

Tuesday, 19 May 2026

1
 2 (10.00 am)
 3 **MS KAUR:** I call Dean Fathers.
 4 **THE CHAIR:** Yes, thank you.
 5 **DEAN FATHERS (sworn)**
 6 **Questioned by MS KAUR**
 7 **THE CHAIR:** Yes.
 8 **MS KAUR:** Mr Fathers, I understand you want to say a few
 9 words at the outset of your evidence.
 10 **THE WITNESS:** If I could offer my sincere condolences and
 11 sympathy to the family and the survivors, and the
 12 victims of this incident. My heartfelt sympathy goes to
 13 you for this, all the events that occurred to you, so
 14 the people of Nottingham are with you.
 15 **MS KAUR:** Mr Fathers, you have compiled a statement for this
 16 Inquiry; the statement is dated 6 February 2026. Can
 17 you confirm that that statement is true to the best of
 18 your knowledge and belief?
 19 **A.** It is.
 20 **Q.** Mr Fathers, you were the former Non-Chief Executive
 21 Chair of Nottinghamshire --
 22 **A.** No, I was the Chair -- Non-Executive independent Chair
 23 of Nottinghamshire Healthcare. It's very different to
 24 a Chief Executive.
 25 **Q.** Sorry, I just -- Non-Executive Chair of Nottinghamshire

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1 ensure that that happened?
 2 **A.** So there are robust governance systems in place. So the
 3 Board operates essentially on a unitary basis. So there
 4 are a number of non-executives who sit around the Board
 5 who are requisite to be competent, capable people, to do
 6 their work. They typically exercise scrutiny of how the
 7 executives before their function through committees, and
 8 the executives operate underneath that scrutiny with the
 9 responsibility for controlling all of their resources.
 10 **Q.** Just practically, how do you say you held the executives
 11 on the Board to account?
 12 **A.** So I personally would do the appraisal for the Chief
 13 Executive on a biannual basis, and the Chief Executive
 14 would then do the appraisals for each of the executives,
 15 but because I chaired the remuneration And Nomination
 16 Committee, the Chief Exec would then present how
 17 effective each of those individuals was to that
 18 committee and the non-executives and I would then hear
 19 that appraisal and make a judgement as to how well those
 20 individuals were performing.

21 Then, through the committee structures, we would
 22 hold them to account for the way they were delivering
 23 their performance, and we would do scrutiny at those
 24 committees, and bring reports up to the Board, which
 25 were then part of the Integrated Performance Report that

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1 Healthcare Trust --
 2 **A.** Yes.
 3 **Q.** -- is that correct? And you were in that position from
 4 January 2000 to December 2019.
 5 **A.** I was.
 6 **Q.** As the Chair of the Board, what did you see your duties
 7 as being?
 8 **A.** So I have the responsibility for ensuring, as it says in
 9 the pack, that the Board is well governed, that the
 10 purpose for the organisation is well understood, that
 11 the processes that the Board operate are in place and
 12 robust, that the executive have the right people in the
 13 right -- with the right skills to do their job, and that
 14 the performance of the Trust is being managed
 15 effectively through them.
 16 **Q.** Would it be fair to say that, in effect, you are leading
 17 the Board?
 18 **A.** I am leading the Board and also it's important to note
 19 that it was a Foundation Trust, so I was also
 20 responsible for the Council of Governors but reported
 21 into the Lead Governor.
 22 **Q.** As I understand it, you steered the Trust through the
 23 process of becoming a Foundation Trust; is that correct?
 24 **A.** I did.
 25 **Q.** In terms of holding your CEO to account, how did you

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1 was presented by the Chief Exec and the executives to
 2 each of the Board meetings.
 3 **Q.** So executives and Chief Executive would, for example,
 4 present various papers, various reports to you, to
 5 provide you with assurance about various changes in --
 6 being undertaken in the Trust?
 7 **A.** So they would have gone to a committee first. So the
 8 committees do the scrutiny and they do all the deep
 9 questioning within the committees. And what we would do
 10 is, as non-executives, meet regularly to make sure that
 11 we understood what the issues were that each of us were
 12 individually dealing with, and I would facilitate that
 13 conversation on a quarterly basis, so that the
 14 non-executives could triangulate what they were hearing
 15 in their respective committees.
 16 **Q.** How did you, as Chair of the Board, reassure yourself
 17 that the different parts of the Board were working
 18 properly?
 19 **A.** So there would be a regular review of the Board on a --
 20 after the Foundation Trust was created, we would, every
 21 three years, do a full independent governance review and
 22 then every year in between that, as part of our
 23 requirement of reporting, the Company Trust Secretary
 24 would do a review of our governance processes and
 25 present to the Board the findings of that review, and

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1 that would then go into our annual plan.

2 **Q.** In terms of, you said, every three years, a governance
3 review would be undertaken?

4 **A.** An independent governance review --

5 **Q.** Independent. And is that why, in 2017, PwC were tasked
6 to undertake a review?

7 **A.** It was.

8 **Q.** What were the results of that review that was
9 undertaken, in a nutshell?

10 **A.** So the top line, the headline, was that the Trust was
11 rated or the Board was rated as being one of the best in
12 the country, and that we were performing all our
13 functions well, but with one concern: that the Board
14 needed to make sure that we had, because of the layers
15 within the organisation, a clarification that risk was
16 actually at board level being discussed and aligned to
17 the risks that were being discussed at the ward level as
18 well.

19 **Q.** As a consequence of that feedback, the concerns around
20 risk, how did you assure yourself that the Board had
21 sufficient oversight of what was happening at ward
22 level?

23 **A.** So what we would do at a governance level is first of
24 all take that feedback into the Trust Secretary and the
25 Trust Secretary took the action to make sure that our

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1 time as Chair of the Board?

2 **A.** Part of my time. It doesn't include the Council of
3 Governors though and again the Council of Governors, who
4 had an oversight committee, and were also actively
5 involved in place-based visits and the Council of
6 Governors would also observe the way that the Board was
7 operating and would also attend committee meetings and
8 give feedback on how well we were doing.

9 **Q.** So the Council of Governors, how often would you have
10 contact with them?

11 **A.** So I would have a weekly attendance with the -- sorry,
12 not weekly, a monthly meeting with the Lead Governor and
13 that was usually with my Vice Chair as well, and was
14 usually with the Trust Secretary too.

15 **Q.** In terms of visits to wards, as the Chair, can I be
16 clear how often you visited the wards?

17 **A.** So if you look at my reports, I would detail when I was
18 visiting, so it would vary from month to month, but
19 invariably there was a ward visit at least every month.

20 **Q.** If we go to the document on the screen, we can see there
21 Dr John Brewin, Chief Executive. He joined the Trust in
22 January 2019; is that right?

23 **A.** He did, yes.

24 **Q.** During your term as Chair, so you were there 2011 to --
25 December 2019 --

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1 systems were robust and effective, and the consequence
2 of that, there was an action plan put into place.

3 What I would then do is make sure I would annually
4 visit each of the Board committees, observe how they
5 were working and make sure that I felt that they were
6 doing the level of in-depth scrutiny that was required
7 and then would give that feedback instantly to the Chair
8 of that committee, but would also wrap that into their
9 biannual appraisals should it need further development.

10 **Q.** So if we go to --

11 **A.** Sorry, the other bit of that is: and of course we would
12 triangulate by going to the wards.

13 **Q.** So you met with the Board committees once a year?

14 **A.** No, I would physically observe. So I wasn't allowed to
15 be a member of any of the committees other than the
16 Remuneration and Nomination Committee. So I would be
17 invited to observe once a year, for the purpose of
18 observing their capability, to see whether the dynamic
19 of the committee was working well, to see whether the
20 Chair was working effectively, and to make sure that
21 what they were talking about was what was strategically
22 important, but also, what was relevant to the people
23 within the system.

24 **Q.** If we go to document WITN0380006, so that is the
25 Management and Leadership Structure during part of your

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1 **A.** I was.

2 **Q.** -- there were three CEOs during your tenure.

3 **A.** There was Mike Cooke, who was there before I joined,
4 there was Ruth Hawkins. There was then a temporary
5 interim CEO, because we were not able to appoint John.
6 John is, being medical, allowed to have a medical pay
7 grade as a Chief Executive, and the consequence of that
8 was John's pay grade was above the Prime Minister's pay,
9 and the consequence of that is we needed to get Cabinet
10 Office approval for his appointment, which consequently
11 meant that John's appointment, from my memory, was three
12 to six months delayed in happening. And so consequently
13 we had to have an Interim Chief Executive for a few
14 months.

15 **Q.** The Interim Chief Executive, Julie Attfield, and she was
16 in place from September 2018 to December 2018.

17 **A.** That is correct.

18 **Q.** John Brewin was your fourth Chief CEO.

19 **A.** Yes.

20 **Q.** Is that an excessive number of CEOs or about average?

21 **A.** I think at the time chief executives in the NHS were
22 lasting roughly about 18 months. There were some chief
23 executives who were lasting much longer. Mike had been
24 there for seven years. Ruth would have been there for
25 longer, (... redacted ...).

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- 1 Q. What did you do to ensure that there were good handovers
2 between the various chief executives?
- 3 A. So Julie was there for the duration, so she was well
4 briefed, well sighted, knew what was going on. When
5 John came in, John and Julie worked together
6 historically in Lincoln, they have a very strong
7 relationship, and work well together. So part of the
8 briefing that was handing over was directly through
9 Julie, but I would meet with John periodically whilst he
10 was waiting to come on board so he was sighted about
11 what was going on.
- 12 Q. So Julie, John Brewin, had worked in Lincolnshire and
13 Devlin, who replaced you in January 2020, had also
14 worked in --
- 15 A. Yes.
- 16 Q. -- Lincolnshire. Was there any concern about people who
17 had worked together in one NHS Trust, joining another
18 and perhaps not bringing sufficient scrutiny or new
19 approaches to their roles?
- 20 A. So I wasn't included in the Chair selection process
21 because clearly that's not good practice, but I know
22 there was debate at the Council of Governors around
23 whether it was an appropriate practice for them to
24 accept Paul as my replacement. I wasn't party to any of
25 those conversations.

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- 1 So technically he started in January, but he was
2 inducted before that time.
- 3 Q. What about the position of your replacement holding two
4 Chair positions; did you have any views on that?
- 5 A. I would point out the fact that there are 33 Chairs in
6 the NHS currently that have two or more Chair positions.
7 So it is a common practice.
- 8 Q. Across two NHS Trusts?
- 9 A. Across separate Trusts.
- 10 Q. If we go to WITN0390001, page 9 of that document --
11 sorry, if we can go to paragraph 35, which is the next
12 page. And we can see there this is, just to put this
13 document into context, Mr Devlin talks about a "period
14 of 'joint running' was explicitly tested at interview by
15 NHFT's Council of Governors, NHS England, and the Chair
16 of another Trust who acted as an independent advisor."
17 So his joint running of two Trusts across the Board,
18 there was satisfaction that that process could work.
- 19 A. There was, but -- I mean, I've not seen this before, but
20 I notice that he's used the word "criticism of my
21 predecessor" in the CQC Report. That wasn't
22 a criticism; it was an observation. And the observation
23 was actually taken from my interview at the CQC process,
24 where I was asked what keeps me awake at night, it's
25 a common CQC, and my comment was: at the time I have

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- 1 Q. And Julie Attfield, did she continue with her other role
2 within NHFT, when she was CEO?
- 3 A. No, she -- there was a whole chain of substitutes came
4 on through, and people acted up into those roles for
5 about three months.
- 6 Q. What we know is that when John Devlin started in
7 January 2020 --
- 8 A. John Brewin, do you mean?
- 9 Q. Sorry, when Brewin started -- no, sorry. I do mean
10 Devlin. So Devlin --
- 11 A. Paul Devlin.
- 12 Q. -- replaced you?
- 13 A. Yes.
- 14 Q. Paul Devlin. And he was still Chair in Lincolnshire,
15 wasn't he? So he was splitting his time between
16 Lincolnshire and Nottinghamshire. Were you aware that
17 that was going to be the situation?
- 18 A. So Paul was selected and was invited to come and shadow
19 the organisation before he joined. So I needed to make
20 sure that he was sighted on all of the matters that were
21 relevant and so he actively engaged in the Trust early,
22 to the effect that when I actually left on the
23 16th December, he was also at the Leadership Forum event
24 that I said goodbye to everybody, and that was the
25 formal handover.

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- 1 a new Chief Executive who is literally new to the
2 organisation, and I am being asked to work across two
3 STPs which has the consequence of me no longer being
4 responsible purely for my Trust but actually operating
5 for the governance of a system which is potentially
6 conflicting of my position here as Chair.
- 7 And so that dilution was the fact that I was working
8 within the system. It was not a criticism; it was my
9 observation.
- 10 Q. Can I take you to CQC NHFT0002015, internal page 5. As
11 Chair of the Trust, how many days were you expected to
12 work?
- 13 A. So the -- as Chair of the Trust, it was up to three and
14 a half days per week and up to ten days per month. And
15 the consequence of that was if you actually look at the
16 number of days I was working, it was far in excess of
17 that time requirement.
- 18 Q. Because a criticism made, if we turn to ... there was
19 criticism in the report ...
- 20 **THE CHAIR:** You can come back to it --
- 21 **MS KAUR:** Sorry, page 5.
- 22 So page 5 of that report, towards the bottom:
23 "What we found
24 "[The overall] rating of the trust went down. We
25 rated it as requires improvement because:

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1 "The executive team lacked confidence in carrying
2 out actions in between one chief executive retiring and
3 another commencing. The chair was on various boards
4 outside of the trust. The impact of this resulted in
5 some loss of leadership focus and action within the
6 trust."

7 Do you think that that was fair criticism by the
8 CQC?

9 **A.** I don't think that was criticism of me personally, and
10 I'm a non-executive, I'm not an executive. If my role
11 is that critical to momentum at an executive level, then
12 that's not my job.

13 So the criticism, if there is -- and I don't think
14 it's necessarily -- I think it's an observation of
15 fact -- we had a new Chief Exec, a new Chief Exec needs
16 to come on in, get established, the inspection started
17 literally within a month or two months of him arriving,
18 and the consequence of that was the Chief Exec needed
19 time to embed, get to know his team, get to know what
20 was going on, make assessments of what he wanted to do
21 in the future. I don't think that is a criticism. It's
22 an observation.

23 **Q.** So where it says:

24 "The Chair was on various boards outside of the
25 trust."

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1 livelihood elsewhere.

2 So how I maintained my livelihood was I also on the
3 Board of the PHSO, which was hugely valuable in terms of
4 the way it enabled me to understand the complaints
5 system and the complexity of how people in our services
6 were able to get improvements into the system through
7 the complaints process. I was also on the -- I wasn't
8 actually on the Board of the University, but I chaired
9 a research centre for the University of Lincoln which
10 was, again, very relevant to the Trust, because the
11 consequence of that was that I was able to understand
12 what good practice was around organisational resilience
13 and how we could get the most out of the workforce, and
14 the University also asked me if I would be on the Local
15 Enterprise Partnership, and the consequence of that
16 within the two days that they paid me each month, I was
17 able to help the Local Enterprise Partnership in the
18 Lincolnshire area to get to invest in things like the
19 new medical school, which was important to us because we
20 were desperately under-doctored at that stage and we
21 were trying to get new doctors into the system.

22 And the only other thing -- so that was basically
23 four days a month of my time. The only other thing
24 I did was I joined the Regulation Board of the Academy
25 for Healthcare Science. Now the Regulation Board is not

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1 That is a reference to you, isn't it, Mr Fathers?

2 **A.** So the evidence as it is, is that those boards were all
3 associated with my role as Chair of the Trust. So I was
4 on the board of NHS Providers, which I was nominated by
5 the previous Chief Exec to go on that to represent the
6 Trust to make sure that we were able to understand what
7 future policy was so that we could actually be proactive
8 in the way that we were leading the organisation, as we
9 had done for the eight years previously.

10 So prior to that, I'd been on the board of the
11 Mental Health Network. This wasn't a new thing. This
12 is something I had had to do for eight years, and it had
13 never impacted negatively on the Trust in any way, shape
14 or form.

15 What was new was the STPs' requirement for me to
16 actually attend their board meetings. So that was the
17 observation that I was making to the CQC when they made
18 that note.

19 **Q.** What other boards were you on, Mr Fathers?

20 **A.** So outside of the Trust, working on the principle as an
21 independent director, I have to not be beholden on my
22 salary within the NHS for my only livelihood because
23 that puts me into jeopardy of being able to make
24 critical judgement and, if need be, resign on principle,
25 if I found bad practice. I had to actually maintain a

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1 a board, it's a subcommittee of the Board, and that
2 subcommittee met four times a year. So that's not time
3 consuming.

4 **Q.** When the CQC opine that in their view, the various --
5 the Chair was being on various boards, this resulted in
6 some loss of leadership focus and action within the
7 Trust; do you accept that?

8 **A.** I don't accept that was a criticism of me.

9 **Q.** So who do you think that was a criticism of?

10 **A.** I think that was a situation at that moment in time
11 because we had literally just transitioned from
12 a full-time Chief Exec through an interim to another
13 full-time Chief Exec and that was a temporary
14 aberration.

15 **Q.** You are the leader of the Board, aren't you?

16 **A.** Of the Board.

17 **Q.** You do not think that is a criticism of you?

18 **A.** I think at that time I didn't do anything which
19 prevented the Board from being well led.

20 **Q.** So you didn't consider, did you give any thought, on
21 receiving this report from the CQC, of perhaps stepping
22 back on the other responsibilities that you had?

23 **A.** So I couldn't walk away from the STPs and I couldn't
24 walk away from the other things that I was doing to
25 represent the Board. When I sat with John, part of his

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1 induction, we did a "Your job, my job, our job"
 2 conversation, and if you actually look at that, John was
 3 very clear that he wanted me to continue with all of the
 4 actions where I was representing the Board on various
 5 NHS bodies because that was giving us insight and
 6 foresight that would enable us to continue to go
 7 forward.

8 The other thing that kind of I think I'd like to
 9 kind of pick up upon is the fact that if you actually --
 10 I don't know what page it is, but in that CQC Report
 11 that was shown yesterday, the actual colour matrix, if
 12 I could put that one up.

13 **Q.** Well, we'll come to that. You were listening to the
 14 evidence yesterday of Mr Brewin, and there was some
 15 criticism, if you recall, about internal processes, that
 16 there was bureaucracy impeding progress. Do you accept
 17 any of that criticism, given you were the leader of the
 18 Board?

19 **A.** So none of that bureaucracy was created through us. I'm
 20 not certain I understand what his comments referring to,
 21 but we were compliant against all of the systems,
 22 procedures and regulations as best we could that were
 23 being exercised over us by our various stakeholders.

24 **Q.** If I could turn to WITN0390020, this is an email, notes
 25 attached to an email, just for context, that Mr Devlin

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1 suggested that board culture had historically not been
 2 as strong as a unitary board?

3 **A.** I don't know where he's taking that evidence from.

4 **Q.** Do you think that that is a criticism of your time as
 5 chair?

6 **A.** It would appear that it is a criticism of my time as
 7 chair, but I don't accept that it's an accurate record.

8 **Q.** During your time as chair, you also led significant
 9 changes in adult mental health, didn't you?

10 **A.** Okay.

11 **Q.** I want to take you to page 61 of your statement, which
 12 is WITN0410001. There is a reference there to a focus
 13 in moving aspects of the adult mental health service
 14 into low-cost community support to decrease the number
 15 of expensive beds. And you referred to this meaning
 16 that the investment between the services needed to be
 17 coordinated, because if one service reduced, for
 18 example, bed stock, other services such as community
 19 investment would need to be increased.

20 Can you just take us through the thinking behind
 21 moving mental health services into the community?

22 **A.** So this was the missives coming from the centre at the
 23 time, so as John said yesterday, there was a large
 24 reduction in the a number of beds over the period of
 25 time. The Mental Health Act requires us to think about

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1 sent to Mr Brewin?

2 **A.** Yes.

3 **Q.** I just want you to look at item 1. These are notes he
 4 has made re the Board papers and this is in respect to
 5 the Chair's report. He comments there:

6 "will be different! Needs to focus on issues, not
 7 pontifications."

8 Do you think, during your time as Chair of the Board
 9 that there was perhaps a lack of focus and pontification
 10 on your part as leader?

11 **A.** I think we have lots of evidence that for the duration
 12 of my period up until 2018 that we were regarded
 13 extremely well for the way that we were governed, and
 14 even when I left in the end of 2019, we were still under
 15 the National Oversight Framework, a level 2 trust, which
 16 meant that we were in the top 30% of trusts nationally.

17 **Q.** If we go to WITN0390001, paragraph 37, this is Mr Devlin
 18 commenting on board culture.

19 We see there that he concluded:

20 "... the board culture had historically not been as
 21 strong a 'unitary Board' as it should have been, and ...
 22 this was something the Chief Executive, John Brewin, was
 23 keen to improve, alongside other cultural changes he was
 24 already leading."

25 What observations do you have in respect of it being

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1 what is in the best interests of those people that we
 2 are serving, and as a consequence, the missives at the
 3 time would suggest that they needed to be supported at a
 4 place in their community as opposed to be put into
 5 a ward. And therefore, we were adopting national policy
 6 in that particular regards.

7 **Q.** That was the Five-Year Forward View for Mental Health?

8 **A.** It was.

9 **Q.** That was a policy, I think, published in February 2016.

10 **A.** It was.

11 **Q.** What did you do to reassure yourself as to the model
 12 that would work in your locality?

13 **A.** So we actually engaged the support of an external
 14 organisation, Cheshire and Wirral Partnership, who were
 15 deemed to be the benchmark role model for us to copy,
 16 and as a consequence of that, they came in and helped to
 17 shape what we were trying to do.

18 What we also did, going back to the conversation we
 19 started off with, is we engaged with our partners. So
 20 we had a lot of conversations with our commissioners
 21 around what it is that we were trying to do and we also
 22 engaged with other partners such as NHS Improvement to
 23 make sure that that was all being done in an appropriate
 24 way.

25 **Q.** What about at ward level? What was the Board doing to

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1 ensure that views at ward level were being listened to?
 2 **A.** That I don't know.
 3 **Q.** Why don't you know?
 4 **A.** That would have been an executive function, and I'm not
 5 sighted on what they were actually doing at the time.
 6 It's a long time ago.
 7 **Q.** But should you not have been asking: well, what do
 8 nurses, psychiatrists, working on the Board, what do
 9 they think about these changes?
 10 **A.** So I would be on the wards myself and seeing and
 11 listening to their views, but as an executive, what
 12 I was wanting to try to -- sorry, well as
 13 a Non-Executive, what I was wanting to do was to make
 14 sure that those processes were being scrutinised through
 15 the committee systems. So all of those processes would
 16 have been going through the Quality Committee, the
 17 Workforce Committee and so on.
 18 What we did do, however, is regularly invite to the
 19 beginning of all of our Boards a thing called Staff
 20 Voice, where the Board literally would have an
 21 engagement with the people who were on the wards,
 22 leading those wards, to enable them to tell us what
 23 their concerns were and so on.
 24 **Q.** So what did you do to reassure yourself that the
 25 processes in place, the various committees, were

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1 a monthly basis, were you talking to the nurses, the
 2 doctors, community mental health workers, to see how the
 3 changes were impacting the care that they were giving?
 4 **A.** I was regularly talking to people on those wards, and
 5 the -- but we also had things like Care Opinion where we
 6 would get the feedback on how people are perceiving the
 7 services. We would have regular conversations through
 8 the Involvement teams, with the population that we were
 9 supporting.
 10 We would also have Council of Governors going in and
 11 visiting those wards as well, listening to those people
 12 in the communities and the staff that we were
 13 supporting. So it was a bigger set of processes than
 14 just me.
 15 **Q.** But as Chair, were you gauging that what was happening
 16 at ground level was working?
 17 **A.** No, the challenge that we'd got at the time that this
 18 was happening was, if I remember rightly, fundamentally,
 19 whilst the missive from the centre was saying we needed
 20 to get rid of beds and invest more in the community, we
 21 were getting a big upsurge in demand.
 22 So I know nationally from the figures that there was
 23 a 5% upsurge. If you look at our figures, it was about
 24 7%. So we knew that what was happening was not right,
 25 and so we were having a considerable conversation about

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1 listening to views at ground level and bringing the
 2 wards along with them as these significant changes were
 3 taking place?
 4 **A.** I was reliant on the feedback from my executive teams.
 5 **Q.** But isn't it your job to not just be reliant on the
 6 feedback, but to scrutinise that feedback? These were
 7 big changes, weren't they, Mr Fathers?
 8 **A.** They were big changes. The job of the committees is to
 9 do the scrutiny and it's my job to make sure they're
 10 doing that, so I do know that those reports would have
 11 gone in front of all of those committees and that, when
 12 they came to the Board, we would have got assurance that
 13 there were no matters or concerns that they had to
 14 raise.
 15 **Q.** How do you know that those groups, those committees,
 16 were doing the scrutiny if you're not pushing back and
 17 scrutinising them?
 18 **A.** So I would, as I said earlier, have quarterly meetings
 19 with my Non-Executives to find out what their concerns
 20 were and whether they were doing it, and the Chairs of
 21 each of those committees were people who were clinically
 22 qualified so they would have been able to use their
 23 clinical judgement around whether these things were
 24 appropriate or not.
 25 **Q.** And when you were going on to the wards, you say in

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1 what was the right model.
 2 The challenge that we'd got was actually that we
 3 didn't believe, as a board, that we should be closing
 4 more wards. We actually reversed the decision to keep
 5 on following that national mandate, and we decided that
 6 we would, taking the debate that you've just said, it's
 7 an either/or, we decided that we needed to do both/and.
 8 And so we took, at risk, the decision to invest in
 9 crisis care teams and support them, and also to pursue
 10 the potential to acquire or build more wards ourselves.
 11 So the bed base would actually go up as a consequence of
 12 that decision-making. And by the time I left, I was
 13 assured that there were plans that that bed base would
 14 be back up to 22 people -- sorry, 22 beds per
 15 100,000 population, which is the current norm, but
 16 actually, because the way NHS data works, when you
 17 looked at the Board, we were benchmarking ourselves
 18 against a historical norm, which suggested that
 19 nationally it was 22 beds but in reality, when you look
 20 at the historic data now, it was actually only 19 beds.
 21 **Q.** If we look at WITN0413002, this is the CQC Report in
 22 early 2018, and just a snapshot there, in terms of acute
 23 wards for adults of working age and psychiatric
 24 intensive care units, we can see across the Board there
 25 at the top, that they required improvement in all areas,

24

1 didn't they?
 2 **A.** Not according to this page that I've got.
 3 **Q.** At page 23, WITN -- if we go to page 23. Across the
 4 top.
 5 **A.** Yes.
 6 **Q.** So they require improvement in all areas. If we go down
 7 to "Community-based mental health services for adults of
 8 working age", and the EIP, Early Intervention Psychosis
 9 Team, is included in that group, isn't it?
 10 In terms of safety, it's rated as inadequate.
 11 **A.** Yes.
 12 **Q.** As Chair, what did you take away that needed to change
 13 at board level?
 14 **A.** So what we needed to do was comply first of all with the
 15 CQC requirements, and in order to do that we needed
 16 assurance that there was a plan of action to rectify
 17 that, and as a consequence of that, we would have put in
 18 an action plan for rectification.
 19 **Q.** If we go to page 10, in terms of the bottom of the page
 20 there, "community-based mental health services ...", we
 21 see -- and if you want to have a look at the bottom half
 22 of that page -- care plans. There were concerns about
 23 care plans, concerns about risk assessments and care
 24 plans not being updated?
 25 The last bullet point:
 25

25

1 part of the process of agreeing cost improvements and
 2 monitoring the impact on patient care."
 3 What did you take from that as Chair of the Board?
 4 **A.** So just going back to your earlier statement, I'm not
 5 certain that I said that we were investing more in the
 6 wards; I think I said that we took it as a board to
 7 invest more in our crisis care services.
 8 **Q.** So from this part of the CQC, cost improvements were
 9 taking place but there were concerns about compromises
 10 around patient safety and care, what did you, as Chair,
 11 take from that?
 12 **A.** So I took it from that that we needed to actually make
 13 sure that our Quality Committee was evaluating our cost
 14 improvement programmes more effectively.
 15 **Q.** If we go then to page 23 of that report:
 16 "We found that there [were inconsistencies] ... and
 17 lapses in governance across the wards. Risk and safety
 18 were not always well managed including staffing ...
 19 clinical activity that kept patients safe ... issues
 20 with bed management ... availability of beds."
 21 What, as Chair, did you ensure happened as
 22 a consequence of that criticism by the CQC?
 23 **A.** So from my memory the action plan detailed that there
 24 would be a new ward relationship, so we would have
 25 better team meetings at the wards, we would supervise
 27

27

1 "Patients and carers were not aware of the
 2 restructure of adult community mental health services.
 3 We saw at some locations, leaflets informing patients of
 4 the service, but were told by staff that patients and
 5 carers were not informed of the restructure due to staff
 6 making a clinical decision."
 7 Again:
 8 "Social care staff said they were not informed of
 9 the restructure and working relationships with local
 10 mental health teams had weakened."
 11 Do you think that that suggests a disconnect between
 12 the ward and the Board?
 13 **A.** I think that suggests that there is a disconnect between
 14 us and the communities that we should be communicating
 15 and consulting with.
 16 **Q.** In terms of the -- if we look, then, at the 2019 CQC
 17 Report, you just said in your oral evidence that there'd
 18 been additional investment in the wards. So if I can
 19 take you to NHFT0002015, and specifically page 10 of
 20 that report. Sorry, if we could go to page 6.
 21 Halfway down the page, the bullet point:
 22 "Where cost improvements were taking place, it was
 23 not always clear that they did not compromise patient
 24 safety and care. Consultants and clinical directors
 25 said consideration of clinical advice did not occur as
 26

26

1 that those meetings were taking place, we would make
 2 sure that the assurance of those meetings was being
 3 reported up through the Executive Oversight Group.
 4 **Q.** And what we see, in terms of the provision of mental
 5 health services, so the restructuring of community care,
 6 if I could take you to WITN0319003, page 58. These are
 7 recommendations made in October 2018. Bullet point 1,
 8 what is that telling you?
 9 **A.** So from my memory what we had was a three-year programme
 10 to work with our commissioners to make sure that we had
 11 a systematic process in place to implement the NICE
 12 recommendations before 2021.
 13 **Q.** And:
 14 "[Local Mental Health Teams] ... are currently
 15 unable to deliver EIP NICE Concordant care it is
 16 recommended that the provider and commissioners review
 17 service model and configuration."
 18 So what we have at ground level there, Mr Fathers,
 19 is NICE guidance in terms of safe care to patients not
 20 being provided. Did that worry you?
 21 **A.** These were new guidance notes, so I don't think many
 22 people in the country were compliant with those at the
 23 time. And the consequence of that was that we had to
 24 make sure that over the next three years we got the
 25 workforce in place to do it, but yes, it does worry me.
 28

28

- 1 Q. Because if we look, you've made reference to the level
2 of compliance across the country, RCPS000011, we can
3 see an audit there. This was an audit undertaken by the
4 National Clinic Audit of Psychosis 2018.
5 If we look at EIP, "Timely access", you're
6 achieving, as I understand it, 64% when nationally the
7 achievement was 76%. So you were significantly
8 underperforming. Would you say that that was fair?
9 A. I would say that there is a context around that, which
10 was we were also ahead of national demand curve as well.
11 So it's -- it is a fair statement, but it needs to have
12 the context of the situation built around it.
13 Q. And in terms of "Cognitive behavioural therapy for
14 psychosis", very low there, weren't you?
15 A. Yes.
16 Q. So you've made a reference there to demand on your
17 services, that is a very low achievement, isn't it --
18 A. It is.
19 Q. -- on the part of Nottingham. And again, if we then go
20 over the page to 2019/2020. Sorry, if we go one page
21 further. In fact you've gone down to 63%, marginal drop
22 from 64%, but again underperforming when we consider the
23 national result. And again, "Cognitive behavioural
24 therapy for psychosis", pretty poor, isn't it, at 4%?
25 A. Yes.

29

- 1 somebody to take responsibility for that new important
2 measure.
3 Q. Was there focus -- was there a focus on trying to keep
4 patients out of hospitals and divert into the community?
5 A. The focus was on ensuring that service users got the
6 right place for the right levels of care that was
7 appropriate for them. So the challenge that we would
8 make would be on a clinical assessment, not on
9 a corporate assessment.
10 Q. In terms of -- sorry, back to this document:
11 "A new discharge procedure had introduced nurse led
12 discharges, which should reduce [the] length of stay and
13 minimise the impact of out of area placements."
14 Minimising the impact of out-of-area placements, was
15 that a financial consideration?
16 A. So there were two drivers for it. One, obviously, if
17 you take the principle around why out-of-area placements
18 were introduced in the first place, is to make sure that
19 people could be in a proximity to their families, loved
20 ones, carers, so that we could aid their rehabilitation
21 back to a place that they wanted to get to as quickly as
22 possible. So there was a very strong clinical drive for
23 doing this.
24 There is kind of a really doubled kind of benefit
25 from doing that, I guess, in that if you can get people

31

- 1 Q. So do you accept that whatever you were steering as the
2 Chair through 2018 wasn't feeding into an improvement in
3 services in EIP?
4 A. So one of the reasons that we decided that we needed to
5 have a medical leader as the Chief Executive was to
6 actually enable us to better understand what was not
7 going well, and to help us to understand how to create
8 the right pathways to facilitate these targets to be
9 achieved by 2021.
10 Q. At ground level, what we have -- and if I can take you
11 to WITN0410022, so WITN0410022, page 11. You see there
12 that -- it's the middle of the page, reference to
13 out-of-area placements.
14 So we have "AMH [that's adult mental health] had
15 worked with CCG" -- what --
16 A. Clinical commissioning groups.
17 Q. "... to put in place plan to reduce Out Of Area
18 placements in line with national guidance ..."
19 And if we continue:
20 "An Out Of Area ... Bed Manager had been appointed
21 ..."
22 Pausing there, can you set out the idea behind an
23 out-of-area acute Bed Manager having been appointed?
24 A. So out-of-area beds were a new kind of measure in
25 2017/2018. So as a result of that, we needed to appoint

30

- 1 into a place where they want to be, back in the
2 community, then those beds become available for others
3 to use as well.
4 Q. What was the benefit of a new discharge procedure where
5 there was to be nurse-led discharges?
6 A. So the comment that I would make is that one of the
7 things that we wanted was a proper care plan for people,
8 so that when they came in, they knew what it is that
9 they needed to do to be able to recover well. And so
10 the discharge planning process started right from the
11 beginning, as I understand it, so that it was actually
12 working alongside, theoretically, with the person who
13 was in the care to enable them to work to get out as
14 soon as they could.
15 Q. So in terms of nurse-led, that was a change in
16 procedure, wasn't it?
17 A. As I remember, yes.
18 Q. And was there -- what was done at ground level to ensure
19 that the nurses leading that procedure had the necessary
20 expertise to lead it?
21 A. I don't know.
22 Q. Should you not have known that, as Chair of the Board?
23 A. That is a very minutiae detail that I suspect was not
24 part of my job.
25 Q. You say it's a minutiae detail --

32

- 1 A. -- (*overspeaking*) -- It's an important detail.
 2 Q. But it's an important detail, isn't it?
 3 A. It is.
 4 Q. Did you make it your business to find out? Well, this
 5 a new procedure, we need to make sure as a board, as an
 6 NHS Trust, we get this right?
 7 A. So we had a workforce --
 8 Q. So you had a?
 9 A. We had a Workforce Committee that was chaired by
 10 a clinically qualified individual whose job was make
 11 sure that the people were receiving the training that
 12 was required in the numbers, but we also had a Quality
 13 Committee that would provide oversight of whether
 14 procedures and training was being done such that it was
 15 able to improve the quality of care.
 16 Q. What we know from evidence that has been given during
 17 the course of this Inquiry is, for example, training
 18 given when individuals started in the EIP did not cover
 19 risk management training in the context of mental
 20 health. Do you think -- were you aware of that?
 21 A. So I believe that part of the recommendation out of the
 22 CQC was going to be met by the plan providing training
 23 to all of those people so that they understood their
 24 responsibilities over the Mental Health Act and risk,
 25 and planning and record keeping.

33

- 1 Afternoon, 10 May 2019. Now you didn't attend this
 2 event. In a nutshell, can you assist us as to what this
 3 event was all about?
 4 A. So from my memory there is the new Chief Executive
 5 basically resetting everything that is going on within
 6 the organisation on the back of the feedback from the
 7 CQC Report so that people would start to recognise that
 8 we needed to be more engaged, more involved in that
 9 decision-making and, as a consequence of that, I believe
 10 that there were collaborative partners in that
 11 conversation too.
 12 Q. If we turn to page 2 of that document, and look at the
 13 top there "Our Service Model", just take your time to
 14 have a read through that column. (*Pause*)
 15 Did you see this document at the time?
 16 A. I don't recall it. I think this was part of the pack
 17 that you sent through to me.
 18 Q. Yes, and are you saying as Chair you would not have been
 19 privy to this report once it was produced?
 20 A. I'm not saying that I would not have been, but I don't
 21 recall it.
 22 Q. Because it refers to, doesn't it, "Process/pathways need
 23 to be improved - [it's] difficult for patients to
 24 navigate". It raises issues about clinical staffing
 25 level.

35

- 1 Q. What about in terms of nurse-led discharge, did you
 2 satisfy yourself as Chair that in this new procedure the
 3 right people are going to be informed and part of the
 4 process?
 5 A. Who do you mean by the right people?
 6 Q. The right people: for example, that GPs will be
 7 informed; that, for example, families of the patients
 8 will be informed; for example, the educational
 9 establishment that a patient is at, that they will be
 10 informed.
 11 A. So every cost improvement programme had at the bottom
 12 an assessment of equality impact. All of those people
 13 would have been people who could have been introduced
 14 and included within that evaluation. And so the process
 15 should, by default, make sure that all of the key
 16 stakeholders that are associated with any improvement
 17 programme are engaged and involved.
 18 Q. But you, as Chair, didn't scrutinise and make sure that
 19 there was, for example, a proper template in place so
 20 that nurses could go through, make sure that the
 21 right --
 22 A. That wasn't my job.
 23 Q. In terms of your job, in terms of what was going on at
 24 ground level, if I could ask you to turn to NHFT0006242.
 25 That is Adult Mental Health Collaborative "Day Zero"

34

- 1 A. It does.
 2 Q. It raises issues about clarity of purpose across adult
 3 mental health. What do you make of that, Mr Fathers?
 4 A. Without the context of why those bullet points were
 5 written, I can't give you an accurate answer.
 6 Q. Well, it suggests, doesn't it, that whatever the changes
 7 that had been put in place in adult mental health 2017
 8 and 2018, that they weren't working?
 9 A. So the question could also be if you've got increased
 10 demand, if you've spent time considering the art of what
 11 the future might look like, you would need to redesign
 12 the processes to make them fit for purpose.
 13 So if you go back to the core purpose of the Trust,
 14 so when I took over the Trust, our funding level was 13%
 15 of the national average in mental health. In the year
 16 preceding this, that had reduced nationally to 8%. So
 17 by effect, we were having to do things because we had
 18 not got the money to do it, but at the same time demand
 19 was going up and therefore we would have to think about
 20 new models of care. So things like new technologies
 21 coming in, maybe needed to be invested in, things that
 22 would streamline processes. But essentially,
 23 reengineering may be what we were doing.
 24 Q. And if we go still on that page "Our Leadership":
 25 "Senior leaders who can't contain own stress."

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1 Senior managers can't have difficult conversations."
 2 What do you make of that, Mr Fathers, about the
 3 organisation at the time?
 4 **A.** I think that is probably common to every other Mental
 5 Health Trust at that time.
 6 **Q.** And so not criticism of your leadership at that time?
 7 **A.** The comments there, if I can read them, is, I think,
 8 based upon the changes that they were having to face
 9 from increased demand, from having constrains (*sic*)
 10 about resources that they'd got. So things like, if
 11 I take "Senior managers can't have difficult
 12 conversations", I would hope that those senior managers
 13 would be able to have a conversation. They certainly,
 14 when I went out and spoke with them, were able to speak
 15 to me in an open way, and I certainly didn't create any
 16 blame culture.
 17 **Q.** You talk about increased demand. That has been
 18 a feature of the NHS since its inception, hasn't it?
 19 And it's really part of the Board's function to ensure
 20 that it delivers caring and effective care.
 21 **A.** It is.
 22 **Q.** When it talks about not open culture, a blame culture,
 23 poor use of time due to demand taken evidencing rather
 24 than doing the job, what do you make of that?
 25 **A.** I think there was an increasing amount of regulatory

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1 each of the Board meetings.
 2 **Q.** Again, what do you do to ensure that the Quality
 3 Committee was doing its job properly and that clinical
 4 risk was being managed at ground level?
 5 **A.** So what I did personally was attend, as I said earlier
 6 on, and observe it to make sure that they were having
 7 the right discussions and that the right forum was
 8 taking place, and that clinical leaders were in that
 9 committee leading the conversations. And that the chair
 10 of that committee was herself clinically qualified.
 11 **Q.** In terms of, if we could go to NHFT0015073, and on to
 12 page 2 and 3. So bottom of page 2, paragraph 3.2:
 13 "Clinical Policies and Procedures:
 14 "August 2013: [there is an] Implementation of
 15 Trustwide Policy ... Treatment risk assessment and
 16 management of treatment risk policy ..."
 17 So that is a policy which deals with clinical risk
 18 assessment, ensuring patients are kept safe and indeed,
 19 third parties are kept safe.
 20 If we go to the next page, what we see there is:
 21 "... a full search of the Trust's archives was
 22 completed and found no evidence that this policy was
 23 reviewed/updated beyond Issue 2. If this policy was
 24 indeed not update as suggested, this would mean that
 25 this policy remained in effect between June 2019 -

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1 burden within the system at the time and I think that's
 2 possibly what they were talking about.
 3 **Q.** What about lack of targeted direction? Do you think
 4 that that is a criticism of the Board?
 5 **A.** I don't know what they were talking about in terms of
 6 targeted direction.
 7 **Q.** Looking back on that, and reflecting on your time as
 8 chair, do you see any of that as being perhaps
 9 a criticism of you and your Board?
 10 **A.** I think the time was a major change of flux, so we
 11 recognised that we were bringing in a number of new
 12 things that were going to have to take transformation
 13 time. I think we'd strategically come to a position
 14 where, as a board, we'd actually got a need to change
 15 the models of care that we were historically delivering,
 16 and hence the reason why we took the decision to bring
 17 John in to help that transformation to take place.
 18 **Q.** Lastly, I want to focus on clinical risk. So this is
 19 the risk of patients to themselves and to others. What
 20 oversight did you have of clinical risk when on the
 21 Board?
 22 **A.** So clinical risk was dealt with through the Quality
 23 Committee.
 24 **Q.** Of which you had oversight of?
 25 **A.** We had oversight, so we received reports from that at

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1 June 2023 despite being very out of date."
 2 What's your view on that, that it seems a very
 3 important policy wasn't reviewed?
 4 **A.** This was a new document that I literally received just
 5 before coming in, but I can't see -- I don't know
 6 whether that is kind of accurate or not, but if it is
 7 accurate, then we were at fault for not reviewing it and
 8 making sure that it was up to date.
 9 **Q.** That would suggest that, for example, the Quality
 10 Committee hadn't been doing its job properly?
 11 **A.** I suspect that in this particular case, because it's
 12 a policy, that would be the Audit Committee.
 13 **Q.** The Audit Committee. So one committee that you were
 14 presiding over hadn't done its job properly?
 15 **A.** It seems that way.
 16 **MS KAUR:** Thank you.
 17 Chair, would that be an appropriate time?
 18 **THE CHAIR:** Yes, we'll take a break now and we'll start
 19 again at 11.45.
 20 **(11.23 am)**
 21 **(A short break)**
 22 **(11.44 am)**
 23 **THE CHAIR:** Yes?
 24 **MS KAUR:** Yes, there are questions from Mr Moloney.
 25 **THE CHAIR:** Mr Moloney.

40

1 **Questioned by MR MOLONEY**

2 **MR MOLONEY:** Mr Fathers, Ms Kaur, during the course of the

3 morning, has addressed with you the many serious

4 concerns that were raised in relation to the care

5 delivered by the Trust and the management of the Trust

6 while you were in post.

7 When you reflected on your time at the trusts, have

8 you been able to identify any concerns on your part

9 about how you carried out your role whilst you were

10 Chair of the Board?

11 **A.** I think the reflection that I have is that in hindsight

12 I wished that I'd actually asked more inquisitive

13 questions in terms of detail. But then I reflect upon

14 that and know that, whilst that's something I would want

15 to do because I'm caring and compassionate, it's not

16 something that necessarily the Chair of the Board in

17 their kind of singularity should be doing by themselves,

18 it's -- I think it's something we all should have been

19 doing maybe and I think it's really important in

20 hindsight that what I think has come out very much from

21 this Inquiry is the important need for carers and

22 families to be considered much more greatly in all of

23 our considerations.

24 **MR MOLONEY:** Thank you very much, Mr Fathers.

25 **THE CHAIR:** Thank you.

41

1 the time that you were Chair of the United Lincolnshire

2 Hospital NHS Trust, would you then have had necessarily

3 working relationships with Mr Devlin as essentially a

4 chair of the neighbouring trust in Lincolnshire?

5 **A.** I would. He was part of the STP.

6 **Q.** He was.

7 Similarly, in that role of Chair of the Lincolnshire

8 Trust, would you similarly have had working

9 relationships with Mr Brewin?

10 **A.** I would.

11 **Q.** Thank you.

12 Now, I think, in your questions and responses from

13 Ms Kaur in respect of the portfolio of work that you

14 had, in light of the criticism which I know you've

15 responded to that in the CQC Report of 2019, about your

16 portfolio, it's right, isn't it, that alongside those

17 other areas where you've identified where you had

18 a portfolio, you were also Non-Executive Directors at

19 the relevant time of a number of private companies; is

20 that correct?

21 **A.** No.

22 **Q.** No? Certainly your LinkedIn profile suggests you were

23 Non-Executive Director of Finegreen Group which had

24 a role in recruitment, particularly recruitment of

25 managers and executives; is that incorrect?

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1 Ms Cartwright.

2 **Questioned by MS CARTWRIGHT**

3 **MS CARTWRIGHT:** Good morning, Mr Fathers. I ask questions

4 on behalf of the survivors.

5 Can we first of all look at paragraph 11 of your

6 witness statement, please, WITN0410001, page 3, please.

7 Thank you. You tell us in the witness statement that

8 after leaving NHS Bassetlaw on 31 December 2010 you took

9 on other roles associated with the NHS, including the

10 Non-Executive Chair of an acute Trust, 1 March 2016 to

11 30 November 2017.

12 Pausing there, obviously that was a Chair role that

13 overlapped with your time at Nottingham Foundation

14 Trust.

15 **A.** It was.

16 **Q.** But was there a reason why you omitted to name what

17 Trust it was that you were working at at that time as

18 the Chair?

19 **A.** There wasn't a reason, it was United Lincolnshire

20 Hospitals.

21 **Q.** That was NHS Lincolnshire Hospitals NHS Trust. And

22 you've obviously revealed as part of your evidence this

23 morning the role of those from the other trusts, the

24 Foundation Trust at Lincolnshire, but then came on to

25 take over roles at Nottingham. Can I ask, then, during

42

1 **A.** No, that is correct, but that was before the period that

2 I was asked to review.

3 **Q.** All right. Certainly that suggests that you had that

4 September 2014 to August 2017, so it sits within the

5 period of time when you were at the foundation trust

6 between 2011 and 2019; would you agree?

7 **A.** It was.

8 **Q.** Similarly, your Non-Executive Director role at Higos

9 Insurance Services Limited also fell within that period

10 of time of January 2012 to March 2018?

11 **A.** It was.

12 **Q.** Similarly, your role, I think, with a number of medical

13 companies, Diagnostics, and another company also falls

14 within that time period; is that correct?

15 **A.** It was.

16 **Q.** So certainly if we were to look at your LinkedIn profile

17 and the companies and organisations you're connected

18 with, particularly for the period 2011 to 2019, would it

19 be fair to say that that chronology is accurate for the

20 other roles and portfolio you had --

21 **A.** It is.

22 **Q.** -- at the relevant time?

23 Then, can I ask you, particularly bearing in mind

24 the significance of Finegreen Group in the recruitment

25 role it had for appointment of managers and to assist

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1 those with appointments to role of chief executives and
2 chairs, can I just, for complete transparency, check
3 that that company had no role or didn't provide any
4 support or advice to Mr Brewin, Julie Attfield or
5 Mr Devlin, just so we're absolutely clear that there was
6 no professional relationship with those individuals and
7 the roles they --

8 **A.** I honestly don't know because I'd left at that time.

9 **Q.** All right. Can I then perhaps just revisit the
10 exploration of the issue that Ms Kaur had with you about
11 the concerns of the CQC about the portfolio of work you
12 had in that 2019 report. When one has regard also to
13 the wider roles you had, would you agree that that
14 probably was a fair criticism about the many groups and
15 organisations you had involvement with, alongside the
16 time that you were chair of Nottingham Foundation Trust?

17 **A.** So I had actually reduced quite considerably my
18 commitments to other boards at the end of 2017.

19 **Q.** Right. Now, then, can I just -- in the knowledge that
20 Mr Devlin is coming, Ms Kaur has explored with you the
21 Mental Health Collaboration Day Zero Afternoon document,
22 10 May 2019, where one of the aspects you were taken to
23 was the issue of the blame culture. I just want to then
24 ask any additional comments you may have, because we're
25 going to hear from Mr Devlin, who tells us within his

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1 Guardian processes worked.

2 I also, as part of my responsibilities, liaised with
3 the NHS England's Workforce Race Equality Standard and
4 bought in people from the Race Equality Standard to talk
5 to a variety of people within our organisation to help
6 us deal with that cultural issue. I actually personally
7 had my Head of Diversity, Annette Magore, upward mentor
8 me, so that I was aware of what she believed we needed
9 to do, and took advice from her as to what we could be
10 doing culturally. And we also invited the Freedom to
11 Speak Up Guardian to do an audit of us to help us to
12 understand what it was that we were doing.

13 And I think we also, in the time that I was there,
14 created a number of forums for equality and diversity
15 groups to come together. One of the proudest moments we
16 got was when we won the Stonewall Star Performer award,
17 and subsequently the year later we won the -- sorry, the
18 Best Company Award, and then the subsequent year we won
19 the Star Performer Award because we were trying to
20 create an inclusive, engaged culture.

21 So that feedback is something that I did take on and
22 was actively trying to make sure that we didn't have
23 that culture.

24 **Q.** Thank you. And then just two final short matters,
25 please. You've obviously told us about the involvement

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1 witness statement about when he joined, and he says
2 this. He says:

3 "I became aware of some of the issues NHFT had at
4 the time, including a sense of an 'historical blame'
5 culture reportedly felt by some staff, that potentially
6 meant staff felt less able to report concerns to senior
7 managers. There were some specific improvement
8 challenges (such as the experience some staff had of
9 racism, the best use of data, and Board culture) that
10 mirrored, albeit on a larger scale, issues I had faced
11 at [Lincolnshire Partnership Foundation Trust] which,
12 alongside Dr Brewin, I believe we demonstrably improved,
13 as shown through the National Staff Survey and
14 significantly improved CQC [ratings]."

15 So just as another source that we're going to hear
16 evidence from about a blame culture, attributable to
17 your time as Chair at Nottingham Foundation Trust, is
18 there anything further you wish to say about that
19 criticism as to the culture at the time when you were
20 Chair?

21 **A.** I think one of the things that I wanted to do at
22 Nottinghamshire Healthcare is to create an open culture.
23 To that effect you'll see that I brought in the Freedom
24 to Speak Up Guardian to talk to our workforce, to then
25 enable them to understand how the Freedom to Speak Up

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1 of the Cabinet Office to approve the appointment of
2 Mr Brewin, bearing in mind he had a medical position, so
3 it meant he was having an increased salary equivalent to
4 the Prime Minister, and during that period of time Julie
5 Attfield acted for three months as the Chief Executive
6 Officer.

7 Can you assist, did the Cabinet Office have any
8 ongoing monitoring role, bearing in mind the salary that
9 Mr Brewin was awarded for his role at the time that he
10 was at the Nottingham Foundation -- (*overspeaking*) --

11 **A.** So there was a requirement that Mr Brewin was put on to
12 a set of performance criteria that was against
13 a clawback, so that if he failed to meet those criteria,
14 they would be able to claw back a sum of money, and it
15 was beholden then upon the Chair to confirm that those
16 criteria were met and in his first appraisal he had met
17 those criteria.

18 **Q.** Thank you. Now just then finally, please, obviously one
19 of the portfolio roles you had was with the
20 Parliamentary Health Ombudsman and I think that's one of
21 the reasons you gave up your Chair role at the
22 Lincolnshire Trust. Certainly, on appointment to that
23 role it references that you delivered transformative
24 change within the Trust. Can I just check: was the
25 transformative change that was being referenced, in any

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1 way did that have anything to do with the changes that
 2 occurred to the EIP service within Nottingham Trust that
 3 had occurred during the time that you were --
 4 **A.** I'm not certain I know what reference you're
 5 referring to.
 6 **Q.** Sorry, it's just in the -- it's just the publication
 7 when you were appointed to the ombudsman role suggests
 8 that part of the reason you'd been appointed is you'd
 9 delivered transformative change in respect of staffing
 10 at Trusts. And so I just wanted to ask, having just
 11 seen that, whether that had included what you did at
 12 Nottingham Foundation Trust to the EIP service in
 13 Nottingham?
 14 **A.** It would not have included the EIP service, because that
 15 came after the appointment, but that would have been
 16 referring to two things, I guess, going back to the
 17 Stonewall kind of assessment, but also I introduced an
 18 introduct -- a thing called Board Apprentice, which
 19 enabled the NHS to then take on the NEXt Director
 20 Programme which was bringing people from
 21 under-represented communities on to boards so that we
 22 could get better representation around board tables and
 23 therefore be more aligned towards those communities that
 24 we serve.
 25 **MS CARTWRIGHT:** Thank you.

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1 involvement centres were run specifically by the people
 2 who were within our community and they were a great
 3 source of intelligence.
 4 **THE CHAIR:** But they didn't include the families of those to
 5 whom the services were being provided.
 6 **A.** They didn't. What we did in that particular regard, if
 7 I remember correctly, is have a conference about
 8 engaging families towards the end of my time, and the
 9 conference concluded with an action plan, but I don't
 10 know the detail of that action plan.
 11 **THE CHAIR:** One of the bullet points in relation to the away
 12 day which you didn't attend, the zero day, refers to too
 13 much time being spent evidencing what was done, and
 14 you've referred to the regulatory burden, but we've seen
 15 in the notes that were taken and on RiO by clinicians
 16 really no notes in relation to multidisciplinary
 17 meetings and so on.
 18 **A.** Yes.
 19 **THE CHAIR:** Generally, were you aware of a lack of desire to
 20 evidence, to effectively to note up what's being done?
 21 **A.** I wasn't aware of a desire to not do it. I was aware
 22 from the CQC inspections that the audits were finding
 23 that that was the case.
 24 One of the things that I would like to see, if that
 25 was the case, is more ambient voice technology put into

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Questioned by the CHAIR

1 **THE CHAIR:** Yes, just a few questions in relation to your
 2 evidence, Mr Fathers. You were involved with the Trust
 3 at the time when there was an Assertive Outreach Team.
 4 **A.** Yes.
 5 **THE CHAIR:** That decision to disband that was taken in 2015.
 6 What was the thinking behind that at the time?
 7 **A.** I honestly don't remember. Sorry, Chair.
 8 **THE CHAIR:** I think you may be aware that we're looking and
 9 we've heard about Assertive Outreach --
 10 **A.** -- (*overspeaking*) -- I heard that yesterday, yes.
 11 **THE CHAIR:** Is it a decision that you regret, now?
 12 **A.** I think, in hindsight, listening to John's evidence
 13 yesterday and his capability in that particular regards,
 14 it would have been something that we would have maybe
 15 done differently if he'd been the Chair at the time.
 16 **THE CHAIR:** And in relation to -- you've referred to
 17 visiting wards in a sort of ward-to-board information,
 18 what about what I'm going to call street-to-board,
 19 because you were actually dealing with community
 20 services as well. Did you ever visit the Community
 21 Team, so for example, Crisis or EIP?
 22 **A.** Over the period I would have gone to practically all of
 23 our services, and one of the things that we did actively
 24 as well was visit our involvement centres. So our
 25

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1 those meetings, and into that note-taking, so that we
 2 were actually able to take contemporaneous notes from
 3 everywhere that is required and that would reduce both
 4 the burden and increase the accuracy of note taking.
 5 **THE CHAIR:** Well, perhaps that's more developed now than it
 6 maybe was then, but certainly in relation to note
 7 taking, was anything done about a lack of notes after
 8 the CQC?
 9 **A.** So yes, there was. So if you follow my evidence trail,
 10 what we put within the plan was a regime where clinical
 11 leaders were given specific responsibility for ensuring
 12 that both the meetings took place, and that minutes were
 13 taken to affirm that those meetings had taken place, and
 14 so there was a supervisory process introduced.
 15 **THE CHAIR:** At board level, as I'm sure you're aware,
 16 there's usually an actions section after the minutes,
 17 isn't there?
 18 **A.** There is.
 19 **THE CHAIR:** And there's nothing of that kind, there was
 20 nothing of that kind in the notes, was there?
 21 **A.** From the wards?
 22 **THE CHAIR:** Yes.
 23 **A.** I am not aware of that.
 24 **THE CHAIR:** No. Just finally in relation to your
 25 relationship as Chair with the Executive Board, that's

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1 to say effectively the management, obviously the
2 management want to stress to some extent the positives,
3 partly for morale reasons but also just generally.

4 What questions did you ask about that approach,
5 stressing the positives? Did you ever ask any difficult
6 questions?

7 **A.** The previous Chief Executive started to do some
8 engagements with staff to find out what was really going
9 on before she left, and the previous Chief Exec and
10 I spoke about what she discovered in that, and there was
11 a very strong belief that because our values were
12 written into the acronym of positives, that people felt
13 that they weren't allowed to be critical, and so the
14 consequence of that is that we decided that we would
15 have to abandon that acronym so that we didn't give the
16 mixed message that we were expecting people to be always
17 positive. And John came in to pick that agenda up and
18 introduced a whole series of engagement exercises to
19 make sure that the values were carefully rewritten and
20 owned by the workforce.

21 **THE CHAIR:** Was "positive" removed as an acronym?

22 **A.** It was.

23 **THE CHAIR:** Just in relation to when you left, so you left
24 in 2019 before Covid, at that time, there'd been the CQC
25 reports, and the assessments that had been made by the

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1 a new nurse apprentice programme, so we were recruiting
2 lots of people in between the care practitioners who
3 were qualified, and the people on the wards, so more
4 people coming in with different positions.

5 Unfortunately, I think if you go back to that time,
6 nurses were -- I can't remember the phrase that were
7 used, but they were a scarce resource. We had to think
8 of new models to bring them through, and that was
9 particularly so in mental health nursing.

10 And I think the other thing that was going on at the
11 time was that we were losing a lot of the people who
12 were in their mid-fifties because of the pension
13 requirements and the fact that it was not to their
14 advantage to stay. So we lost a lot of senior leaders
15 who were mature, capable, and able to do the mentoring
16 that was needed, and got the experience to actually give
17 insight and assurance and deal with the stress issues.

18 And one of the statistics that I look at, which is
19 quite frightening, is that I believe that when I first
20 started, 19% of our workforce was -- had been with us
21 fewer than five years. By the time I left, something
22 like 24% of our workforce had less than five years'
23 experience.

24 So people were less experienced, less capable, and
25 without the right supervision in the system to be able

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1 CQC at that stage. Covid then hit. What sort of state
2 did you leave the organisation in prior to that?

3 **A.** I think it was in a very positive mood. People were,
4 with the exception of a big caveat, which I'll come back
5 to in a moment, of the belief that they were taking
6 actions to address the matters that were necessary. The
7 big challenge was around workforce, and from my memory,
8 that really has two big implications.

9 So the first big implication was all around
10 sufficiency. So we'd brought in a new measurement
11 system, the safe staffing tool, that was introduced by
12 Keith Hurst, and that was giving us alerts as to where
13 safe staffing were concerns or not, and they were being
14 put onto our serious incident reporting tools, Ulysses,
15 so that Ulysses was elevating those concerns and we were
16 then doing deep dives into, "if a staffing level had
17 occurred, was there a resultant harm caused by ..." and
18 then taking actions as appropriate.

19 So I think the -- we were positive as a result of
20 that, that we were starting to put better procedures in
21 place to ensure that we were actually doing the things
22 right with the staff we had, but we were also keen,
23 prior to my leaving, to engage very heavily with the
24 Universities. We'd worked excessively with the
25 Universities to make sure that we'd got new -- there was

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1 to deal with it, it was -- staff was the big issue that
2 I was most concerned about.

3 **THE CHAIR:** There were quite a few vacancies, weren't there,
4 particularly --

5 **A.** Lots of vacancies.

6 **THE CHAIR:** -- at the time that we're dealing with.

7 Yes, thank you.

8 Yes, that completes your evidence. Thank you. And
9 I think we'll go on to the next witness, please.

10 **THE WITNESS:** Okay.

11 **MR WESTON:** Chair, I call Paul Devlin.

12 **THE CHAIR:** Yes, thank you.

13 **PAUL DEVLIN (affirmed)**

14 **Questioned by MR WESTON**

15 **THE CHAIR:** Yes.

16 **MR WESTON:** Mr Devlin, you've prepared a witness statement
17 for these proceedings dated 12 February 2026.

18 **A.** Yes.

19 **Q.** And is that statement true to the best of your knowledge
20 and belief?

21 **A.** Yes, it is.

22 **Q.** Mr Devlin, you were the Chair of the Nottinghamshire
23 Healthcare NHS Foundation Trust between January 2020 and
24 December 2025.

25 **A.** Yes.

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1 Q. And in terms of your background, I'm going to start back
2 in the 1980s, so 1988 to 1997 you worked for OXAID, the
3 charity?
4 A. Yes.
5 Q. -- providing HIV and drug support. 1997 to 2007 you
6 worked for another charity, Age Concern, in various
7 managerial positions.
8 A. Yes, I did.
9 Q. Thereafter you spent a year as the National Director of
10 Services for Headway, the Brain Injury Association?
11 A. Yes.
12 Q. That's in 2007. In 2008 you started work as Head of
13 Inclusion at Action for Children?
14 A. That's correct.
15 Q. You spent five years there.
16 A. Yes.
17 Q. And you were appointed as the first Chief Executive of
18 Healthwatch Birmingham in 2013?
19 A. Yes.
20 Q. In 2007 you were appointed as a Non-Executive Director
21 of NHS Derby and Derbyshire and PCT?
22 A. That's correct.
23 Q. And you performed that role until 2015?
24 A. Yes.
25 Q. In 2015 you were appointed as the Chair of the

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1 the witness box, if I may, so we can just go through
2 that. As Chair, you lead the Board of directors, don't
3 you?
4 A. I do.
5 Q. Directors and the Board have the overall responsibility
6 for leading and directing the Trust?
7 A. That's correct, and operating as a unitary board which,
8 for me, is important because everybody around that table
9 has an equal individual and collective responsibility
10 for the actions of the Board, and that's something that,
11 in the way that I led that Board, I would want to make
12 sure came through in the way that we operated. There
13 may be specifics that we can come to later on that.
14 Q. Perhaps if we just stop here. Could you explain what
15 a unitary board is, please?
16 A. Yes, so the unitary board is saying that this is a board
17 that has a collective responsibility and that all of
18 those members, so the Non-Executive Directors, of which
19 I was one, and also the Executive Directors, have
20 a similar level, same level responsibility. So it's
21 a contrast with perhaps some commercial boards where
22 Non-Executive Directors have a totally different
23 responsibility to the Executive Directors.
24 So around the Board table, for example, I would
25 expect Executive Directors to be challenging one another

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1 Lincolnshire Partnership NHS Foundation Trust?
2 A. That's correct.
3 Q. And then in November 2019 you were appointed the Chair
4 of the Nottinghamshire Healthcare Trust?
5 A. To begin in January 2020.
6 Q. Indeed, you commenced in January 2020 and you completed
7 two three-year terms; is that right?
8 A. That's correct, yes.
9 Q. And as I think you've said, finished in December of
10 2025.
11 A. That's correct.
12 Q. Going back to 2007, you became a Non-Executive Director
13 at Lincolnshire Partnerships NHS Foundation Trust?
14 A. Not in 2007.
15 Q. The Non-Executive Director?
16 A. That was at the primary care trust.
17 Q. Apologies, at Derbyshire, apologies. When you took that
18 role, at that point you didn't have any previous
19 experiences working in a hospital; is that correct?
20 A. Absolutely.
21 Q. All the experience you've had since then is at the
22 director or Chair level; is that right?
23 A. That is correct.
24 Q. Can I -- we've heard some evidence about the role of the
25 Board. I just want to summarise some of it with you in

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1 and indeed challenging Non-Executive Directors. It
2 wasn't solely Non-Executive Directors providing the
3 challenge and scrutiny.
4 Q. The day-to-day running of the Trust, that was done by
5 the executives, wasn't it?
6 A. The day-to-day running of the Trust absolutely is in the
7 hands of the operational leaders. So the senior leader
8 of that was the Chief Executive -- Inquiry Chair, you
9 heard from those yesterday -- and it's a very important
10 distinction for me that my job was to lead the Board in
11 scrutinising that operational leadership, but not
12 straying into -- directly into actually managing that
13 operational leadership.
14 Q. You were there to provide oversight and quality
15 assurance?
16 A. Yes.
17 Q. It's unworkable for you, as a chair of a board, to be
18 over all of the detail of all of the Trust?
19 A. Yes, it's -- well, yes, it is and I would say it's not
20 part of that role. It's a clearly distinct
21 responsibility, and there are the other responsibilities
22 of holding the strategic direction of the organisation
23 that I was responsible for.
24 Q. So matters of strategic importance?
25 A. Yes.

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- 1 Q. Matters of systemic importance?
- 2 A. Yes.
- 3 Q. These are issues that the Board has to have oversight
- 4 over?
- 5 A. I would expect so, yes.
- 6 Q. Now, you perform that role of oversight by being
- 7 provided information, and that can come from various
- 8 sources: it can come from the executives, it can come
- 9 from other committees, it can come from reports that are
- 10 made to the Board; that's right, isn't it?
- 11 A. Yes, and a number of other sources as well, such as
- 12 feedback that we get, I would get, from visits to
- 13 services. It would come from feedback from other
- 14 organisations. It would come from a whole manner of
- 15 different sources in addition. I think the ones you
- 16 described were the formal ones.
- 17 Q. But it's far from a passive role, is it? You need to
- 18 ensure firstly that the structure below you allows
- 19 a transparent flow of information to your board. You
- 20 need to set that up, make sure that information flow is
- 21 there, don't you?
- 22 A. I would absolutely agree and I think you're absolutely
- 23 right: the role of the Chair is not a passive role.
- 24 Q. You need to ask searching questions of your executives
- 25 and others, as necessary, to ensure that your job of

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- 1 of processes, culture or policy, those are matters that
- 2 are relevant to the Board and to you as the Chair of the
- 3 Board.
- 4 A. That's correct.
- 5 Q. When you started in January 2020 you would have been
- 6 fully aware of the 2019 CQC inspection?
- 7 A. I was, yes.
- 8 Q. Can I take you to that, please. It's NHFT0002015.
- 9 Start there on page 1, please.
- 10 A. Yes.
- 11 Q. We can see that in terms of "Are services safe", it
- 12 "Requires improvement", and "Are services well-led",
- 13 also "Requires improvement".
- 14 Page 5, at the bottom there, "What we found",
- 15 "Overall trust":
- 16 "Our rating of the trust went down. We rated it as
- 17 requires improvement because:
- 18 "The executive team lacked confidence in carrying
- 19 out actions in between one chief executive retiring and
- 20 another commencing. The chair was on various boards
- 21 outside of the trust".
- 22 That's the previous Chair we're talking about.
- 23 A. Yes.
- 24 Q. The matter we've just heard some evidence about:
- 25 "The impact of this resulted in some loss of

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- 1 scrutinising the working of the Trust takes place
- 2 properly?
- 3 A. Yes, so I would say I absolutely did, and indeed I would
- 4 expect all of my board colleagues to do similar.
- 5 Q. If there's an issue that comes to your attention that
- 6 you're not content with, you can ask for more
- 7 information, you can ask for specific reports to be
- 8 undertaken, you can ask for investigations to be done,
- 9 sometimes we've seen reference to a deep dive being
- 10 done. These are all measures that you can ask to be
- 11 done in your role as Chair, or you can ask the Board to
- 12 ensure that is done?
- 13 A. They are, and, again, those are some examples of those.
- 14 There are others, such as commissioning independent
- 15 external investigations, some of which will be familiar
- 16 to the Inquiry.
- 17 Q. As the Chair, you are part of setting the agenda of what
- 18 the Board need to know. So if you focus on an area
- 19 you're more likely to get information fed up on that
- 20 area, aren't you?
- 21 A. Yes.
- 22 Q. Patient health and safety, that's one of the core
- 23 functions of any NHS Trust, isn't it?
- 24 A. It is.
- 25 Q. If clinical practice at the Trust is unsafe as a result

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- 1 leadership focus and action within the trust."
- 2 The second bullet point, three lines down:
- 3 "However, the executives were struggling to finding
- 4 the right balance between attending to internal versus
- 5 external priorities. Leaders recognised that they
- 6 needed to increase management and leadership capacity to
- 7 deal with organisational development, IT, and the
- 8 provision of business support."
- 9 Can I take you to page 10. Half way, if we can show
- 10 the second half of the page please, I'm grateful. Third
- 11 bullet point:
- 12 "The executive team lacked confidence in carrying
- 13 out actions in between [the] ... chief executive
- 14 retiring and another commencing."
- 15 That's what we've just seen.
- 16 "The chair was on various boards..." and if we go to
- 17 the next bullet point:
- 18 "There was a disconnect between operational staff
- 19 and the board in ... communication[s] of messages and a
- 20 lack of consultation and engagement."
- 21 So the flow of information was a problem in 2019.
- 22 You're nodding.
- 23 A. Yes. My apologies, Chair.
- 24 **THE CHAIR:** Yes, you have to say yes or no, because
- 25 otherwise it won't be recorded -- (*overspeaking*) --

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1 A. Yes, I'm agreeing with you.

2 **MR WESTON:** Third bullet point:

3 "The board assurance framework included a number of
4 risks that were considered to be high impact risks. The
5 board had kept these risks and rage monthly review.
6 Staff and clinician engagement and culture was not
7 specifically defined as one of the organisations top
8 risks despite the deterioration in staff survey results
9 and engagement culture of the organisation since the
10 last inspection."

11 A. Yes.

12 Q. So we can see before your time, but in terms of what you
13 were coming into, there were some serious concerns there
14 about safety and about governance.

15 A. Yes. I think, if I could just say in relation to the
16 CQC, one of the things we didn't mention was that I had
17 had seven years' experience of being specialist advisor
18 on governance matters with the CQC. So I'd been on
19 a good number of inspections and involved kind of on the
20 other side, if I could describe it like that.

21 What I would say, therefore, is that as with all of
22 the CQC reports, there's a great deal behind the
23 headline statements, but in terms of the flags that
24 you're raising there, absolutely.

25 Q. Sometimes, for example, when you're looking at how the
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1 the due diligence conversations I'd had, which were with
2 both people involved in the Trust but also external
3 people, such as NHS England and others, that there were
4 some concerns about reporting and staff feeling less
5 able to report concerns up through the organisation.
6 That was confirmed for me, looking at the Freedom to
7 Speak Up changes that I then supported and helped
8 introduce to improve some of that after I'd arrived.

9 Q. Can I take you to page 11, please, paragraph 37, towards
10 the bottom.

11 "As a result of my due diligence, I concluded that
12 the Board culture had historically not been as strong
13 a 'unitary Board' as it should have been, and this was
14 something the Chief Executive, Dr ... Brewin, was keen
15 to improve ..."

16 A. Yes.

17 Q. You've explained what a unitary board was, so in terms
18 of what needed to change towards a unitary board,
19 greater degree of responsibility amongst the Board
20 members; is that fair?

21 A. Yes, and how that was evidenced as well. So for me, my
22 observations were that I didn't think there was always
23 robust challenge, for example. What I described earlier
24 about the responsibility from all those around the table
25 for bringing some of that challenge, and seeking out

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1 Board is operating it's quite difficult for the CQC to
2 penetrate that and you actually need voices from inside
3 the Board to understood that sort of working, don't you?

4 A. Yes, although the CQC, when doing Well Led inspections,
5 and certainly when I was involved in those inspections,
6 would be doing things like observing Board meetings,
7 observing the committee meetings, and drawing on very
8 large volumes of reports, as well as then engaging with
9 people verbally when they were physically doing an
10 inspection.

11 Q. Can I take you to your statement, please --

12 A. Yes.

13 Q. -- WITN0390001, page 10. About a third of the way down
14 the page, it says:

15 "I became aware of some of the issues NHFT had at
16 that time, including a sense of an historical 'blame
17 culture' reportedly felt by some staff ..."

18 Can you just elaborate on that, please?

19 A. Yes, in this part of my statement I was reflecting on
20 some of the due diligence I had been doing prior to
21 deciding to apply to be Chair.

22 The historical element of the blame culture went
23 back considerably further than the, I guess, ten years
24 plus I was looking back at the various versions of the
25 organisation. And that I had picked up through some of
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1 assurance, if I could describe seeking out assurance
2 rather than reassurance. So actually seeking out: well,
3 what's the evidence behind statements?

4 Q. If challenge wasn't being done, if reassurance wasn't
5 being attained, then the Board wasn't doing its job
6 properly, was it?

7 A. I think my statement would be that I think the Board
8 could be doing better at that. I don't think I'd go
9 quite as far as to say that the Board wasn't doing its
10 job properly. I think it could have been doing it
11 better and with a higher degree of scrutiny. I say that
12 because there are other safeguards, including the
13 regulators, that I would have expected would have picked
14 up if they'd said the Board wasn't doing its job
15 properly.

16 Q. Can I take you to page 18, please, paragraph 54.

17 A. Yes.

18 Q. You touch upon the similar issue:

19 "At Board meetings before my leadership, there had
20 been a practice of allowing non-Board members to present
21 items directly in the Board meeting as part of its
22 formal session. I take the view that it is best
23 practice for members of the unitary Board to present
24 agenda items, as they are responsible for any subsequent
25 decisions ..."

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1 So the members of the Board were not presenting
2 their own information, therefore not necessarily being
3 entirely over the detail or owning the matters that they
4 were presenting to the Board; is that fair?

5 **A.** That is fair, yes.

6 **Q.** Page 41, paragraph 108, please. This comes back to a
7 matter that you have just touched upon, but I just want
8 to re-explore with you, please.

9 **A.** Yes.

10 **Q.** So fourth line:

11 "At the time of joining NHFT, I felt that
12 reassurance was not always further tested to seek
13 assurance. A challenge for Non-Executive Directors in
14 assessing data and information is to consider the scale
15 of what they are not cognisant of, whether others
16 (including Executive Directors) may know, and whether or
17 not information is unavailable, available but unknown,
18 or potentially deliberately being withheld."

19 A critical part of the scrutiny of the Board, isn't
20 it, the matters that you set out there?

21 **A.** I think so, yes.

22 **Q.** If that was not happening, at least in part, then there
23 are gaps in terms of the Board doing its job properly,
24 aren't there?

25 **A.** Yes.

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1 the core for me about what comes before boards should be
2 able to have very clear actions, why it is in front of
3 the Board, what's expect of the Board, and what I often
4 had described -- well, I think I mention it a little
5 later down, actually -- the "So what?" So why is this
6 in front of us?

7 I felt that, in terms of The Chair's Report, that
8 that ought to be a document that clearly set out what
9 I was doing as Chair and why, and not just to give kind
10 of reflections on some of the big issues that were going
11 on in the NHS, for example.

12 I haven't reviewed the actual board papers of that
13 meeting, but that's certainly the sense that I get from
14 remembering what I was writing at the time.

15 **Q.** This was after you looked at the last set of board
16 papers, wasn't it?

17 **A.** It was.

18 **Q.** You say the need to focus on issues was because there
19 needs to be very clear actions.

20 **A.** Yes.

21 **Q.** So when you were observing what was going on when you
22 came in, there wasn't a focus on very clear actions.

23 **A.** In that particular set of board papers, this was my
24 observation, so this related to that, I think, November
25 set of board papers that I'd gone through, thinking:

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1 **Q.** Can I take you, please, to WITN0390019; email from you
2 to the CEO, Mr Brewin, dated 10 December 2019.

3 **A.** Yes.

4 **Q.** You say there you've attached some high-level bullet
5 points that would be good to discuss.

6 **A.** Yes.

7 **Q.** Can I take you to those bullet points, please.

8 WITN0390020:

9 "Chair's report".

10 **A.** Yes.

11 **Q.** "Will be different! Needs to focus on issues not
12 pontifications."

13 Can you give us some examples of what the
14 pontifications were that you found on the Chair's
15 reports when you were reviewing them before you started
16 at the Trust.

17 **A.** I think what I was trying -- as I respond to that,
18 I think it's important to say that obviously different
19 people in the role as Chair of an NHS Trust approach
20 that in their own way, in their own style, and the
21 intent from this email was to just present through my
22 approach some clarity on some of what I would have
23 expected.

24 So in terms of the referring to "Needs to focus on
25 issues, not pontifications", I think it goes right to

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1 okay, if I was Chair at this time, what would I be
2 looking at?

3 **Q.** Number 3, it refers to "Staff voice reports".

4 **A.** Yes.

5 **Q.** "light on actions/recommendations". So again, nothing
6 in terms of what needs to be done.

7 **A.** No, this was prior to me starting.

8 **Q.** Yes, I understand that.

9 **A.** This was purely -- I'm sorry, do you mean the --

10 **Q.** The information, your review was that in terms of staff
11 voice reports --

12 **A.** Yes.

13 **Q.** -- it was light on actions and recommendations.

14 **A.** That's what I felt at the time, yes.

15 **Q.** So a theme, then, the Chair's Report wasn't looking at
16 actions, the staff voice reports were not looking at
17 actions or recommendations. No -- if there's no
18 suggestion about what the actions are, the Board is not
19 doing its job to change things, is it?

20 **A.** I think it makes it far more difficult for that to come
21 out of that discussion, yes.

22 **Q.** "heavy on detailed narrative of respondents' comments
23 rather than giving analysis".

24 **A.** Yes.

25 **Q.** So lack of analysis, lack of next steps.

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1 A. Yes, and also to say that that giving detail of
2 narrative, that doesn't necessarily make it easy to be
3 able to focus on the analysis.

4 Q. Can we take that down, please.

5 One of the concerns that the CQC had in 2019 was
6 that the previous Chair had been on various boards
7 outside of the Trust.

8 A. Yes.

9 Q. When you started at Nottinghamshire Healthcare you
10 maintained a role as the Chair of the previous Trust you
11 were working at --

12 A. Yes, I did.

13 Q. -- for a period of 15 months.

14 A. That's correct.

15 Q. Given the concerns we've seen about safety and
16 governance, and the level of change that it seems you
17 thought was needed in terms of board culture, board
18 work, could you properly perform your role as Chair
19 whilst leading two Trusts for well over a year?

20 A. I think the start point of that is to say that was a key
21 question that I asked myself before applying, and indeed
22 talked with many others, including at Lincolnshire
23 Partnership Foundation Trust as well as Nottinghamshire
24 Healthcare, and, as I refer in my statement, it's
25 something that was then explored in detail through the

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1 a fair challenge there. It was not. And I think that
2 I had a visibility that not only met what was required,
3 but I was very deliberate in how I was visible. So part
4 of that was physical visibility, part of that was being
5 really careful about, for example, making sure that
6 where there were internal events bringing together large
7 groups of staff, I made sure I was able to be there and
8 not only just dip in and dip out, but actually engage
9 with colleagues, and I think the feedback that, as part
10 of the work that I was doing, was that colleagues did
11 see me as a visible leader.

12 Q. Were other Board members on multiple boards?

13 A. In my Board?

14 Q. When you started in 2020, yes.

15 A. I can't quite remember. It's possible. But again, for
16 the Non-Executive Directors, there in terms of the time
17 commitment for them is far less than for a Chair, and in
18 terms of the Executive Directors, no. I'm separating
19 out, if I may, system boards, because I saw those as
20 part of NHS role. So when I joined I was, by default,
21 a member of the system board in Nottingham and
22 Nottinghamshire. But that was a part of my role. That
23 wasn't a separate board role; that was a part of being
24 the Chair of Nottinghamshire Healthcare, and similarly,
25 the Chief Executive at the time was part of that board,

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1 interview process.

2 I made the personal decision to stop doing a number
3 of other activities that were income generating
4 activities for me as well. I considered that in terms
5 of where Lincolnshire Partnership Foundation Trust was
6 and the position it was in, I was able -- I would be
7 able to carry out my functions for both organisations.
8 There was -- I had considered that there would be
9 an important -- it was important that I was able to give
10 perhaps more time to Nottinghamshire because of where it
11 was as an organisation, and also for me coming in new,
12 and I had explored that explicitly with both
13 organisations.

14 Q. You talk in your statement about the importance of the
15 visibility of the Chair --

16 A. Yes.

17 Q. -- and about the Chair being seen to lead the Trust.

18 A. Yes.

19 Q. In terms of that, what sort of message does it put out
20 when you come to a Trust that in your view had
21 difficulties with governance, difficulties with safety,
22 difficulties with board, and you're spending a lot of
23 time at another Trust? What message does that put out
24 in terms of visibility and leadership?

25 A. I think, if the Chair role was a full-time role, there's

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1 but that wasn't -- that was part of his role and the
2 expectation on that particular job.

3 Q. We've touched upon the Board problems that you
4 identified in 2020. I want to move forward to when the
5 CEO, the new CEO joins, Mr Majid. He joins at the end
6 of 2022, start of 2023.

7 A. Yes.

8 Q. And I want to focus on that because he can give evidence
9 about how the Board was actually working rather than
10 a sense of governance in general.

11 A. Yes.

12 Q. Can I take you to his statement, please. It's
13 WITN0263001, page 21.

14 We see at the bottom there, paragraph 83, which
15 starts:

16 "However I observed and heard that relationships
17 between Executive and Non-Executive Directors were
18 professional but perhaps not mature, and this was
19 something I could see in my early Board meetings.
20 Challenge tended to be more of a superficial nature and
21 was often met by a more defensive response from
22 Executives. Assurance seemed to rely heavily on
23 narrative reporting rather than triangulated evidence,
24 by which I mean rather than referencing data or feedback
25 from staff or patients or the content of [their] ...

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1 reports, responses to challenge tended to be the
2 thoughts or views of a single Executive Director. This
3 dynamic, in my view, resulted in the depth of assurance
4 not being as comprehensive as it could be. Challenge
5 tended to follow a pattern of single question followed
6 by a defensive response, with limited follow-up or
7 deeper interrogation. In a more mature board dynamic,
8 I would expect to see multiple levels of challenge from
9 Non-Executive Directors, with 2-3 rounds of questioning
10 that probe deeper into the assurance being provided."

11 We're told there about narrative reporting --

12 **A.** Mm-hm.

13 **Q.** -- rather than triangulating evidence. That was
14 a concern you had in 2020, wasn't it?

15 **A.** Yes, it was.

16 **Q.** We're told about a lack of challenge. That was
17 a concern you had in 2020.

18 **A.** Yes, it was.

19 **Q.** We're told about there's not the depth of assurance.
20 That again was a problem that you identified in 2020.

21 **A.** Yes.

22 **Q.** So the issues that you had identified, in terms of board
23 problems, they still persisted three years later.

24 **A.** I would want to draw attention to a key difference.

25 So when Mr Majid was making those observations,

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1 and the Board discussions.

2 **A.** Yes.

3 **Q.** So in 2023, when Mr Majid is noting this, there were
4 ongoing board failures because the culture wasn't there.

5 **A.** I don't think those were board failures, if I may. What
6 I would say, in terms of the cultural point, absolutely,
7 and I was very alert to those. The Board development
8 programme that I referenced in other parts of my
9 statement actually was seeking to build that board, to
10 build that collective team and, as a Chair, it would be
11 important, it was important, for me to invest in that
12 development and not to assume that anybody coming in to
13 that board could, from day one, be operating to their
14 full.

15 I think one other reflection I would make is that
16 I think Mr Majid's references and his analysis can be
17 accurate, and that doesn't mean to say that the state of
18 the Board he was observing was at the same level as the
19 version that I was referencing back in 2019, either.

20 **Q.** Move forward to February of 2024, an Integrated
21 Improvement Plan is put in place whilst you're Chair.

22 **A.** Yes.

23 **Q.** There was a Recovery Support Programme agreed with NHS
24 England.

25 **A.** Yes.

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1 actually there had been, the previous period that I'd
2 had building the Board with Dr Brewin as Chief Executive
3 and with that Board team, there had been a fully stable
4 Board.

5 At the point of Mr Majid's observations there, we --
6 he was observing a board which had an Interim Chief
7 Executive, which is always -- and we've seen this across
8 other NHS bodies too -- is always a point of
9 uncertainty. There were also, from my recollection,
10 three new Executive Directors and four Non-Executive
11 Directors who were in their first or second board
12 meetings at that point.

13 All of those changes were appropriate changes to the
14 Board structure. However, it meant that, at that point
15 of observation, the Board was less mature than the
16 version had been in the previous time when I had been
17 working with Dr Brewin.

18 **Q.** You lead the Board?

19 **A.** Yes.

20 **Q.** To effectively lead a board, there has to be the right
21 culture, doesn't there?

22 **A.** That's correct.

23 **Q.** You do that by both bringing in the right people?

24 **A.** Yes.

25 **Q.** And by supporting them in terms of the Board structure

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1 **Q.** As part of that, the Director of Corporate Governance
2 was removed from post.

3 **A.** I think that happened, I -- that wasn't a direct --
4 I don't think it's right to say that that was because of
5 what was happening there. I wouldn't want to get drawn
6 into those individual -- that particular individuality
7 and that person's employment. I don't think it was
8 a direct consequence, no.

9 **Q.** There's evidence before the Inquiry that the Director of
10 Corporate Governance was removed because of capability
11 issues.

12 **A.** Again, that was operational matters. That wasn't for
13 me. You're asking me about the specifics of an
14 individual member of staff there. And I think there
15 were broader concerns, obviously, around the corporate
16 governance, but I wouldn't want to be drawn to pointing
17 a finger at an individual.

18 **Q.** Do you think there was a problem with corporate
19 governance by February 2024?

20 **A.** I think corporate governance was a challenge that we had
21 not got correct, and it was something that had been
22 a frustration for a number of years, and was something
23 that we were seeking to keep on trying to invest in, to
24 be getting the right resourcing in there, and also to be
25 getting the level of not only expertise but also robust

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1 governance in there. So I do accept that there were
 2 challenges in corporate governance, yes.
 3 **Q.** Challenges in 2019?
 4 **A.** Yes.
 5 **Q.** Challenges in 2024?
 6 **A.** Yes.
 7 **Q.** We're seeing a consistent pattern here, aren't we? That
 8 corporate governance remained a problem throughout your
 9 time as Chair of the Trust?
 10 **A.** I think we may be using "corporate governance" in two
 11 different ways as a descriptor. So if you're talking
 12 about -- I'm referring to the governance, the processes
 13 behind what we were doing as a board, all of those
 14 processes and practices to support the Board. I don't
 15 think it refers to the governance of the whole
 16 organisation. So I am not sure which version of using
 17 that phrase "corporate governance" you're referring to.
 18 **Q.** So in terms of the processes behind the organisation,
 19 those were a problem from 2019 to 2024?
 20 **A.** Yes.
 21 **Q.** Why didn't you improve them over that five-year period?
 22 **A.** I would say that --
 23 **Q.** Four-year period, excuse me.
 24 **A.** -- we absolutely did, and we kept on seeking to improve,
 25 and where we found challenges, we sought to improve

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1 new non-executives that was appointed had a clinical
 2 background.
 3 What I also did was talk with both the Council of
 4 Governors and NHS England to ask NHS England to support
 5 the rare step of extending the non-executive role of my
 6 Vice Chair, who was a clinician, by an additional year.
 7 So that's something that was not normally done.
 8 I sought and got support from NHS England to extend her
 9 for an additional year, because I wanted to make sure
 10 that we had got that additional clinical voice around
 11 the table.
 12 **Q.** Part of the Recovery Support Programme was that there
 13 should be more clinical acumen on the Board. Do you
 14 accept that in 2024 there was a lack of clinical acumen
 15 on your Board?
 16 **A.** No, and I say that because in terms of clinical acumen,
 17 I had a Non-Executive Director with a clinical
 18 background, I had an Executive Director who was the
 19 Medical Director, I had an Executive Director as the
 20 Chief Nurse, and I had a Chief Executive who also had
 21 a career as a clinician.
 22 And going back to the comments -- the conversation
 23 we were having earlier about the unitary Board, my
 24 expectation was that they would be bringing their
 25 clinical voice into that.

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1 them. That continued post-2024 as well. But in that
 2 time, we absolutely did do that.
 3 **Q.** Sought to improve --
 4 **A.** Yes.
 5 **Q.** -- but to an extent ineffective?
 6 **A.** Partially so, and we may talk about it later, some of
 7 the additional challenges that we had, particularly in
 8 the first two years of my time at the Trust.
 9 **Q.** In February 2024, as part of the -- well, in the part of
 10 the Recovery Support Programme that was brought in from
 11 that time, NHS England felt there was a lack of clinical
 12 acumen on the Board; do you recall that?
 13 **A.** I don't recall the specific words, but I understand,
 14 absolutely, there was a challenge there, yes.
 15 **Q.** They took steps, as part of the recovery programme to
 16 ensure there were more clinicians, more clinical voices
 17 on the Board?
 18 **A.** They didn't. I did, as Chair of the Board.
 19 **Q.** When was that, in 2024?
 20 **A.** It was part of -- there were two elements to that. So
 21 it was looking at the opportunities with the
 22 Non-Executive Directors where we were going to
 23 a recruitment round, and I deliberately said that we
 24 would seek out specifically clinical expertise as one of
 25 the factors that was desirable, and indeed, one of the

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1 **Q.** So that part of the Recovery Support Programme that was
 2 crucial to the interaction between you and NHS England,
 3 that part of it, more clinical acumen wasn't necessary,
 4 in your view?
 5 **A.** I did not say that. I think that it was absolutely
 6 appropriate for them to be advising us and giving us
 7 perspective that we could improve that. I think what
 8 I was wanting to say was that it would be inaccurate to
 9 say there wasn't any clinical governance.
 10 **Q.** There was also, in this period, within NHS England,
 11 discussions about the work capacity of various
 12 executives, wasn't there?
 13 **A.** Yes.
 14 **Q.** Why didn't you pick up about these capacity issues
 15 earlier?
 16 **A.** I would say that we absolutely did. So through my
 17 conversations with both the Chief Executive, when
 18 I would -- whenever I would meet with the Chief
 19 Executive, a part of what we would talk about would be
 20 the pressures within his team. We had, both in those
 21 conversations and at Board, clear discussions about, for
 22 example, the pressures of external demand on executives
 23 and those pressures.
 24 So I think we did look at those, and we were always,
 25 as a Board, open to be thinking through different

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1 approaches and whether or not the -- that resource
 2 needed to be increased.
 3 **Q.** So you did look at this, but when NHS England came in,
 4 they continued to identify work capacity issues.
 5 **A.** Yes, I think that -- I think that's a consistent
 6 analysis with ours. I don't -- yes.
 7 **Q.** So that issue wasn't dealt with before NHS England
 8 advised as regards executive overwork, if I can put it
 9 that way?
 10 **A.** Again, I think the framing of that, to say it wasn't
 11 dealt with, I don't think is accurate. I think that, in
 12 terms of us looking at how we managed the workload of
 13 those people. So for example, I know that, as we moved
 14 into that period where we were having particular
 15 scrutiny, we would look at, and I would -- I encouraged
 16 the Chief Executive to look at -- the priorities for the
 17 time of those people, and making sure that we were
 18 prioritising their time in the right ways.
 19 **MR WESTON:** Chair, is that a good moment?
 20 **THE CHAIR:** Yes, it is. I think we'll start again at 1.50.
 21 Thank you.
 22 **THE WITNESS:** Thank you.
 23 **(12.50 pm)**
 24 **(The short adjournment)**
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