

THE AIREDALE INQUIRY

**REPORT TO THE YORKSHIRE AND THE HUMBER STRATEGIC
HEALTH AUTHORITY**

To be presented to the Strategic Health Authority Board on 8 June 2010

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FOREWORD

We thank the following people:

- i) The patients, former patients and relatives who have allowed us access to their medical records and those of their family members. All have permitted us to see witness statements made at the time of the police investigation. Some have provided supplementary statements, some have given evidence. As a result we have been able to come to secure conclusions about the events we have investigated based on contemporaneous documentation and accounts. We understand that this process will have brought back difficult memories for many, years after the event. On our own behalf and on behalf of all who will find this report of use we express our thanks.

- ii) West Yorkshire Police who made available, often at short notice, thousands of documents - statements and exhibits. They answered every question they were asked. Two officers (one of them now retired) involved in the original criminal investigation gave evidence. Without that generous assistance the work of the Inquiry would have taken very much longer. We are particularly grateful that the police permitted us to read the expert reports of Professor Forrest, formerly Professor of Forensic Toxicology at the University of Sheffield, now Honorary Professor of Forensic Chemistry at the University of Sheffield and Honorary Professor in the Department of Health and Welfare at Sheffield Hallam University. Professor Forrest gave generously of his time to review the many reports he had prepared for the police in evidence with us and gave us the benefit of his considerable expertise and experience on difficult medical, ethical and toxicological issues. We are very grateful to him.

iii) The Inquiry team:

Heidi Robinson, administrator and her assistant, Emma Cruise,
Tracey Longfield of Beachcroft LLP, Solicitor to the Inquiry,
Vanessa Marshall, Counsel to the Inquiry.

Their collective prodigious hard work led to the tracing of witnesses, the effective examination of witnesses and a complete, ordered and audited set of Inquiry documents.

iv) The staff and former staff of Airedale NHS Trust who have cooperated with the Inquiry, providing witness statements, documents, and, in many cases, attending to give evidence. Their cooperation has allowed us to investigate and report within a reasonable time scale.

We have reported and made recommendations as requested. We believe that the recommended actions are worthwhile and practicable. They could be achieved at little cost and in a reasonable timescale. What action is taken is, in the end, for others to determine.

Kate Thirlwall QC
Eddie Kinsella
Professor Aidan Mullan

EXECUTIVE SUMMARY

Background

1. In 2004 Sister Grigg Booth was charged with 3 offences of murder, one offence of attempted murder and 13 offences of administering noxious substances with intent to cause grievous bodily harm or harm. The victims of the alleged offences were patients at Airedale NHS Trust where Sister Grigg Booth had worked as a Night Sister for over a quarter of a century. Her case was listed for hearing in the Crown Court in April 2006. She died on 29 August 2005.
2. This Inquiry was set up in 2009, 4 years after her death and 7 years after the most recent of the incidents under consideration. The delay was regrettable.
3. The Inquiry process has stirred difficult and painful memories for patients and families years after unhappy events. It has challenged many members of staff and former staff. A number are plainly still struggling to understand what happened.
4. For many who read this report its principal interest will be in our review under the first paragraph of the Terms of Reference: what happened? We have endeavoured fairly to assess the evidence available to us to come to conclusions about what happened. It is no part of our task to review the criminal charges or to guess what a jury might have done in due course.
5. This summary does not contain our conclusions in respect of the incidents we reviewed in detail. There is no substitute for reading that part of the report. At the end of this summary we set out a number of findings of fact which should assist those who want to have some understanding of what was going on at Airedale at night at the relevant time, and when matters came to light.

Anne Grigg Booth

6. Sister Grigg Booth was not a Beverly Allitt or a Colin Norris in that her actions were almost entirely open. She recorded what she was doing in clinical records, prescription charts, notes. We think it unlikely that she

deliberately set out to harm patients. She was utterly convinced of her own clinical prowess; we have no doubt that on occasions she went well beyond the boundaries of acceptable nursing practice at that time and beyond the boundaries of her own clinical understanding. We are satisfied that she acted unlawfully from time to time.

7. Some staff in the hospital thought her intimidating, others considered her a bully. Almost without exception medical and nursing colleagues recognised that she was a hard working, experienced and caring nurse who could be relied on in a crisis. We believe she enjoyed that reputation, and the fact that at night she was effectively in charge of the hospital.

The Trust

8. We acknowledge that there can be few more traumatic events for the patients, staff and Board of a hospital than a police investigation into allegations of serious wrongdoing by a health care professional. In our view the Trust Board failed in December 2002 and thereafter to recognise and act upon the fact that, whatever Sister Grigg Booth had done, she was part, if not a symbol, of a system that was not working. The Trust Board's understanding and approach was that here was a rogue nurse, and that all else was well. That this was untrue could and should have been known about at Board level long before December 2002 and at every stage thereafter.
9. Part of the difficulty for the Board at that time, in accepting that there may have been a systems failure, was the fact that the Trust appeared to be very successful. It achieved a 'three star' rating, the highest possible, within the NHS performance management system prevailing at the time. It enjoyed very low mortality rates and enviable levels of patient satisfaction with its services. Members of staff were proud to be associated with the Trust and the organisation subsequently achieved a number of prestigious national awards for the quality of its services. It is clear from the panel's many discussions with witnesses, including former Board members that the failures which occurred came as a great shock to the organisation, and to those who had responsibility for leading it. It is equally clear, that those failures are regarded with deep regret and sadness at all levels of the organisation. However, it is also clear that the shortfalls in the governance arrangements within the Trust did not occur overnight, but were a recurring

feature of systems failure in some critical aspects of the Trust's activities. The most striking failure was in the disconnection between what was happening on the wards at night, and what the Board knew. The Board had no idea. Save for three visits by the Director of Nursing (DN1) between 1995 and 2003 no Board member visited the wards at night.

10. From the mid 1990s senior night nursing staff were working as Night Nurse Practitioners (NNPs). Sister Grigg Booth was the most senior. The purpose of the NNPs' role was to reduce the workload of junior doctors. Thus they took on additional tasks so that junior doctors could get more rest at night. The four NNPs whose practice we looked at closely all administered intravenous opiates. So did other NNPs. This was against official hospital policy. They did so for years. The Board was unaware that this was going on. Senior managers knew or should have known it was going on. They did nothing about it.
11. To make matters worse some staff alleged that there was a club culture amongst the managers. People were afraid to challenge Sister Grigg Booth because they believed she would be protected by the Divisional Manager (DM).

The Police investigation

12. The police were first involved at the end of January 2003. They asked the Trust not to interview those who may be witnesses in the police investigation. Plainly the Trust Board had a responsibility to cooperate with the police, and did so, but it also had a responsibility to patients to establish what had been going on, and what was still going on in the hospital at night. It did almost nothing in that regard. It was acquiescent, rather than seeking high level discussion with the police. It did not have the right information to take effective action. Such information was readily available. When, in March 2003, important information did reach the then Chief Executive (CE1) about what DM knew, CE1 did nothing for over a year because of his understanding of the requirements of the police investigation. It is right that DM was very senior and highly regarded; he was carrying out important work for the Trust at that time.

13. We do not underestimate the strain on an organisation of a police investigation. We can only emphasise the need for all hospital managers to plan for such an event, to be familiar with the Memorandum of Understanding between the NHS, the Association of Chief Police Officers and the Health and Safety Executive published in 2006, and to take responsibility for patient safety. It is not acceptable simply to leave everything until after a police investigation. We underline the cardinal importance of early high level discussions between hospital managers and police to set out a way of working that allows both to carry out their duties.
14. We recognise the value of joint working between organisations. It is our clear view that in this case there were real problems with the secondment to the police of a nurse employed by the Trust. We recommend that where such arrangements are suggested in future there be careful and detailed consideration of the purpose and consequences of such an arrangement, together with an agreed plan of action to support the secondees/s.

The current position

15. We say immediately that very significant improvements have resulted from enormous efforts by Trust Board and staff at every level, particularly since 2005. We set out in detail in our report the many examples of good practice in every area we have been asked to review. It is for that reason that the recommendations directed at the Trust are relatively few. From what we have seen and read we have confidence in the determination of the current Board to maintain those improvements and to build upon them.
16. We are satisfied that the systems and processes currently in place at Airedale NHS Trust are commensurate with current NHS policies, guidance, best practice and professional standards. We have met on a number of occasions with the current Chief Executive, Medical Director and Director of Nursing. We were all impressed by and have confidence in their professionalism. We hope that by offering meetings with those whose lives have been affected by events at the Trust in the early part of the last decade the Trust will be able to reassure those whose health and well being should be at the centre of their concerns.

Findings of fact

17. Because this report is the only opportunity for patients, former patients and families to hear in full the history of their/their relatives' care we have set out many of the incidents in great detail in the report. This is so the whole picture is understood in respect of each patient. After so long it is, we believe, the least that can be done for patients and former patients. We have summarised only where it is necessary for reasons of confidentiality. The findings are in chapter 2. We do not summarise them here.
18. We make the following general findings. We are satisfied on the balance of probabilities that throughout the period 2000 to 2002:
 - Sister Grigg Booth and the 3 other NNPS from whom we heard routinely administered opiates intravenously. Sister Grigg Booth did so much more frequently than her colleagues. We find that they all reasonably believed that they were permitted to do so. There is evidence that they received training which led them to believe that they were equipped to do so competently. Their actions were entirely open and were recorded in clinical records, nursing Kardex, prescription charts, controlled drugs books. Senior managers were aware or should have been aware of this. Until January 2003 no action was taken to stop it. It had been going on from at least the mid 1990s.
 - The NNPs all accepted verbal orders from doctors for the prescription of opiates and other medication. They all carried them out until at least mid 2001. Senior managers were aware or should have been aware of this. This too had been going on for many years.
 - On some occasions Sister Grigg Booth prescribed opiates without reference to a doctor at all. Her actions were unlawful. Sometimes, but not always, she got a doctor to approve her actions retrospectively.
 - Other NNPs may, very occasionally, have prescribed opiates without reference to a doctor.

- At that time there were no circumstances in which a nurse was permitted to prescribe opiates. It was unlawful.
- Many nurses and doctors working at night believed that the NNPs were entitled to prescribe opiates, to take verbal orders for opiates, and to administer them intravenously.
- The official policy of the Trust (that opiates should be administered intravenously only by certain nurses, not including NNPs) was far from clearly expressed and it was of no practical effect at night.
- Pharmacists did not check that prescriptions were signed by doctors. Time constraints meant that their role was restricted to checking that the prescriptions were correct for the conditions being treated.
- The role of the NNP had been developed to reduce the workload of junior doctors, in accordance with the New Deal, and to ensure compliance with the European Working Time Directive. The fact that NNPs carried out doctors' tasks improved the Trust's compliance with both. Whilst the success of the NNPs in reducing the work of junior doctors was acknowledged no one asked how it was being done.
- The incidents were not hidden. The documentary records of the NNPs' actions were there to be seen by doctors, nurses, pharmacists, managers. They came to wider attention almost by chance when an audit committee was reviewing a set of patient records for another purpose.

Investigation

- An internal investigation was carried out in December 2002 and the police were contacted on 20th January 2003. Sister Grigg Booth, who was off sick at that time, was suspended on 22nd January. The police arrived at the hospital on 29th January and took away the findings of the internal investigation.
- In March 2003 the police took statements from scores of staff, including two of the NNPs. Managers were present when those statements were taken. We believe that this may have led witnesses to be less than forthcoming about what they knew about what was going on at night.
- The investigations revealed eventually that other NNPs had also taken verbal orders, administered opiates intravenously, and, possibly, prescribed opiates. The other NNPs were interviewed by the police. No charges were brought against them.
- In due course the other NNPs were subjected to disciplinary action at the Trust. One took early retirement, the other two were downgraded and eventually left the Trust.
- Although it was known from at least the middle of 2003 that DM knew of some unlawful practice and had apparently done nothing about it he remained in post until late September 2004 when he was suspended. He was arrested in October 2004. He was interviewed by the police, he was not charged. He resigned upon his arrest. The NNPs' line manager (NNP Manager 2) was suspended on 1st October 2004. He was arrested and interviewed by the police in October 2004. He was not charged. He was dismissed by the Trust.

CHAPTER 1

INTRODUCTION

2003-2005

- 1.1 By a letter dated 22nd January 2003 Sister Grigg Booth, a night sister of over 25 years standing at Airedale NHS Trust, was suspended for *“acting outside the scope of professional practice and in breach of Trust protocols and procedures concerning:*
- a) *the prescription of opiate drugs,*
 - b) *the administration of opiate drugs,*
 - c) *the prescription and administration of other drugs, without the authorisation of a doctor.”*
- 1.2 Her activities were reported to the police. On 19th March 2003 she was arrested. A far ranging police investigation was carried out. In August and September 2004 Sister Grigg Booth was charged with a total of 17 criminal offences: 3 offences of murder, one offence of attempted murder and 13 offences under the Medicines Act of administering noxious substances. All the charges related to the period 2000 to 2002 and involved 16 patients. She was subsequently dismissed from her employment at the Trust. A hearing in the criminal proceedings was listed at Bradford Crown Court in April 2006.
- 1.3 Throughout the period with which we are concerned Sister Grigg Booth’s job title was Night Nurse Practitioner (NNP). She carried out an extended nursing role which we explain below.
- 1.4 In October 2003 another NNP was arrested and interviewed. In 2004 another two NNPs were arrested and interviewed. No charges were brought against any of them. Two senior managers were also arrested in late 2004. They too were interviewed. No charges were brought against them. Two of the NNPs were disciplined and downgraded by the Trust, a third took early retirement. One manager was dismissed, the more senior manager resigned.

- 1.5 On 29th August 2005 Sister Grigg Booth died. After her death the prosecution was discontinued.

Background to this Inquiry 2005-2009

- 1.6 In January 2005 the Trust had decided to set up an internal review. The Strategic Health Authority (at that time the West Yorkshire Strategic Health Authority, WYSHA) advised them to make sure that their review did not impede the police investigation.
- 1.7 In the middle of 2005 the Trust set up a panel consisting of independent and Trust members to conduct a documentary review. The panel's final report was completed in October 2006. We deal with the detail of that report in Chapter 6.
- 1.8 On 30th August 2005, the day after Sister Grigg Booth's death, WYSHA announced the launch of an independent investigation into the systems and processes governing the prescribing and administering of drugs by night nurse practitioners at Airedale NHS Trust between 2000 and 2002. Terms of Reference were yet to be announced.
- 1.9 In September 2005 the Coroner informed WYSHA that he was considering whether or not to write to the Secretary of State and ask to carry out inquests. There was a very large volume of information for him to consider. On 8th September WYSHA announced that the independent inquiry would begin as soon as a Chairman had been identified. WYSHA contacted those patients, former patients and relatives whose cases had been the subject of criminal charges against Sister Grigg Booth, to inform them of the Inquiry.
- 1.10 Later that month WYSHA accepted advice from a senior barrister that they should delay their Inquiry until after a decision had been taken as to whether or not inquests were to take place.
- 1.11 In October 2005 WYSHA inquired of the Coroner as to whether inquests were likely to be opened. The Coroner informed WYSHA that he was at that time considering the voluminous documentation in order to decide

whether or not to refer the cases to the Secretary of State for Constitutional Affairs.

- 1.12 In September 2006 the Coroner reported the facts surrounding 3 deaths which had led to murder charges to the Secretary of State under section 15 of the Coroners Act 1988. From that time the matter rested with the Department of Constitutional Affairs, which, in June 2007 was subsumed into the newly formed Ministry of Justice.
- 1.13 It was not until August 2008 that the Ministry of Justice informed the new Yorkshire and the Humber SHA (SHA) that the Minister did not intend to direct the Coroner to carry out inquests. The SHA asked the Department of Health whether the Secretary of State for Health intended to set up a Public Inquiry under the Inquiries Act 2005.
- 1.14 In October 2008 Department of Health officials confirmed to the SHA that the Secretary of State for Health had decided that the SHA should set up an Independent Inquiry. Thereafter the SHA, in consultation with the Trust, the Department of Health, patients and family members, drafted Terms of Reference and identified panel members.
- 1.15 Thus, regrettably, almost 4 years passed between the death of Sister Grigg Booth and the first hearings in this Inquiry, 7 years from the most recent events being considered. The unfortunate result was that memories had faded, inevitably. Individuals lived with uncertainty for far longer than was desirable.

Terms of Reference

- 1.16 The Terms of Reference for this Inquiry are set out in full at Appendix 1. They are wider than was originally planned and, importantly, include a requirement to determine the facts of the incidents which were the subject of criminal charges. The core paragraphs are:
- 1 To establish the facts, by reference to documentary evidence and interview, in each of the 17 incidents that were the subject of criminal charges against Sister Grigg Booth, and any other incidents of a serious nature that come to light during the Inquiry.

- 2 To review, and comment on, how the incidents came to light and how further matters of concern were raised and investigated in the Trust.
- 3 To review, and comment on, the information and support provided to the victims, relatives and Trust staff once the incidents had been identified.
- 4 To review and comment on the systems and processes in place at Airedale NHS Trust from 2000 to 2002 with reference to the NHS policies, standards, guidance and best practice prevailing at that time, specifically in relation to:
 - a) corporate governance;
 - b) corporate management;
 - c) nursing management;
 - d) the human resources function;
 - e) the management of medicines, including prescribing, recording of medicines usage and the audit of medication;
 - f) multidisciplinary team working, especially during the night and;
 - g) the confirmation of deaths.
5. To review and comment on the quality of the internal investigations, notably the extent to which they identified all salient factors, and the quality of the action plans arising from these investigations.
6. To review and comment on the implementation of action plans arising from the internal investigations.
7. To review and comment on the systems and processes currently in place at Airedale NHS Trust (with particular reference to those specified under point 4) and comment on the extent to which these are commensurate with current NHS policies, guidance, best practice and professional standards.

8. To report the panel's findings, identifying any further learning points and making recommendations to minimise risk and improve services to the Boards of Yorkshire and the Humber Strategic Health Authority, Airedale NHS Trust, Bradford and Airedale Teaching PCT and where appropriate the wider health and social care community.

Methodology

- 1.17 The three panel members were appointed by the end of February 2009. From February 2009 the West Yorkshire police released to the Inquiry all its statements, some 800 in total, and many thousands of pages of exhibits. The Inquiry administrative officer wrote to all those who had made relevant statements and asked that the panel be given permission to read them for the purposes of the Inquiry. This was a huge task. The assistance of the Trust was sought in approaching all current and former members of staff. The Trust diverted considerable resources to enable this to happen. It was time consuming and in most cases productive. Almost all those who replied consented to the use of their statements for the purposes of the Inquiry. This saved hundreds of hours of time in obtaining initial witness statements. We are grateful to the witnesses, the police and the Trust staff who made this possible. The saving of costs and time has been very significant.
- 1.18 All patients, former patients, or, where patients are no longer alive, family members were contacted and asked to agree to the use of their/their relatives' records for the purposes of the Inquiry, and also to consent to the use of any police witness statements. With one exception, to which we refer below, all those with whom the administrative team were able to make contact agreed to the use of the medical records and statements for the purposes of the Inquiry.
- 1.19 One family member asked the panel to make no further contact after the initial approach. That person also asked the panel not to investigate the circumstances of his family member's death. The panel postponed consideration of his request until after we had reviewed the cases in respect of which we had consent. Having conducted that exercise at some length we are confident that we are able to come to conclusions about what happened at Airedale without it being necessary to consider that particular case. We are satisfied it is not in the public interest to cause unnecessary

further distress to a bereaved person when we are able to fulfil our obligations under the Terms of Reference. In respect of the criminal charges therefore we make findings in respect of 16 incidents, not 17.

- 1.20 Sister Grigg Booth's family was approached via her former solicitors. They did not wish to be involved in the Inquiry. Given the press coverage of this case at the time Sister Grigg Booth died we understood that. At a much later stage there was something of a change of heart and expert reports that had been prepared in Sister Grigg Booth's defence were provided to the panel by her former solicitors. The panel had asked for those reports and were grateful to receive them. We have taken the contents into account in coming to our conclusions.

Preliminary meetings

- 1.21 All patients/former patients and families were invited to a meeting with the panel so that the process of the Inquiry could be explained to them, and so that they could ask questions. The meeting took place on 14th May 2009 at the hotel which was later used for most of the hearings. On the same day the panel held two meetings with staff and former staff at Airedale. Again the process was explained and questions were asked and answered. The Terms of Reference were provided to all who wished to have a copy.

The Trust

- 1.22 We invited the Trust to submit evidence in respect of Terms of Reference 1 to 7. This was clearly not an easy task for the Trust; many senior staff had left, others remembered little and the records were not always well kept. We have no doubt that individuals worked extremely hard to produce information. In due course we heard evidence from a number of witnesses currently or formerly employed by the Trust and from several former and current Board members. We deal with the detail later in the report. We were surprised at how few former Trust Board members took the trouble to familiarise themselves with any of the documents before providing statements or giving evidence. We should say that both the Chief Executive of the Trust for the relevant period (CE1) and the Director of Nursing and Quality for that period (DN1) did seek access to documents and carried out some preparatory reading in advance of the hearings as well as providing statements and follow up submissions and observations.

Witnesses

- 1.23 We approached the evidence thus: where statements were uncontroversial we did not ask the witness to come to give oral evidence. Where matters needed to be developed or clarified witnesses were asked for further information in writing. Most witnesses who were asked for further information provided it.
- 1.24 Where there was a dispute between witnesses as to an important issue we invited them to give oral evidence so that their accounts could be tested. All witnesses who might be the subject of criticism were given notice of the likely areas of criticism and invited to attend. Sometimes the rigours of the timetable meant that there was not much time for witnesses to familiarise themselves with documents in advance. All rose to the challenge and all were given the option, if they wanted to, of taking more time. Some chose to do that. A very few witnesses took up the offer of reviewing documents in advance of the hearings.
- 1.25 With only one exception every witness who was invited to come and give evidence did so, 82 in total. For some people the experience was uncomfortable. For many it was inconvenient. We are grateful to all who gave of their time to assist us in our task. Several were asked to return on a second occasion and did so without complaint. We do not underestimate the strain on witnesses of trying to remember events that occurred many years ago. We know that some witnesses will have felt that their conduct was particularly closely scrutinised, and that the questions were extremely detailed. This was necessary and illuminating. With very few exceptions every witness cooperated fully with the process. Some asked to bring someone along as support. We permitted this.
- 1.26 Regrettably one witness, the Divisional Manager at the material time (DM), and a key figure, has not given evidence despite being invited to do so and an offer by the Panel to take his evidence by way of video link. Nor has he answered most of the questions that were put to him in writing. It follows that our conclusions in respect of his conduct have been reached without the benefit of hearing from him. That was his choice, not ours. We have read and taken into account what he said to the police in interview in 2004. We refer to him throughout as DM although his position changed over the years. His final post was as Divisional Manager.

The hearings

- 1.27 Hearings took place at a hotel in Skipton over 23 days in July, August, September, October, November and December. The proceedings were recorded contemporaneously. This allowed us to hear the evidence of 82 witnesses in a relatively short period. Most witnesses appeared without representation. Three asked to be represented and they were given permission. Counsel to the Inquiry asked questions of all witnesses. Panel members asked supplementary questions of the witnesses and, before and after the hearings, all read all the thousands of pages of documents. A full list of all the documents considered has been provided to the SHA together with a list of all the witnesses from whom we heard and whose evidence we read.
- 1.28 The hearings were held in private but not in secret. Patients/former patients and their families were invited to attend those parts of the hearings in which they had an interest. Several did so. The solicitor to the Inquiry was in frequent contact with the patients and their families, informing them of when witnesses were to attend whose evidence they may wish to hear. Several attended. Others preferred not to. Where sickness or some other unforeseen problem prevented a patient or relative from attending they were invited to read the transcripts. Several of them did so.
- 1.29 Employees, former employees and Board members past and present were also informed that they may ask to attend. A small number did so, and were permitted to attend. No one who asked to attend was refused entry. In our view the approach we took allowed the appropriate level of scrutiny by interested parties, particularly by the patients and their families who have lived with uncertainty about the events we were looking at for several years. All in attendance (witnesses, supporters, observers) agreed in writing that they would keep matters confidential. We believe that everyone has honoured that agreement. Throughout the hearings the Trust was represented by a senior member of staff, including, on many occasions, the Director of Nursing and, from time to time, the Chief Executive. On occasion a witness indicated that they would prefer to give evidence in the absence of the Trust representative. There was no difficulty about this; the Trust representative left without being asked to do so. As a result there was no disruption to the proceedings.

1.30 The panel visited the hospital one morning. Professor Mullan also observed the twilight shift. Mr Kinsella attended a Trust Board meeting. The staff and Board members were welcoming, forthcoming and helpful.

What this report is not

1.31 Anne Grigg Booth was charged with 3 offences of murder, one of attempted murder and 13 further offences. It is inevitable that readers of this report will look for our views on the charges. They will not find them. The criminal charges are not within our Terms of Reference, nor should they have been. It is not for the SHA to seek to investigate a prosecution. All the incidents which led to the charges are firmly within our Terms of Reference and we have done our best on the evidence to determine what happened. What we have not done is to second guess what a jury might have done. That is not a matter for us.

1.32 We observe that it was a feature of the evidence of a number of former employees that they believed that because Sister Grigg Booth had been charged with serious offences she was guilty of them. Some seemed to regard the fact of the charges as a validation of their own actions and views. Others were very clear that a terrible injustice had been done, that the charges were misconceived. Some felt that they had led to Sister Grigg Booth's death. We make it clear that the charges are irrelevant to our determination of the facts, whether in respect of the actions of Sister Grigg Booth or the actions of others.

Findings

1.33 Where we have made findings of fact we have done so on the balance of probabilities.

1.34 In order properly to assess the facts of the incidents we are asked to consider it has been necessary for us to go back some years to establish the context in which events unfolded in the years 2000 to 2002.

1.35 We have not dealt with every issue that was raised in the various statements or in the course of the hearings. Some issues that appeared important at an early stage became less important. We have tried to keep the Inquiry within reasonable bounds, in terms of time, expense and

disruption to those who have been required to give evidence or provide information. We have not conducted a trawl of medical records in respect of every patient who was looked after by any of the Night Nurse Practitioners who were the subject of investigation. In our view there was sufficient information in the records we have considered in detail to provide a clear picture of their conduct during the relevant period.

- 1.36 We have no doubt that the relatives of patients who died in hospital have been in turmoil; first they lost a relative and later, sometimes years later, learned that a nurse may have murdered their loved one or attempted to. Former patients wondered whether they had indeed been the victim of a criminal offence. They were then deprived of a criminal trial. Whilst many chose not to attend the Inquiry, some did. They heard the same evidence as we did. They will have made up their own minds as to what happened. We hope that the findings we make are of some assistance in helping people understand what happened to them, or to their relatives.

Airedale NHS Trust

- 1.37 Airedale NHS Trust is a district general hospital. It was opened in 1970. It is situated in idyllic countryside between Skipton and Keighley. It serves a population of over 200,000, across a very large area, some 500 square miles. It employs around 2,500 people and is supported by 400 volunteers. Each year, the Trust provides care for some 25,000 inpatients, 22,000 day cases and 104,000 outpatients. 47,000 patients are seen in Accident and Emergency each year.
- 1.38 During the period 2000 to 2002 Airedale NHS Trust was an “*integrated*” Trust. It provided acute services from Airedale General Hospital; in-patient, out-patient and community mental health services; community nursing services. It also consisted of a number of smaller hospitals in addition to Airedale General Hospital. It employed 3,500 staff.
- 1.39 For many years the Trust had an excellent reputation and was consistently top ranked in the NHS performance ratings. Members of staff were proud to be associated with the Trust and the organisation achieved a number of prestigious national awards for the quality of its services. It had low mortality rates and high levels of patient satisfaction. It is clear from the panel’s many discussions with witnesses, including former Board members,

that the failures which occurred came as a great shock to the organisation, and to those who had responsibility for leading it. It is equally clear that those failures are regarded with deep regret and sadness at all levels of the organisation. However it is also clear that the shortfalls in the governance arrangements within the Trust did not occur overnight but were a recurring feature of systems failure. We consider this in detail under Terms of Reference 4 below.

Anne Grigg Booth

- 1.40 Since so much of our Inquiry has been directed to the actions of Sister Grigg Booth we set out below a synopsis of her career.
- 1.41 Anne Grigg Booth was born in March 1953. Between 1972 and 1975 she trained as a nurse at St George's Hospital in London. The following year she spent some time abroad, and then worked as an agency nurse in London. Between 1976 and 1977 she was a Senior Staff Nurse/Relief Sister at St George's. In 1977 she was appointed to the post of Night Sister at Airedale General Hospital. She spent the rest of her professional life there until she went on sick leave in July 2002. She was suspended from her position in early 2003 before she was able to return to work. In 2004 she was charged with criminal offences. A hearing in the criminal proceedings was listed for April 2006. She died on 29th August 2005. The coroner recorded a verdict of accidental death.

Professional responsibilities

- 1.42 Our conclusions here are based on statements and oral evidence from staff and former staff at Airedale, many of whom had worked with Sister Grigg Booth for some years. During the period with which we are principally concerned (2000-2002) Sister Grigg Booth was a Grade G nurse, working as the senior member of a team of Night Nurse Practitioners. Although a senior Manager was always on call the reality was that Sister Grigg Booth was responsible for the running of the hospital at night. She and the team of Night Nurse Practitioners were the first port of call for ward staff who were concerned about their patients. They worked closely with doctors. Sister Grigg Booth was responsible for bed management i.e. organising which patients went where when admitted in the night. Sister Grigg Booth plainly relished her responsibilities. She was one of the

longest serving members of staff at the hospital. She enjoyed her work and for many years appeared to thrive on the camaraderie and her status. She worked very hard. She worked many extra shifts, particularly towards the end of her employment. She left her telephone number with colleagues when she was on holiday. She was happy to be contacted when off duty. A long time friend and former colleague told us that in his view she worked far too hard. In our view Sister Grigg Booth, whilst clearly devoted to her work, needed to be needed and contributed to the development of a dependent culture at night. She frequently referred to the fact that she was “*in charge*”.

Reputation

- 1.43 Sister Grigg Booth worked on night shift at Airedale for over 25 years. We have read statements from, and heard live evidence from, scores of witnesses who worked with her in one capacity or another. We have considered evidence from former patients. Almost without exception the witnesses comment on her physical appearance and presence. She was tall, with cropped hair and, outside of work, she dressed in a way that many found unconventional; she rode a motorbike and wore leather biker clothes. A number of nurses commented on the fact that she would frequently swear at work, which they rightly considered unacceptable and unprofessional but there was no effective challenge of her by her managers, by which we mean that even on the odd occasion she was admonished there was no change of behaviour. Some found her intimidating. Many people describe her as larger than life. It is clear from the evidence of some nurses that she was vocally critical of the actions of others (nurses and doctors), particularly where in her opinion they were lazy or incompetent. Some nurses and junior doctors found her overbearing, others, including NNPs 2, 3 and 4 described her as a bully.
- 1.44 Notwithstanding the reservations that were expressed, we should record that nearly every witness (doctors, nurses, patients) spoke very positively about Sister Grigg Booth’s abilities as a nurse. The following is a representative sample of the evidence in this regard. From nursing staff we heard on numerous occasions “*if you were sick you would want Anne looking after you*”. “*At times she was an overpowering lady but most of the staff got on with her...she was very good in dealing with patients. She was firm with problem patients but considerate with poorly patients and their*

families". *"She was outspoken but also very supportive with relatives and patients and staff. She could be quite scary sometimes. She was a very good nurse with patients. I trusted her."* A number of witnesses described her as *"competent, conscientious, caring"*. Several witnesses told us she was unflappable, good and calm in a crisis, particularly during "crash" calls. She was confident, took charge and got things done. *"I was always happy when Sister Grigg Booth was on duty if I had poorly patients to deal with or concerns. She was reliable and you knew she was going to give her full support"*.

- 1.45 Junior Doctors, Registrars and Consultants who had worked with her were also complimentary. *"I thought she was one of the best at her job. I rate her very highly"*. *"She was a very good surgical nurse and sister. I would rely on her word above that of the junior medical staff, on occasions the registrars as well"*. *"She was forthright and direct. Her priority was always to ensure the patient received prompt and appropriate treatment. She was an excellent professional colleague who worked with doctors to ensure a good outcome for the patient."* We record that a consultant told us that he had occasional complaints from junior doctors about the way Sister Grigg Booth treated them. They thought she was a bit "rough" as he put it. He elaborated by saying that if she called them out at night she really wanted them to come out at night. This correlates with some letters we have seen from Sister Grigg Booth where she specifically complains about some junior doctors who were unwilling to get out of bed at night and who needed to be "sorted out". We have no doubt that if Sister Grigg Booth summoned a junior doctor from his or her bed she expected that doctor to attend. We say that because it is plain from the evidence we have heard, that it was a matter of importance to Sister Grigg Booth that doctors were disturbed as little as possible in the night. Indeed we think that her determination to achieve that end led to some of the actions which in turn led to her being charged with criminal offences.
- 1.46 On one, or possibly two, occasions Sister Grigg Booth brought a parrot onto the ward. These incidents have become part of the folklore of the hospital. A number of witnesses pointed to them as evidence of unprofessional conduct. Others saw it as a genuine attempt to cheer up the patients. Sister Grigg Booth was told not to do it again on the grounds that the parrot brought with it a risk of infection. So far as we can tell she accepted that. At its worst it seems to us the incidents reflect a cavalier approach to the

rules. This manifested itself in other ways too; we heard that she did not always attend training events, or grumbled vociferously when required to do so. It is clear that she did not put form filling or administration high on her list of priorities. It may be that many years of being highly regarded and very experienced led Sister Grigg Booth to bend or ignore other rules. She may have considered she was above them. We shall explore this issue later in the report when we consider the detail of some of the incidents with which we are concerned.

Junior doctors' hours / The New Deal

1.47 The “*New Deal*” was introduced into the NHS in 1991 to improve the working lives of junior doctors. It was linked with the European working time directive. In 1991 it restricted their average hours of work to 56 hours per week, though it allowed for them to be rostered on for longer periods of duty where rest was included (subject to the rota complying with Working Time Directive rules on the definition of work and rest). The New Deal detailed 4 different work pattern types that junior doctors could be timetabled to do. The NHS workforce publication explained it thus:

On-call: Periods of duty must not exceed 32 hours (56 at weekends) and the average duty hours for the week should not exceed 72 hours. Rest requirement: approximately 8 hours of rest in total (12 per weekend day), of which 5 should be continuous between 22.00 and 08.00.

24-hour partial shift: This is similar to an on-call rota except that the period of duty must not exceed 24 hours and the average duty hours for the week should not exceed 64 hours. Rest requirement: 6 hours of rest in total, of which 4 should be continuous between 22.00 and 08.00.

Full shift: The maximum length of duty for a full shift is 14 hours and the maximum average should not exceed 56. Natural breaks of 30 minutes uninterrupted rest should be taken every four hours.

Partial shift: The maximum length of duty for a partial shift is 16 hours and the average duty hours for the week should not exceed 64 hours. Rest should total one quarter of the out-of-hours duty period.

- 1.48 These arrangements marked a very significant reduction in the availability of junior hospital doctors across the country. All hospitals faced the challenge of maintaining patient care while reducing the number of hours worked by individuals.
- 1.49 DM (then a service manager) had the task of considering how best to use nursing resources to support the New Deal and to reduce the requirement for doctors at night. He was a longstanding manager, extremely highly regarded and valued by the Chief Executive (CE1) and the Trust Board. He was known as a man who got the job done. He was a nurse by background and kept his NMC registration up to date but his work for the Trust was as a manager.
- 1.50 In 1995, DM contacted a Health Lecturer at the University of Bradford. He asked her to carry out research and write a paper on developing the role of Night Nurse Practitioners. She was a qualified nurse and had previously worked at Airedale. As part of her research she visited Airedale. Sister Grigg Booth was given the role of supervising her when she was at Airedale. The Health Lecturer produced a paper which outlined the existing role of a night sister and highlighted the extended role that an NNP would have. She appended to the paper a draft Job description for an NNP. Amongst the suggested duties were the following:
- to provide site management and administration of the (Unit/Hospital),
 - participate in staff development programmes and clinical supervision,
 - to provide clinical support, expertise and advice to all night staff,
 - to assist medical staff with the assessment of patients, coordinate requests to doctors from nursing staff, and
 - undertake extended role/clinical skills following appropriate training and within the guidelines of the UKCC (Scope of Professional Practice) and clinical procedures as determined by the Directorate/Trust e.g.:
 - IV cannulation,

- Venepuncture,
- 12 lead ECG recording and interpretation,
- defibrillation, crash team,
- administration of IV drugs,
- urinary catheterisation (male),
- limited prescription/receipt of verbal prescription of IV fluids & drugs,
- verification of inevitable death.

1.51 We observe that at the time this job description was drafted several night sisters (including Sister Grigg Booth and NNP4) were already administering IV drugs, and had been doing so for some years. They were already taking verbal orders for drugs.

1.52 In due course funding was made available for night sisters to be trained as NNPs. Although DM had informed DN1 of the proposed extended role for the NNPs she was not consulted about the role nor, she told us, was she aware that the change had taken place until afterwards. Whilst we understand that there was a difference between managing and professional supervision we would have thought that this development required close communication between DM and DN1. That does not seem to have happened.

1.53 We have considered very carefully a file with the reference H40. It bears the title "*NNP training file*". It was taken from the DM's office by the police in March 2004. The documents within it fall into 2 categories:

- i) documents pertaining to a pilot study of the work done by night staff to alleviate the load on junior doctors and;

- ii) training records and competency sheets for a number of NNPs. (Other training records appear in the individual personal files of the NNPs).

Because of the importance of these documents we deal with them in some detail.

First stage

16/02/96 Memo from DM to Junior Doctors, *'we operate a system of fielding night calls by Senior night staff who are shortly to become nurse practitioners. In preparation for this we have started to develop the role and would be grateful for your opinions on how the system is working here at Airedale. A brief feel for how useful you feel the other activities would be will also be helpful. Please tick below re the activities we propose: IV drugs, phlebotomy, cannula siting, verifying expected deaths'*.

The Junior Doctors who replied ticked all categories as very useful.

The training

- 1.54 During 1996 the first Nurse Practitioner training course was run. It was not just for night staff and a number of day staff attended. Lectures took place at Bradford University. Practical sessions and the assessment of competence took place at Airedale. We observe that at the time of the first course several night staff were already carrying out some of the roles that were new to others, including the administration of intravenous drugs. According to NNPs 2 and 3 Sister Grigg Booth did not attend all the lectures, as she didn't think she needed too. They were not able to be specific, at this distance of time, as to how many she missed although NNP3 believed she did not attend more than half. This is a further indication of Sister Grigg Booth's confidence in her own abilities and an indication of her attitude to training. In addition to attending lectures and receiving practical training the nurses were required to complete an essay which was a review of a critical incident in which they had participated. Sister Grigg Booth did not do that.

- 1.55 All the nurses were required to obtain a record of the assessment of their competency under various headings. Sister Grigg Booth did that, as did the other NNPs. All of them were assessed, by a number of different assessors, as competent in all areas. We note that sometimes Sister Grigg Booth assessed and certified another NNP as competent and vice versa. Whilst it is highly unlikely that such practice would be acceptable now, it appears to have been accepted by the DM without reservation. As the witness responsible for devising the course informed us, Sister Grigg Booth may not have written the essay but she appears to have been competent in all required areas.
- 1.56 In September 1996 DM sent a memo to Sister Grigg Booth, *"I would be grateful if we can qualify our position with regard to the Night Sisters being able to fully operate as Night Nurse Practitioners. Can you please tick the enclosed sheet and return to me asap. Please complete one for yourself, NNP2 and NNPX"*. Sister Grigg Booth completed this further sheet in respect of herself, as requested, saying that she was competent and undertaking, *'IV cannulation, phlebotomy, IV drugs, verification of death, male catheterisation, ECG performance, CPR – signed: She then added "have been assessed in all areas and attended updates as necessary for personal development etc"*
- 1.57 Sister Grigg Booth completed another form in respect of NNPX saying that she is undertaking, *"IV cannulation and phlebotomy"* - noted by Sister Grigg Booth, *"feels happy to do both and had but feels she requires more practice which we are organising - and competent and undertaking, IV drugs, verification of death, male catheterisation, ECG performance, CPR"* .
- 1.58 NNP2 completed a competency sheet saying that he/she is undertaking, *"IV cannulation"* – noted by Sister Grigg Booth, *"needs more practice at the moment. Being organised' and "competent and undertaking phlebotomy, IV drugs, verification of death, male catheterisation, ECG performance, CP"* – noted by Sister Grigg Booth, *"assessed by NN"*.

The pilot study

- 1.59 There were 2 forms. The first was headed *"Junior Doctors monitoring (nights)"*. On this the NNPs were required to record when they had called out a doctor and the reason for it. The second was headed *"Duties carried*

out by practitioner to reduce Drs workload". The night staff were asked to fill in the forms and to return them to the DM at the end of each shift.

- 1.60 We comment that this was a good initiative, we assume its purpose was to obtain an evidence base upon which to review and from which to develop the role of the NNP. Again, DN1 was not aware of this initiative.
- 1.61 A number of the night staff cooperated willingly with the filling in of the forms. We cannot tell whether the file we have contains all the forms there were, or just a selection. In any event there are no forms from Sister Grigg Booth. That may be because she was not part of the study or that she simply had no truck with form filling. For the purposes of this report it does not matter. The important point is that she seems to have had nothing to do with the pilot study.
- 1.62 We set out the more significant entries from some of the forms below:
- 19/10/96** Junior doctors monitoring (nights) NNPX – *"04.10 acute admission seen via A&E, asked to come to ward to prescribe drugs".*
- 20/10/96** Junior doctors monitoring (nights) NNP4 – *"01.39 I needed advice with regard to drug dosage/frequency in a patient who was dying"; "04.20, patient with severe unrelieved chest pain".*
- Duties carried out by practitioner to reduce doctors' workload (NNP4), *"22.48, siting of diamorphine infusion".*
- 25/10/96** Duties carried out by practitioner to reduce doctors' workload (NNP2), *"22.10, patient collapsed IV cannula inserted group and cross match gelofusin given until Dr arrived. All at his request".*
- 29/10/96** Junior doctors monitoring (nights) NNPX – *"23.15 called doctor to prescribe pain relief for patient (controlled drug)".*
- Duties carried out by practitioner to reduce workload (NNPX) ; *"23.15 IV drug given"; 03.30, "IV Maxolon given; took verbal message from doctor to give patient having a rigour PR*

paracetamol & PR Metronidazole" - all witnesses who were asked about this agreed that the IV drug was likely to be controlled drug for pain relief mentioned on the preceding form.

Junior doctors monitoring (nights) NNPY – *"03.30 took verbal message for insulin"*.

Duties carried out by practitioner to reduce workload (NNPY), *"03.30 took verbal message for insulin"*.

01/11/96 Duties carried out by practitioner to reduce workload (R NNPX), *"22.30 resited s/c diamorphine syringe"*.

Duties carried out by practitioner to reduce workload (NNPY), *"06.00 Gave IV diamorphine 06.45 confirmed death of patient"*.

1.63 **We pause in the chronology. Here on the face of a document, an NNP (not one of those with whom we have been concerned) openly recorded administering an opiate to a patient who died 45 minutes later. In 2002 the death of a patient, 2 hours after the intravenous administration of an opiate, set off the Trust investigation which led to the police investigation and prosecution. If this conduct were truly against hospital policy it should have been picked up and stopped six years earlier – well before any of the incidents we have reviewed.**

1.64 The entries continue:

04/11/96 Junior doctors monitoring, *"07.00, asked to see patient with sudden onset chest pain & breathlessness urgently"*.

05/11/96 Duties carried out by practitioner to reduce workload (NNPX), *'verbal message taken to give patient breathless after blood transfusion oral Frusemide'*.

07/11/96 Duties carried out by practitioner to reduce workload (NNPX), *"23.45, IV ranitidine given"*.

08/11/96 Duties carried out by practitioner to reduce doctors' workload (NNP2), "22.45, *patient requesting night sedation, said she could have temazepam 10mg, dr wrote it up when he visited later*".

10/11/96 Duties carried out by practitioner to reduce doctors' workload (NNP2), "05.20, *patient in LVF phoned dr verbal order for IV frusemide 40 mg given*".

1.65 Taken in conjunction with other evidence these notes demonstrate that it was expected, accepted and approved practice at night:

- i) That doctors issued and NNPs accepted verbal orders for a variety of drugs;
- ii) That NNPs administered opiates and other controlled drugs intravenously.

1.66 No one commented, still less complained.

1.67 There is no written record of the NNPs undertaking specific training for the giving of opiates intravenously. As we have already said there is evidence that they were trained to administer other drugs intravenously. They supervised other nurses administering drugs intravenously. There is plenty of evidence that the NNPs were aware of the risks of giving opiates intravenously and that they took a responsible approach to doing so. Sister Grigg Booth and NNPs 2, 3 and 4 had all received training in Advanced Life Support. This included training in the intravenous administration of opiates. There is no evidence that any of them ever administered an intravenous opiate incompetently. They certainly believed they were competent. Their belief was reasonable.

1.68 As at March 2002, when progress with the New Deal Implementation was considered, the Trust's compliance rate at 56%, 2nd from the bottom in the Yorkshire League table, was considered to be a disappointing result and a monitoring report stated, "*there is a commitment to meet the New Deal but the implementation of solutions seems to be met with resistance*". The monitoring visit also showed that whilst 6 surgical Pre-Registration House

Officers (PRHO's) worked a full shift rota, with a week of nights (20.00–09.00) every 6 weeks, and a late shift 1 in 6 (08.00-20.30), the 6 medical PRHO's worked a full shift rota but, during the week one of them worked a late shift from 10.00 to midnight and it is not entirely clear what actual cover there was after midnight. At weekends, there was only 1 PRHO working a day shift from 09.30–22.30 and one working a night shift from 21.00–11.00.

- 1.69 In April 2002 there was a monitoring visit for educational approval of PRHO posts. The notes of the report include the following, *“6 medicine PRHOs working a full shift rota. During the week one of the PRHOs works a late shift from 10.00-midnight. At weekends one PRHO works a night shift from 21.00-11.00, one works a daytime shift from 09.30 to 22.30. Rotas are compliant. Weekend on your own is stressful and depends on help from SHO. NNPs play an important role in supporting PRHOs and the best NNPs are described as fabulous. Main problem is that if one is ill or on hols they are not replaced”*.
- 1.70 Many of the junior doctors plainly appreciated the NNPs. This was at a time when Sister Grigg Booth was working very hard indeed. One witness told us that at a meeting in May 2002 to discuss junior doctors she made it clear to DM that she wrote up prescriptions and doctors would sign in the mornings so that the doctors could get their sleep.
- 1.71 Sister Grigg Booth was furious when junior doctors complained about lack of support from NNPs, and wrote to the Junior Doctors Project Officer on 24th May 2002 in trenchant terms, making a number of recommendations including the following *“PRHO read our handouts – I am responsible for the hospital 50% of the year. They should make themselves familiar with how the place works and who is who. There are only 8 of us”*.
- 1.72 She also described the length of shifts she was doing to cover for illness *“I did stretches of 10-13 nights...I did a couple of shifts 17.00 to 08.30am to help the doctors 15 1/2 hours – never again”* We note that less than 2 months after she wrote this somewhat intemperate memo she took sick leave.
- 1.73 It is clear from the evidence we heard that Sister Grigg Booth was driven by the need to avoid calling junior doctors out unless she thought it absolutely necessary. She imposed the same demands on the NNP team. That sort

of attitude would have been of enormous help to managers who were trying to get more work done with fewer doctor hours.

- 1.74 After 1996 no one seems to have asked what the NNPs were doing, and how they were doing it ie there was no effective audit of their tasks or methods. In his interview with the police DM indicated that his role was managerial, not supervisory. That is not, we think, an answer to the failure to audit what the NNPs were doing.
- 1.75 The NNP job description was updated from time to time but it continued to include roles such as receiving verbal orders. By May 2002 it referred to the receipt of *verbal prescriptions for certain named medications and IV fluids; carry out limited nurse prescribing, in accordance with Trust policy; IV drug administration*.
- 1.76 We note that DN1 told the police *“there was never any mention of the Night Nurse Practitioners administering any drugs under any group protocols. Nurses were not allowed to prescribe drugs under any circumstances therefore the question of the Night Nurse Practitioners prescribing drugs never arose”*. We asked her about this. She said that at the time she spoke to the police she had not had the opportunity to refresh her memory from the documents. In particular she had not seen the NNP job description for many years, although she accepted she had seen it at some stage. The job description did refer to nurse prescribing. DN1 pointed out that at that time nurse prescribing was not allowed. Nurses were administering drugs. Whatever the precise position there is no doubt that the term *“prescribing”* was being widely used. We return to that later in this section.

Intravenous administration of Controlled Drugs

Generally

- 1.77 It was not unlawful per se for a nurse to administer a controlled drug intravenously. A controlled drug could only be administered if it had been prescribed by a doctor. It was for the doctor to prescribe the route of administration. Historically only doctors were permitted to administer drugs intravenously. Nurses were trained to administer drugs subcutaneously or intramuscularly.

- 1.78 With the expansion of nursing practice this changed during the 1990s in many hospitals. Policies were changed to permit nurses to administer certain drugs intravenously. Many nurses were trained to administer antibiotics intravenously. Some nurses were trained to administer opiate drugs intravenously in certain settings. The same was true of chemotherapy drugs. A nurse who administered an opiate without proper training and authorisation ran the risk of causing serious harm to a patient, and of criminal prosecution in addition to any professional sanctions.
- 1.79 There are particular advantages and dangers to the intravenous route; principally the speed of action of the drug. Whilst this is of enormous value when the purpose of the drug is to reduce pain, the side effects also occur quickly and the nurse has to know how to recognize those side effects, and how to deal with them, if necessary, quickly.
- 1.80 Nurses are required by their own code of conduct always to use their professional judgement when considering whether they are a) trained and b) competent to carry out any procedure. Thus NNP3 told us that although he/she had received training some years earlier in the intravenous administration of opiates he/she did not, in 1996, feel comfortable in carrying out that task until he/she had done so several times under supervision. Thereafter he/she considered him/herself competent to do so. (It was he/she who sought additional training from an external source in the giving of chemotherapy drugs. We return to that topic later).

Intravenous administration of Controlled Drugs Within Airedale NHS Trust

- 1.81 The Trust's "*Administration of Medicines*" document, produced in March 1995 and updated in 1998 was silent as to whether a nurse could administer controlled drugs intravenously. It directed readers to the Marsden Manual of Clinical Nursing Procedures on drug administration, which set out the legislation in some detail. When dealing with the intravenous administration of drugs it emphasized that a nurse should be qualified and have undergone a period of training and assessment in both theoretical knowledge and practical procedures involved in such drug administration.

- 1.82 There was a further Trust document dated September 1998, headed *"Protocol for Administration of Loading Doses of Morphine by a Patient-controlled Analgesia (PCA) or IV bolus by approved Anaesthetic/Recovery Nurse"*. This document makes it clear that only anaesthetic or recovery nurses who have undergone the Trust's IV training as well additional training and supervised practice and have full knowledge of the hospital protocol for the administration of intravenous drugs may administer IV morphine. The Sister who carried out this training said it was specific to the theatre department and no other nursing or medical staff from elsewhere in the hospital had ever attended this training, including NNPs. It is not apparent that this document was circulated beyond the nurses who were undergoing the training.
- 1.83 However other nurses were administering IV opiates in the ITU and Coronary Care Unit. It was generally understood they had been trained but there were no records of this and no protocol. The Nurse Consultant who arrived in December 2000 was surprised to discover this. She told DN1 and set about drafting a protocol to cover the situation. The protocol was not ratified until the end of December 2003 because it was not in the right format. In the mean time the practice continued in accordance with the training package and protocol devised by the Nurse Consultant. We are satisfied that those who underwent the training understood the scope of their practice. We observe that Sister Grigg Booth and the other NNPs were called to assist on the ITU from time to time. When being interviewed by the police, Sister Grigg Booth said that it was ridiculous to suggest that she, as the senior person on duty, was not permitted to administer opiates intravenously, when those for whom she was responsible were so permitted.
- 1.84 We saw and examined at some length a document dated November 2001. It is not clear why it was produced or to whom it was given. It is headed *"Nurse Administration of IV Drugs on Adult Wards"*. It says: *"The list of drugs that can be administered IV by nurses has been extended to include all drugs previously prescribed intravenously, provided that the individual nurse has satisfactorily completed the Trust's IV training course and feels competent to administer a prescribed drug."*

- 1.85 It then lists three exceptions where *“it is expected that specialist training would be required before nurses may administer these drugs: cytotoxic agents, intravenous opiate bolus doses, Dopamine and Dobutamide infusions.”*
- 1.86 A number of witnesses suggested that this document made it clear that specialist training was required. We disagree. If specialist training was mandatory the document should have made it crystal clear. However no one suggested that they had administered an opiate intravenously in reliance on this document. Its distribution seems to have been rather patchy. Several of those who remembered it said that they knew that nurses in ITU, Recovery, Coronary Care and NNPs could administer opiates intravenously. It does not seem to have reached the NNPs at all. At that time the NNPs were administering opiates intravenously.

Verbal Orders

- 1.87 Verbal Order is the term generally used to describe the practice of a doctor giving an instruction over the telephone to a nurse for the prescription of a drug which the nurse then obtains and administers in accordance with the instruction. Verbal Orders were a feature of many hospitals at night for many years. Change seems to have begun in the 1980s.
- 1.88 The Trust had produced a document in about 1995 and updated in 1998, *“Nursing Guidelines policy: Administration of Medicines”*. It dealt in particular with telephone prescribing of medicines at section 2 and says this:
- 2.1. *“The practice of prescribing medicines over the telephone is discouraged.*
 - 2.2. *If a patient's life is at risk, or he or she has severe symptoms, a doctor may prescribe medicines by means of a verbal message to a registered nurse or midwife.*
 - 2.3. *Controlled drugs may not be prescribed by this method except in the community.*

2.4. *When taking a verbal message, the nurse should repeat the instruction back to the doctor and have him or her confirm that the message has been received correctly."*

There is then a section for hospitals:

2.5. *"The nurse must record the verbal instruction in the nursing records and the administration of the medicine in the once-only section of the prescription chart. He or she should ensure that the latter is countersigned by the doctor within 12 hours. Where the administering nurse completes her shift before a countersignature can be achieved, this becomes the responsibility of the nurse taking over the care of the patient."*

1.89 Most of the witnesses who attended at the Inquiry were asked whether they had seen this document. Most had no memory of ever seeing it. A minority believed they had seen it, or something like it. Some nurses said they knew they were not permitted to take verbal orders. Many believed that verbal orders were permitted, particularly at night. A number of consultants were very clear that they were not permitted, an equal number were equally clear that they were, that they had given them for years. Even the Senior Nurse Clinical Governance (whose role we consider later in the report) had not seen this document until she began working on the investigation.

1.90 Irrespective of these guidance documents we are quite sure that verbal orders were being given to NNPs who acted upon them well into 2001, sometimes in an emergency, but not always.

1.91 On 9th April 2001, DN1 received a letter from the regional nurse prescribing facilitator, which said: *"I have become aware of instances where nurses appear to be acting on telephone instructions to administer a previously unprescribed substance and to change medicine dosages. As a result of this, I would like to bring to your attention the most recent guidance from the UKCC."* That was a reference to the October 2000 guidelines for the administration of medicines. She quoted this:

"Instruction by telephone to a practitioner to administer a previously unprescribed substance is not acceptable. In exceptional circumstances, where the medication has been previously prescribed and the prescriber is

unable to issue a new prescription, but where changes to the dose are considered necessary, the use of information technology such as fax or e-mail is a preferred method. This should be followed up by a new prescription confirming the changes within a given time period. The UKCC suggests a maximum of 24 hours.”

- 1.92 This was discussed at a clinical leaders meeting. The Senior Nurse Practice Development said she would deal with it. Her work in that regard was combined with work in respect of nurse prescribing (see below from paragraph 1.95).

Nurse prescribing

Generally

- 1.93 The position now is very different from that which pertained between 2000 and 2002. Nurses who have been appropriately trained and assessed are permitted, within the scope of their practice, to prescribe from the British National Formulary. For some nurses working in palliative care this includes prescribing opiates. That was not the position 10 years ago. Controlled drugs, which included opiates, could be prescribed only by a doctor. It was unlawful for a nurse to prescribe a controlled drug during the years 2000-2002. We are quite sure that all the NNPs knew that. Indeed none of them has ever suggested otherwise.
- 1.94 In 1989 June Crown and others produced a report on behalf of the Department of Health (the first Crown Report). It recommended extending the role of nurses to include prescribing. No legislative changes were made at that time.
- 1.95 In the early 1990s, many hospitals drafted “*group protocols*” which the hospitals considered permitted nurses to administer medication from an authorised list without an individual doctor’s prescription for the individual patient. The legality of this practice was questionable and it was further considered in the second Crown review between 1997 and 1999.

Nurse prescribing Within Airedale

- 1.96 There was in existence in the early 1990s a list of medication, named after DN1's predecessor. It was described as "*drugs given within the directorates*". Its status is not entirely clear but it was a list of medication which certain nurses, including senior night staff, could administer without an individual doctor's prescription. DN1 believed it had never been used much. Others witnesses, including the Chief Pharmacist, were clear that it had been in use for years. It did not include opiates. A number of witnesses seemed to understand that when nurses administered drugs from this list they were also prescribing. This may well be where the notion of "*limited prescribing*", referred to in the NNP job description, came from. Whatever its origins there was a belief within the Trust among nursing and medical staff that nurses were permitted to prescribe certain drugs in certain situations.
- 1.97 On 30th June 1998, DN1 sent a memo to DM and others about the second Crown Report. This recommended that Patient Group Protocols should comply with a specified guidance framework. It defined Patient Group Protocols thus "*a specific written instruction for the supply or administration of named medicines in an identified clinical situation. It is drawn up locally by doctors, pharmacists and other appropriate professionals and approved by the employer, advised by the relevant professional advisory committees. It applies to groups of patients or other service users who may not be individually identified before presentation for treatment*". The writers of the report observed that group protocols were already widespread in the NHS. The legality of such arrangements had been called into question and some arrangements fell short of the standards required to ensure safe clinical practice.
- 1.98 What was being considered for inclusion in Patient Group Protocols were simple linctus, normal saline, GTN spray, salbutamol, nebulisers and paracetamol. DN1 had worked with the Chief Pharmacist and agreed guidelines for the production of protocols which met the new guidance. Her memo said "*Please identify all areas in your Directorate that are operating to group protocols. There is some urgency to doing this work, because we are presently operating outside of the Medicines Act.*" – i.e. current practice is unlawful. So far as we can tell this memo was ignored. Over a year

later, in September 1999, DM sent a chasing memo to a number of senior nurses and managers, including the then NNP manager, NNP Manager 1, and Sister Grigg Booth, asking for those “*group protocols concerning nurse and blanket prescribing*” that DN1 had requested a year previously.

- 1.99 In 2000 a legislative change introduced the term Patient Group Directive in place of Group Protocol. There were further requirements to ensure that such directives complied with the law. The details are not material here.
- 1.100 As described above at paragraph 1.89, in April 2001 DN1 received a memo from the regional nurse prescribing facilitator. The Senior Nurse Practice Development took responsibility for dealing with it.
- 1.101 A few weeks later, on 23rd April 2001, NNP Manager 1, sent a letter to Sister Grigg Booth and all the other NNPs headed “*Nurse Prescribing at Night*” saying this: “*It has come to my attention that there appear to be some irregularities involved with nurse prescribing of drugs at night. Until these current issues are resolved, all nurse prescribing at night must cease immediately. To assist me with these investigations, I need you to furnish me with copies of all the drugs you have prescribed at night and your supporting information, i.e. lists, protocols and guidelines.*”
- 1.102 There then followed a meeting between Sister Grigg Booth, NNP Manager 1 and the Senior Nurse Practice Development. (We observe in parenthesis that she told us her interventions were not always welcome. Having reviewed the NNP diaries she was clearly right about that. We suspect the NNPs resented her).
- 1.103 On 30th April 2001, NNP Manager 1 sent a memo to Sister Grigg Booth, which was copied to DM, headed “*Re Nurse Prescribing*”. He said this: “*Thanks for meeting with me and [the Senior Nurse Practice Development]. You realised how important and urgent it was and that we needed to address with some speed these issues concerning NNPs and their prescribing of drugs.*”

1.104 He highlighted the following issues:

- *"NNPs appear to be prescribing a range of medication for which we do not have any protocols written.*
- *Some verbal order prescriptions from doctors have not been countersigned, and/or have been written in the "to be given when necessary (PRN)" section of the drug sheet, leading to confusion.*
- *Generally there appears to be a lax attitude towards the role of nurse prescribing at night."*

1.105 He went on, *"I explained to you that nurse prescribing other than small exceptions is still illegal under the Medicines Act 1968. This has been reviewed under the Crown Report March 1999 and further clarification made under the Patient Group Directive, a copy of which [the Senior Nurse for Practice Development] gave you for future reference and reading."*

1.106 He then referred to his earlier letter stopping verbal orders and then a subsequent letter clarifying the procedure for verbal order drugs and the process for record-keeping. The letter also clarified the position when there was a cardiac arrest in relation to the administration of drugs by staff who were advanced life support trained - referred to as ALS providers.

1.107 He also said this: *"The final issue we discussed at the meeting was around the use of a GTN infusion, the details of which I am still waiting for from the staff on Ward 2. At this stage, it appears to be another example of poor practice of verbal orders from doctors, which we have already discussed."*

Letter sent by Sister Grigg Booth to DM, 22nd May 2001

1.108 This letter is one of the most revealing documents amongst the thousands we have read. It was sent in response to the letter from NNP Manager 1 but was sent directly to DM. It was typical of Sister Grigg Booth that she went over the head of her line manager to DM. When talking about nurse prescribing she says:

"I am aware about NNP3 and the GTN infusion on Ward 2. I have heard of

pethidine being given IV on one of the wards downstairs. I am checking the DDA books" – presumably a reference to the Controlled Drugs Books. She went on "NNPX does not prescribe anything because [he/she] tells the wards to phone the doctors! [An evening practitioner] does not prescribe. [Another evening practitioner] will prescribe paracetamol for fever, but the doctor sees the patient and countersigns. NNP4 and myself work the same way. In fact, both you and DN1 have been with us and helped us when patients have collapsed. I appreciate in an emergency we are covered by ALS, but, even so, a doctor is quickly summoned to the wards. DN1 helped with a patient who was given a small dose of diamorphine and Frusemide for left ventricular failure and that was a verbal order from a doctor. That was by NNP4 . The doctor then refused to come to the ward, but that was sorted out!!"

She then goes on to say: **"DDA", controlled drugs, "very cautious. I find one small dose of pethidine in the night works well. It is written on the front of the script and signed by the doctor who is contacted anyway. I can honestly say I have given it a handful of times this year and NNP4 less so."** (our emphasis)

1.109 She then talks about how another NNP, who had asked a doctor to come to the ward to prescribe diamorphine, had initially refused and said "Get NNP3 [he/she] will do it", but she pointed out the NNP refused and the doctor eventually came to the ward.

1.110 Whatever may have gone before, here was Sister Grigg Booth setting out enough detail of unlawful practice to merit an immediate inquiry and action by the service manager (DM). He responded to Sister Grigg Booth that same night:

"There are a number of issues here. I would prefer to meet with you to discuss them. I'll ask the new NNP manager (NNP Manager 2) to attend as well, owing to a change of line management. I'll arrange for NNP Manager 2 and I to come and see you when he gets back from leave"

1.111 He noted this:

"The issues seem to be:

- (a) *Clinical leader role and representation.*
- (b) *NNP3 working outside protocols.*
- (c) *Developing Crown Report proformas for drugs you prescribe and administer." (Note the use of "prescribe".)*
- (d) *Staff absence/sickness*

This was quite an understatement. There is no reference at all to *"a little dose of pethidine"*. When he was interviewed about this by the police DM said that he had understood this to be a reference to verbal orders for pethidine, not a prescription by Sister Grigg Booth. We are not convinced that the words can bear that interpretation, but even if that were DM's understanding he simply accepted without challenge the use of verbal orders for an opiate. When asked by the police about verbal orders he said *"you have to decide as a nurse whether you are happy doing what the doctor has asked of you and if not, saying so."* When asked whether NNPs would give IV opiates in any circumstances, he said, *"I personally wouldn't but I can't vouch for their professional judgment given the set of circumstances"*. He told the police that he had no knowledge of them giving patients intravenous drugs. Presumably he had forgotten the pilot study forms. We should add that DM denied that he was aware that nurses were prescribing opiate drugs at night.

1.112 On DM's copy of the letter he directs that it be given to NNP Manager 2, presumably to inform him of the subject of the proposed meeting. Sister Grigg Booth replied to the letter on 24th May 2001. She began her letter by saying *"Thank you for your letter and a quick reply, it is much appreciated. I felt better just reading it."* She goes on to explain that she will be away until 8th June but that she would happily stay on at the end of a shift after that for a meeting.

1.113 There is no record of any meeting taking place. NNP manager 2 did not recall that it happened, nor did he recall being given the letter. DN1 was not

asked for her views on what was being said. Indeed DN1 was not told about this apparent breach of professional conduct at all. We deal with the detail, of her apparent involvement in the incident described in the letter, later.

1.114 Here was a clear opportunity to review the NNPs' practice, focused directly on the prescription and administration of opiates, amongst other matters. Another opportunity was lost to identify poor practice and correct it. It meant, inevitably, that Sister Grigg Booth and others believed that they were permitted to act outside the rules when, in their judgment, circumstances at night required them to do so.

1.115 NNP manager 2 took over line management responsibility from NNP manager 1 in May 2001. NNP Manager 2 did nothing to follow up the work done by his predecessor with regard to NNP prescribing. This was a significant failure. It formed part of the Trust case against him when he was disciplined in 2004.

1.116 On 7th June 2001 The Senior Nurse Practice Development reiterated to the ward and department managers by way of a memo:

"We can no longer accept verbal orders over the telephone for previously unprescribed drugs. Please inform all concerned."

She enclosed with the memo a copy of the UKCC guidance re verbal prescriptions from 2000 that had previously been sent by the Regional Nurse to all the directors of nursing in April of that year, to which we refer above.

1.117 NNP3 raised the issue of verbal orders at a clinical leaders' meeting in July 2001. According to the note of the meeting he/she said,

"As it is no longer acceptable to receive a verbal telephone order from a doctor, problems have arisen in medication being prescribed."

1.118 The note continues:

"a possible solution could be sending a prescription change via the pod system from the doctor. It was highlighted that the medical doctor only

stays on duty until 22.00 at the weekends. This time is unsuitable for wards, as jobs for the doctors are not always identified at this time." The note continues "[The Senior Nurse Practice Development] *will speak to [the consultant responsible for the junior doctors]*". The NNP daily diaries reflect a certain amount of frustration amongst the NNPs at the directives coming at them and, as they saw it, interfering with their ability to work.

- 1.119 In April 2002, at a Grade D nurses focus group a query was raised about whether or not NNPs had to administer a drug prescribed via a Patient Group protocol. There is a note in the ward minutes regarding nurse prescribing on 7th May 2002 indicating that NNP manager 2 had written to all practitioners to remind them of the agreed protocol.
- 1.120 On 24th May 2002, Sister Grigg Booth, in a memo to the Junior Doctors Project Officer, recorded the drugs that NNPs could prescribe. In that document she simply listed those referred to already under the Patient Group protocol. She made no reference to the prescription of controlled drugs. As we said earlier we are quite sure that none of the NNPs ever thought they were permitted to prescribe controlled drugs.
- 1.121 For many years junior doctors who attended induction days at Airedale were provided with a booklet, "*A Guide for Staff who Work at Night*". It was written by Sister Grigg Booth with some assistance from NNP4. It was on the wards until the middle of 2004 when it was drawn to DN2's attention. She had it removed from all wards.
- 1.122 The document explains in general and practical terms the roles and responsibilities of the night staff. "*Our main role is the assessment and care of acute admissions and ill patients. We will initiate emergency treatment of a patient whilst medical aid is being summoned*" – we note, in passing, that the NNP diaries record many crash calls at which the NNPs assisted.
- 1.123 The document goes on "*We endeavour to work with the medical staff and the ward staff to deliver efficient patient care. One of our aims has always been to allow medical staff to have undisturbed sleep whenever possible. We screen all requests for doctors from ward staff. We have in the past had a variety of skills; depending upon the areas we have worked in, but have undergone further training to enhance our skills to ensure that we are all working to the same guidelines. Some of this training was implemented*

*to assist in the “reduction of junior doctors working hours” and has enabled us to perform extra practical skills”. The document ends thus “A point worth remembering; we are all primarily senior clinical nurses. We are guided by our own professional codes of conduct and it is within our rights to refuse to do anything we are not happy about. **There are many occasions when we 'cross the fine line or grey area' between nursing and medical duties, but will only do so in the interests of effective patient care**” (our emphasis).*

- 1.124 It is on this “grey area”, in a hospital working at night, that much of our Inquiry has been focused.

CHAPTER 2

THE INCIDENTS

TERMS OF REFERENCE 1

To establish the facts, by reference to documentary evidence and interview, in each of the 17 incidents that were the subject of criminal charges against Mrs Anne Grigg Booth, and any other incidents of a serious nature that come to light during the Inquiry.

- In coming to conclusions under this heading we have reviewed medical records, read statements and heard evidence of fact from people involved at the time. From time to time signatures were not easy to read. There is (as always in our experience) inconsistency between practitioners as to whether the time recorded on a note is the time the note was written (either when it was started or finished) or the time of the beginning of the events being recorded. Sometimes timings were wholly absent. Overall however we considered that the medical records and Controlled Drugs books were sufficiently well kept to allow us to come to conclusions with reasonable confidence.
- **Professor Forrest**

We also had the considerable benefit of the evidence of Professor Forrest, former Professor of Forensic Toxicology at the University of Sheffield. He provided detailed help in respect of reports he had written on behalf of the police. He assisted us with the interpretation of the records, and with his views on causation. Professor Forrest has a particular interest in health care professionals who cause harm and is highly experienced in that field of investigation. We accept his view, having reviewed the evidence, that Sister Grigg Booth was no Beverly Allitt.

She undoubtedly acted unlawfully on many occasions, and in breach of the rules on many other occasions as we shall set out but she recorded in detail almost everything she did, her conduct was almost always entirely open, as our examination of the evidence reveals below.

- We have read the 45 police interviews carried out over more than 12 months with Sister Grigg Booth. In some of the interviews she was very clear, in others her evidence was very difficult to follow. We have pieced together what she might have said to us from her interviews and contemporaneous documents.
- As we were completing our report we were provided by Sister Grigg Booth's former solicitor reports prepared for her defence from Dr (now Professor) Ferner, Consultant Physician and Clinical Pharmacologist. He too is a toxicologist. His reports were also of great assistance. It was unfortunate that given the time at which they arrived (end February 2010) and the need to complete the report within a reasonable time, we were not able arrange to meet Dr Ferner but we have taken account of his reports. We have done our best to come to reasoned conclusions on the basis of all the evidence. Often the experts are not very far apart.
- All the incidents upon which we report are referred to in the detailed chronology at Appendix 2. For ease of reference we deal with the incidents in respect of each individual NNP separately, and in chronological order. Although the first incident within the period 2000 - 2002 concerns a different NNP we begin with Sister Grigg Booth, since there are a greater number of incidents to consider in her case. We deal in detail with the incidents that led to criminal charges, as required by our Terms of Reference. However there are many other examples of Sister Grigg Booth acting outside the official hospital policy. The incidents are very similar to the ones we have considered in detail. We are quite satisfied that the incidents we describe accurately reflect Sister Grigg Booth's conduct at the material time, and probably before that too.
- We have scrutinised 16 out of the 17 incidents. As explained in Chapter 1 the next of kin of one patient requested that the patient's case be omitted from our Inquiry. For the reasons given at paragraph 1.19 above we have agreed to that.
- All patients have been assigned initials to protect their identity.

June 2000

HS

- 2.1 HS was born on 22nd November 1938. Her death was unconnected with the events at Airedale which we are investigating. She was admitted to Airedale on 15th June 2000. She was suffering from lower abdominal pain and weight loss. Sadly she was diagnosed with bowel cancer on 23rd June. On 24th June surgery was carried out. The cancer had spread. HS remained in hospital. On 29th June she was admitted to Ward 13. The records show that she was in severe pain. According to the nursing Kardex a nurse bleeped the night sister *“and verbal message taken to give IM pethidine 50 milligrams. Given at 1.40.”* It seems clear that Sister Grigg Booth **issued** a verbal order over the telephone. In other words she was acting as a doctor might have done. The Nurse carried it out. According to the Controlled Drugs book for the ward two nurses were responsible for removing the drug from the cupboard, in accordance with the proper procedure. One administered the drug, the other witnessed it. The Nurse witness told the police that it was his usual practice to check the prescription before removing drugs from the controlled drugs cupboard. On this occasion it is clear that there was no written prescription at that time. Sister Grigg Booth must have signed it later on. The Nurse signed the chart to record that she had administered the drug.
- 2.2 A few hours later, at 04.20 the records state the patient was again complaining of pain *“Night sister was bleeped and said to give IM pethidine 50mg, given to patient with effect. Settled and slept for periods.”*
- 2.3 In the event HS recovered sufficiently to go home on the 5th July 2000. Professor Forrest was asked about the prescription of Pethidine. He said there was nothing in the notes to suggest that HS had come to any harm as a result of having it administered to him. His concern was that a nurse had prescribed it, not a doctor, and that she had done so over the phone without seeing the patient. He pointed out that there may have been something sinister about the pain, since it occurred several days post operatively. Administering a powerful painkiller could mask, say, an infection. In the event it did not.

- 2.4 When Sister Grigg Booth was interviewed about this on 14th May 2004 (i.e. some 4 years after the event) she could not remember whether or not she had seen the patient. Given the other evidence we think it likely that she had not. She said that she must have been with a doctor when she gave the prescription. This is unlikely. Had she been with a doctor presumably the doctor could have given the prescription over the phone, rather than Sister Grigg Booth. He or she would have signed the prescription chart later on, not Sister Grigg Booth. Sister Grigg Booth may have been acting from the best of motives (ie to relieve the patient's pain without disturbing a doctor) but it is inescapable that she prescribed an opiate over the phone without seeing the patient. What she did was unprofessional and unlawful. The effect of the drug was to reduce HS' pain. As Professor Forrest said, the patient came to no harm as a result of this treatment.
- 2.5 In respect of her treatment of this patient Sister Grigg Booth was charged with administering a noxious substance with intent to cause grievous bodily harm, or harm.

July 2000

KP

- 2.6 KP was born on 20.11.71. She was admitted to Airedale on 12 July 2000 via her GP. She arrived with her 9 week old baby who she was breastfeeding. KP had an extremely painful abscess. She was admitted to Ward 13 and then taken to theatre. The abscess was drained but the patient continued to suffer great pain. Initially the pharmacist advised morphine at dressing change but otherwise regular tramadol which was suitable while breast feeding. Unfortunately this was nothing like adequate. The acute pain team were called. The Clinical Nurse Specialist for Acute Pain attended. She examined KP and discussed the case with the consultant anaesthetist. The anaesthetist visited the patient and advised in person. She advised the nursing staff in very clear terms (and in capital letters) that their patient needed regular oral medication with morphine IM *"TO BE USED IN ADDITION IF ORAL MEDICATIONS ARE NOT ENOUGH". "I HAVE JUST GIVEN HER 20MG iv AND SHE IS STILL USING n2O/O2."* The anaesthetist made it very clear what level of pain KP was then complaining of. She was surprised by the degree of pain and asked for a further review to make sure there was not another problem.

- 2.7 In the days that followed pain remained a very real problem for KP. On the 18th July she was given a patient controlled analgesia pump (a PCA pump) through which she could administer morphine.
- 2.8 On the 20th the Nurse Specialist for Acute Pain saw her again. She noted (amongst other things) patient in pain ++ at time of visit. Bolus dose of morphine given via PCA pump. She then records blood pressure and respirations *"Sleepy therefore no further dose given. Review tomorrow"*.
- 2.9 At 04.00 the following morning KP was in pain again. The night staff called Sister Grigg Booth. She attended and recorded what she did in the clinical records thus *"ATSP [asked to see patient]. Pain relief inadequate. Patient in tears. PCAS being used. DF 118 30mgs given earlier. No effect. Bolus IV morphine 10mg given with good effect until 05.00 when tears again. Explained difficulty with breast feeding and too much analgesia. She said it was taking the edge off"*.
- 2.10 On the prescription chart Sister Grigg Booth has signed the once only section; her initials appear in the prescription and *"given"* sections of the chart. She has recorded the time at 04.30. The prescription of morphine was unlawful and potentially dangerous. Given that earlier a dose of 2.5mg had made the patient sleepy and lowered her respiration rate Professor Forrest considered the administration of 10mg as *"something that could be regarded as reckless"*
- 2.11 At 09.00 the same morning the Nurse Specialist for Acute Pain recorded the Acute Pain Team Review. The record follows on the same page as and immediately after Sister Grigg Booth's entry which we set out above.
- 2.12 Her entry starts thus *"Poor night requiring morphine bolus as above"*. The Nurse Specialist had obviously read Sister Grigg Booth's entry which shows that Sister Grigg Booth had administered an IV bolus of morphine. When asked about this the Nurse Specialist for Acute Pain said that the fact that Sister Grigg Booth had recorded *"Bolus IV morphine 10mg given with good effect"* did not mean that Sister Grigg Booth had given the morphine. It might have been given by the anaesthetist. This is unlikely given that there was no record anywhere of an anaesthetist being called or attending. It appears to us from having read many sets of notes that this was the

conventional way of recording actions taken by the writer of the note, often a nurse. The Nurse Specialist recorded her own actions in the same way.

2.13 The Nurse Specialist was asked about the prescription chart. She said she might not have seen it if it was with the pharmacist. We are surprised that an effective review of medication could take place in the absence of the prescription chart.

2.14 We make it absolutely clear that we accept entirely that it did not cross the Nurse Specialist's mind that Sister Grigg Booth had prescribed an opiate or administered it intravenously. The point is that every piece of information that was required to put her on notice was there. We say this not to criticise the Nurse Specialist, but rather to demonstrate that Sister Grigg Booth was entirely open and clear in her recording. She was not challenged and so, as she did in due course to the police, she was able to say that no one had complained when she was carrying out these activities. It is an example of the way that professionals assume that those around them are also behaving correctly, particularly if they have a good opinion of them. The Nurse Specialist had already told us that she considered Sister Grigg Booth a good and caring nurse, good fun to work with and reliable. That would have led her, no doubt, to trust that she was working within the law and procedures as well as in the best interests of her patients.

2.15 In respect of this incident Sister Grigg Booth was charged with administering a noxious substance (morphine) with intent to cause grievous bodily harm or harm.

2.16 There is a record of a further administration of morphine to this patient by Sister Grigg Booth on 24th July 2000 although the records are not entirely clear. It was Sister Grigg Booth's account that if she did administer the morphine she did so to reduce KP's pain. Plainly if Sister Grigg Booth prescribed morphine, again she was acting unlawfully. She could have put the patient's life at risk, as Professor Forrest said.

2.17 Sister Grigg Booth was charged with a second offence of administering a noxious substance (morphine) with intent to cause grievous bodily harm or harm to the same patient.

- 2.18 KP did eventually recover from her extremely painful condition. Sister Grigg Booth's actions seemed to be consistent with a desire to relieve pain. They were nonetheless illegal and dangerous. She should have called the anaesthetist. The consultant anaesthetist said that in her opinion Sister Grigg Booth would never maliciously harm a patient, but it was more likely that a lack of appropriate training led her to make bad judgements.

July 2000

BY

- 2.19 BY was born on 1st June 1933. She was a retired nursing sister. She was admitted to Airedale on 25th June 2000. Her daughter was also a nurse. BY was suffering from a very painful infected right hip replacement. She was admitted to Ward 10 and on the 26th June the infected hip replacement was removed under general anaesthetic. The plan thereafter was to allow her to recover from the infection before inserting a further replacement. Her recovery seemed uneventful. As at 19.30 on the evening of 23rd July 2000 a Staff Nurse assessed BY as independent, with no complaints.
- 2.20 Not much more than an hour later nursing staff noticed that BY was very unwell indeed. The Staff Nurse said in her police statement *"so much so that I felt the need to call for the Night Sister"*. Another Staff Nurse who works permanent nights recalled that she called for Sister Grigg Booth because she was concerned that BY was very unresponsive. The Staff Nurse assessed her according to the Glasgow Coma Scale (GCS – a method of assessing the functioning of very ill patients). The score was 3/15, an extremely low figure. She recalled that Sister Grigg Booth and NNP4 attended. The medical note that evening was completed by Sister Grigg Booth and timed at 20.45 on 23rd July 2000. It records that an examination was carried out, a venflon was sited and they took blood. As the first Staff Nurse observed *"I was more than happy to leave the patient under the care of Sister Grigg Booth who I would say was very good at her job and someone whom I had full trust in doing the job"*.
- 2.21 Sister Grigg Booth contacted the house officer. He attended. He assessed the GCS score at 5, ie a higher score indicating that in his view the patient was in a better condition than when previously assessed. He began resuscitation attempts. He was concerned that the patient had suffered a

stroke. He therefore called the medical registrar who attended. It was his impression that BY had suffered from a bleed in the brain. Later on a CT scan confirmed the presence of an acute subdural and possible intracerebral bleed. As Professor Forrest explained in his report for the police BY had been receiving treatment for atrial fibrillation over a long period. The therapy, warfarin, is effective in preventing the fatal complication of a blood clot forming. Unfortunately such treatment can be associated with excessive bleeding. It is his view that the bleeding that occurred on 23rd July 2000 was probably a complication of the warfarin therapy. Dr Ferner agreed with this analysis.

- 2.22 When the registrar examined BY he noted a slightly higher GCS score, at 6/15. He made the following entry in the medical notes *“For palliative care only. She would not benefit from CPR in the event of cardiac or respiratory arrest therefore not for 666 call.”*
- 2.23 It appears that in the early hours of the 24th July the registrar spoke to the neurosurgical team at Leeds General Infirmary and took advice. Manitol was prescribed but there was no improvement. In the early hours the Glasgow Coma Scale was recorded at 3/15. The Leeds neurosurgeons suggested another dose which, on the face of the records, was prescribed by Sister Grigg Booth but it produced no improvement. The registrar was contacted again and advised a further 100mls of Manitol and review in 1 hour *“If any improvement ... for transfer (intubated). Otherwise for TLC only”* – the entry is signed by the registrar. At 02.15 BY was reviewed. The Doctor’s note reads *“Reviewed. No change GCS (Glasgow Coma Scale 3/15. Pupils non reactive 5mm.)*
- 2.24 *P [plan] keep comfortable. Diamorphine PRN”* (i.e. as required). The doctor also records, and he and the patient’s daughter in their statements confirm, that the prognosis and management was explained to the patient’s daughter. She understood what was proposed and agreed with it. She was aware of the plan, subsequently abandoned, to transfer her mother to Leeds.
- 2.25 The patient’s daughter had been present with her mother from shortly after midnight on the 24th July. At around 04.00 the daughter became very distressed. Her mother was arching her body, she was unconscious. She was making a noise from the back of her throat. As the daughter said in her

second statement, although she knew what Cheyne-Stokes breathing was, she did not realise that was what she was observing, although she did understand that her mother was dying. She was distressed and called the nurses because she was alarmed and upset by the noise.

- 2.26 According to the Staff Nurse, Sister Grigg Booth was called and came to see the patient. The daughter remembers her being very reassuring. The Staff Nurse recalls that Sister Grigg Booth asked the patient's daughter whether she would like her to give BY something to make her more comfortable. She warned her that it may affect her breathing. According to the Staff Nurse the patient's daughter said she understood that, and the doctors had explained it to her. The patient's daughter makes no reference to that conversation in her police statements and we asked her about it when we were preparing the report. Of course the events are now over 7 years old. She does not recall the doctors explaining matters to her in the way the Staff Nurse suggested. She does recall Sister Grigg Booth offering to make her mother more comfortable. She did not appreciate what that might mean. She thought it might mean some sort of suction being applied.
- 2.27 We find that it is probable that Sister Grigg Booth offered to make the patient more comfortable and administered diamorphine intravenously. She did not record that in the medical records, nor on the drug chart. She should have done. The Staff Nurse recorded it in the nursing Kardex. The daughter noticed her mother becoming more relaxed and her breathing became very slow. Within minutes she had died. She rang the bell and Sister Grigg Booth came back, examined her mother and confirmed that she had died. The patient's daughter felt at the time that she and her mother had been very well looked after.
- 2.28 As Professor Forrest said in his statement *"the patient was clearly dying at the time the injection was given, but I do not believe she would have died at the time she died had she not been administered an injection of Diamorphine at the time she was."* In evidence to us he confirmed that he believed BY would have died within the hour, without the injection of diamorphine. Dr Ferner says that she may well have died at the same time without the administration of the diamorphine.

- 2.29 It appears to us that Sister Grigg Booth believed the patient to be in distress, she said so in interview. The records support her in that there is reference to the arching of her back and that she seemed to be choking. Professor Forrest said that because she was so profoundly unconscious BY would not have been experiencing distress at all. As another consultant at the hospital to whom we shall refer later, put it, it is impossible to know whether or not that is right. To the patient's daughter what she witnessed appeared to her, at the time, to be distress. Dr Ferner considered that it was appropriate to administer diamorphine to alleviate distress. The dose was a modest one.
- 2.30 It is likely that Sister Grigg Booth knew that to administer morphine at that stage would hasten death. At most she did so by one hour, probably less. At the same time she alleviated what appeared to be distress in a dying woman.
- 2.31 These facts formed the basis of a charge of murder against Sister Grigg Booth.

October 2000

PK

- 2.32 The Inquiry team were unable to trace this patient. We deal with the facts in outline only. The patient was a young woman admitted to hospital with acute abdominal pain requiring surgery. She was given a PCAS to administer small amounts of morphine. This was taken down a short time afterwards. Unfortunately the patient contracted an infection and became quite unwell. She had a very high temperature and had septicaemia. Sister Grigg Booth has recorded that she prescribed and administered 10 milligrams of morphine intramuscularly to help her settle.
- 2.33 Sister Grigg Booth was not qualified to prescribe morphine, as we have already established. We think it likely that she prescribed it to relieve agitation. As Professor Forrest says there was no evidence of any pain, although the patient was extremely unwell. In his view to prescribe morphine was wholly inappropriate. Sister Grigg Booth should have called the doctor. We agree. Fortunately the patient suffered no ill effects of the injection. This was an example of Sister Grigg Booth pushing her

knowledge beyond its limits, and acting unlawfully. What she did posed a clear risk to the patient.

- 2.34 Sister Grigg Booth was charged with administering a noxious substance (morphine) with intent to cause grievous bodily harm or harm.

November 2000

MN

- 2.35 The Inquiry team were unable to trace this patient. We deal with the facts in outline only. The patient was a young woman, admitted to hospital with acute lower abdominal pain. There were a number of possible causes. She was admitted to the hospital and the doctor who reviewed her prescribed 50 milligrams of pethidine via intramuscular injection together with a separate prescription for Stemetil, to stop vomiting. It is clear from the prescription chart that Sister Grigg Booth doubled the dose of pethidine from 50 to 100 milligrams and additionally prescribed Maxolon to relieve nausea. The prescription chart was then read by the Pharmacist who noted TDS (three times daily) on the Maxolon prescription. The Pharmacist presumably did not notice that the prescription had been written by a nurse. As we have noted elsewhere the pharmacy did not consider it their role to check signatures. They checked medication.
- 2.36 The prescription records show Sister Grigg Booth administering both Maxolon and pethidine, in accordance with her prescription in the early hours of the morning. Professor Forrest told us that, whilst no harm came to MN, Sister Grigg Booth should not have changed a doctor's prescription. We agree. She should have contacted the doctor so that he could change it. We believe that she justifiably considered herself competent to administer pethidine intravenously. She carried out the injections competently.
- 2.37 In due course she was charged with administering a noxious substance (pethidine) with intent to cause grievous bodily harm or harm.

February 2001

DW

- 2.38 DW was born on 24th April 1919. She was 81 years old. She had been bed bound for some time as a result of a stroke. She was living in a nursing home. On 12th February 2001 she was admitted to Airedale, suffering from abdominal pain. She was seen on Ward 15 by the Junior House Officer and she prescribed medication, including 2.5 milligrams of morphine to be administered no more than 4 hourly. At 03.15 a nurse administered 2.5mg morphine intramuscularly. Less than 2 hours later nursing staff noted that DW was clammy and distressed. Sister Grigg Booth was called to see her.
- 2.39 Sister Grigg Booth noted in the clinical records at 05.00 “ATSP [Asked to see patient]. *Blood pressure 60 over 30. Patient complaining of pain. Pale and sweaty.*” She gave a Gelofusine infusion and administered 50 milligrams of pethidine intramuscularly. There was no previous prescription for pethidine. The drug chart shows on the once only prescription section that 50 milligrams of pethidine IM was signed as being prescribed and given by Sister Grigg Booth at 05.15. At 7am Sister Grigg Booth wrote in the clinical records that the patient was feeling warmer and was now pain free. She also wrote “*Doctor aware*”. At 07.45 DW was seen by the consultant surgeon, on his ward round. She was very unwell indeed. He diagnosed a small bowel infarction. She was in sudden collapse and in his opinion she was unfit for surgery. He advised that she should not be resuscitated. DW’s daughter was informed of the very poor outlook. DW died that afternoon.
- 2.40 It is the view of the consultant surgeon and of Professor Forrest that at 5 o’clock in the morning a doctor should have been called. When interviewed about it Sister Grigg Booth agreed that a doctor should have been called. She was adamant that she had called one. She said that there was “*no way*” she would not have called a doctor with a patient who was that ill, who had collapsed and with a blood pressure like that. If that is true then it is most unfortunate that Sister Grigg Booth made no note of calling the doctor at that stage.

- 2.41 There is no record of anyone arriving, nor of any telephone conversation about the patient nor of a verbal order being given. The prescription was written by Sister Grigg Booth and there is no countersignature. Sister Grigg Booth said that the doctor probably forgot to countersign the form. Whilst we cannot rule that out completely, given what we know about verbal orders in the hospital generally, we think it more likely that Sister Grigg Booth took charge of the situation at 05.00 and did not call a doctor. It was plainly an emergency and no doubt she believed she was equal to the task. She asserted in interview that pethidine was better than morphine because it would not have such a dramatic effect on blood pressure. That rather suggests that she had thought about which drug was appropriate.
- 2.42 We have no doubt that Sister Grigg Booth knew that she was not entitled to prescribe pethidine but considered that she was competent to do so. The Junior House Officer who was on duty that night had no memory of being called out, and having seen her notes of her earlier dealings with the patient we are confident that she would have made a record had she attended. The SHO at that time said to the police that had he been called his management would have been different, but he was unable to elaborate on that, perhaps unsurprisingly so long after the event.
- 2.43 The Consultant Surgeon who gave statements to the police and provided further information to the Panel, said that pethidine should not have been administered because morphine had been given only 2 hours earlier. He saw the patient at 07.45. It was his normal practice to read the clinical records. He would therefore have seen the administration of the pethidine. The fact that Sister Grigg Booth prescribed it does not appear there; it appears on the prescription chart. The fact that morphine had previously been administered was recorded in the nursing Kardex only. The Consultant Surgeon told us he would not routinely review a prescription chart unless he was intending to change the medication, nor would he have looked at the Kardex. Thus although Sister Grigg Booth recorded her actions no one put the available information together to see that she had:
- a) prescribed pethidine, which was unlawful; and
 - b) administered pethidine within 2 hours of a morphine injection.

- 2.44 The Consultant Surgeon knew that nurses were not permitted to prescribe opiates. We are confident that, had he realised that was what Sister Grigg Booth had done, he would have acted upon it. As it was, as so often, the information on the documents was not put together and so the obvious conclusions were not drawn.
- 2.45 It was Professor Forrest's initial view that pethidine was the appropriate drug, although of course Sister Grigg Booth should not have been prescribing it. Later on he wrote a further report in which he criticised the doctor. He said that morphine should not have been prescribed in the first place. He also criticised Sister Grigg Booth's actions and went on to say that because no post mortem was performed it was difficult to come to a firm conclusion about the cause of death. If the Consultant Surgeon's diagnosis was correct then it was unlikely that Sister Grigg Booth's actions made a significant contribution to the mechanism of death. Whilst other diagnoses may well be possible, as Professor Forrest identified, we see no reason to doubt the Consultant Surgeon's opinion. He was the treating doctor.
- 2.46 When interviewed about this patient Sister Grigg Booth was adamant that she was allowed to prescribe and give opiates in an emergency and on a verbal order. She said she would have been authorised by the doctors who were on the ward at the time. None of the doctors recalled that 2 years later when the police asked about it. Sister Grigg Booth reminded the police that she had attended the advanced life support course. In her view the patient was obviously nearly dying and she would have died without the emergency treatment. She gave it because this was an emergency.
- 2.47 She asserted that the fact that she had written "*Doctor aware*" in the notes suggests that she had discussed the patient with a doctor. That may well be right and her note was there to be seen by any doctor who subsequently read the notes, but it relates to her management at 07.00, not at 05.00. She may well have spoken to a doctor at 07.00 about her earlier management of the patient, but we do not accept that she spoke to a doctor at 05.00. Indeed her insistence that she was allowed to prescribe and give opiates in an emergency and on a verbal order rather supports our view that she was responding to an emergency and just got on with it.

- 2.48 We note the difference between what Sister Grigg Booth said in respect of this emergency, as she characterised it, and the one involving another patient which occurred 17 months later. On that occasion she said she had acted in a particular way because it was an emergency, even though she knew she should not have done it.
- 2.49 Sister Grigg Booth was charged with administering a noxious substance (pethidine) with intent to cause grievous bodily harm or harm.

June 2001

JQ

- 2.50 JQ was born on 28th September 1921. He died in late 2001, not long after his eightieth birthday. His death was unrelated to the events we are considering. He was suffering from lung cancer, severe emphysema and other conditions.
- 2.51 On 4th June 2001 he fell while out walking his dog. He was taken by ambulance to Airedale. In the A&E department a diagnosis was made of a fractured neck of femur in the right hip. According to his daughter JQ remained in the A&E department until about midnight when he was moved to the orthopaedic ward. He was in pain in casualty and 10 milligrams of morphine were prescribed by a doctor.
- 2.52 Once on the ward a further 10mg of morphine was prescribed. The prescription reads 10 mg IV/IM. At 04.30 a nurse administered 10 mg morphine intramuscularly in accordance with the prescription. During the 5th June, JQ's daughter was not happy with the way her father was being cared for and asked for him to be transferred to the private ward. He was transferred to Ward 19 that afternoon (ie on the 5th June). That evening his daughter was very concerned. Her father was upset, agitated and in a lot of pain. The nurses called Sister Grigg Booth who attended.
- 2.53 The patient's daughter recalls that Sister Grigg Booth had a very confident attitude. She assessed JQ and told her she would give him something to calm him down and help him to have a good night's sleep. She put a cannula into JQ's left hand and inserted a syringe. JQ's daughter remembers Sister Grigg Booth saying that she was not doing things in an

orthodox way. The Staff Nurse recorded in the nursing Kardex *“Maxolon and paracetamol were administered. No effect on pain, so called Anne Grigg Booth. Anne Grigg Booth resited the venflon to the hand and administered morphine 7.5mg IV (given slowly) to relieve patient’s pain”*. She noted that the patient’s respirations were not compromised. JQ was checked and was noted to be comfortable.

2.54 Professor Forrest takes issue with the assertion that JQ’s respirations were not compromised. He says they were not properly recorded and by the time they were, many hours later, there is some evidence that at that stage JQ’s breathing was compromised. We remind ourselves that JQ had very serious lung disease and on the evidence it appears that after the morphine was administered he settled and was able to get some rest. We remind ourselves that the prescription was that of a doctor, not Sister Grigg Booth.

2.55 The issue here was whether she should have administered the drug intravenously. Sister Grigg Booth was unshakeable in her view that she was entitled to administer opiates intravenously. The consultant said *“In relation to the intravenous administration of a controlled drug by a senior nurse rather than a medical practitioner, at the time of the incident I would not have been surprised or concerned that a very senior night nurse was allowed to administer intravenous opiates which had been properly prescribed by a doctor for an appropriate indication. It was my understanding at the time that this practice occurred in a variety of different hospital settings (ITU/CCU etc) and that it might not have been practicable for on call members of the junior medical staff to administer all doses of intravenous opiates throughout the hospital in addition to all their other emergency duties. I was not aware of any Trust policy covering the administration of opiates by non-medical practitioners, for example whether certain groups of trained nursing staff were permitted to administer opiates, and by which route they were allowed to administer them. I would have expected a senior nurse to know whether he or she was permitted to administer these drugs”*.

2.56 For the reasons we set out in detail elsewhere we are satisfied that Sister Grigg Booth reasonably believed that she was entitled to administer opiates intravenously.

- 2.57 In respect of this patient Sister Grigg Booth was charged with administering a noxious substance (morphine) with intent to cause grievous bodily harm or harm.
- 2.58 The following day the consultant orthopaedic surgeon carried out a hip replacement. This was carried out under epidural anaesthetic, because of the risks of a general anaesthetic to a patient with very serious lung disease. JQ remained in hospital. On 18th June Sister Grigg Booth was called to see him at 03.35. He was having difficulty breathing, despite the use of oxygen, wheals had appeared all over his shoulders and down the upper arms. Sister Grigg Booth attended. According to the nursing notes, *“Sister contacted Dr T, SHO surgery, and she gave adrenalin. 1mg IM and Piriton 10mg IM.”* Sister Grigg Booth’s note reads *“ATSP [asked to see patient] urgently. Anaphalaxis (sic). Query, to what? On examination patient extremely breathless and wheals over shoulder and chest. Adrenalin 1 mg IM given and Piriton. Spoke to Dr. Stayed with patient. Blisters disappearing.”*
- 2.59 There is no doubt that Sister Grigg Booth spoke to a doctor. The doctor accepts that although she does not remember the conversation. She says she did not give a verbal order for adrenaline. Presumably then she approved what Sister Grigg Booth had done otherwise she would be expected to come and see the patient or to alert someone more senior.
- 2.60 Professor Forrest thinks it was unlikely that the patient was suffering from anaphylaxis as the recovery was far too rapid. He considers it to be more likely to have been an acute allergic reaction to medication. Adrenalin was therefore unnecessary and potentially dangerous. In any event a suspected anaphylactic shock is a medical emergency and Sister Grigg Booth should have ensured that a doctor attended. We accept his view about that. In the event JQ suffered no ill effects of the adrenalin and recovered from the reaction. No charge arose out of these facts.

November 2001

CX

- 2.61 CX was born on 9th June 1926. She was a life long heavy smoker. She was admitted to Airedale on 12th November 2001 with possible pneumonia, she had a 2 day history of shortness of breath. An X-ray suggested lung cancer. CX was admitted to Ward 15 at 9.15 in the evening. At that time she was complaining of being short of breath and that her right arm was numb. On examination her arm was cyanosed and discoloured. Immediate action was necessary and CX was taken to theatre where the vascular surgeon, performed a right brachial embolectomy under local anaesthetic.
- 2.62 In the early hours of the 13th November CX was transferred back to the ward. She was most unwell. She had renal problems. Initially it was planned to move her to Bradford Royal Infirmary for additional kidney support but it soon became clear she was not well enough for this. Her blood pressure dropped very significantly and despite a number of interventions by medical staff her condition worsened. At 00.30 the Specialist Registrar examined CX. She was conscious and agitated but obeying commands. He decided to treat the agitation with a small dose of diamorphine and wrote a prescription for 1.25 to 2.5 milligrams to be given intravenously *“prn”*, ie as required. He also prescribed Maxolon.
- 2.63 At 01.20 Sister Grigg Booth attended and she administered 2.5 mg of diamorphine and 10 milligrams of Maxolon. This was recorded in the prescription record and in the nursing record. At 01.45 Nurse M recorded in the nursing notes *“very settled after administering diamorphine”*. At 02.00 the Specialist Registrar recorded a number of interventions that were made to try and improve the patient’s circulation. They included the administration of Gelofusine and adrenaline. They failed.
- 2.64 It was clear that CX was dying and family members were contacted so they could be with her. According to the nursing record by 02.30 the Specialist Registrar had decided there was no purpose in further intervention. His note at 02.00 reads *“Patient is moribund with Cheyne-Stokes breathing. Very poor prognosis. Family agree with above management plan”*. The plan was, effectively, to keep CX comfortable. At 02.35 the nursing record

shows that CX was settled and comfortable with one of her sisters sitting with her. Her oxygen supply was removed.

- 2.65 Although it is not recorded in the medical or nursing notes (and it should have been) it is clear from the prescription chart and the controlled drug book that at 03.00 a further 2.5 mg of diamorphine was administered to CX by Sister Grigg Booth. Sister Grigg Booth signed both documents to record her actions. Sister Grigg Booth is shown as giving the drug and a Nurse colleague witnessed it. Nurse M told the police that if the patient was settled at 02.35 she could not understand why a further diamorphine dose was necessary at 03.00. The other Nurse said that she did not think it unusual for 2 doses of 2.5 mg to be given to the patient on the grounds that it was a relatively small dose and the pain relieving effects would wear off quite quickly.
- 2.66 Professor Forrest correctly pointed out that if CX was comfortable at 03.00 then there could be no reason to give an injection of 2.5 milligrams of diamorphine intravenously other than to shorten her life. We agree. The doctor had prescribed morphine so that the patient could be kept comfortable in her dying hours. The issue that is now very difficult to determine is whether or not CX was comfortable at that time.
- 2.67 The care of this patient threw into sharpest relief a difference of view between experts from 2 disciplines: Professor Forrest, an expert in toxicology, with clinical experience, and a consultant gastroenterologist. Neither of them saw the patient. Each is dependent on the notes and records. Professor Forrest was quite clear that there was no reason to administer the morphine. The Consultant Gastroenterologist said that Sister Grigg Booth's actions were appropriate. In his view they would not have significantly contributed to the outcome of the patient (ie to her death) but would have relieved the patient's distress and kept the patient comfortable. In evidence before us he said the following *"I can't, having read Dr Forrest's statement, reconcile myself to the fact I had not seen this patient, nor was in the room when this patient was unwell, so we do not know what distress the patient was in. It was an assumption, I think, that the patient is so terminal at that point, and about to die, that she could not possibly have been in any stage distressed, but we don't necessarily know that, and in the circumstances I have had in my career, such moments can*

be extremely distressing both for the nursing practitioners in attendance, the relatives and possibly for the patient. We are not really to know that."

- 2.68 The Consultant Gastroenterologist also told the panel that on occasions a dying person can cry out, apparently in distress, and causing distress to relatives and those in attendance. Dr Ferner said that in the rapid breathing stage of Cheyne-Stokes breathing patients are aware of pain and distress.
- 2.69 As to cause of death Professor Forrest said this, "*Whilst it is difficult to say whether or not the final dose of Diamorphine actually killed CX because of the high probability that she might have, although not necessarily would have, died at any time from about 02.30 onwards [ie before the last dose of Diamorphine was given at 03.00], I am in no doubt that the final injection of Diamorphine has made a significant contribution to the final mechanism of her death by further depressing her respiratory drive*". Dr Ferner was of the view that she could well have died at the same time without the morphine.
- 2.70 CX died at 03.35. One of her sisters gave a statement to the police. She described being called by the hospital to say that her sister was very ill and was not expected to survive the night. Her niece came to collect her and take her to the hospital where she met her other sister. She recalled that her other sister was sitting on CX's bed when she arrived with her niece who had taken her to hospital. From the time she arrived she did not remember any nurses administering anything to her sister. It follows that she must have arrived after 03.00 when the last morphine dose had been given. When her sister and niece arrived together CX looked up at her sister and said "*Come and climb into bed, it's lovely and warm*". Even at that late stage she was apparently not unconscious. She then went back to sleep and did not wake again. Throughout the time she was there her sister did not appear to be in pain, nor was she distressed. After a time the nurse came in and told the family that CX had died. It was a peaceful death.
- 2.71 It is regrettable that no one recorded the condition of the patient just before the morphine was administered. Sister Grigg Booth could not remember the patient when interviewed. She began by saying she had probably given the diamorphine subcutaneously. We think that most unlikely, given the contemporaneous records she made. She went on to say, emphatically, that she would not have given the diamorphine unless the patient was in pain or distress. Given the findings we make below in respect of patients

AZ and BY we think this could well be true. We are less confident in our finding here, than in respect of those patients, but we are fortified in our view because we think it most unlikely that the experienced nurse working with Sister Grigg Booth would have stood by whilst diamorphine was being administered to a patient who appeared comfortable.

2.72 These facts led to the third charge of murder against Sister Grigg Booth.

January 2002

GT

2.73 Attempts to contact this patient were unsuccessful. We deal with the facts in outline only in order to record the actions of Sister Grigg Booth in context. The patient was admitted into Airedale via the A&E department in early 2002. He was in pain. An X-ray showed he was suffering from a collapsed right lung. He had other lung conditions. He had arrived at the hospital by ambulance just before 01.00. He arrived at the ward on a trolley some time between 02.00 and 03.00. He was put into the trolley bay awaiting assessment. He had received no analgesia. According to the nursing Kardex he was given pethidine and Stemetil "*on warding*". This is consistent with the prescription record which shows that at 02.45 Sister Grigg Booth prescribed pethidine to be given intramuscularly. She administered it herself. She recorded her actions on the prescription chart. The nurse on the ward recorded it in the Kardex. The Senior Registrar arrived at 03.45 and inserted a chest drain. At 04.30 the Registrar recorded that he had prescribed and administered 5 mg of diamorphine and 10 mg of Maxolon intravenously. These were neither prescribed nor administered by Sister Grigg Booth.

2.74 Professor Forrest criticises the administration of pethidine to a patient with compromised lung function. We note that there is no record of Sister Grigg Booth assessing the patient or asking about drug allergies. As on a number of other occasions, she ran the risk of harming the patient if her decision to prescribe and administer pethidine was wrong. In the event the patient received pain relief and came to no harm.

- 2.75 The nurse who made the nursing records and who was on duty throughout the night believed that Sister Grigg Booth was entitled to prescribe opiates. She had also seen and been aware of the NNPs receiving and acting upon verbal orders from doctors for opiates. She was unaware that when that happened she should record it in the nursing Kardex. Thus if there had been a verbal order to Sister Grigg Booth on this occasion she may not have recorded it. She explained that there were not many doctors available at night. She also said that on many occasions when she had difficulties with patients in the night the NNPs were much more helpful than junior doctors because they were much more experienced.
- 2.76 We note that by this time Sister Grigg Booth and the other NNPs knew that it was hospital policy that verbal orders were no longer acceptable. It is not apparent that anyone monitored their practice to make sure the change was observed.
- 2.77 In respect of this patient Sister Grigg Booth was charged with administering a noxious substance (pethidine) with intent to cause grievous bodily harm or harm.

2002

In the early part of 2002 a Staff Nurse was concerned that Sister Grigg Booth was repeatedly directing her to administer drugs that she, Sister Grigg Booth, had prescribed. The Staff Nurse raised it with the ward manager. The ward manager spoke to Sister Grigg Booth about it. Sister Grigg Booth assured the ward manager that she had only prescribed when the doctor was too busy, and he had come up later to sign. The ward manager accepted that explanation. This is another example of professionals assuming that their colleagues are behaving within the law and in the best interests of their patients.

January 2002

NM

- 2.78 NM was born on 19th June 1965. She was admitted to Airedale on 21st January 2002. She underwent a total abdominal hysterectomy. She was then admitted to Ward 19, the private ward. She was given a PCA pump to control her pain. By the evening of the 24th January the PCA pump

had been withdrawn. She was however still suffering from pain. At 23.15 she was given oral analgesia by Nurse B who recorded the following in the Kardex *“Given Sevredol, 10 milligrams already. Patient in tears due to pain and very distressed. PCA pump has been withdrawn and totally removed. No relief after 30 minutes. Called Sister Grigg Booth and she attended and advised to give morphine, 10 milligrams IM stat at 20 minutes past midnight. This had a good effect and she has slept”*. The controlled drugs book records the use of the morphine and the drug chart records *“Morphine 10 milligrams IM was given by Nurse B and prescribed by Sister Grigg Booth.”*

- 2.79 Nurse B was confident no doctor had been contacted. She said it was very normal for Sister Grigg Booth to prescribe controlled drugs without contacting a doctor. She believed that Sister Grigg Booth had taken over a number of the junior doctors' jobs some years earlier and she assumed she was authorised and trained to prescribe controlled drugs.
- 2.80 At 07.30 the next morning NM was in pain again. The consultant gynaecologist was contacted and he sent a junior doctor to see her. The junior doctor prescribed morphine that was given at 07.45.
- 2.81 Plainly Sister Grigg Booth acted unlawfully in prescribing morphine. Professor Forrest said that a close inspection of the drug chart showed that the patient had a number of allergies so any prescriber should have paused before prescribing morphine. However NM had already been prescribed substantial doses of morphine and he would have had no concern about the prescription of a small dose of morphine by injection after review by a doctor. Fortunately NM came to no harm.
- 2.82 Sister Grigg Booth said she would not have prescribed morphine. She would have phoned the consultant or the registrar. She said the doctors work very hard and need their sleep. She did not want to get them out of bed if her judgment was right, but she would have discussed it with the doctor. The consultant on this case was confident he had not been contacted. There is nothing in the records to show that he was. Whilst Nurse B would not have been privy to any discussion Sister Grigg Booth had with the doctor before arriving on the ward Sister Grigg Booth did not mention any such discussion with her and we think it unlikely that such a discussion took place.

2.83 In respect of this patient Sister Grigg Booth was charged with administering a noxious substance (morphine) with intent to cause grievous bodily harm or harm.

June 2002

IR

2.84 IR was born on 13th March 1960. She worked as a nurse at Airedale. She was 42 when she was admitted to the hospital via the GP unit on 3rd June 2002 at 04.00.

2.85 She was suffering from severe abdominal pain. It was thought she may be suffering from cholecystitis. She was directed first to Ward 15 where Sister Grigg Booth was working at the nurses' station. She told staff to take IR to Ward 19, the private ward. We were told that Ward 19 was often used for staff members to give them some privacy.

2.86 Sister Booth came along to Ward 19. By that time, according to IR's police statement, the pain was excruciating. Sister Grigg Booth said *"We'll get you something for your pain"*. According to IR, Sister Booth asked Nurse B to draw up some pethidine, which she did. The nursing Kardex, completed by the nurse, records that Sister Booth sited a venflon. She took bloods and administered 50 milligrams of pethidine and Maxolon *"with rapid pain relief"*. Nurse B later recorded the administration of the pethidine on the prescription chart. She inserted the initials AG and the time so that all would know what the patient had been given. Sister Grigg Booth's prescription was not otherwise recorded.

2.87 The junior house officer, now a registrar, attended at about 05.00. We heard from her. She had seen the patient after the pethidine had been administered. She was aware of the pethidine being prescribed, as she refers to it in the clinical records. She prescribed pethidine IM to be given 4 times a day, for pain. Later in the morning the SHO increased the frequency of the pethidine and the amount.

- 2.88 Sister Grigg Booth told the police that she may have received a verbal order, possibly from the house officer. The house officer denied this, and it seems to us that her denial is supported by the evidence of Nurse B and the nursing Kardex. We accept her evidence.
- 2.89 IR considered Sister Grigg Booth very capable and caring towards her patients. When she had first met her she thought she was quite a scary character. Like many witnesses IR recalled that Sister Grigg Booth often stated that she was in charge of the Hospital at night and certainly gave that impression to patients. *“Anne swore a lot and could be quite condescending, especially with junior doctors. I was once present when she was having a telephone conversation with a female doctor, when Anne put the phone down she began swearing about the Doctor. I was quite shocked by her attitude.”* She also confirmed that Sister Grigg Booth prescribed medication as a matter of course. *“As long as I have known Anne she has prescribed various medication. I have seen her prescribe temazepan and diamorphine for patients. At that time I thought nothing of it because the Night Sister was to be contacted before the Doctor on nights. It would be the Night Sister’s decision whether to call the Doctor out to assess the patient. I just presumed that she was allowed to prescribe these medications as part of an extended role.....I have witnessed Anne giving IV opiates to patients, again I thought she was authorised to do this.”*
- 2.90 With respect to her own care IR observed that Sister Grigg Booth did not take a previous medical history, nor did she check her drug allergies before prescribing pethidine. A doctor would have done this (see for example the actions of the house officer with the same patient). Sister Grigg Booth should have done so.
- 2.91 Again we find that Sister Grigg Booth acted unprofessionally and unlawfully in prescribing pethidine to IR. It is plain on the records that the pethidine was appropriate and IR came to no harm as a result of its administration. She went home on 5th June 2002.
- 2.92 In respect of this patient Sister Grigg Booth was charged with administering a noxious substance (pethidine) with intent to cause grievous bodily harm or harm.

LO

- 2.93 LO was born on 26th December 1959. He died on 18th June 2002 at the age of 42. For over 20 years he had lived with Advanced Hodgkin's Disease. In the early 1980s he was treated with chemotherapy. He had 3 years' free of disease and it recurred in 1986. After 12 courses of chemotherapy the disease went into remission for a second time and LO had a further 5 years free from disease. In 1993 he suffered a further relapse, and over the next 9 years he underwent repeated procedures and treatment. In the early part of 2002 he took a trip to Australia. He contracted an infection and he was admitted to Airedale in April 2002. He was discharged and attended again by arrangement on 5th June 2002. His sister accompanied him. LO was due to have a platelet and blood transfusion. He was very unwell on admission. The consultant haematologist at Airedale had known LO since 1986. On 5th June she admitted him immediately to Ward 19, the private ward. On occasion very ill NHS patients were cared for there to give them greater privacy.
- 2.94 By this stage LO was suffering from acute myeloid leukaemia, precipitated by the many years of chemotherapy. He was given supportive treatment over the following two weeks, but his condition deteriorated. The consultant haematologist discussed with him possible chemotherapy options but he said he did not want any more. He would accept supportive treatment to control the symptoms of his leukaemia, to keep him comfortable for as long as possible. He knew that the prognosis was very poor. On 14th June Dr L assessed him and discussed his management with him, his mother and the ward sister. According to her statement there was a discussion about cardio pulmonary resuscitation (CPR). LO said that he just wanted to be kept comfortable "*I've been through enough*", he said. Dr L made it clear to him that this did not mean giving up on his care and that any condition would be actively treated. This conversation is also recorded in the notes. LO's condition continued to deteriorate. On 16th June 2002 at about 17.15 LO asked nursing staff to contact the consultant haematologist; he had things he wanted to say to her. She was not working that day but the nurse rang her at home and she came to see LO within the hour. She reassured LO that he would not die that night; we see this in the notes. The consultant told the police that she wrote that to reassure relatives who were very concerned that LO should not die alone. It is clear from the records that his mother was devoted in her attendance, as were other members of his

family. At that time LO was receiving treatment via a syringe driver – both diamorphine and midazolam 50mg of each over a 24 hour period.

- 2.95 On the morning of the 17th the consultant haematologist asked her SHO to reduce the midazolam to 20mg over 24 hours. She discussed the position with LO's mother. The notes record that she explained that he had deteriorated and that his prognosis was "days". That afternoon the palliative care specialist reduced the diamorphine and midazolam to 30mg and 12mg respectively over 24 hours. This was because LO was complaining of hallucinations. He also suggested that it might be necessary to reduce diamorphine the following day. The Consultant Haematologist saw LO again at 18.00. He was deteriorating. She increased the amount of diamorphine and midazolam to 50mg and 20mg per 24 hours respectively. She also recorded that extra 5mg doses of diamorphine could be administered subcutaneously if pain relief was required and 5mg midazolam for anxiety.

She told us "I was using my clinical assessment of LO to ensure that he was comfortable, bearing in mind that we were in an increasingly hopeless scenario in terms of being able to reverse the infection, and I felt that LO was dying, and my top priority was to ensure that he wasn't distressed or in pain".

She was very clear that she had specified subcutaneously as she knew that senior nurses were permitted to administer diamorphine intravenously only on Coronary Care or Intensive Care units, according to written protocols. Intravenous diamorphine could otherwise be administered only by a doctor. She visited LO at 20.30 and wrote on the records that she could be contacted overnight if she was needed. Had she been called we have no doubt that she would have attended.

She told us "I think it is a very important point – if I had been asked to review LO, and I was concerned that he was distressed, I could have prescribed and administered 5 milligrams of intravenous diamorphine and that would have been an appropriate intervention for somebody who was distressed. That would have been perfectly acceptable medically and legally, based on my experience and clinical assessment. Sadly, I wasn't invited to assess the patient on that evening, but, had it been administered by a doctor and prescribed and administered by a doctor, I don't think we would be having this discussion today."

- 2.96 In the event she was not called. Staff Nurse T was on duty that night. She was looking after LO. She recalls that at 22.30 she recorded that she had administered diamorphine to LO subcutaneously (i.e. as prescribed). LO seemed to be in pain, he was jumpy and twitching hence her decision to administer the diamorphine.
- 2.97 Just after midnight LO had become agitated. He was thrashing about, trying to roll over. He was semi conscious. His mother was very upset. Staff Nurse T bleeped Sister Grigg Booth. Sister Grigg Booth rang her back and asked her what medication was on the prescription chart. Sister Grigg Booth told her to give LO midazolam to calm him. Staff Nurse T did so and recorded her actions. Sister Grigg Booth arrived on the ward a little while later, and spoke to LO's mother and his sister. LO had not settled. Sister Grigg Booth assessed him and decided to increase the diamorphine dose in the syringe driver to 50ml/24 hours. This was recorded. LO was moaning and twitching. He did not appear comfortable. Sister Grigg Booth said that she would not disturb the consultant Haematologist, nor did she call another doctor.
- 2.98 The controlled drugs book for the ward shows that Sister Grigg Booth and Nurse T removed diamorphine from the cupboard and that the 5mg was administered by Sister Grigg Booth. The Staff Nurse recorded this in the nursing notes. She told the police that beforehand LO *“seemed uncomfortable and was moaning, he was semi-conscious and couldn't tell us that he was in pain.”* She recalls that Sister Grigg Booth gave the drug quickly and did not monitor LO's breathing. LO appeared to settle. Staff Nurse T checked on him after a while. The clinical record completed by Sister Grigg Booth reads as follows:
- “18.6.02 Unsettled, 01.30 15 Diamorphine increased via syringe.
01.45 diamorphine 5mgs given IV Settled.”*
- 2.99 Her signature appears to the right of the page.
- 2.100 Some 2 hours later LO's mother came to see Staff Nurse T to say that LO was shaking. Staff Nurse T went to his room and saw that he was shaking uncontrollably. She asked another member of staff to contact Sister Grigg

Booth who told the nurse to get some diazepam ready. In the mean time Staff Nurse T went to find LO's sister who was not in the room. Staff Nurse T went to get the diazepam. Before she returned to the room LO had died. Sister Grigg Booth arrived a few moments later. Her record in the clinical note is as follows:

"04.30 ATSP [asked to see patient]. Fitting. Ran to ward ready to give IV diazepam. On arrival to ward L had died. Mother and sister present. Verified as dead 04.40."

2.101 She then signed it Sister Grigg Booth, Night Sister.

2.102 Below that is a further entry about her discussions with relatives. The entry ends *"May his soul rest in peace"*.

2.103 The Consultant Haematologist arrived at 07.30. She certified death as follows:

I a) acute myeloid leukaemia

I b) Transformed myelodysplasia .

II Treated Hodgkin's disease

Acute renal failure

2.104 We note that had the consultant read the entry further up the page, written by Sister Grigg Booth, she would have seen that she had administered diamorphine intravenously.

2.105 Professor Forrest thought it likely that the administration of the 5mg of diamorphine by Sister Grigg Booth at 01.45 probably contributed to LO's death at 04.20 even though the effects would have been wearing off by this stage. He pointed out that LO would have died without the diamorphine having been administered, although he could not give a precise time. He said that had a doctor administered the diamorphine he would not have been concerned about it. The panel asked Professor Forrest whether or not he would have had a difficulty with the diamorphine if it had been administered by a qualified person. He replied as follows: *"No, I wouldn't. I*

would go further than that. I would say if I was the patient, I would consider it, provided I was able to consider it, a blessing.”

- 2.106 Professor Forrest was then asked whether he agreed with the evidence of the Consultant Haematologist which was as follows, *“At that stage of his illness, relief of distressing symptoms was the top priority as he was close to death.”* He replied *“Absolutely. I hope whoever cares for me in my final illness takes that view as well.”*
- 2.107 Dr Ferner also expressed the view that the care given was appropriate.
- 2.108 LO’s family were very distressed at his death. It was a terrible loss of a young man who had been through so much.
- 2.109 It is also clear that Sister Grigg Booth and the other nursing and medical staff were upset. We note that Sister Grigg Booth recorded the death in the Night Sisters diary *“LO died, Ward 19, 04.30, 44-year-old ... patient.”*
- 2.110 One of the other NNPs told the panel that Sister Grigg Booth was very fond of LO. When Sister Grigg Booth was interviewed by the police about this patient she became distressed. She said that she had wanted him to have a dignified death, free of pain. She had talked to him and he told her he was in pain that was why she had increased the morphine driver and why she subsequently gave the additional dose. She asserted that she had given the additional dose subcutaneously, as prescribed and that she made a mistake in the records.
- 2.111 We think that unlikely for 2 reasons: first she recorded it as IV and second that is how Staff Nurse T describes it. We find that she administered the drug intravenously. She said that he was dying in a lot of pain and that is why she did what she did. Whilst we do not know what was in Sister Grigg Booth’s mind, the evidence tends to support her explanation for what she did. The diamorphine was prescribed by a doctor. That she administered it intravenously rather than subcutaneously made no difference to LO. As we have said elsewhere Sister Grigg Booth reasonably considered herself competent and permitted to administer diamorphine intravenously.

- 2.112 After LO's death Sister Grigg Booth gave a glass of brandy to his mother and sister and went outside with them onto the patio where she cut some roses, because she recalled that LO liked them. It is right to observe that she should not have been serving alcohol in a hospital and her conduct in that regard has been criticised. LO's sister asked her about it, and she said she could do it because she was in charge. Whilst it was clearly unprofessional to do this it was not unkind. Indeed many might think that her actions were of comfort at the time.
- 2.113 The Consultant Haematologist made the following observations about Sister Grigg Booth in her police statement *"I have known Anne Grigg Booth for several years and have always found her to be very caring, attentive, kind and an experienced Nurse. She had always shown a keen interest in providing high quality care to my patients and their families"*.
- 2.114 Sister Grigg Booth was charged with the attempted murder of LO.

OL

- 2.115 OL was born on 11th August 1975. He was admitted to Airedale on 21st June 2002 via his GP with suspected appendicitis. At about 03.30 he was admitted to Ward 15. We say *"about"* because the precise timings are not clear, not least because there is a disparity between the notes made by the doctors and the nurse. At some time between 03.30 and 04.30am he was seen by Dr K who recorded in the clinical notes that the plan was (amongst other things) for analgesia. He also ordered some blood tests. His impression was that OL had appendicitis. At 04.30 Staff Nurse C noted that Dr K had seen the patient and a venflon had been sited. She wrote *"Given 50mg of pethidine and 10mg of Maxolon IV by Sister Grigg Booth with good effect"*. We infer that *"with good effect"* means that it relieved the patient's pain. The drug chart shows a prescription of pethidine and Maxolon by Sister Grigg Booth, and that she administered it. The pethidine is correctly recorded in the controlled drugs book. Whilst Staff Nurse C's entry is timed at 04.30 and Sister Grigg Booth's prescription is timed at 05.00 the controlled drugs book shows the pethidine being obtained at 04.50. Staff Nurse C (who gave evidence in respect of this patient and a number of others) was certain that this latter time would be correct. We find that all are referring to the same events, and in particular, to the same prescription. On the face of it, this is a prescription of an opiate by

Sister Grigg Booth for a patient with abdominal pain. Staff Nurse C told us that she knew Sister Grigg Booth was not entitled to prescribe opiates and she thought it probable that there had been a verbal order. Otherwise she would have challenged the prescription. Whilst she did not take verbal orders herself she knew that the NNPs did so.

- 2.116 Later on, we think at around 08.30, OL was reviewed by an SHO who planned for an appendectomy, which was carried out the next day. Before that, Dr K had prescribed 10 milligrams of morphine to be given hourly, as required. That prescription may have been written at around 03.30, in which case we do not understand why Sister Grigg Booth felt it necessary to prescribe pethidine or, perhaps more likely, it was prescribed later. We see that at 06.30 10 milligrams of morphine were given intramuscularly by the nurse, in accordance with that prescription.
- 2.117 When interviewed about this in March 2003 Sister Grigg Booth accepted that she was not entitled to prescribe pethidine and wondered whether it was a verbal order. She also wondered why she had given it intravenously. Given Staff Nurse C's evidence there is more than a possibility that this was a verbal order, i.e. that Sister Grigg Booth physically wrote up a prescription given by a doctor. It is odd, however, that the doctor did not write the prescription himself, nor did he countersign it, given that he was available at the time.
- 2.118 Professor Forrest was critical of the use of opiates in a patient with abdominal pain. That said, the junior doctor prescribed opiates at about the same time. Professor Forrest also criticises the wide range of blood tests that were carried out. We have not reviewed that issue, since it is not clear why that happened, nor did it lead to any unpleasant consequences for the patient.
- 2.119 In respect of this patient Sister Grigg Booth was charged with administering a noxious substance with intent to cause grievous bodily harm or harm.

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EV

- 2.120 EV was born on 27th February 1917. She is no longer alive but her death was unconnected with the events with which we are concerned.
- 2.121 She was admitted to hospital on 16th July 2002, complaining of shortness of breath and it was thought that her heart may be failing. The doctor who saw her in A&E assessed her at some length and recorded his impression as *“acute LVF”* [left ventricular failure]. The nursing Kardex, completed later on Ward 15 says *“Acute admission via A&E with history of increasing shortness of breath, unwell, cold, clammy on arrival to A&E. Given aspirin by paramedics and Frusemide 50mg IV by ambulance crew. Arrived in A&E. V SOB. Given further 50mgs IV Frusemide, salbutamol neb and hydrocortisone 200mgs IV in A&E. On arrival [ie on Ward 15] very breathless, EWS [Early Warning Score] – 4. Dr S aware. Given 50mgs IV Frusemide, 2.5mgs diamorphine and Maxolon 10mgs IV with good effect by Sister Grigg. C X- Ray, bloods and cultures done.”*
- 2.122 It is clear from this note that the patient’s condition was such that Dr S was contacted immediately, i.e. some time around 04.20. We can also infer that Sister Grigg Booth was contacted. Dr S attended some time later. Her note of her attendance is not timed but from other evidence we can tell that she was there some time between 06.20 and 07.00. It is most unlikely that having been contacted urgently in the night, Dr S did nothing about the patient for 2 hours or more. It is far more likely that she discussed the patient with Sister Grigg Booth. Whether that was before or after Sister Grigg Booth administered the diamorphine we cannot tell.
- 2.123 Sister Grigg Booth was interviewed about this patient 8 months after the event on 19th March 2003. She said that patient was in left ventricular failure hence the combination of drugs. She said it was an emergency. She said she probably hadn’t been able to get any doctor to come and see the patient at the time. She said that she knew she had done something that she shouldn’t have done, but she said if she hadn’t done it the patient would probably have died. She did not suggest that Dr S had given a verbal order. Dr S told the police that she would have given a verbal order only in an emergency and would have recorded it. There is no record of a

verbal order and in the light of Sister Grigg Booth's answers to the police there is no reason to suppose that Dr S gave a verbal order. It follows therefore that Sister Grigg Booth relied on the assessment of the doctor in A&E, and on her own assessment that the patient was suffering from left ventricular failure. She gave the correct treatment for left ventricular failure and the patient improved.

- 2.124 We note that some months later EV was admitted to hospital again with the same symptoms, the same treatment was given, this time by a doctor.
- 2.125 Professor Forrest made the point, correctly, that if the diagnosis had been incorrect and diamorphine had been administered the patient would probably have died. Sister Grigg Booth's response would no doubt have been that, had she not administered the diamorphine the patient would have died in the early hours of that morning. That is what she said to the police. At this remove we cannot tell.
- 2.126 For Sister Grigg Booth to prescribe diamorphine was unlawful. In acting as she did she took a risk (albeit one which did not materialise) with the patient's life and with her own professional future. As our reviews of her care of these patients shows she did this repeatedly.
- 2.127 In respect of this patient Sister Grigg Booth was charged with administering a noxious substance (diamorphine) with intent to cause grievous bodily harm or harm.

AZ

- 2.128 AZ was born on 6th May 1906. On **24th June 2002** she was admitted to Airedale Hospital. She had fallen and sustained a displaced fracture of the neck of the femur on the left side. She was admitted to Ward 10, the orthopaedic ward, for bipolar furlong hemiarthroplasty under the care of Mr R. Mr R performed the surgery on 25th June. According to the records the following day AZ was "*drowsy*" and "*apyrexial*". The following day her condition deteriorated. She was seen by the Care of the Elderly staff doctor who thought it likely that she had suffered a stroke.
- 2.129 On the 29th June Mr R recorded speaking to AZ's daughter and agreeing with her that her mother should be given the status "*not for resuscitation*"

and her notes were marked accordingly. It is not apparent that this status was ever formally reviewed. It should have been. AZ's daughter said in her statement that she was told that her mother had suffered a stroke as a result of the operation, that she would not be able to come home and would require 24 hour nursing care. In fact AZ's condition improved and her family were considering a nursing home placement for her. Until this admission to hospital she had been living with her daughter at home.

- 2.130 There are no entries in the clinical notes for the period 3rd July 2002 to 12th July 2002 although she was visited regularly throughout by her daughter and grandchildren.
- 2.131 On 15th July 2002 her condition appeared to have deteriorated. She was eating and drinking poorly and needed chest physiotherapy to avoid an accumulation of secretions. She was recorded as looking brighter on the 18th but on the 20th she began to deteriorate again.
- 2.132 By the early hours of the 21st July Staff Nurse W had recorded her condition as poor. Oxygen therapy was prescribed (ie an oxygen mask over the face) and her records were annotated "*not for active resuscitation*". She was connected to an IV infusion. That afternoon her daughter visited for about an hour and her granddaughter was going to visit later.
- 2.133 At about 18.30 her daughter received a call from the hospital and she was told that her mother was not very well. She was asked if she would like to go back to the hospital. She did so and arrived at about 20.00. She met the doctor who assessed her mother. The doctor told her that AZ was struggling and there wasn't much more the hospital could do for her. She stayed with her mother through the night. Her own daughters joined her for part of the time. At about midnight she remembers that her mother was becoming "*wound up*"; she was pulling at the mask on her face. AZ's daughter alerted Staff Nurse W who saw AZ pulling the mask away from her face.
- 2.134 Staff Nurse W contacted Sister Grigg Booth who was the NNP on duty. She attended and recorded her actions in the medical notes. She examined AZ. AZ's daughter recalls that Sister Grigg Booth took control of the situation. She took hold of AZ's hand and asked her to squeeze it if she

was in pain. AZ did not respond. Staff Nurse W recalled that “[AZ] was *struggling to breathe and was distressed*”.

- 2.135 Sister Grigg Booth said after examining AZ that she needed some hyoscine and diamorphine. According to Staff Nurse W she remained with AZ’s daughter while Sister Grigg Booth went to get the drugs. AZ’s daughter recalls that it was Staff Nurse W who went for the drugs. We think it more likely that it was Sister Grigg Booth who did so since she had taken charge and plainly intended to obtain and administer the drugs. She came back into the room, carrying the drugs in a kidney dish. It is clear on the evidence that she then administered the diamorphine intravenously. It appears she administered the hyoscine subcutaneously. As AZ’s daughter put it, “*After the sister injected my mother she became more settled and the sister left.*” According to the notes this took place at 01.40. Nursing staff kept calling into the room to assess AZ’s condition. About 2 hours after the intravenous injections AZ’s breathing deteriorated and she stopped breathing at around 03.50. AZ’s daughter recalls the nurses confirming the death. The records show that Sister Grigg Booth was called to verify the death and she wrote that in the notes.
- 2.136 AZ’s daughter told us that she was sure that no doctor attended her mother during the early hours of that morning. We believe she is right about that. There is no record of any doctor being called or attending. Sister Grigg Booth completed the medical notes thus “*ATSP [asked to see patient] Restless, chesty and appears uncomfortable. Daughter and granddaughter upset. Diamorphine 2.5 mgs given IV. Settled – looks peaceful*”. On the prescription chart in the once only prescriptions section she inserted diamorphine and hyoscine in the drug section. She recorded the dose and the route of administration. She wrote in the time as at 01.40 and inserted her own initials in the signature section. She then recorded the time given as 01.40 (i.e. the same time as the prescription) and in the given by column she entered her own initials with the date.
- 2.137 On the prescription chart next to Sister Grigg Booth’s initials a further signature appears, that of a junior doctor. He gave evidence and confirmed to us, as he had told the police, that he had signed the prescription chart.

- 2.138 Sister Grigg Booth gave a number of different explanations of the prescription of diamorphine in 3 police interviews. In the final interview she said that she had received a verbal order.
- 2.139 The Doctor was unable to assist us with why he had written on the prescription chart. He accepted that the records were consistent with a verbal order having been given. He was asked whether he would have given a verbal order without seeing the patient. He was unable to help about that. He was unable to say whether he had given a verbal order although he said it was a possibility.
- 2.140 We bear in mind that no one refers to a doctor attending AZ in her last hours. Her daughter was quite clear that none attended. We also take into account that Sister Grigg Booth left the room to obtain drugs, having already decided what she was going to administer. She had an opportunity to make a phone call but she has not marked the records "*Dr aware*" or anything similar. It seems to us there are 3 possibilities:
- The first is that Sister Grigg Booth spoke to the Doctor and he gave a verbal order.
- The second is that the Doctor had nothing to do with the patient at the time of the administration of the drugs, but at some time after she had administered the drug Sister Grigg Booth told him what she had done and he countersigned the prescription, presumably on the basis that he agreed with it.
- The third is that the Doctor had nothing to do with this patient at any time and simply signed the chart because Sister Grigg Booth asked him to. The Doctor said that this was possible. We found this a very surprising answer. However inexperienced he was, the doctor would have known that in countersigning the prescription he was approving it. We think it most unlikely that any responsible doctor would sign a prescription chart just because he was asked to and we doubt that this Doctor did so.
- 2.141 We cannot rule out the possibility that the Doctor gave a verbal order but, of the three scenarios, we believe the most likely is the second, i.e. that Sister Grigg Booth took responsibility for the prescription and administration of the drugs, confident in the expectation that a doctor would approve it retrospectively. She probably gave the Doctor the details of the patient's

care at some stage after she had administered the drug. We cannot tell whether this was before or after AZ died. The Doctor signed it because he agreed with the treatment prescribed.

2.142 Staff Nurse W told the police that she believed Sister Grigg Booth was authorised to administer opiates intravenously. She knew that she was not entitled to prescribe opiates. She then said *"On this date I am aware that this did happen. Although I am aware that this was not strictly in accordance with hospital policy, it was done in the best interests of the patient and so I did not confront the issue"*.

2.143 Professor Forrest gave evidence about this patient. We reproduce an important section of his evidence below:

"You say this, Professor Forrest: that you have no doubt that the injection of diamorphine has directly shortened AZ's life, and you say that even though, as recorded in the notes, approximately two hours has elapsed between the time of the injection and the time of death, the depressant effects of diamorphine on the respiration would still have been acting during that time:

A. Yes.

Q. -- and would have depressed AZ's breathing, and consequently would have led to her death. But you go on and say this:

"I appreciate that AZ was clearly dying at the time the injection was given and a view may be expressed that, even in the absence of the injection, she would have died."

You ...say, in fact, that was a very real possibility?

A. Yes.

Q. You then say:

"I would respond by saying at the time she died, the diamorphine would still have been having an adverse effect on her respiration and consequently would have made a more than minimal

contribution to the mechanism of her death at the time she did, in fact, die."

- A. *Correct. In effect, the diamorphine has shortened AZ's life, brought forward the time of her probably inevitable death in the next hours by an unquantifiable but definite and more than minimal amount.*
- Q. *... we see references in the notes, .. at 1.50 that AZ had become distressed.*
- A. *Yes.*
- Q. *Can you see circumstances in that situation where, if a doctor had been attending to AZ, that the same treatment would have been given as Anne Grigg Booth gave?*
- A. *I think it is entirely possible that if a doctor had attended, if a medical practitioner had attended, then he or she would have adopted the same course of action, and I think that course of action is probably the right course of action.*

I guess the question in my mind when I wrote this was: does the doctrine of dual intent apply to a nurse who is making a decision which is beyond that which a nurse in this time, 2002, would normally have been able to make?

...if a doctor was called to see the patient, there would have been two things he would have considered:

First of all, is this patient dying? Secondly, is she in distress? If, on careful examination, he formed the conclusion that a definitive treatment to cure her would be futile and, secondly, that she was in distress, in effect, that she was dying and in distress, then relieving in particular the distressing shortness of breath and the death rattle, if you like, then it is entirely legitimate for the doctor to relieve the process of dying."

- 2.144 Sister Grigg Booth's prescription of diamorphine was unlawful. It appears that she administered it to relieve the patient's distress in her dying hours. She would have known that to do so may hasten death.
- 2.145 As a result of the depression of AZ's breathing, the use of diamorphine may have resulted in death occurring earlier than it would otherwise have done (Professor Forrest), although Dr Ferner suggests that it is just as likely that it postponed death by relieving pulmonary oedema. We cannot say with any confidence which is right, the differences are marginal. Sister Grigg Booth did what a doctor would have done had he been called. Had a doctor done what she did it would have been "*entirely legitimate*", as Professor Forrest put it. But it was done by a nurse who could not lawfully prescribe, however experienced she was.
- 2.146 It seems on the evidence that the fact that Sister Grigg Booth gave the treatment rather than a doctor made no difference to the patient who received appropriate treatment. The result for Sister Grigg Booth was little short of catastrophic. It was the perusal of the records of this patient that led to her suspension and to her arrest (see Chapter 3). Ultimately she was charged with the murder of AZ.

Sister Grigg Booth's health

- 2.147 Sister Grigg Booth went off sick in July 2002, shortly after the death of AZ. According to NNP4 she had been rather moody in the weeks leading up to this. He/she also reminded the panel that Sister Grigg Booth and her husband had been among the first nursing staff to assist with the injured at the Omagh bombing in August 1998. They were on a family holiday at the time. It was his/her view, and this is echoed in other statements, that Sister Grigg Booth was psychologically affected by the experience. He/she felt Sister Grigg Booth became more difficult to deal with after that time. Other witnesses agreed with that. That said, neither he/she nor anyone else saw any change in her conduct with patients (as opposed to colleagues) right up until the time she took sick leave. In those circumstances it seemed to us that there was no need to consider Sister Grigg Booth's health as part of our Inquiry. However it is plain that a number of people working in the hospital were aware of her visits to hospital in the latter part of 2002 and they had become the subject of some gossip. It is probable that awareness of her hospital visits and her behaviour at that

time (ie mid 2002) may have influenced those who were later involved in investigating her earlier conduct. For that reason we set out the main points in bullet point form only. We do not think a detailed exposition is necessary or desirable.

- By July 2002 Sister Grigg Booth was drinking too much. It seems likely that she had become an alcoholic.
- In the months July 2002 to October 2002 Sister Grigg Booth was complaining of a number of physical symptoms, including joint pain and debilitating chest pain. She was a frequent attender at A&E. On several occasions she rang the hospital to say she was coming in. She would tell the nurses to have some diamorphine ready. The last time this happened was in October 2002. On one occasion she was irritated by what she considered the slow speed of the nurse administering the diamorphine. She took the syringe from her and administered the intravenous diamorphine herself. This was quite wrong, as she no doubt knew.
- This became known by some in the Trust as "*opiate seeking behaviour*". There was a rumour that Sister Grigg Booth had been using diamorphine. We found no evidence to support this, nor did the police. We should say that, in the absence of records of what happened to wasted opiates, a complete analysis was not possible but certainly no one ever saw anything that suggested Sister Grigg Booth was using opiates which should have been wasted.
- On one occasion in September 2002 Sister Grigg Booth came into hospital accompanied by her husband who at that time was a bank nurse at Airedale. Her husband pressurised a nurse into giving him some tramadol for Sister Grigg Booth. This was unprofessional and wholly unacceptable. He was disciplined by the SNCG.
- Sister Grigg Booth was referred to occupational health. She received medical and psychiatric help. It seems that her health improved and the visits to A&E stopped. She was planning to return to work part time, on days, in the early part of 2003.

- The effect upon her of her suspension was disastrous. She already had financial difficulties. She entered into a spiral of drinking and depression.

The other NNPs

- 2.148 The other 3 NNPs who gave evidence complained, to varying degrees, of bullying by Sister Grigg Booth. We asked them what form the bullying took. NNP3 gave examples of Sister Grigg Booth's tendency to be disparaging about people when they weren't there, saying that another NNP colleague was an alcoholic and that NNP4 needed close supervision. She also expressed the view that people who went off sick were wimps with no loyalty to the organisation. NNP2 told us that Sister Grigg Booth had been very supportive and kind to him/her at times of difficulty in his/her life but that she had been, in hindsight, a bully.
- 2.149 NNP4 repeated in evidence that he/she considered Sister Grigg Booth a bully. When asked, indeed pressed, by the panel for an example of her bullying behaviour he/she thought for some time and then said that she had told him/her that he had to go onto days to bring his/her skills up to date. He/she knew that she was passing on something from management but considered her to be a bully for having done so. Whilst we understand the wide definition now given to bullying, in order to ensure that allegations are always taken seriously, we have to say that we cannot see how this was bullying on any definition. NNP4 is really complaining about a manager managing.
- 2.150 We think it likely that Sister Grigg Booth had a very high opinion of her own abilities and work ethic. Given what others have said about her that is not surprising. We suspect she thought that others did not work as hard as she did. She may have been wrong about that. We think it likely that she conveyed to her NNP colleagues that her skills were greater than theirs, her experience more impressive and her devotion to the patients second to none of theirs. It is no surprise that they considered themselves, in hindsight, to have been bullied. Again, this was something that no one did anything effective about at the time it was happening.

2.151 In her statement of mitigation when he/she was being disciplined and Sister Grigg Booth faced serious charges, NNP3 asserted that the reason he/she had administered diamorphine intravenously was because Sister Grigg Booth had bullied him/her into doing so. When he/she gave evidence before us he/she accepted that he/she would not have done anything that he/she did not feel competent to do. Indeed he/she had initially refused to administer opiates until he/she had done so in a supervised capacity. He/she, like the other NNPs believed that they were permitted to administer intravenous opiates. When he/she was asked to carry out chemotherapy he/she obtained training at the University of Huddersfield. He/she took a very responsible approach to her practice.

2.152 NNPs 2, 3 and 4 had been in post at Airedale for many years, All of them had attended the Nurse Practitioner Course at Bradford (although not all at the same time) NNP4 said he/she had taken the course because it was put to him/her that unless he/she did he/she would be out of a job. NNP2 said something very similar. It is clear that there was no more consultation with the nurses about the changing role than there was with DN1. NNP3 was seconded from another post.

NNP4

2.153 NNP4 told us that he/she understood the course would give him/her some additional skills that he/she could then use in the new role. He/she recalled that the additional skills (for him/her) were intravenous cannulation and phlebotomy. There was also a component on the intravenous administration of drugs, which was a new skill for some people on the course with NNP4, but not for him/her. The verification of expected death had been part of his/her role for some time. Presumably it was new for some people. The same applied to the administering and interpreting of ECGs and to cardio pulmonary resuscitation with which NNP4 was already very familiar. He/she had retained his/her job description which he provided to the panel.

2.154 All 3 NNPs had attended the advanced life support course. Curiously NNP4 recalled that the course did not involve the administration of opiates intravenously. We think his/her recollection is incorrect. The other NNPs, both recalled that it did, as did Sister Grigg Booth when she was

interviewed by the police. NNP4 said that in the mid 1990s Sister Grigg Booth had shown him/her a letter from DN1 which authorised the NNPs to administer 2.5 mg of morphine intravenously in cases of chest pain. That is what he/she told the police when they asked him/her for a statement in March 2003. DN1 denied that she had ever written such a letter. We accept her evidence about this. Whether NNP4's memory is incorrect or Sister Grigg Booth drafted the letter and forged the signature of DN1 herself is impossible for us to resolve now. No copy of the letter survives.

- 2.155 On the topic of verbal orders NNP4 was very clear that he/she had accepted verbal orders for almost all his/her career on nights i.e. from about 1977. He/she said many of the night sisters did so and he/she believed it was permitted. It was plainly accepted. He/she believed that at some stage Sister Grigg Booth had shown him/her a list of drugs in respect of which he/she could receive verbal orders. He/she said that it included opiates. He/she could not remember whether or not it had been signed by DN1. Again we find that if the list existed it was not signed by DN1. She did not begin working at the Trust until 1995. We do not believe she would have signed such a list. We wondered whether NNP4 was referring to the list of medication compiled by DN1's predecessor to which we referred earlier, but that did not refer to verbal orders or to opiates.
- 2.156 NNP4's evidence about when verbal orders were stopped was inconsistent and his/her memory may not have been reliable. He/she remembered the instructions in 2001, which are referred to in the NNP diary. In the end it was his/her view that they were stopped after he/she and others received a letter from NNP manager 2 in January 2003. NNP2 and NNP3 remembered that the instruction was given mid way through 2001.
- 2.157 NNP4 was asked about the letter to DM from Sister Grigg Booth in May 2001. He/she confirmed that DN1 had witnessed him/she taking a verbal order from a doctor over the telephone, and she had seen him/her administer diamorphine intravenously to a patient. She had not questioned his/her conduct at all. Given that he/she was the director of nursing he/she told us that he/she would have expected him/her to do so were he/she acting in an unauthorised manner.

2.158 NNP4 told us that when he/she spoke to junior doctors on their induction day he/she would tell them that the NNPS were able to take verbal orders for medication. He/she also was instrumental, with others, including Sister Grigg Booth in drafting the guide to “*Senior nurse cover at night*”.

2.159 We reviewed NNP4’s care of 4 patients.

January 2001

ZA

2.160 ZA was admitted to Airedale in the evening of 6th January 2001 after a road accident. According to the triage notes he was seen by a doctor immediately. He had been involved in a head on collision and was complaining of pain in the abdomen and chest. He was put onto 2 hourly observations and blood was taken for testing. X-rays were normal but a scan showed a grossly abnormal kidney. He was also put on a spinal board because of back pain and catheterised. At about 21.00 10 mg of morphine was administered intravenously. The patient was still in the Accident and Emergency Department at this stage. He was moved to Ward 15 at 11.00. At that time he was complaining of left sided back pain. The pain was assessed as acute, at 8/10.

2.161 The allegation against NNP4 was that he/she had prescribed and administered 10 milligrams of morphine intravenously on the ward. On the drug chart NNP4 recorded a verbal message from a doctor. There is no counter signature from the doctor. She wrote up other medication on the same chart half an hour later. She must therefore have seen what NNP4 had written (assuming he/she wrote it at the time, as he/she says he/she did). On balance therefore we are prepared to accept that this may have been a verbal order for an opiate which NNP4 accepted and administered.

2.162 We note in passing that Sister Grigg Booth was also involved briefly with this patient, changing the morphine prescription from IM to IV.

January 2001

YB

- 2.163 This is another patient in respect of whom NNP4 is adamant that he/she received a verbal order from a doctor for diamorphine. He/she has recorded the fact of the verbal order and the name of the doctor but the doctor has not signed.
- 2.164 The doctor in question gave evidence and was equally adamant that she would not have given a verbal order for diamorphine for such an elderly patient without first examining her.
- 2.165 Both witnesses were dealing with events nearly 9 years earlier. The doctor had seen hundreds of patients in scores of settings by then. We accept that the doctor is honestly certain that she did not give the verbal order. Nonetheless the fact that NNP4 did record it openly – where it would have been seen (and indeed was seen by the consultant) tends to support his/her account. With some hesitation we accept that this may have been a verbal order.

November 2001

FF

- 2.166 There were no charges brought in respect of this patient although the circumstances of his death were investigated by the West Yorkshire Police. The patient's son believes that his father was murdered by Sister Grigg Booth. We were therefore asked to include consideration of his treatment as part of our Inquiry under paragraph 1 of our Terms of Reference. We have done so. We have reviewed the medical records and read the police statements. We have also read the correspondence from FF's son. He did not attend the hearings.
- 2.167 FF was born in November 1919. He lived in a nursing home. He had a number of medical problems, including non Hodgkin's lymphoma. On 2nd November 2001 he was admitted via his GP to Airedale. He had a urinary problem. In addition he was not eating and was confused. A catheter was inserted and FF was kept in over night. The next morning an

SHO reviewed him. He was feeling better. He was discharged with an appointment to return in 7 days. In fact he returned to the A&E department the same evening with a letter from the nursing home saying his catheter was blocked, he had been vomiting and was suffering from central chest pain and lower abdominal pain. FF was readmitted to Ward 15. He was seen by the SHO at 23.30. He ordered a number of tests. At about 00.30, according to the nursing Kardex he was vomiting. The house officer was informed. 10mg of metoclopramide was administered intravenously by the nurse on the ward. It had been prescribed earlier. Saline was also administered.

- 2.168 The house officer asked the SHO to see FF. The SHO has timed his note of attendance at 03.45. FF was very unwell at that stage. The house officer remained involved with the patient and wrote up the prescriptions. Although she did not enter the time on the chart she said in her police statement that she would have written them at about the time the SHO was carrying out his review. The SHO thought they were written later, after a review by the medical registrar. We think the house officer may have written prescriptions on 2 occasions. The diamorphine was probably written up before 04.25 since that is when it was administered (see below). The rest of the medication that appears after diamorphine may have been written up later and was not, in the event, administered.
- 2.169 Nurse C, who gave evidence before us, and made a statement to the police, helped about the events of the night of 3rd/4th November 2001. She and another nurse removed an ampoule of diamorphine from the controlled drugs cabinet on the ward, in accordance with hospital procedure. She put half of it down the sink as it was not required. The remaining 2.5mg were given to the Night Nurse on duty, NNP4. He/she then administered it to the patient intravenously and signed in the “*given by*” column in controlled drugs book and on the prescription chart, timed at 04.25. The documentation was all properly completed by the nurses. NNP4 told the police, as he/she told us, that he/she believed he/she was authorised to administer the diamorphine intravenously. We know from other evidence that he/she had done so on many occasions in his/her long career at Airedale.

- 2.170 The SHO discussed FF's condition with the medical registrar. His initial view was that FF should be transferred to the High Dependency Unit. In the meantime nursing staff were trying to contact relatives as they were concerned to let them know of FF's deteriorating condition. The nurse on duty wrote in the Kardex *"Attempted to contact relatives due to deteriorating condition but unable. Nursing Home stated they tried to contact relatives earlier but also unsuccessful. Patient to transfer to HDU after consultation with medical registrar"*. The following then appears in Sister Grigg Booth's writing *"Son contacted by myself and aware of condition and transfer to HDU"*. That is the only record of any dealings by Sister Grigg Booth with this patient. There is no record of her assessing or treating the patient at any stage nor does anyone suggest that she did.
- 2.171 The next note on the Kardex was written in the High Dependency Unit. By that stage FF was in *"crashing heart failure"*. Frusemide was prescribed and given and a chest X-ray was performed. The medical registrar reviewed FF. His note is timed at 05.30. It begins *"patient exceedingly unwell – sudden further deterioration"*. It was his impression that FF was suffering from an acute myocardial infarction, cardiogenic shock. He was probably suffering from sepsis and renal failure. He spoke to FF's son over the telephone. He records the following *"Discussed with Son. Very poor quality of life. Unable to mobilise due to pain in lungs. Does not want aggressive resuscitation. "Don't let him suffer"."* In the Kardex the following appears *"The Medical Registrar spoke to FF's son on the phone as he lives in Sheffield and is unable to visit at present due to transport problems. Son aware of poor prognosis and that it is unlikely that his dad will survive. Monitoring sinus rhythm. Decision make (sic) that any further medical treatment would be futile. FF to be kept pain free and comfortable and no further resuscitation measures to be taken"*.
- 2.172 FF was in the last stage of life. His son and daughter in law arrived at around 08.15. He died peacefully at 08.25. The medical registrar certified death. NNP4 told the police he/she could not remember whether he/she had given the drug as prescribed (i.e. intravenously) or not. In evidence before us he/she accepted that he was likely to have given it intravenously.
- 2.173 Professor Forrest considered that the prescription of diamorphine was correct; in his report on this patient he said diamorphine is used in that situation to reduce the workload on the heart and to allow it to work more

efficiently. We accept his evidence about that. The NNP appears to have given it competently. The question of whether or not he/she was authorised to administer an opiate intravenously we have already dealt with repeatedly. We accept that he/she believed that he/she was and had reasonable grounds for so believing. There is no basis for saying that the administration of diamorphine to FF was linked to his death.

2.174 FF's son believes that Sister Grigg Booth was responsible for the death of his father. We have seen no evidence to support that from any of the contemporaneous records. There is nothing to suggest that Sister Grigg Booth was involved in any aspect of his care (other than to contact his son).

2.175 FF's son made an application to the Criminal Injuries Compensation Authority in respect of the death of his father. He sent us some documents pertaining to the application. The first was a minute sheet dated 23 February 2006 which reads as follows

"To [name], CICA

From [name], Crime Clerical Officer, Keighley CID

Subject: FF (dec'd)

I refer to your letter dated 23rd January 2006 regarding the above [the panel has not seen that letter].

Attached is a brief description of the circumstances in which the death occurred.

The date of the inquest and court where held are unknown.

No person(s) have been charged with this offence

The deceased was in no way to blame and there are no convictions."

On the photocopy we have there is a signature from a Detective Inspector.

- 2.176 We believe that the document headed "*submission sheet – fatal application*" is the document said to be attached to the minute sheet.
- 2.177 The submission sheet records FF's name, date of birth and the date of his death. Under the title "*Description of Incident*" someone has written "*nurse unlawfully prescribed lethal dose of drugs*". Later on the form under cause of death someone has written "*Acute left ventricular failure*".
- 2.178 It is upon these 2 documents that FF's son relies in his assertion that Sister Grigg Booth murdered his father. From the documents we have seen no nurse prescribed any drug for FF, still less a lethal dose. The Solicitor to the Inquiry contacted the Detective Superintendent who is now responsible for these cases, and asked whether he could shed light on these documents. He replied as follows:

"The minute sheet dated the 23rd February 2006 is a report submitted to the Criminal Injuries Compensation Authority, briefly outlining the events, as known to West Yorkshire Police surrounding the death of FF. Whilst details of the request from the authority are not known, it would have been a response compiled by the host Division (Keighley) to such a request.

Requests by the authority for such information are commonplace and generally are dealt with by a Crime Clerical Officer within the Division. On this occasion I note that it has been endorsed by the Detective Inspector [name]. In general terms such requests are made by the authority to the police at a time, subsequent to a claim being made to them from either a victim of violent crime or a surviving relative. Any response in the first instance would contain nothing more than brief details of the events to enable the authority to form a preliminary view with regard to a compensation award.

West Yorkshire Police has no information with regard to the outcome of the claim for compensation.

The 'fatal application' sheet which appears to have been copied to the rear of the aforementioned minute sheet is a form used by the Criminal Injuries Compensation Authority.

The form contains brief details of the incident which correlate with details found on the crime report covering this specific investigation, recorded

by West Yorkshire Police.

The initial crime report that was recorded did in fact record the details of the 'allegation' in respect of FF's death and a brief section of this was recorded as per the 'fatal application sheet'. The detail on the fatal application sheet, I can only presume, were replicated on that sheet from a copy of the West Yorkshire Crime report provided to the Criminal Injuries Compensation Authority. What it does not explain is the lengthy investigation that followed after which no evidence could be found to support that allegation. Regrettably, problems were compounded when the crime report was not finalised appropriately which then added to the complications with the deceased family and their understanding of the events leading up to FF's death.

Suffice to say that issues are currently being considered at Assistant Chief Officer level to remedy the inaccuracies in this report.

What is clear from the investigation is that whilst FF died within the hospital, there was no evidence to support an allegation or charge against any individual for his death. There are undoubted inaccuracies in the crime reporting processes which were considered and finalised by officers remote from the investigation and some time after the investigation had been completed. The involvement of officers in this finalisation process was in order to properly administer the crime recording and finalisation process.

Regrettably, this was not well handled and as stated previously the circumstances are under review."

- 2.179 It would appear therefore that the information on the submission sheet is simply wrong. It does not cause us to change our view about the facts of this case.

April 2002

XC

- 2.180 During the evening of 5th April 2002 XC was admitted to Ward 8 of Airedale Hospital via her GP. She was short of breath. The SHO's impression was that she had right ventricular failure. She also had a chest infection. She remained in hospital overnight during which she was prescribed (by doctors) oxygen and a number of drugs including diamorphine and Frusemide. At 07.15 the nursing Kardex records that the patient was seen by a doctor who had increased the oxygen. The note also records "*Given stat doses of 80mgs IV Frusemide, 2.5mg diamorphine IV and Maxolon IV 10 mgs given by NNP4*".
- 2.181 NNP4 has no memory of this patient. That is not surprising at this distance of time. He/she told us that since the prescription was for the drug to be administered intravenously or intramuscularly he/she would have asked the doctor which route was preferred. He/she assumes he/she was told to administer it intravenously since that is what he/she did. We find that he/she did administer the diamorphine intravenously, as set out in the Kardex.
- 2.182 The issue was whether or not NNP4 was authorised to administer opiates intravenously. It is clear from everything that we have read that he/she reasonably believed that he/she was. There is no suggestion that he/she administered the diamorphine incompetently.

NNP2

- 2.183 NNP2 was another long standing night practitioner. He/she had worked on nights since the late 1970s. We have referred already to the NNP training file. He/she too had undergone training in the IV administration of drugs, advanced life support and so on. He/she told us he/she was aware of the risks of intravenous administration of opiates and understood how to administer such drugs safely and competently. He/she did not recall ever having a job description. He/she recalled that throughout his/her time on nights he/she had taken verbal prescriptions for a whole range of medicines. He/she was unclear about when he/she started to take verbal prescriptions for opiates. He/she had not always done so, he/she said. By

the late 1990s he/she was doing so. He/she would leave the prescriptions on the ward for the doctors to sign the next morning.

- 2.184 NNP2 made the point that pharmacists and others audited the prescription charts. Consultants read the records. He/she believed that if she was doing something wrong he/she would be told. He/she recalled NNP Manager 1 stopping all prescribing in mid 2001. At some later point he/she became aware that verbal orders were no longer acceptable.
- 2.185 NNP2 also told us that DM visited the wards at night from time to time. He always praised Sister Grigg Booth, described her as a good, safe practitioner.
- 2.186 He/she said that Sister Grigg Booth was telling him/her and the other NNPs that she was getting hassle from the managers for getting the doctors out of bed. Sister Grigg Booth suggested he/she could prescribe e.g. paracetamol. He/she did not say that Sister Grigg Booth had told him/her to prescribe opiates. He/she said that when a patient was in collapse and no doctors could attend he/she would prescribe and administer an opiate. He/she also told us that she understood from discussions with others that NNPs were expected to administer opiates intravenously. Often he/she felt he/she could do that better than the junior doctors. He/she had had a period of supervised practice and felt competent to do so.
- 2.187 We have reviewed 5 patients with whom NNP2 was involved.

January 2000

CY

- 2.188 We deal with the facts here in outline only. CY was an elderly lady. She was admitted to hospital at the end of 1999. In January she was complaining of a great deal of pain, particularly on the night of 12th-13th. The entry for 07.00 on the 13th, completed by Nurse W says "*pethidine given for pain, after discussion with Dr M*". In the morning of the 13th the Kardex records the patient complaining of pain at 05.25 and that hot water and Gaviscon had had little effect. The drug chart signed at 06.30 shows the following under the "*as required prescriptions*" "*Pethidine 50mg IM 4-6 hourly Prescribed by NNP2 Given by CMG*".

- 2.189 NNP2 says he/she received a verbal order from Dr M. The records support this although he/she did not specifically record the fact of a verbal order on the chart, nor did Dr M sign it. We accept his/her evidence that he/she took a verbal order for an opiate and then recorded it as a written prescription on the chart. We repeat that verbal orders for opiates were not permitted under hospital policy. Nonetheless they were going on.

April 2000

SH

- 2.190 This patient was admitted via A&E with severe back pain and vomiting. She reached the ward at 03.40 with a management plan of *“Adequate Analgesics. Bed rest for 24-48 hours then attempt mobilisation”*. According to the drug chart, in the once only prescription chart *“morphine 10mg”*. Signed as prescribed and given by NNP2. The prescription and administration is reflected in the nursing records also.
- 2.191 There is no documentary evidence that this was a verbal order. On the face of it NNP2 prescribed and administered morphine to alleviate the patient’s pain. In prescribing he/she was acting unlawfully. Professor Forrest said *“It certainly cannot be said that there is any realistic probability or even possibility that in this context the patient did, or could have come to harm as a result of this prescription.”* NNP2 was sure that it must have been a verbal order. Whilst that is possible, it does not seem likely, given the absence of records from a practitioner who did normally make a record.

January 2001

BZ

- 2.192 Again we deal with the facts in brief. The patient was terminally ill and in pain. We have reviewed her medical records for her final admission in January 2001. It is plain that NNP2 was closely involved with this very poorly patient. He/she recorded in the clinical notes at 03.40 *“Asked to see patient acutely distressed.”* He/she recorded his/her findings and assessment. He/she then wrote *“discussed with Dr K to have Frusemide*

40mg, Diamorphine 2.5mg and other drugs". The drug chart shows the following entries:

Buccal sus, diamorphine 2.5mg iv 03.45 signature – verbal order Dr K time given 03 45 given by NNP2/Nurse H.

- 2.193 The nursing Kardex reflects his/her entry "*NNP2 called and spoke with Dr on call. Frusemide 40mg IV , diamorphine 2.5mgs iv given with no effect. Dr contacted again*" the note at 4.20 records that the on call doctor saw her again and a further 50mgs of Frusemide and 2.5 mgs of diamorphine was given IV at 04.10.
- 2.194 It looks as though the prescription was written out in anticipation of the doctor attending, hence the time has not been completed – only the numbers 04 appear. The time given is recorded as 04.10 in a different hand, the given by section contains the initials of NNP2 and Nurse H. The nursing Kardex records that a verbal order was given.
- 2.195 NNP2 said he/she had received a verbal order for this medication, including opiates. We accept his/her account.

March 2001

EW

- 2.196 EW was admitted to Ward 22 on 13th March 01. Again we give outline facts only. He had a serious underlying condition and was complaining of pain in the left foot. At 11.20 on the 12th March Oramorph 2.5mg orally 6 hours maximum was prescribed by a doctor, together with other medication. Oramorph was given on several occasions during the afternoon. At 19.30 the Kardex note records "*Dr wrote up outstanding meds and no further analgesia prescribed*".
- 2.197 Later in the evening NNP2 prescribed Oramorph 5mg/2.5mls ls. orally. The prescription seems to have been given in the early hours by a different nurse.

2.198 NNP2 could not really understand or remember this patient. The notes are not easy to follow. It does appear however that NNP2 prescribed an oral opiate and another nurse administered it. As was usually the case no questions were asked. The prescription appears to be unlawful. In the event the patient benefited from it.

December 2001

DX

2.199 This patient had a complicated medical history. He had been admitted to hospital with acute abdominal pain and vomiting in the early hours of the morning. He was prescribed morphine to be administered intravenously or intramuscularly every 2 to 4 hours on 6th December 2001. NNP2 administered a dose intravenously. He/she accepted that he/she did so. He/she believed she was competent to do so, and he/she understood he/she was permitted to do so. For the reasons we have already given we accept his/her position.

NNP3

2.200 NNP3 was, we believe, the most hostile to Sister Grigg Booth. He/she lays at her door responsibility for a great deal of his/her own professional and personal unhappiness. During the time he/she was an NNP he/she made many applications for other jobs. He/she did not succeed. He/she told us that he/she is now much better than he/she was at the time of these events.

2.201 We have already recounted his/her methodical approach to training and professional development. He/she confirmed to us that NNPs supervised day nurses in the giving of IV drugs. He/she told us she recalled the Senior Nurse Practice Development's memo from June 2001 dealing with verbal orders. He/she was quite certain that nothing was said about the intravenous administration of opiates until January 2003 when the message came via NNP4.

2.202 We turn to the 4 patients we reviewed with him/her.

January 2001

TG

- 2.203 TG was admitted to hospital with suspected appendicitis in January 2001. She was in pain and waiting for surgery.
- 2.204 The records show a prescription by NNP3 for morphine. It is countersigned by Dr D. We cannot tell whether the doctor examined the patient before NNP3 wrote out the prescription for morphine. Given what was already known it may have been reasonable to rely on NNP3's judgment. It seems clear that Dr D did give a verbal order for morphine. NNP3 wrote it up, and others administered it. This incident demonstrates very simply just how far from the expressed hospital policy accepted conduct at night was. Whatever was said about controlled drugs, they were the subject of verbal orders. NNPs were writing the prescriptions, at least on behalf of the doctor, and someone else again was administering that which had been prescribed by the doctor who had not seen the patient.
- 2.205 The patient's pain was assuaged by the morphine. She later underwent surgery.

March 2001

UF

- 2.206 We deal with the facts in outline only. The patient was elderly. She was admitted to hospital with swollen and painful legs. In the course of the late evening she became breathless, developed chest pain and became very anxious and agitated. NNP3 prescribed and administered intravenous diamorphine and Maxolon. At that time the doctor had not seen the patient. Professor Forrest is of the view that because these symptoms were new NNP3 should not have come to his/her own diagnosis but should have called a doctor. NNP3 says that he/she remembers the patient and that he/she discussed her with the doctor before administering anything and that this was a verbal order. His/her note refers to the patient being "*for review*" by the doctor after he/she had finished treating her and there is no mention of preceding discussion. We know this is one of the areas in which NNP3 felt particularly confident and we are not satisfied that this really was a

verbal order. It might have been. In the event Professor Forrest did not suggest that the patient had suffered as a result of this.

September 2001

WD

2.207 We deal with the facts in outline only. The patient was admitted to hospital with chest pain. He was prescribed diamorphine in a dose of 2.5 milligrams to be given either intravenously or subcutaneously. NNP3 was called to see the patient in the night when he became very anxious and complaining of chest pain. NNP3 gave oxygen and then administered the diamorphine intravenously. Given the observations we have already made about intravenous administration of opiates by the NNPs we see no purpose in pursuing this further. Professor Forrest criticises the choice of the intravenous route rather than the subcutaneous route but he acknowledges that the patient settled after the injection. It was wholly unrelated to his death some days later.

October 2001

VE

2.208 The patient had a complex medical history. She was admitted to Airedale, aged 48, suffering from a very severe headache, a particularly unpleasant form of migraine. The specialist registrar prescribed intravenous diamorphine and administered an intravenous dose at 22.15. A further 5 milligrams were prescribed to be given intravenously later. NNP3 administered the diamorphine at 04.25. He/she recorded his/her actions and that the diamorphine had settled the patient.

The patient suffered no harm as a result of the injection, she obtained some relief from her pain. Given what we have already said on the subject of intravenous administration of IV opiates by NNPs we see nothing to be gained by reviewing this incident any further.

CHAPTER 3

TERMS OF REFERENCE 2

To review, and comment on, how the incidents came to light and how further matters of concern were raised and investigated in the Trust.

Summary

- 3.1 As is clear from our findings under the first paragraph of the Terms of Reference the actions of the NNPS were not hidden. Their records were available to and seen by nursing staff, medical staff, pharmacists and managers. Those who looked at them, as we have seen, either did not register what the records showed, or assumed they showed something permissible. A number of nursing staff commented that they would have expected the pharmacy to notice since the ward pharmacists visited every day, as they still do. It was made clear to us that ward pharmacists at Airedale are too busy to be checking signatures. Their role is to check that medication is correct for patients, not to check who has been signing what. At least we can infer therefore that in general the drugs that were being prescribed, administered, were correct for the patients being treated by Sister Grigg Booth and other NNPs.
- 3.2 The practices at night came to wider attention almost by chance. At the instigation of the then Medical Director the Trust had set up a Performance Indicators Committee which conducted clinical audits. This was a good initiative. In the latter part of 2002 the committee was auditing the records of a number of patients who had died, with a view to examining the care of patients who were said to be "*not for cardio pulmonary resuscitation*". In September 2002 two members of the committee, a consultant and the Nurse Consultant in critical care took copies of the medical records of AZ for review. At a meeting in December 2002 to discuss the records the Nurse Consultant noticed that Sister Grigg Booth had recorded that she had administered an opiate intravenously. The Nurse Consultant was a relative newcomer to the Trust and she asked her consultant medical colleagues whether this was permitted at Airedale; in her experience intravenous administration of opiates was the province of doctors and a very few, trained nurses in particular hospital settings. The doctors on the committee did not know the position at Airedale and the Medical Director asked the

Nurse Consultant to make some inquiries. She checked with the Clinical Nurse Specialist for Acute Pain at the Trust (who had worked there for some years) and with the Senior Nurse Clinical Governance. Both assured her that this was not permissible at Airedale. In fact the Senior Nurse Clinical Governance recalls that she also checked with the Nurse Specialist for Acute Pain as she was not quite sure herself. She also confirmed to us that it was the Nurse Specialist for Acute Pain who provided her with the relevant documents and who described the role of the Night Nurse Practitioners to her.

- 3.3 We thought it surprising that someone with the title Senior Nurse Clinical Governance was not already aware of these matters. We suspect it reflects in part the generally poor understanding of the role and work of the NNPs and in part due to the true nature of her role.

Senior Nurse Clinical Governance

- 3.4 The Senior Nurse Clinical Governance (SNCG) provided to the Inquiry a very long and extremely detailed statement. She gave evidence at some considerable personal inconvenience, and despite ill health. In early March 2010 she kindly provided a further detailed statement when we asked her to deal with further issues that had arisen in the course of the hearings. We are grateful to her. It is quite clear that she had a key role in the investigation, at first within the Trust, and then as a member of the police team. As she put it she “*drove the thoroughness of the investigation*”. It is important therefore to understand what her role was at the Trust.
- 3.5 The term “*Senior Nurse Clinical Governance*” suggests that this nurse was responsible at high level for clinical governance. That was not the case. She was fairly new in this post, although she had worked at Airedale for some years and had time off for maternity leave. She had family and health issues and the Divisional Manager offered her the role of SNCG with an assurance that it would allow her flexibility. She says that although this was said, she did not trust the Divisional Manager (DM) and did not avail herself of any flexibility. Her distrust was based on what others had said the DM had said about her. There was no great clarity about the role when she took it on. It was not, in practice a senior management role. She described herself to us as rather embarrassed to have to acknowledge that what she was asked to do was really a series of tasks, rather than high level

management. In particular she had done a lot of work on complaints handling within the Trust, and, she told us, made improvements. It seemed to us (and we were unable to ask DM about this) that the post was available, the nurse needed a job so the two were put together.

- 3.6 The SNCG had had previous dealings with Sister Grigg Booth. She felt she was unprofessional - because of her language, her attitude to training and the parrot incident. She had also found her intimidating, on occasion. More recently she had been responsible for disciplining Sister Grigg Booth's husband after he had put pressure onto a ward nurse in September 2002 to give him some tramadol for Sister Grigg Booth when she was in pain. During the disciplinary process Sister Grigg Booth telephoned her repeatedly. In addition, in the course of her investigation of the tramadol incident the SNCG obtained Sister Grigg Booth's medical records and reviewed them. She also discussed them with medical staff. She told us that Sister Grigg Booth was considered to be displaying "*opiate seeking behaviour*". When giving evidence she considered that her previous knowledge of and dealings with Sister Grigg Booth contributed to the way she considered the information she received; they were part of the jigsaw.

December 2002

- 3.7 The Nurse Consultant gave the patient records to the SNCG on about the 5th December 2002. The SNCG reviewed them. She noticed that as well as administering the diamorphine Sister Grigg Booth had signed as prescribing it, although there was a second signature (that of a junior doctor) also on the prescription chart. The SNCG thought this was very suspicious. It did not occur to her, she told us, that there may have been a verbal order from the doctor. She was unaware that verbal orders were used at night. She told us that she did not think the doctor's signature was a forgery. In that case the assumption must have been that the doctor had approved the prescription after the event.
- 3.8 The SNCG told NNP Manager 2 of her findings. She expected him to deal with it. She asserts that he did not revert to her, despite a number of reminders. Having heard from NNP Manager 2 during the hearings we think it likely that he simply did not get round to it, in the same way as he did not get round to dealing with many issues in respect of which, according to

several staff members, he would say “*leave it with me*” – and that was literally what happened. It stayed with him with no action.

- 3.9 The SNCG did not let it go, quite rightly. She wanted the matter pursued; she was correct to ensure that something was done.
- 3.10 NNP Manager 2 suggested that he and the SNCG approach the DM with the findings. This was towards the end of December 2002. DM instructed them to carry out a snap shot investigation. DN1 recalls NNP Manager 2 and DM coming to her and explaining to her what had been found in the first set of notes. She agreed with the course taken by the DM.
- 3.11 The SNCG and NNP Manager 2 understood that they should not ask staff for information since there might be a need to inform the police about the patient’s death. Both DM and DN1 considered that this initial audit should be low key and on the documents. Whilst we understand this approach we suspect that had anyone asked the NNPs at that time whether any of them were administering opiates intravenously they would have been told the truth. Had anyone troubled to read their daily diary they would have noted that some of the NNPS were administering chemotherapy drugs, far more toxic and dangerous than the opiates and other medication. They appeared to have permission to do so. Had that been noticed at that early stage far reaching questions as to what was going on at night would have been unavoidable.

January 2003

- 3.12 Over the next 3 weeks the SNCG and NNP Manager 2 reviewed the controlled drugs registers, identified Sister Grigg Booth’s signature and then obtained the medical records for all patients who had received controlled drugs from Sister Grigg Booth. They discovered many instances of Sister Grigg Booth administering opiates intravenously, and apparently prescribing opiates and other medication. As we said earlier, given that this was all done so openly it is not surprising that so much was found so easily.
- 3.13 We record that there is a dispute between the SNCG and NNP Manager 2 about their attitudes to the investigation. The SNCG took the view that NNP Manager 2 was less than assiduous in his task, flicking through notes rather than reading them properly. NNP Manager 2 believed that SNCG brought

considerable enthusiasm to the task and seemed pleased when she found evidence against Sister Grigg Booth. The SNCG disputes that she was pleased, she told us she was increasingly shocked and amazed by what she read. At this distance of time and after all we have read and heard the best we can do is to say that it was our impression that NNP Manager 2 was less energetic in his pursuit of evidence against Sister Grigg Booth than the SNCG. We suspect that is a reflection of their respective approach to work generally.

3.14 NNP Manager 2 and the SNCG reported their findings to DM. DN1 was also told. It was her view that the police should be informed – for the purposes of seeking their advice, she told us, rather than reporting a crime. She recalls informing the CE1 (who, until this point was also wholly ignorant of the investigation). Although CE1 could not remember the details of any conversations with the Director of Nursing, and there are no records, he was quite sure he had been consulted by DN1 about the decision to call the police and he agreed with it. We accept that. The evidence about precisely who called the police is inconsistent. What matters is that the police were contacted on the 20th January 2003. According to DN1 the police said the hospital should not conduct any investigation themselves until they had spoken to the police. No one at the Trust recorded that instruction or the reason for it. That should have been done.

3.15 The same day the following entry appears in the NNPs daily diary

"message from [NNP Manager 2] via [NNP4]. Please do not administer IV opiates until further notice. Anne on A/L now from 14th"

3.16 We have to say that this instruction would only have been necessary if there was some reason to believe that intravenous administration of opiates may still be going on. We note that it is not an absolute ban, but it is expressed to be until further notice. The NNP who made the entry confirmed that the instruction had been given by NNP Manager 2. The NNPs believed that the manager was aware that the NNPs were administering opiates intravenously. NNP Manager 2 was adamant in his evidence to us that, apart from what he had learned about Sister Grigg Booth's activities, he did not know that anyone was administering opiates intravenously.

- 3.17 The following day, 21st January 2003 the Trust Risk Manager contacted the SHA Risk Manager. From then on there was close liaison between the Trust and the SHA about the investigation. Members of the SHA visited the Trust and received a briefing as to events from, amongst others, the SNCG and the NNP manager. After this initial meeting the Director of Corporate Affairs at the SHA wrote to the Director of Nursing in relation to the Trust's initial response to the incidents coming to light and said *"we were strongly impressed with the way the situation has been handled and are keen to lend our support to you and your colleagues"*.
- 3.18 On 29 January the police came to the hospital and took away the investigation files. In the meantime efforts had been made to contact Sister Grigg Booth and suspend her. These failed and a letter was sent by the NNP manager on 22nd January 2003. On 30th January 2003 the SHA issued an alert letter.

February 2003

- 3.19 Whilst CE1 remembers discussing the situation informally with the Trust Chairman he did not arrange for it to be included in the agenda for the Board meeting scheduled for the 3rd February 2003. He and the Chairman agreed that it would be dealt with under any other business. It was dealt with under any other business after DN1 had been called from the meeting to take a call from the police. The Board meeting minute records that DN1 *"was called urgently from the meeting. Upon her return, she informed the board that, recently, a member of the nursing staff had been suspended from duty for administering an IV opiate without authority. The telephone call had been to confirm that the police department (sic) was now pursuing with the coroner the possibility of a charge of manslaughter, along with a charge of possession of drugs. Both the medical director and the director of nursing believed there had been no malicious intent on the part of the nurse concerned. The chief executive was concerned that unauthorised administration of drugs could be occurring elsewhere in the Trust. The medical director felt this was extremely unlikely. A minimal study of other practitioners drug administration practice had been carried out, which revealed no anomalies"*.

3.20 Three things arise from this:

First, there was no reference in this account, to the fact that Sister Grigg Booth was thought to have been prescribing opiates unlawfully. That is wholly different from administering opiates without authorisation.

Second, CE1 was absolutely right to be concerned that unauthorised administration of drugs could be occurring elsewhere in the Trust. We do not know upon what basis he could be reassured that it was not. As a matter of fact it was.

Third, we have no details of the minimal study of other practitioners.

3.21 The SNCG prepared a Serious Untoward Incident (SUI) report dated 9 February 2003. In the report she recorded that "*all nurse practitioners' practice were audited using the same method. None have been found to be prescribing medication outside of the identified Patient Specific Directions*".

3.22 In a recent note to the panel the SNCG said that she was sure that "*we actively audited notes in relation to the other NNPs*". We accept that but unfortunately there is no record. Had the same approach really been taken to the task as to the investigation into Sister Grigg Booth it would have shown that other NNPs were, on the face of it at least, prescribing opiates and other medication. We conclude that whatever was done at that time was not sufficient to find what was there to be seen. Like the discussion in the Board meeting on 3rd February 2003 the assertion about the practice of the other NNPs gave unwarranted reassurance about the scope of the perceived problem.

We note that the SUI report does not deal with the issue of whether other NNPs were administering opiates without authorisation.

3.23 The SUI report was sent to the NMC on 18th February 2003. They placed Sister Grigg Booth on an interim suspension order from 8th April 2003. Sister Grigg Booth had already agreed not to work as a nurse while suspended from duty.

The Trust Board

- 3.24 Shortly after the police took away the initial documents they sought a briefing from the Trust. DN1 was unable to attend so the SNCG took the lead in briefing the police as to her findings. NNP Manager 2 was also in attendance. We think it unfortunate this important first meeting took place in the absence of any Board member. A message needed to be given to the police that this matter was being considered at the highest level. At a much later stage DN2 reported to CE1 that the police had doubts about his level of commitment to the investigation because he had not been closely involved. CE1 took issue with that. We asked the retired Detective Superintendent for his views. He told us on reflection that he thought that CE1 was working very hard to keep the hospital running effectively, he had delegated the liaison with the police to the DN (1 and later 2) and that was probably entirely reasonable. We accept CE1's evidence about this issue.
- 3.25 The Director of Nursing was the initial point of liaison between the police and the Board. At an early stage DN1 provided the police with some information about hospital policies. She updated the Board from time to time on the progress of the police investigation, principally from what she was told by the SNCG but also from her own contact with the police.
- 3.26 From February 2003 the Trust Board proceeded on the basis that the police had effectively prohibited them from carrying out any sort of internal investigation during the currency of the police investigation and criminal proceedings. Some contemporaneous documents are inconsistent with this (e.g. a note written by the DN1 in which she records that the police asked the Trust to carry out a further investigation and she said, on behalf of the Trust, that they would provide clinical support to the police but they had sufficient information for their own disciplinary purposes and any further investigation must be the responsibility of the police.) The DN1 and every other Board member who provided a statement and/or gave evidence assured us that they honestly believed that the police position was that they should not investigate. The police witnesses confirmed that it was most unlikely that they would have asked the Trust to carry out an investigation, for that was a police role. We conclude therefore that the notes were inaccurate. We accept that the Board honestly believed they could not investigate. This confusion highlights the need for effective communication

between a Trust or any other public body being investigated and the police. It also demonstrates the need for proper records of discussions to be made.

- 3.27 More than one member of the Trust Board asserted that the police had asked them not to minute their discussions about the investigations. We had already noted that the recording is extremely brief. The police did not accept that this had been said and we cannot see why it would have been. There may have been a misunderstanding. Plainly the question of what the Trust was entitled to do should have been debated at Board level within the Trust and with the police and a proper record of conclusions should have been made. We can see no proper basis for prohibiting the proper recording of Trust Board discussions.

Difficulties for the Senior Nurse Clinical Governance

- 3.28 According to the SNCG at this relatively early stage she asked DM to take her off the investigation. She did this because she felt that others were criticising her for her approach to it. The NNP manager had told another senior manager, apparently, that the SNCG seemed to have “*got it in for*” Sister Grigg Booth.
- 3.29 In the event she was not taken off the investigation. DM said that he would have regular meetings with NNP Manager 2 and the SNCG. These petered out after a while. The SNCG continued to play an active role helping the police; obtaining medical records, advising on procedures, analysing documents and so on.
- 3.30 The SNCG told the panel that her life became increasingly difficult at Airedale; people were avoiding her, those colleagues, medical and nursing, with whom she had previously had a good working relationship became distant. We suspect that their conduct was coloured by their views of Sister Grigg Booth too. The SNCG said that the conduct towards her of managers in the Acute Division was particularly unpleasant. She was told that the prevailing view was that she had blown the case up from nowhere. This was all entirely foreseeable. No attempt was made to manage the situation.

March 2003

3.31 The SNCG had heard gossip that Sister Grigg Booth had not completed her NNP training course. At the request of the police she obtained Sister Grigg Booth's personal file. There she found the letter date May 2001 from Sister Grigg Booth to DM. She appreciated the significance of the contents of the letter and drew it to the attention of DN1 who also understood the importance of the letter. She said the file should be passed to the police immediately. DN1 reported the contents of the letter to the Chief Executive. He was shocked. The way he put it to us was as follows

"I did find it a challenging document. I think I must have recalled being challenged at the time by it. The main reasons for being so challenged were two things, really. First of all, hitherto I had always regarded DM as an excellent manager. He was innovative. He delivered on targets. He engaged with his staff, often spending his own time on workshops and so on. So this information was contrary to my picture of him."

3.32 At the very least this letter suggested that a very senior manager was aware of unlawful practice and (on the face of it) had condoned it. It did not occur to anyone that Sister Grigg Booth may have honestly believed that her actions were supported at a very senior level within the Trust. DM was still working at the Trust. The police did not want potential witnesses being spoken to. The Trust did nothing, save that CE1 "*marked his card*" for future reference. We find it remarkable that DM continued to work in an important role for the Trust when this document was known about at the highest level. There was, we think, no appetite within the Trust to challenge him, irrespective of the police position. Were it otherwise we are confident CE1 would have engaged the police in robust debate as to how the situation could best be managed. We deal with the way in which CE1 ultimately dealt with this in Chapter 6, under Terms of Reference 5. We note that he was prepared, in March 2004, to complain to the police on behalf of his managers when their homes were searched.

3.33 We note the reference to DN1 in the letter from Sister Grigg Booth in May 2001. We have looked at the NNP diaries and we can see that DN1 visited the NNPs on duty at the end of 2000. DN1 described that visit to us. Its purpose was, as we understand it, to look at staffing levels. At one point she was with NNP4 on the ward. He/she was dealing with an elderly

patient who, he/she thought, was in left ventricular failure. DN1 recalls that NNP4 made a telephone call. NNP4 told us that he/she was calling the doctor. That must have been obvious. Thereafter he/she drew up an intravenous drug and administered it. NNP4 told us that the doctor had given a verbal order for diamorphine which is what he/she then administered. DN1 told us that she did not know that diamorphine was used in that situation. That matters not. The point is she was with NNP4 when he took a verbal order. She asked nothing about that. She saw him/her administer a drug intravenously and asked no questions. Unsurprisingly he/she considered that she approved of what he had done. What is surprising is that DN1 never made the very obvious connection between what she had seen and what the NNPs came to be accused of.

- 3.34 In about June 2003 the police asked the Trust to carry out a further, more detailed, audit. Again the work was delegated to the SNCG and the NNP manager. The same tensions arose between them. The SNCG was doubtful that the NNP manager was applying the same rigour to the task as she was. She was not satisfied that the information produced was reliable, and she rightly told the police of her concerns. The police therefore asked DN1 that NNP Manager 2 be removed from involvement with the case. This was done. DN1 agreed that the SNCG would be the sole point of contact and support for the police. This confirmed her already isolated position.

Secondment of Senior Nurse Clinical Governance

- 3.35 In August 2003 the police made a request of DN1 that the SNCG be seconded to work with them full time. DN1 was concerned about the resource implications of that (the Trust would be paying the SNCG but she would be doing no work for the Trust). The police told her that the SNCG would be the best choice because she had been working very well with them for some time. DN1 discussed the request with CE1 and DM. Their principal concern was cost but all agreed to the secondment, subject to the agreement of the SNCG. That the DM was involved in these sorts of decisions given what appeared in the letter of May 2001 which was now known about is frankly baffling.

3.36 It does not appear that any consideration was given by anyone to any of the following issues:

- i) Whether the SNCG was the right person to carry out the role, given her lack of knowledge of how the hospital worked at night, her previous dealings with Sister Grigg Booth, and the difficulties she was already experiencing from colleagues.
- ii) How she was to be supported and managed while on secondment in a role for which she was completely untrained. We acknowledge that DN1, and later DN2 took direct responsibility for her management, but DN1 and DN2 had no more experience in this sort of investigation than the SNCG. Indeed the SNCG remarked that she believed DN1 and DN2 felt as beleaguered as she did.
- iii) How she was to manage the inevitable suspicion with which she would be regarded by former colleagues. How the Trust was to explain her role to minimise difficulty.
- iv) How she was to manage the tension between her loyalties to the Trust and to the police.
- v) Whether and how she would be able to return to her pre existing role.
- vi) What direction the SNCG should be given as to the use of documents she generated during the course of the police investigation. Many of them, reports and such like, remain with the police papers but she retains her private notes. They include detailed reviews of the care of many patients and her notes of reviewing various documents.
- vii) Given the likely timescale (thought at that time to be one year) whether a rota of individuals might be more appropriate.

3.37 The SNCG accepted the offer of a secondment with alacrity. She told us that she felt that her future at the Trust was blighted. She could not return. She viewed the secondment as something of a safe haven. She also wanted to see through what she had started.

- 3.38 In our view the professional and personal price paid by the SNCG for this secondment was far too high. She was isolated from the Trust, except for contact with DN1 and, later DN2. She was working very hard. She had to keep secret from her Trust colleagues matters that the police did not want to share (e.g. the news of imminent arrests, suspicions about other staff). She was privy to important information about DM. He was particularly unpleasant to her, she told us. She was not a police officer and did not have the benefit of their support network. She enjoyed the investigation, but she was struggling without effective support in a field in which she had no experience, no training and too much responsibility.
- 3.39 We understand why the police sought a secondment and in many ways from their perspective it worked well. The retired Detective Superintendent did say that in hindsight the selection of the SNCG may not have been the right one.
- 3.40 We understand that the secondment of a senior nurse to work with the police in an investigation at the Leeds Teaching Hospitals NHS Trust was considered to be very successful. The situation there was very different from the situation at Airedale; in Leeds the police and Trust were dealing with a relative newcomer to the Trust who had, over a relatively short period, systematically killed or injured patients by administering insulin to them. In Airedale they were investigating the conduct over some years of a very long established nurse with a good reputation as a dedicated and caring nurse. It was obvious to the Trust from an early stage that the case would be lengthy and complex, that feelings may run high, and that there would be a significant burden on individuals. It is not apparent that this was considered.
- 3.41 We add, by way of completeness, that in due course, and before the police investigation was concluded the SNCG found alternative employment and left the Trust. She brought proceedings for constructive dismissal against the Trust. These were settled and the Trust acknowledged the work that she had done for the Trust with the police.

The other NNPs 2003/4

- 3.42 In the latter part of 2003 the activities of NNP2 were reviewed. He/she was arrested and suspended from duty on the grounds that he/she had unlawfully prescribed opiates and other medication and that he/she had administered opiates intravenously without authorisation. As we said earlier this was no surprise. The NNP had made no secret of what he/she was doing. Almost a year later the activities of the 2 NNPs who had previously made statements were investigated. Again everything they had done they had recorded. They too were arrested in October 2004.
- 3.43 Sister Grigg Booth was subject to disciplinary proceedings in her absence. After a long drawn out process she was eventually dismissed in October 2004. She had earlier sent the following letter:
- “I am qualified to give Class A drugs and have always checked them with another nurse as is protocol with any Trust. I have never prescribed class A or any drugs without consent from a doctor. I would not harm anybody and never end somebody’s life”*
- 3.44 In due course the other NNPs were subjected to disciplinary action at the Trust. One took early retirement, the other two were downgraded and eventually left the Trust. All 4 were reported to the NMC. NNP3 told us that he/she had to go to London for a hearing but no further action was taken against him/her. No action was taken against the other NNPs or NNP Manager 2.
- 3.45 DM resigned at the time he was arrested.
- 3.46 Both senior managers were interviewed under caution by the police in October 2004 but no charges followed.

Trust documents

- 3.47 As was to be expected the police took possession of thousands of documents. Whilst effective arrangements were in place to ensure that patient records were provided with consent, and that they were effectively tracked, the Trust made no arrangements to record or monitor any other documents. No copies were retained. The Trust was wholly reliant on

finding duplicates of documents in other parts of the hospital or on the notes and memory of the SNCG for a record of what had been taken. She was not always there when documents were removed. This was elementary. A moment's thought would have led to some sort of system being put in place. There was plenty of time between the call to the police and the police arrival on the 29th January to develop a simple system for recording what was taken, and to agree with the police a system for retrieval of documents that were needed. Because this was not done the Trust was deprived of its own records for years. As a result when a team came to carry out a documentary review in 2005 not only were documents unavailable, the team was unaware of much of what existed. In this Inquiry we were reliant on the cooperation of the police (which was given unhesitatingly) in order to piece together important information.

File H40

- 3.48 We have dealt with the contents of this file in some detail already. It was taken from the DM's office in March 2004. The SNCG's contemporaneous notes which she provided to the panel in early March 2010 show that she reviewed the file in some detail. Perhaps unsurprisingly she does not now remember all the documents in it. At the time she made a particular note of the entries for 2.11.96, 29.10.96, 13.11.96, 15.10.96, 10.11.96, 9.11.96, which revealed NNPs giving IV diamorphine, NNPs taking verbal orders, and giving temazepam.
- 3.49 The SNCG said in her supplementary statement that because there were no patient names on the forms it was difficult to know how the incidents could be properly investigated. She also said that these forms were from outside the police period of choice (2000-2002). All of that is correct. What the SNCG may not have thought about was the significance of the fact that several NNPs (not including Sister Grigg Booth) had openly recorded various activities which the SNCG believed were unlawful, they had provided the records to a senior manager (who was by now the Divisional Manager) and nothing had been done.
- 3.50 There is no record of this information ever getting back to the Trust until it was considered in the course of our hearings. Its contents were clearly completely unexpected to CE2 who described listening to that evidence as "*harrowing*".

CHAPTER 4

TERMS OF REFERENCE 3

To review, and comment on, the information and support provided to the victims, relatives and Trust staff once the incidents had been identified.

Victims and relatives

- 4.1 The first contact by the Trust with patients, former patients and relatives was when they approached a number of them jointly with the police to ask for their consent to review their/their relative's medical records. The Chief Executive drafted an appropriate letter. The SNCG visited relatives with the police. This was all good practice.

Helpline

- 4.2 A helpline was set up for use when matters were reported in the media. We have seen some of the documents generated by the helpline. It was described to us in detail by the Assistant to DN1 who had responsibility for running it. It was open 12 hours a day. Each shift was manned by 2 senior nurse managers who were working on a rota. Details were taken from callers as to name, date of birth, dates of admission to hospital and so forth. Sometimes it was possible to tell the caller that Sister Grigg Booth had never worked on those wards, in which case they could be reassured. Often the case was sent to the Assistant to DN1 for her to check the records and provide a response to the caller firstly by telephone and then in writing with an invitation to contact the Trust if they had any further questions. The helpline ran for some weeks and once the level of calls had reduced the Assistant to DN1 dealt with calls directly.
- 4.3 Many people got in touch with the police who passed their queries to the Assistant to DN1 so they could be dealt with. In our view, the helpline, and the follow up system run by the Assistant Director of Nursing, was well thought out. It was efficient and of assistance to the people who called in.

During the criminal proceedings

4.4 Relatives told us that during the police investigation they felt well supported. They were informed of what was going on at each stage. This reflects well on the police and also on the SNCG who was involved with them on behalf of the Trust.

2005 onwards

4.5 Some relatives and patients complained that once the prosecution came to an end with Sister Grigg Booth's death they were simply "*dropped*", as they put it. In our meeting with them in May 2009 they asked whether procedures in the hospital were still the same as they were in 2002. This question demonstrated that no action had been taken by anyone at the Trust to reassure relatives and patients about improvements made at the Trust (from a very early stage) over the 7 years since the investigation began. This was very disappointing. It led to unnecessary anxiety for patients and relatives.

4.6 We recognise that the very prolonged delay in the setting up of this Inquiry was no fault of the Trust. We know that the SHA had written to relatives in October 2008 to update them on the subject of the Inquiry. It may be that the Trust and the SHA felt they had nothing new to tell patients and relatives about any investigation or Inquiry but it was a serious error not to inform the families of developments within the Trust between 2002 and 2009. We acknowledge that enormous improvements had been made within the Trust. In the well intentioned determination to establish effective systems and processes, the Trust forgot about the people. This should not happen again. We consider the Trust ought, at this late stage, to make contact with the relatives and invite them to meet the current Chief Executive, Medical Director and Director of Nursing.

Staff

4.7 As we have described in Chapter 3 information was at first restricted to the SNCG, NNP Manager 2, DN1 and the Divisional Manager. The Medical Director, as part of the Performance Indicator Group was also aware. In January 2003 the Chief Executive (CE1) was informed.

- 4.8 Some senior medical staff learned of what was going on through discussions in the corridor. Most did not know what was going on.
- 4.9 When Sister Grigg Booth was suspended, that fact was communicated to the on call manager, the modern matrons and bed managers so that she was not permitted on site. They were told that there was a police investigation relating to adherence to the hospital drugs policy.
- 4.10 We have no doubt that as time went on rumour and gossip (some of it ill informed) undermined morale at the hospital. CE1 said that the police were “*crawling all over*” the hospital: Officers were a constant presence, there was a police incident room on site. All of this was necessary, of course, but it was disconcerting for staff. Nothing was done to allay their anxieties.

Staff witnesses

- 4.11 When the police decided to interview staff (for the purpose of taking statements from them), the SNCG was keen that staff should feel supported. It was agreed that she and the NNP manager should accompany staff while they were interviewed. We question the wisdom of managers sitting in on interviews in this situation. We think that could have been an inadvertent impediment to witnesses speaking freely about what they knew and did not know about what was happening at night. Some of the statements reveal that the witness was given a lot of information apparently for the first time during the interview process (e.g. being told that NNPs were not entitled to prescribe opiates or other medication, or to administer opiates intravenously). We should make clear that the witnesses in the main did their best to assist the police, without reservation. We simply make the point that it may have been easier for them to do so without a manager listening to what they had to say.
- 4.12 We endorse the principle that consideration should always be given to providing support where witnesses would like it. We acknowledge that some people welcomed it. We note that the Assistant to DN1, who sat in on some interviews, recalls comforting anxious and distressed witnesses before and after they were interviewed.

Further communication with staff

- 4.13 We heard detailed evidence from the then fairly recently appointed Communications Officer. Her contemporaneous notes reveal that all her information about the investigation was coming from the SNCG. It is plain that the external communication strategy was to be reactive to media interest and to work with the police in responding to the media. The internal strategy was to brief staff only at the points where it was thought there was to be media coverage. We understand the concern that all organisations face when there is a police investigation going on in its midst. Nonetheless it should have been possible to give some information to staff about what was going on. This could and should have been negotiated with the police. It is quite wrong, in our view, that what the staff were told, and whether they were to be told anything, was decided solely by reference to what the media was going to do. That surely was only part of the picture. The other part was the need for the organisation to be functioning well for the good of its patients. If the staff are demoralised or, at least, disconcerted, this is much more difficult.
- 4.14 It is clear from the NNPs daily diary that the remaining NNPs felt very isolated and almost under siege. No support was given to them. They were expected to (and did) continue with their duties. It is not apparent that any thought was given to them at all.

CHAPTER 5

TERMS OF REFERENCE 4

To review and comment on the systems and processes in place at Airedale NHS Trust from 2000 to 2002 with reference to the NHS policies, standards, guidance and best practice prevailing at that time, specifically in relation to:

- a) corporate governance;**
- b) corporate management;**
- c) nursing management;**
- d) the human resources function;**
- e) the management of medicines, including prescribing, recording of medicines usage and the audit of medication;**
- f) multidisciplinary team working, especially during the night and;**
- g) the confirmation of deaths.**

Corporate Governance

Context

- 5.1 The purpose of the governance arrangements within the Trust was to ensure that the organisation's objectives were delivered effectively. That is, to provide safe, high quality, efficient and responsive healthcare to individual patients and the wider population served by the Trust, within the resources available to it. Given the events which transpired within Airedale Hospital, it seems obvious that there was a manifest failure within those governance arrangements: both patients and staff were placed at risk by individual and systems failures.
- 5.2 However, during the period in question, the Trust was not perceived to be a failing organisation, by any of the normal measures which would be applied against an NHS Trust. It is important to place the events which occurred within the context of the successful reputation which the Trust had enjoyed since its inception. It was a high performing organisation, which was subject to regular external audit of all its services. The Trust achieved a 'three star' rating, the highest possible, within the NHS performance management system prevailing at the time. It enjoyed very low mortality rates and

enviable levels of patient satisfaction with its services. Members of staff were proud to be associated with the Trust and the organisation subsequently went on to achieve a number of prestigious national awards for the quality of its services. It is clear from the panel's many discussions with witnesses, including former Board members that the failures which occurred came as a great shock to the organisation, and to those who had responsibility for leading it. It is equally clear, that those failures are regarded with deep regret and sadness at all levels of the organisation. However, it is also clear that the shortfalls in the governance arrangements within the Trust did not occur overnight, but were a recurring feature of systems failure.

- 5.3 Effective governance is not a 'one-off' event, but rather a continuous process of vigilance. It is the duty of any NHS Board to systematically and rigorously hold the organisation to account for the achievement of its objectives. It should do so by scrutiny of evidence and the exercise of judgement on a constant, iterative basis.
- 5.4 By its nature, healthcare carries a rich level of risk. There is no simple way to ensure absence of risk, and it is debatable whether that is even possible given the complexities of modern medicine. A critical element of the Board's scrutiny process is the identification and ongoing review of the key risks to which the organisation, its patients and the communities it serves are exposed. The dilemma facing all NHS Boards, is how to avoid falling into the trap of attempting to directly manage services, rather than taking an overview of them; whilst at the same time ensuring sufficient 'grip' on all of those things which are critical to the successful delivery of its objectives.
- 5.5 A balance also has to be struck between the conflicting pressures associated with the development of a risk sensitive versus a risk averse culture. Insufficient attention by NHS organisations to the negative aspects of risk can have disastrous consequences. However, risk averse organisations can often translate into lowest common denominator management, with little emphasis on innovation or the essential pursuit of continuous improvement. This may result in similarly disastrous results over the longer term.
- 5.6 In order to achieve the appropriate balance, NHS Boards are required to have a systematic and comprehensive assurance framework in place to test

risk related policy and practice and to deliver the robust evidence which forms the foundation of what may be regarded as reasonable assurance.

- 5.7 At the time of the events which are the focus of the panel's investigation, governance arrangements within the NHS were still in their relative infancy, and the term 'intelligent information' had not yet been coined. (However, the concept of effective governance was not new and there had always existed a duty of care to all patients and their families served by the NHS.)
- 5.8 Intelligent information is an appropriate blend of hard data provided by means of detailed and systematic analysis, leavened with 'softer' information derived from patient, staff and visitor feedback, ward and department visits, and a multitude of 'reality checks' necessary to make informed judgements on the part of the Board.
- 5.9 Quite properly, the Board must be some distance removed from the 'front line' of services, but without this blend they cannot achieve reasonable assurance that their objectives are being fulfilled. It also must be said that even the best assurance systems cannot offer certainty, let alone infallibility. In practice, this means that a Board must have in place below it, an appropriate sub-committee structure, whose remit is to test the effectiveness of clinical and management systems and processes, in order to be satisfied that performance is compliant with declared objectives, and to alert it to significant variation so that corrective action can be taken immediately.
- 5.10 Board governance has, aptly, been described as the application of collective wisdom to complex and often profound uncertainty. Along with many other NHS organisations, Airedale NHS Trust was entering into a significant period of complexity and uncertainty at the time of the incidents. Major restructuring of the NHS was taking place, which would have significant consequences for the range of services provided by the Trust; it would also impact upon the organisational shape and scale of the Trust. Additionally, the Government was committed to the European Working Time Directive and the implementation of what was termed the 'New Deal' in the NHS: a nationally agreed policy to limit the number of hours worked by junior medical staff.

5.11 Failure to achieve compliance with the targets for junior doctors' hours would have resulted in the application of severe sanctions upon the Trust, including, in the worst case scenario, the removal of training recognition for such posts. In simple terms, this would have meant the Trust would have been unable to recruit junior doctors and services to patients would have been curtailed accordingly. Taken together, the pressures arising from the implementation of those major policy issues would have represented a significant challenge. However, effective governance arrangements are designed to enable organisations to adapt to, and resolve difficulties arising from, operational pressures and changes to the external environment in which they operate. We set out below the governance structures which the Trust had in place during the period in question, together with national policy guidance which sets the context:

The Trust's Assurance Committees

The Trust Board had two Assurance Committees comprising the Audit Committee and the Clinical Governance Committee, in addition to the Board of Directors. A Risk Management Committee was in place supporting the assurance process. Both committees had terms of reference, which had been agreed by the Trust Board, contained in the Trust Standing Orders and Standing Financial Instructions, which were in hard copy.

The Audit Committee

The Audit Committee provided the Trust Board with a means of independent and objective review of financial and operational systems and compliance with law, guidance and codes of conduct.

The Clinical Governance Committee

The purpose of the Clinical Governance Committee was to assure the Trust Board and Chief Executive that high standards of care were provided throughout the Trust.

Policies, standards, guidance and best practice

- 5.12 The NHS Executive issued a Health Service Guideline on 24 March 1997 – 'Corporate Governance in the NHS: Controls Assurance Statements' which was intended to bring together existing measures for corporate governance under one controls assurance statement. This was followed by a variety of further guidance in subsequent years, designed to enhance existing procedures. The focus was on ensuring that an integrated framework was in place in each NHS organisation to verify that risks are assessed and mitigated to enable the Board to sign a Controls Assurance Statement, embracing all internal control.
- 5.13 From 1999/2000 Boards were required to produce a statement which would appear in their Annual Report, providing assurance that the organisation had a comprehensive risk management strategy in place. This required evidence that the risk management strategy was being actively implemented, that systems/procedures were being regularly reviewed and that, where required, developments and improvements were being made. Within Airedale it was recommended that a Board sub-committee should be established to oversee the process. Verification of the process would be evidenced by minutes, action plans, procedure notes and ad-hoc reports.
- 5.14 On 1st February 2000 the Trust Board received a NHS Confederation update 'Controls Assurance in the NHS' outlining guidance for implementing controls assurance in the NHS. The CE1 reported that further reports would be brought to the Board. The work was progressed by the Audit Committee and an action plan (approved by the Audit Committee in June) was presented to the Trust Board on 6th September 2000. The next presentation of the Controls Assurance Action Plan to the Trust Board was 5th September 2001. The plan had been submitted to the NHS Executive at the end of July prior to Board approval.
- 5.15 The Risk Management Strategy and Report 2000/01 was presented to the Trust Board on 3rd October 2001. The Board noted their responsibility for promotion of risk management and resolved to report risk management to the Board via the Audit Committee and Clinical Governance Committee. The report highlighted 24 red rated risks although none were related to medicines management.

- 5.16 On 5th June 2002 the Trust Board received an executive summary of the 'Risk Pooling Scheme' for Trusts outlining action required to comply with the new Controls Assurance Risk Management Standard. On 3rd July 2002 the Trust Board received additional information to support the Trust's adoption of the Australia and New Zealand 4360 risk management standard as a method of rating risk; this was widely accepted across the NHS as best practice. On 2nd October 2002, the Trust Board was presented with the first draft of the Risk Register. This would be a standing agenda item for the Risk Management Committee. The Trust Board minutes of 5th December 2002 state that the assessors for the Risk Pooling Scheme for Trusts had been impressed with the Trust's documentation and wished to use this as an example of good practice. The Trust had been asked to act as a pilot site for level 2 assessment. The Annual Report & Accounts 2000/01 published the Trust's Controls Assurance Statement, identifying the responsibilities of the Trust Board for maintaining a sound system of internal control, including risk management, and for reviewing its effectiveness.
- 5.17 To demonstrate the delivery of objectives, there was and still is a requirement that all NHS Chief Executives sign a Statement of Internal Control, which forms part of the statutory accounts and annual report.
- 5.18 Patient safety, clinical error, and adverse reporting had become a high priority within the NHS. The Government set out its plans for promoting patient safety in its publication "*Building a Safer NHS for Patients*" (DOH 2001). This placed patient safety in the context of the NHS quality programme and highlighted key linkages to other Government initiatives, i.e. Controls Assurance, Clinical Negligence Scheme for Trusts (CNST), Trust Performance Ratings, Clinical Governance (via Commission for Healthcare Audit and Inspection (CHAI)), and the Risk Pooling Scheme for Trusts (RPST). The CHAI report, RPST and Controls Assurance documents were all received either at Trust Board level or at sub-committee level. From the documents reviewed there should have been evidence of linkage between the committees to raise awareness of emerging risks e.g. via presentation of minutes at Trust Board level or by raising issues. This appears to have been a gap in the assurance process which from the documents reviewed appears to have been raised once the guidance document on the Controls Assurance Framework was issued in 2000.

- 5.19 However, the overall picture is that the governance structures within the Trust matched up with best practice prevailing across the NHS at the time of the events. So how could things go so badly wrong?

Weaknesses in the assurance process

- 5.20 Crucially, the assurance process itself did not prove to be sufficiently robust. The Board papers for the period in question do not provide sufficient evidence of assurance, nor did there appear to be a systematic framework in place for follow up of key agenda items. Follow up actions did routinely take place following Board meetings, but there was a potential for items to slip through the net as a failsafe mechanism was not in place to enable a guaranteed correlation between discussions in the Board, and the necessary steps to bring those discussions to fruition. Equally significant, the management structure in place below the Board did not always reflect back the reality of what was actually taking place at the 'coalface'. Reasonable assurance requires a close match between 'top down' policy dissemination and 'bottom up' feedback, otherwise there is a danger that the Board can find itself inhabiting a parallel universe to that of staff.
- 5.21 That feedback should come not only from those charged with responsibility for the implementation of policy, but also from those directly affected by the consequences of the way in which policy is implemented. In turn, that requires effective two-way communication to avoid distortion of the truth, whether deliberate or inadvertent. We find that communication throughout the Trust was not effective, and we will return to that in the management section. Ensuring ownership of the Trust's policies also requires a commitment to the values of the NHS which is not only articulated at all levels, but which is consistently demonstrated at all levels. Values should not only be spoken, but tested, validated, and refreshed regularly. Failure to 'live' the values of the organisation can create an environment of distrust and cynicism amongst front line staff.
- 5.22 We do not doubt at all that the Trust Board was sincere in its commitment to those values, but our investigations demonstrated that the Trust was, sadly, deficient in the way in which those values were tested throughout the organisation. From the documents we have read and the testimony we have gathered from witnesses, it seems likely that one or more senior managers took advantage of their position of delegated authority to impose upon

subordinates their personal view of the way in which the organisation should be run. Their personal values almost certainly failed to match with those declared by the Board.

- 5.23 Any management structure is only as strong as the weakest link in the chain, and the chain of command from the Board downwards was effectively broken in terms of the way in which the NNPs were managed. As a result of ineffective supervision of line managers, and a failure to take the opportunity for face to face discussions with night staff, the Board was party, unwittingly, to the creation of an environment which was totally at variance with their declared values and policies. We heard from a number of witnesses that staff did not have confidence in the HR policies, or the system for reporting grievances, and that a 'club culture' existed amongst an important cohort of senior management which was regarded as virtually untouchable. Additionally, a number of witnesses attested to the fact that Airedale Hospital was perceived to be quite insular and inward-facing.
- 5.24 A lot of staff had worked there, and in quite a few instances only there, for many years. Although this provided the advantages of stability and a 'family atmosphere', it also presented potential disadvantages: a lack of impetus to challenge the status quo, assumptions not being sufficiently tested, and scepticism about proposed changes. We can find no evidence from the documentation that these were issues that the Trust Board considered or sought to address.
- 5.25 The night staff in particular appeared to operate in a vacuum, separated from the world of day staff, save for brief handover arrangements for continuity of patient care. The normal arrangements for ensuring their involvement in management meetings and professional briefings appeared to be deficient and the supervision, challenge and professional support offered to Sister Grigg Booth and the NNPs was woefully inadequate. Of great concern is the fact that they were effectively left to their own devices. DM did visit the NNPs from time to time in his role as Service Manager and thereafter. The frequency of his visits is a matter of some dispute. Apart from 3 visits from DN1 between 1995 and 2003, no visits were made by members of the Trust Board at any time. CE1 and the then Chairman both acknowledged to the panel that they had never visited their hospital at night. We find this astonishing: CE1 had been in post since January 1992.

- 5.26 We have already made clear that it is not the function of any Board to attempt directly to manage services. However, by failing to undertake any 'reality checks' at night, whether formally or informally, in effect they were only taking an overview of governance arrangements during daylight hours. Hospitals are quite unusual as organisations, in that they operate 24 hours a day, 365 days a year and their governance arrangements should reflect that accordingly.
- 5.27 Despite the accolades it had received, the Trust was at risk: in a number of important respects the systems and processes in place did not 'close the loop' for the completion of an appropriate audit trail between declared Trust Board policy and its implementation. Without this, it is not possible to achieve reasonable assurance.
- 5.28 The panel heard conflicting views from witnesses about the level of debate within the Trust Board, and in particular the level of challenge offered by Non Executive Directors. Some claimed a good balance of support versus challenge to the Executive Directors; others suggested the Board meetings were not an effective forum and Non Executives tended to accept what was put before them. If the latter, perhaps this was not surprising since, at face value, the organisation was performing well against nationally agreed criteria. However, the minutes of Board meetings for that period certainly do not record any evidence of contentious debate, which given the complexity of the agenda faced by the Trust and the competing pressures on priorities, seems remarkable. This suggests one of two things: the debate was not sufficiently robust, or the minutes were not particularly well written. Either way, the outcome is a deficient assurance process.

Corporate management

Values and standards

- 5.29 There were, and still are, three crucial public service values which underpin the work of the NHS:

Accountability

Everything done by those who work in the NHS must be able to stand the test of parliamentary scrutiny, public judgements on propriety and professional codes of conduct.

Probity

There should be an absolute standard of honesty in dealing with the assets of the NHS: integrity should be the hallmark of all personal conduct in decisions affecting patients, staff and suppliers, and in the use of information acquired in the course of public duties.

Openness

There should be sufficient transparency about NHS activities to promote confidence between the NHS Authority or Trust and its staff, patients and the public.

All members of staff are required to demonstrate high ethical standards of personal conduct, such as those set out in the Nolan Committee's review of "*Standards in Public Life*".

- 5.30 The NHS issued a Code of Conduct for NHS managers in October 2002. Compliance with the code was mandatory for Chief Executives, Directors and other relevant Senior Managers.
- 5.31 The Trust Board received the draft Code of Conduct on 3rd July 2002, where it was noted that the Code would be incorporated into the Trust's Standing Orders in due course. The Management Board on 24th September also noted the Code. It is therefore evident that there could be no confusion

about the parameters within which corporate management should have operated within the Trust.

Systems and processes

- 5.32 The Standing Orders which would govern the constitution, the conduct of meetings and proceedings of the Trust had first been adopted on 15th January 1992. These were reviewed on an annual basis; however there is no evidence from the minutes of the Trust Board of these being approved at Trust Board level prior to issue. The Trust Board did however note that the new NHS Code of Conduct would need incorporating eventually into the Standing Orders. The Standing Orders included the Terms of reference for the Trust Board, Audit Committee, Clinical Governance Committee (established 1999/2000) and the Remuneration Committee.
- 5.33 A document binder was issued to the Trust Board and other senior managers containing (in hard copy) the Constitution and Standing Orders, Scheme of Reservation and Delegation, Code of Conduct, Code of Practice of Openness in the NHS etc.

Corporate management structure

- 5.34 The management committee structure in place was not dissimilar to many organisational structures across NHS organisations at that time and, as such, should have provided the necessary safeguards to ensure the Trust complied with the principles of corporate governance, clinical governance and the Code of Practice on Openness. In October 2000, the Trust's management arrangements were revised following a review by CE1 and an extensive consultation process.
- 5.35 The rationale put forward for change seemed perfectly sensible at that time in the life of the Trust. The existing structure had been in place for 10 years and had originally been designed to prepare for the internal market, integrated Trust status, involvement of clinicians in management, delegation of decision making and an emphasis on outcomes and quality in patient care areas. CE1 felt that the structure needed to be modified to reflect the future strategic direction of the Trust as a result of evolving Government policy; amongst other external changes which would impact upon the Trust was the creation of Airedale Primary Care Trust.

- 5.36 A greater focus would be placed on performance management, with significant power delegated to new Divisional Managers, whilst attempting to maintain the involvement of clinicians. From the evidence we have heard and the documentation it is clear that the new arrangements did not enjoy universal support. Almost certainly, they were a contributory factor to the apparent schism between professional and line management accountability for nursing staff, effective communication and clinical engagement.
- 5.37 The new arrangements created separate divisions of management for particular service areas, replaced the Clinical Director's Board with Service Working Groups and replaced the Operations Board with a new Management Board. The Management Board was the main executive management body below Board level and received minutes and reports from a number of sub-groups. Membership of each of the sub-committees (other than the Audit Committee) included CE1 and DN1.

The management of change, communication and culture

- 5.38 The process of change is notoriously difficult and there are many factors which potentially militate against the successful implementation of change. There are perceived winners and losers in any new arrangements. The NHS had already been subject to significant change and the possibility of 'change fatigue' arises within the organisation. There was also the perceived insularity of certain members of staff and an inherent resistance to the disruption which accompanies change. Any judgement about the impact of the new managerial arrangements must be set within that context. There is no one, perfect solution and achieving ownership of proposed changes across all staff can be extremely difficult. It was therefore essential that the consequences of significant changes to the management structure should have been subject to regular review, evaluation, and if necessary modification.
- 5.39 Again, measurement should have included not only hard data, but also 'softer', intuitive measures. There is no substitute for regular face to face dialogue with staff at all levels, and that dialogue should involve night staff as much as day staff. Had the opportunity been taken to engage with night staff more regularly, we believe it is highly likely that abuses of agreed Trust policies would have emerged much earlier and corrective action taken

accordingly. It is reasonable to assume that feedback from night staff may also have given rise to further discussion about the managerial changes and evaluation of their effectiveness; whether as a process of incremental refinement or whether as a process of radical amendment.

- 5.40 It is important to make clear that we believe the Trust Board, CE1 and other Executive Directors did make genuine attempts to obtain staff feedback and to promote an open culture. However, the panel heard conflicting views from various witnesses about staff morale and the culture prevailing within the Trust. At one point the annual staff survey demonstrated that the Trust was in the top 5% of organisations across the NHS where staff felt they were in a position to speak out about bullying and harassment. Conversely, at the private session of the Trust Board meeting on 1st May 2002, concerns highlighted in the staff survey about bullying and harassment, and staff working long hours were brought to the attention of the Board. The results of such surveys should be used to act as a catalyst for deeper analysis within the organisation; whether good or bad they need to be interpreted with some caution. In effect, they should be a supplement to existing processes and not a substitute for ongoing testing of morale.
- 5.41 We did find evidence of established mechanisms within the Trust for cascading information down to staff and receiving feedback from them, but unfortunately it appears that those mechanisms were not particularly effective. We found that focus groups were in existence, which are recognised as good practice for obtaining staff feedback. However important concerns were expressed within those focus groups with no corresponding evidence of follow up action to address those concerns. Without a tangible demonstration that the views of staff are listened to and acted upon, such groups rapidly lose any credibility and hence any value. We certainly heard from a number of witnesses that they felt there was no point in complaining as nothing would change as a result.
- 5.42 We also heard from a number of consultant staff that they found the communication process ineffective. They complained of being overwhelmed with irrelevant information and many were confused about official Trust policies. This is perhaps not surprising given the lack of a co-ordinated approach to the development, dissemination and review of policies and guidelines throughout the Trust: a matter which was subsequently brought to the attention of CE1 by a group of concerned senior nursing staff. Very

few consultants had been involved in any debate about the role of NNPs and their introduction and some felt that the consultant body as a whole did not enjoy significant influence over management policy. From their testimony it seems highly likely that a number of consultants would have openly expressed surprise or disbelief at the accusations against Sister Grigg Booth, had the opportunity been taken at the outset to engage them more fully. In turn, it is possible that this may have caused CE1 to pause and reflect again on the course of action which had been chosen. The majority of witnesses claimed that their knowledge of the incidents involving Sister Grigg Booth and the NNPs was obtained by hearsay or the 'rumour factory'.

- 5.43 A number of witnesses also suggested that there was a controlling and directing style of management within certain parts of the Trust and that the 'club culture' referred to earlier had prevailed for quite some time and could not safely be challenged without fear of victimisation. That may not be true for the organisation as a whole, but the evidence from the documents we have read and testimony taken from various witnesses certainly suggest strongly that was the case within the Acute Services Division and it was also the nature of the environment in which NNPs operated. The DM was regarded as an extremely effective manager by CE1 and the Trust Board, but the evidence suggests strongly that he abused his position of authority and not only condoned the actions of Sister Grigg Booth and the NNPs, but effectively initiated and authorised those actions. Ironically, by using him as the main conduit for the two way communication process between the top of the organisation and the front line staff at night, the Trust Board was unwittingly disenfranchising itself from the process of effective governance. Without other forms of feedback, the Board was receiving a distorted picture of reality.

Clinical Governance and Risk Management

- 5.44 The key issues of clinical governance and risk management presented the panel with apparent contradictions. It is clear that the Trust had in place, systems, structures and processes which compared with best practice prevailing at that time across the NHS. It is also the case that the issues were accorded high priority and significant attempts were made to ensure that the policies were implemented systematically throughout the organisation. A well constructed and well attended clinical governance

workshop was organised for staff in order to give the process momentum at an early stage. CE1 and the Medical Director for that period both made the point in their evidence to the panel that Sister Grigg Booth's actions were picked up as a result of the existence of relevant clinical governance structures in place in the Trust. To counterbalance this, it must be noted that the mismatch between Trust policy and the NNPs' clinical practice had been occurring without challenge for many years.

- 5.45 The Board agreed comprehensive strategies for clinical governance and risk management and established appropriate mechanisms for receiving regular progress reports against action plans. It was agreed by the Board that both the Audit Committee and the Clinical Governance Committee had important scrutiny roles, prior to any consideration of issues by the full Board meeting; this was good practice. At the outset of the Government's drive to improve quality across the NHS, CE1, Medical Director and DN1 met with representatives of each department/directorate in the Trust to discuss and review their baseline assessment of clinical governance for their area. These contributions then fed into the overall Trust clinical governance strategy. This was commendable and a good example of 'bottom-up' and 'top down' strategy in action.
- 5.46 The Trust was also subject to detailed audit of their arrangements on many occasions by external bodies, including the Commission for Health Improvement, District Audit and the Dr Foster Organisation's 'Guide to Good Hospitals'. Overall, the Trust performed extremely well against these external validations.
- 5.47 However, it was not clear to us that this early momentum was maintained in the light of other pressures on the Trust. In particular the NNPs seemed to operate within a different set of quality standards without the knowledge of CE1 or the Trust Board. Their clinical practice had been in place for many years without challenge by the guardians of the Trust's systems for safeguarding patients.
- 5.48 The SNCG was appointed to her post following a lengthy period of sickness absence from her previous role. She informed the panel that she received no formal induction or training for this important role, which we find remarkable. She also informed us that she was not a standing member of the Trust Clinical Governance Committee, although she contributed to their

discussions from time to time. Her recollection of the role was that it was very much task oriented. If this was indeed the case, then it may be considered the very antithesis of true clinical governance which should be centred upon the values, culture and ethos of a patient-focused organisation. Clinical governance is also designed to be an appropriate balance of quality assurance and continuous quality improvement. A predominant focus on tasks and a failure to adequately prepare the post holder suggests very strongly that the concept of clinical governance was not sufficiently embedded at all levels throughout the Trust. It also suggests that the early momentum for its introduction had slowed or that the necessary focus amongst senior management had been diluted as a result of operational pressures to achieve targets.

5.49 Similarly, the line management of the Trust's Risk Manager was delegated to the Director of Finance, rather than a clinical member of the Executive Directors. The Medical Director for that time, who was also the Chair of the Clinical Risk Committee, told the panel that he had no particular dealing with the post, which again seems remarkable. Although it does not automatically follow that this arrangement was necessarily detrimental to the organisation's drive to improve the management of risk, it is difficult not to conclude that the association of risk management with the financial agenda may give rise to the impression that either the concept of risk management was not properly understood, or alternatively the process within the Trust was disproportionately skewed towards non-clinical issues.

5.50 Tellingly, NNP Manager 2 told the panel that he did not think it was part of his role to follow up Serious Untoward Incidents, but that they should simply be handed over to the clinical governance department to deal with. This demonstrates both an abrogation of management responsibility, and also a lack of ownership of the true meaning of clinical governance and risk management. In summary, it seems that the organisation had made great efforts to assure and improve systems for the management of risk and quality standards, but they had not succeeded in the critically important matter of 'winning hearts and minds'. The organisation's espoused values and objectives had not taken root in key areas of the organisation.

Nursing management

Professional management of nursing

- 5.51 Between June 1995 and December 2003 professional leadership for nursing was provided by DN1. Her role included responsibility for the standards of practice, safety and competency of nurses and for ensuring they acted, at all times, in accordance with the code of conduct of the national regulatory body for nurses and midwives. She was supported by an assistant, (who held that post for the period September 1995–April 2007). DN1 was a member of the Trust Board, Management Board, Clinical Directors Board, Operations Board, Clinical Governance Committee and Practice Advisory Group, at the time of the events. The Assistant to DN1 attended the Drugs and Therapeutics Committee.
- 5.52 Nursing and midwifery professional leadership was managed through the Nursing and Midwifery Professional Advisory Group (PAG). Membership at the time of the events included the Divisional Manager Acute Services, the General Manager for Women's and Children's Services, all Service Managers, plus representatives from Nurse Education. Professional decisions were made and clinical protocols and guidelines were ratified by PAG. The outputs were then supposed to be managed through the divisional management structure. The PAG minutes were disseminated to all wards and departments, and the divisional management structure was charged with responsibility for ensuring all staff attended a monthly cascade meeting to enable ongoing communication. The PAG minutes were used at these meetings to inform nursing staff of the professional agenda. Nursing leadership was developed through a programme known as LEO (Leading Empowered Organisations).

Operational management of nursing

- 5.53 The operational management of nursing in the Acute Division was led by the Acute Divisional Manager, who managed a number of Clinical Service Managers, the Lead Nurse for Clinical Governance, the Acute Pain Nurse, the Nurse Consultant Critical Care and the Nursing Practice Development Team. Ward Sisters reported directly to the Clinical Services Manager within their field of practice. Direct management responsibility for NNPs was, in the first instance, through the Support Service Manager/Matron and

ultimately to the Divisional Manager. Both of these managers had nursing qualifications and were therefore professionally responsible to DN1, although the Divisional Manager had a line management responsibility to the Chief Executive.

United Kingdom Central Council (UKCC) and Nursing and Midwifery Council (NMC)

5.54 The UKCC were the regulatory body for nurses and midwives until April 2002 when the NMC took over this function. The UKCC and NMC respectively have produced guidance for nursing and midwifery practice, including a professional code of practice to which all registrants must adhere. During the period in which the events took place the following UKCC/NMC publications relating to the acute care setting and shaping the nursing agenda included:

- January 2000 – Enrolled Nursing developing an agenda for action.
- January 2000 – Perceptions of the scope of professional practice.
- April 2000 – Continuing Care for people with mental health problems.
- October 2000 – Administration of Medicines.
- September 2001 – Covert administration of medicines (discussed at PAG 17/04/02).
- October 2001 – Fitness for practice and purpose.
- January 2002 – Higher level of practice report.
- February 2002 – Therapeutic management of violence.
- April 2002 – NMC established.

5.55 Other major national publications which influenced the nursing agenda were as follows:

- Clinical Governance moving from rhetoric to reality – 1st January 1998.
- A First Class Service – 1st July 1998.
- Making a Difference – 1st July 1999.
- An Organisation with a Memory – 13th June 2000.
- The NHS Plan: a plan for investment, a plan for reform – 27th July 2000.
- External Inquiry into the adverse incident that occurred at Queen's Medical Centre, Nottingham, 4th January 2001 – published 19th April 2001.
- The Essence of Care: Patient Focused Benchmarking for Health Care Practitioners – 23rd February 2001.
- Building a safer NHS for patients (implementing an organisation with a memory) – 17th April 2001.
- Doing Less Harm – 27th June 2001.
- NPSA – The National Patient Safety Agency was established in July 2001.
- The Inquiry into the management of care of children receiving complex heart surgery at the Bristol Royal Infirmary – Final Report July 2001.
- Delivering the NHS Plan: next steps on investment, next steps on reform – 18th April 2002.

Difficulties arising from the structures

- 5.56 Although the demarcation between professional and managerial accountability for nurses and midwives was not out of step with the management structures of many NHS Trusts at that time, it seems that this dividing line was a cause of confusion, assumption and ultimately failure in the way NNPs were controlled at Airedale. A number of witnesses expressed their dissatisfaction about the new structures and the Director of Personnel at that time was particularly critical. He suggested a conflict in terms of day to day management of operational issues within the Trust; a breakdown in previously clear business planning arrangements; and confusion on the part of senior nurses with what some may have regarded as split loyalties. As we remarked earlier, a certain amount of dissatisfaction is to be expected in some quarters of the organisation when changes to long standing structures are made. It is unusual for strong criticism to be openly expressed at such a senior level but we can find no evidence of debate or challenge within the Trust Board about the impact of the changes.
- 5.57 Setting individual criticisms to one side, what is clear from the evidence is that the structures did not achieve their purpose in terms of the effective management of the NNPs. All of the NNPs who gave testimony informed the panel that they were actively discouraged from attending management briefings of any form and that they very rarely saw a member of management at night. They felt that they were deliberately kept in the dark about Trust policy by Sister Grigg Booth and also felt that they had no other avenues to pursue: their perception was that Sister Grigg Booth was effectively a member of the 'club culture' within the Acute Services Division.
- 5.58 On her part, Sister Grigg Booth seemed to treat the management structures with contempt. She apparently attended management meetings only infrequently, often arrived late, and some NNPs claimed that she did not provide proper briefings to those under her control; this claim was subsequently moderated when one of the NNPs accepted that the night diary system was effective. Sister Grigg Booth referred disparagingly to some management meetings as 'Masonic' meetings and, other than one letter of admonishment from the Divisional Manager about the importance of her attendance at those meetings, appeared to be able to act with impunity to normal sanctions.

- 5.59 She was not subject to effective supervision, either from a managerial perspective or a professional perspective. A recurring feature of the evidence we have considered is the openness with which Sister Grigg Booth and other NNPs carried out and recorded their actions. They were completely transparent in what they did and yet they were not challenged by those above them until very late in the scheme of events. The schism arising from the demarcation of accountability appeared to serve no party's interests: the Trust, patients, staff and even Sister Booth herself were placed at a disadvantage.
- 5.60 The initiation by the Divisional Manager of the handover of supervision of NNPs from one senior manager (NNP Manager 1) to the new NNP manager (NNP Manager 2) in June 2001 reinforced a pattern of managerial sloppiness. The handover arrangements were not formalised and were therefore inadequate. At best they allowed scope for misinterpretation; at worst they provided opportunity for obfuscation or deceit. NNP Manager 2 told the panel that he believed the concerns about the lack of agreed protocols for the prescribing and administering of drugs, set out by his predecessor in his letters of 23rd and 30th April 2001, had been resolved by the time he took on responsibility for the management of the NNPs. His predecessor informed the panel that he disagreed with that view and would have expected immediate follow up action regarding these important concerns. NNP Manager 2 also told the panel that he did not review any of the files regarding NNPs when he accepted responsibility for them, nor did he arrange to meet with all of them. This was a very strange interpretation of his new role.
- 5.61 What is clear is that warnings about a critically important issue were apparently lost in the managerial 'ether'. A variety of erroneous assumptions were made by NNP Manager 2, which were then compounded by his failure to make any direct check on the actions of the NNPs. In turn his actions, or lack of them, were not tested by his superiors. Similarly, there is no evidence at any stage of events that the Trust's adverse incident reporting system was initiated. Self-evidently, policies designed to act as safeguards have no value if senior managers fail to use them; these were not minor issues but were such that they should have triggered instant action. The management chain of command was dysfunctional and as a result patients were placed at risk.

5.62 All witnesses, whether advocates for Sister Grigg Booth or critics of her, agreed that her management style was autocratic in the extreme. Regrettably, this was not addressed either in terms of personal development and support via the Staff Development Review process, or ultimately via counselling or the disciplinary process at that time. The levels of stress under which she worked may well have been a contributory factor to her sickness absence. This was not managed effectively by those above her; to her detriment and that of the organisation. Her training and refreshment of clinical practice was not kept up to date and corrective action did not take place. Some of the NNPs suggested that she almost took pride in this and considered her level of professional competence to be such that further training was superfluous. A Consultant Anaesthetist who specialised in pain relief told the panel that she felt Sister Grigg Booth would never maliciously harm a patient, but it was more likely that a lack of appropriate training led her to make bad judgements. Either way, the agreed management systems and processes seemed to bypass Sister Grigg Booth and the NNPs. Effectively they fell between the 'two stools' of managerial and professional accountability. Neither system acted as an appropriate safeguard.

Human Resources function

5.63 Responsibility for setting overall HR policy was held by the Director of Personnel, reporting to CE1. The small central personnel team supported managers who had delegated responsibility for implementation and record keeping in line with policy. A benchmarking report demonstrated that for the period in question personnel staff numbers and function costs were relatively low in comparison to other NHS Trusts. This may have been a contributory factor to the shortfalls in HR best practice which took place and which in turn allowed some of Sister Grigg Booth's actions to go unchecked. The necessary synchrony between central and departmental personnel functions appears to have been less than satisfactory in certain areas.

5.64 The Trust had a track record of using staff surveys to inform policy and improvement initiatives before the national survey was introduced in 2002. The forerunner to the current Airedale Partnership Group was the District Joint Staff Committee (DJSC) and it is noted in Board minutes that HR policy issues were referred to, and considered within this forum. This was good practice and demonstrates a willingness of staff to engage. The

central personnel department was responsible for monitoring certain aspects of workforce information e.g. diversity of staff, staff turnover and staff survey responses, and as requested, reported on this to the Management Board and Trust Board. They were also responsible for developing action plans to improve employment practice.

- 5.65 During the years 2000-2002 there was a move nationally in the NHS to delegate responsibility and authority down the hierarchy as much as possible. The then Secretary of State, Alan Milburn was cited as wanting "*power to the front line*" in April 2001. The Trust's devolution of responsibility to line managers and away from central functions was in keeping with the NHS trend at this time, but it is clear that the oversight of that delegated responsibility was not in line with the normal checks and balances which could reasonably have been expected. Put simply, the HR processes were not applied correctly or consistently in terms of the performance management, appraisal, counselling, development and support of NNPs during this period. Ironically, this is consistent with what had gone before. The original recruitment and selection of NNPs was not the subject of an open competitive process and was contrary to best HR practice.
- 5.66 In 2000 the HR Performance Framework for the NHS was introduced (HSC 2000/030). The NHS Executive was to monitor the standards within the framework. A summary of the related action plan was presented to the Trust Board on February 2001 by the Director of Personnel, following approval by the Management Board. The Board minute confirms that "*most of the objectives were already being achieved by the Trust; however a minority required more work*". At the same February 2001 meeting of the Board, the Department of Health 'Improving Working Lives Standard' was received.
- 5.67 The Performance Framework provided an alignment of various key HR activities and as such, could have been expected to become a Board monitoring tool. An update was provided to the Board as scheduled in May 2001. In December 2001, the Board received a post-recognition review report for the Investors in People (IIP) Standard. This had originally been awarded to the Trust in May 1997. In mid 2002 a Commission for Health Improvement (CHI) inspection took place at Airedale. The June 2002 Board minutes on staffing and staff management within the CHI standard makes reference to a wide range of activity underway in the Trust.

Recruitment and selection

5.68 There was an extensive guide covering all aspects of recruitment and selection in place throughout the period under review. They were contained in the Personnel Policies and Procedures Manual published to all managers and on the Trust intranet. Recruitment and selection was the responsibility of line managers. In-house training on best practice was available and line managers were expected to attend. The Trust automatically enrolled new staff onto the two day corporate induction workshop and departmental induction was also expected but there was no Trust wide prescribed format. The Investors in People (IIP) recognition review to the Trust Board on 2nd December 2001 reported that *"those new to the Trust described an effective induction"*.

Staff appraisal and development

5.69 At face value, the award of 'Investors in People' and 'Improving Working Lives' (important external accreditations), provides reassuring evidence of the Trust's commitment to staff appraisal and development. Valuing and supporting the contribution of staff, and personal and professional development and training were central to the achievement of both awards. The main tools available to achieve this were the Staff Development Review (SDR) and personal development planning. However, the documentary review correctly highlights significant weaknesses and areas for improvement in the SDR process during that period. Senior management objectives appeared to have no correlation with key issues which the Trust faced; the results of the staff survey concerning bullying and harassment, and medicines management problems did not feature. The SDRs for the senior managers in the Acute Services Division were largely task oriented, rather than addressing personal development or behaviours. This was a missed opportunity, which had it been taken would at the very least, have minimised the nature of the problems which arose with Sister Grigg Booth's actions and those of other NNPs.

5.70 An HR Strategy submitted to the Management Board on 21st May 2002 highlighted proposed improvements to the SDR process, consistent with best practice. The model proposed was commendable, but unfortunately the available evidence does not show that the momentum for its systematic implementation was maintained throughout the organisation.

Bullying and harassment

5.71 Between 2000 and 2002, the Trust's policy guidelines on whistle blowing/how to raise issues of a broader concern (1995) were updated and republished into a broader policy; the 'Openness Policy' which was based on best practice. This advised staff how to raise concerns and the ways in which they would be supported to do so. A 'Dignity at Work' policy was also produced in May 2000, underpinned by the recruitment and training of Harassment Advisers in conjunction with other local Trusts. These policies were monitored by central Personnel. Again, this may be considered best practice. Additionally, there was a long standing (1978) grievance procedure in place, based on ACAS advice, providing another potential route for staff to access a Board level hearing of unresolved complaints. Corporate induction, staff leaflets and the intranet were used to publicise the new policies. Following a discussion of the staff survey results at the Board in May 2002, a further paper was issued to all staff via payslips in October identifying potential bullying behaviour and reminding staff how they should behave at work.

5.72 Notwithstanding all of these initiatives, it is clear that within the Acute Services Division and for NNPs there was a dislocation between declared HR policy and its implementation. We must concur with one of the conclusions of the Documentary Review, *"If policies and procedures are not robustly implemented, then inappropriate behaviours can become embedded in the whole or in parts of an organisation"*. Sadly, good intent did not consistently translate into good practice within the Trust.

Management of medicines, including prescribing, recording of medicines usage and the audit of medication

Context

- 5.73 A national policy document, 'Pharmacy in the Future – Implementing the NHS Plan' was published in 2000. Three particular recommendations have relevance to this Inquiry:
- Pharmacy services will be designed around the needs of patients – not organisations.
 - Pharmacists are highly qualified professionals, whose skills the NHS has been underutilising for too long.
 - The NHS Executive Controls Assurance standard, 'Safe and Secure Handling of Medicines' issued earlier this year (2000) clearly identified hospital chief pharmacists as responsible for all aspects of the safe and secure handling of medicines throughout the organisation.
- 5.74 If we consider each of those recommendations in turn we can see that through a mixture of individual and systems failures, the Trust was out of kilter with both the spirit and the substance of that policy document. In its desire to ensure achievement of the targets associated with the implementation of the 'New Deal', it seems that the focus at night shifted from an emphasis on compliance with the new rotas, to an unofficial policy of allowing junior doctors to stay in bed at night. That may have been a well intentioned arrangement, but the consequence was to create the potential for patients to be put at risk. We heard from several witnesses who claimed that it was routine for doctors to come on duty in the morning and expect to sign documentation retrospectively for drugs which had been authorised in the night. Without realising it, the Trust Board had a system in place which inadvertently, put the needs of the organisation before that of patients. The lack of effective supervision of NNPs resulted in the opposite consequence of that which had originally been intended. Similarly, by removing the Chief Pharmacist from the locus of the new management structure, the Trust was denying itself the opportunity to make best use of his experience and expertise – his sphere of influence actually diminished rather than

increased. In respect of the final recommendation, the Chief Pharmacist was apparently kept 'out of the loop' by DM and therefore was not in a position to fulfil the obligation to ensure the safe and secure handling of medicines throughout the organisation, particularly at night. It seems almost certain that the Trust Board was oblivious to its failure to comply with this major national policy.

- 5.75 Following publication of the NHS Plan, the Audit Commission made Medicines Management one of the four components of its Acute Hospital portfolio for 2001. This was to complement the Department of Health's Medicines Management Framework which was a part of the Controls Assurance Framework. Areas to be covered by the Audit Commission included, staffing; reassurance about present performance; capacity for change and barriers to improvement.
- 5.76 The Audit Commission undertook their work by means of Trust data collection April – July 2001; a diagnostic report based on the data from November 2001; an in-depth audit 2002.
- 5.77 The summary findings of the data by the Audit Commission were as follows:
- The Trust Board was not fully aware of medicines usage.
 - There was no overall strategy for medicines use and control.
 - Support for prescribers was in place but more would have been appreciated by junior doctors and nurses.
 - Clinical risk management reporting could be improved.
- 5.78 An action plan was created by the Trust with support from District Audit. The Airedale NHS Trust would be one of the Audit Commission's pilot sites for this work, which would be carried out in 2002.

Weaknesses in medicines management

- 5.79 The documentary review refers to the professional obligations upon pharmacists contained in the Duthie report (1988), from the Royal Pharmaceutical Society of Great Britain. Those obligations are reinforced by their professional code of conduct. In essence, there is an obligation upon pharmacists to ensure that medicines management is compliant with regulation and systems and processes assure patient safety. Clearly, that was not the case as far as the practice of NNPs was concerned but, as we have already described, the Chief Pharmacist and his staff had only limited influence. The Trust's Clinical Governance Committee also appeared to give little consideration to medicines management and the main source of advice was the Drugs and Therapeutics Committee: its remit was relatively narrow and did not encompass all areas of potential concern.
- 5.80 Many warning signs about nurse prescribing had been raised in various ways over a number of years, but it seems that those concerns were not brought to the attention of the Chief Pharmacist or his staff. It seems that neither he nor his staff had been involved in any way in the much earlier process relating to the creation of NNP posts and the limits of their professional discretion. What seems even more remarkable is that the Chief Pharmacist was not made aware of the allegations against Sister Grigg Booth through official channels. He informed the panel that he found out about the alleged incident by means of a chance discussion with colleagues in the hospital corridor. It is difficult not to conclude that the role of the Chief Pharmacist and his department was not accorded sufficient priority within the management arrangements for the Trust at the time.
- 5.81 The systems in place for monitoring drug sheets may also have been expected to act as the catalyst for action, but again that proved not to be the case. We heard conflicting views about this. Some felt that the process of validating signatures on drug sheets was a responsibility of visiting ward pharmacy staff but others felt that the onus was on clinical managers at ward or departmental level, bound within the expectation that staff would work within professional guidelines at all times. It seems that there was a great deal of assumption but not a lot of shared clarity. (Strengthened governance arrangements for safer management of controlled drugs were introduced throughout all NHS Trusts in England from 2005 onwards as a

result of the Government's response to the Fourth Report of the Shipman Inquiry.)

- 5.82 What we can be certain about is that pharmacy staffing levels were such that it was not possible to undertake sufficiently robust scrutiny of all aspects of medicines management at ward level at that time. We were informed that significant improvements have been made in subsequent years. A process of prioritisation was applied by pharmacists with the major emphasis being placed on checking whether the drug was appropriate for the patient, rather than detailed scrutiny.
- 5.83 The Chief Pharmacist and his staff did not play a strong part in the revised management structure and this was exacerbated by failures of liaison on the part of the Divisional Manager for Acute Services. We heard from the Chief Pharmacist at that time, that the management restructuring, including the removal of the Clinical Directors Forum had, in his view, been detrimental to effective medicines management in the Trust. This was a view which he claimed he had brought to the attention of CE1 but there is no evidence of any amendments to the structures as a result or of any debate in the Trust Board. The Chief Pharmacist was not a member of the Management Board, nor did he appear to be a regular participant in the Service Working Groups. Additionally, the role of pharmacy and medicines management issues did not appear to have a high profile at the Trust Board or its sub-committees. There seemed to be a gap in accountability between the role of the Chief Pharmacist and the statutory responsibilities of the Trust at that time. As a result the normal safety mechanisms were bypassed.
- 5.84 The Audit Commission's evaluation of pharmacy services in the Trust, based on the review of data in 2001, was very favourable, notwithstanding the areas for improvement which were identified. Overall the Trust was found to be compliant with the NHSE Controls Assurance Framework. Once again, it appears ironic that the Trust was passing external accreditation with flying colours, despite fundamental weaknesses in its systems. However, it must be stressed that the focus of the Audit Commission review would not necessarily have been targeted on unlawful prescribing practice. The weaknesses in the systems, although clearly known by some senior managers, had not been shared with other professionals who could have instigated corrective action.

- 5.85 The timing of this review in relation to Sister Grigg Booth's alleged unlawful actions is of great significance. The NNP Manager 2's letters of 23rd and 30th April 2001, warning of the problem and banning verbal orders overlapped the time in which the information was being collected. Unfortunately, neither the Chief Pharmacist nor his staff had been made aware of these problems. We have not been able to ascertain whether any of the nursing staff who participated in the data collection process, or who were interviewed, knew about the problems. What we do know from many witnesses who gave evidence, including consultants, junior doctors and nurses, was that there was considerable confusion and assumption about the role of NNPs and their levels of authorisation for administering and prescribing drugs. A number of the NNPs we interviewed made the point that their actions were explicitly documented and patient's records were reviewed by clinical staff every day: nobody had ever told them their practice was wrong.
- 5.86 The report did comment on whether pharmacy staff had adequate time to devote to clinical care and whether there was enough supervision of prescribing in the Trust, but neither of these comments was related to the issue of unlawful activities. The report did not address the issue of the level of management supervision of ward pharmacists, nor the representation of pharmacy in the management structure of the Trust.
- 5.87 In March 2003 a document on medicines management was presented to the Trust Board, 2-3 months after the discovery of alleged unlawful medicines management and the involvement of the police. It is understandable that a document that probably took 12-15 months to prepare would not address these recent events but there is no documented evidence in the Trust Board minutes that the document should be amended to include preventative measures for such a contingency.

Multidisciplinary team working, especially during the night

- 5.88 The overall impression of the Trust gained by the panel was of an organisation which, in the majority of instances, had a good basis for co-operation across professional boundaries in order to ensure the needs of patients came first. Many staff apparently enjoyed their work, remarked on the good atmosphere in the hospital and took pride in the excellent

reputation it enjoyed within the local community. However, our investigations did highlight a number of examples of tensions which arose from time to time between specialties, different professional groups and individual members of staff. This is perhaps both understandable and inevitable given the scale of the organisation, the level of activity and in some instances relatively low staffing ratios – particularly junior doctors – compared to other NHS organisations. Moreover, the day to day front line pressures were undoubtedly added to as a result of the major organisational restructuring which was taking place across the NHS, both nationally and locally. This was a time of great upheaval and uncertainty for the organisation and the staff working within it, and this may well have impacted upon staff morale, and in turn, the environment in which multidisciplinary team working best flourishes.

5.89 However, it seems that throughout most of the organisation multidisciplinary team working was a concept that was well established and accepted. The minutes of the Trust Board on 5th December 2002 record with pride the receipt of a national 'Golden Service Award' for the best In-house Hotel Service in Health Care. Tribute is paid by the head of that department to the teamwork that prevailed within the Trust and which underpinned the success of her department. In the same meeting the Board was also pleased to note that the pathology laboratory had also received a national award for the best public laboratory. The award was in recognition of the teamwork involved in modernising the pathology department. Even the hospital gardeners provided evidence of good team working by taking pride in the environment for patients, visitors and staff; receiving accreditation from the 'Britain in Bloom' competition. These are solid examples of good multidisciplinary team work, within and across departments. It seems likely that, in the majority of instances, clinical team working was regarded equally highly. We certainly heard from a number of consultant staff that they enjoyed good working relationships with other healthcare professionals within their specialty and throughout the hospital.

5.90 Unfortunately, to offset those markers of success the information within the documents the panel considered and the testimony of various witnesses, suggests strongly that the 'club culture' referred to earlier was an impediment to effective team working across the whole of the organisation. When members of staff witness unprofessional behaviour going unchallenged, it impacts negatively upon their perception of the way in

which the organisation is managed and, potentially, upon their level of commitment. The danger which arises in such circumstances is that effectively a 'bunker mentality' is created; whistleblowing is regarded as too great a risk. Individuals may decide simply to do the minimum required by the organisation and not to concern themselves too much with the actions of others. That is the very antithesis of teamwork. The nature of healthcare is such that close collaboration between all staff is required in order to ensure that the 'whole is greater than the sum of the parts' if patients are to receive the best care possible at all times.

- 5.91 In terms of the way in which the hospital was managed at night, it seems that the usual methods of multidisciplinary team working were influenced by the autocratic style adopted by Sister Grigg Booth. It seems that it was her way of working and no other which prevailed amongst NNPs. She liked to be regarded as an old style Matron who carried ultimate authority at night; she was often heard to refer to herself as Matron.
- 5.92 Many of the NNPs accused her of deliberately creating an environment of distrust and uncertainty; in effect a policy of 'divide and rule'. By the very nature of their work, NNPs apparently did not enjoy much opportunity to share practice and learn together, but the accusation is that Sister Grigg Booth's management style further exacerbated their isolation. The overall impression conveyed is one of 'silo' working. Additionally, Sister Grigg Booth's increasingly erratic behaviour created tensions with other parts of the hospital at night. At one stage her immediate line manager wrote to her stating that "*on this occasion you have clearly overstepped the mark*", which resulted in an apology from Sister Grigg Booth. Similarly, there was evidence of attitude and behaviour problems with Sister Grigg Booth identified by the Senior Nurse in the Accident & Emergency Department. He had cause to write insisting that she stop berating staff in his department at night.
- 5.93 It is probably the case that true multidisciplinary team working at night was constrained by Sister Grigg Booth's actions. However, it seems equally likely, that those above Sister Grigg Booth either failed to recognise these shortfalls, or more likely were complicit in their acceptance and continuation. Sister Grigg Booth had a track record of keeping things running smoothly, so it may well have suited her superiors to put to one side any underlying concerns about the impact of her behaviour on team

working. If that was the case then, effectively, the Trust failed in its duty of care to all NNPs, including Sister Grigg Booth. Her line managers had a responsibility to ensure that she acted at all times in accordance with the values and agreed policies of the Trust. When she strayed from those parameters, she should have received challenge, correction, guidance and support, in that sequence and on an incremental basis. We can find no evidence that was the case. Any failures in multidisciplinary team working must be seen as a shared responsibility and do not simply fall upon the shoulders of Sister Grigg Booth.

The confirmation of deaths

- 5.94 The Trust could not provide the panel with any Trust policy relating to the confirmation of death for the period in question. However, Trust Nursing Guideline No. 31 sets out the policy for the performance of respectful last offices that concludes the care given in life. That document was approved by the Practice Development Forum in December 1995 and it seems likely that it was still in force during the years 2000 -2002. It makes clear that nurses were required to inform the duty doctor of the time and place of death of a patient. It further explains that a registered medical practitioner who has attended the deceased person during the last illness is required to give medical certification of the cause of death. The certificate requires the doctor to state the last date on which he/she has seen the body after death.
- 5.95 Of significance is an audit of death certification carried out by a consultant histopathologist at the hospital in May 2000. He audited all death certificates within the hospital which were signed between 28th July 1999 and 19th December 1999. 295 certificates were examined. From these certificates it was ascertained that:
- In 62% of cases the doctor signing the death certificate had viewed the body personally after death.
 - In 35% of cases the body had been viewed after death by another doctor but not the doctor signing the death certificate.
 - In 3% of cases the body had not been viewed by a doctor after death.

5.96 The introduction to the report states that the audit therefore implied that the practice at that time allowed bodies to be certified without having been viewed by a doctor after death. This unsatisfactory situation was further compounded by virtue of the role afforded to NNPs. A potential conflict of interest arose with a scenario whereby NNPs were apparently authorised to verify (as distinct from certify) expected deaths of patients for whom they may have been giving care, and in some instances to whom they may have been administering opiates, at the natural end stage of the lives of those patients. This was unacceptable for both patients and staff.

CHAPTER 6

TERMS OF REFERENCE 5 and 6

To review and comment on the quality of the internal investigations, notably the extent to which they identified all salient factors, and the quality of the action plans arising from these investigations.

To review and comment on the implementation of action plans arising from the internal investigations.

- 6.1 We have already dealt with the lack of internal investigation during the currency of the police investigation and the failure to address with DM the important questions raised on the documents.
- 6.2 That is not to say that the Trust did nothing. We acknowledge that work was done in areas where it was understood there would be no interference with the police investigation. Feedback from the police and SNCG was used to some effect. Thus in the latter part of 2003/beginning of 2004 a policy was developed to support NHS guidance on nurse prescribing powers. DN1 was particularly concerned at the high level of ignorance amongst nurses and doctors in that regard. DN1 was sure it was not unique to Airedale. Indeed she took her concerns to the Chief Nursing Officer (CNO), the SHA, and later to the CNO for Wales. The Medical Director and DN1 agreed with the SHA that they would look at ways of educating doctors about the extent of nurse prescribing powers. Training was given in the use of Patient Group Directives. Greater discipline was introduced in respect of PRN (as required) drugs. A policy for the retention and maintenance of controlled drugs book was developed by the Chief Pharmacist and the Risk Management Committee. A requirement that wastage of controlled drugs should be recorded was imposed. Steps were being taken towards the Trust getting its house in order.
- 6.3 DN1 left the Trust in December 2003. Her successor, DN2, arrived in February. Until she arrived at the Trust she had not appreciated quite what was going on. She commented that from her reading of available documents the NNPs had been very open in their activities. She could not understand why queries had not arisen long before. She commented on the "*paralysis*" that seemed to have overcome the Trust in respect of

investigating what had gone on. In August 2004 she commented in a report to the SHA that given what was known about DM his position at the Trust was wholly untenable.

- 6.4 According to a note of a meeting between the Trust and the SHA regarding DM on 12th September 2004 CE1 *“advised that as he was not allowed to speak to the individual regarding the allegations made he was not able to suspend. This person is a “superb manager” doing very good work for the Trust and CE1 was not in a position to be able to do anything at this point”*. After further discussions with the SHA, the police and then with DM, CE1 suspended him on 21st September 2004, 20 months after the suspension of Sister Grigg Booth.
- 6.5 DN2 set up an Incident Review Group (DN2, Chief Pharmacist and MD2) to look to the future and improve medicines management. She reviewed progress on the Trust’s responses to the unlawful prescription and administration of controlled drugs in April 2004 and updated the SHA in June 2004. It is clear that the Incident Review Group worked hard on a medicines management policy, taking support and guidance from the SHA. A further action plan was drafted and by the end of 2004 progress had been made. As well as a detailed approach to medicines management, the plan also acknowledged the need to review the Trust’s policies on bullying. The need for improved induction programmes for junior doctors and nurses was also acknowledged and improvements made. In December 2004 a new medicines code was introduced.
- 6.6 CE1 left the Trust in October 2004. He told us that the Trust’s application for Foundation Status (which was running in parallel with these events) had just failed on financial grounds. He was approaching retirement and knew he would not be at the helm by the end of the next Foundation assessment process. The SHA agreed to his request to be seconded elsewhere. In the period, October 2004 to August 2005 the Finance Director acted as an Interim Chief Executive.
- 6.7 DM resigned upon his arrest in October 2004. He was later reported by the Trust to the NMC for a number of matters. We understand he remains on the NMC register.

- 6.8 A Performance Support Team was sent in by the SHA, after consultation with the Trust. It was headed by the Consultant who was later to chair the documentary review. It did not deal with the issues raised by the police investigation. It reported on the Trust's clinical governance structures. It acknowledged that there was enthusiasm for improvement and that the building blocks were in place. The Team remained available to the Trust for advice and support, which the Trust accepted throughout 2005.
- 6.9 In the early part of 2005 the then acting Interim Chief Executive of the Trust and the Board decided to set up a review of events leading up to the police investigation and to assess the overall appropriateness of the Trust's response, to help the organisation learn from it. This was not before time. A team of 5 was appointed; 3 members, including the Chair, were external to the Trust. The new Medical Director and the (now) Assistant Director Patient Safety were the 2 members of the team from within the Trust. The Assistant Director Patient Safety had been recruited by DN2 in December 2004, initially on secondment to the Trust to assist with the demands of the police investigation. Later she joined the Trust staff.
- 6.10 Terms of Reference were agreed in consultation with the SHA. The purpose of the investigation, as explained in the report was *"to examine the circumstances leading to the police investigation, to identify active factors and latent conditions, and to make recommendations to enable the Trust to learn from the experience and to put in place robust systems and processes to prevent recurrence"*.
- 6.11 The first Term of Reference was *"to review all documentary evidence relating to the incidents and resulting action taken by the Trust to date"*.
- 6.12 DN2 left the Trust on 24 June 2005.
- 6.13 CE2 arrived at the Trust in September 2005. He had been in frequent contact with the Trust for some months before that. He was actively involved in the setting up of the review panel. He had considerable experience of dealing with a police investigation within the Leeds Teaching Hospital NHS Trust. He had offered support and assistance to DN2 when she first arrived at the Trust.

- 6.14 When the review was set up Sister Grigg Booth was still alive and a trial was expected. She died days after the review panel began its work. The Trust did not seek to broaden the review to include oral evidence. The review panel did not seek power to do so either. This was understandable because a significant widening of the scope of information would have meant a further delay in the effective examination of events. That said those who were criticised in the subsequent report could and did complain that they had not been able to give their account of events as a result of which mistaken conclusions were drawn. Those complaints were justifiable and could have been avoided had they simply been asked, as a minimum, for their written account of events.
- 6.15 A more significant problem was that the review panel did not have access to much of the documentation. They were reliant on such documents as had not been seized by the police. They did not have patients' notes, they had none of the documents that had become police exhibits, except where copies happened to be at the Trust. They had none of the statements provided to the police. The Panel heard from the Chair, and from another member, of the review panel. They recalled visiting the police and asking for access to the documents. The police refused. The police witnesses did not remember this and could not now recall why they would have refused the request. There is no written record of the conversation. Assuming that it was refused it was probably because at that time the coroner had not yet decided whether or not to seek to open inquests. By the same token, had the Trust wanted to examine the facts of the incidents that led to charges they may well have been impeded by the need to await the decisions in respect of Inquests.
- 6.16 The review panel did not know what the police had, neither did the Trust. We wonder whether it might have been possible to agree a way of working which permitted some access by the review panel at least to the list of documents held by the police. In the event, almost inevitably the review panel asked for a briefing from SNCG who by then was working elsewhere. The fact of this briefing is not recorded in the report. It would have been better had that been done, so that those reading the report would have known the source of the information.

- 6.17 The problem with a briefing from only one person was, in hindsight, plain to the review panel witnesses. It meant firstly that the review was no longer confined to the documents and secondly that for a significant amount of important information the team were wholly dependent on the judgement of one person as to what was relevant, and on the accuracy of her memory. We know that, for example, SNCG did not tell the review panel of the existence of the NNP training file, or of its contents. This flawed process led, inevitably to a number of flaws in the conclusions about the facts. On reviewing the file H40, and in particular the pilot scheme forms, the chair of the review panel said it “*changed everything*” and also that NNPS must have believed they were acting with the Trust’s approval.
- 6.18 We note that the review of the NNP daily diaries simply records that they contained foul language. Whilst there is some unacceptable and unprofessional language in the diaries, that is not what characterises them. We consider that the diaries were a useful source of information about morale within the NNP team, about their practices – and the only documentary evidence there was at the time that some of the NNPs were administering chemotherapy drugs, apparently with the approval of managers.
- 6.19 We challenged CE2 at some length about the decision not to ask the review panel to expand its remit to consider oral evidence. His response, and this was reflected in the evidence from the Chair of the review panel, was that the real purpose of the review was not to get to the facts of what had happened, the place for that was in a wider Inquiry such as this one. The purpose was to try and obtain some learning about the Trust’s response to events from April 2004 and to develop a clear plan of action which would lead to an improvement in confidence in patient care at Airedale. We think that is probably right. It would have been better therefore had the Terms of Reference been amended to remove reference to identifying the circumstances that led to the police investigation, so that the true focus was clear.
- 6.20 In our view the value of the report to the Trust lay in its analysis of the systems failures and in identifying areas where improvement was necessary.

6.21 The Action Plans developed in response to the review panel report were well thought out. The Trust delivered on them systematically at a time when many systems and processes were being comprehensively overhauled. Rather than analyse here the process of change and systems that have now been superseded we look at the detail of the current systems and processes under Terms of Reference 7.

CHAPTER 7

TERMS OF REFERENCE 7

To review and comment on the systems and processes currently in place at Airedale NHS Trust (with particular reference to those specified under point 4) and comment on the extent to which these are commensurate with current NHS policies, guidance, best practice and professional standards.

Corporate Governance

- 7.1 We referred earlier to the purpose of governance within the Trust: to assure the provision of safe, high quality, efficient, and responsive healthcare to individual patients and the wider population, within the resources available to the Trust. Achieving that purpose is as much to do with mindset as it is do with systems and processes, important though they may be. The starting point for our consideration of whether the Trust's governance systems are commensurate with current NHS policies, guidance, best practice and professional standards must therefore be whether the main focus of the Trust Board itself, and the organisation as a whole, is upon the business of clinical care, as distinct from the myriad activities which are a by-product of that core purpose. In simple terms, the Trust exists to look after patients in the best way possible and their systems and processes should reflect that.
- 7.2 It is clear to us that the events which took place in earlier years are regarded as a stain upon the reputation of the hospital. There is a deep felt desire at all levels of the organisation to put right any wrongs which may have occurred in the past and to rebuild the confidence of patients and the wider community in the services provided. We have been impressed with the willingness to learn from past mistakes; the drive to harness the energy and commitment of all members of staff around a common purpose; and the clarity with which the Trust Board has articulated that purpose.
- 7.3 The strong impression gained is of an organisation which seeks to use past difficulties as a catalyst not only to meet the minimum standards which the public can reasonably expect, but to aspire to excellence in everything they do. There is some way to go before that objective can be achieved. However, the recognition on the part of the Trust Board and its management team that the pursuit of excellence is a continuous journey,

rather than a series of activities, of itself provides a degree of reassurance that improvements will continue to be made.

- 7.4 The starting point for resolving shortfalls in the standards of care is insight: there is a considerable body of research which demonstrates the startling fact that many failing NHS organisations either simply do not acknowledge that they may have problems, or alternatively do not accept that such problems may be their fault. We are confident that the syndrome of withdrawing into a 'defensive shell' does not apply to the current Trust Board; rather, we believe they are moving forward in accordance with the values set out in the NHS Constitution.
- 7.5 We have been impressed with the openness with which the Trust and its senior managers have responded to the Inquiry. It has not been a perfect process and from time to time the Trust has made mistakes in the way in which information was collated and made available to the Panel. However, at all times any deficiencies have been acknowledged and corrective action taken, and there has been a significant commitment of time and energy on the part of senior management to the successful completion of the Inquiry. Throughout the hearings, the Chief Executive, Director of Nursing and the Assistant Director of Patient Safety, have consistently made themselves available not only to give evidence but, equally importantly to hear evidence from all interested parties. That would undoubtedly have entailed a major rescheduling of existing priorities and hard pressed business diaries. At times, the testimony of various witnesses may have also caused them some discomfort but their presence offers tangible evidence of a desire at the highest levels to become what may be termed a 'learning organisation'.
- 7.6 The Trust Board has undertaken a comprehensive review of existing systems and processes of governance, on an iterative basis, in order to match best practice. This has been further strengthened by means of rigorous external examination to ensure compliance with the requirements associated with authorisation of their application for Foundation Trust status at some stage in the near future. The national external assessment process has been subject to considerable refinement and improvement in recent years, but external assessments should be regarded as a supplement to, and not a substitute for, local vigilance. Ultimately accountability for effective governance rests with the Board itself.

7.7 We set out below the current arrangements within the Trust, together with our views of them.

The Trust's assurance committees

7.8 The Trust provided an up to date organisational diagram to the panel which sets out clearly the Trust's Board sub committee and management structure; together with their terms of reference. The Board of Directors is responsible for the direction and control of the Trust and the strategic delivery of its services, targets and performance.

7.9 The Board of Directors meets monthly and on a quarterly basis the Trust Board and other Executive Team members hold time-outs to discuss matters of strategic importance. This is a key element of a structured Board Development Programme to ensure ongoing Board effectiveness. This is particularly commendable, as again, research has shown that, both in the public and private sector, one of the most important determinants of the success or otherwise of a Board is the nature of the 'social dynamics' prevailing within it.

7.10 In plain English, does the chemistry between the different members of the Board facilitate robust, critical and sometimes uncomfortable challenge within a constructive environment? The more time Board members spend together discussing often complex issues in greater detail, the more likely it is that all members will grow, both in understanding and confidence. This is especially important for Non-Executive Directors (NEDs) to assist them in fulfilling their role as guardians of the public interest. It is also essential to achieve the necessary cohesiveness of the Board and synchrony of common purpose. In turn, that can only be good for the patients served by the Trust.

7.11 Key management structures feed in to and out of the Board of Directors and are separate to the Board sub-committee structure. These are the Executive Directors Group, Executive Strategic Risk Management Group, and the Strategy Development Group. Membership of the latter group includes all Clinical Directors, General Managers and Senior Matrons as well as the Executive Team. All terms of reference for Board committees and management groups have been developed under the guidance of their

professionally qualified Company Secretary and in accordance with NHS and corporate governance best practice and standards.

7.12 All agendas include a review of the meeting itself. Again, this is a very useful safety check. At the end of each meeting opportunity is provided to all members of the Board to reflect upon the effectiveness of the meeting against their expressed common purpose and to voice any reservations or unhappiness they may have: there can be no excuse subsequently for confusion about decisions or avoidance of accountability for those decisions.

7.13 A systematic approach to improvements undertaken within the Trust includes the following:

Trust Board

- An increased level of Non-Executive Director (NED) challenge at Trust Board meetings is evidenced in the minutes of those meetings and also via the SHA assurance process for the Trust's Foundation Trust application.
- Formal reporting of the committee and management meetings by presentation of minutes to the Trust Board by the Chair of the respective committee or management group. The Trust Board receives minutes of the Audit Committee, Finance Committee, Remuneration Committee, Quality and Safety Assurance Committee, Executive Strategic Risk Management Group, Trust Clinical Council, Charitable Trust Sub-Committee, Executive Directors Group, Contract Management Board and Strategy Development Group.
- The emphasis of agenda items and discussion at the Board is on clinical quality and safety as evidenced by Board agendas, minutes and papers.
- The Board agenda and Board papers have been reformatted to ensure greater clarity and focus.
- Implementation of a Board Development Programme to ensure ongoing effectiveness.

- Quarterly review of the Assurance Framework.
- Introduction of an annual work plan and monitoring of Board actions at every Board meeting.
- Rescheduling the cycle of Board meetings to ensure more timely and accurate reporting.

Audit Committee

- The committee comprises three NEDs, all with extensive knowledge and experience in business and finance (two of whom are qualified accountants).
- Introduction of an annual work plan.
- Introduction of governance and the Assurance Framework as standing agenda items.

Quality and Safety Assurance Committee (QSAC)

- Committee membership was expanded to include the appointment of a further NED, the Director of Service Delivery, Company Secretary and Deputy Director of Nursing.
- The committee is chaired by a NED, and comprises another two NEDs, including the Chairman of the Trust, along with Executive Director membership which signals a high level of Trust involvement.
- Terms of reference were revised to reflect the change in membership and reporting arrangements, linking with the Executive Strategic Risk Management Group, Audit Committee and the Trust Board.

Finance Committee

- Establishment of a Finance Committee in early 2008 which meets on a monthly basis. It comprises all Trust Board members.
- The committee focuses on financial preparedness for Foundation Trust status and the Trust's overall financial health.

Executive Strategic Risk Management Group (ESMRG)

- Revision of the terms of reference to reflect the new risk arrangements.
- Presentation and review of the Assurance Framework and risk register at alternate meetings.

Charitable Trust Sub Committee

- Establishment of a sub committee comprising a NED, two Executive Directors, a Consultant and a Matron representative.
- Introduction of quarterly meetings, with ad hoc meetings as required.
- Regular liaison with the Charity's Investment Manager.
- A full review of policies and procedures applicable to the Charity undertaken and implemented.
- Preparation and monitoring of risks through a risk register.

Quality Safety and Operational Group

- Revision of the Terms of Reference to reflect the new quality and safety arrangements.

Strategy Development Group

- Fortnightly meetings established comprising Director of IM&T, General Managers, Director of Facilities, Deputy Director of Finance, Deputy Director of Nursing, IT Programme Manager and Head of LEAN.

Performance Review Group

- Monthly meetings established including Executive Directors, Associate Directors, Operational Managers, Planning and Performance, Finance, Human Resources and IM&T staff.
- Its purpose is to provide a strategic overview of the Trust's current performance against the regulatory and performance framework the Trust is assessed by, including the Monitor Compliance Framework, Healthcare Commission Annual Health Check, Corporate Objectives and the PCT contracts.

Trust Clinical Council

- The Trust Clinical Council is a consultative body of senior clinicians whose prime purpose is to advise the management team and debate matters of strategic clinical importance. The recently appointed Medical Director is in dialogue with senior clinical colleagues regarding the role of the Trust Clinical Council in strengthening clinical engagement.

Executive Directors Group (EDG)

- Weekly meeting established for Executive Directors and Associate Directors to raise and discuss matters requiring executive attention.
- The EDG receives minutes from the Clinical Programme Board, reviews agenda and holds pre-meetings, Safety and Patient Initiative walkrounds, Capital Investment Group, Performance Review Group and the Airedale Partnership Group.

Executive Safety Walkrounds

- In addition to the formal Board committee structure is a programme of structured weekly visits to all parts of the Trust to discuss safety, with agreed actions for improvements. All members of EDG participate in the walkrounds to maintain a focus on front line service delivery.

Policies, standards, guidance and best practice

- 7.14 Clinical governance is the framework through which NHS organisations demonstrate accountability for continually improving the quality of their services and safeguarding high standards of care, by creating an environment in which excellence in clinical care will flourish. This means being able to produce and maintain effective change so that high quality care is delivered.
- 7.15 The Trust has a committee structure designed to monitor and take forward the improvements to the clinical quality and safety of the services it offers to patients. The Trust Board is accountable for quality and safety of patient treatment and care. It is supported by a committee (QSAC), and a number of other specialists groups and committees. The Trust Board also receives regular detailed reports documenting progress and assurances from these various groups and committees that quality is improving.
- 7.16 The Trust has a corporate risk register that sets out potential risks to achieving targets and objectives. The committee structure incorporates regular review of the register and the Assurance Framework. Significant investment has been made in risk management training for staff to ensure ownership of the process at all levels of the organisation.
- 7.17 The Trust's Sharepoint portal (intranet) has a dedicated section showing all its policies. On accessing the policy section, the policies are listed in alphabetical order based on subject matter. The Trust has a formal procedure for the drafting and approval of policies. All policies have to be reviewed and approved by the governing committee. Access to the Sharepoint portal is controlled by the Knowledge Manager: no documents can be amended or replaced other than by the Knowledge Manager.

7.18 External validation and auditing of the Trust's corporate systems and processes is undertaken on a regular basis. Amongst others, these include the following:

- **Auditors Local Evaluation.** The Audit Commission audit the Trust annually. The Trust achieved a score of 3 (out of a possible 4) over the five themes of: Financial Reporting, Financial Management, Financial Standing, Internal Control and Value for Money. The latest published report relates to 2007/8.
- **Historical Due Diligence (HDD).** The Trust has been audited during the last year by KPMG and Deloitte to ensure the Trust's preparedness for Foundation Trust status. The HDD exercise focused on three key areas: Is the Trust legally constituted? Is the Trust well governed? Is the Trust financially viable? No concerns were raised by KPMG or Deloitte.
- **Strategic Health Authority Foundation Trust Assurance Report.** As part of the assurance process for ensuring the Trust is prepared for FT status, the SHA conducted its own assurance review, based on the Trust Integrated Business Plan (IBP), Board observation and review of the Trust Board papers. A report giving feedback on the IBP, together with an assurance questionnaire was issued to the Trust. No concerns were raised in either report.
- **NHS Litigation Authority (NHSLA).** This is a quality assurance exercise conducted annually and validated externally by the NHSLA. The Trust held Level 1 Acute status from December 2007 and Level 2 Maternity status from December 2007.
- **Register tracking of external regulatory visits.** The register is reviewed every 6 months by QSAC.
- **Audit Commission review of strategic risk management.** This audit was undertaken by the Trust External Auditors in 2008. The report published in December 2008 made a number of recommendations mainly relating to the Assurance Framework and the risk appetite of the Trust Board and clinicians to develop commercial opportunities for the Trust.

- **A number of audits undertaken annually by the West Yorkshire Audit Consortium, the Trust Internal Auditors.** Recent audits have included incident management including Serious Untoward Incidents and review of complaints and claims processes.
- **Standards for Better Health (S4BH) assurance process.** This is an externally validated assurance process undertaken by the Healthcare Commission (now the Care Quality Commission). The Trust declared compliance with all S4BH standards for 2007/08 except for two relating to equality and diversity.

Systems and processes

7.19 To demonstrate the delivery of objectives, there is a requirement that all NHS Chief Executives sign a Statement of Internal Control, which forms part of the statutory accounts and annual report. The following paragraph is taken from the Statement of Internal Control in the 2008/09 Annual Report and Accounts:

"The Trust uses the Australia/New Zealand risk scoring system to evaluate all risks, including information and reporting risks. The resulting information is used in the production and prioritisation of a comprehensive risk register."

7.20 The Quality and Safety Operational Group meets on a monthly basis and their work, in turn, is overseen by the Trust's Quality and Safety Assurance Committee. The QSOG considers both clinical and operational risk. The Trust's public stakeholders are involved in the risk management process. The Trust has a lay representative on QSOG and the Assurance Panel, who play an important and active part in the process. The Trust also ensures the Patient and Carer Panel is used to consult and engage on all matters relating to risk.

7.21 As described above there is also an Executive Strategic Risk Management Group (ESRMG) that meets regularly on a monthly basis. The ESRMG has delegated powers from the Trust Board to oversee, coordinate, review and assess the effectiveness of risk management and arrangements and activities within the Trust.

- 7.22 The Director of Information, Management & Technology has provided comprehensive and reliable assurance in respect of information risks within the Trust. The work undertaken in 2007/08 as part of the Information Governance Assurance Programme ('IGAP') was completed during the year. We have continued to make good use of the NHS Information Governance Toolkit in order to assist us in achieving desired standards.
- 7.23 The Assurance Framework details the risks associated with the corporate objectives. The framework identifies the source of independent assurance in relation to each objective and risk.
- 7.24 The framework is dynamic, to reflect changes in priorities and developments in the external environment. It is a strategic management tool, and is not designed to reflect every potential risk, but to focus attention on those which are most significant and are therefore priorities for management.
- 7.25 The Assurance Framework is reviewed by the Trust Board, Audit Committee and the ESRMG and updated on a regular basis.
- 7.26 Assurance about the system of internal control is given to the Board both directly and indirectly through its subcommittee structure where issues of governance are considered and judged by Non Executive and Executive Directors supported by officers of the Trust. The Board and its sub committees have thus reviewed, for example, the Healthcare Commission's "*Standards for Better Health*".

Comment

- 7.27 It is clear that the Trust has invested significant time, financial and intellectual resource into the review of its governance arrangements. That review has been both systematic and comprehensive, reinforced by the rigorous discipline associated with the application process for Foundation Trust status. Equally important, the process has been, and remains, an iterative cycle of planning, implementation, evaluation and refinement. We remarked at the outset of this report that governance is not a 'one-off' event and it is important that the new arrangements are the subject of careful reflection within the Board from time to time to ensure that systems and

processes do not inadvertently take precedence over the intended outcomes for patients. We acknowledge that the Board has made explicit provision for this within its schedule of business.

- 7.28 In light of the profound external pressures for change it is also essential that the Trust Board remains constantly vigilant in ensuring that it serves its patients in the best way possible. Given the nature of the economic climate which faces the NHS it is more important than ever that the Board retains its 'moral compass' if it is to engage effectively with front line staff, and demonstrate to the public that the ethos of the NHS is truly being fulfilled within the Trust.
- 7.29 Difficult choices will have to be made, the pace of change will increase rapidly and financial pressures will be magnified. Such an environment will be a stern test of the effectiveness of the new governance arrangements. The maxim that 'strategy is not what you say, but what you do' will be important to keep in mind when moving forward.
- 7.30 To help us in our task we took the opportunity to have escorted walks around the hospital: the whole panel during the morning and Professor Mullan during the 'twilight shift' when we were able to observe systems in action and hear the views of front line staff. We received very positive feedback and noted some innovative work (eg telemedicine, the Acute Care Team (ACT), the use of volunteers to obtain real time patient feedback, the smart card for accessing the room in which controlled drugs are kept in A and E, benchmarking information for ward sisters – there is much more).
- 7.31 Mr Kinsella also had the opportunity to sit in as an observer during the public and private sessions of a Trust Board meeting which was invaluable: best practice in the conduct of those meetings was apparent, as was the desire to ensure a focus on the patient and a clear link between policy formulation and implementation.
- 7.32 Two brief notes of caution are important. We are conscious of the enormous amount of time and energy which is being expended on the application process for Foundation Trust status. This must not become an end unto itself, but rather a means to achieve greater autonomy in the way in which patient care is planned and delivered. Unfortunately, there are examples across the NHS where it would appear that the process has beguiled

Boards into losing sight of their over-riding goal of serving patients in the best way possible. The tragic events at Mid-Staffordshire are a sad illustration of this phenomenon.

- 7.33 Additionally, we have some reservations about whether the management structure which has been adopted throughout the Trust may not be too 'committee rich'. They will require significant investment of management time and energy to service them effectively, with the potential for duplication of effort and debate. This is not a criticism, but an observation: there is no perfect template for management structures and they should be bespoke to each organisation's particular environment and culture. We recognise that the Chief Executive and his team have already given this matter consideration and have given a commitment to keep the effectiveness of the structure under constant review.
- 7.34 The Trust Board in place at the time of the events which are the subject of this Inquiry effectively suffered from what has been termed the 'disconnected hierarchy', where a schism takes place between the policy at the top and the delivery at the front line of the organisation. However, from our investigations we are satisfied that the potential for that to occur again has been significantly minimised, if not removed altogether: the main focus of the Trust Board and of the organisation as a whole is very much upon clinical care and ensuring the best possible experience for patients and their families.
- 7.35 Strong building blocks are in place. Systems and information flows are well integrated; relationships appear to be healthy with a focus on team working, strong clinical leadership and effective clinical engagement; there is robust challenge within the Board itself. Overall, there is an impression of a learning environment which takes into account, and acts upon, feedback relating to the patient experience.

Corporate management

Corporate management structure

- 7.36 The Trust Board Committee structure is described in the previous section of the report and shows the links between each of the committees and how these feed in to the Board assurance process.

Trust Board structure

7.37 Membership of the Trust Board is in accordance with its Standing Orders. The Trust Board members both chair and sit on a number of committees and management groups thereby ensuring appropriate checks and balances as well as cross referencing of knowledge and experience. The Trust Board structure is shown in Appendix 3.

Corporate management link with clinical management

7.38 Over the last two years there has been an alignment of corporate and clinical leadership and management. Medical and nursing leadership and engagement has been incorporated into the service operational delivery and strategic development decision making structures.

7.39 Designated Clinical Directors and Senior Matrons with clear portfolios are responsible to the General Managers as part of the service delivery operational structure with professional responsibility for delivering high quality, safe, value for money services. The structures are shown in Appendix 4.

7.40 This team of professional managerial and clinical leaders meet every fortnight in the Strategic Development Group (SDG) with the Executive Directors to consider national, regional and local developments and determine impact and opportunities on the Trust's business.

7.41 This alignment at both operational and strategic levels has resulted in a shared emphasis on safety and value for money, increased accountability and ownership and a better understanding of performance, underpinned by rigorous risk management systems and processes.

Risk Management and Assurance Process

7.42 The Trust is committed to minimising, managing and preventing risk through a comprehensive, systematic system of internal controls, whilst maintaining potential for flexibility, innovation and best practice delivery.

7.43 They have developed a structure for risk management to ensure all areas of risk are identified and managed through the Trust's management,

accountability and assurance mechanisms. This is done according to risk ratings defined in the Risk Management Strategy, Policy and Risk Assessment Procedure. The Trust Board receives the Assurance Framework and the risk register as a formal mechanism for considering key risks on a regular basis. The Board also receives reports where risks are identified as follows:

- Clinical governance and risk management monitoring reports which are aligned to the Standards for Better Health domains on a quarterly basis.
- Reports on compliance with Standards for Better Health core standards.
- Financial performance on a monthly basis.
- Performance reports against key national and local targets on a monthly basis.
- Serious untoward incidents, as they occur.
- Serious emergent risks, as they are identified

7.44 A proactive approach to risk management has been implemented; one which addresses every element of the organisation's activities. It uses the four-phase cycle of:

- Risk identification.
- Risk analysis.
- Risk control and action planning.
- Risk funding through the financial and business planning processes.

- 7.45 The following training arrangements are now embedded practice:
- All staff receive training in the use of the Risk Management Process at Corporate Induction on joining the Trust.
 - All staff receive mandatory training on Risk, and Health & Safety. This includes awareness of the process for investigating incidents.
 - Advice and support on the Risk Management Process is provided by the Risk Management Team, including how to grade and classify risks.
 - Leads for Risk Management within services and specialties are provided with additional training as identified through their personal development plans. This is provided in-house by the Risk Management Team, or externally as appropriate.
- 7.46 In addition, all Senior Managers (Band 7 and above) must attend mandatory training on Root Cause Analysis and Investigation Skills.
- 7.47 The Trust integrates governance through four broad governance domains which relate to its strategic objectives:
- Clinical quality and safety.
 - Workforce planning, development and management.
 - Financial and performance management.
 - Consumer and commissioner choice.
- 7.48 The Trust Board has overall responsibility for the effective management of risk. It is supported by the Audit Committee, Executive Strategic Risk Management Group, Quality safety and Assurance Committee and the Clinical Governance and Risk Management Operational Group. The corporate risk management structure and assurance process is shown at Appendix 5.

Comment

- 7.49 In line with the recommendations of the review of the NHS led by Lord Darzi, the Trust has placed great emphasis on the alignment of corporate and clinical leadership throughout the organisation. We have been impressed with the steps already taken, and equally important the vision which has been articulated and the mechanisms put in place to secure that vision. Again, it is encouraging to observe that this is an iterative process with 'clinical champions' having been identified at all levels of the organisation to act as a catalyst for positive change. Significant time and energy will be required to harness the total intellectual capital invested in the clinical workforce, but there is every reason to be confident that goal will be achieved.
- 7.50 It is equally reassuring to see consistent evidence that the Trust Board places risk management and patient safety at the very top of its agenda: it enjoys a very high profile right throughout the organisation. The investment in training and development in this area is significant and the Assurance Framework adopted by the Trust Board is both comprehensive and dynamic.
- 7.51 We make no apology for repeating ourselves at this point: it is critically important that the Board continues to invest equal energy and commitment in living the values it has espoused if it is to continue to win the 'hearts and minds' of staff. Studies by the National Patient Safety Agency demonstrate clearly that systems and processes of themselves are not enough, and patient safety will only be constantly assured where members of staff are effectively engaged and when they believe those at the top of the organisation truly share the values of the NHS.

Nursing management

Context

- 7.52 A whole system approach to delivering an integrated system for safeguarding the quality and safety of patient care has been developed and embedded by the Director of Nursing since her appointment in October 2005. It is underpinned by core principles of getting the basics right first

time, while seeking to provide a high standard of care and treatment that is safe and effective for individual patients.

- 7.53 The Director of Nursing has Board level responsibility for professional nursing and midwifery practice, providing influential and effective leadership to both professions. The Trust's systems are designed for the benefit of individual patient needs and are fully integrated within its clinical governance and performance frameworks. The nursing and midwifery career structure has been developed to allow for personal growth and clinical progression within a competency framework based on a high level of supervision, guidance, support and professional development.

Nursing and Midwifery structure

- 7.54 There are 583 registered nurses and 100 registered midwives employed by the Trust. In addition there are 52 bank nurses and midwives. The nursing structure, together with the governance and management arrangements are set out in Appendix 6. The Director of Nursing is directly supported by a corporate nursing team comprising a Deputy Director of Nursing, Assistant Director of Healthcare Governance, Assistant Director of Patient Safety, Head of Midwifery, two Nurse Consultants and Lead Cancer Nurse: all report directly and are accountable to the Director of Nursing. The corporate nursing team is directed by the Director of Nursing to influence and transform nursing and health related policies/strategy into effective clinical practice at ward and individual patient level.
- 7.55 In order to strengthen nursing leadership at all levels, the clinical nursing structure was revised early in 2008 to increase the number of matrons from 8 to 14. The revised structure sets out clear lines of managerial responsibility, enabling visible leadership at ward level in order to safeguard standards of clinical care while providing an effective interface between the corporate and ward teams. All matron job descriptions were changed at the same time to reflect this.

7.56 A number of key leadership, governance and development groups led by the Director of Nursing and corporate nursing team are well established in order to provide nursing leadership at all levels. These ultimately report to the Trust Board through the Director of Nursing and inform Trust management and assurance committees. Details are set out below:

- **Nursing and Midwifery Leadership Group** – its aim is to monitor, maintain and develop evidence-based nursing practice and clinical standards in order to ensure safe and effective, individualised care for patients and their relatives/carers.
- **Matrons' Forum** – it concentrates primarily on operational issues and the development of evidence-based practice to enable effective service delivery.
- **Nursing and Midwifery Forum** – its aim is to have a Trust-wide approach to developing the nursing and midwifery profession and create an effective learning environment to share and debate key practice and professional issues.
- **Medicines Management Group** – its aim is to bring together and critically review all aspects of medicines management in the Trust, ensuring that this operates within the appropriate legal frameworks.
- **Patient Group Direction and Dose Adjustment Protocol Assurance Panel** – its aim is to ensure that the Trust is fully compliant with systems and processes set out in the Standard Operating Procedure. It reports directly to the Medicines Management Group in order to provide it with robust evidence of assurance that the administration of medicines using a Patient Group Directive/Dose Adjustment Protocol is compliant with Trust and national medicines management policies and legislation.
- **Clinical Benchmarking Steering Group** – its aim is to facilitate, oversee and monitor the 'Essence of Care' (national standards) within all wards/departments in the Trust in order to benchmark, share and develop best practice.

- **Patient Safety and Practice Development Group** – its aim is to ensure a consistent and evidence-based approach to clinical practice development across all wards/departments

Standards, clinical guidelines, policies and care pathways

- 7.57 Trust standards, clinical guidelines and policies undergo formal consultation and ratification processes and set out clear guidance for evidence-based practice that can be evaluated through a programme of audit, enabling improvement plans to be implemented and further audited. Operational and clinical policies are ratified via the Trust's Quality and Safety Operational Group while clinical guidelines are ratified by the Trust's Clinical Guidelines Group.
- 7.58 The Trust has adopted the Royal Marsden Hospital Manual (2008) 'Clinical Nursing Procedures' which sets out clear standards for clinical practice. All policies and guidelines are available electronically to all Trust staff on Sharepoint. Any changes to nursing practice, policies or procedures are discussed and agreed at the Nurses and Midwifery Leadership Group before final ratification by the Quality and Safety Operational Group. Nursing and midwifery policies are then formally disseminated via the Nursing and Midwifery Leadership Group in accordance with an implementation and audit plan for cascade and communication with ward/department teams.

Measuring and evaluating quality and standards

- 7.59 A number of measures are used to evaluate the quality of nursing care and clinical practice against approved standards, guidelines and policies. These include the incidence and prevalence of hospital acquired pressure ulcers; in-patient falls rate; healthcare associated infection and MRSA bacteraemia and C Diff rates; failure to rescue – cardiac arrest rate; and medication errors. Measurement and evaluation of these measures are undertaken using a variety of means.
- 7.60 'The Productive Ward' (recent national guidance on best practice in patient care) is well established on several wards with plans to include all wards, including theatre and maternity.

7.61 Nursing Key Performance Indicators (KPIs) are audited monthly by all wards and departments and the data presented at the Nursing and Midwifery Leadership Group. These evaluate the quality of nursing documentation against nursing care criteria in a number of areas such as medicines management, fluid balance recording, nutrition using the Malnutrition Scoring Tool (MUST) and the use of the early warning score.

7.62 Fitness to practise: a number of governance and assurance systems and processes are embedded within the Trust to ensure that nurses and midwives have the necessary knowledge and skills for safe and effective practice in accordance with the Nursing and Midwifery Council publication 'The Code. Standards of Conduct, Performance and Ethics for Nurses and Midwives' (2008). These are as follows:

- **Advancing Practice Assurance Group** – The Trust 'Advancing Clinical Practice Policy' (2008) provides clear guidance for registered nurses, midwives, pharmacists and allied health professionals seeking to undertake adjustments to the scope of their clinical practice to work at a level beyond initial registration and/or to an advanced level of clinical practice. An Advancing Practice Assurance Group was established to govern its implementation in order to safeguard the public and ensure safe and effective care. The Trust has an Advancing Practice Register which is reviewed on a monthly basis.
- **Clinical Supervision** – in addition to supervision processes at ward level for registered nurses and midwives provided through preceptorship, mentorship and management, the Trust is presently piloting the implementation of a formal clinical supervision framework. All qualified nurses in the Trust are encouraged and supported to engage in this form of clinical supervision. It is mandatory for those who are working in clinical nursing roles as, essentially, lone workers where they have high levels of professional autonomy and clinical decision making. In addition, nurses who are working towards advanced practitioner status must engage in clinical supervision and adhere to the processes set out in the Trust policy. The nomination, selection and appointment of midwives is in accordance with LSA national forum publication 'Guidelines for the Statutory Supervision of Midwives' (UK 2007).

- **Preceptorship/Induction** – all new staff attend the Trust's induction and all new nurses/midwives undertake local induction and a period of supervision and mentorship/preceptorship according to their individual requirements. A Practice Learning Facilitator is responsible for overseeing student nurse placements and liaising with the local universities to ensure that these are in accordance with the Trust, University and Nursing and Midwifery Council frameworks.
- **Annual Performance Review** - all nurses and midwives undergo annual performance review using the 'NHS Knowledge and Skills Framework' in order to ensure that they have the requisite knowledge and skills to undertake their roles and responsibilities

Professional development, education and training

7.63 A number of learning and practice and professional development opportunities exist within the Trust to develop nurses/midwives competence and performance. These are as follows:

- **Nursing and Midwifery Education Steering Group** – its aim is to provide strategic leadership, guidance and support for the continuing professional development, training and education of support workers, nursing/midwifery students and qualified nurses working in collaboration with local Higher Education Institutes.
- **The rolling Training and Education Programme** – this is aimed at providing education and training for qualified nurses on a wide variety of clinical competencies. The programme is reviewed and updated annually by the Nursing and Midwifery Leadership Group. A training needs analysis has also been undertaken which helps to identify the core skills and training required for each ward's nursing team, based on the clinical speciality. The rolling programme is held every two months.
- **Clinical Induction programme for Nurses and Midwives** – all nurses new to the Trust attend the clinical induction programme which includes key information on professional accountability and medicines

management. They are held on a monthly basis. All new midwives also attend clinical induction, organised separately.

- **Nursing Leadership** – A leadership development programme and separate coaching programme were implemented for matrons and ward sisters (band 7) over the course of 2007/08. So far, 21 senior nurses have completed one of these programmes. In addition, all band 7 nurses and above, are currently attending the Trust's management development programme.
- **Bradford and Airedale Education Partnership** – The Trust works in partnership with the University of Bradford with the aim of ensuring that the next generation of practitioner is 'fit to practise' and clinically competent.

Comment

- 7.64 The Trust has comprehensive, integrated systems of nursing leadership and management in place, which seeks to safeguard the quality and safety of care through implementation of evidence-based clinical practice supported by a programme of audit, policy development and effective clinical governance. These systems are under the leadership of the Director of Nursing who has Board responsibility, thus ensuring that there is effective 'Board to Ward' leadership influencing every level of clinical and professional nursing and midwifery practice.
- 7.65 Our observations demonstrate clearly that the current Director of Nursing has already made a positive difference for the better for patients and staff. The starting point is that she enjoys significant confidence in her leadership ability and her commitment to high standards of patient care, amongst her senior managerial and clinical colleagues. Equally important, that confidence appears to be shared amongst the staff for whom she is directly accountable.
- 7.66 There is close collaboration with medical and other professional staff, which facilitates a consistent approach to the measurement and evaluation of the quality of care offered to patients. There is also a commendable focus on assuring the necessary knowledge and skills for safe and effective practice,

backed up with appropriate clinical supervision and continuing professional development.

- 7.67 The fundamental weaknesses in the previous systems for nursing involvement in medicines management have received scrupulous attention and appropriate safeguards have been put in place. Similarly, the deficiencies in communication systems have been addressed with common sense and vigour; the scope for confusion or distortion has been significantly reduced.
- 7.68 There is much to commend and a very strong foundation upon which to build further. The only reservation we express relates to the affordability of the current nursing management structure. The significant strengthening of the numbers and roles of the matrons within the structure has clearly proved to be a worthwhile investment which has reaped benefits for improved patient care and increased staff morale. The Trust needs to give careful consideration to the likely consequences of a more stringent economic climate and having to 'cut its cloth' accordingly. Quite properly, every NHS organisation must live within its means but it is important that the gains which have been made are not lost due to financial pressures. The Trust will need to find innovative ways of resolving this conundrum.

Human Resources

Context

- 7.69 In April 2009, the Trust recruited a new Director of Human Resources who is a Fellow of the Chartered Institute of Personnel and Development. The post holder is an Associate Board member and is responsible for all aspects of the human resources function, including learning and development; additionally there is accountability for Day Nursery and Occupational Health Services for staff.
- 7.70 The national regulatory framework provides the minimum operating standards for Trusts. Since its inception, the Care Quality Commission's assessments for the Trust have been 'excellent and good'. The independent Doctor Foster Hospital of the Year Award for the third out of the last four years also provides evidence of achievement against those standards. The Trust was awarded 'Best Large Employer in Yorkshire and the Humber' by

the Learning and Skills Council for its work with apprentices in 2008/09. It is also a partner in the Higher Education Innovation Cluster bringing its expertise in the telemedicine field.

- 7.71 The 'NHS Plan 2000' has been the major driver of HR policy and practice for the last decade and the Trust's workforce has been reshaped within that policy in order to deliver the service improvements required by government. The profound change in financial climate has led the Trust away from increasing staffing numbers, to concentrate on redesigning the workforce to deliver greater productivity within existing or less resources.
- 7.72 The Trust's Organisation Development Programme is focused on delivering excellent patient experiences by attending to both regulation and risk management and performance/productivity. The Trust has spent the last three years building capability to implement LEAN (system and service redesign) methods of delivery and is recognised as a leader in this area of good practice. An important aspect of adopting these approaches is that they provide key staff with clear accountability and responsibility for working towards Trust objectives which is a well established form of engagement in the workplace.
- 7.73 Other major policy drivers include the following:
- **Modernising Medical Careers and the European Working Time Directive** – placing a requirement upon the Trust to change the means of recruiting and training its doctors.
 - **The Boorman Review of the Health and Well Being of NHS Staff** – this resulted in the approval by the Board at its meeting on 3rd December 2009 of a Health and Well Being Strategy for the Trust.
 - **The NHS Next Stage Review – 'Our NHS, Our Future'** – a comprehensive review led by Lord Darzi, which places great emphasis, amongst other things, upon effective clinical engagement to improve quality and safety.
 - **'A High Quality Workforce'** – it sets out a vision for long term sustainable workforce planning, education and training.

- **'The NHS Constitution'** – which requires NHS organisations to live the values of the NHS. An implementation plan was approved by the Board in December 2008.
- **'What Matters Most to Staff in the NHS'** – with emphasis upon staff understanding their role, where they fit in the organisation and involving and listening to staff.

7.74 Current priorities for the HR Department include:

- Addressing staff survey outcomes.
- Tackling stress in the workplace.
- Improving the quality of appraisal and personal development planning.
- Taking forward the Organisation Development Programme to ensure a successful future as a Foundation Trust, including Board, team, clinical leader and line manager development.
- Embedding the NHS Constitution throughout all the activities of the Trust.

Human Resources policies and procedures

7.75 The Director of HR is responsible for development of HR policy with supporting operational procedures, in collaboration with internal and external stakeholders, including the Airedale Partnership Group. Guidance from NHS Employers which represents Trusts on workforce issues helps to inform all Trust policies and systems. The Executive Directors Group has corporate responsibility for final approval and implementation of policy. Individual directors are accountable for the implementation of policies within their areas of responsibility and the HR Department provides Trust-wide support.

7.76 All line managers are required to participate in a comprehensive development programme to ensure knowledge of policies and to facilitate development of people management skills. The annual staff survey is used to check the impact of employment policies, to address problems identified and to develop new ways of working.

7.77 Monitoring of HR policies is undertaken in a number of ways:

- The annual Standards for Better Health assessments.
- Data collection and analysis provided to the Board and appropriate committees e.g. Airedale Partnership Group, Health & Safety Committee, monthly Performance Monitoring Committee, monthly Service Delivery Management Team.
- Learning from Risk Assessments/Serious Untoward Incidents/Adverse Events reporting.
- External audits/third party assessments e.g. NHSLA, PMETB, OFSTED

7.78 HR policies are reviewed on a three year cycle or earlier in response to issues identified by monitoring, or to changes in legislation, national policy or best practice.

Recruitment and selection

7.79 The Trust has developed comprehensive 'Recruitment Guidelines' to ensure all those involved in recruitment and selection adopt best practice and meet NHS Employers Standards. They are available on Sharepoint.

7.80 Managers are required to attend a two day training course on effective application of those guidelines. Full documentation of recruitment processes and selection decisions are required for all staff appointments. The HR team are currently undertaking an exercise utilising LEAN methods to streamline processes and exit interviews are being piloted in Surgical Services to inform further guideline developments.

Induction of new staff

- 7.81 The Trust introduced a new induction policy in 2007 which promotes effective induction practice and sets out mandatory requirements. The document is available on Sharepoint.
- 7.82 All staff must attend corporate induction. Attendance is monitored and attendance failures reported to line managers for follow up action. The programme receives consistently good feedback and attendees are given a handbook covering key issues and a set of 'must know' practical information. Attendance is routinely reported at +90%. Additionally all staff must undertake a departmental induction, which is monitored by the Training Department. A review is undertaken at the end of the induction process to prepare for the annual appraisal. Newly qualified clinical staff are also subject to preceptorship arrangements, led by the Practice Development Unit.

Staff appraisal and Personal Development Planning

- 7.83 The Trust is reported as being in the highest 20% of all Acute Trusts for undertaking annual appraisals with individual Personal Development Plans. It is also regarded as a national centre of good practice in full utilisation of e-KSF (an electronic Knowledge and Skills Framework for capturing performance review data and plans). The Board receives a monthly KPI and, at the end of March 2009, the Trust achieved its 90% target for completion of annual appraisals.
- 7.84 The Trust's current goal is to improve the quality and outcomes from appraisal. Evaluation of sample activity and outcomes will take place in 2009/10 to test the quality of appraisals and design and delivery of Personal Development Plans. The declared intent is to align individual contributions with Trust priorities, to enable the workforce to meet future challenges and to ensure safe, positive experiences for patients.
- 7.85 Personal development opportunities for staff include a comprehensive in-house training prospectus, practice development, clinical skills training and management and leadership development programmes. External education and training, secondments and extensions to practice qualifications are also available to staff.

Bullying and harassment

- 7.86 The Chief Executive provides a strong lead in promoting a climate in which harassment is known to be unacceptable; he personally follows up any allegations relating to bullying and harassment.
- 7.87 All new staff receive information regarding dignity at work and how to raise concerns, and the issue is impressed upon staff at corporate induction. The Dignity at Work policy signals a number of routes by which bullying and harassment can be dealt with and a network of Harassment Advisers is in place to provide confidential help for staff. All managers are required to undertake training in tackling harassment, bullying and other unacceptable behaviour.
- 7.88 Monitoring takes place via the HR Department and an annual Equality Report is produced. This report will also be followed up by the Equality and Inclusion Steering Group.
- 7.89 The 2008 annual staff survey shows the Trust is above average in being seen as taking effective action when issues are raised and staff report that they are aware of how to raise issues of concern. The Trust also operates a Raising Concerns and Whistleblowing Policy; a private log of concerns raised is held by the Chief Executive who personally ensures appropriate action is taken.

Comment

- 7.90 The Trust has taken positive steps to improve the synchrony between the development of HR policy and its implementation on the ground. Commendable progress has been made in a number of important areas and there is recognition of the crucial importance of learning from previous mistakes; staff did not attach credence to HR policies in the recent past and therefore their value was questionable. The regular review and evaluation of HR policies is a key priority and it is important that focus continues in light of the challenges which the Trust faces in the years ahead.
- 7.91 We are pleased to note the improvements which have been made in the induction process for new staff and the staff appraisal and personal development planning process in particular. It is particularly important that

the Trust follows through rigorously its declared intent of switching the emphasis towards the quality of the experience of appraisal together with a focus on outcomes. All too often, NHS staff regard the process of appraisal as a mechanistic chore, which bears little relationship to the reality of the pressures which they face on a daily basis. Symmetry between Trust Board objectives and the objectives of individual members of staff will only be achieved where those at the top of the organisation show genuine concern for the individual; the leadership culture must offer unequivocal evidence of that on a consistent basis and the HR Department exists to promote that culture. The Chief Executive's strong lead on bullying and harassment is commendable.

7.92 We have some reservations about the capacity of the HR Department to deliver against the ambitious Organisational Development Programme, given its central importance in the scheme of things. The landscape which the Trust operates within is about to change dramatically and it will require a 'sea change' in approach to the design of services and the deployment and training of the workforce, and thus will require a greater investment of time, energy and intellect than hitherto.

7.93 We recognise that the Trust has acknowledged this already by means of a review and refinement of the programme, but we strongly recommend that this focus be maintained. Ultimately, HR policies and procedures are not a paper programme, but rather a 'people' programme.

Management of medicines including prescribing, recording of medicines usage and the audit of medication

7.94 A review of pharmacy processes and medicines management commenced in April 2009 with the appointment of a Pharmacy Operations Manager. Following the retirement of the Director of Pharmacy/Chief Pharmacist in June 2009, the Pharmacy Operations Manager acted up as Director of Pharmacy/Chief Pharmacist for a period of several months and was the lead on medicines management. Following a formal interview process he was appointed as Director of Pharmacy/Chief Pharmacist on a substantive basis on 1st December 2009.

Governance arrangements for medicines management

7.95 The Chief Executive has ultimate responsibility for medicines management. The Chief Pharmacist is the accountable officer for the Trust and is responsible for making sure the organisation handles controlled drugs safely and complies with relevant legislation.

7.96 The Chief Pharmacist is a member of the Trust's Service Delivery Senior Management Team, as well as the following quality and safety groups:

- Executive Strategic Risk Management Group (ESRMG).
- Quality and Safety Assurance Committee (QSAC).
- Quality and Safety Operational Group (QSOG).
- Advancing Practice Assurance Group (APAG).
- Pandemic Flu Steering Group.

7.97 The Chief Pharmacist is either chair or a key member of the following multidisciplinary medicines related groups:

- Medicines Management Group (MMG) – chair Chief Executive.
- Medicines Safety Group (MSG) – chair Chief Pharmacist.
- Pharmacy Service & Process Review Group (PSPRG) – chair Chief Pharmacist.
- Patient Group Direction Assurance Panel – chair Chief Pharmacist.
- Drugs and Therapeutics Committee – chair Chief Pharmacist

Clinical management of medicines

- 7.98 Standards of practice in relation to storage, handling, prescribing and administration of medicines are stated in the Trust's Medicines Code (last updated in 2008 and currently under review). Detailed Standing Operating Procedures (SOP) have been written to support the Medicines Code at an operational level.
- 7.99 The Yorkshire-wide drug chart was introduced across the Trust in September 2009. Amongst other things it requires the prescriber to print their name and bleep number in addition to signing the prescription chart. We were told that authenticity of prescribers will be best addressed by electronic prescribing (with electronically verified signatures and audit trails). A project is underway at the Trust to develop such electronic systems. Medicines will be prescribed in accordance with regional prescribing standards and the Trust's SOPs.

Staff training

- 7.100 A Senior Pharmacist gives an introduction to medicines management for all new starters at the Trust's mandatory corporate induction programme. More in-depth training is given to professional groups as part of their local departmental induction. In addition, nursing staff have a mandatory annual medicines update. Specific training relating to intravenous opiate administration is given at induction to all medical staff, led by the Trust's Post-Graduate Education Tutor and a Senior Pharmacist.
- 7.101 Medicines management processes have been mapped and multidisciplinary work groups have embarked on a programme of service redesign. Action plans are being developed that will ensure most appropriate use of resources and equipment to optimise medicines management. This programme includes a structural review of the pharmacy service and the roll out of electronic prescribing.

Recording of medicines

- 7.102 Records associated with the distribution, prescribing and administration of medicines are kept in accordance with the Medicines Code, SOPs and regional prescribing standards.

Audit of medicines usage and controls

- 7.103 The Medicines Safety Group commissions audits relating to medicines management and initiates corrective and preventative actions as necessary. An outline annual audit plan (including National Patient Safety Agency monitoring requirements) has been prepared.
- 7.104 Several audits of medicines management have been undertaken:
- In 2006, an audit of medicines management at Airedale NHS Trust was carried out by the West Yorkshire Audit Consortium. This audit is currently being repeated with additional focus on management of medicines at the point of prescribing and in relation to the interventions made by clinical pharmacists.
 - An audit of ordering, storage, prescribing and administration of Controlled Drugs was carried out in 2007 and repeated in 2009. An action plan has been developed and is underway.
 - A medicines management audit was carried out by the pharmacy team in early 2009. The outline plan has since been modified in line with similar work.

Comment

- 7.105 We are particularly pleased to see that medicines management has been the subject of extensive and robust scrutiny and improvement. The issue takes great prominence in Trust Board consideration and the post of Chief Pharmacist is fully integrated into the clinical and managerial structure, thus minimising the potential for failures in systems to be repeated.
- 7.106 There is a clear link between policy and procedures, and this is further strengthened with the consistency of approach offered by the adoption of the Yorkshire-wide drug chart. Major investment has taken place in the training of clinical staff, linked to process mapping and service redesign and effective audit arrangements are in place. We are satisfied that governance arrangements for medicines management are as they should be.

Multidisciplinary team working, especially at night

The Acute Care Team

- 7.107 The Trust established an Acute Care Team (ACT) in April 2007 which provides a 24 hour, seven days a week service. Its primary function is to support the provision of high quality, safe care to the acutely ill adult patient.
- 7.108 The ACT work under the direct clinical and professional leadership of a Nurse Consultant, Critical Care, who reports directly to the Director of Nursing. The team is line managed by the Matron for Critical Care. The team, together with the relevant site manager on-call, is also responsible for ensuring that the hospital site is managed safely out of hours.

Objectives for the Acute Care Team

- 7.109 The ACT has very clear objectives specified in their job descriptions, and each nurse's individual competence and knowledge are evaluated at annual performance appraisal using the Knowledge and Skills Framework. They are expected to:
- Maintain a high standard of care for the acutely ill patient in accordance with appropriate guidelines and protocols.
 - Participate in the provision of early intervention with appropriate assessment, observation and treatment for seriously ill patients.
 - Support ward staff in the management of sick patients.
 - Manage the hospital at night.
 - Ensure effective management of beds out of hours in the absence of the bed managers.
 - Manage clinical services and ensure efficient deployment of staff, according to workload.

- Ensure effective site management at night in accordance with Trust guidelines and protocols with the support of the senior manager on-call.
- Participate in practice development programmes and assist with the audit and evaluation of clinical standards.
- Participate in the in-service training, preceptorship and supervision of junior staff, post-basic course nurses and students, with a commitment to self development.
- Develop good Trust wide working relationships and communicate effectively with nursing colleagues and members of the multidisciplinary team.
- Promote quality care and non-discriminatory practice as outlined in trust policies and procedures, acknowledging a patient's personal beliefs and identity.

7.110 The ACT works according to a rota system, which ensures that a 24 hour service is provided. This enables them to keep up to date with all developments in the Trust and in the acute care arena.

Team working, professional boundaries and supervision of clinical practice

7.111 Effective professional boundaries operate between the ACT nursing staff and the attending medical team, which out of hours comprises a medical and anaesthetic Specialist Registrar and Foundation Year 1 and Foundation Year 2 core trainees.

7.112 An acutely unwell patient, out of hours, may be initially attended by the ACT sister who will operate within his or her professional competence, in accordance with Trust protocols. Interventions are strictly limited to those for which the nurse has the requisite competencies operated in accordance with the Trust's Advancing Clinical Practice Policy (2008).

7.113 In all cases, a management/treatment plan is carefully documented in the medical notes, which provides clear guidance for the ACT nurses' practice. In addition it is usual for an acutely unwell patient to be reviewed by another

ACT nurse on subsequent shifts, enabling effective peer review of clinical practice and treatment decisions.

7.114 Clinical practice is further supervised out of hours (with respect to the actions of both doctors and nurses) during the next consultant review. Consultant reviews take place as a minimum within 24 hours, but increasingly within twelve hours of admission. The ACT team has 24 hour access to consultant medical and surgical opinion. The medical teams conduct at least one ward round per day at weekends and will routinely review care given to the patient by the ACT and attending medical staff as part of the clinical assessment process.

7.115 **Guidance and protocols to facilitate team effectiveness**

- **Early warning scores** – protocols have been further developed to predict patients who are deteriorating, using simple clinical scoring systems.
- **Bleep policy** – after 9pm the ACT take calls, and coordinate and prioritise the workload for the medical on call team at night.
- **Patient Group Directions** – ACT sisters are trained and assessed as competent to administer Oxygen and Normal Saline against a PGD.
- **The non-medical prescribing course** – this has been undertaken by the Nurse Consultant, Critical Care and is presently being undertaken by two of the ACT Sisters. Once registered, they will be able to prescribe to a set Trust formulary for the ACT.
- **Doctors on call roles and responsibilities** – to facilitate effective team work an operational framework has been produced outlining what is expected of all tiers of on call medical staff.
- **Medical Assessment Unit escalation policy** – to ensure prompt review of acutely ill patients, especially out of hours, an escalation policy has been developed.

- **Protocols** – the Trust has developed a number of protocols available on Sharepoint to guide the treatment of acutely unwell patients

Team competencies

- 7.116 Professional and clinical leadership is provided by the Nurse Consultant, Critical Care who is Chair of the Royal College of Nursing Critical Care Forum and a member of the National Confidential Enquiry into Patient Outcome and Death Review Panel. She exercises strong clinical leadership by working as a clinical practitioner within the team.
- 7.117 A set of competencies has been developed through which the ACT sisters are enabled to develop their practice. These competencies are used during their eKSF review to set future objectives and to ensure continual learning and supervision.

Supervision

- 7.118 Clinical supervision and leadership for the team is provided by both the Nurse Consultant and Consultant Physicians. The Acute Care Nursing Team has monthly meetings where clinical, operational and managerial issues are discussed at length. Clinical supervision sessions have been held and the team are keen to develop these further, based on the Trust's policy (2009).

Outcomes

- 7.119 The introduction of the ACT has had a number of benefits:
- Reduction in the number of cardiac arrest calls as deteriorating patients are picked up early, before they arrest.
 - Increased support for ward nurses when caring for ill patients; the ACT have been able to support the senior ward nurses by helping to carry out clinical competency assessments, i.e. cannulation, phlebotomy, non-invasive ventilation etc.

- The Trust has a low Standardised Mortality Rate (SMR). This can be attributed, in part, to early recognition and intervention of the deteriorating patient.

Comment

7.120 The Trust has adopted an innovative approach to multidisciplinary team working, which offers a better deal for patients, not only at night but on a 24 hour, seven days a week basis. The team has clarity of purpose, effective leadership and promotes good working relationships across the Trust as a whole. Emphasis is placed on peer review, increased clinical supervision and support and the use of appropriate protocols and guidance. In summary, it is an exemplar of effective team working and the Trust is to be commended on its approach.

Confirmation of deaths

7.121 The legal process for death certification is firmly established. When completing a death certificate, the medical practitioner is asked to state one of the following:

- The medical practitioner completing the death certificate had viewed the body personally after death.
- The body had been viewed after death by another medical practitioner but not by the medical practitioner signing the death certificate.
- The body had not been viewed by a medical practitioner after death.

7.122 We referred in an earlier section of the report to the audit carried out by a Consultant Histopathologist in May 2000. The results of that audit implied that practice within the Trust at that time allowed bodies to be certified without having been viewed by a medical practitioner.

Death certificate practice and audit – August 2009

- 7.123 The current practice in the Trust is that all deceased patients are seen after death by a medical practitioner. Senior nursing staff from the Acute Care Team have competencies to verify death when an expected death has occurred.
- 7.124 However, there are clear lines of responsibility which ensure that no patient has their death certified without viewing of the body by a registered medical practitioner.
- 7.125 To assure that the processes are working effectively, the trust re-audited a sample of 189 consecutive death certificates for the period 1st May 2009 to 31st July 2009:
- The medical practitioner completing the death certificate had viewed the body personally after death in 41% of cases.
 - The body had been viewed after death by another medical practitioner, but not by the medical practitioner signing the death certificate in 59% of cases.
 - The body had not been viewed by a medical practitioner after death in 0% of cases.
- 7.126 This audit confirms that in this consecutive series, no patient was certified dead by any healthcare professional other than a medical practitioner.

Comment

- 7.127 We are satisfied that the Trust has accorded this sensitive matter the priority it deserves and the current arrangements are in line with accepted practice.

CHAPTER 8

CONCLUDING REMARKS

- 8.1 We hope that this report will assist in the understanding of what happened at Airedale Hospital at night between 2000 and 2002. We conclude that the events we have investigated occurred as a result of a combination of individual and systems failures.
- 8.2 Lessons have been learned and the Trust has undergone enormous change for the better. We hope that this reassures the community who use Airedale Hospital, and in particular those who have been affected by or involved in the matters we have investigated. Our recommendations for the Trust, if followed, ought to assist in increasing confidence in Airedale.
- 8.3 There have been a number of developments within the NHS nationally in recent years, including the development of the Memorandum of Understanding with the police. This, together with guidance, should be a useful tool for organisations involved in criminal investigations. In the light of the views we express in relation to joint working we believe that some development of the guidance would be helpful and we have made recommendations to that effect.
- 8.4 Where the roles of health professionals are extended the health professionals should be adequately trained and supported. The scope of the new role should be properly understood within the organisation and by those who use it.
- 8.5 In the last month reports have been published into recent events at Mid Staffordshire NHS Foundation Trust and at the Leeds Teaching Hospitals NHS Trust in 2002. We have read those reports and the recommendations. Some of them will have application in Airedale Hospital as in every hospital. We do not repeat them.
- 8.6 We believe our recommendations are proportionate to the issues they aim to address, practical and easy to implement.

RECOMMENDATIONS

The Trust

Patients and families

1. The Trust should consider, (in discussion with the SHA) how best to communicate with the patients and families who have been affected by the events we have considered. As a minimum we would expect the Trust to invite those patients and families who wish to do so to meet the current Chief Executive, Medical Director and Director of Nursing.

Corporate Governance

2. The Trust should make time in the Board agenda for periodic reviews of the new corporate governance arrangements to ensure that systems and processes do not take precedence over patients.

Corporate management

3. The Trust Board should demonstrate how it will ensure that the Chief Executive and his team keep the effectiveness of the management structure under review.

Human Resources

4. The Trust Board should satisfy itself regularly that:
 - i) staff appraisals and personal development planning are effective.
 - ii) the HR department is sufficiently resourced to deliver the organisational Development Programme.

Training/Induction

5. The Trust should consider:
 - i) whether or not doctors should be required as part of their practice when examining patients to review the prescription charts as well as the clinical records.
 - ii) whether induction courses for junior doctors and nurses are sufficiently explicit about the role and scope of practice of the other professionals.

National

6. When the scope of healthcare professionals' roles are extended to incorporate new responsibilities that impact on patient care eg nurse prescribing, NHS organisations should ensure:
 - i) that clear lines of accountability are in place;
 - ii) that training and development plans are fit for purpose;
 - iii) that there is appropriate evaluation of the effectiveness of the role within the organisation; and
 - iv) that there is effective dialogue and engagement with patients, carers and the public.
7. Governance systems in NHS provider organisations need to be designed to reflect Boards' 24 hour a day responsibility for all areas of service delivery.

Training/Induction

8. The Department of Health should reflect on the matters raised in paragraph 5 above and consider whether they should be the subject of wider consideration within the NHS.

Working with the police

9. The Department of Health should seek information from health care providers about their experiences of working with the police in order to review the effectiveness of the Memorandum of Understanding and the Department's guidance from the perspective of the health care providers. Guidance on the retention, recording and copying of documents and the need for control and access may need to be more detailed and robust.
10. The guidance should be developed so that it includes detailed help on the following:
 - in what circumstances, if ever, should a member of the staff of the hospital being investigated be seconded to work as part of the police team. What considerations should be borne in mind when a request is made from the police for such support? We suggest the following matters ought to be considered:
 - a) why is it necessary to second someone rather than use them as an adviser?
 - b) is the person wholly independent of the matters and people being investigated?
 - c) what is the adviser/seconded permitted to discuss outside the police team? What effect may this have on the adviser/seconded professionally and personally?
 - d) what support is the proposed adviser/seconded to be given?
 - e) how is the adviser's/seconded's role to be explained within the organisation?
 - f) for how long is the secondment to last? Should it be a rotating secondment amongst a group of staff?

g) can the work needed by the police be carried out by someone or a team from outside the organisation?

11. The guidance should also alert organisations to the need to give effective support to those who are giving witness statements (should such support be considered necessary). It may not be appropriate for managers to sit in on such interviews.

GLOSSARY

CE	Chief Executive.
Clinical audit	A quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.
Clinical governance	The system through which NHS organisations are accountable for continuously monitoring and improving the quality of their care and services and safeguarding high standards of care and services.
Controlled drugs	Some prescription medicines contain drugs that are controlled under the Misuse of Drugs legislation. These medicines are called controlled medicines or controlled drugs.
Corporate Governance	The system by which an organisation directs and controls its functions and relates to its stakeholders.
DM	Divisional Manager.
DN	Director of Nursing.
DOH	Department of Health.
EDG	Executive Directors Group – see paragraph 7.13 of the report.
Marsden Manual	The Royal Marsden Hospital Manual 'Clinical Nursing Procedures' is a text which sets out the standards for clinical practice and provides a source of expert knowledge to help nurses to deliver effective patient-focused care.

NED	A Non Executive Director (NED) is a member of the board who represents community interests and uses their knowledge and expertise to work with the Executive Directors to help improve trust services. Non Executive directors are appointed by the independent NHS Appointments Commission.
New Deal	The New Deal was introduced to improve the working lives of junior doctors and restrict their average hours of work – see paragraph 1.47 of the report.
NMC	The Nursing and Midwifery Council (NMC) was set up to ensure that nurses, midwives and health visitors deliver a high standard of care through professional standards.
NNP	A night nurse practitioner (NNP) is a senior nurse who has a range of specialist nursing skills and management responsibilities during the night - see paragraph 1.50 of the report.
Opiates	An opiate is a medication derived from the opium poppy, such as morphine and codeine. Opiate drugs are sedatives that depress activity of the central nervous system, reduce pain, and induce sleep.
PAG	Nursing and Midwifery Professional Advisory Group (PAG).
Patient Group Protocols	Patient Group Protocols are a specific written instruction for the supply or administration of named medicines in an identified clinical situation.
PRHO	Pre-Registration House Officers – Until 2005 the job Pre-Registration House Officer (PRHO) was the role open to medical graduates, who had passed their final examinations at medical school. Following changes in postgraduate medical education, the PRHO year became the first year of Foundation Training and trainees now have the job title of Foundation House Officer 1.

QSAC	Quality and Safety Assurance Committee – see paragraph 7.13 of the report.
SDR	Staff Development Review – see paragraph 5.69 of the report.
SHA	Yorkshire and the Humber Strategic Health Authority (SHA) was set up by the Government in July 2006 to act as the regional body for the NHS. The SHA was formed from the merger of the three former SHAs: West Yorkshire; South Yorkshire; and North and East Yorkshire and Northern Lincolnshire.
SHO	Senior House officer - After completing their PRHO year, junior doctors usually became Senior House Officers to further their career. Between 2005 and 2007 SHO posts became Foundation Year 2 or core specialty training posts and the term SHO ceased to formally exist as a job description.
SNCG	Senior Nurse Clinical Governance – see paragraph 3.4 of the report.
Trust	Airedale NHS Trust – see paragraph 1.37 of the report.
UKCC	United Kingdom Central Council (UKCC) – see paragraph 5.54 of the report.
WYSHA	The West Yorkshire Strategic Health Authority (WYSHA) joined with North and East Yorkshire and Northern Lincolnshire and South Yorkshire Strategic Health Authorities to form the Yorkshire and the Humber Strategic Health Authority in July 2006.

APPENDICES

- 1. Terms of Reference**
- 2. Chronology**
- 3. Current Trust Board Structure**
- 4. Current Corporate/Clinical Management Structures**
- 5. Current Corporate Risk Management Structure and Assurance Process.**
- 6. Current Nursing and Midwifery Management Structure and Assurance process**
- 7. The panel**