

Monday, 18 May 2026

1
 2 (1.19 pm)
 3 **MS LANGDALE:** May I call the next witness, please, Mr Majid.
 4 **IFTIKHAR MAJID (affirmed)**
 5 **Questioned by MS LANGDALE**
 6 **THE CHAIR:** Yes, Ms Langdale.
 7 **MS LANGDALE:** Mr Majid, you have prepared two statements for
 8 the Inquiry, the first dated 7 January 2026 and the
 9 second 23 February 2026; is that right?
 10 **A.** That's correct.
 11 **Q.** Can you confirm the contents are true and accurate as
 12 far as you're concerned, subject to something you want
 13 to clarify in a moment?
 14 **A.** Yes.
 15 **Q.** If we can have on the screen so you can clarify,
 16 WITN0263001, page 157. I understand you wish to clarify
 17 paragraph 605 and 606 in terms of the correct sequence.
 18 **A.** That's correct. I think there's a repetition that's in
 19 here, and I wanted to be clear about the sequence, which
 20 was the -- first of all, the Summary Serious Incident
 21 Report was sent, then there was the meeting with the
 22 families, then there was the KC advice, and then there
 23 was the full report sent. Just to clarify.
 24 **Q.** So the summary of the SI was provided to the bereaved
 25 families on 5 July 2024; is that right?

1

1 Accountable Officer, under the Act, which means that I
 2 need to ensure value for money, that I'm responsible
 3 for, ultimately responsible for, resource allocation
 4 across the organisation.
 5 Of course, I do all of these things through creating
 6 a team and look to create an engaging, open culture
 7 through the organisation.
 8 **Q.** Who holds you to account in respect of that role?
 9 **A.** Yeah, that would be the board of directors, the chair of
 10 the organisation would hold me to account.
 11 **Q.** Can we have, please, NHFT0015005, page 345. That's the
 12 board structure accountability which came into effect,
 13 I understand, Mr Majid, in July 2025. So it's page 345.
 14 Before we go to the board structure accountability,
 15 can we just agree the Trust governance overall? You set
 16 this out in your statement at paragraph 77, we don't
 17 need to go to it, but essentially the board and
 18 committee assurance, the board of directors are
 19 supported by clearly defined committees for that, aren't
 20 they?
 21 **A.** That would be correct, yes.
 22 **Q.** So if we do look at this, the board of directors, there
 23 are five committees that report to the boards --
 24 **A.** Yes.
 25 **Q.** -- who are presumed to provide assurance to the boards,

3

1 **A.** Correct. Correct.
 2 **Q.** The meeting in London took place 6 August 2024?
 3 **A.** That's correct, yes.
 4 **Q.** King's Counsel advice then obtained?
 5 **A.** Yes.
 6 **Q.** And a minimally redacted full report provided on
 7 21 August 2024?
 8 **A.** That's correct. Thank you.
 9 **Q.** That can come down then, please. Can you tell us
 10 something of your background and qualifications and your
 11 role as Chief Executive?
 12 **A.** Yes, thank you. I'm a mental health nurse by
 13 background. I practised for the first -- probably the
 14 first half of my career. I then moved into various
 15 management and leadership roles, covering community,
 16 mental health services, and inpatient mental health
 17 services. I became a Director of Operations in about
 18 2010, maybe slightly before that, and then I have been
 19 a Chief Executive now for some 10 years.
 20 The role of a Chief Executive is to be accountable
 21 and responsible for the delivery of structures and
 22 processes to make sure that we're able to meet the
 23 requirements of the Trust strategy, the strategic
 24 objectives, the regulatory and contractual requirements.
 25 I'm also the accounting, sometimes maybe called the

2

1 depending what they're asked about and depending what
 2 information they're providing?
 3 **A.** Yes.
 4 **Q.** And for that relationship to work effectively, there
 5 needs to be complete candour and transparency, doesn't
 6 there?
 7 **A.** That's right.
 8 **Q.** Do you know, before your time, whether it was the same
 9 in 2022, before you joined the Trust in December 2022,
 10 whether there were the same number of committees
 11 reporting to the board of directors?
 12 **A.** I don't know for certain. I seem to recall that at some
 13 point there were less committees. I think the Quality
 14 Committee and the People Committee might have not been
 15 separate committees, but I want to be careful what I'm
 16 saying because I can't recall for certain.
 17 **Q.** Perhaps you can always follow it up afterwards, but
 18 certainly by July 2005, so 2024, I think, you had
 19 started to consider restructuring, hadn't you?
 20 **A.** That's right.
 21 **Q.** So that's where we are then. The Inquiry is interested
 22 to know as well, obviously, where it was in 2022 and
 23 2023, but looking at that doesn't immediately remind you
 24 what you added or reduced in respect of committees?
 25 **A.** In 2023, the structure on the left-hand side, the purple

4

1 structure as we're looking at it, would have been the
2 same.

3 **Q.** In terms of operational governance, before we go back to
4 this, services are organised into three groups, aren't
5 they: mental health, community health and specialised
6 services, and forensic services?

7 **A.** Yes.

8 **Q.** So that's your three groups and each is led by a Care
9 Group Director, Nurse Director, and Associate Medical
10 Director?

11 **A.** Yes.

12 **Q.** Was that the case from 2022?

13 **A.** No.

14 **Q.** When was that introduced?

15 **A.** That was introduced at the end of November 2023.

16 **Q.** Before that, when you first joined, how was it divided
17 into groups?

18 **A.** It had three divisions, each division had an executive
19 director who reported straight into the Chief Executive.
20 There wasn't the same -- I call it a triumvirate
21 leadership structure, so there wasn't --

22 **Q.** You call it what, sorry?

23 **A.** A triumvirate. So a three-person leadership structure.

24 **Q.** Stick to the plain language, that will help.

25 **A.** Yes, so that three-person structure wasn't in place.

5

1 **Q.** Is there overlap? We see for example, "Quality
2 Governance & Effectiveness", "Health & Safety
3 Committee". Is there some overlap between them?

4 **A.** Well, there needs to be some overlap between them
5 because we want to look for common themes and we need to
6 make sure we are able to share cross-learning, but also
7 we want to make sure we have the right specialisms, the
8 right specialist corporate staff leading this structure.

9 So for example, when I joined, there was a single
10 Quality Oversight Group, and one of the issues with that
11 is that you don't necessarily have the expertise, then,
12 to lead two very different things, which is patient
13 experience and quality oversight alongside patient
14 safety and learning from deaths. So these are
15 specialist things that need to have specialist staff
16 that are supporting them.

17 **THE CHAIR:** I'm going to ask you to slow down a bit because
18 a note has to be taken.

19 **THE WITNESS:** Oh sorry, okay.

20 **MS LANGDALE:** Again, in terms of what you inherited and what
21 this represents on the page, was it the case, then, that
22 you were enhancing and adding to the number of groups
23 with a view to the expertise on them, rather than
24 reducing them?

25 **A.** I think I did add to them at this point. And partly we

7

1 There was a lot of emphasis put on the executive
2 director who was leaving that.

3 **Q.** And what was the reason for changing the three divisions
4 to the organisation of these three groups?

5 **A.** When I joined the organisation, I was concerned about
6 the relationship between the divisions, I was concerned
7 they were siloed in nature. I didn't feel there was
8 opportunity for sharing, best practice for sharing,
9 learning, and therefore for improving. And I also was
10 concerned that the divisions all had slightly different
11 structures, they had slightly different governance
12 processes.

13 Colleagues in the organisation were telling me they
14 didn't quite know where decisions got made. I was also
15 concerned that there was no coming together of
16 a leadership team of the operational delivery of the
17 organisation. It went all the way up to the Board in
18 the silos and I felt that was a real missed opportunity
19 for thinking differently.

20 **Q.** If we look at what's on the screen then, please, so this
21 is the performance management framework, isn't it, how
22 the board is supposed to seek assurance and we see
23 a number of groups feeding in to the Executive
24 Leadership Team. That's a lot of groups, isn't it?

25 **A.** It is, yes, it is a lot of groups, yes.

6

1 had to add to them because the column on the right-hand
2 side, the -- underneath the Integrated Improvement
3 Portfolio Board, this is a part of the governance
4 section that we were mandated to introduce when we went
5 into the National Oversight Framework Level 4. So that
6 whole right-hand side had to be brought in as part of
7 the mandated requirements.

8 **Q.** We'll come to those later, thank you. The first
9 performance management framework you say was established
10 in 2018/2019, and you tell us in paragraph 75 of your
11 statement:

12 "... the feedback I have received was it provided
13 limited escalation mechanisms."

14 What did you mean by that? And if it helps to
15 cross-refer to this, please do.

16 **A.** My concern was that information, whether that was
17 information about operational performance or quality
18 performance or even risks and the outcomes of serious
19 incidents wasn't flowing up the organisation in a way
20 that enabled senior leaders, executives or even the
21 Board to understand what was happening on the frontline.

22 And I would say that Theemis, for example, in the
23 report in Theemis sort of reinforced that actually when
24 that happened and when they looked back on this period
25 of time. So that's what my concerns were.

8

1 I'd also picked up from colleagues that the previous
2 Accountability Framework had become more of a positive
3 sharing what was working well, as opposed to a true
4 holding to account based on clear KPIs.

5 **Q.** So over-optimistic and a bit of an echo chamber?

6 **A.** I think, yes. Yes, I would say so.

7 **Q.** Can we have NHFT0002015, page 1, please. This is the
8 CQC report before your time.

9 **A.** Yes.

10 **Q.** You mentioned earlier what the board would know.
11 Clearly the board knows CQC reporting, doesn't it?

12 **A.** Yes.

13 **Q.** This is corporate knowledge --

14 **A.** Yes.

15 **Q.** -- by the time something is reported in this way.

16 So in 2019 the Trust was rated as "requires
17 improvement", and if we go to page 6, four paragraphs up
18 from the bottom:

19 "Staff did not always use audits and complaints
20 effectively to make improvements to the care and
21 treatment delivered to patients or demonstrate that
22 staff consistently shared and discussed essential
23 information, such as learning from incidents."

24 So learning from incidents was a flag, wasn't it,
25 back in 2019? If we go to page 20 of the report,

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1 The training comes in -- the core training of
2 psychiatric nurses and psychiatrists as part of the
3 rotations. Training comes when -- within the
4 organisation when we are delivering mandatory training.
5 So we would deliver training around restrictive
6 practice, we would deliver training about when we might
7 need to restrict somebody.

8 There is, of course, training around the Mental
9 Health Act, Mental Capacity Act. And I would say that
10 over the last seven or eight years, probably, the drive
11 to deliver more restrictive practice -- sorry, to be
12 less restrictive in our practice -- has grown. And my
13 observation would be that a lot of -- there's a lot of
14 focus in regulatory activity on checking about whether
15 or not there are -- there is restrictive practice in
16 place.

17 **Q.** We see here the way it's commented upon:

18 "They minimised the use of restrictive practices and
19 followed good practice ..."

20 It's a positive, isn't it?

21 **A.** Yes.

22 **Q.** However, they seem to be using restrictive practice and
23 the Inquiry is aware, of course, in VC's case, two short
24 admissions, relatively short, in May and July at a time
25 when the inspection is undertaken. If you don't know,

11

1 "Ratings", we see at the top:

2 "Acute wards for adults of working age and
3 psychiatric intensive care units."

4 Rated "inadequate".

5 Five down:

6 "Community-based mental health services for adults
7 of working age" was rated as "good" and the overall was
8 "requires improvement".

9 So that's 2019.

10 If we can go to 2020, please, NHFT0001778, the date
11 of the inspection, 19 to 29 July 2020. So in fact at a
12 time when VC was an inpatient on the ward, and we see at
13 page 2:

14 "The ward environments were safe and clean."

15 Top paragraph.

16 "The wards had enough staff to meet the needs of the
17 patient group. Staff assessed and managed risk well.
18 They minimised the use of restrictive practices and
19 followed good practice with respect to safeguarding."

20 Least restrictive practice. The Inquiry has heard
21 a deal of evidence about this and what that means. What
22 is your understanding around the training that
23 psychiatrists and clinical staff have in respect of how
24 use of restrictive practice is to be interpreted?

25 **A.** I think that training will come in a number of ways.

10

1 please say so, but is it your understanding that within
2 the Trust more widely, least restrictive practice is
3 understood to be a positive consideration? You nod, but
4 yes?

5 **A.** Well, I was thinking further than beyond the Trust.

6 I think in mental health practice generally it would be
7 my view that least restrictive practice is what is
8 expected to be aimed towards.

9 **Q.** Do you think that the risk a patient presents to others
10 is adequately considered within that interpretation of
11 least restrictive practice at a broad level, at a level
12 of principle?

13 **A.** It's a personal opinion, but my opinion would be that,
14 over recent years, that has -- the focus on that has
15 reduced and the -- sorry, the focus on safety to others,
16 safety to the public, has reduced. There has been an
17 increased focus, I think, on risk to self, and --
18 risk --

19 **Q.** And patient autonomy?

20 **A.** -- to the individual, yes. And the drive for least
21 restrictive practice.

22 **Q.** That can come down, please, and can we have CQCM0016478,
23 page 1, and this is the 2022 inspection published in
24 November 2022 just before you arrive. It's not -- this
25 isn't where VC was staying. But if we go to page 4,

12

1 please, three paragraphs from the bottom, we see:
 2 "Not all governance processes operated effectively
 3 at team level. Some of the mental health and community
 4 health core services were still waiting for the roll out
 5 of the governance dashboards. It was planned within the
 6 next 10 months they would all be in place. Governance
 7 processes including clinical and pharmacist audits and
 8 recording of meeting decisions were not embedded into
 9 practice and therefore the service might not be aware of
 10 findings that would improve practice."

11 Were you aware of that as an issue, therefore, when
 12 you began in December?

13 **A.** I was aware from the conversations I'd had prior to
 14 starting that there were issues around governance and
 15 how well the governance was working within the
 16 organisation, yes.

17 **Q.** Recording of meeting decisions, because we see,
 18 examining VC's case, as late as 2022, meeting decisions
 19 still not being recorded, not being noted, no action
 20 plans. So this was a consistent and chronic issue,
 21 wasn't it?

22 **A.** Yes, it goes back beyond this report.

23 **Q.** Again, corporate knowledge in the sense that this is
 24 being expressed via CQC reports, these observations?

25 **A.** The organisation would have been well aware -- was well

13

1 **A.** No, no.

2 **Q.** Were you aware your predecessor appears to have done so?

3 **A.** No, I didn't know that. I was -- I, during my time,
 4 I am aware that members-off my leadership team had
 5 meetings with the coroner.

6 **Q.** Right, and would they feed those back to you if there
 7 were issues of concern?

8 **A.** They would feed them to me or they would feed them
 9 through the Executive Leadership Team, yes.

10 **Q.** And what level of your Leadership Team would have
 11 meetings with the coroner?

12 **A.** It would either be the Chief Nurse or the Medical
 13 Director, so, you know, reporting to me, senior.

14 **Q.** Can we have, please, NHFT0009667. May 2022, is this
 15 Quality Operational Group document. So again before
 16 your time, Mr Majid, but if we go, please, to page 3.
 17 It looks as though the Quality Operational Group have
 18 considered within this period a number of themes or
 19 failings. We see there listed 1 to 9, including:

20 "Risk Assessment (quality, process and documentation
 21 of).

22 "Poor quality Care Plans.

23 "Poor or missing documentation.

24 "Lack of communication/understanding of processes
 25 with other agencies.

15

1 aware of this, yes.

2 **Q.** Can we have on the screen now, please, WITN0356017.
 3 These are briefing notes in preparation for a meeting
 4 with the Senior Coroner referred to earlier in the
 5 evidence today with Dr Brewin. It pre-dates your time,
 6 16 December 2021.

7 If we go into "Risk Assessment" at the bottom:

8 "Noted that the documentation relating to risk
 9 assessment, detail of risk factors, decision-making
 10 rationale and agreed outcomes was lacking within the RiO
 11 records potential[ly] impacting on a patient's pathway
 12 between services and explanation of outcome to others."

13 Were you aware of this document at the time you
 14 began meetings with the Senior Coroner?

15 **A.** Not this document, no.

16 **Q.** Did you have meetings, when you took over with the
 17 Senior Coroner?

18 **A.** No.

19 **Q.** So you were never invited to something to discuss
 20 inquests or failing to record matters that were of
 21 concern, or ...?

22 **A.** Certainly meeting with the coroner wasn't part of my
 23 induction when I joined the organisation.

24 **Q.** When you were in post, did you have meetings about
 25 individual cases or generally?

14

1 "[...]

2 "Lack of medical liaison at times when decisions are
 3 being made/information shared which goes against the
 4 initial plan implemented by the doctor involved. [And]

5 "Lack [of] ... adherence to local procedures."

6 A number of failures, I mean the references to
 7 learning are identified but they're failings, aren't
 8 they? Failings in the provision of care?

9 **A.** Yes, they are.

10 **Q.** Can we have, please, WITN0380054, page 1. This is the
 11 page, thank you.

12 I don't know if you heard Dr Brewin's evidence
 13 earlier, Mr Majid, but he spoke about a meeting with
 14 Ward Managers back in October 2021, a "very sobering",
 15 it's described:

16 "... and at times harrowing conversation about their
 17 concerns. They were professional committed and
 18 passionate about doing the right thing."

19 And essentially it was about staffing and not having
 20 enough to fulfil and to do what they needed to do.

21 Did you have a handover where this document was
 22 included or reports of this meeting were shared with
 23 you?

24 **A.** Certainly this document wasn't shared with me. I was
 25 aware that as I joined the organisation that staffing

16

1 was an issue, and I was aware of that because staffing
2 was an issue across the mental health sector, so I was
3 familiar with that from my previous organisation.

4 **Q.** So if you hadn't seen the document you knew the point
5 that the staff were worried about not having enough
6 staff.

7 **A.** *(The witness nodded).*

8 **Q.** And in stark terms here we've reached a point where
9 they're not safe. It's dire, isn't it, at late 2021
10 when this is being stated here?

11 **A.** This is a concerning email to read.

12 **Q.** "We will prepare," we see in the actions, "a verbal
13 update to private Board for Tuesday."

14 "A verbal update". This is as serious as it gets,
15 isn't it, in terms of communication from frontline staff
16 who are passionate, committed? No criticism of their
17 perspective whatsoever. And they're saying, "We've
18 reached a point where services aren't safe and need
19 an immediate response."

20 Do you think, in those circumstances, it's adequate
21 governance to speak of a verbal update to a private
22 board as opposed to a minuting action, proper paper
23 reflecting what's involved; would you agree?

24 **A.** If I can comment generally rather than specifically,
25 because I wasn't here, but a very practical point is

17

1 since 2019. Who's responsible for then ensuring the
2 improvement?

3 **A.** From the point that I take up post, that would be my
4 responsibility.

5 **Q.** You tell us in your statement you remained focused, well
6 into 2023, on restructuring the executive and board
7 functions and mechanisms for oversight; is that right?

8 **A.** That's right. With a purpose.

9 **Q.** What was the purpose?

10 **A.** My belief is that if you want to bring about a sustained
11 change, if you want to move an organisation to be
12 more of a learning organisation, you have to have
13 certain structures and processes in place that work well
14 and work well together. And we've talked about one of
15 those already, which the new care group structure. But
16 you also need to have a sort of way of escalating
17 quality and performance issues, a way of escalating risk
18 issues. You also have to have things like strong
19 clinical leadership. You also have to have capacity and
20 capability in specialist parts of the organisation to
21 help with things like patient safety, and you will note
22 from my evidence that I shared some of my concerns about
23 this with the Board early on in my tenure -- I think on
24 two occasions -- spelling out that in order to move the
25 board forward -- move the organisation forward,

19

1 that board papers are submitted a week in advance,
2 formal board papers are submitted in advance and
3 therefore sometimes if an incident or something arises
4 within that time period, you might report that verbally.
5 The meeting itself would be minuted and there would be
6 action notes that would come out of that meeting. And
7 so I'm giving you that information generally. I don't
8 know specifically if that happened here.

9 **Q.** And certainly giving the primary information or
10 summaries shares the knowledge and shares the
11 responsibility with the board, doesn't it, even if
12 someone can't sit and write a report, just to have the
13 information shared?

14 **A.** Yes.

15 **Q.** Do you err on that side, sharing primary information, if
16 you haven't got time to put it all together?

17 **A.** In the Board at the moment there's a -- in the private
18 board at the moment, there is a chief exec session where
19 I'm able to share, or I'm able to invite executive board
20 members to share urgent information that's -- that we've
21 not had time to create a formal paper for, yes, and
22 I think that's quite important for contemporaneous
23 escalation.

24 **Q.** So when you start your post, Mr Majid, you were clearly
25 aware the Trust has been rated as "requires improvement"

18

1 I thought we needed to make some of these fundamental
2 changes.

3 **Q.** Did you think there was a disconnect between ward and
4 board?

5 **A.** I felt that there was a lack of escalation, yes.

6 **Q.** Is that the same thing? They don't know what's going
7 on? They don't want to find out the detail of what's
8 going on?

9 **A.** As I was saying it, I was reflecting that it probably is
10 the same thing from a different angle, yes.

11 **Q.** Sorry, say that again.

12 **A.** I think it was -- I think it is the same thing.

13 **Q.** And what is required if they are going to know what is
14 going on on the ward? It needs sensible system of
15 feedback, doesn't it, like that note we've seen in 2021
16 where the ward staff are speaking to Dr Brewin, it needs
17 sensible feedback from people on the wards first?

18 **A.** It does. But it needs a clear and defined structure and
19 process to be able to back that up. Because otherwise,
20 you're relying on *ad hoc* feedback.

21 **Q.** Yes.

22 **A.** And my view is that you need a structure in place, not
23 dissimilar maybe to the one where we have now, where you
24 have a clear operational structure that maps across on
25 to a clear accountability structure and a clear risk

20

1 escalation structure. And that means that there is
 2 a process behind what information gets escalated, how
 3 you try and feed that information back. So that means
 4 that you're not relying on individuals.

5 **Q.** The feedback clearly, before it gets to the board, needs
 6 to be assessed and analysed in another way, doesn't it?
 7 **A.** Yeah.

8 **Q.** And it needs multidisciplinary assessment, very often as
 9 you have in some of the committees, so you have the
 10 feedback and a multidisciplinary assessment, would you
 11 agree, to understand what that means?
 12 **A.** And this is why, when I joined the organisation, one of
 13 the points of feedback I was giving was that it felt to
 14 me like the clinical voice was quite quiet in the
 15 organisation. It was very operationally driven, and
 16 what we know, and I would refer you to Helen Collins's
 17 report where she talks about the importance of quality
 18 improvement coming through an organisation, having clear
 19 systems in the organisation for quality improvement, led
 20 by clinicians. Because that's how you get sustained
 21 change.
 22 When I joined, that was exactly what my feeling was:
 23 that that wasn't the case.

24 **Q.** Did you consider there were sufficient numbers of
 25 clinicians on the various committees and board in fact

21

1 talking about.

2 **Q.** Would they consider whether there were policies or
 3 protocols? Because we're going to come onto the failure
 4 to have risk assessment policies and protocols, and the
 5 importance of understanding those and embedding them?
 6 **A.** That would be part of the process, yes.

7 **Q.** Can we have, please, NHFT0000905. This is your first
 8 board meeting. If we go to page 6, actually, second
 9 box, fourth paragraph.
 10 "IM envisaged a sea change in the next year through
 11 areas around performance expectations, efficiency,
 12 investment value; with a return to pre-Covid levels of
 13 performance management and new responsibilities within
 14 the ... (ICB)."
 15 Sea change; why did you consider a sea change was
 16 required or likely?
 17 **A.** I think that this -- it partly relates to the
 18 conversation that we were having about the need for
 19 different levels of information coming through the
 20 organisation. It partly also relates to the need for
 21 different levels of reporting to the ICB, and when I had
 22 a quick look at this paragraph I think that's what I was
 23 referring to here: that I was expecting the ICB to want
 24 more information from us around performance management,
 25 and that they would be taking on more of that role. The

23

1 as well?

2 **A.** Well, you have a statutory clinical membership on the
 3 board, so there are two executive posts which are
 4 statutory from a clinical perspective, which is the
 5 Director of Nursing and the Medical Director. That's
 6 -- (*overspeaking*) --
 7 **Q.** That's a minimum though, you could have more?
 8 **A.** It's a minimum, it's a minimum, yes.
 9 **Q.** So in your view is there enough clinical representation
 10 on the various committees that are assessing feedback
 11 and scrutinising?
 12 **A.** I think there is. I think there is. But what I would
 13 say is where I wanted to see more of that was, well,
 14 what you were describing almost a multidisciplinary
 15 approach the different layers within the organisation.
 16 So within the operational framework of the organisation.
 17 So if we were talking about risk, if we were talking
 18 about change or transformation, that was something that
 19 was led or clinically informed for our -- I'll share an
 20 example with you now. We have something called the
 21 clinical senate, which is a group of senior clinicians
 22 from lots of different professions that advise the
 23 executive on any changes and are responsible for things
 24 like quality impact assessments on changes, so that
 25 we've got that multidisciplinary approach that you were

22

1 holding to account role of the organisation.

2 **Q.** When you say, "Return to pre-Covid levels of performance
 3 management", what was your understanding of the levels
 4 of performance management during Covid, particularly in
 5 relation to mental health services?
 6 **A.** Again, if I can talk generally because -- not healthcare
 7 because I wasn't here at that time, but my observation
 8 was that the focus on mental health performance metrics
 9 understandably reduced nationally, and that was
 10 happening at the same time, particularly latterly, there
 11 felt to me like a lag during Covid of the impact on
 12 mental health services and we saw the big impact on
 13 things like out-of-area bed placements coming towards
 14 the end of Covid. So I was talking about -- so if we're
 15 talking about out-of-area beds, there was a big focus
 16 before Covid on reducing the use of out-of-area beds,
 17 and I think I was trying to indicate that that sort of
 18 focus would return in my view.

19 **Q.** Can we have, please, NHFT0000905, page 19, and this is
 20 your report for the board meeting on 26 January 2023,
 21 and at page 19, please, you say:
 22 "I think there are three areas we need to focus on
 23 over the next 6 - 12 months ..."
 24 It's halfway down the box.
 25 **A.** Yeah.

24

1 Q. "... which are, of course, in line with our strategy."
 2 If we go to the second point:
 3 "We must focus on getting the basics right, and
 4 I mean that in both our clinical standards but also the
 5 culture we create."
 6 So the basics right, would you agree with me that
 7 the basics are about looking after patients and doing no
 8 harm to them?
 9 A. Yes, and the various standards that you would expect to
 10 come from that, most certainly.
 11 Q. But sometimes the guidance and the standards and the
 12 documents are sufficiently lengthy, perhaps, to obscure
 13 that key message, isn't it, that it's do no harm and
 14 look after the patients?
 15 A. That's where the premise that you've just described is
 16 what we sign up to when we come to work in the NHS,
 17 yeah.
 18 Q. What did you think, in terms of clinical standards in
 19 mental health services the Trust was getting wrong? So
 20 focus, getting the basics right in clinical standards.
 21 So you'd read obviously the reports, you'd been there
 22 a couple of months by now, what did you think they were
 23 getting wrong in mental health?
 24 A. The thing that I was talking about from my memory here
 25 was actually related to the feedback that we'd had from
 25

1 challenges and a lot of failures to address at this
 2 point, haven't you? Is that an over-optimistic tone and
 3 language?
 4 A. I'm not sure that I would say that it was
 5 over-optimistic. I think what I am trying to convey
 6 there is the importance of, as a Chief Executive,
 7 getting out and about into the organisation to hear how
 8 it is for colleagues delivering direct care is very
 9 important, and that sometimes that can give you
 10 a different perspective on the perspective that maybe is
 11 coming through general grounds of reporting, or general
 12 rounds of reporting.
 13 And I-- so I think that's the first part of it. And
 14 I think the second part of it is really it's really
 15 important, isn't it, to understand what our ambition is?
 16 Q. You understood by then that there were failings and key
 17 failings and basics that needed to be gotten right?
 18 A. *(The witness nodded)*.
 19 Q. Can we go, please, to your statement, paragraph 279, so
 20 if you have WITN0263001, page 67. You mentioned the
 21 Collins reports.
 22 A. Yes.
 23 Q. Or review.
 24 A. Yes.
 25 Q. This followed, didn't it, an increase in serious
 27

1 the CQC. But also, when I talk about getting the basics
 2 right, I was also referring to things like understanding
 3 what the drivers of low staffing levels were. That was
 4 a theme that came through the previous -- the 2022 CQC
 5 Report.
 6 So it wasn't just clinical standards, it was --
 7 Q. There was also staffing, and you were concerned
 8 colleagues should have a good environment to work in?
 9 A. Yeah, and so the basics would extend beyond that, and
 10 also, you know, I was hearing, it's maybe a little bit
 11 much detail, but I was hearing things about colleagues
 12 having to travel around the organisation for equipment,
 13 to pick up equipment and that was leaving people feeling
 14 frustrated. So it was the basics in a broader sense of
 15 the word, is the point I'm trying to make.
 16 Q. You say:
 17 "I look forward to continuing to listen, learn and
 18 lead the Organisation as my understanding of our key
 19 opportunities and challenges grow."
 20 Again, with understanding of how documents are put
 21 together and management tone, if you like, that is
 22 an interesting description of effectively a failing
 23 organisation that needs to get things right, that you
 24 say, "I'm looking forward to looking at our key
 25 opportunities and challenges." You've got a lot of
 26

1 incidents and Prevention of Future Deaths Reports which
 2 you address here in your statement. You set out at
 3 paragraph 280:
 4 "During 2023 the trust received a significant
 5 increase in [Prevention of Future Deaths] -- 8 in total.
 6 During the preceding five years [...] it had received
 7 a total of 5 ... During this period, with court
 8 proceedings mainly being held virtually, there was
 9 a reduction of cases being heard leading to delays. In
 10 2023, there was a focus on recovery with a resulting
 11 increase in the number of complex inquests being held."
 12 What are you saying about that? That the number in
 13 eight didn't reflect that year? I don't understand the
 14 caveat at the end about the number of complex inquests
 15 being held.
 16 A. I was -- some of the inquests, because of Covid, the
 17 inquests were running behind so I think what I'm talking
 18 about here is catching up with some of those previous
 19 inquests.
 20 Q. If we go to paragraph 281, please, and people can read
 21 that, if we can have it at the same time as 282, if
 22 possible, on the next page. You asked for comparative
 23 data issued to other Trusts at the time in order to
 24 benchmark.
 25 Can you tell us about what you tried to do there,
 28

1 even though you couldn't get the data?

2 **A.** The -- one of the issues when I -- that -- as I began to
3 understand the organisation, was my concern about the
4 way that serious incidents were managed, and the
5 number -- and I had a sense that there was more serious
6 incidents and more PFDs than I was expecting or I would
7 have expected. And therefore, what I was trying to do
8 was to understand: well, for an organisation our size,
9 with the demographics that we have, is there such
10 a thing as a benchmark? And I was told that there isn't
11 that level of information available.

12 **Q.** Where did you look for that? NHS England or anywhere
13 else?

14 **A.** My colleagues in the Patient Safety Team were the people
15 that I asked and they went out to see what they could
16 find, yes.

17 **Q.** 282, paragraph 282. You had "similar concerns about the
18 number of Serious Incidents" and we see here now the
19 number of serious incidents, don't we?

20 **A.** Yeah.

21 **Q.** 2019, 401; 2020, 292; 2021, 369; 2022, 442, and 2023,
22 449.

23 You also set out at the bottom of the page:
24 "... the Trust's data on incidents where serious
25 violence has occurred in the past 5 years ..."

29

1 "Record keeping and recording of non-face to face
2 interactions, admission/detention threshold,
3 decision-making and outcomes following a [Mental Health
4 Act] assessment ... and correct basic patient and next
5 of kin details."

6 She notes:
7 "There was a noticeable lack of Trust-wide safety
8 incident investigation, learning ... and family liaison
9 capacity and capability."

10 So echoing what was found by the CQC back in 2019,
11 an inability to learn and improve quality; do you agree?

12 **A.** Yes, that's right. That's what this report says, yeah.

13 **Q.** If we go to page 9, please:
14 "The learning to address the above findings is as
15 follows ..."

16 And we the second bullet point:
17 "The lack of Trust-wide quality improvement projects
18 and programmes should be governed by the ELT to give
19 them the priority they require. The absence of such has
20 ... led to repetitive safety problems and serious
21 incidents. Often, at Coronal Inquests, these
22 repetitive problems have been identified, which in turn
23 have created a detrimental impact on the reputation of
24 the organisation."

25 Were you surprised to read that or did you expect

31

1 And we see three in 2019, two in 2020, four in 2021,
2 three in 2022, and five in 2023, including VC. And more
3 recently, outside the dates of the Inquiry, three in
4 2024, post-April 2024, and two in 2025.

5 Can we have then, please, at the Collins review
6 which you commissioned in the light of those numbers.
7 NHFT0000423. And if we can go, please, to page 7.
8 And Helen Collins was an Independent Safety Specialist
9 and Registrant Senior Nurse; is that right?

10 **A.** That's true, yes.

11 **Q.** And the report was produced on 11 January 2024. And we
12 see at the bottom of page 7:
13 "... a lack of Trust-wide quality improvement
14 projects addressing a number of repetitive problems
15 within the organisation. These problems were reported
16 by many and are as follows".
17 We see:
18 "Triangle of care, care and crisis planning ...
19 regular review --
20 "Staffing recruitment and retention ...
21 "Seclusion/restrictive practices".
22 Over the page at page 8, second one down:
23 "Falsification of observation records."
24 Further down:
25 "Clinical risk assessment and regular review ..."

30

1 that conclusion in the light of what -- everything else
2 you knew about the organisation?

3 **A.** No, I wasn't surprised to read this, and this relates
4 to -- or this is the statement that I was -- the
5 paragraph that I was referring to when I was talking
6 about the need for enhanced clinician leadership, the
7 need for the three-person leadership approach that I was
8 talking about which would enhance clinical quality, and
9 safety overview. And the importance of thinking about
10 structures that would support quality improvement, and
11 those structures being led by our clinicians.

12 So this is repeating, I suppose, is affirming what
13 my concerns were.

14 **Q.** If we go to page 10, please, fourth paragraph down:
15 "Duty of Candour intelligence and training was not
16 rolled out to the appropriate personnel at all levels
17 within the organisation."
18 The Duty of Candour effectively requires clinicians,
19 doesn't it, to make people aware or alert them of
20 failings or potential failings --

21 **A.** Yeah.

22 **Q.** -- that may have arisen?
23 In your experience, is this breached more often than
24 not?

25 **A.** Not at the moment, it's not. One of the things that we

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1 changed when we were developing and enhancing our
 2 patient safety and learning from desks function was
 3 specifically investing in the expertise of Duty of
 4 Candour. You do have to have the expertise in the
 5 organisation, and around about the time of the Helen
 6 Collins report as I was joining the organisation, I
 7 believe that the compliance rate with Duty of Candour
 8 was something like 33%, which is what Helen is referring
 9 to here, and at the moment in the organisation, the
 10 compliance rate is 100%.

11 **Q.** On the basis of what you know. You don't know what you
 12 don't know?

13 **A.** On the basis of what -- well, on the basis of the
 14 incidents that are reported through the organisation.

15 **Q.** You may get an underreporting of incidents, mightn't
 16 you, but in 100% they've been reported, that's your
 17 understanding?

18 **A.** There is always a risk of underreporting of incidents.
 19 In this -- in the same report here, Helen Collins does
 20 talk about our incident profile, and she, if I remember
 21 correctly, she talks about the incident profile looking
 22 like she would expect it to look like for an
 23 organisation like ours, which suggested that there was
 24 a good incident reporting culture.

25 **Q.** Is it more common that clinicians are able to admit

33

1 **A.** -- candour. To tell you what's happened, yes.

2 **Q.** So how have you made efforts to drive that culture?

3 **A.** My view about what you have to do to bring about
 4 a culture of learning, unfortunately, you can't flick
 5 a switch, and you have to bring about some of the
 6 structural changes that I was talking about earlier.

7 You have to empower your clinicians, you have to
 8 have structures and processes that not just identify
 9 good policies, but actually then go from identifying and
 10 developing and changing a policy to using that policy,
 11 for example, as a benchmark for training and then using
 12 that as a way of defining how do you create audit, how
 13 do you create checks for that policy that's being
 14 delivered?

15 So learning comes from these structures and these
 16 processes as well as clear dissemination -- and I've talked
 17 about putting those structures and processes in. It
 18 also comes from opportunities for dissemination of
 19 learning, and that's where I believe things like the
 20 clinical senate, for example, some of the methods that
 21 were used in the organisation for sharing, learning from
 22 incidents work well in terms of briefings and thematic
 23 reviews and things like that.

24 **Q.** If we can have page 19 of the document, please, the
 25 "Driver for the independent evaluation", so the driver

35

1 failings rather than admitting failings and saying how
 2 that might have made a difference to outcome? Because
 3 they're different, aren't they? One is to say "this is
 4 happened", alerting someone to a failing, and another is
 5 to say, "And if I had done this, this would be
 6 different"? Or even may be different in certain
 7 circumstances?

8 **A.** Yes, and I think that this is the importance of
 9 reflective practice and opportunities for reflective
 10 practice to try to move to the second approach that you
 11 described, which I think is a build, or it's part of the
 12 same spectrum, isn't it, but that's what we should be
 13 aiming for through those processes of reflection and
 14 supervision, yes.

15 **Q.** Without fear for reputation or standing that candour
 16 trumping all?

17 **A.** Yes. Yes. But also there's something about the
 18 structures and processes in the organisation that
 19 support that Duty of Candour approach, and, for example,
 20 if I draw you to the CQC, the recent CQC Well Led,
 21 there's a phrase in there where they mention that
 22 leaders talked about moving from a culture of fear to a
 23 culture of learning. And of course if you have
 24 a culture of learning, you're more likely to get --

25 **Q.** People to tell you --

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1 for the report.

2 "The Trust's ELT recognised in early 2023 ... there
 3 was a growing volume of serious incidents."

4 When in 2023? Was that before June in 2023 that you
 5 recognised the growing volume of incidents?

6 **A.** My concern, this was -- was part of my concern when
 7 I joined the organisation: that there wasn't a formal
 8 reporting into my -- into the Executive Team of
 9 incidents and it felt too informal to my mind.

10 And as I was getting to understand more about that,
 11 so we are talking about, before June, I would say we're
 12 talking about the first two or three months of 2023,
 13 I was concerned about what I was seeing in terms of the
 14 incidents.

15 **Q.** If we look at the methodology, if we go back to page 6
 16 of the report, please, we see the evaluation physically
 17 took place between September and November 2023:
 18 "... used multiple methodologies to reach its
 19 conclusions ... [including] observations of 17 meetings
 20 ... (... reports, policies, procedures, minutes of
 21 meetings) and a consultation with 109 persons ..."

22 Do you know if patient records were considered in a
 23 number of cases? Just going through on a deep dive to
 24 see patient records? You had the serious incidents and
 25 obviously that will have happened in relation to those,

36

1 but was this a time when you realised these numbers were
2 increasing to really get in and look at the records of
3 other patients, including those that may have been
4 discharged, including those that were inpatients, just
5 to see the level of risk that was being tolerated within
6 the patient care?

7 **A.** I can't say for certain, but I don't believe that
8 individual patient records were looked at.

9 **Q.** It doesn't look like it, does it. So in terms of
10 looking at anybody else who might be in the same
11 position and pose the same risks that the serious
12 incidents raised, this was never going to identify that
13 person. It was a systemic review; is that fair?

14 **A.** At this -- I -- I think that is fair. Yes. I think
15 this was aimed at systemic concerns, structures, and
16 processes that do support clinical care, absolutely.
17 I don't think it was a thematic review in the way that
18 the homicides and attempted homicide review that we
19 completed was a thematic review that looked at patient
20 records.

21 **Q.** Again, those thematic reviews, the homicide review, they
22 look at the patients you know about where that's
23 happened. Has there been a review of the patients you
24 still may not know about and what might happen? In
25 other words, looking at the records of discharge to see

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1 DNAs.

2 **Q.** Can we have, please, CQCM0016517, page 53. This is an
3 extract from the CQC Section 48 Review, referring to the
4 reporting and learning from patient safety incidents.

5 We see in the bottom paragraph:

6 "To assess how well [the Trust] monitored and learnt
7 from patient safety incidents, we reviewed data from the
8 NRLS from 1 February 2023 to 31 January 2024. During
9 this period, the trust reported 13,766 incidents ..."

10 If we go, please, to page 55, a number of findings.
11 Third paragraph down:

12 "Feedback from staff, along with evidence of poor
13 quality internal investigations and lack of engagement
14 with the inquest process, suggest that the Trust did not
15 have a learning culture."

16 Next paragraph:

17 "Staff also told us there was little time for
18 reflective practice and we found that they did not
19 always know what this meant."

20 "We also found that the Trust did not learn from
21 serious incidents well and make rapid changes to
22 services to improve safety and reduce the chance of them
23 reoccurring. During our review we saw evidence to
24 suggest there were previous cases where mental health
25 played a factor in harm to others. At the time of our

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1 who has been discharged in what circumstances, whether
2 they should have been? Actively considering those cases
3 that haven't been brought to your attention through
4 a serious incident?

5 **A.** There have been, there have been reviews of people who
6 are discharged and what circumstances they were
7 discharged. So there was a review of patients in the
8 Early Intervention Service when they were discharged.

9 I'm not aware that we've done, certainly not in my
10 time, we haven't done a review over the whole
11 organisation looking at -- looking for that sort of
12 learning.

13 **Q.** Well, with the EIP team in particular to be looking at
14 all of the records for all of the patients in a 12,
15 24-month period, around these events of serious
16 incidents, may well flag up concerns that should have
17 been recognised at the time but would be recognised at
18 such a review, would they not?

19 **A.** It would do, and just to, I suppose, to some degree,
20 some of the checks that we put in place to look back at
21 those who were discharged would pick some of those
22 things up. And of course, that's the sort of thing, or
23 those reviews were what drove, along with the learnings
24 through VC, were the things that drove our changes to
25 the processes, the whole processes around discharge and

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1 review, the trust told us they had been advised against
2 carrying out their own internal investigations as these
3 incidents were under criminal investigation."

4 Was that your understanding at the time: that you
5 couldn't have parallel investigations with criminal
6 proceedings?

7 **A.** It is, in all of my experience, it's been common
8 practice, when there -- not just to do with serious
9 violence, but any co-occurring need for an investigation
10 between health and the police, that criminal
11 investigations will take precedence, and we would be
12 asked to pause. And I had a look at, or asked for some
13 figures looking back to 2019, for example, and the
14 average delay in these sorts of processes over that
15 period was ten months. So it was significant, and it is
16 something that, as I say, was commonplace.

17 **Q.** What's your understanding was the barrier to doing your
18 own internal investigation about how a patient was
19 treated or the medication they had or the consultant
20 they were working with and what had happened? Why did
21 you think that couldn't happen at the same time as the
22 actual criminal act or the violence events were being
23 investigated? Presuming it wasn't on someone in the
24 hospital, that is.

25 **A.** Yes, the -- my understanding is there was concern about

40

1 sort of multiple interviewing of potential witnesses, or
 2 a danger of contaminating the criminal process that was
 3 underway, and I think this is an area where we've learnt
 4 significantly.

5 **Q.** Did you, at that time -- and don't tell me if you did
 6 who from or what it was -- but did you get legal advice
 7 about that issue at the time or did you just accept that
 8 either from the police --

9 **A.** No.

10 **Q.** -- or generally as your policy?

11 **A.** We would have accepted the advice or request from the
 12 police.

13 **Q.** But would you now know, in new circumstances, of the
 14 need to obtain your own advice if you had any lack of
 15 certainty about that where other patients may be kept
 16 safe from investigation to find out what has happened in
 17 a particular case, so that best practice or better
 18 practice could be implemented immediately?

19 **A.** Absolutely. Today the process is completely different.
 20 We haven't got any delays today, working with the
 21 police. We have a regular meeting with the police where
 22 we talk about these sorts of in common investigations
 23 and understand how we can proceed in ways that prevents
 24 the risks that historically have been concerned about.

25 **Q.** So do you have a key point of contact between the police

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1 fourth case listed there, the attacks on the 13 June.

2 **A.** Yes.

3 **Q.** You have here reports of homicides in other cases, and
 4 we see two paragraphs down from the box:

5 "There was a lack of family involvement in several
 6 of the reports with reasons cited as 'not wanting to
 7 cause further distress' and that they had already been
 8 involved in a review. None of the reports showed
 9 engagement with families from the point of incident,
 10 including input into the terms of reference and ensuring
 11 that they had adequate support and information.
 12 Overall, we felt ... the engagement of family members
 13 was poor with the panel's view that [the] investigators
 14 did not see the importance of involvement."

15 If we go over the page to page 4.
 16 "Poor engagement ..." at the bottom, please.
 17 "... lack of follow-up and risk assessment.
 18 "In five cases poor engagement and non-compliance
 19 was evident in a variety of ways. ... two cases
 20 patients were discharged due to non-engagement with
 21 community teams. In both cases there were concerns
 22 about violence to others."
 23 The last paragraph:
 24 "... panel felt that risk was often viewed through
 25 the lens of self-harm and risk to the staff rather than

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1 and the Trust to discuss any --

2 **A.** Yes.

3 **Q.** -- cases that affect both of you? You to be looking at
 4 safety measures for others --

5 **A.** (*The witness nodded*).

6 **Q.** -- and for the police to pursue criminal proceedings?

7 **A.** Yes.

8 **Q.** Who's that; would that be you?

9 **A.** Our Patient Safety Team --

10 **Q.** The Patient Safety Team?

11 **A.** -- will meet with police every couple of months, or as
 12 and when needed, and, as I say, I think the results are
 13 proving positive at the moment.

14 **Q.** Can we have, please, NHFT0000518, page 1. This is the
 15 Thematic review of homicides and attempted homicides
 16 conducted by Jonathan Warren for the Trust in
 17 August 2002. Did you commission this, Mr Majid?

18 **A.** I think it was commissioned by my Chief Nurse, but of
 19 course I was well aware that this was being
 20 commissioned.

21 **Q.** Why was this commissioned?

22 **A.** This was commissioned to check our thematic learning, an
 23 awareness, or growing awareness, of similar themes
 24 emerging and wanting to externally check that out.

25 **Q.** We see, if we go to page 3, and VC is actually the

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1 risk to the wider public. As well as this report we saw
 2 evidence in other reports of minimising risk of domestic
 3 violence, and of only carrying out two person visits due
 4 to risk to staff, but no consideration given to the risk
 5 to families or to the wider public".

6 Was that ever mentioned to you in the context of any
 7 meeting or case, that staff were doing visits in any
 8 case in a combination for their own safety?

9 **A.** It was the case with VC -- (*overspeaking*) --

10 **Q.** Yes, it was, but before then had you heard of that in
 11 any other case?

12 **A.** Not as I recall specifically, but it's not uncommon
 13 practice --

14 **Q.** Would you --

15 **A.** -- in my-- (*overspeaking*) --

16 **Q.** -- have seen that as a risk of other members of the
 17 public as well as those care professionals if you saw
 18 that it was deemed necessary for two people to visit
 19 a patient?

20 **A.** I would expect, as part of the explanation of that
 21 action, that risk of violence or whatever it was, would
 22 extend beyond just staff.

23 **Q.** We see at the top of page 5:
 24 "We saw early discharge from inpatient care on two
 25 occasions with discharge meetings tokenistic."

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1 If we go to page 6, please, "Quality improvement
 2 plans":
 3 "We reviewed the QIPs [quality improvement plans]
 4 for the reports."
 5 Further down the paragraph:
 6 "The panel is of the view that few of the changes
 7 cited will have any meaningful change in the staff
 8 involved in the incident, let alone the wider Trust. We
 9 could find no evidence of the Trust measuring or
 10 understanding the changes in practice there were
 11 recommended having happened outside of changes to forms,
 12 policies, procedures, and Standard Operating Procedures
 13 ..."
 14 That's a condemning criticism, isn't it, that few of
 15 the changes cited will have any meaningful change in
 16 practice?
 17 **A.** It is really, it's really problematic, and I think that
 18 this speaks to an issue about transactional change. So
 19 bringing about lots of individual change as opposed to
 20 thinking more broadly about quality improvement and
 21 transformation as, for example, Helen Collins was
 22 talking about. And one of the dangers that I have
 23 experienced, or the problems I have experienced, that
 24 actually the CQC in the Well Led report talked about is
 25 lots of regulatory activity drives lots of action plans,

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1 introduced in 2024 a new Clinical Risk and Safety
 2 Policy, introducing a policy like that on its own won't
 3 change practice. Introducing a policy, using that
 4 policy to change the way you train and develop staff,
 5 and then using that to think about this is how we're
 6 going to monitor compliance and how we're going to do it
 7 continuously, now that starts to change practice.
 8 And if you look at, for example, using that, you
 9 look at our SafeNow completion rates of risk
 10 assessments, they've significantly increased to around
 11 about 90%.
 12 So if you want to bring about learning, it's not
 13 just these one-off actions, it's bringing about this
 14 culture of improvement and unfortunately that takes
 15 a little bit time.
 16 **Q.** Is the SafeNow, if we go to your statement, WITN0263001,
 17 page 28, these are ICB metrics, are they, that are used
 18 within the mental health services now? Is that what
 19 you're referring to, these metrics?
 20 **A.** Sorry, could you just point to me which paragraph?
 21 **Q.** Paragraph 106:
 22 "During 2024 the Trust, with some support from
 23 the --
 24 **A.** Yes.
 25 **Q.** -- Integrated Care Board ... developed a further suite

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1 which drives lots of actions like this, that from
 2 a regulatory perspective you have to chase. Does it
 3 really bring about change?
 4 And to give you some context, since my time or since
 5 the middle of 2023, Notts Healthcare has had something
 6 like 90 -- above -- more than 90 visits from the CQC,
 7 more than 60 inspections, each of those drive separate
 8 action plans.
 9 So there is a real tension, in my mind, between
 10 regulatory activity and sustainable learning that drives
 11 improvement.
 12 **Q.** Is it because the action plans are too convoluted and
 13 don't stick to the point sometimes?
 14 **A.** I think it's because, it's because the action plans will
 15 tend to drive at this policy must have been in place, or
 16 this policy should be in place, without thinking about
 17 well, how -- it's not the policy that makes something
 18 happen in the frontline --
 19 **Q.** It's the person.
 20 **A.** -- it's the person, it's how we support the person, it's
 21 how we then check -- sorry about this phraseology, but
 22 how we then check that the person does what they should
 23 be doing, how do we support them with any queries?
 24 Those are the things that are -- what brings about
 25 the change, and I suppose back to my point about we

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1 of metrics that emerged from mental health services
 2 referred to as 'Safe Now'.
 3 **A.** Yes.
 4 **Q.** So you were saying you think this is more helpful than
 5 the action plans?
 6 **A.** This is much, much more helpful. This is really
 7 innovative, because it -- of the -- of how regularly the
 8 data is updated. So to answer your question, there are
 9 some of the metrics come from national requirements, but
 10 actually there's also quality metrics in here as well,
 11 and safety metrics. And there is a drumbeat within the
 12 organisation of weekly refresher of the data, evaluation
 13 by teams, escalation of risks to the care group and then
 14 to the executive, and then of course time for bringing
 15 about changes before the next sort of iteration or cycle
 16 and --
 17 **Q.** So who does this? How does it work? So they cover the
 18 number of patients waiting for a bed. Is someone
 19 filling this in each day on the ward or with patients?
 20 What's --
 21 **A.** It's taken from data systems within the organisation.
 22 People aren't filling things in. It would be picked up
 23 from RiO, the clinical record, for example.
 24 **Q.** So people are entering data where they fit in terms of
 25 treatment of a patient, and that's being analysed

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1 separately or is it entered on a specific dashboard?
 2 **A.** No, the data -- there is a -- SafeNow is a specific
 3 dashboard that tells -- that has got all the metrics
 4 listed and it tells you the current performance against
 5 each of those metrics. It starts off -- so the view
 6 that I might look at would be an organisational-wide,
 7 for example, to do with completion of risk assessments,
 8 but the care groups can drill it down to see: well, what
 9 does that mean for our care group? An individual team
 10 can drill it down. A team manager could look at
 11 individuals who haven't got a care plan, why haven't
 12 they got a care plan or a risk assessment?
 13 So --
 14 **Q.** Does it depend on the person recognising they don't have
 15 a care plan or an adequate care plan? Because there may
 16 be occasions where care plans are completed and somebody
 17 thinks that's what's required and it isn't what's
 18 required; it's not adequate.
 19 **A.** This is why you have to have lots of different routes of
 20 triangulation. So we also now, in the organisation,
 21 have things like sort of mandated review of clinical
 22 records, and supervision has to include a review of
 23 clinical records. So you can do exactly what you're
 24 just describing.
 25 **Q.** This type of information is the sort of information the

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1 reviewed?
 2 **A.** Widening it is to also look at other issues that give
 3 a much more rounded or triangulated view of what's
 4 happening in the organisation. So, for example, having
 5 a look at complaints or having a look at we call it
 6 a PiPoT investigation, so persons in positions of trust
 7 investigation. So things that can have -- that can add
 8 depth to our understanding. That's why we widened it.
 9 **Q.** How does it impact in terms of how people learn from the
 10 matters considered?
 11 **A.** I think there's something -- there is something about
 12 understanding wider context. There is something about
 13 being able to pull themes together. So what do I mean
 14 by that? So if you are looking at an area, a ward or
 15 a service where you have some serious incidents that
 16 have cropped up and you notice that there's also an
 17 increase in complaints, perhaps there's a safeguarding
 18 issue or a Freedom to Speak Up issues that are arising,
 19 that gives you a different triangulation of that
 20 ward/team/department than if you were just thinking:
 21 there's been an incident.
 22 **Q.** Can we have please WITN0263061, page 1, and it's the
 23 "Terms of Reference" for the Complex Incidents Oversight
 24 Group --
 25 **A.** Yes.

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1 Board should have been in receipt of in 2023 and
 2 earlier, shouldn't it, this kind of analysis and
 3 information?
 4 **A.** I think it's imperative for boards to have this sort
 5 of -- this level of information, yes.
 6 **Q.** Why was it, then, that it took until 2024 for the Trust
 7 to obtain it in this format and provide it?
 8 **A.** Because I think, I suppose, the things that I was
 9 talking about earlier to do with structures around
 10 putting the care groups in place, putting a -- it was
 11 first of all called the Quality and Performance
 12 Framework, so putting that sort of framework in place.
 13 And then of course, once you've got that in place, so
 14 you understand what the metrics are that are needed, you
 15 can then bring something like this in which is why it
 16 took us the length of time -- I can't talk to you about
 17 why it wasn't in place before me, but that's why it took
 18 me this time to bring it in, or my Leadership Team this
 19 time to bring it in.
 20 **Q.** Can we have, please, WITN0263059, page 1 on the screen.
 21 This is the Terms of Reference for the Significant
 22 Issues Review Group, and this was the Serious Incident
 23 Review Group widened, as I understand it, Mr Majid, by
 24 you to be the Significant Issues Review Group. You
 25 widened it. Has that impacted on the number of cases

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1 **Q.** -- formerly the Homicide and Attempted Homicide Group.
 2 You tell us in your statement the objective is
 3 "joined-up ... consistent response" from the Trust. How
 4 does this group, in your view, enable that?
 5 **A.** You need to have part of an organisation that oversees
 6 the -- well, the commissioning and the completion of
 7 serious incidents under the new PSIRF framework. You
 8 need to have a part of the organisation that is
 9 experienced enough, or a group that is experienced
 10 enough to receive draft reports and make sure they're up
 11 to the standard that's required.
 12 If we go back to some of our earlier conversations,
 13 and some of the findings about the quality and standard
 14 of the reports, the timeliness of the reports, it's
 15 important that we oversight that, and that's what this
 16 group has done. But I think it's also our concern was
 17 that if you just restrict it to homicides and attempted
 18 homicides, you're potentially missing other incidents
 19 that are complex that maybe haven't resulted in such
 20 a level of violence that you need to look at.
 21 **Q.** That can come down, please. And can we have
 22 INQY0000034, page 2. This is an Inquiry Legal Team
 23 document, Mr Majid, that summarises six other cases or
 24 patients where there was a Trust investigation and
 25 findings and learning, and also police involvement, in

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1 a number.

2 So if we look at "Patient 1", August 2022, and if we
3 go to page 3, please "Findings and learning":

4 "... two key findings: ... a lack of 'curious
5 enquiry' by staff, and ... an .. 'emphasis on "opt-in"
6 engagement with services' in the context of individuals
7 where the threshold for a Mental Health Act Assessment
8 had not yet been reached. This was in the overall
9 context of no substantive treatment having been provided
10 by the Trust."

11 So serious concerns there about risk and risk
12 assessment: consideration that Mental Health Act
13 Assessment hadn't been reached, but opting in is not the
14 answer in those circumstances, is it?

15 **A.** No. No.

16 **Q.** And if we go over the page, please, to page 4,
17 paragraph 11:

18 "Other changes following the incident included
19 improving clinical risk assessments, and amending the
20 clinical supervision template."

21 We understand the clinical risk training was
22 enhanced to provide face-to-face training; is that
23 right, after that.

24 **A.** That's correct, yes. Well, more than face-to-face
25 training; it's also we use case scenarios that are more

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1 how we would operate in the NHS, yes.

2 **Q.** "Patient 2", we see an "attempted homicide briefed to
3 [the] executives" in February 2023. And if we go to
4 page 5, we know it's reported to StEIS:

5 "... Comprehensive Investigation Report
6 [paragraph 15] ... completed in July 2024 ..."

7 And we see at page 6, "Findings and learning":

8 "... related to matters including:

9 "... staff understanding of mental capacity;

10 "... Early Intervention in Psychosis medication drop
11 off;

12 "... risk formulation and management;

13 "... information-sharing with the police; and.

14 "... community forensic referrals."

15 Each of these matters may well on their own have
16 required or encouraged an investigation into other EIP
17 cases at that time, mightn't they? To see how risk had
18 been formulated and was being managed. So in real time,
19 getting this, looking at that? Would you agree?

20 **A.** Yes, and we -- and there was a review of Early
21 Intervention Services at the end of 2023, that was
22 independently carried out.

23 **Q.** And the delay in investigating and understanding that
24 that's what had happened in this case, you say was
25 because of not considering that you could look at it

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1 relevant to individual services.

2 **Q.** And "clinical supervision template", is the expectation
3 that the supervisor is going to discuss risk to ensure
4 dynamic risk assessment?

5 **A.** And review case records, yeah.

6 **Q.** That should have happened anyway, shouldn't it? It
7 shouldn't need an incident like this to require that
8 learning. That should have been understood: that
9 supervisions need to consider risk; would you agree?

10 **A.** I would agree, I would agree. There are always two
11 things that you have to look at, aren't there. There's
12 individual practice, and what you would expect
13 a supervisor to know that they need to do, and I agree
14 with you, in terms of this. But there's also systemic
15 issues, so are there things in the way that we are
16 asking people to operate as an organisation that maybe
17 prevents them from doing that? So that's why sometimes
18 things like templates can act as that important
19 reminder.

20 **Q.** Well, they can make it a useful tool but actually the
21 fact that it's required should be known anyway to people
22 in senior roles, and people in junior roles likewise:
23 that they need to run things past more senior people.
24 That's a basic understanding, isn't it?

25 **A.** It is a core understanding, and a core understanding of

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1 while there were other matters progressing?

2 **A.** This was -- yes, this was one of the issues to do with
3 the -- with that police overshadowing.

4 **Q.** If we go, please, to "Patient 3", further incident,
5 April 2023. By now, you know there's been longstanding
6 issues in risk management since 2019; is that fair?

7 **A.** Yes.

8 **Q.** And we see "Findings and learning":

9 "... Concise Investigation found ...

10 "... there were issues with engagement and
11 concordance;

12 "... there may have been a missed opportunity to
13 offer ongoing support, though they did not present to
14 mental health services for some time".

15 Do you consider that in April 2023 there was a case
16 for reconsidering risks of violence for all patients,
17 including those discharged in the last few months?

18 **A.** I think that with hindsight, in April '23, there could
19 have been an opportunity, had we had the right
20 structures in the organisation, bearing in mind that by
21 this time the structures that I introduced hadn't kicked
22 in, that there would have been an opportunity for
23 a thematic review that would have picked up the things
24 that you're describing.

25 **Q.** Let's look at the page 8 at the top:

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1 "c. there should have been assertive attempts to
2 engage the patient whilst dropping off medication".
3 That wouldn't require a thematic review, would it?
4 Just looking at the facts, could be a clinician, could
5 be yourself, could be a medical director. Looking at
6 the facts might provoke thought about how medication was
7 being given and whether it was being taken and whether
8 there was a wider issue that could be examined there.

9 It doesn't need to be a thematic review; it needs to
10 be getting into patient records, doesn't it, and seeing
11 what's going on?

12 **A.** It certainly needs to be about understanding what was
13 happening when we're dropping off medication, and
14 whether or not we're using that as an opportunity to
15 engage the patient. Yes, I agree. And I also -- and
16 I think the point that you're getting at is that
17 I accept we could have brought about the changes more
18 quickly, in terms of things like medication drop-offs,
19 and we have brought in that change. We could have done
20 that more quickly.

21 **Q.** We see "Patient 4", "attempted homicide", considered
22 July 2023, and we see at page 9, paragraph 36, "a number
23 of findings and learning points", "quality of risk
24 assessments", and "recording of MDT discussions".

25 When did you become aware of the inadequate MDT
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1 NHFT0015073. "Clinical Risk and Safety".
2 You spoke earlier, Mr Majid, about policies and
3 protocols about them. If we go to page 2 and have 2 and
4 3 perhaps on the screen together, we see at the bottom,
5 3.2:

6 "August 2013; implementation of Trustwide Policy,
7 ... Treatment, risk assessment and management of
8 treatment risk ..."

9 Previous version of that policy ratified in
10 October 2012, "Review date: August 2014".

11 If we go to the top of page 3:

12 "With the support of the Trust's Clinical Policies
13 colleagues, a full search of the Trust's archives was
14 completed and found no evidence that this issue was
15 reviewed/updated beyond Issue 2. If this policy was
16 indeed not updated as suggested, this would mean that
17 this policy in effect between June 2019 [to] June 2023,
18 despite being very out of date."

19 So this was some work undertaken in response to
20 a Rule 9 Request but it looks like a Clinical Risk and
21 Safety Policy was last in place in 2012, and not
22 revisited until a version, if I can take you to it,
23 please, NHFT0003231, in October 2024.

24 So this is the policy that was introduced post-the
25 attacks, so Trustwide policy, yes?
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1 recordkeeping?

2 **A.** During -- for certain I can say that during the -- my
3 understanding of the investigations that were in place
4 in the organisation related to VC's care and treatment.

5 **Q.** And in terms of the cases I've just gone through, cases
6 1 to 4, when did you become aware of those cases? At
7 the time they happened, presumably? You're the --

8 **A.** Or apart from patient number 1, the other patients
9 I would have been told immediately by the Chief Nurse or
10 the Medical Director, and then of course part of the
11 reporting structure of the incidents.

12 **Q.** And do you think that the delays between the review by
13 senior management and the implementation of changes is
14 a serious failure in governance?

15 **A.** (Pause) I think that -- yes, I think that the delay
16 here -- the delay of -- in the instances that you've
17 described, I think that those delays were too long.
18 I think that some of that was driven by the instances
19 that we've talked about before of the delays in the
20 comprehensive investigations being completed. There is
21 no doubt that you get a better learning through those
22 processes.

23 But your core points about could we have taken
24 action quicker, I think that we could have done.

25 **Q.** That can come down, please. Can we have, please,
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1 **A.** Yes.

2 **Q.** And if we go to page 4, paragraph 1:

3 "Assessment and management of clinical risk is an
4 essential and core component of health care. Clinical
5 risks include [suicide] ... self-neglect, self-harm,
6 other risks to self and risks to others."

7 And if we go please to page 11, paragraph 5.9:

8 "Risk assessments and personalised plans should not
9 rely on self-report alone and should aim to be
10 a collaboration between the individual, their family and
11 social network, healthcare professionals and a range of
12 other sources."

13 Do you think it might be helpful there, to be clear
14 about what those other causes might be? Specifically
15 police, probation, educational establishments.

16 **A.** Where you read it now like this, you could add in that
17 further detail. I think you need to look at this, don't
18 you, alongside the information that's in the training,
19 because that can also form part of through some examples
20 within the training. Your core point I accept.

21 **Q.** Because the former -- the beginning of that paragraph
22 references effectively to individuals' families, social
23 networks, so people they know, then you need people who
24 are outside and able to give other material or
25 independent material, potentially, like the police, yes?
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1 I certainly agree that should form part of a good
2 risk assessment, yes.
3 **Q.** If we go to page 13, please, "Multidisciplinary ...
4 Working":
5 "Psychosocial assessment, formulation and care and
6 safety planning should be included in multi-disciplinary
7 team reviews and working. If clinical practitioners
8 feel they are unable to formulate risk and produce plans
9 that will adequately protect the safety of the patient
10 or others, they must consult a senior clinician or
11 others in the multi-disciplinary team."

12 How widely is that communicated, particularly to
13 more junior staff?

14 **A.** That I would -- I would expect that that is part of the
15 training that we now have in place, in terms of the
16 clinical risk policy.

17 **Q.** And if we go to page 15, please. 13.1, the second
18 bullet point. What does that mean?

19 **A.** So earlier on we were talking about the template and the
20 need for documents to be reviewed as part of
21 supervision. So I think that this is relating to that
22 check on records.

23 **Q.** Again, as with other policies, do you think that could
24 be expressed more simply? "We'll check -- advise staff
25 we'll check that you've done this," or something

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1 cause, and bringing about change that is more sustained
2 in the way that we actually did, in terms of -- and have
3 done, in terms of risk assessment. I think it's that
4 difference, and getting that balance right.

5 **Q.** If we go, please, to WITN0155033, this is page 16.
6 Section 48 review, part 2, the risk assessment and
7 recordkeeping, in respect of VC. So 16 and then 17:

8 "While some key risks were identified, we found that
9 risk assessments minimised or omitted key details
10 including:

11 "refusing medicine

12 "ongoing and persistent symptoms of psychosis

13 "levels of violence against others when his

14 psychosis was not managed well

15 "Escalation of violence towards others in the later
16 stages of his care under NHFT.

17 "Risks assessments did not provide a suitable
18 analysis of the risks or identify the factors that may
19 reduce his risk of violence and how this would be
20 managed. They also did not outline the seriousness and
21 the immediate threat of the risks and the known issues
22 that would increase his risks, or provide a written
23 outline of the scenarios where the risk of violence
24 would escalate and who may be put at risk. As a result,
25 the extent of the risk did not fully inform his care and

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1 similar?

2 **A.** It could certainly be. We could certainly simplify the
3 wording that's used. We tend to over-complicate.

4 I accept what you're saying, yes.

5 **Q.** Could we have, please, CQCM0016517, page 46. This is
6 the CQC Section 48 Review, part 1. It's the bit that
7 refers to managing risk. This is March 2024. Sorry,
8 can we go to page 46. We see under "Managing risk":

9 "How well staff assessed and managed risk in
10 community mental health and crisis services varied, and
11 the approach to risk assessment was inconsistent. In
12 our review of records, we found that many people who
13 used services did not have an updated crisis or risk
14 plan."

15 If we can go, please, to page 50, the bottom of
16 page 50:

17 "We found ... senior leaders did not appear to have
18 clear oversight of the risks to quality and safety of
19 care in services, and had not acted with the required
20 grip and pace to make rapid improvements."

21 What do you say about that, that you, as a senior
22 leader, had not acted with the required grip and pace?

23 **A.** I think that it's important to get the balance right
24 between the sort of rapid actions that we were talking
25 earlier about that don't necessarily address the real

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1 treatment planning."

2 You deal with the review in your statement, please,
3 if we can have WITN0263001, page 56. You set out at
4 page 56, paragraph -- the end of your paragraph 2.30 --
5 the list of findings, common themes described by you as
6 common themes; and they are, aren't they?

7 **A.** Yes, yeah.

8 **Q.** You say:

9 "It is my understanding the Trust offered clinical
10 risk training both through an e-learning package ...
11 managed by the Learning and Development Department until
12 ... Covid ..."

13 After that, face-to-face package.

14 What steps are being taken to monitor the
15 effectiveness of that training to see if it's getting
16 through?

17 **A.** So I think this speaks to the point that I was raising
18 about how do we monitor the improvements that come about
19 through training that's linked to a policy? So, you
20 know, we are, through SafeNow, we're able to look at how
21 many individuals have got risk plans, for example.
22 We're able to understand and go into the detail now,
23 which we weren't before, of an individual, just from the
24 database, from the record. If somebody has not got one,
25 we can drill down to find out why that is, which means

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1 that we can immediately escalate that issue and talk to
 2 the individual clinician about what's happening.
 3 **Q.** How frequent is this training for staff?
 4 **A.** I don't want to give you information, I'm sorry, that
 5 I'm not 100% clear about. It's something that we can
 6 find out for you.
 7 **Q.** Is there any dip sampling in respect of risk
 8 assessments? So somebody just going to have a look at
 9 a random patient, not particularly chosen for any reason
 10 but going to have a look at how that risk has been
 11 managed? Does that happen now at the Trust?
 12 **A.** That will be part of the Regular Records Review that
 13 happens in community services.
 14 **Q.** That can come down and one more document before we
 15 break, if I may, WITN0263041, page 1, and it's the risk
 16 assessment escalation framework.
 17 **A.** Mm.
 18 **Q.** How does this work in practice? So somebody working,
 19 let's say a care coordinator, shares, "I've got too many
 20 patients, I can't see them as often as I'd like to.
 21 I don't think it's working for patients and it's not
 22 working for me." Would that come through this system in
 23 any way --
 24 **A.** Yes.
 25 **Q.** -- if that's shared? How? How would that work through

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1 Right, we'll start again, I think, at yes, 3.15.
 2 **(3.00 pm)**
 3 **(A short break)**
 4 **(3.15 pm)**
 5 **THE CHAIR:** Yes?
 6 **MS LANGDALE:** Can we have, please, NHFT0000461, page 1.
 7 This is, Mr Majid, the Nottingham EIP review,
 8 December 2023, also prepared by Jonathan Warren, retired
 9 Chief Nurse. This review involved undertaking an audit
 10 of 15 purposefully sampled clinical records; is that
 11 right?
 12 **A.** Yes.
 13 **Q.** We see that on page 2, undertook an audit of 15 sampled
 14 clinical records, and we see at page 3:
 15 "In 2021 ... decision ... taken to 'uncouple' the
 16 EIP from the LMHTs. [You] were told that this was due
 17 to the evident fall in the service meeting expected
 18 standards and targets.
 19 "Whilst Care Coordinators were released from LMHT
 20 duties and allocated EIP caseloads, they remained based
 21 within the LMHTs. The consultants remained within the
 22 LMHTs and [were] allocated sessional time with ... EIP.
 23 Dedicate[d] psychology, social work and OT time is not
 24 part of the core offer from the EIP team. If needed, it
 25 is sourced via the LMHT, but this rarely happens."

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1 your system?
 2 **A.** So if we take that issue of a clinician not being able
 3 to do something because of being too busy or not having
 4 enough staff, that would get raised as an incident at
 5 level 1 on this diagram.
 6 If there were -- the premise here with this Risk
 7 Escalation Framework is, if I can be a little bit crass,
 8 is to mitigate or escalate. So if that could be
 9 mitigated at the next level, then it should be
 10 mitigated, so it should be -- the risk should be reduced
 11 and resolved, and quite often, if there are risks raised
 12 about individual teams or things that are happening in
 13 individual teams, they can be resolved at that local
 14 level.
 15 What I would then expect is that if it's not able to
 16 be resolved, it gets escalated to the next level, and so
 17 on, and would eventually end up at the Trust Risk
 18 Management Group which is the first, which is level
 19 four, which is the first senior -- well, it is the group
 20 that is shared by the Chief Operating Officer and
 21 executive director, where you would expect to see the
 22 most senior -- the most serious risks coming to.
 23 **MS LANGDALE:** Yes, thank you. That might be a good moment
 24 to stop.
 25 **THE CHAIR:** Yes, thank you.

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1 Did this lead to confusion in respect of
 2 responsibility and accountability and who was doing what
 3 where?
 4 **A.** Obviously this decision was taken prior to my 2021,
 5 prior to my time within the organisation. So it's
 6 difficult to comment about what happened at the time.
 7 I think that it -- I think what it's describing is
 8 a halfway house between the original fidelity to the
 9 model that was developed under the National Service
 10 Framework for mental health that defined the evidence
 11 base behind EIP, Early Intervention Services.
 12 And an issue that was happening at this time with
 13 capacity and resources, and the need to try to find
 14 a middle ground. That would be my interpretation.
 15 **Q.** Of what happened?
 16 **A.** Of what happened. But it is my interpretation, yeah.
 17 **Q.** If we go to page 4, please, under the box at the top:
 18 "We were unable to gain absolute clarity on the
 19 available sessions of Consultant Psychiatry time
 20 available to the EIP team."
 21 The Inquiry has heard evidence from Dr Lloyd, who
 22 says she had only 1.5 days' consultant time for
 23 oversight of the EIP patients.
 24 We see also, if we go further down:
 25 "Several staff we spoke to felt that the absence of

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1 specialised staff had a detrimental effect on the direct
2 care of patients and the team milieu, we would recommend
3 that as vacancies arise ... consideration is given to
4 those specialist roles to support the teams and
5 patients."

6 If we go to page 5, please, top paragraph:

7 "One member of staff described how they often felt
8 left on their own to make decisions, describing their
9 manager and consultant as fantastic but the reality is
10 they cannot be in more than one place at a time."

11 We referred earlier to pressures of caseloads and
12 the like.

13 A. Mm.

14 Q. Were you aware, when this report came back, of the
15 impact of that?

16 A. Yes, that's why it was important to act on the findings.
17 So, you know, we have now got psychologists due in posts
18 imminently, we've had an OT join the team, we are
19 looking to review the -- or are reviewing the
20 geographical make-up of the team, as suggested here.

21 One of the challenges, because I think there is --
22 my personal view is that there is real merit in the
23 fidelity of the model, both of the Early Intervention
24 Team and the Assertive Outreach Team. If we are going
25 to move the organisation in that way forward, we have to

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1 where we've got to with the wider MDT and psychology and
2 social work.

3 I understand that there is work underway in terms of
4 the medical input into the services, and there is work
5 happening around the geographical nature, the hub and
6 spoke nature of the teams. So I would say there that
7 the improvements are underway.

8 Q. Can we have, please, CQCM0016517. This is the
9 March 2024 special review. If we go to page 2, please,
10 issues of staffing are raised within this. We see on
11 page 2, at the bottom:

12 "Our rapid review identified 3 enduring areas of
13 concern ... including:

14 "[...]

15 "staffing."

16 If we go to page 3:

17 "The gaps and challenges we have identified ... are
18 longstanding issues at the trust which need to be
19 addressed. ... looking more widely, we can see that
20 other community mental health services are facing many
21 of the same challenges ..."

22 Page 4:

23 "High demand for services and issues with staffing
24 levels meant that patients were not always being kept
25 safe."

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1 review all of community services. We are told there's
2 no more resources. There is a potential risk for us
3 there in all the community services that we have --

4 Q. There is a potential risk?

5 A. In other -- in Community Mental Health services more
6 generally, if we're going to move resources from, for
7 example, Community Mental Health Teams into Early
8 Intervention Services or into newly formed Assertive
9 Outreach Services. We need to work that through more
10 and maybe, if I dare be so bold, something that maybe
11 might be a recommendation, I think it was something
12 I suggested might be a recommendation from the Inquiry
13 because this would be something that trusts up and down
14 the country are struggling with.

15 Q. Struggling with the resourcing?

16 A. With the resourcing, having reintegrated services back
17 into Community Mental Health Teams into larger teams, to
18 then pull elements out again will have an impact on the
19 resourcing of those core teams.

20 Q. Can we look at page 11 of the document, please. The
21 recommendations of the report. We see, page 11: have
22 you been able to implement those recommendations?

23 A. I would say that we've partially implemented some of
24 the -- or all of these recommendations, though there is
25 more work to do, around -- I was just explaining about

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1 Setting out the complex staffing arrangements
2 thereafter.

3 "Leaders were aware of risks and issues faced by
4 NHFT, but action to address safety concerns [were] often
5 reactive."

6 Did you attend safer staffing meetings between 2023
7 and 2024?

8 A. No, I would not expect to attend those sorts of detailed
9 meetings as the Chief Executive.

10 Q. Who did attend them, then, who did you rely on for
11 information from those?

12 A. Well, they would be attended by the staff -- leaders
13 within the care groups, the members of the triumvirate,
14 the three people that are leading the care groups and
15 escalations from those meetings would come through to
16 the Executive Leadership Team and --

17 Q. Would they reach the board?

18 A. Oh --

19 Q. Concerns about staffing? Because they're clearly there,
20 aren't they?

21 A. Staffing is something that we talk about at the board on
22 a regular basis and you get information -- we get
23 information from lots of different sources, and it's
24 important to review issues of staffing in the round, and
25 the CQC touch on it because I think we've made

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1 significant strides forward in terms of staffing within
2 the organisation, more than 200 more nurses since 2023,
3 80-odd more healthcare assistants.

4 However, you also have to look at the other side of
5 the equation which is capacity and demand that is coming
6 in particularly into community services, but also demand
7 for inpatient beds is going up. So you have to see both
8 sides of the equation and our work around staffing looks
9 at both sides.

10 **Q.** We heard evidence from Stephen Quartey, as an agency
11 member of staff, that he didn't have access to the RiO
12 system and if he wanted to access it to look at VC's
13 records, he had to have another member of staff next to
14 him logging in. Is that still the case, that it's
15 restricted access to RiO for agency staff?

16 **A.** We've --

17 **Q.** If they're on a shift and not able to see material?

18 **A.** I don't know whether agency staff can access the
19 clinical record. One of the reasons that we are using
20 lots of temporary staff is -- does have an impact on
21 quality within the organisation and on continuity of
22 care, and that's one of the reasons we've been working
23 so hard to reduce reliance on agency staff so it is our
24 staff that are delivering the care and treatment to
25 individuals.

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1 that.

2 **Q.** Have you become aware of that since?

3 **A.** Yes, I have, since.

4 **Q.** Do you know if patients are placed now in areas that
5 have been rated as inadequate; would that be something
6 that would concern you in terms of placing a patient?

7 **A.** It would absolutely concern me. I know that we've
8 worked quite hard to overhaul how we see patients who
9 are placed out of area. We've invested quite
10 significantly in a bed management team and in
11 caseworkers to support people who are out of area and
12 bring them back quickly. So we would be overwriting the
13 quality in a different way today than we did previously.

14 **Q.** NHHNB0018961, page 13, please. NHS England placed NHFT
15 in segment 4, didn't it, on 27 February --

16 **A.** It did.

17 **Q.** -- 2024? Page 13. Thank you. Briefly, what does that
18 mean?

19 **A.** That means that concerns around the performance of our
20 organisation are such -- and it could be performance in
21 a number of areas, for us it was quality -- were such
22 that we needed enhanced oversight and in fact mandatory
23 intervention to support improvement within the
24 organisation.

25 **Q.** If we go, please, WITN0356028, NHS England conducted

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1 **Q.** We know from Dr Milton, who went to conduct an
2 assessment, a psychiatric assessment, of VC, that VC's
3 notes were locked down very quickly, his clinical notes?

4 **A.** Yes.

5 **Q.** Dr Milton couldn't get access to them. Did you lock
6 down with the same urgency the victims' notes and
7 medical records or not?

8 **A.** We didn't have any records for the victims. The victims
9 weren't receiving care and treatment in Notts
10 Healthcare.

11 **Q.** Did you have any communication with the Trust who had,
12 or generally within Nottingham and across hospitals
13 about the sharing of records and information?

14 **A.** There was. One of the things that we were trying to do
15 was to make sure that our staff hadn't inappropriately
16 accessed any records, and I know my Medical Director
17 made enquiries at NUH, Nottingham University Hospital,
18 about this. So that was the liaison that I was aware of
19 between ourselves and NUH.

20 **Q.** The CQC Report, it doesn't need to go back on again, but
21 it referred to access to inpatient beds and patients out
22 of area. Were you aware that the Priory was rated as
23 inadequate when VC was sent there?

24 **A.** I wasn't in Notts Healthcare or in the Nottinghamshire
25 system at that time, so I don't remember being aware of

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1 a Well Led review after you were in segment 4; is that
2 right?

3 **A.** Yes, the developmental Well Led, yes.

4 **Q.** We see at page 5, key findings:

5 "Board members and senior leaders [you] spoke to
6 mentioned that the size of the challenges the trust is
7 facing, including the journey towards improvement, need
8 to be articulated better.

9 "... staff ... are finding it difficult to
10 understand the direction of travel given multiple
11 priorities.

12 "Leaders below executive level said they were asked
13 to attend multiple meetings to discuss the same things,
14 with no clear output."

15 Over the page to page 6, fourth bullet point down,
16 fifth bullet point:

17 "Culture in the Trust was described by many staff in
18 the focus groups as top-down, closed, directive, silo
19 working, and/or unsupportive."

20 Page 7:

21 "Board members agreed ... further work needed to
22 improve further culture."

23 Page 11:

24 "Review the board composition to include more
25 clinical representation. This can be included in the

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1 new [non-executive directors] recruitment process."

2 Do you see the advantage in that, if it were?

3 **A.** Without -- yes, we were talking earlier, weren't we,
4 about increasing clinical presence in either around the
5 board or in senior leadership. It's a good thing to do.

6 **Q.** At page 19:

7 "Staff and ... leaders expressed ... some leaders
8 expressed frustration around the pace of change ...
9 They felt ... within the organisation [it] was reactive
10 rather than proactive.

11 "Staff had mixed views in terms of effectiveness of
12 incident reporting and feedback. Most staff in our
13 focus group said they had not had any feedback after
14 reporting an incident."

15 Very serious concerns remain; do you agree?

16 **A.** I do. And I think that there are -- I think that I
17 alluded earlier to pressures that are on organisations
18 when they enter such a significant period of regulatory
19 oversight, and I share this not as an excuse, but as an
20 explanation. And what I have experienced is that we are
21 constantly chasing regulatory action plans, regulatory
22 improvement, and that tends to be, I talked earlier
23 about transactional improvement, and I really
24 understand, you know, that that feels to colleagues like
25 it's top-down. And we have to make some decisions about

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1 organisation and its position of being a learning
2 organisation, to how learning and changes in practice
3 had been implemented in some services.

4 "We saw evidence that whilst the Trust believed
5 a learning organisation vision and culture shift was
6 active and dynamic, we saw areas where in practice,
7 learning and [the] shift from blame culture was not
8 taking place as the board may have hoped."

9 If we go over the page at 44, reference to a blame
10 culture. "... learning ... not shared effectively."

11 We see at page 46, paragraph 3:

12 "Through our assessment of services, examples where
13 communication about learning, led by corporate services
14 was not as effective as that of the patient safety team
15 who had good relationships with care groups."

16 Why does the corporate services not have good
17 relationships with care groups, or as good?

18 **A.** I think that the model that we have tried to use within
19 corporate services is a partnership model where
20 corporate services reach into clinical care groups, and
21 I have to be fair to leaders in corporate services, and
22 they are often getting pulled into dealing with the
23 regulatory demands that are on the organisation, and
24 I think that has an impact on the relationship with care
25 groups.

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1 where our focus is. And the agreement through the
2 Integrated Improvement Plan, the IIP, with NHS England
3 and the Recovery Support Programme is that we should
4 focus on these regulatory action plans. That should be
5 the drive. And that's what's contained in our
6 transition criteria.

7 And I was aware that, as we've been going through
8 this journey, we would reach a point where you -- where
9 we as an organisation tip from working in that way to
10 thinking about more transformational change, which is
11 where we're able to bring around the cultural
12 improvements, and at the point of the Well Led review,
13 the CQC's Well Led Review, that was the point that we
14 were at and actually they referenced that a little bit,
15 didn't they, in the findings of the Well Led. And in
16 our new strategy that we're currently refreshing it has
17 that focus on the things that are raised here around
18 culture.

19 **Q.** The CQC Well Led Review is at CQCM0029106, page 1.
20 You've prepared a second statement dealing with your
21 response to this, January 2026, so I won't take much
22 time on it.

23 If we look, please, at page 43 we see the disconnect
24 described:

25 "... between the vision executive leaders had of the

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1 **Q.** If we have, please, WITN0263134, page 1.

2 A warning notice was served by the Care Quality
3 Commission on 31 October 2025, wasn't it?

4 **A.** It was, yes.

5 **Q.** We see -- I'll wait for it to come up -- if we can go,
6 please, to page 24, one aspect of that involved mental
7 health services, didn't it, and the oversight at board
8 level of compliance with the Mental Health Act?

9 **A.** It did, yes.

10 **Q.** Can you tell us what that's about, please, and what you
11 are doing about that?

12 **A.** Yeah, this is an issue about the committees that we were
13 talking about earlier and whether or not the oversight
14 of mental health legislation was done through the
15 Quality Committee, which historically it has been in our
16 organisation, or whether you have a separate Mental
17 Health Legislation Committee.

18 Prior to the CQC carrying out their Well Led Review,
19 we had already decided as an organisation to move to
20 a separate Mental Health Legislation Committee which has
21 subsequently happened, and this was the CQC coming to
22 the same conclusion.

23 **Q.** That can come down, please. And can we go to your
24 statement to pick up a couple of matters, please. So
25 WITN0263001, page 93. And we see at page 93 you refer,

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1 Mr Majid, at paragraph 405 to:
 2 "... the trust implemented an Assertive Outreach
 3 model [in 2025] ..."
 4 Is this team or is it a team distinct from the EIP
 5 team, or how does this work?
 6 **A.** This is not -- this is an Assertive Outreach approach,
 7 I believe.
 8 **Q.** Right, so it's not a model, it's an approach --
 9 **A.** (*Unclear*).
 10 **Q.** -- from existing EIP team staff, or?
 11 **A.** From within existing Community Mental Health Team staff.
 12 **Q.** And what confidence do you have that that works in any
 13 way more effectively than what was being done before?
 14 I don't know if you've received or heard the
 15 evidence of Dr Dissayanaka about the specific
 16 requirements for Assertive Outreach that it's not
 17 an approach, it's a --
 18 **A.** Yes.
 19 **Q.** -- particular model? Do you think --
 20 **A.** I think that's right, and that's why, as an
 21 organisation, we are moving as NHS England issued
 22 a request to all ICBs to review the standards of
 23 Assertive Outreach interventions and, as part of that
 24 process, it's our aim to move towards a separate team,
 25 model, because of the reasons that you describe and the

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1 which, you know, help and support training, and it's
 2 things like training, it's supervision, it's access to
 3 MDTs, it's access to specialists in the organisation
 4 that can give advice on information sharing. That's
 5 what makes the real difference.
 6 **Q.** If we go, please, to page 131. You say at
 7 paragraph 557:
 8 "I am aware that the Trust's Head of Safeguarding is
 9 working with the Police through the Potentially
 10 Dangerous Persons Panel. She has informed me that the
 11 Police have had a potentially dangerous person's process
 12 in place for many years although it could have been
 13 described as 'dormant' and partners were not previously
 14 aware of the process."
 15 So it wasn't a process if no one was aware of it,
 16 was it?
 17 **A.** I wasn't aware of it, no.
 18 **Q.** So "dormant" means it didn't exist, really; it's now
 19 you're thinking about having a Potentially Dangerous
 20 Persons Process; is that fair?
 21 **A.** It's not an NHS process; it's the police's process and
 22 we are working closely with the police on how we can
 23 best use that process.
 24 **Q.** And what's the aim of that process?
 25 **A.** My understanding is that the aim of the process is for

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1 witness described.
 2 **Q.** Who's accountable for ensuring EIP discharge decisions
 3 receive appropriate clinical oversight?
 4 **A.** The -- that would be the responsibility of the clinical
 5 teams, the clinical team, the care coordinator, the team
 6 manager.
 7 **Q.** Page 129, please, "Information sharing with the Police".
 8 You set out that there has been an agreement signed now
 9 in relation to sharing responsibilities, and there's
 10 a final version currently with Nottinghamshire Police.
 11 Shouldn't it always have been clear that information
 12 sharing with the police was required, in terms of
 13 patients, their encounters with the police, involvement
 14 with the police?
 15 **A.** (*The witness nodded*).
 16 **Q.** Why has it taken so long to get an agreement being put
 17 together in 2026?
 18 **A.** Well, the information-sharing agreement is agreed, and
 19 I agree with you. I think information-sharing
 20 agreements are important. They provide parameters for
 21 organisations. Then they don't -- I don't believe that
 22 they lead to the success of information sharing, that
 23 requires on individual practitioners from the
 24 organisation sharing data to understand when that data
 25 should be shared, and information-sharing agreements

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1 people who don't meet three MAPPA criteria. It's
 2 a direct access into -- I think it's into neighbourhood
 3 policing. But it would increase engagement, I suppose,
 4 is what I'm interpreting for people who don't meet that
 5 MAPPA criteria.
 6 **Q.** You refer at the end of your statement, at
 7 paragraphs 618 and 617, to recommendations to the
 8 Inquiry, everybody having been asked what they thought
 9 about that. And you say at paragraph 618 -- well, set
 10 out what you're saying there.
 11 **A.** Sorry, I can't see it.
 12 **Q.** It'll come on the screen in a moment. It's page 160.
 13 **A.** It was paragraph 618?
 14 **Q.** Yes.
 15 **A.** This is -- well, I think what I'm trying to articulate
 16 here is that earlier on in my career I felt that
 17 initiatives like the National Service Framework and the
 18 Policy Implementation Guidance put real focus on working
 19 with people with severe mental illness.
 20 My own personal view is that over more recent years,
 21 whilst investment has been very welcome in mental health
 22 services, the focus has perhaps been on services that
 23 are away from working with those with the most severe
 24 diagnoses, and what I'm saying here is I would welcome
 25 support as the new, modern version of those service

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1 frameworks is currently being discussed, if there was
2 perhaps a recommendation out of this Inquiry to support
3 that refocusing on the people with the most severe
4 mental illness.

5 **Q.** That can come down, please.

6 Finally a few emails, if I may, that you sent to
7 colleagues at the Trust. The first is NHFT0019997,
8 13 June 2025, page 2.

9 **A.** I'm sorry, I can't see it at the moment.

10 **Q.** It'll come up in a moment, I think. If we see page 2,
11 June 2025:

12 "Hi, everybody".

13 Who does this go to?

14 **A.** It goes to colleagues in the organisation. It's
15 everybody.

16 **Q.** So is that everybody?

17 **A.** Yeah.

18 **Q.** So it's a significant position of influence, isn't it,
19 when everybody can read something you're saying?

20 **A.** Yes.

21 **Q.** "Firstly", you say in paragraph 2:

22 "... I want to talk about the dreadful events that
23 happened in Nottingham two years ago ... which have so
24 devastatingly affected people's lives. We can only
25 imagine how those whose lives were so tragically

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1 week has been spent with the Inquiry team completing my
2 own Rule 9. For those not familiar with the term,
3 a Rule 9 is a formal, written request from a public
4 inquiry for a person or organisation to provide
5 a statement and evidence. As I mentioned last week,
6 it's an extremely time intensive process and I know all
7 of us who are completing them are finding it tough
8 going. I hope everyone is getting the full support they
9 need."

10 Would you like to comment on any of those --

11 **A.** Yes.

12 **Q.** -- particularly the second one where you say, "I'm fed
13 up with needing to do this."

14 **A.** Yes. Thank you.

15 So if I start with that one and move on to the third
16 one, maybe, I want to make it absolutely clear that when
17 I'm talking about being fed up I'm talking about being
18 fed up with letting colleagues down by needing to cancel
19 clinical visits. The reason for that is that clinical
20 visits, as we've talked about here today, are a really
21 important way of engagement and escalation, and I've
22 been criticised in a Section 48 report that we were
23 looking at for cancelling clinical visits.

24 Chair, I want to make it absolutely clear that in no
25 way am I talking about being fed up with the Inquiry,

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1 affected by the events ... will be feeling today and our
2 thoughts must remain with them."

3 And at the bottom of the page you say:

4 "I'm sorry that scrutiny on the Trust is going to
5 continue through the summer unrelenting as the CQC will
6 be back to do Well-Led inspection and of course the
7 Nottingham Inquiry is properly underway which drives
8 media coverage. Please do remember, if you find
9 yourself struggling ... seek support from our wellbeing
10 team. I was impressed to hear how quickly you can get
11 an appointment ..."

12 If I can go to the next one, please, you can comment
13 on all of them at the end, 17 October 2025. Also you
14 say at the end of this one on page 3, so NHFT0019998.

15 Page 3:

16 "Now, I do need to make an apology that links to the
17 next few weeks. Along with many colleagues in our
18 Trust, I now have to respond to a very detailed
19 Nottingham Inquiry Rule 9 (set of legal questions)
20 within a set timescale and I am so sorry, but this means
21 that many of the sessions I have had planned to come out
22 to teams and services need to be postponed. I am fed up
23 with needing to do this, but I am afraid needs must".

24 Then one on 31 October, NHFT0019999, page 2:

25 "It's a short one from me this Friday as most of my

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1 and I'm recognising the importance of the Inquiry. But
2 also, as I talk about in the second of the -- the third
3 of the things -- the messages that you've put up, I'm
4 recognising how hard colleagues work to meet the needs
5 of the Inquiry, and I think it's important that I thank
6 them for doing that.

7 I'm also aware, and think that it's important to
8 note and recognise that the -- I talk about the
9 challenges, and of course it is challenging for
10 colleagues to carry out business-as-usual activity and
11 respond to any regulatory requirements, and we have to
12 recognise that to avoid that being a risk, and that was
13 what I was doing.

14 I would also want to say that I would really not
15 want this to be -- I don't want this to be interpreted
16 in any way as any non-commitment to the Inquiry. I put
17 an awful lot of effort within our organisation, delayed
18 my retirement, in order to ensure that the organisation
19 knows the importance of the Inquiry, knows the fact that
20 we have an opportunity to support changes within mental
21 healthcare as we go forward and to learn from
22 an organisational perspective.

23 That is my clear narrative into the -- and has been
24 always my clear narrative into the organisation. I'm
25 very keen for the Inquiry to recognise that, to know

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1 that.

2 **MS LANGDALE:** Chair, those are my questions. There will be

3 more.

4 **THE CHAIR:** Yes, thank you, Mr Moloney.

5 **Questioned by MR MOLONEY**

6 **MR MOLONEY:** Just a very few questions, please. May I ask

7 you this, just about your experience in terms of your

8 role at the Trust, have you ever seen a situation where

9 a person who is sectioned or should be sectioned, having

10 to wait in the community for a bed because there isn't

11 a bed for them?

12 **A.** That does happen. That does happen, yes.

13 **Q.** Yes. May I ask you -- actually, can I just follow up on

14 that very briefly. How often would you say that does

15 happen, say, in a year that you've experienced?

16 **A.** I think it's very -- I would find it difficult to

17 quantify that. I am aware that we have provided some

18 more information for the Inquiry around Mental Health

19 Act, and Mental Health Act activity.

20 **Q.** Okay. Thank you. May I ask you a question about Elaine

21 Newton, the bereaved partner of Ian Coates.

22 **A.** Yes.

23 **Q.** Did you write to Elaine Newton in February 2025, after

24 the Theemis Report was delivered to invite her to a

25 meeting?

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1 in failings around the care of VC?

2 **A.** I can genuinely say that I don't recall that.

3 **Q.** Just finally, you've spoken about -- today, you've

4 spoken about problems in the past and improvements that

5 have been made and the need for what you've described as

6 transactional change.

7 **A.** Mm.

8 **Q.** Yeah. Now, if there is to be hope of that change coming

9 about, would you agree that there has to be a positive

10 willingness to accept that change is needed?

11 **A.** Completely.

12 **Q.** Yeah, and a positive willingness to do what's required

13 to effect that change in order for that change to come

14 about?

15 **A.** Certainly that you have to have systems and processes in

16 place to support the change. Some of the evidence that

17 we've seen coming out of the various reviews talk about

18 needing to have clear programme change structures and

19 how that improves the outcome of change.

20 **Q.** And that willingness being so important, would you say

21 that there has to be leadership from the top in the

22 organisation, from encouraging that willingness on the

23 part of others further down in the organisation?

24 **A.** Certainly, a culture of change is very important, yes.

25 **Q.** Ms Langdale has just asked you about various comments in

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1 **A.** I -- if I remember correctly without looking at the

2 document, I wrote to her explaining that we were

3 accepting the findings of the Theemis Inquiry, and

4 offering a meeting to discuss it.

5 **Q.** And you remember that there was a meeting with Elaine

6 Newton?

7 **A.** I do remember meeting with her, yes.

8 **Q.** And in that meeting, did Ms Newton ask you if one factor

9 in the failings around the care of VC was that staff

10 levels were too low?

11 **A.** I didn't catch what you said, I'm so sorry.

12 **Q.** In that meeting, did Ms Newton ask you if one factor in

13 the failings around the care of VC was that staff levels

14 were too low?

15 **A.** Too low?

16 **Q.** Yes.

17 **A.** Yes. I can't remember the details of that, of that

18 specific point.

19 **Q.** And did she also ask you whether or not staff had needed

20 more training than they'd had?

21 **A.** I'm sure I -- I accept that that may well have been

22 a topic of conversation, yes, because it's something

23 that was covered off in the two reports.

24 **Q.** And did you tell Ms Newton that neither of those things,

25 either low staffing or inadequate training, were factors

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1 your emails. Would you now recognise that comments

2 about being fed up could be interpreted as being fed up

3 with having to prepare for the Inquiry?

4 **A.** No, I don't think that is true. I think that I was

5 clear in my previous answer that being fed up was about

6 cancelling clinical visits and engagement with teams,

7 and I repeat what I said about firmly and strongly

8 believing that there is -- that the huge value that this

9 Inquiry will bring to not only Notts Healthcare but to

10 the whole of the mental health sector. I put

11 significant effort, in the organisation, into putting

12 that message across.

13 **MR MOLONEY:** Thank you very much, Mr Majid.

14 **THE WITNESS:** Thank you.

15 **THE CHAIR:** Ms Cartwright.

16 **Questioned by MS CARTWRIGHT**

17 **MS CARTWRIGHT:** Good afternoon, Mr Majid.

18 Can we look, just first of all, on an issue of

19 culture when you took on the role of Chief Executive

20 that you deal with, please, in paragraph 83 of your

21 first witness statement which is WITN0263001, at

22 page 21, please. Thank you. Thank you.

23 Now so this is really dealing with your experience

24 of the relationship between executive and non-executive

25 directors when you joined in 2022.

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1 A. Yes.

2 Q. Thank you. You say this:

3 "... [You] observed and heard that relationships

4 between Executive and Non-Executive Directors were

5 professional but perhaps not mature, and this was

6 something [you] could see in [your] early Board

7 meetings."

8 You go on to say:

9 "Challenge tended to be more of a superficial nature

10 and was often met by a more defensive response from

11 Executives. Assurance seemed to rely heavily on

12 narrative reporting rather than triangulated evidence,

13 by which I mean rather than referencing data or feedback

14 from staff or patients or the content of other reports,

15 responses to challenge tended to be thoughts or views of

16 a single Executive Director."

17 So again, then you go on about that defensive

18 response. And was that really what you experienced when

19 you took over in 2022?

20 A. That's what I observed.

21 Q. You observed. But I think perhaps you observed it

22 yourself, but was that what you saw essentially as

23 broadly speaking a Trust that was defensive in nature?

24 A. Well, what I saw was a process happening at Board that

25 didn't necessarily always explore the detail of

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1 order to carry out learning.

2 Q. Yes.

3 A. And in order to look at what changes you might need to

4 make, and we certainly have recognised that that

5 incident should have been incident reported, and

6 therefore there is some learning happening regardless of

7 whether or not an incident form has been completed or

8 not.

9 Q. No, but --

10 A. It's the trigger. An incident form trigger

11 -- (*overspeaking*) --

12 Q. I appreciate that, but is your answer really you're not

13 quite sure whether it has been?

14 A. I would need to check whether it had been or not.

15 Q. Because would you agree if this was now really a Trust

16 that was acting in accordance with its duties, are you

17 able to tell us whether the Trust have approached Feven

18 and done what's the first thing, when something goes

19 wrong under that system, of offering an apology and

20 explaining to her where things went wrong?

21 A. I don't believe that we have contacted Feven, and

22 I think it's something that we need to look to do.

23 I recognise the point that you're making.

24 Q. Well, we're now in 2026. And certainly we looked

25 through the documentation in your bundle the issues

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1 a particular point in a way that I was perhaps used to

2 seeing that. I don't necessarily think -- I wouldn't

3 necessarily extrapolate that across to a broader

4 organisational culture, is what I was observing within

5 the board.

6 Q. All right. And then can I pick up, then, having looked

7 at that with the issue you've dealt with around incident

8 reporting, and what you've said broadly about the need

9 for there being a culture of candour.

10 A. Yes.

11 Q. You'll be aware that part of the Inquiry has looked at

12 the incident in May of 2020, and the injuries that were

13 caused to Feven, you'll have heard Mr Brewin this

14 morning accepting that that incident should have been

15 subject to incident reporting. Can I check first of all

16 you don't dispute that either?

17 A. No, absolutely not.

18 Q. And so can then we look at the fact that has the Trust

19 then, at any point to date, essentially done an incident

20 report for what happened in May 2020? Has it put it

21 through the process that should have occurred in

22 May 2020?

23 A. So I don't think that -- I will have to check whether or

24 not we have actually incident reported it. I guess,

25 when you incident report something, you're doing that in

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1 relating to that discharge of VC and not sectioning him

2 and then the harm event that was caused to Feven. Would

3 you agree, it's incredibly surprising if it's the Trust

4 that's now saying it's operating in accordance with

5 a culture of candour, transparency, and frankness, that

6 still, in May of 2026, the basic steps of offering

7 an apology to Feven have still not taken place?

8 A. I'm -- I recognise your point that we absolutely need to

9 contact Feven and offer an apology. And in terms of

10 your point about the improvements that we've made around

11 the organisation being a learning organisation, we

12 certainly use incident reporting in different ways today

13 than we did back in 2020.

14 Q. Now, the Inquiry has heard some evidence from Annette

15 Palmer, who is now discharging a clinical lead role, and

16 so can I ask, if you've not approached Feven, has the

17 Trust investigated why Annette Palmer, particularly

18 bearing in mind the significance of the leadership role

19 she has, why she didn't incident investigate that back

20 in 2020?

21 A. Well, that would be part of the same process and I would

22 expect, as part of the reflections and learnings that we

23 are going through -- and we will go through during the

24 Inquiry -- that we will be having those conversations

25 with our colleagues in terms of actions that have been

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- 1 taken.
- 2 **Q.** And can you see how with that, plainly you can deal with
3 statistics as to incident reporting now, and the process
4 and particularly under the new PSIRF model --
- 5 **A.** Mm.
- 6 **Q.** -- but would you agree also that until you've got to
7 grip with the level of understanding or lack of
8 understanding for incident reporting, that there may be
9 many other incidents like Feven that have not gone
10 through an incident reporting and learning process?
- 11 **A.** It is really important to make sure that we've got
12 a positive culture of incident reporting. I completely
13 agree. And perhaps I can draw you back to Helen
14 Collins's report, which was received in 2024, that
15 talked about her view of the incident reporting culture
16 in the organisation, and that we -- that we are
17 reporting at a rate that she would expect, and that's
18 quite important to see, as a marker, isn't it, in terms
19 of our level of incident reporting.
- 20 **Q.** Now can I ask you, your evidence to Ms Langdale KC was
21 still, as of today, and your evidence, you don't know
22 whether -- is it bank and --
- 23 **A.** Agency.
- 24 **Q.** -- staff can access the clinical records?
- 25 **A.** Agency staff.

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- 1 of 2023, actually, after those incidents occurred with
2 those other patients, actually speak to the consultants
3 in the EIP team?
- 4 **A.** There was an Immediate Management Review that was
5 completed after the tragic events of 13th June, yes.
- 6 **Q.** No, I'm talking about the incidents before then where
7 again it related to involvement in the EIP team relating
8 to other patients who had gone on to be involved in
9 serious and fatal incidents.
- 10 So before that, before we get to June, bearing in
11 mind it's suggested that that would have revealed some
12 of the real issues that this Inquiry have identified to
13 the EIP, and so before the June event, had anyone spoken
14 to the consultants in the EIP relating to those earlier
15 incidents with other patients?
- 16 **A.** The other incidents would equally have had a management
17 review. Now whether that would have included talking to
18 the consultants or not, I can't speak with certainty on
19 that.
- 20 **Q.** All right. And then can I just be clear, because
21 Ms Langdale KC also asked you about when you became
22 aware of the significant issue within the relevant EIP
23 team of not taking notes from the MDTs, and I think you
24 said it came to light during VC's case.
- 25 **A.** That was when I first recognised it or heard about it.

99

- 1 **Q.** Agency staff. And is that not remarkable that that's
2 obviously one of the issues that's been identified, that
3 you're not able to say what steps the Trust have taken
4 to ensure that any workers on your wards can actually
5 access the records so that they can look at the clinical
6 history and input on the records? And so would you
7 agree that it's remarkable that now, in your role of
8 Chief Executive, that you're not able to assist with
9 what steps the Trust have taken to ensure agency or bank
10 staff can record on RiO?
- 11 **A.** It's not -- I think I started at the beginning of my
12 statement by saying that, as Chief Executive, my role is
13 to have an overview. That doesn't necessarily always
14 mean that I will hold the detail of things like this.
15 I will respond to understanding things that are raised
16 to me. This -- or escalated to me. This isn't
17 something that has been escalated to me that I can
18 recall.
- 19 **Q.** Can I ask, then, you were asked about the previous
20 incident, significant incidents, that had occurred
21 before VC's attack in June.
- 22 **A.** Yes.
- 23 **Q.** And obviously there are systemic and thematic issues
24 relating to the EIP team. And can I ask you, did anyone
25 actually, before that review was commenced in December

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- 1 **Q.** But it would assist, can you be clear, when in the
2 investigation of VC's case did you become aware that the
3 EIP team were not documenting the Multi-Disciplinary
4 Team meetings?
- 5 **A.** I think it was something that was referenced in the
6 level 2 review, though I can't be sure, but I think that
7 was when I first heard it.
- 8 **Q.** Have you been able to look at it? It was suggested that
9 it was known that there was this systemic failing due to
10 a failure of the Trust to provide individuals to
11 document those meetings? Had that not been brought to
12 your attention before VC's attack?
- 13 **A.** No, no. And early on in my evidence, I talked about the
14 Risk Escalation Framework and this is the sort of thing
15 that can be -- the Risk Escalation Framework is the sort
16 of thing that can be used to escalate these sorts of
17 issues.
- 18 **Q.** Now, you've already been asked by Ms Langdale KC about
19 the email, this is the last question, and the impression
20 that email gave, and obviously you've given your answer
21 about what you meant by being "fed up". I think an
22 email that went to 11,000 or so staff.
- 23 But can I just ask another thing about impression,
24 because you had a meeting with those that I represent,
25 Wayne Birkett and Tracey, his partner, where you

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1 attended at his address with the Chief Nurse, and
2 certainly their impression of that meeting was that you
3 didn't participate in the discussions in that meeting.
4 In fact, you seemed rather distracted and more focused
5 on wanting to go and get your lunch.

6 So would you agree that there can be a time where
7 you gave an impression that my clients had at that
8 meeting that you weren't particularly interested in
9 giving them the learning that they so desperately
10 wanted?

11 **A.** I feel really saddened, I feel really saddened by what
12 you're describing, and those who know me know that that
13 would never be my intention, in order to increase
14 distress caused to people who are already suffering from
15 such dreadful circumstances. So it's something that
16 I need to think and reflect seriously on.

17 **Q.** Then finally, again linked to that meeting, obviously
18 you'll be aware that Mr Birkett sustained a brain
19 injury.

20 **A.** Mm.

21 **Q.** Did you or the Trust, those attending, seek any guidance
22 or advice about how to best engage and make reasonable
23 adjustments in that meeting for someone who has
24 sustained such an injury, and the communication style?

25 **A.** I don't think that we took specific advice, no, but we
101

1 to your reflections, it's at paragraph 596, so that's
2 page 154, please.

3 Okay I so that's 596, you say:

4 "Engaging with families even when an individual
5 withholds consent for sharing, certain aspects of care
6 is so important and I have to reflect in the latter
7 stages of our care for VC, we did not do that as well as
8 we could have done."

9 Can I just briefly ask you, then, about some of the
10 findings that underlay that statement from you? So if
11 we could just go to the Trust's internal investigation,
12 that's NHFT0000452, and it's page 22, please. Thank
13 you.

14 So that's paragraph 67 that I want to ask you about.
15 I won't read it all out, but if we just look at the last
16 line, please:

17 "In the panel's view it would have been appropriate
18 to inform the family of VC's discharge, and to advise
19 them on how to access services should they have concerns
20 in the future."

21 So some practical suggestions being raised there
22 about giving advice on accessing services; is that fair?

23 Sorry, nodding doesn't pick up on the --

24 **A.** Sorry, no, I've not heard your question -- no, I --

25 **Q.** Practical advice should have been given to VC's family
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1 were aware of that before we attended.

2 **MS CARTWRIGHT:** Thank you.

3 **THE WITNESS:** Thank you.

4 **THE CHAIR:** Thank you. Yes, Ms Heaven?

5 **Questioned by MS HEAVEN**

6 **MS HEAVEN:** Good afternoon, Mr Majid.

7 **A.** Good afternoon.

8 **Q.** I ask questions on behalf of VC's family. Can I just
9 start by asking you about information sharing with VC's
10 family. So if we could just have your witness statement
11 up, please, it's page 151. Okay, so it's paragraph 586,
12 please, and this is where you're dealing with the
13 Theemis investigation.

14 So:

15 "The findings contained within the Theemis Report
16 were similar to those findings detailed above in the
17 preceding internal and external investigations that had
18 been conducted ... This included errors, gaps and missed
19 opportunities in relation to the approach taken to the
20 assessment of risk, shared decision-making across teams
21 at the Trust, communication with VC's family ..."

22 I think you accepted publicly those findings, didn't
23 you --

24 **A.** Yes.

25 **Q.** -- on behalf of the Trust? Can we just go down, please,
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1 on how to access services in the future?

2 **A.** Absolutely. Yes.

3 **Q.** Can we just move forward, then, to page 35 of this
4 report, and it's learning point eight. So you see that,
5 learning point eight, three bullets down:

6 "Ensure discharge processes are collaborative in
7 nature, with detailed risk formulation and future crisis
8 plans shared with the recipient of the discharge, as
9 well as the service user."

10 So indicating there, that there should be a crisis
11 plan, certainly I think in VC's case in September 2022,
12 and there needed to be some collaboration with VC's
13 family around this; is that fair?

14 **A.** Absolutely right. I've accepted these findings in
15 public.

16 **Q.** Can I ask you, then, about how this is articulated
17 a little bit differently in the Theemis Report. That's
18 NHFT0000530, and it's page 28. Thank you. So it's area
19 for improvement 5, family engagement. I'll just read it
20 at:

21 "We found that whilst there were attempts to
22 actively engage VC's family in aspects of his care,
23 there were important milestones when decisions were not
24 discussed with them. We also found that there were
25 opportunities to co-produce aspects of care planning
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1 with VC and his family, particularly around safety and
2 scenario planning."

3 If, for completeness, we could just go to page 32
4 because it's picked up again there in a slightly
5 different context.

6 So that's area for improvement 11. If we see the
7 last line there under that first paragraph:

8 "We did not find evidence that safety planning or
9 scenario planning took place to help support VC and his
10 family."

11 So pausing there, Theemis makes clear that not only
12 should planning have been co-produced, so collaborative,
13 in other words; is that right?

14 **A.** It does, yes.

15 **Q.** It should have included a discussion with VC's family to
16 understand their views and their understanding being
17 taken into account before any plan was agreed; is that
18 fair?

19 **A.** I don't dispute any of the findings that we've spoken
20 about in terms of this discharge.

21 **Q.** Now, safety or scenario planning, can I just explore
22 what that means in practice? So that's the Theemis
23 recommendation.

24 Does it include ensuring the family knows and
25 understands a patient's diagnosis?

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1 GP?

2 **A.** Certainly that is -- that is best practice. That's why
3 it's important to have, and why, in our new discharge
4 policy, you have to have those conversations with
5 family, with GP, with other people who are involved in
6 the care of the individual.

7 **Q.** Particularly important for patients diagnosed with
8 a serious and enduring mental illness like paranoid
9 schizophrenia, to have a crisis management plan?

10 **A.** Absolutely right yes.

11 **Q.** Okay. Now, just to understand why that didn't happen in
12 VC's case, if we could just go back to your witness
13 statement, please, paragraph 556. That's page 134,
14 please. That's page 134. Thank you. So your
15 paragraph 566. You say here, and just to situate you,
16 the heading above is "Engagement with families", that's
17 what you're dealing with here. You say:

18 "There are a number of reports both historically and
19 currently that are received by the Board that identify
20 issues with Families and carers particularly about the
21 fact that they are not engaged in care."

22 So are you referring here to reports before the
23 board pre-dating June 2023?

24 **A.** I believe so.

25 **Q.** Okay. Can I move on, then, to what the CQC in their

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1 **A.** Yes.

2 **Q.** Does it include things like identifying and exploring
3 with the family a patient's relapse indicators or early
4 warning signs that a patient is becoming unwell?

5 **A.** That, I think you're describing as psychosocial
6 education and that is important, yes.

7 **Q.** Describing the crisis management plan; yes?

8 **A.** Yes.

9 **Q.** Does it include clearly explaining a patient's risk to
10 a family and discussing how to spot when risk to self or
11 others may be increasing?

12 **A.** It certainly includes having a dialogue and a discussion
13 about those things, yes.

14 **Q.** So that they understand risk?

15 **A.** Yes.

16 **Q.** Yes. Does it include setting out what the family should
17 do if a patient is unwell or relapsing, including what
18 services a family can access? So practical steps like
19 who do you phone and in what order?

20 **A.** Yes, completely. That's a rapid access plan, yes.

21 **Q.** Is there anything else that it should include, crisis
22 management plan?

23 **A.** I think you've captured the core things.

24 **Q.** Okay. It should all be clearly written down, shouldn't
25 it, and given to the family and other services like the

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1 part two review said on a similar topic. So that's
2 CQCM0016518, please, and it's page 6. Thank you very
3 much.

4 Fourth bullet point down, do you see that there:

5 "We also identified issues of families feeling
6 excluded, not listened to or that staff weren't
7 communicating effectively in our wider review of care at
8 NHFT."

9 That's the CQC Review. So just pausing there, is it
10 fair to say that the failures of communication with VC's
11 family were not one-offs, they were part of a broader
12 systemic failure in how the Trust was communicating with
13 families and carers and that that had been
14 a longstanding problem by the time of June 2023?

15 **A.** That's what the various reports certainly show. That's
16 what the thematic homicide -- attempted homicide and
17 homicide review showed up, yes.

18 **MS HEAVEN:** Yes, thank you.

19 Chair, there's just one more topic, it's very short,
20 just one more minute, if I may.

21 **THE CHAIR:** Yes, one minute.

22 **MS HEAVEN:** Julie Attfield, who is going to be giving
23 evidence shortly, I think you know who she is, she talks
24 about in 2021 to 2022, patient feedback and safety
25 reports raised concerns about family involvement and it

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1 was a Trust quality priority and there was improvement
 2 programme recruiting carer peer supporters including in
 3 the community. And she explains that that role was
 4 about working with families to give them support and
 5 help them navigate the system, practical advice, and
 6 particularly at key points of discharge. Okay?

7 Can you assist? Between 2020 and 2023, were there
 8 actually any carer support workers employed by the Trust
 9 to work with families of patients with serious and
 10 enduring mental illness?

11 **A.** I don't know about the time before I became chief exec,
 12 I'm sorry.

13 **Q.** Well, did they come in when -- (*overspeaking*) --

14 **A.** We've done significant work more recently, in terms of
 15 looking at different ways of engaging carers, we've
 16 invested in development and training around families.

17 **MS HEAVEN:** Okay. Thank you very much.

18 Thank you, Chair.

19 **THE CHAIR:** Thank you.

20 Mr Beer.

21 **Questioned by MR BEER**

22 **MR BEER:** Just three short topics, Mr Majid.

23 Firstly, you were asked about the document prepared
 24 by the Inquiry --

25 **A.** Yes.

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1 April 2023, that highlighted those four matters?

2 **A.** Well, they would have come -- these four matters would
 3 have come out of the concise investigation, and if that
 4 was completed in June 2023 then that would have been the
 5 case.

6 **Q.** In any event, was there any recommendation for a general
 7 review of the risk of violence posed by all patients
 8 including those recently discharged from services?

9 **A.** Not in the concise investigation.

10 **Q.** Or at all?

11 **A.** Or at all.

12 **Q.** Thank you. And the second topic, please, is in relation
 13 to the question of whether there ought to have been
 14 an investigation into why VC was not detained on the
 15 first occasion that he came into contact with Trust
 16 services on 24 May 2020. You remember --

17 **A.** Yes.

18 **Q.** -- a decision was made not to detain him?

19 **A.** Yes.

20 **Q.** And then very shortly afterwards an incident occurred --

21 **A.** Yes.

22 **Q.** -- in which a member of the public sustained serious
 23 injury.

24 Was that, ie, the first and the second incident,
 25 included in the investigation undertaken by the Trust,

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1 **Q.** -- in relation to six other cases; do you remember?

2 **A.** (*No audible answer*).

3 **Q.** You were asked by Ms Langdale that if at April 2023
 4 there was a case for reviewing the risk of violence from
 5 patients including those discharged in the last few
 6 months before April 2023; do you remember?

7 **A.** Yes, I remember the conversation, yes.

8 **Q.** You were referred, in this connection, to the case of
 9 what is described as Patient 3. Can we look at that,
 10 please, INQY0000034. And at page 7, please. You were
 11 taken, I think, to paragraph 24 and you'll see from that
 12 that the incident resulting in a charge of either
 13 causing or inflicting grievous bodily harm was discussed
 14 on 18 April 2023.

15 **A.** Yes.

16 **Q.** So I think where the date of April has been taken from.
 17 Can we also look, however, at paragraphs 25 and 27,
 18 slightly further down the page. The concise
 19 investigation was completed in June 2023, ie two months
 20 later, yes?

21 **A.** Yes.

22 **Q.** And that concise investigation found the four things
 23 listed in a, b, and if we went over the page we'd find c
 24 and d.

25 So was it the case that it was in June 2023, not

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1 the level 2 investigation?

2 **A.** Yes.

3 **Q.** Were those two incidents of contact with the Trust
 4 included in the Theemis review?

5 **A.** Yes.

6 **Q.** Undertaken on behalf of the NHS England?

7 **A.** Yes.

8 **Q.** Were those two incidents of contact with the Trust
 9 included in the CQC Section 48 Review?

10 **A.** Yes.

11 **Q.** Thank you. And then lastly, the question of access to
 12 agency staff -- of agency staff to RiO on the ward. You
 13 said that you didn't know the position one way or the
 14 other.

15 **A.** That's correct.

16 **Q.** And Ms Cartwright suggested to you that it was
 17 remarkable that no action had been taken by the Trust in
 18 that regard. If it is the case that in fact agency
 19 staff do have such access to RiO on the ward, would you
 20 agree this turns into a question of you not knowing that
 21 one way or the other?

22 **A.** Can you say that again?

23 **THE CHAIR:** I think I've got your point, Mr -- it's not
 24 a question of whether he knows it or not, it's
 25 a question of whether it was it case.

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1 **MR BEER:** Yes. I just want to ask two points on that. How
2 many staff do the Trust employ?

3 **A.** 11,500 staff.

4 **Q.** And do you know the working practices of them all?

5 **A.** No.

6 **Q.** How many patient contacts a year does the Trust have?

7 **A.** 2.5 million patient contacts a year.

8 **MR BEER:** Thank you very much.

9 **THE CHAIR:** Thank you.

10 **Questioned by THE CHAIR**

11 **THE CHAIR:** Yes, just picking up that point, partly that
12 Mr Beer has raised, you also had relationships with the
13 out-of-area hospitals, and the Priory Arnold. You had
14 a contract with them. We've seen that it's been very
15 difficult to get separate notes from those institutions
16 even though they were dealing with the effectively your
17 patients.

18 **A.** Yes.

19 **THE CHAIR:** Was there no arrangement which would allow all
20 of those notes to be passed on from one institution to
21 another, because you can see that there are difficulties
22 in continuity of care?

23 **A.** Absolutely, and it's my understanding that there is a --
24 or there was a -- is and was an information-sharing
25 agreement in place with the Priory hospitals that would,

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1 **THE CHAIR:** It would take time for that to happen, wouldn't
2 it --

3 **A.** It certainly --

4 **THE CHAIR:** -- at each stage?

5 **A.** It does take time, but I think what we've not had
6 previously in our organisation is something that defines
7 what you expect people to do at each of the phases, and
8 we couldn't have that, because we didn't have clarity
9 with the care group structure that I was talking about
10 or the accountability structure that I was talking about
11 and, in order to bring about the changes, you have to
12 have all of those three things working with the same
13 levels.

14 So actually, when you understand -- colleagues in
15 our organisation understand, now, the concept of care
16 group, therefore, when they see on this diagram "Care
17 Group", and "This is what should happen here", they will
18 understand that, because it's terminology that is now
19 familiar to them and built into their way of working.

20 It does look dreadfully complicated, I accept that.

21 **THE CHAIR:** -- (*overspeaking*) -- doesn't it?

22 **A.** I accept that.

23 **THE CHAIR:** Yes. But in terms of actually moving things
24 quickly and making sure that risks are escalated in
25 a way which is timely, and deals with them when they

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1 at an organisational level, conformed with the
2 Continuity of Care Agreements which would give us access
3 to their records -- a read only, not entering on them --
4 and the same the other way around.

5 I think more the issue is about how that was
6 deployed and acted upon, which talks to the points I was
7 raising earlier about it's not necessarily the
8 information-sharing agreement; it's how it's worked on
9 the ground that's important.

10 **THE CHAIR:** But it is in fact, for management, if you like,
11 at whatever level of governance, to ensure that it all
12 works, doesn't it?

13 **A.** I agree. Absolutely. It is.

14 **THE CHAIR:** Just in relation to that, I'm rather intrigued
15 by the Risk Management Guidance and the Escalation
16 Framework.

17 If we can just get that up for a minute, that's
18 WITN0263041, page 001. It's the table. This, when it
19 comes up -- I'm sure you're familiar with it.

20 **A.** I'm familiar with it. I'm happy to take a question.

21 **THE CHAIR:** So there's a great -- a selection of narrative
22 afterwards which goes on for about three pages, but just
23 looking at it, it's immensely complicated, isn't it?

24 **A.** I think, looking at it, it is, Chair. I would agree, it
25 looks --

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1 need to be dealt with, this is a complex structure,
2 isn't it?

3 **A.** It's a complex structure, and I think risk management in
4 an organisation like ours, the size we were just talking
5 about, it is a complex matter. And this -- I think this
6 makes it clearer than processes that had been in place
7 previously.

8 **THE CHAIR:** I see. Just finally, you said that you didn't
9 want to start investigating the incidents which are set
10 out in the Inquiry legal documents, the other cases,
11 because of ongoing police investigations. Were you
12 intending to wait until the court proceedings were
13 complete, or not?

14 **A.** I think what I was trying to describe is that, in older
15 cases, the police previously would have had
16 a conversation with us and asked us not to carry out our
17 investigations. And so therefore, that's why we needed
18 to set up some different ways of liaising and
19 communicating with the police, to find ways of not
20 having to wait, because that's not right, to wait that
21 long. For us to learn lessons and for individuals to
22 get answers to what's happened, that can't happen.

23 So if I gave an impression that I'm in support of
24 delaying, absolutely not.

25 **THE CHAIR:** Well, it wasn't necessarily in support of

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1 delaying; it's just the fact that if you wait for the
 2 police investigation and/or the court proceedings that
 3 might follow, it could take years, couldn't it?
 4 **A.** As it has done previously on occasions, yes, that's
 5 right.
 6 **THE CHAIR:** In the meantime, those risks remain within the
 7 organisation?
 8 **A.** They do. They do. That's why it's -- now, the process
 9 has changed so that we're able to investigate straight
 10 away.
 11 **THE CHAIR:** Yes, thank you.
 12 Right. Well, we'll finish there and we'll start
 13 again tomorrow at 10.00. Thank you.
 14 **(4.29 pm)**
 15 **(The hearing adjourned until 10.00 am the following day)**
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