical and cost effectiveness; governance; patient focus; accessible and responsive care; care environment and amenities; and public health.
<b>Trust Clinical Governance Committee</b>	The committee's primary duty is to receive reports on the performance of clinical governance activities across the trust and advise the Board.
<b>Trust Medical Director</b>	The Trust Medical Director's responsibilities include Quality, Research and Development, Medical Education and Training and a number of areas of governance. He chairs and leads many groups within the Trust .
<b>Whistleblowers</b>	A whistleblower is a person who publicly alleges concealed misconduct on the part of an organization or body of people, usually from within that same organisation
<b>Yorkshire and the</b>	NHS Yorkshire and the Humber was set up by the

---

<b>Humber Health Authority</b>	<b>Strategic</b>	Government in July 2006 to act as the regional body for the NHS. We are one of ten strategic health authorities (SHAs) for England set up on this date. The SHA was formed from the merger of the three former SHAs of West Yorkshire, South Yorkshire, North and East Yorkshire and Northern Lincolnshire
------------------------------------	------------------	--

---

## Appendix 2 – Documents used in preparing this report

1. Census data. National Statistics. 2001.
2. Scores for wards in England and Wales. Jarman, Carstairs and Townsend
3. Statutory Instrument 2004 No. 1765 Nurses and Midwives (Parts of and Entries in the Register) Order of Council 2004.
4. Independent Inquiry relating to deaths and injuries on the children's ward at Grantham and Kesteven General Hospital. London: HMSO, 1994
5. An organisation with a memory- Department of Health Expert Group (Chairman, CMO) 13/06/2000
6. Section 46 of the Health and Social Care (Community Health and Standards) Act sets out the legislative basis for the Healthcare Standards. 2003
7. Good doctors, safer patients- Department of Health. A report by the Chief Medical Officer. July 2006
8. The Nursing and Midwifery Order 2001(SI 2002/253)
9. A Risk Management Standard –IRM, AIRMIC and ALARM. 2002
10. Report of a clinical governance review at Oxford Radcliffe Hospitals NHS Trust. Commission for Health Improvement. December 2001
11. Chartered Institute of Personnel and Development. *Recruitment, retention and turnover* London: CIPD. 2005.
12. Bevan, S. Choosing an approach to reprofiling and skill mix. NHSME/Personnel Development Division: London. 1991
13. Royal College of Nursing Setting safe nurse staffing levels. RCN: London. 2003
14. Liam Donaldson writing in Medical Mishaps: Pieces of the Puzzle. Rosenthal M M, Mulcahy L and Lloyd-Bostock S (Eds). Open University Press, February 1999
15. Coulter A, The Autonomous Patient: Ending Paternalism in Medical Care (London: The Nuffield Trust, 2002).
16. Wanless D, *Securing Our Future Health: taking a long term view The Wanless Report. London: MH Treasury. 2002*
17. NMC Code of Professional Conduct – standards for conduct-performance and ethics. 2004
18. Numerous documents provided by the Leeds Foundation NHS Trust.
19. Caring to Death. A discursive analysis of Nurses who murder patients. J G Field 2007
20. The care of fragility fracture patients published by the British Orthopaedic Association, September 2007. The Blue Book.
21. Learning from tragedy, keeping patients safe doh 2007
22. NMC Code of Professional Conduct : standards for conduct ,performance and ethics
23. Guidance on Statutory Crime and Disorder Partnerships. Crown Copyright 1999
24. Document bundles provided in relation to SUI 2001/55 and SUI 2002/1655 (including court/legal documents)

25. Clinical Governance arrangements Leeds Teaching Hospitals Trust.
26. Governance Committees/Groups from February 2007
27. Clinical Governance Committee Draft Terms of Reference (N.B. These were further updated in December 2008). Minutes of the Clinical Governance Committee meeting held October 13<sup>th</sup> 2008
28. Draft Clinical Governance Committee work programme
29. The Monitoring and Assessment of Compliance with Medicines Codes and Medicines Management Policies (Sept 2007)
30. Paper titled "Business Planning Requirements" setting out a range of actions for directorates including recommendations on medicines management audits to be undertaken.
31. General Surgery Directorate (LGI and SJUH), Non Surgical Oncology and Medical Physics assurance reports of compliance with the Healthcare Commission core standard (C4d) for medicines management
32. Part year (2008/09) report to the Trust Board of Trust compliance with the Healthcare Commission core standard (C4d) for medicines management
33. Ward Stock List Management
34. SOP for Review of stock drugs held on wards or in clinical departments. (N.B. The Independent Inquiry Team was informed that this SOP was reviewed at a Pharmacy Senior Managers meeting held on November 25<sup>th</sup> 2008 along with a pilot Medicines Management Assurance tool and that a plan was agreed to link this to a wider medicines management assurance review process conducted by ward pharmacists and sisters/charge nurses)
35. Agenda of Pharmacy Senior Managers Meeting November 25<sup>th</sup> 2008 (review of stock list and Pilot)
36. Pharmacy Incident Reporting and Documentation Procedure 2005
37. Risk Management Sub Committee (RMSC) of the Drug and Therapeutics Committee including:
  - Terms of Reference (updated 2007)
  - Memberships (2008)
  - Minutes of meetings held August and October 2008
38. Medicines Management and Pharmacy Services Annual Report including the DTC and RMSC report and reporting arrangements
39. Drug and Therapeutics Committee (DTC) including:
  - Constitution (October 2004) N.B. The Independent Inquiry Team was informed that the constitution was under review and is awaiting finalisation of PCT led Pan Leeds Medicines Management Committee Arrangements
  - Draft revised constitution (April 2008)
  - Membership
  - DTC Structure Explained
  - Medicines Management Committee reporting arrangements
40. Procedures for Post Operative Pain Management

- Current Leeds Health Pathways Guidelines
  - Adult Acute Pain Analgesic ladder
  - Documents in development to add to post operative pain management guidance
  - Current opioid prescribing, administration and monitoring recommendations (May 2004)
41. Ward Pharmacists Procedures
- SOP for Scheduled Visits by pharmacists to wards and clinical departments (the Independent Inquiry Team were informed that this SOP was under review and had linkage to the SOP for review of stock drugs held on wards or in clinical departments)
  - Policy on Clinical Pharmacy Practice
42. Medicines code
- Leeds Teaching Hospitals Medicines Codes Policy
  - The Pocket size copy of the Medicines Code (2006) and updated copy of the intranet version plus pocket sized versions of specific sections of the code including controlled drugs, borrowing of medicines, prescribing for patients, prescribing of individuals who are not LTHT patients, What Nurses Need to Know, Medicines Supply, Storage, and Transportation.
  - Medicines Supply, Storage and Transportation leaflet
  - Borrowing Medicines leaflet
  - Drug Administration – section 13 of the Medicines Code (N.B. The Independent Inquiry Team was informed that this section of the policy was currently being updated in the light of new NMC Guidelines). Additional Information relating to administration of intravenous products is set out in the injectable Medicines Code and this forms part of the mandatory injectable medicines management training programme.
  - Drug administration guidelines for agency and temporary staff (section 16.2 of the Medicines Code and section 2.8.8 of the Injectable Medicines Code)
43. Out of Hours Drug Cupboards
- Information for staff – Leeds Teaching Hospitals intranet
  - Sample information for Leeds General Infirmary
44. Patients own drugs
- Leeds Teaching Hospitals Policy for Managing patients Own Medicines (N.B. The Independent Inquiry Team was told that this Policy is under review to link to the updated trust policy for Self Administration of Medicines)
  - Medicines Management and Pharmacy Standard Operating Procedure for Re-labelling of Patients Own Medicines
45. Controlled Drugs (SOPs are available through the Trust intranet)
- Trust Controlled Drug Policy
  - Standard Operating Procedure (SOP) for Destruction of Controlled Drugs OPS6.14 (current)
  - SOP for Destruction of Controlled Drugs (draft December 2008)

- Draft poster to be used to highlight changes to CD waster disposal SOPs
  - Controlled Drugs Leaflet (plus version 4 hard copy)
46. Submissions to the RMSC relating refrigerators remaining unlocked in the Adult Intensive Care Unit and the Paediatric Intensive Care Unit to allow access to drugs required in an emergency.
  47. A summary report of insulin issues discussed by the RMSC 2003 – December 2007
  48. A report titled “Safe use and storage of insulin at LTHT: review and summary of actions. Dated January 2008
  49. Trust Audit reports including:
    - Internal Audit Report 2004/40 Review of insulin and pethidine action plans
    - List of individual medicines related reviews undertaken by LTHT Internal Audit since 2002
    - Medicines Supply Chain audits conducted since 2002 (these include controlled drug transaction and audit trail reviews.
  50. Minutes of the Leeds Controlled Drugs Local Intelligence Network (LIN) meeting held September 18<sup>th</sup> 2008
  51. LIN Occurrence Reports for Leeds Teaching Hospitals NHS Trust for the periods April – June 2008 and July to September 2008.
  52. Current (i.e. as at the time of the visit as part of this review) report of three monthly audits of stock lists and controlled drugs management in wards and departments
  53. Sept 2008 Controlled Drug three monthly check Discrepancy Report
  54. Leeds Teaching Hospitals NHS Trust Internal Audit reports
    - Nos 2005/30 and 2008/12 – Pharmacy supply chain: LGI In-patients
    - No. 2005/60 – Quality of pharmacists’ chart endorsements
    - No. 2005/64 – Non administration of prescribed doses on in-patient medication charts (N.B. The Independent Inquiry Team was informed this is to be repeated in 08/09
  55. Newsletters and bulletins issued between 2002 and 2008 referring to insulin and controlled drugs.
  56. Staff training documents
    - Presentation example: Medicines Management for Nurses and List of items and supporting training covered in the specific intravenous administration of medicines training course
    - Medicines Code Leaflet “What nurses need to know”
    - Presentation example: How not to poison your patient – an example of the foundation year 1 PDP session led by the Deputy Medical Director (Medicines Management)
    - The Medicines Code leaflets: Prescribing for patients and Prescribing for individuals who are not Leeds Teaching Hospitals patients

- Mandatory Medicines Management training for Pharmacists Work Book (2008)
  - Extract form Trust mandatory training policy (Medicines Management)
  - Update on mandatory training plan presented to RMSC October 2008 (paper and minutes 3.6)
57. Policy for the Development and Management of Policies in Leeds Teaching Hospitals NHS Trust
  58. A copy of the trust drug treatment chart for inpatient titled "Prescription and Administration Record"
  59. Caring to Death. A discursive analysis of Nurses who murder patients. J G Field 2007
  60. The care of fragility fracture patients published by the British Orthopaedic Association, September 2007. The Blue Book.
  61. Learning from tragedy, keeping patients safe. DoH 2007
  62. NMC Code of Professional Conduct : standards for conduct, performance and ethics
  63. Guidance on Statutory Crime and Disorder Partnerships. Crown Copyright 1999

### **Appendix 3 – The Independent Inquiry Team**

#### **Professor Pat Cantrill MSc, BA Hons, RGN ,RHV, RHVT,TC (Man).**

Pat is a Registered Nurse and Health Visitor and was a senior civil servant at the Department of Health, providing Ministers, the Permanent Secretary, Chief Executive and other Executive Directors and wider department with expert and informed advice and support. As Assistant Chief Nursing Officer, (DoH England) for Clinical Practice and Regional Nurse Director, Pat developed leadership qualities and professional credibility nationally. She held two of the most senior nursing posts in the country, both of which have demanded a high public profile.

As Regional Director of Workforce Development, Pat had the responsibility for medical and non-medical education and training for all staff in the then Trent Region. Pat has considerable experience in the development and performance management of clinical practice. She has worked with a number of organisations to assist them to redesign their service, for example the British Forces Health Services in Germany. She has also undertaken primary care contract and service development and assisted in the implementation of the first Darzi health and social care service in Leicester.

She has a proven academic track record holding an MSc in Race Relations and Community Studies and a BA (Hons) in Social Studies and she is a qualified teacher. Pat is a Visiting Professor at Sheffield Hallam University and Adjunct Professor at the University of Lethbridge, Alberta, Canada. Pat is also the Chair of the Rotherham Adult safeguarding Board.

She has led a number of high profile reviews of serious untoward incidents and safeguarding children overviews for organisations across the country and is identified as an national expert in safeguarding vulnerable children and adults.

#### **Mrs Eileen Foster MSc. RGN. DOHM.**

Eileen is a Registered General Nurse and Occupational Health Nurse who has worked for the NHS for 25 years. During this time, she has held a number of roles at a clinical and senior management level which have provided her with a wealth of knowledge and experience. She has a detailed understanding of Health Service legislation, Health & Safety legislation and Employment Law. She has a Masters Degree in Strategic Health Service Management which enables her to contextualise and ground knowledge of legislation with the current national health care agenda.

She has recent experience of working in a large Acute Trust, Primary Care Trust and completing contract work for the provision of Primary Care Services (General Practice). As a Patient Safety Manager in a large hospital for the care of the elderly, Eileen reviewed and redesigned existing systems, policies and procedures and supported culture change with clinical staff.

She has extensive experience of leading both strategically and operationally on all Clinical Risk issues within a PCT.

She is expert in undertaking detailed investigations and service reviews following adverse clinical incidents. She has undertaken a significant amount of extra training in Root Cause Analysis and Risk Assessment & Risk Management and has a detailed knowledge of system management.

She has worked with organisations to assist them to convert national policy and legislation into local policies and procedures on matters relating to health & workplace safety, risk management and patients safety. She is presently working as an Associate Portfolio Manager supported the Department of Health's National Programme to reduce MRSA, C. Difficile and other Healthcare Acquired Infections.

### **Professor Pat Lane MB ChB, D.Obst.RCOG, FRCGP**

Pat recently retired as the Director of Postgraduate General Practice Education for NHS Yorkshire and Humber. He was appointed as a visiting professor to the School of Health and Related Research (SchARR) at Sheffield University in 2005 (previously an Honorary Lecturer with the University of Sheffield School of Medicine from 1996).

During 30 years in General Practice, he has been a GP trainer, VTS Course Organiser, Associate Adviser at Nottingham University and the Chairman of COGPED (Committee of GP Postgraduate Education Directors - UK) from 2002 – 2005.

His experience in quality assurance reviews involved work as a lead visitor for the Post Graduate Medical Education and Training Board (PMETB) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP).

Prior to entering general practice, Pat had experience of work as a junior doctor in orthopaedics, A&E, medicine, obstetrics and gynaecology. He has published on the development of recruitment methodology, informatics training and education in general practice.

### **Ron Pate BSc. MCPP, FRPharmS**

Ron works two days per week at Keele University where he provides Secondary Care Pharmaceutical advice to the Department of Medicines Management to support Commissioners. In the remainder of his time Ron undertakes consultancy work.

Ron was formerly Secondary Care Pharmaceutical Adviser to NHS West Midlands (incorporating the three former Strategic Health Authorities in the West Midlands) and prior to that he was Clinical Director Pharmacy and Medicine Management Services for the Dudley Group of Hospitals.

In the former role Ron was a member of a number of national groups including the reference panels that resulted in the Healthcare Commission medicines management national reports “The Best Medicine” and “Talking About Medicines”. As a result of this and his extensive experience, Ron’s strengths are founded in the provision and development of modern medicines management services to meet the requirements of commissioners and providers alike.

Ron is a past President of the Guild of Healthcare Pharmacists and was former Honorary Secretary to the European Association of Hospital Pharmacists. In 1996 he was recipient of the Medeva Gold Medal “for an outstanding contribution to hospital Pharmacy” and was designated a fellow of the Royal Pharmaceutical Society in 1997 “for distinction in the profession of Pharmacy”. Currently Ron is a governor of the College of Pharmacy Practice and a member of the College Officers committee.