Tuesday, 19 May 2026

(1.50 pm)

THE CHAIR: Thank you. Yes, Mr Weston.

MR WESTON: Mr Devlin, before the break we looked at an overview of board functioning from 2019 or 2020, when you joined, to around 2024. I'd like to go back in time and I'd like to focus upon one of the regulatory requirements made by the CQC in 2019, please.

A. Yes.

Q. Can I take you back to that report, please, NHFT0002015, page 13. You can see there, five points down, one of the requirements from the CQC is that:

"The trust must ensure risk assessments are in place ..."

A. Yes.

Q. "... and that they contain all relevant risk information."

That was a mandatory requirement from the CQC.

A. Yes, it was.

Q. Clinical risk assessments, Mr Devlin, are a function to be undertaken by clinical staff.

A. Absolutely, yes.

Q. To do that, they need clinical training and they need guidance?

A. Yes.

Q. If a single clinician is not doing a risk assessment, that's clearly not an issue for the Board?

A. Yes.

Q. But if the risk assessments are not being done because of policy, training or support reasons, or may not be being done because of policy, training or support reasons, that is an issue for the Board, isn't it?

A. Yes, it is.

Q. Also, if the CQC are raising it, it's in itself an issue for the Board?

A. Yes.

Q. You gave evidence earlier about the importance of asking questions, setting off chains of enquiry, being inquisitive. This CQC Report was received a few months before your time as Chair. You were no doubt aware of this recommendation.

A. Yes, that's right.

Q. This requirement, I should say. What questions did you and the Board ask when you came in about where the clinical risk assessments were being done and whether they were being done properly at the Trust?

A. For me personally, what I would have been doing would have been asking questions about -- asking for sight of the action plan, and understanding that I would be expecting every single -- both the "must dos" and the

"should dos", from the CQC. I would be asking questions about the action plans in relation to those, how they would then be being evidenced through the governance structures of the Trust, some of which I would expect to come back to the full board, some of which I would have expected to have had oversight within committees and probably for some, oversight within teams or other parts of the organisation.

But I would have expected there to be a detailed action plan. Whilst I wouldn't be wanting to track personally every item, I'd want to know that that was there and that would be part of the evidence that I would be seeking.

Q. You've told us before that you had concerns about Board functioning when you came to the Trust?

A. Yes.

Q. The action plan was devised by others, wasn't it?

A. Yes, it was.

Q. How did you reassure yourself that the action plan and the steps that were taken were ones that you thought were necessary to meet the CQC requirement?

A. So if I say -- I will talk about -- the assurance for me would have been to first of all look to see that there were clear actions in place and to be testing out what the steps were that were in place and how we would know

whether or not actions had been successfully delivered or not.

Q. So you would be looking to see if the regulatory side of things were being met in terms of the action plan. But what about understanding the issue of risk assessments, clinical risk assessments? Did you ask whether this was a recurring theme, something that was happening throughout the Trust? Did you make those enquiries?

A. I don't recollect whether I did or did not. I think my -- in relation to any CQC "must dos" or "should dos", I would always be seeking to say is this something that is unique to a particular service, or is this something that is wider across the organisation?

So I think that is a question that I would have been asking whether or not there was something more broadly across the organisation. I'm afraid I don't recollect specifically what I may have asked at the time.

Q. So you're not -- I couldn't quite understand that bit of your evidence, and it may be that memory is difficult, but you can't recall whether you did ask whether this was a wider systemic issue or not, or ...?

A. I'm saying that in relation to the specific -- the specific bullet point you've drawn my attention to, I don't recollect whether I had specifically asked about risk assessments. What I was trying to say was that I

would be confident that what I would have done would have been saying: have we checked as an organisation whether or not these were isolated incidents or wider incidents? And that's what I would have been asking in relation to all of the feedback from the CQC.

Q. Can you recall what you were told about risk assessments?

A. No.

Q. If you'd have been told that it was a recurring theme, an ongoing concern, you'd remember that, wouldn't you?

A. I hope I would. I honestly can't give you that -- can't give you that reflection.

Q. Can I take you, please, to WITN0410045. This is a board meeting from before your time.

A. Yes, it is.

Q. 28 February 2019. Can I take you to page 8, please. At the bottom there you can see that a "Learning from deaths and mortality surveillance -- quarter ... 2018/19" was presented to the Board. You would have gone back and looked at these Board meetings when you started as Chair, wouldn't you? This is the year -- the 12 months beforehand.

A. I would not necessarily have gone through every set of minutes of every Board in that previous year.

Q. The report that was presented is at WITN0410046.

Page 4, please. I'm just waiting for that to come on the screen.

A. Yes. *(Pause)*

Q. I'm grateful. Page 4, please. Section 4, towards the bottom of the page, "Learning from Deaths".

A. Yes.

Q. "A number of recurring themes have been identified", at the end of that paragraph, and if you just turn over the page, please, one of the recurring themes was "Risk assessment".

A. Yes, it was.

Q. If you'd have asked other members of the Board, or asked anyone in the management, whether risk assessment was a recurring theme, this would have been part of the corporate memory, wouldn't it, this report?

A. I think it will have been part of the corporate memory, whether or not I'd asked, yes.

Q. If you'd have asked, you would have been told, wouldn't you, that risk assessments are a recurring theme?

A. Yes. I also suspect that I would have seen risk assessments being a recurring theme once I had arrived in the organisation, rather than having to look back through previous -- through the previous year as well.

Q. But it's the CQC Report, isn't it. That should be a trigger for an active Chair to start asking questions

about whether there are concerns more generally at the Trust about risk assessment?

A. Yes, absolutely.

Q. Had you been asked that question, you would have been told this was a recurring theme, when you started in January 2020.

A. Yes, the fact that I didn't ask the question doesn't mean I didn't know it -- would not have known it was a recurring theme, and also that I would not have given that, realised that that was a serious statement. It was part of a CQC "must do" response. Those are serious for us as a Board to take account of.

Q. If you'd have known this was a recurring theme in 2020, you'd have wanted to get more information, wouldn't you?

A. Yes.

Q. You could have done or organised through the executives an audit, a risk assessment?

A. I could have had the conversation to seek out such an audit yes.

Q. Dip sampling?

A. Yes.

Q. We've heard about deep dives. That could have been done by the Board if you felt it was necessary?

A. Yes.

Q. But when we look at the Board activity from 2020 to June

of 2023, clinical risk assessments just don't feature there, do they?

A. They do not, and you're very aware of some of the context around that in relation to the governance of the organisation, because during that period we were also dealing with the first two waves of the pandemic as well, and the governance expectations from NHS England.

I'm absolutely not taking away from the importance of the point you're making about risk assessment, clinical risk assessment not having been on those agendas. There were other priorities that were being pushed as well.

Q. Risk assessment is a crucial part of managing Covid, isn't it?

A. Absolutely.

Q. So if you'd known that there was a recurring theme about actually risk assessments being undertaken and done, that would have been highly relevant to the dominant issue in the Board in 2020 and 2021, wouldn't it?

A. Yes, and there was -- again, it's not the sole driver for us having conversations about risk in the context of the pandemic, either.

Q. Did you have insight in your first year at the Trust as to where the Trust sat comparatively in terms of serious incidents?

A. To a point of being able to say -- not -- not to say to a point of direct data. However, as an organisation, I knew that we absolutely had serious incidents, as had my other trusts, the Lincolnshire Partnership, as indeed had every other mental health providing trust across the country.
Q. But no idea where you sat comparatively to other organisations; more, less, similar?
A. My understanding was that we were in a similar -- at a similar level for comparative organisations. The comparative piece is quite difficult, I think, to be able to measure.
Q. Well, serious incidents are recorded, aren't they?
A. Yes, they are.
Q. There's always a data number in terms of the number of serious incidents in any particular trust?
A. Yes, I also think there's the -- my apologies.
Q. -- no, no, please.
A. There's also the context of the range of services that different trusts provide and I think that -- and the size and scale of those services. I think that's a part of that that makes comparison is not quite as simple as there were X number in this trust and Y number in that trust.
Q. Can I take you, please, to document WITN0223001, page 19

to begin with. This is the first witness statement of Amanda Sullivan, who is the Chief Executive and Accountable Officer of the NHS and Nottinghamshire Integrated Care Board?
A. Yes.
Q. Can I take you to paragraph 119 of her report at page 47.

"Throughout the rest of 2020 the CCG continued to note ..."

The CCG was in place before the Integrated Care Board, wasn't it?
A. Yes, it was.
Q. "... continued to note concerns regarding workforce capacity, governance maturity and the pace of improvements, particularly in adult mental health and community services. NHFT also consistently reported the highest number of serious incidents across the local NHS system, with a significant portion linked to self-harm, falls, and suboptimal care of deteriorating patients."

So the ICB were aware of this. Did you make any enquiries of the ICB, or anyone else, as to where you sat comparatively to other organisations?
A. Again, I think it's important for me to point out that, across the local NHS system, there weren't directly comparative organisations in terms of the services. So

in terms of us having the highest number of serious incidents across the Nottingham and Nottinghamshire system, that in itself is not saying that we were an outlier compared with other mental health providers in other systems. There aren't the other mental health providers in that Nottingham and Nottinghamshire system.

I understand the point that you're making in terms of the Trust being -- having the highest number of those serious incidents, of course, but I think it's just to be clear that there's not a direct comparison in terms of those services.
Q. To even start the comparison, you need to ask about the numbers elsewhere and then you can adjust things and make the comparison, can't you?

Just to go back to my question: did you enquire about the comparative position; what the numbers were elsewhere in the local area? Is that an enquiry you made of the Board?
A. It would have been conversations that we had across the broader -- the broader region and across the country. So actually trying to find comparator -- to get a sense of comparison with similar providers, not with very different providers, which would be the only ones in the Nottingham and Nottinghamshire system.
Q. Can I please take you to NHFT0003346, page 91. This is

a document dated 13 December 2022.
A. Yes.
Q. It's a briefing pack for the Quality & Mental Health Legislation Committee, that's one of the committees that sit below the Board.
A. That's correct, yes.
Q. Meeting to be held on 13 December. Point three that's highlighted there.
A. Yes.
Q. "Risk assessments including absence of clearly documented risk assessment; not considering key risk factors; communication of risk assessment within teams and to other interested persons."

Now, this is a report, as I say, to a committee below the Board.
A. Yes.
Q. Was this concern from the Patient Safety Report, was this brought to the attention of the Board?
A. It will have been -- I don't know honestly whether or not that was reflected in the highlight report from the Quality Committee. However, everybody around that Board table will have been alert to the document and many members around that table would have been members of that committee. Obviously I was not a member of that committee. But, yes.

Q. So in 2022, in December 2022, were you aware of this ongoing concern with risk assessments, the absence of clearer documented risk assessments?
A. Yes.
Q. You were aware of that?
A. Yes.
Q. Did that lead to a discussion about risk assessment policy?
A. *(Pause)* My hesitation is just, again, not quite remembering. It will have done at either the Board or that particular committee, in terms of that policy, and it will have led to questions being asked about, "So what can be done to try and fix a problem that has clearly been identified as an ongoing challenge for the organisation?"
Q. When I asked earlier whether clinical risk assessment was something that was discussed at board level between 2020 and June of 2023, I understood that you'd said it wasn't.
A. I don't think I -- if that's how my answers came across, it wasn't --
Q. Maybe I misunderstood. That's what I understood your evidence to be.
A. My intent was to say that it may well have been. I could not give you -- I couldn't say definitely: yes,

we had an item on that. I think that's different from me saying it was not discussed.
Q. But you're aware that risk assessment is a crucial issue that --
A. Absolutely.
Q. -- the Inquiry is looking at.
A. Yes, I am.
Q. You had access to the notes and probably gone back and looked at some of the previous board meeting, haven't you?
A. Yes, I have.
Q. When was clinical risk assessment discussed at the Board level between January 2020 and June of 2023?
A. I can't give you a specific answer to that, I'm afraid.
Q. Had it been discussed, the fact that the policy had not been updated -- and we've heard it was out of date by this point -- that would have been brought up, wouldn't it? Someone would have brought that up?
A. I would have had expected that, yes.
Q. We can draw the inference, can't we, that risk assessments, clinical risk assessments, just weren't discussed, or if they were discussed they were very low on the priority, weren't they?
A. *(Pause)* That inference can be drawn.
Q. If risk assessments were something that was a focus of

the Board, that policy would have been updated.
A. I would have hoped so. I think the expectations around policy updates, I think, again, across the organisation, there were clear expectations on when policies should be reviewed and when they should be updated, and again, aside from a period where there was some recognised guidance from NHS England on some policies being allowed to be extended beyond their deadline, I would expect policies to be updated in that way.
Q. We've heard it was out of date; do you agree with that?
A. Yes.
Q. Yes. Can I take you to the CQC Review of this issue. It's from the special review in 2024, it's CQCM0013499.
A. Yes.
Q. Can I take you to page 4, please. Recommendation 1(a), at the bullet point:
"all patients receive appropriate ongoing assessment of their risks including those waiting to receive treatment and care.
"appropriate and effective risk management plans are formulated and implemented."
Those recommendations were made because there was considered to be a lack of proper and rigorous risk assessment, clinical risk assessment, at the Trust.
A. Yes.

Q. Page 28, please:
"Managing Risk
"How well staff assessed and managed risk in community mental health and crisis services varied, and the approach to risk assessment was inconsistent. In our review of records, we found that many people who use services did not have an updated crisis or risk plan."
Then over the page, please, to 29, at the bottom there's a box, in terms of:
"Key points
"... a lot of changes in leadership in recent years, with 3 out of 7 executive directors having taken up post since 2023."
"Leaders were aware of some of the current risks in safety and quality of services but we were concerned senior leaders did not appear to have a clear oversight of these risks."
Do you agree that you did not have a clear oversight of the issue of clinical risk assessment at the Trust, Mr Devlin?
A. I do in the context of this Section 48 Review from the CQC, yes.
Q. Well, what other context do you agree --
A. Purely because that's the document you put in front of me.

Q. "While there was evidence of the trust taking action to address safety concerns including those raised by our review, we are concerned that the trust activities are predominantly reactive."

That may have been a reference to steps that were taken since June 2023, since the attacks.

A. Yes, and I think it's important for the Trust to absolutely be responding to new evidence that comes through. I think it's about as -- the concern about being predominantly reactive, I absolutely accept. I think it's also important that that plays to the importance of us seeking to respond to new evidence that gets raised with us, notwithstanding whether that's something that we ought to have known ourselves previously.

Q. Risk assessment raised as an issue in 2019 by the CQC. Risk assessment raised as an issue in 2024 by the CQC.

A. Yes.

Q. It doesn't seem, based upon the inference that we just discussed, that this was discussed at board level. Given the findings of the CQC in 2024, this needed to be discussed at board level. This was a systemic issue, wasn't it?

A. Yes.

Q. The fact it wasn't discussed, despite the fact -- or

raised at all, it seems -- despite the fact it was raised by the CQC at the book ends before and after, that is a failure in governance?

A. I think, in terms of that -- the Board oversight piece, I agree with that statement. I think that there may well -- there will have been other work being done in other parts of the organisation about that risk assessment. But in terms of that being able to evidence clear board oversight of risk assessment in this way, I agree with that statement.

Q. So a systemic failure to consider clinical risk -- or systemic issue with clinical risk assessment, and a failure at the Board level to understand that systemic problem; do you agree?

A. Yes.

Q. Can I take you to your witness statement, please, WITN0390001, paragraph 168. It's page 63. So paragraph 168.

A. Yes.

Q. "The organisation has many risks that are captured through operational risk registers. However, the BAF ..."

What's the BAF, please?

A. It's The Board Assurance Framework.

Q. Thank you.

"... is designed to focus on a small number of high-level strategic risks".

Those are really business level risks, aren't they?

A. They are strategic risks that would be regarded as affecting the whole organisation, yes.

Q. "This does not preclude a specific operational risk coming to the attention of a Board Committee or the Board, if escalation requires that ..."

A. Yes.

Q. It means:

"... the Board holds its strategic responsibility and does not get drawn into managing local operational risks."

A. Yes.

Q. "Clinical risk assessment for individual patients sits with clinicians and, in terms of governance, does not get Board scrutiny."

This systemic issue did not get Board scrutiny.

A. Yes, I think in the way I was describing in paragraph 169 there, I was trying to present clinical risk assessment about the individual patient, and saying that that does not come through to the Board, and that that is proper.

Q. This is a clinical issue that, Mr Devlin, you didn't at the time think was something that needed Board scrutiny?

A. I -- did not need to be raised as part of the Board Assurance Framework.

Q. Because it was clinical --

A. Yes.

Q. -- and not, in your view, business or strategic; that's why it wasn't looked at.

A. No, in terms of individual patient clinical risk, no. I think the broader point about clinical risk assessment I've agreed with you that that had not had the level of scrutiny.

Q. We've heard that part of the 2024 improvement plan, when you're working with NHS England, was that there should be more clinical acumen at the top of the organisation.

Do you consider that in the period before June 2023, that the Board was too focused on strategic risk and didn't have enough focus on clinical risk, because of the make-up and constitution of the Board that you oversaw?

A. I don't think the -- that causal link is there, no.

Q. Because quite simply, Mr Devlin, if you had asked the right questions back in the beginning of 2020 about risk assessment, this would have been an issue on the Board, wouldn't it?

A. Yes.

Q. We've looked at some internal communications, we've

looked at the CQC reports that identified issues with safety. I want to look at another source of information coming from outside of the Trust --

A. Okay.

Q. -- if I may. Can I take you to WITN0356017. This is a document that other witnesses have been taken to, but I just want to understand it from your perspective, please.

This is a meeting with the Senior Coroner on 16 December 2021, follow up to previous issues. The attendants, in terms of executives, is Anne-Maria Newham, Executive Director of Nursing; Sue Elcock, Executive Director and Director of Forensic Services.

A. Yes.

Q. "Family Involvement", first bullet point:

"Family involvement in care, including risk assessment, history taking, decision making. Highlighted that there'd been several cases where the family had communicated during the inquest process that they had information to share and concerns but had not been given the opportunity."

Further down under "Risk assessment":

"Noted that the documentation relating to risk assessment, detail of risk factors, decision making rationale and agreed outcomes was lacking within the RiO

records potential[ly] impacting on a patient's pathway between services and explanation of outcome to others".

This is the coroner obviously reporting about cases which have ended in deaths.

A. Yes, it is.

Q. Were you aware of the coroner's concerns in December 2021 or at any point?

A. Yes, I was, and will have been aware of them in December '21.

Q. Can I take you to the discussion of this at board level, please, NHNB0012321. *(Pause)*

If you can go to page 2, please. There is a discussion there -- sorry, just the date of this is 1 March 2022.

A. Yes.

Q. So a few months after that meeting with the coroner --

A. Yes.

Q. -- the Board is being updated about the coroner's views.

A. Yes, it is.

Q. The executive summary, explains what a PFD, a preventing future deaths report is, under Regulation 28 of the Coroners rules, and then it goes on to say:

"There are several strong ... themes that have emerged from the learning identified within the main body of this report".

2:

"Risk assessments including absence of clearly documented risk assessment; not taking into account key risk factors; communication of risk assessment within teams ..."

So this update, there was information coming to the Board about risk assessment here.

A. Yes, there was there.

Q. But no plan put in place in relation to it.

A. In -- I think there were significant plans put in place in relation to the facts as they were raised by the coroners. So I think risk assessment will have been picked up as part of the concerns being raised by the coroners as an important other source of information as you describe.

Q. It was picking up the theme from 2019 --

A. -- *(overspeaking)* -- *(unclear)*

Q. -- in the CQC, we discussed earlier the various different matters which could be done if this issue was live in the minds of the Board: dip sampling, audit, investigation, deep dive; none of that was done, was it?

A. Not as -- under instruction from the Board, no. And I don't know whether or not those were done. From an operational point of view, there are others who will be better placed than me to be able to give you that

information.

Q. WITN0263001, please, page 67. Paragraph 279, I should apologies, this is Mr Majid's statement.

A. Yes.

Q. "PFDs are sent directly from the coroner to myself as the CEO and I am responsible for the acceptance and response to the report. As the new CEO at Notts Healthcare I had concerns about the volume of PFDs compared to what I was familiar with from being the CEO of a neighbouring NHS mental health trust."

Were you aware of Mr Majid's concerns about that?

A. Yes, I was, and I shared them, if I may say that."

Q. "All PFDs were reported to the Trust Executive Team meeting which is where this concern arose."

280:

"During 2023 the trust received a significant increase in PFDs-- 8 in total. During the preceding five years from 2018 to 2022 it had received a total of 5 PFDs."

So in terms of the eight PFDs in 2023, what were the numbers for the following years before you left?

A. The numbers in later years were decreasing, and in terms of the coroners, my recollection in my final year was that we were getting explicit feedback from coroners who were saying that they -- I can think of at least

a couple of occasions where coroners, having considered whether or not a PFD was appropriate, had been minded not to judge a Prevention of Future Deaths Notice explicitly saying that because they had confidence in the way that the organisation was embedding its changes.

Q. Do you know the numbers for 2024?

A. I don't know the numbers. I'm sure that they are in the evidence.

Q. So reducing PFDs, progress is being made, and you likely think that's because of steps that were taken inside the Trust?

A. Yes.

Q. Had those steps been taken earlier, these concerns could have been allayed earlier, couldn't they?

A. They may have been, yes.

Q. Beyond the coroner's concerns, you, as the Chair, were made aware of serious incidents that resulted in death or very serious injury, weren't you?

A. Yes, I am, yes.

Q. Can I take you, please, to INQY0000034, page 2, please. This is an Inquiry Legal Team document that --

A. Yes.

Q. -- provides information in an anonymous form about several incidents being considered by various CPs in terms of the detailed information there?

A. Yes.

Q. Just so you know what you're looking at. It was not a document that was produced by you or the Trust.

A. Thank you, yes, I'm aware of the document.

Q. It's been considered by those for the Trust.

Can I first of all just touch upon Patient 1. We can see that the information in paragraph 1 came to light in 2022, certainly the first information we have there is August 2022. Related to an incident just a little time, a few days before that, actually.

A. Yes.

Q. This was a mental health related homicide, wasn't it?

A. I believe so. The anonymising of these examples in this case made it a little more difficult for me to correlate to the specifics, but I believe so, yes.

Q. Any death that arises from a previous patient of the Trust is a very serious concern for the Board, isn't it?

A. Yes, it is.

Q. Paragraph 3:

"A patient safety incident investigation was ... approved on 2 May 2025."

Do you see that?

A. I do.

Q. So two years and nine months for a patient safety plan, or the patient safety action plan, to be signed off.

A. Yes.

Q. The delay, as I understand it, and perhaps you can assist, was because you were awaiting for the end of the police investigation?

A. I think that was a key factor and I think you've heard in previous evidence from Mr Majid about what's been put in place to change those arrangements, but that's my understanding, yes.

Q. That's since June 2023, isn't it --

A. Yes, it is.

Q. -- those arrangements.

I just want to focus upon the position in 2022, if I may, because were you aware at the time that you were awaiting a police investigation?

A. I will have been, yes.

Q. Did you question whether it was wise to wait?

A. My recollection is that it was that it wasn't a matter of whether it was wise or not; it was an instruction, and there was a legal framework in there. I think the framework -- it appears that the Partnership has developed since then and there is a different way of operating. But that was what I understood at the time was that this wasn't a matter of choice, this was an instruction rather than a matter of choice for the Trust.

Q. A death as a result of a -- or at the hands of a former patient --

A. Yes.

Q. -- you want to learn lessons from this as soon as reasonably practicable, don't you?

A. Yes.

Q. If you're being told that there's a legal framework, did you take legal advice about that framework?

A. I don't believe we did.

Q. So you didn't challenge the information that was coming in relation to why you had to wait for this Patient Safety Investigation and Patient Safety Action plan; is that fair?

A. Yes.

Q. Can I just take you to the findings of that investigation, it's paragraph 9, so that's over the page, please:

"The Patient Safety Incident Investigation identified two key findings: ... a lack of 'curious enquiry' by staff; and ... an 'emphasis on "opt-in" engagement with services' ..."

A. Yes.

Q. "... in the context of individuals where the threshold for a Mental Health Act assessment had not yet been reached."

So there's quite important learning there, isn't there, about Assertive Outreach towards patients, isn't there?

A. Yes.

Q. The alternative is to have opt-in where patients are approached, even if they are choosing to opt out. That's the alternative model, broadly?

A. Yes.

Q. So just taking you over the page, please, paragraph 10:

"Related learning in the Safety Action Plan included considering alternatives to 'opt-in' engagement, such as phone calls or referrals to other mental health services."

Then paragraph 11:

"Other changes following the incident including improving clinical risk assessments, and amending the clinical supervision template."

So this incident, August of 2022, raised an issue about clinical risk assessments as well.

A. Yes.

Q. And this was brought -- this particular incident was brought to the particular attention of the Broad *(sic)* shortly if it had happened.

A. Yes.

Q. Can I take you to that board meeting, please.

TCLT0000374, a meeting of 6 September 2022. Page 3. If I can take you to page 3 please, there is a section 7: "Reportable Issues Log Assurance".

A. Yes.

Q. "TD presented the Reportable Issues Log to ensure the Board [were] ... aware of the most serious incidents and other significant issues within the Trust.

"The Board received assurance from the report."

Now, that log -- I'm not going to take you to it, it's got personal information in it.

A. Yes.

Q. But that log informed that there had been a fatal attack, and that it happened after the perpetrator had previously had contact with the Trust's mental health services, and there was an issue raised, or at least a mention of discharge in there.

A. Yes.

Q. Do you recall that?

A. I -- it relates to one of the patient examples, it gives -- it's more detail, yes.

Q. So previous contact and then discharge.

A. Yes.

Q. Now, the log simply states at the end in terms of what's happening next, it says:

"Concise investigation once police have concluded

investigation." *(As read)*

So in line with what we discussed, you were awaiting for the police investigation.

A. *(The witness nodded)*.

Q. That's the plan in terms of what the log said?

A. Yes.

Q. It was reporting matters, it wasn't an investigation as such; it's a log alerting the Board to matters.

A. Yes.

Q. And the investigation was waiting for the police.

A. Yes.

Q. So if that was the plan from the log, just looking at the Board notes again:

"The Board received assurance from the report."

So you had details of a fatal incident, no investigation was going to be undertaken until the police said you could, and indeed that turned out to be years later.

A. Yes, it did.

Q. How was the Board then assured from the report?

A. I think at the time, that relates to an assurance that the usual processes were under way. I think what we had learned subsequently, and is now the case, is exactly what you're saying about those delays being far too long, and being able to have developed a different

operating model with that. I think the assurance with my recollection is that the processes that were in place at that time were being followed in that way, which I appreciate does not bring a great deal of assurance, looking back at that.

Q. You've referred to "the usual processes".

A. Yes.

Q. The process that was going on was a police investigation.

A. Yes, and what I was meaning by that was the usual process of, because of the police investigation, there was an instruction that we were not able to therefore do that follow-up work ourselves.

Q. So the usual processes was a police process?

A. No, what I'm meaning is the combination of the two. So that usual piece of having to wait for the police investigation, that's the usual process --

Q. Okay, I understand.

A. -- that I was referring to.

Q. Because the Trust weren't doing anything about this until the police came back to them, were they?

A. I don't know. I don't know if that is fair. I think there will have been a lot of looking at the circumstances of that. From an operational team perspective, that will have been being looked at. The

formal investigative route, however, was -- would -- was regarded as having to be on hold because of that police investigation.

Q. Did you ask whether other steps were being taken, for example, informal analysis before the investigation took place? Did you ask about that?

A. In relation to the specific case, I don't know whether I will have done. It is a conversation we had had at the Board in relation to other serious incidents, because this obviously applied to other situations too.

Q. To undertake any investigation, you need to speak to the people involved, don't you?

A. They need to be spoken to by the investigation, yes.

Q. And we were told that the reason that the clinical investigation couldn't take place before the police was not to pollute the evidence line.

A. That's -- that was my understanding of that particular process at that time, yes.

Q. So the people involved with this particular case wouldn't have been spoken to at this stage, would they? Because that would have been contrary to the processes that you'd understood to be proper.

A. That's correct.

Q. In terms of any other kind of -- I think you referred to informal analysis of this, what was done?

A. Er, I --

Q. -- *(overspeaking)* -- *(unclear)* specifically?

A. I would have expected that what was done would have been for senior leaders to be, notwithstanding having those conversations with those -- with the people who the police would have had interest in, would have been to try and see if there were lessons that could be learned from that.

Q. Nothing in the Board minutes that that should be done, are there?

A. Not at that stage, no.

Q. And indeed, it says there was assurance from the report but I think you've accepted that there wasn't really proper assurance at that stage.

A. Not in relation to the content of those cases, no.

Q. So from a Board level, not enough was done in relation to this incident in August of 2022.

A. I accept that.

Q. We're a few weeks before VC's discharge, when he was discharged from the Trust to the GP.

A. Yes.

Q. We've got a case here that involves a former patient and some issue about discharge, but no meaningful steps are being taken by the Board at this stage; do you agree?

A. Yes.

Q. This was a missed opportunity, wasn't it?

A. Yes, it was.

Q. Even with a police investigation, even with the concern about polluting the evidential line, you could ask for some analysis, some higher-level analysis, about, for example, discharge policies. That could have been asked for by the Board, couldn't it?

A. Yes, it could.

Q. There could have been a request for a review of other discharges in this period.

A. There could have.

Q. It's a serious incident this, isn't it: a death from a former patient?

A. It absolutely is.

Q. These are the sorts of steps that should have been taken in September 2022 when this matter was put before the Board.

A. Yes.

Q. Can I take you to the next incident, please, that's touched upon in that document. So it's back to INQY0000034, page 4, please. Patient 2. This is another fatal incident.

A. Yes.

Q. Came to the attention of the executives in February of 2023. Just turning over the page, please, to page 5,

paragraph 15. Apologies, paragraph 14:

"... initial Management Review completed on 24 February ..."

So that's completed quite quickly, the initial management review.

A. Yes.

Q. But in terms of a comprehensive investigation report, that wasn't completed until July of 2024, so some 17 months later.

A. Yes.

Q. The Initial Management Review, it's on a template document, isn't it?

A. Yes.

Q. And under the heading "Lessons learned" it just says, "None currently".

A. I take your word for that.

Q. Whereas when the actual comprehensive report is done, we have quite a number of findings and lessons.

Can I take you over the page, please, to paragraph 20:

"Learning points identified by the investigation report related to matters including:

"... staff understanding of mental capacity;

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

"... risk formulation and management;
"... information-sharing with the police; and
"... community forensic referrals."
Those are findings that are all relevant to the VC case, aren't they?
A. They are, yes.
Q. But the findings, the learning, was a year after the attacks, despite this event happening several months beforehand?
A. Yes.
Q. That's far too late, from a governance perspective, isn't it?
A. It -- it is.
Q. Far too late to assist those that were harmed in the interim?
A. Yes, and also therefore as part of what drove through these reviews to be able to change the practice to make these timeframes shorter, as is the case now.
Q. When Mr Majid was giving evidence yesterday about these incidents, he -- his evidence was that it was a serious failure of governance as regards the delay in taking actions following the incidents in 2022 and 2023; do you agree?
A. Yes, I do.
Q. That serious failure in governance was one that the

Board had sight of albeit not proper oversight of; do you agree?
A. I do agree, yes.
Q. Third case, third patient, please, if I may, page 7, paragraph 24. This is a non-fatal attack.
A. Yes.
Q. First discussed or first raised in terms of the documentation April 2023; do you see that at paragraph 24?
A. Yes, I do.
Q. The investigation into this, or at least the concise investigation, was done quite quickly in June 2023; do you see that?
A. Yes, I do.
Q. That's the sort of speed you want the investigation done to meet the Government requirements; do you agree?
A. I would ideally want that, yes.
Q. From the documents we have -- and certainly from this document -- it doesn't seem that this specific incident was discussed at board level. Given the previous two incidents, you'd expect something like this to be raised with the Board, wouldn't you?
A. Yes, I would.
Q. There was a discussion of incidents in May 2023 at board level. Can I take you please to TCLT0000353. This is

the Board meeting of 25 May 2023, as we can see on the first page, and we can see that you were there --
A. Of course.
Q. -- as well as the CEO, of course. Can I take you to page 3, please:
"Reportable Issues Log ...
"The Board of Directors receive the Reportable Issues Log to ensure awareness of the most serious incidents and other significant issues within the Trust for information and discussion as appropriate.
"YM highlighted incident 501667 ..."
That's not this incident that we were just talking about.
A. No.
Q. "... advising [that] media coverage was expected, but the Trust had not been mentioned to date. A briefing statement will be available and has been drafted ready.
"AMN advised the Trust had reviewed twenty-two investigations of serious incidents which would be reported through to the Quality Committee. MD commented that this was a particularly important piece of work given the Trust relationship with the coroner. PD enforced the Trust needed to do as much as it could to reduce the number of serious incidents."
Clearly that's a sentiment that everyone would agree

with.
A. Yes.
Q. That much needs to be done to reduce the number of serious incidents and from this it appears that the thing that was being done is that there had been review of 22 investigations of serious incidents --
A. *(The witness nodded)*.
Q. -- which were going to be reported through to the Quality Committee. That was the step there.
A. That was the specific step there, yes.
Q. If there was a lot more to the plan in terms of trying to avoid -- reduce the number of serious incidents, that would be in the Board minutes here, wouldn't it?
A. Not necessarily, because I think that review work would have gone through to the Quality Committee itself, and wouldn't necessarily be reflected in the minute of the Board.
Q. No sense from the minute that there's a discussion, an active challenge, a to-and-fro about this particular issue?
A. No.
Q. Your contribution is to say that the number of serious incidents should be reduced, but you don't suggest any other plans or way forwards in relation to this, do you?
A. Not that are minuted there, no.

Q. Just going back to the second paragraph, the other incident, the main concern there was:

"... advising media coverage would be expected, but the Trust had not been mentioned to date".

The main concern there is reputational, isn't it?

A. That was the role of that particular person to absolutely focus on that. That wouldn't necessarily be a reflection that the Board -- that was the priority for the Board in looking at that incident.

Q. It then goes on to talk about the 22 investigations of serious incidents, and it then says:

"MD commented this was a particularly important piece of work given the Trust relationship with the coroner."

A. Yes.

Q. Again, a reputational concern that's focused upon there.

A. I don't think that was about a reputational piece; that was actually trying to draw a link back to the concerns that the coroner had been raising and the conversations we were having with the coroner about improving what we were doing. I think that was more about a correlation rather than being concerned about a reputational matter.

Q. There were the systemic issues about risk assessment, there were the concerns raised by the coroner. There are now these deaths that are being reported to the

Board, which I think you've accepted in at least 22 of them more should have been done and the Board should have had oversight?

In terms of what more could have been done, you would have wanted the investigations of those incidents to be expedited, wouldn't you, so you could learn from patient issues as quickly as possible?

A. That would be one factor, yes.

Q. You would have wanted a review of policies that are relevant to those deaths?

A. I would have expected that to have been part of that work, yes.

Q. That would include the policies as regards risk assessment?

A. In those cases, yes.

Q. Policies as regards discharge --

A. Yes.

Q. Policies and processes as regards discharge.

You could have asked for a review as to whether discharges in recent times had been safe.

A. Yes.

Q. That would have been a logical piece of work when the report is of previous patients causing fatal or very serious injuries to others, wouldn't it?

To avoid this, are we awaiting for another one? Is

there something in the system that's going to come forward in due course? That's what would have been the most important piece of work here --

A. Yes.

Q. -- to reassure yourself.

After the attacks in June of 2023, work was done to understand --

A. Yes.

Q. -- the incidents. As well as some others. Can I take you, please, to the "Thematic review of homicides and attempted homicides", NHFT0000518. Dated August of 2024.

A. Yes.

Q. So some time after the attacks in June of 2023. Can I take you to page 7, please. These are the recommendations of this thematic review. Number 1:

"The Trust's Serious Incident Policy needs to be re-written and should include process for Executive oversight of the most serious incidents and include the following:

"... Process for sign-off.

"... Process for the appointment of panel members.

"... Understanding when a 'tabletop' review is acceptable.

"A method of approving the recommendations and the

accompanying QIP".

Number 3:

"That an audit is designed to identify those patients who have a risk history and have been discharged following a period of disengagement so they can be identified, re-reviewed and options considered."

Those are lessons that could have been learned from the three cases that we looked at before.

A. Yes, they are.

Q. And those steps that we just touched upon a moment ago, considering policy, considering process, discharge, risk assessment, they could have been ordered back in 25 May -- or should have been ordered back on 25 May 2023, when this was before the Board.

A. Yes.

Q. Indeed, going back to September of 2022, a very serious incident involving a former patient; that should have been the trigger point to review the policies, shouldn't it?

A. Yes.

Q. That should have been the moment when an audit was undertaken to check whether discharge policies were safe, and whether anyone else was potentially being discharged in an unsafe way; do you agree?

A. Yes, there's the recommendations that were put forward

in this piece of work. I accept that those could have been brought in at those earlier stages.
Q. Post-June of 2023, we've got a series of new policies, two in particular. I think it's a nine-step discharge policy that was brought in?
A. Yes.
Q. And the new risk policy, the out of date risk assessment policy was updated in 2024.
Those policies, Mr Devlin, were aimed at trying to avoid attacks like VC's happening again, weren't they?
A. Yes, they were.
Q. Those policies were required, because the practices and processes as regards risk assessment and discharge were not fit for purpose before, as per the CQC Report and the Theemis Report.
A. Yes.
Q. The Trust were aware, and the Board were aware, of the concerns with risk assessment, potential issues with discharge. By September of 2022 you've said that these policies should have been reviewed.
Had that opportunity been taken, these policies would have been in place or some learning would have been in place long before June 2023.
A. Yes, some learning would have been.
Q. If there'd been an audit of unsafe discharges, as

I think you agree should have happened in September of 2022, that process would have picked up VC's case, wouldn't it?
A. It may well have done, yes.
Q. And steps could have been taken to avoid the attacks in June of 2023.
A. It may be the case, yes.
Q. They certainly would have been aimed, those steps, to avoid this kind of incident, wouldn't they?
A. In terms of -- in terms of the discharge element, yes.
Q. I want to move on to a different topic, if I may: community staffing and resources, or particularly staffing and resources at the Trust, please.
A. Okay.
Q. Can I take you, please, to NHFT0002015. This is -- we're going back again, so I'm looking at the issues and going back and then we'll work through chronologically as we've done with the risk assessment and safety point. Can I take you back to 2019 so we can see what the situation is when you started at the Trust. Page 7, please. Down the page a little, please.
"Are services safe?"
The penultimate bullet point:
"The Trust did not meet safe staffing levels across the three services inspected. These were the health

based place of safety, forensic services, and adult acute admission wards. The trust risk register listed staffing as a major risk and the trust had a robust recruitment and retention strategy in place."
Now you would agree: you were no doubt aware of this particular concern of the CQC when you started as the Chair of the Trust?
A. I was, yes.
Q. Can I take you, please, to NHNB0004596. Page 14. So this is the "NHS Long Term Plan [for] Investment in Mental Health", dated 1 February 2020. And we can see as part of the overall NHS plan, in terms of Community Mental Health Teams, it says that:
"If the funding is not available to support service development and transformation, people with mental ill health will continue to have significant waits to be diagnosed and access treatment. This can led to deterioration in their condition and potentially a mental health inpatient admission. It will also mean that community teams will not have capacity to accept referrals and step downs from mental health inpatient services and specialist teams for example crisis resolution and home treatment."
I'm sure you'd agree with all of those difficulties that can come from a lack of funding and lack of support

and development?
A. Yes.
Q. Further down:
"Early Intervention in Psychosis:
"Funding for EIP is essential to main the current performance against the access standard. Without investment the EIP service will not be delivered in line with NICE standards and will not achieve the MHFYFV ..."
Can you just assist with what that is?
A. I can't, actually.
Q. "... or LTP standards"? Can you assist there?
A. Long-term plan standards, I would guess.
Q. I'm most grateful.
So this the NHS plan urging trusts to consider the issue of funding in the sorts of teams that we are concerned about in this Inquiry.
A. It's broader than that, if I may say so, because the funding doesn't sit with the Trust; the funding sits with the commissioners.
So the fact that the funding is essential, I would agree with a statement like that. It's not that we are sitting there with funding that we can put into that; that's a negotiation with commissioners.
Q. A negotiation you would have, in particular, with the commissioners?

A. The -- the operational leaders would have. It would be -- it would not be for me personally to be having that specific negotiation. I might well raise concerns about mental health funding in the broader NHS funding, but it would be for the operational leaders who would be involved in contract negotiations to be talking about the detail of that.

Q. If you were concerned that there needed to be more funding, that's something that you could lead as the Chair, couldn't you? That was something that you could ask others to do, that's an issue that you could lead?

A. Yes.

Q. Can I please take you to WITN0380054. This is an email --

A. Yes.

Q. -- from Mr Brewin, you're cc'd --

A. I am.

Q. -- we can see further down. And the third paragraph:

"... reached a point where ... services are not safe and we need an immediate response to help support them.

"There is a sense of despondency that despite flagging this since at least June nothing has happened.

"And that if [the] CQC arrived we would be threatened with closure, so let's work on the principle that this has happened.

"So from a 'can do, solution-focused and optimistic' position I would like the following to happen from next week for starters".

Then there is a series of measures --

A. There are.

Q. -- put in by Mr Brewin -- Dr Brewin. Apologies, I called him Mr Brewin.

That's a very concerning picture, isn't it?

A. It absolutely was and it's wider within the actions taken with some immediacy after that.

Q. Indeed, it was discussed at the Board of Directors, wasn't it, this concern?

A. It was discussed, there was -- this was on a Friday that this email was sent. The Board of Directors was meeting on the following Tuesday and it was raised appropriately as an urgent verbal matter there, and then came back in a formal, written report with plans and updates to the following board meeting.

Q. Can I take you to that board meeting, please. It's NHFT0002204, page 5. So we can see there the dates, as you've said, the Tuesday, 2 November --

A. Yes.

Q. -- 2021. Part 5:

"CEO update

"Assurance

"JB updated the Board [that] there were concerns at Highbury Hospital with regards to the staffing situation on the Adult Mental Health wards, advising a plan would be pulled together with some specific outputs from the Executive Team meeting, assuring Board members would be kept updated".

Next paragraph talks about some background details being gathered. Can I take you over the page, please, second paragraph:

"JB stated that one of the fundamental questions that would be asked is why concerns had not been spotted sooner which he believed would be the correct challenge and is an issue the Executives were very aware of."

Do you agree that was a concern, that these issues should have been spotted sooner?

A. Yes.

Q. Going down the page, the third paragraph from the bottom there's a contribution from you, Mr Devlin:

"PD supported the actions in moving staff around, advising if the solution required funding then that should be provided, reaffirming staff/patient safety was of the utmost importance."

You say there if the solution required funding, then that should be provided. Funding would certainly have helped, wouldn't it?

A. Apologies, I didn't catch that.

Q. Funding would have helped. That was an important part of the solution, wasn't it?

A. Yes.

Q. Were any steps taken to secure further funding for this particular problem?

A. You would have to take me to the follow-through document from the following board meeting to give me a prompt about that. I'm afraid I can't say that. I think this reflects my concerns about the staffing matter and basically saying that if this was going to cost us in that short term, we needed to make -- we needed to take steps on that. That is still my perception and the operational leaders will have taken that.

Q. The position at Highbury Hospital was very concerning, I think you've accepted that in terms of --

A. Absolutely, yes.

Q. Was a wider piece of work done to understand whether that was a concern trust-wide, a systemic issue?

A. Yes.

Q. As the Board you do that because you want to make sure that you've got all the information before you that could be affecting patient safety in a systemic sense?

A. That's one of the key drivers, yes.

Q. You want to know if there are systemic problems that are

affecting patient safety?
A. Yes.
Q. You need to know that, as a board, don't you?
A. Yes.
Q. We've heard evidence during the Inquiry of various matters being raised by staff at the Trust as regards the capacity, particularly on the EIP team. Emma Robinson described that managers had an inability to access psychologists, available to the Local Mental Health Team. We've heard about care coordinator caseloads that were in excess of the recommended caseload of 15, and a lack of administrative support, so notes weren't taken at MDT meetings.
A. *(The witness nodded)*.
Q. Were you aware of any of that?
A. At the time, I wasn't, and certainly -- well, I think the challenges around staffing in many mental health services are something that trusts wrestle with a great deal. Some of those, for example, there are some roles where the specific roles there are -- the pool of people to fill those roles is relatively small. There are lots of challenges around staffing across services is something that both myself and the Board were very aware of, staffing was a regular item. There were no quick-fixes.

Q. We've got quite a lot of evidence about that in your witness statement which is before the Inquiry.
A. Yes.
Q. I just want to focus on the Board oversight of these particular issues.
A. Okay.
Q. So we've got three particular matters being referred there. You said you weren't aware of them at the time. When did you become aware of these concerns?
A. I will have become aware of them in the -- in that December meeting with the actual paper, I think. I may well have -- I may well have been aware of them through a conversation, a one-to-one conversation with the Chief Executive, Dr Brewin, at the time, but formally, through the Board meeting.
Q. Sorry, I think I may have -- we may be at cross purposes.
A. Okay.
Q. I asked you before about whether there was information coming to the Inquiry that there was an inability to access psychologists available to the Local Mental Health Team, and there were an overcapacity, care coordinators were over the caseload of 15. Did you know about these things at the time?
A. I will have -- I expect I will have known about the

first of those --
Q. Yes.
A. -- in terms of the staffing. In terms of the caseload piece and the specific of that, I suspect not. I would have expected that to have been part of what the operational leaders were scrutinising.
Q. Via the Safer Staffing Meeting?
A. For example.
Q. There was another issue that I raised: lack of admin support so that MDTs weren't noted; were you aware of that at the time?
A. I was not.
Q. Can I take you to your witness statement, please, WITN0390001. Page 96, please.
A. Yeah.
Q. Paragraph 264:

"The Safer Staffing Meeting was an operational meeting that operated from 2020 to 2024 and focused upon reviewing staffing across clinical areas."

So if information was coming up, as we understand some of it was from the staff about concerns, this is the meeting it would be considered at?
A. I believe so, yes.
Q. You go on to say at paragraph 265:

"It was an operational group that I [had] ... no

direct knowledge of, including its membership, attendees or specific powers, though I believe it reported to the Quality Committee."

You should have had direct knowledge of the Safer Staffing Meetings, at least where it was in the reporting structure, Mr Devlin.
A. Yes, and that's what I think I was reflecting there was my understanding of that. In terms of the specifics of that, it's -- what I was trying to convey there was that that, as an operational group, it would not have been for me to be party to the detail of that particular body.
Q. I can see that, but you're not quite saying that there, are you; you're saying that you didn't know it's membership, you didn't know it's attendees, you didn't know it's specific powers. You believe, but you don't confirm, despite the fact that you've had --
A. *(overspeaking)* -- That's correct.
Q. -- a lot of time to prepare this witness statement, you believe it reported to the Quality Committee.
A. Yes, that's correct.
Q. The fact you didn't know all of this about the Safer Staffing Meeting that's receiving this kind of information suggests that issues about patient safety being raised by staff were under-prioritised, weren't

they, in terms of the structure and in terms of your knowledge?
A. I think that's a broad -- that's a broad conclusion to come from that one point, because of the other routes for being aware of Safer Staffing matters that did come to the Board's attention.
Q. No one knows better than the clinicians, do they, in terms of this kind of information at the time?
A. Of which information?
Q. The granular information about where there are staff shortages. The staff really are on top of that, aren't they?
A. Yes. I think it's not solely them, though, but yes.
Q. And that's fed up to this meeting which you had little awareness of or understanding of?
A. Yes. However, there were other -- I think there were other bodies that I was aware of. So for example, the People Committee of the Board was very much was focused on, would have been considering staffing matters, and indeed, as I indicate in this witness statement, that Board discussion around staffing was, and continues to be, a very regular item for the Board.
So I think my awareness of what was happening in this particular group wasn't -- that wasn't the sole place where issues relating to staffing were being

considered in the organisation.
Q. Risk assessments, deaths that weren't properly followed up, staffing committees that you weren't on top of in terms of their function: all of that suggests that patient safety was not sufficiently prioritised by the Trust and by the Board.
A. I see the reflection that you're making there. I don't think that that, as a statement, is -- across the whole organisation, and in terms of us not prioritising patient safety is a fair, full description to come to.
Q. Can I take you back, please, to page 91. Paragraph 245, you reflect upon staffing issues. At the bottom of 245, you say this:
"However, there is no national guidance on expected staffing levels against numbers or acuity of mental health patients, which is different from the position in physical health settings."
Do you think, from your perspective as a Chair, there should be national guidance on those expected levels?
A. I think that would be a very helpful thing for us, yes.
Q. Of course, the alternative to there being national guidance is to speak to the staff.
A. That is one of the alternatives. Another alternative is for us to be constantly trying to review staffing levels

through the Safer Staffing Reviews that were carried out as a Board and by operational leaders. But yes, I agree that is an option.
Q. Another way, in the absence of national guidance, is to look at comparators, discuss with other trusts?
A. Yes.
Q. Did you do that?
A. As an organisation, that comparative work will have been done. Not by me personally.
Q. When the CQC reported in 2024, they certainly identified a staffing issue. That was something you had identified throughout your time as Chair?
A. Yes, and continued right through to when I left the Trust. Staffing issues are a major concern, I would suggest, not just for Nottinghamshire Healthcare, but for the bulk of other mental health providers throughout the country as well.
MR WESTON: Chair, those are all the questions I have.
THE CHAIR: Yes.
MR WESTON: Is now a potentially good time to break?
THE CHAIR: I think so. We'll take a break now until 3.25.
Thank you.
MR WESTON: Thank you.
(3.11 pm)
(A short break)

(3.25 pm)
MR WESTON: I've been asked to clarify one matter.
A. Okay.
Q. September 2022, Patient 1. You can't assist with the exact contours of when the patient was having links with the Trust or when they were in contact with the Trust at the particular time, can you?
A. No.
Q. It's not something that you've read the records of?
A. I may well have read the records of. It's about the particular document you placed in front of me was that anonymised document, and it was about making the cross-reference to the individual who obviously I would have been aware of the name that was there, but I -- obviously you weren't wanting to bring those names into the Inquiry public space.
Q. But in terms of your recall of the detail, that's not something that you can assist with now, in terms of what the detail was about that particular case?
A. No.
MR WESTON: Yes.
THE CHAIR: I think, Mr Weston, we can always pick that up with another witness, if necessary.
Yes, Mr Moloney.
Questioned by MR MOLONEY

MR MOLONEY: I'd like to ask you about one matter that relates to VC's case, please. You were aware that VC was admitted to Priory Arnold in October 2021.
A. Yes.
Q. Yeah. Was the Board aware that, in March 2021, Priory Arnold had had a CQC inspection and that inspection had resulted in restrictions being applied?
A. It will have been if that was in the public domain. I'm not totally sure, forgive me, in terms of the timing of when that was actually in the public domain. We will have been, once it was in the public domain.
Q. Was the structure that the Quality Assurance Group was dealing with contracting?
A. Yes, I believe so.
Q. Yeah, and was it reporting to the Board through the Executive Leadership Team or into the executive --
A. Yes, it would have come through the Executive Leadership Team.
Q. In reality, when VC was in Priory Arnold, in October 2021, you were contracting out care from your services which, as we've seen from an email, was thought to be unsafe by some Ward Managers, to private services which required restrictions by the CQC.
May I ask you this: was it questioned whether that was the right thing to do for patients or public safety?

A. So my understanding, Mr Moloney, was that the -- in terms of where the Priory was with the CQC, that any new admissions had to be approved by the CQC themselves and, as I understand it, the discussion around VC and the potential of VC going there would have been -- was taken to the CQC for them specifically to advise whether or not that was appropriate.
So those concerns, organisationally, we were aware of. My understanding is that one of the operational leaders who is coming up before the Inquiry, I think later this week, can give you more detail of that.
Q. Yeah. But just in terms of the Board's appreciation of potential risks, did the Board consider it necessary to think about any formal criteria for enhanced supervision or guaranteed engagement and oversight of placements and safe discharge, for example, when patients were going out of area into institutions that were subject to restrictions in that way, or was it left to operations?
A. I would expect that that was a part of what the operational leaders would absolutely have done, when faced with that challenge of somebody who needed a service that we were not able to provide. And then, if there were challenges of the safety or quality of those services, absolutely I would expect that those would have been raised with the CQC to seek guidance in

this particular case.
And even if there were concerns that had been raised about an out-of-area provider, I would have expected that our operational leaders would have been wanting to have considered the pros and cons in relation to that care, yes.
Q. Should this issue have been visible at board level, the idea of going out to an out-of-area provider about which concerns had been expressed?
A. I would say that as a Board member I was aware of that as a possibility. I would not expect the Board to have been aware of a single specific example. In terms of a provider, once it was in the public domain, yes, I would expect that the Board would be aware of that.
MR MOLONEY: Thank you very much, Mr Devlin.
THE WITNESS: Thank you.
THE CHAIR: Yes, Ms Cartwright.

Questioned by MS CARTWRIGHT

MS CARTWRIGHT: Good afternoon, Mr Devlin.
A. Hello.
Q. Mr Devlin, can I start first of all with just a very peripheral issue but one of importance to those I represent.
A. Yes.
Q. Obviously your background of roles and responsibilities

include that you had a role with Headway, the brain injury charity?
A. Yes, I do.
Q. Can you assist, before there were the visits to those I represent and in particular Mr Birkett, had anyone sought to speak to you about what might be needed for a meeting where you had someone who had sustained a brain injury, bearing in mind your background and experience?
A. No, they had not.
Q. Now, can I ask you, then, please, in respect of your paragraph 51 of your witness statement, which is at page 16, just to understand, I think, the changes of cultures from chair to chair, I think you give a very practical example of a change that you introduced. So paragraph 51, please.
A. Yes.
Q. So you describe:
"An important function as Chair is how visible I am in the organisation ... to those using our services. In a Trust as complex as [Nottingham Health Foundation Trust] with a workforce of over 11,000 staff, true visibility can be difficult to achieve. However, I took deliberate steps to be as visible as I could be, including ..."

One of the examples you have given is:

"... changing access to the Chair's electronic calendar so all members of staff could see exactly what I was doing, when, and where, on behalf of [the Trust]".

Is that correct?

A. That is correct.

Q. Would it be fair to say, therefore, that hadn't been the access arrangements for your predecessor?

A. That's my understanding, yes.

Q. I think you have also dealt with how you reduced your private, I suppose, consultancy role when you took on the role of Chair at Nottingham Foundation Trust?

A. That was a very deliberate decision, in order for me to feel confident at being able to carry out the two chair functions for that overlap period.

Q. Thank you. Then can I also ask you this, because certainly, through your consultancy that you now work through, you've obviously written blogs and written blogs that existed from earlier in time, and certainly that seems to give an impression of the sort of Chair you are, and the approach to being a Chair, which almost seems to be everyone's equal type of role, I think you describe a sort of cooperative mode. That may be an unfair analysis, but certainly in a blog you wrote you talked about that being the way you'd approach being

a Chair.

So perhaps could you just typify how you would describe, how you approach the role of being a Chair when you were at Nottingham?

A. Do you mean in terms of around the Board table?

Q. Yes.

A. Yes, absolutely I would be talking about the unitary Board that I discussed with the counsel earlier, and that I would see around that table that all of those voices had an equal value and that part of my job, therefore, was to try and ensure that all of those voices were brought out around that table.

Q. Thank you. And obviously the Board of a Foundation Trust should operate as a unitary body, and would you agree that means that both the Executive Directors and the Non-Executive Directors, all have a similar duty to act on behalf of the Trust, and to ensure that you're all working together as one team?

A. Yes.

Q. Thank you. And then can I ask similarly, with that being the approach, do you think during your time at Nottingham -- and I'm going to pick up one of the issues you dealt with around the thematic reviews from the homicides -- do you actually think, when you were in the role of a Chair, you actually did sufficiently

scrutinise those that had an operational role to ensure that there really was the proper oversight and operational delivery of matters?

A. I do believe that, yes.

Q. You do. All right. Well, perhaps then we'll look at that when we look at the thematic together.

Can we then just briefly pick up on the theme on risk assessment and the approach and how it was fed back to the Board, please, together. Can I just pick up part of the chronology you dealt with around the Risk Committee and go to paragraph 94, please. It's at page 34. And obviously we know you commenced your duties in the January of 2020. You say this:

"In October 2020 a Risk Committee was established ... and Minutes of the Risk Committee meeting ... This was set up as an operational group ..."

A. Yes.

Q. "... rather than a formal Board Committee (so was not part of the formal Board Governance), though was observed by a Non-Executive Director to ensure that possible content which needed to be considered in a formal Board Committee was duly escalated. This was in direct response to one of the recommendations of the Grant Thornton Well-Led Report of the [Trust] ...from August [of] 2020."

So can I ask you about that, please. One of the things that the Grant Thornton report had said is that many Trusts had an executive-led Risk Committee.

A. Yes.

Q. But yet that's not what was implemented following that report. And so essentially it's -- there's a function of someone observing it but it's not directly reporting to the Board, is it?

A. It is exactly what -- my understanding is it is exactly what Grant Thornton had proposed, which was an executive-led committee, and the non-executive -- if it had been a formal Board committee, by definition a non-executive would have been chairing that.

So I -- as I understand it, it was -- we were absolutely implementing the recommendation that Grant Thornton themselves had put in that Well Led.

Q. So can I ask, then, just practically --

A. Yes.

Q. -- from when this committee was established, how did the Board have oversight for what essentially was the issue of risk management that had been identified by the Grant Thornton review?

A. It would have come through from the Executive Team, and the additional piece was the Non-Executive Director who has an observation role --

Q. Thank you.
A. -- of that.
Q. Can we, just bearing in mind the significance of that report, can we just briefly look, please, at WITN0356018.
Thank you. If we can go to page 7, please. We obviously can see a red rating --
A. Yes.
Q. -- for "... clear and effective processes for managing risk, issues and performance".
Then if we can perhaps move forward to I think it's page 28, thank you.
There's obviously comments about the Board Assurance Framework in respect of risk, but can I ask you about this, please: it's the final paragraph on page 28:
"The Trust needs to review the presentation of its [Board Assurance Framework] ... Many Trusts do not present their [Board Assurance Framework] ... as a 'cut' from the risk management system (Ulysses) ..."
Just pausing there, Ulysses is a system that essentially collates the incident reports; that's correct, isn't it?
A. Yes.
Q. And previous incidents --
A. Yes.

Q. -- for the Trust to identify areas where there's been issues relating to risk and also actions that need to be taken as a result of Datix incidents; is that correct?
A. Yes.
Q. And then if we go on, it says:
"We have shared reports with your Risk Manager from some of the best performing Trusts we have worked with to assist your development of this."
So would it be fair to say that this report was also raising an issue about how the Trust was dealing with Datix incidents and the operation of the Ulysses system?
A. I don't know if it would quite say that. I think it was more about the Board oversight and the way that the -- that the BAF was operating.
Q. Can you help us who the Risk Manager was in August of 2020?
A. You'd need to check with colleagues. I think it was Virginia, I can't remember Virginia's surname.
Q. All right. To the best of your knowledge, did that Risk Manager remain as the same person right through to your retirement from the Trust?
A. Yes.
Q. Thank you. Can we just, then, with the theme of incident reports, can we just go back to the thematic review you were taken to. So the reference we're using

is not the one you appended to your statement, but perhaps just to contextualise that and your concerns, can we look at your paragraph 107 of your witness statement, please, at page 40.
A. Yeah. So paragraph 107, page 40. You say this:
"In the 26 September 2024 private board [...] we discussed the Thematic review of homicides and attempted homicides 2019-2023. I was concerned at that time that some of the poor practice in robustly investigating and reporting on those incidents may have included not escalating them to the Board in a timely fashion."
A. Yes.
Q. "Whilst it is clear that incident reporting had since improved (demonstrated by the more detailed reports that now include specific sections on lessons learned, and clear timelines of actions taken in reviewing and overseeing each serious incident) this analysis of some less good practice prior to 2023 helped drive the development of the current more robust investigating and reporting to Board practices".
And essentially, they followed, essentially, after VC's attacks; would that be right?
A. Yes.
Q. But can we then just go back to the report you were taken to, NHFT0000518. Thank you.

In terms of just identifying Mr Warren, he is someone with relevant experience from another Trust; is that correct?
A. That is correct, yes.
Q. Thank you. If we can move forward, please, to page 2. Thank you. Obviously that review identified, when looking at this cohort that had been part of the review, I think research that we've already heard about, about the increased risk of violence in those living with schizophrenia. But then if we can please look at "Quality of reports" -- and certainly when we look over the page in a minute at the timeline and you were just asked a question about one of the patients -- each of the investigation reports that had been conducted in respect of these homicides or near-miss homicides were all completed during your time as Chair, weren't they?
A. I believe so.
Q. We can see this:
"The prerequisite to fulfilling the Terms of Reference was having high quality, well written reviews from which to draw themes and understand learning. We were aware from the start that the small sample size of seven would limit our capacity to draw generalised themes but felt that this would be possible."
If we go over the page, please.

"We were also hopeful to see good evidence of organisational learning via the Quality Improvement Plans ... We were disappointed to find that several of the reports were of poor quality and not delivered or finalised in a timely fashion. Many had panel members without the appropriate expertise or a limited scope and remarkably two consisted only of a desktop notes review."

Then there's an outline of the summary there of those matters.

So can I again just contextualise this, as well as each of those reports being completed at the time you were Chair, each of those reports also were completed after the Trust had its responsibility of the statutory duty of candour; would you agree?

A. Yes.

Q. So what that requires is a duty on every Trust, is the necessity for essentially appropriate investigations and, would you agree, if a Trust can't get it right, on an investigation into a homicide, then it's a real indicator of how it's dealing with other incidents where there's not a homicide?

A. I think what I would say, I think the disappointment that was referenced by Jonathan Warren is a disappointment I was sharing, and I think the fact

that some of those reports were both of poor quality and also had not been escalated in the way that I was wanting them to -- would have expected them to, rather -- was very concerning.

I don't think I would draw quite such a broad conclusion.

Q. Perhaps then, if we -- and I appreciate, to be completely fair to you, there's very summary information on this table, but in terms of, if we look at the scope of the investigations that the Trust had completed in these seven reviews, "3 months prior" -- sorry, back to the table, please: "3 months prior" for that comprehensive homicide review.

For an "Attempted murder", a case note review only. Similarly for a homicide.

A. Yes.

Q. Then we have obviously the incident involving VC where there's "Full care".

Another homicide, simply looking at "15 days prior [to the] incident"; another homicide, "3 months prior [to the] incident".

And so would you agree that with what we look at later in what was found, and I may not be able to deal with it, there was a real issue about first of all the robustness and thoroughness, even in the event of

a homicide that the Trust had conducted in respect of these homicide cases?

A. I would agree with that, and indeed at the time that is why, on the back of this review, some of those were revisited, because we were so concerned about the quality of what had happened at the time.

Q. And so can you just help us with those, just so we're absolutely clear, because you made clear from a perspective of you being a Chair and not being operationally involved, can you just help us just so we're clear: we've got Executive Director there; are you able to help us with those, who the Executive Director, who the General Manager, who the Associate Director of Nursing were that signed off those reports which are criticised in this document?

A. I would not know, without looking at the documents, the General Manager or the Executive Director, and in terms of the Associate Director of Nursing, it would relate to who was in post at the time. I would need to look back to be absolutely confident. That person I would -- would have been a member of the Board.

Q. So can you help us then with this: when the Board received this report and the concerns you've expressed what steps did you take to speak to the authors and those that had signed off these inadequate reports to

understand why on earth they had closed down some of these reports in the way that are criticised for their inadequacies? Did that take place?

A. I -- yes, it would have done. Yes, it did, rather. And that would have been led by the operational leader, so that's something that Mr Majid would have made sure was happening.

Q. And is there an audit trail that sits around those issues of sign-off being raised with those individuals that signed off each of these reports?

A. I would expect so, but I can't direct you to that.

Q. All right. Then can we look then just later down in the page, obviously I think this review confirms the position that you've already had explored with you: that the fact that there's police involvement we see in the following paragraph, that goes over the page, doesn't mean it should hinder the investigation. So essentially, that's Mr Warren saying that.

A. Yes.

Q. But then you asked about this:

"We were unclear as to the process[es] of how the completed reports were challenged and signed off. Most trusts reports of such serious incidents would go to either the Trust Board or to its Quality Committee, and reported by the Chair of the committee to the full

Board. This does not seem to have happened except for the last report."

Which is the VC report.

So can you help us with that: did those other six reports come to you during the time you were Chair?

A. Not in terms of them coming to the Trust Board and, for some of those cases, I was aware of those incidents. But that actually, on the back of this Warren report, on the back of that, a number of changes were subsequently made so that the Board is now made alert in exactly that way through the Quality Committee. And indeed, as part of that, thematic lessons learned are identified as part of that.

Q. All right. So are you able to give us any further detail then, insofar as you seem to be saying you had some knowledge of these cases, the full extent of that?

I just want to understand, in your role of Chair, and the questions you've already been asked by Mr Weston about the ability of the Board to have identified these themes and issues and trends, particularly as it picked up around discharge, and also those that are then withdrawing from engagement, whether they were picked up at any point by you during your time as Chair before the attack by VC?

A. The ones that I was aware of will have been raised, and

I would have absolutely had conversations with the Chief Executive and I would expect that they would have been considered somewhere in Board or its committees. I can't be specific in relation to the other six examples that Mr Warren had looked at.

Q. Then can we look at page 6, please, regarding the quality improvement, which is obviously part of the purpose of the investigation. The review found this:

"We reviewed the [Quality Improvement Plans] for the reports. In many of the updates the actions bore little resemblance to the recommendations ..."

A. Yes.

Q. "... actions included ..." and then there's obviously some specific actions there.

"The panel is of the view that few of the changes cited will have had any meaningful change in the practice of the staff involved in the incident, let alone the wider Trust. We could find no evidence of the Trust measuring or understanding the changes in practice that were recommended having happened outside of changes to forms, policies, procedures and standard operating procedures ..."

Would you agree that that is evidence, essentially, of investigation reports and plans that are completely meaningless because they've not resulted in meaningful

change required from these homicides?

A. They did not deliver that meaningful change, no.

Q. Again, why did the Board not pick up on that?

A. It goes back to the point I was saying about the level of awareness and the fact, just to contextualise slightly, this is a review that we commissioned and instigated, and on the back of that, because we had concerns that we needed to look back and have a better understanding. What came through from Mr Warren's report absolutely raised some significant concerns and board practice, and trust practice changed on the back of that.

THE CHAIR: Ms Cartwright, you've had two and a half times your allocated time.

MS CARTWRIGHT: I do apologise.

THE CHAIR: Yes, thank you.

MS CARTWRIGHT: Thank you very much. And perhaps I'm not going to have time --

THE CHAIR: No, we've got (unclear) of the time. Thank you.

MS CARTWRIGHT: Thank you. Thank you for your indulgence. Thank you.

THE WITNESS: Thank you.

THE CHAIR: Yes, Ms Heaven.

Questioned by MS HEAVEN

MS HEAVEN: Good afternoon, Mr Devlin. A very short

question on behalf of VC's family, and it relates to communication with the families, carers.

I want to go back to some of the coronial paperwork. Mr Weston read to you, I don't know if you recall, the briefing notes for the meeting with the senior coroner for December 2021.

Let's see if I can jog your memory. The very first thing that were mentioned on that document were concerns around family involvement and care.

A. Yes.

Q. Do you remember that, it was read to you?

A. Yes, I do.

Q. Mr Weston also took you to the Board minutes, 1 March 2022, I think it was. In those board minutes we can see there was very detailed discussion around these issues that there were concerns about family involvement in care?

A. Yes.

Q. This was coming up in numerous inquests, and one of the other issues that was raised was that families were not being given crisis plans or safety plans?

A. Yes.

Q. Would you accept that from me?

A. Yes, I do.

Q. Just in terms of some of the coronial documents then,

please, can we just go to -- this is February 2022 so it slightly pre-dates the Board minutes but it feeds in to what I think was being updated to the Board. It's NHNB0012044, and it's page 1, thank you.

You see there "General Learning" down at the bottom. Just to situate you: at the top this is 8 February, so we just jump down. It's from CIRCLE. Who is CIRCLE?

A. CIRCLE was, it was an acronym for one of the bodies within the Trusts that was responsible for oversight of the --

Q. I see. So we see there, don't we:

"Lack of involvement of family members, carers ..."

A. Yes.

Q. "... (including absence of consideration and documentation of family concerns, not providing families with crisis/care plan/involving family in crisis safety planning/risk assessment ..."

So it seems as though that was the information that formed the basis of what was fed into the Board in the March 2022 that I have just taken you to; is that fair?

A. It will be fair, yeah.

Q. Another one, please. Sorry, before we get to that, it's clearly clear, isn't it, that long before VC is discharged in September 2022, the Board were well aware that there was this long-standing problem around

communication with families, including not providing families with crisis plans and safety plans?

A. Yes.

Q. Okay. Let's move forward in time, please, to 5 May 2022, this is NHFT0009667. This is 5 May Quality Operational Group, and if we could have a look at page 8, please. So learning from inquests again.

This is a specific case that's now being raised on the 5 May by the coroner, "Family involvement in patient care":

"In this case the family were not offered involvement in crisis safety planning/risk assessment."

If you look to the right there, if you can read it, it says:

"These points have been fed back to the directorate."

What's that -- what does that mean there, "the directorate"? Was that you?

A. No, no, that would be into the operational structure, those who would be providing services.

Q. Okay.

"Family involvement in care is again identified and there is a working group already dedicated to making improvements in this area."

And there's reference to the "Triangle of Care".

A. Yes.

Q. "Family support workers".

But here again, we have it being raised with the Board in March, the problem is recurring in the May, and being brought to the Trust's attention.

Does that suggest there was a lack of urgency, after the Board became aware in the March, moving through, really, the whole of 2022? Because we see the same problems recurring.

A. I don't think it necessarily indicates a lack of urgency. I think we were very aware and concerned, and actually it was one of the factors that then drove us really trying to review better the learning from coroners and how we could make use of that.

Q. Well, the Theemis Report and the CQC Reports, after the June 2023, identified long-standing systemic failure --

A. Yes.

Q. -- around communication with families.

A. Yes.

Q. It talked about a lack of safety planning, a lack of crisis management planning --

A. *(The witness nodded)*.

Q. -- including in VC's case. That problem was clearly known to the Board well before June 2023, wasn't it?

A. Yes, I do accept that.

Q. There was an opportunity, wasn't there, I think as has already been established, to introduce that nine-point discharge plan well before June 2023?

A. Yes, I've acknowledged the missed opportunity there.

MS HEAVEN: Thank you very much.

Thank you, Chair.

THE WITNESS: Thank you.

THE CHAIR: Thank you.

Yes, Mr Beer.

Representations by MR BEER

MR BEER: Chair, I've come up to say that I'm not asking questions. That's not because there are no issues that arise from the evidence, but it's because in relation to in particular some questions that were put on the basis of the INQY0000034 document re Patients 1, 2 and 3, can't properly be addressed without infringing upon the restriction that's been properly imposed by the Inquiry on referring to the individual circumstances of Patients 1, 2 and 3, and therefore I'll have to take up with the Inquiry Legal Team separately how that matter is addressed.

THE CHAIR: Yes, I think it's really more the dates and contact, isn't it? You don't have to necessarily disclose the names and further --

MR BEER: Definitely not names and referrals, but some of

the questions were put on the basis in particular that Patient 1 involved a discharge from the Trust services, and that that was an opportunity that was missed to review past recent discharges.

I won't say any more about it.

THE CHAIR: Well, I think if there are any issues with that then they should be taken up and, if any correction is necessary, then it should be done within the parameters that have already been set.

MR BEER: Yes. Thank you very much.

THE CHAIR: Thank you.

Questioned by THE CHAIR

THE CHAIR: Yes, Mr Devlin. I just wanted to ask about whether there was a risk register that was gone through at board meetings.

A. There are a number of risk registers in the organisation. The key risk document that the Board looked at was The Board Assurance Framework which is a strategic risk register, and is informed by other operational -- *(overspeaking)* --

THE CHAIR: Does it have regular updates?

A. Absolutely.

THE CHAIR: As far as the risks that have been referred to, so, for example, systemic failure in clinical risk assessment, do you recall what the potential damage

would be other than reputational to the Trust?

A. It would --

THE CHAIR: Did it include risk to the public?

A. It should have. I can't say that it did have. It would not have been raised -- flagged in that way at the Board Assurance Framework, but I think in the context of what the Inquiry has looked at, that is a key risk.

THE CHAIR: Yes. You say it wouldn't have been flagged at the Board Assurance Framework. Why not?

A. Because of the strategic nature of that Board Assurance Framework. So whilst I absolutely accept that is a big risk, in terms of the strategic risk across the whole organisation, that wouldn't reach the Board Assurance Framework. It would still be -- should still have been getting robust scrutiny, though.

THE CHAIR: Where would it appear as a risk?

A. That would have appeared in operational risk registers, would have been picked up through the Risk Committee, the executive group that was being referred to previously, and potentially would have been raised through one of the Board committees.

THE CHAIR: Were you, as Chair, and/or the Board, unitary Board, made aware of all of those other risk registers?

A. We're absolutely aware of all of those other risk registers. There are many hundreds of risks that are

recorded in them in the different parts of the organisation. So I and my non-executive colleagues would not have been aware of all of the elements of that. Some will have been aware of some of those, depending on which committees they were on, and obviously Executive Directors will have been aware of those risks, both for their areas of particular expertise, but also for that executive-led risk review body.

THE CHAIR: So when you were seeing the thematic review of homicides, was any work done as to whether that should appear in the risk register that the Board should look at?

A. I think, again, not specifically. However, as a Board, we were very alert to the risk elements that were coming through from that thematic review, as indeed with the other reviews that have informed a number of the pieces of work of your Inquiry, Chair.

THE CHAIR: Yes, thank you. Right, well, we'll finish there for today and we'll start again tomorrow at 10.00. Thank you.

(4.03 pm)

(The hearing adjourned until 10.00 am the following day)

I N D E X