

Thursday, 21 May 2026

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 2 (10.01 am)
 3 **THE CHAIR:** Yes.
 4 **MS LANGDALE:** May I call the next witness, Diane Hull,
 5 please.
 6 **THE CHAIR:** Yes.
 7 **DIANE HULL (sworn)**
 8 **Questioned by MS LANGDALE**
 9 **MS LANGDALE:** Ms Hull, you have prepared two statements for
 10 the Inquiry, one dated 5 September 2025 and the second
 11 dated 19 January 2026.
 12 **A.** Yes.
 13 **Q.** Are both true and accurate as far as you're concerned?
 14 **A.** Yes.
 15 **Q.** Your role is as Chief Nurse at Nottinghamshire
 16 Healthcare NHS Foundation Trust and you have been there
 17 since 31 July 2023; is that right?
 18 **A.** That's correct.
 19 **Q.** Can you give us something of your background before that
 20 appointment and also something of the role of the Chief
 21 Nurse?
 22 **A.** Absolutely. So I qualified as a Registered Mental
 23 Health Nurse in 1990. I spent most of my career in East
 24 London Foundation Trust. Most of my clinical experience
 25 was in inpatient services, so acute mental health and

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1 **A.** More -- I suppose the presentation is the more
 2 complicated. So we see more people who have got -- who
 3 have had significant trauma in their lives and we've
 4 seen people who are much younger, particularly
 5 post-Covid. But there's been huge developments since
 6 when I first started, but equally, there's challenges as
 7 well, and particularly challenges around the nursing
 8 workforce.
 9 **Q.** Why do you say you've seen more post-Covid?
 10 **A.** I think that Covid was really, really difficult, really
 11 hard. And all of the things that we say to patients
 12 that will help them keep better, like go out, be with
 13 people, socialise, do things, are the very things that
 14 we told people not to do during Covid.
 15 I think for young people, particularly those at
 16 university or maybe school, you know, that kind of
 17 absence of social contact, of doing the things that you
 18 would normally do, as a young person, did have an impact
 19 and I think that people, particularly people who lost
 20 people during Covid or maybe had Covid themselves, it
 21 was just a terrible time.
 22 And we saw a number of nurses who held on during
 23 that Covid period because they're absolutely dedicated
 24 to working with people, but then they retired.
 25 **Q.** Is that why you say there's more challenges with nursing

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1 psychiatric care, although I did spend some time in
 2 forensic services. I was the Deputy Chief Nurse there
 3 for a number of years.
 4 I then went to Sussex Partnership Trust as the Chief
 5 Nurse there and have been a Chief Nurse for 10 years.
 6 **Q.** So how many years roughly have you been involved, or
 7 aligned with psychiatric care, nursing care?
 8 **A.** Over 40.
 9 **Q.** Over 40?
 10 **A.** Yeah.
 11 **Q.** So as an overview, what's your perspective of where
 12 services are at now compared with other times in your
 13 career?
 14 **A.** I think these are very challenging times, particularly
 15 post-Covid. I think that we've seen huge increases in
 16 demand and the levels of acuity and complexity.
 17 **Q.** Just to break that down, levels of demand, acuity and
 18 complexity? You mean more patients --
 19 **A.** Yeah.
 20 **Q.** -- in need of psychiatric assistance?
 21 **A.** Absolutely. So more people needing our support and
 22 people presenting with far more levels of complexity
 23 that I knew when I first came into psychiatry.
 24 **Q.** So what do you mean about that? It's got even more
 25 complicated to understand?

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1 workforce now, or are there other challenges? What is
 2 the issue around mental health nursing from your
 3 perspective?
 4 **A.** So we have seen, if we go back to 2010, there was around
 5 40,000 mental health nurses in the country. By 2017,
 6 there was 35,000. So already a reduction of 5,000,
 7 although an increase in posts.
 8 **Q.** An increase in posts?
 9 **A.** Yes, so an increase in the need for mental health
 10 nurses. So expansion of services, mental health nurses
 11 in acute general hospitals, in GP surgeries.
 12 **Q.** So these roles were available, but people weren't
 13 applying for them or they weren't financed and they
 14 weren't even available to apply for?
 15 **A.** A combination. So I think that -- I mean, nursing is
 16 a fantastic career, but I'm not sure that it's always
 17 attractive to young people. I think we need to do more
 18 to promote nursing as a career, and the opportunities
 19 that it gives you.
 20 I think that the taking away of the bursary, you
 21 know, going to where you then had to have a student
 22 loan, stopped maybe more mature students from applying.
 23 **Q.** Is mental health nursing a particularly difficult area
 24 to attract people into?
 25 **A.** I think it -- well, I know it is. I think there's far

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1 more that we should be doing about that. I think that
 2 often, acute nursing, in, you know, general medicine, is
 3 more attractive. But I think that's around the
 4 narrative around mental health nursing.

5 **Q.** What's the narrative around it?

6 **A.** I think that people often focus on the challenges and
 7 the complicated work whereas maybe the focus should be
 8 on the difference that you can make, and the support
 9 that you will get, and the opportunities that it gives
 10 you.

11 **Q.** The difference you can make to patients, what about the
 12 difference you can make to the public generally, if
 13 nursing is working well and patients are kept safe from
 14 themselves in some cases and towards others in others?

15 **A.** Absolutely. It's a difference we can make to
 16 communities and there is that element around public
 17 safety as well.

18 **Q.** Can we have a look then, please, NHHB0012044, page 1,
 19 and Ms Hull I don't know if you've had a chance to
 20 listen to the evidence thus far from some of your
 21 colleagues --

22 **A.** I have.

23 **Q.** -- particularly Dr Elcock, and Mr Majid. You've heard
 24 that. So I'm not going to take you through all the
 25 documents we have from 2021, issuing with summaries of

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1 **A.** So I came in on 31 July. As part of my due diligence
 2 prior to starting, I did read the CQC reports, and
 3 then -- and had the opportunity to talk to Ifti and
 4 others.

5 When I came in I became aware really quickly about
 6 some of the concerns and some of the challenges that the
 7 Trust was facing and some of those systemic issues.

8 **Q.** We've heard now recognition of them, both at the
 9 corporate level, both in executives giving evidence to
 10 the Inquiry, when you arrived and saw the extent of
 11 these failings and difficulties, did you understand why
 12 that was the case? There's general acceptance it was
 13 the case, but with your eyes, why did you think it was
 14 the case?

15 **A.** I think there was a number of reasons. I think that it
 16 had been a very operationally-driven organisation.

17 **Q.** What does that mean?

18 **A.** It means that there was not -- there was not enough
 19 clinical leaders in senior posts and maybe the focus had
 20 been around operational and performance management as
 21 opposed to patient safety and quality management.

22 I think the other thing -- and I think that
 23 colleagues have said this -- is that the organisation
 24 had been performing as three divisions, and there was
 25 lots of silo working.

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1 concerns from the Senior Coroner and generally, but this
 2 document, which is a Trust document, neatly summarises
 3 at February 2022 the learning from inquests.

4 If we go to the bottom, please, "General learning",
 5 we see two bullet points there, if we can scroll up:
 6 "General learning - Lack of involvement of family
 7 members/carers ...
 8 "Risk assessments (including absence of ...
 9 documented risk assessment ..."
 10 Over the page to page 2, please:
 11 "Inappropriate [Mental Health Act] Admission risk
 12 assessment (failing to consider all collateral
 13 information/relevant factors; absence of clearly
 14 documented admission criteria ...)"
 15 Then we see:
 16 "Lack of communication ... with other
 17 services/agencies ..."
 18 In the bullet point three down: "Discharge process"
 19 and the like.

20 So systemic criticism of processes at that point in
 21 2022. You came in July, didn't you, July 2023?
 22 Did you read or have this provided to you, this
 23 catalogue of failings that were noted at the time by
 24 both the CQC, Senior Coroner and in this internal
 25 documentation?

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1 **Q.** Three divisions in mental health?

2 **A.** No, there was --

3 **Q.** Generally --

4 **A.** Sorry, there was a Mental Health Division, Forensic
 5 Division, Community Health Division.

6 **Q.** Yes.

7 **A.** And there wasn't that -- and there was three -- there
 8 was an Exec Director attached to each one. So when
 9 Ifti Majid came in he changed that structure so there
 10 was one overarching COO. I think the benefit of that is
 11 that you get the helicopter view.

12 **Q.** One chief overarching?

13 **A.** Chief Operating Officer, sorry.

14 **Q.** But those three divisions of Forensic, Community and
 15 Acute Mental Health, even running as three divisions,
 16 the people at the top can liaise, can't they? That's
 17 a weekly meeting between three of you to communicate key
 18 messages to each team, isn't it? Is this more about the
 19 people rather than the structure?

20 **A.** I think a lot was around the structure, and how that
 21 structure enabled real silo working. I also think that
 22 maybe -- but particularly if you think about patient
 23 safety and quality, that the central team, maybe there
 24 wasn't -- and that's Managing Patient Safety and
 25 Quality -- maybe there wasn't the experience and

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1 expertise there to lead that team, and there was
2 an absence of the kind of systems processes and
3 structures to support really good safety and quality
4 governance.

5 **Q.** If we look at what's on the screen, for example:

6 "Discharge process, in particular, sharing risk
7 information with community teams and GP."

8 Simply transmission of that line to all staff might
9 make people aware that there's an issue with discharge
10 process and a need to rethink.

11 So can I just ask you about messaging. We've seen
12 emails where Mr Majid email, the whole organisation.
13 It's a wonderful thing, when it works well, to alert
14 people to problems, and sometimes getting lengthy
15 policies rather than a short two or three lines, perhaps
16 risk not being read, don't they?

17 So in terms of short messages, whatever the
18 structure, surely short messages can be communicated to
19 people on the ground --

20 **A.** Absolutely.

21 **Q.** -- about how they need to focus on aspects of care?

22 **A.** Yes, definitely. I think you do need the policy and
23 process to support that and the training.

24 I think what's also really important is that it's
25 a huge organisation, and so, you know, you also know

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1 you're right: things can get lost in a kind of sea of
2 words and emails.

3 **Q.** You have described, and as indeed the Medical Director
4 did, that former divisional structure as being the bar
5 to effective communication about key issues. But again,
6 those -- how you choose to do that is more important
7 than the structure itself, isn't it? Because it's the
8 same people you're trying to reach whatever the
9 structure.

10 **A.** Yeah, absolutely. And that is why we've really had
11 a relentless focus on quality and safety, and we've put
12 posts into those divisions where their sole kind of
13 function and purpose is to drive the quality agenda.

14 **Q.** So the divisions is one aspect of why you say things
15 went wrong over this period for years, effectively.
16 What else? You mentioned quality and safety positions,
17 senior roles. Were there not sufficient senior roles
18 looking out for that, do you think, when you arrived?

19 **A.** I think that historically those safety roles and the
20 safety function had been within the divisions, with
21 minimal central team. They had then gone to a central
22 team, but it is about the experience and the expertise
23 of the people leading that team, and also, at that time,
24 they had quality and patient safety together, two big
25 areas, and if you really, I believe, if you really want

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1 that there's so many emails. So I think there was --
2 it's really important that you have the right people in
3 the care groups who are continually setting the
4 parameters, setting expectations, and being really clear
5 about discharge processes, risk assessment, risk
6 information.

7 **Q.** When you say "really clear" you've obviously, in your
8 lengthy career, been a nurse on the ward at the
9 beginning and now you're in this Chief Nurse role.

10 Do you think that the communication to all staff
11 could be simpler and clearer? We've seen lots of
12 policies, messages, terms, really, that are more
13 management, presumably, used than --

14 **A.** Yeah.

15 **Q.** -- than the rest of us might readily understand. Is
16 thought given to how simple messages can be communicated
17 simply instead of making people think: this is too
18 complicated and I can't really understand it?

19 **A.** Yeah, at the moment we're reviewing policy because we
20 want to go to "policy on a page" because of that. You
21 know, so really clear, crisp, pithy messages followed up
22 in training.

23 I think also that's why huddles are really
24 important, the kind of daily safety huddles where you
25 have ten minutes with really clear messaging, because

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1 to focus on patient safety, you need to have the right
2 expertise, the right experience --

3 **Q.** What is that?

4 **A.** So we appointed, following the Helen Collins Review, we
5 appointed two senior leaders, Associate Director of
6 Patient Safety, and a Lead for Patient Safety Learning
7 from Deaths, people with significant experience who were
8 then able to action the Helen Collins Review but also to
9 make sure that we had the right structures in place. We
10 did the same for the quality governance part of that,
11 part of that function.

12 **Q.** What about accountability? I'm going to come
13 specifically to the issues we're dealing with, but
14 accountability for staff as well? You've spoken about
15 support.

16 **A.** Yeah.

17 **Q.** That's obviously important, and there will be cases,
18 won't there, where there needs to be accountability and
19 disciplinary processes. Do you think the Trust has that
20 in hand, recognising when it's not about the job, it's
21 about the person doing the job, and steps need to be
22 taken?

23 **A.** I think we heard yesterday about how the Trust had
24 adopted kind of a just culture, but for me, just culture
25 is about proportionality and it's about being just to

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1 the person, to the patients, and to communities.
 2 I think we are currently really clear about
 3 accountability, but accountability in a fair and
 4 proportionate way. If I think about qualified nurses,
 5 we have NMC Code of Conduct. There are clear
 6 expectations and clear parameters, and yes, you want to
 7 be fair and yes, you, want to be proportionate, but we
 8 also are accountable. I think we are currently really
 9 clear about accountability, but accountability in a fair
 10 and proportionate way. If I think about qualified
 11 nurses, we have NMC Code of Conduce. There are clear
 12 expectations and clear parameters, and yes, you want to
 13 be fair and yes, you, want to be proportionate, but we
 14 also are accountable.
 15 **Q.** We see from the GMC relevant guidance in relation to
 16 risk assessment and duties to patients and information
 17 sharing in the like. Do you get anything similar for
 18 nurses for your professional body?
 19 **A.** We have our Code of Conduct which is really clear about
 20 our roles and responsibilities, about remaining
 21 compassionate and kind, about our omissions and -- so
 22 that's really clear, but also people have a job
 23 description, which is -- clearly defines expectations.
 24 **Q.** And ethical helplines from the Royal College of Nursing
 25 or elsewhere, where people can speak with someone if

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1 **A.** Because I think you need one overarching policy which
 2 clearly defines the Trust's position, which leads you to
 3 another documents, because it provides the framework and
 4 it ensures that people practise in a safe way.
 5 **Q.** The description at the beginning is important, isn't it,
 6 of any policy, to say why it's there, and if we go to
 7 page 4. 1.1 sets out:
 8 "Assessment and management of clinical risk is an
 9 essential and core component of healthcare."
 10 If we go to page 11, please. 5.9 sets out how
 11 a self-report alone should not be relied upon.
 12 Again picking up on what you were referring to
 13 earlier, this could be more simply expressed,
 14 couldn't it?
 15 **A.** Yeah.
 16 **Q.** Indeed, it doesn't address the range of other sources.
 17 It's important, and the Inquiry has got a lot of
 18 evidence on this point, not to simply rely on
 19 self-reports from patients, but it doesn't set out, one,
 20 why that's important, which would be useful as
 21 a starting point, wouldn't it, to some people who didn't
 22 realise why that isn't important and aren't necessarily
 23 conscious as they're working with patients to question
 24 and be curious all the time as to whether the answers
 25 are correct that they're giving them?

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1 they have issues? Because there must be issues on the
 2 ward sometimes that nurses are concerned about and would
 3 like to discuss thorough with somebody?
 4 **A.** Yeah, the RCN are particularly supportive, and they've
 5 got the -- they've got the education part of the College
 6 as well.
 7 **Q.** In terms of what went wrong, we have seen, and you are
 8 probably aware from earlier evidence, that effectively
 9 there was no Clinical Risk and Safety Policy, there was
 10 a version that was in place I think 2012 and 2013 but
 11 never updated until a policy was issued in 2024.
 12 It's unconscionable really, isn't it, that something
 13 as serious as that wasn't committed to paper at all in
 14 a way that members of staff could follow, appreciate and
 15 be reminded of when the policy was updated and generally
 16 when they chose to have a look at it if they were
 17 worried about something?
 18 **A.** My understanding is that within the internal working
 19 instructions within the care groups and care units,
 20 which were the divisions, there was guidelines or
 21 guidance on risk assessment, but you must have a central
 22 policy.
 23 **Q.** Why must you? Can we have while you're thinking about
 24 that, please, NHFT0003231 on the screen, which is the
 25 policy now. But why do you need one?

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1 **A.** I think it could give more information. I'm sure that
 2 the training would really focus on that but you are
 3 right: the report -- sorry, the policy, the wording
 4 could be clearer.
 5 **Q.** The other thing that's useful in policies is numbers and
 6 details. So for example, other sources, it might be
 7 police, probation, education, but details of where
 8 people can find who to contact, what form to fill in if
 9 they're requesting information, the practical?
 10 **A.** Yeah.
 11 **Q.** This is theoretical and people on the job often want to
 12 know what they need to do.
 13 **A.** Yes, and I think that is why the training is really
 14 important. That's why the RAM meetings are really
 15 important, and that's why the safety huddles are,
 16 because you can then think about how you operationalise
 17 risk assessment and talk about the kind of -- the
 18 conundrums and the difference and the challenges you
 19 might be facing.
 20 **Q.** And do you think, if we go, please, to 8.1, it's the
 21 same point, relating to multidisciplinary working,
 22 reference to the need for multidisciplinary working:
 23 "Psychosocial assessment, formulation and care and
 24 safety planning should be included in multi-disciplinary
 25 team reviews and working ..."

16

1 But multi-agency working is critical too, isn't it?
 2 **A.** Absolutely.
 3 **Q.** There's no express reference to that: the need to liaise
 4 and work with other agencies, to understand patients; if
 5 you're worried about risk, risks of serious harm,
 6 sharing information. It's not referred to here. And
 7 there's no express reference to that: the need to liaise
 8 and work with other agencies, to understand patients; if
 9 you're worried about risk, risks of serious harm,
 10 sharing information. It's not referred to here.

11 Is that fair?

12 **A.** Yes, yes.

13 **Q.** It's all part of adequate risk assessment, isn't it?

14 **A.** Yes, getting as much information as possible,
 15 corroborating information, testing out information, is
 16 really, really important.

17 **Q.** Just the way you say that, that would be more helpful to
 18 somebody, to have it's important to corroborate, test
 19 information, know the factual basis, in respect of the
 20 risks you are assessing and managing.

21 **A.** Yes.

22 **Q.** That can come down, please. That's actually version
 23 2024, I think, of the version 1. It hasn't been updated
 24 since then, but it can be, presumably, and should be;
 25 would you agree?

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1 something also important about the relationships you
 2 build at every level with the police. So within that,
 3 I meet with the Assistant Chief Inspector on a monthly
 4 basis. We have our Patient Safety Team, who meet with
 5 the police. The police have a Vulnerability Hub and
 6 they have a Neighbourhood Offender Management (*sic*) team
 7 as well, which we're kind of involved in. The NORM, as
 8 it's called, the Neighbourhood Offender Risk Management
 9 team.

10 **Q.** I don't mean to be facetious, but does everything have
 11 an acronym?

12 **A.** I think it does, yeah --(*overspeaking*) --

13 **Q.** Except when you look at a document, there's so many, and
 14 they seem to change as the groups change. But that's
 15 designed for offenders, is it, that one?

16 **A.** So it's -- I'm sorry, it's the Neighbourhood Offender
 17 Risk Management Team and our safeguarding team work
 18 really closely with them and that is where the
 19 Potentially Dangerous Person's pathway, it's part of
 20 that team. And we've been working to raise the profile
 21 of that. We've done some training with the police as
 22 well, and we're evaluating the effectiveness of that
 23 with them.

24 **Q.** So two questions arising: this statement was
 25 5 December 2025. Has that Memorandum of Understanding

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1 **A.** Oh absolutely, it's a dynamic document.

2 **Q.** And with practical information that supports those who
 3 may need it.

4 Your statement, if we can go to it, please,
 5 WITN0133001, page 191, deals with this important issue
 6 of multi-agency working and information sharing. And we
 7 see "Interagency working", the box at the bottom which
 8 continues if we can have next to it page 192 so we can
 9 see both. We see there:

10 "The Trust and Nottinghamshire Police have worked
 11 (through the Police Liaison Oversight Group) to make
 12 expectations of communication explicit by a Memorandum
 13 of Understanding. The Trust has agreed the draft, and
 14 the police are currently going through their final
 15 internal information governance checks before
 16 finalising. This is in addition to enhancing joint
 17 working where there are specific patient risks that
 18 require a further cross organisational
 19 understanding/actions."

20 Dealing with this Memorandum of Understanding first,
 21 what's that designed to address and what are the
 22 principles within it?

23 **A.** So it's designed to improve information sharing. We've
 24 done huge amounts of work with the police. So you can
 25 have an information-sharing agreement but there is

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1 been finalised now since then?

2 **A.** My understanding is that it has.

3 **Q.** So the Inquiry will be able to get a copy of that?

4 **A.** Yes.

5 **Q.** So we can see what that's driving at. Then the
 6 Potentially Dangerous panel, has the Terms of Reference
 7 of a person for that been agreed now, then?

8 **A.** Yes, yes. And the referral process is live. We have
 9 had people referred through that pathway as well.

10 **Q.** Again, we can get some information from you about that.

11 **A.** Yes, definitely.

12 **Q.** You say:

13 "The Trust is working through the forum [this is
 14 back on page 192, the second paragraph] of the
 15 Integrated Care Partnership to strengthen partnership
 16 working with primary care. ... This work is ongoing
 17 and will take time to ... implement and embed."

18 So again, what were the issues in terms of working
 19 in partnership with primary care?

20 **A.** So this was strengthening the relationship and
 21 particularly thinking about the information that we
 22 share on discharge, how we work, how we share
 23 information together, how we think about people at every
 24 step of their pathway. So we developed an e-learning
 25 kind of discharge process and that was based on the

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1 information that GPs would find helpful, because they
 2 felt we were providing too much information where they
 3 wanted it to be succinct.

4 **Q.** The Inquiry has seen a very clear policy that was in
 5 place at the time of VC's discharge from community
 6 services. That made it very clear what information
 7 should be sent to primary care and, between
 8 professionals, that's both GPs, and those discharging to
 9 GPs, presumably that can broadly be understood?

10 **A.** Yes.

11 **Q.** Generally.

12 **A.** Yes.

13 **Q.** It's back to basics, isn't it, what the condition is,
 14 prognosis, medication, what you're asking of the GP.

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

16 **Q.** That message should be fully understood across the
 17 medical profession, shouldn't it, both --

18 **A.** Yes.

19 **Q.** -- for those in hospital --

20 **A.** -- *(overspeaking)* --

21 **Q.** -- and those as GPs, and yet we see here:
 22 "It will take time to fully implement and embed".
 23 Forgive me if I'm missing the point, but it seems
 24 obvious that that kind of information needs to be passed
 25 on. If you're discharging a patient, you need to pass

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1 universities would be beneficial ..."

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

3 **Q.** It's likely the case, isn't it, that the Trust sometimes
 4 will be seeing students on the threshold of their adult
 5 life, who may be at serious risk of suicide, causing
 6 harm to themselves, and also maybe treating patients,
 7 such as VC, who they knew by his actions has caused
 8 serious harm to a woman who jumped out of a first-floor
 9 window requiring surgery.

10 So you are seeing patients in mental health who are
 11 at risk of serious harm to themselves or to others.

12 In those circumstances, do you think there's
 13 a sufficient understanding that, irrespective of
 14 consent, if there's a risk to others and a risk of
 15 self-harm, that that information can be shared or should
 16 be shared?

17 **A.** I think we have done much more work around that.
 18 Clearly there is the -- and I think Dr Elcock spoke
 19 about this yesterday -- about the -- about permission to
 20 share. However, risk and safety do supersede
 21 everything.

22 **Q.** Indeed, particularly in relation to self-harm, young
 23 people if they're 19 and they've just gone to university
 24 move, don't they, from these thresholds of safeguarding
 25 concerns and multi-agency working at 16, 17, to falling

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1 on information to primary care.

2 **A.** Absolutely, and there is a clear policy around this.
 3 This is further developing that work and further
 4 developing relationships.

5 **Q.** So the relationships are important, aren't they, which
 6 isn't necessarily the work of policy and training?

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

8 **Q.** It's about the relationships on the ground.

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

10 **Q.** The GP surgery having a good point of contact with the
 11 hospital, or many points of contact. That's how the
 12 world works in practice, isn't it?

13 **A.** Yes, you should be able to. The GP should be able to
 14 phone somebody if they are concerned about one of their
 15 patients. Relationships are everything.

16 **Q.** Equally, if the GP gets something they think is unclear,
 17 they should be able to do that too. Does that not
 18 happen as a cultural issue in terms of it being
 19 identified here as these relationships needing
 20 strengthening?

21 **A.** It should happen, but I think that there is work that
 22 we've had to do to strengthen those relationships.

23 **Q.** You refer as well at page 192:
 24 "The Trust recognises ... clearer routes for
 25 escalation and information sharing between it and the

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1 off a cliff, if you like, in terms of protection or
 2 protection for them?

3 **A.** Yes, although --

4 **Q.** Statutory protection. They're in a different category
 5 then.

6 **A.** Yes, although I think safeguarding is applicable to any
 7 age.

8 **Q.** So you would see that as a principle of thinking about
 9 sharing, whether the universities needed to have
 10 information to safeguard and support students?

11 **A.** I think first and foremost we'd be sharing with families
 12 and parents, and be talking with them and the patient
 13 about the sharing of information.

14 **Q.** Indeed, that's a given, isn't it?

15 **A.** Yeah.

16 **Q.** It's astonishing, really, that the Coroner is raising it
 17 in 2021 that families aren't being given basic
 18 information about diagnosis, discharge, safety. What is
 19 the possible explanation for that existing for a period
 20 of years, failure to implement the Triangle of Care?

21 **A.** I mean what I can tell you is that we have focused on
 22 improving our work with families and our work with
 23 carers and thinking about the Triangle of Care.
 24 2021, I think there was only 53 services that had
 25 completed the Triangle of Care assessment. Last year

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1 there was over 150 who had. And we're at 89%, I think,
 2 compliance. But we did -- we have appointed
 3 a Trust-wide carers lead to drive through and forward
 4 the kind of, the work on working with families.
 5 Safeguarding do Think Family training as well, and
 6 again, that's around the 89% compliance. It has been
 7 an absolute focus for us, because families are, and
 8 carers, are so important, and we know that patients who
 9 use our services, if they have good relationships with
 10 their families, they do so much better. They need the
 11 support from them.
 12 **Q.** Even if they don't consent to sharing information, it's
 13 still important, isn't it?
 14 **A.** I think even if people don't consent, it doesn't mean
 15 that we can't listen to families.
 16 **Q.** And share some key information around detention,
 17 discharge.
 18 **A.** Those would be decisions that the clinical team would
 19 have to make, based on the reasons for the person not
 20 wanting to share. Because I'm always mindful around
 21 safeguarding as well.
 22 **Q.** Of course, but the capacity to make a decision around
 23 that is also a key issue, isn't it?
 24 **A.** It is.
 25 **Q.** Can we have, please, NHFT0000581, page 001, and it's the
 25

1 really.
 2 **Q.** Can we go please to TCLT0000818, page 1. This is the
 3 Level 2 Comprehensive Investigation Report. This was
 4 commissioned pursuant to the attacks on 13 June,
 5 wasn't it?
 6 **A.** Yes, it was.
 7 **Q.** I think it was part of your responsibility to oversee
 8 patient safety and quality and to act on this and the
 9 results of this; is that right?
 10 **A.** Yes.
 11 **Q.** If we look at page 34 of the report, we see at
 12 "Discharge process", further down:
 13 "Although there was significant learning in relation
 14 to the community discharge to the GP ... discharge
 15 planning was also rather limited in relation to
 16 discharge from inpatient settings to the Community Team.
 17 For complex individuals, particularly where engagement
 18 and concordance are a concern, discharge planning should
 19 be a collaborative process between ... patient, the
 20 discharging service and the receiving service, with the
 21 needs of latter held in mind. This should include how
 22 services might work together to respond effectively to
 23 future crises."
 24 You set out in your statement, if we can have it on
 25 the screen, please, WITN0133041, your second statement,
 27

1 CQC Report, 2024 -- March 2024. And we see again,
 2 page 2, the list at the bottom:
 3 "Our rating of acute wards ... went down. We rated
 4 them as inadequate because:
 5 "There was an inconsistent approach to
 6 recording patients details when they accessed
 7 their leave from wards.
 8 "... inconsistent approach on which
 9 documentation to use when recording seclusion
 10 observations [...]
 11 "... found incidents of assaults on
 12 patients by staff members."
 13 And further down:
 14 "... service did not always learn from
 15 incidents."
 16 Why do you think at that point, in effect,
 17 it was inadequate?
 18 **A.** So this report was following an inspection I think in
 19 October 2023. So it's take a time, takes a little while
 20 for the report to be published. I think it goes back to
 21 my earlier comments around patient safety focus, patient
 22 safety governance. There were problems around
 23 record-keeping, and again that's why we focussed on
 24 improving that with training, and through our safety
 25 huddles, and I guess it goes back to what I first said,
 26

1 from paragraph 433 your response and the draft action
 2 plan. If we can have page 17 and 18 (sic) on the
 3 screen, please.
 4 "On 18 March 2024". I don't think that's the right
 5 page. WITN0133041, page 117. Sorry, Amanda.
 6 There we see -- and then we want 118 next to it,
 7 thank you -- 18 March 2024. Investigation report shared
 8 with you. You say the learning points highlighted, and
 9 the actions taken.
 10 So if we can have perhaps 118 and 119, we can see --
 11 117, sorry, and 118 -- we can see what you say has
 12 happened since.
 13 Can you see paragraph 438?
 14 **A.** Yes.
 15 **Q.** Would you like to take us through that, please?
 16 **A.** So we moved from -- thinking about risk assessment, we
 17 moved from e-learning risk assessment training to
 18 face-to-face risk assessment training, and we changed
 19 the content of the risk assessment training so that
 20 there was a focus on risk to others, to longitudinal
 21 risk, and to consider the dynamic, how dynamic risk
 22 assessment is, and to see it in the -- see it in its
 23 changing context.
 24 So it was much more detailed than the previous
 25 e-learning training. And we had really senior
 28

1 clinicians deliver that training, not only did we
2 deliver it individually, but we delivered it via teams,
3 so that we could look at case scenarios, so that we
4 could talk about -- talk through those scenarios so that
5 we could challenge and support each other.

6 You'll see also that the Trust risk policy was being
7 developed. There was changes to the standing operating
8 procedure, clear standards around discharge, and the
9 need to have a face-to-face assessment prior to being
10 discharged.

11 There was a change in focus that if people were
12 disengaging from services, the responsibility should be
13 on us as clinicians to think how -- what we can do
14 differently to support engagement, and that
15 disengagement should not be a reason for discharge. So
16 a real change.

17 The quality of discharge, we were really clear about
18 the expectations, about the parameters, about the things
19 that needed to be completed, and we were really clear
20 actually that the recommendations from this report and
21 the other reports, that we absolutely supported those,
22 the content around discharge because that discharge was
23 not acceptable.

24 **Q.** There had been plenty of evidence before, indeed since
25 2021 from the Senior Coroner, that discharges were not
29

1 and I think Dr Elcock spoke about this, that there was
2 this real focus to risk to self and suicidality, but
3 actually there is a need to think about risk to self,
4 risk to others, and risk from others.

5 **Q.** Can we have please NHFT0000464. This is a follow-up,
6 30 May 2024, a report you present in relation to the
7 level 2 review, but it's actually the comments on
8 page 38 about the police and the background, please.

9 "Police gave permission for the serious incident
10 investigation on 10th November 2023. Prior to this,
11 staff could not be interviewed, or notes reviewed."

12 What was your understanding about the police
13 position in terms of what the Trust could do or not do?

14 **A.** So my understanding, when I came into post, was that
15 there had been a directive from the police to say that
16 we couldn't interview staff, that we couldn't start the
17 investigation, because it could compromise the police
18 investigation.

19 I think it is important to say that given -- because
20 of the changes in our relationship, that doesn't happen
21 now. We talk about -- we talk more about how we can do
22 things, not about why we can't do them.

23 **Q.** Were the staff around the time of the police
24 investigation given that message: that they shouldn't
25 speak about it or talk about it generally, or not?
31

1 acceptable. Was it because in this case the families
2 were pushing and were concerned to have answers?
3 Because this wasn't the first discharge that had been
4 inadequate, was it? Not by a long reach, looking back
5 at the history.

6 **A.** I think part of our overall improvement plan was always
7 going to include discharge. It was always going to
8 include risk assessment, and it was always going to
9 include care planning, and it was always going to
10 include the work we do with families. Because they are
11 the basics.

12 **Q.** They are basics, aren't they?

13 **A.** Yes.

14 **Q.** And that's the point, really. So the mandatory risk
15 assessment training for Community Mental Health Teams
16 that were 89% compliant, that should have been taking
17 place in 2021. I know you weren't there then but it's
18 the same message that was being given about risk
19 assessment; it was just more powerfully present in this
20 case than by people who were rightly bringing it to
21 public attention.

22 **A.** I am really mindful that that was during Covid, and
23 I don't want to use that as an excuse. And so training
24 had gone to e-learning, whereas I think before that, it
25 had been face-to-face. But there had been this move,
30
32

1 **A.** Obviously I wasn't -- I wasn't in post. I would imagine
2 that people were asked right at the very beginning not
3 to talk about it outside of their team, but it would be
4 wrong for me to give an opinion on that because I wasn't
5 there.

6 **Q.** Understood.

7 **A.** I'm sorry.

8 **Q.** Can we go, please, to NHFT0000423, and this is the
9 Collins review that was produced on 11 January 2024, and
10 addressed concerns about clinical decision-making as
11 well.

12 So if we go to page 7, and have 7 and 8 alongside
13 each other, we see lists of concerns at the bottom of
14 page 7:

15 "Triangle of care, care and crisis planning and
16 regular review ..."

17 Over the page:

18 "Falsification of observation records [...]"

19 "Clinical risk assessment and regular review ..."

20 "Record keeping ..."

21 "... noticeable lack of Trust-wide safety incident
22 investigation, learning ... and family liaison capacity
23 and capability."

24 You had the responsibility for reporting to the
25 boarding as well about this and the various responses to
32

1 this; is that right?

2 **A.** Yes, I did.

3 **Q.** And if we go, please, to NHFT0017658, page 1. In this

4 report, which is the 11 March 2025, you refer in the

5 penultimate paragraph:

6 "Significant actions have been taken since

7 January 2024 ..."

8 There we have it, the paragraph there. Tell us what

9 those actions were.

10 **A.** So it was an incredibly comprehensive report by Helen

11 Collins. So as I said earlier, we appointed two very

12 senior leads for the Patient Safety Team, separated

13 Patient Safety from Quality. We introduced improvements

14 in governance. We implemented PSIRF as well. We put in

15 place a Complex Incidents Committee, we strengthened the

16 Patient Safety and Learning from Deaths Committee. We

17 made that was from ward up to board level.

18 **Q.** So it had a wider remit, took more cases, did it?

19 **A.** Yes. I think in my statement I describe the Serious

20 Incident Review Group which is held weekly. We changed

21 that to a Significant Incidents Review Group which

22 I chair, and so we review incidents there, but equally

23 we triangulate by hearing at Freedom to Speak Up,

24 looking at complaints, looking at staffing issues,

25 looking at safeguarding issues, so triangulating it in

33

1 collated?

2 **A.** Yes, so the Trust did always have that information but

3 that -- this is in one place. It's updated weekly. You

4 can -- I don't know if you've looked at it in any

5 detail, but you can see it across of the whole care

6 group, you can see it in the care unit, but you can go

7 down to individual teams and individual patients. And

8 I see that in action all the time, you know, our

9 Community Matrons, our Inpatient Matrons, they look at

10 that data, they probe it and they interrogate it, they

11 then act on it.

12 **Q.** -- (*overspeaking*) -- Can you audit who's looking at it

13 and who's assessing it? Because it's all very well to

14 collect it, but it's how it's used, isn't it?

15 **A.** Sorry?

16 **Q.** How do you see who uses and accesses that information?

17 **A.** Oh, you can see that, and also we report on SafeNow to

18 the Executive Leadership Team weekly, and we report on

19 it monthly to the Oversight Assurance Group as well.

20 **Q.** This in front of us, this paragraph you say:

21 "The focus of patient safety is moving away from

22 counting, reporting, to learning and embedding."

23 What does that mean?

24 **A.** So what I mean by that is it's not just about counting

25 the incidents and kind of thinking about when the

35

1 its entirety.

2 **Q.** Did you feel more confident that you were at least

3 hearing the problems at this point by having these extra

4 committees?

5 **A.** Definitely hearing, but also the opportunity to really

6 understand, to kind of probe, to dissect, to think about

7 what would the actions would be. Because we moved

8 really quickly from waiting for a lengthy review or

9 report to thinking about what's the immediate learning?

10 What's the immediate actions? What do we need to do

11 now?

12 And you can -- you will be able to see that from the

13 SIRG reports. And the SIRG reports didn't used to go in

14 written form to the Executive Leadership Team. They do

15 now weekly. One of the other things which we developed

16 which has really helped and supported is the SafeNow

17 dashboard which I know you've heard about.

18 **Q.** We've seen that -- we've seen the reference to that.

19 **A.** Because that allows you to use data to further drive

20 improvement.

21 **Q.** It does, and it's the type of data that the Trust should

22 always have had, isn't it, for example about out of

23 patient area bed placements and the like.

24 Is it, you say, more effective because it's easier

25 to use and it's a mechanical process the way it's

34

1 reports are due in, and when the reports are signed off.

2 It's actually thinking about the learning, and not only

3 the learning but the understanding and the actions and

4 then furthermore, how do you make sure that you are not

5 only taking action, but that action is embedded?

6 **Q.** And again, my question: why wouldn't that always have

7 been the case, that when there's a critical incident or

8 event, or deaths, which we're speaking about? Whenever

9 that occurs, it's about the learning and making sure it

10 doesn't happen again rather than just responding to

11 a report as a matter of technicality, if you like.

12 **A.** Yes, it should be and I think that the implementation of

13 PSIRF gives you so many other tools to use.

14 **Q.** Can we have, please, NHFT0017629. This extract of

15 minutes to the Board of Directors, 26 September. And

16 you're providing, we see, page 4:

17 "... an update on serious incidents, including

18 homicides ... significant quality issues from July to

19 September 2024."

20 And over the page on page 5, second paragraph from

21 the top:

22 "Board discussions addressed ongoing challenges and

23 improvement plans ... concerns about issues such as risk

24 assessment weaknesses and the use of Community Treatment

25 Orders ..."

36

1 Use of Community Treatment Orders. What was the
2 issue there? Can you remember?
3 **A.** I can't exactly, but I should imagine it would be about
4 are we using them? I'm really sorry, I can't remember.
5 I don't want to give you the wrong information.
6 **Q.** It looks like that may well have been raised. It was
7 clearly a key point in the case that was being examined.
8 **A.** Yes.
9 **Q.** The failure to use one.
10 **A.** Yeah.
11 **Q.** So a discussion generally about Community Treatment
12 Orders.
13 **A.** Yes, and there's -- there has been a number of
14 discussions around them, and particularly the numbers,
15 and I think there's 12 people under EIP who are under
16 a Community Treatment Order, and around I think over 50
17 in the AO pathway as well.
18 **Q.** Do you -- or you may not be able to comment on it, but
19 do you sense any resistance or reluctance to use
20 Community Treatment Orders in the Trust?
21 **A.** I haven't sensed that. I think that clinicians will
22 always think about will it get them the outcome that
23 they need? I've seen Community Treatment Orders work.
24 I do know the limitations of them. I think that if
25 you've got a Community Treatment Order and you've got

37

1 **A.** Yes.
2 **Q.** And no doubt the Inquiry will hear further evidence in
3 a national picture in respect of that.
4 If we go, please, to page 4:
5 "Poor engagement, lack of follow up and risk
6 assessment."
7 We see that at the bottom of the page.
8 "... panel felt ... risk was often viewed through
9 the lens of risk of self-harm and risk to staff rather
10 than risk to the wider public."
11 In your experience again, is that a risk that's been
12 neglected?
13 **A.** I'm not sure if "neglected" is the right word but
14 I think, as I said earlier, I think the focus was very
15 much on the risk to self.
16 **Q.** And the patient's needs or wishes, even if they might
17 not have the capacity to express those. That's
18 a different matter, isn't it?
19 **A.** Are we talking about least restrictive?
20 **Q.** Yes.
21 **A.** Yeah. I mean there has been a move towards least
22 restrictive, but I think that, in my own experience,
23 least restrictive interventions, it's really clear, it's
24 about, when I think about them: what is the risk to the
25 person, the patient? What is the risk to the public?

39

1 really good engagement, and you've got good
2 relationships, that can work but it can't -- it doesn't
3 always mean that somebody is going to live in the same
4 place or that they are going to take their depot. What
5 it does help with is that it helps to be able to quickly
6 recall them back into hospital.
7 **Q.** And if a person doesn't wish to be in hospital that's an
8 incentive to do it, even if they don't want it.
9 **A.** Oh absolutely.
10 **Q.** So it's not about only voluntary engagement; it's about
11 secondary gain, presumably, for some patients, that
12 that's better than the alternative?
13 **A.** Yes.
14 **Q.** Can we have please NHFT0000518. This is the "Thematic
15 review of homicides and attempted homicides ..."
16 conducted by Jonathan Warren in August 2024.
17 We see at page 3 finding "lack of family involvement
18 in several of the reports". It's the penultimate
19 paragraph:
20 "... reasons cited as 'not wanting to cause further
21 distress' ... they had already been involved in a
22 safeguarding review ... None of the reports showed
23 engagement with families."
24 We've spoken about that, a systemic and chronic
25 problem, wasn't it?

38

1 What is the risk to staff? Are the interventions
2 proportionate to that risk? So I think that should be
3 the starting point.
4 **Q.** So from a nursing perspective, the risk, as you've just
5 set them out to be, that's what should be interpreted in
6 the context of restrictive practice?
7 **A.** It is for me, yes.
8 **Q.** Page 6, please. Three emerging themes at the bottom:
9 "Poor engagement, lack of followup ... risk
10 assessment."
11 "Delays and waits."
12 "Multi-agency working ..."
13 It was clear, wasn't it, from this report, that VC's
14 case was not an isolated case with the themes that had
15 been identified?
16 **A.** Yes. This is why I commissioned this report, because
17 following on from the Helen Collins report, I wanted to
18 make sure that -- I wanted to be assured around not only
19 the quality of the reports in previous homicides and
20 attempted homicides, but also to look at the learning
21 and whether that had been embedded.
22 **Q.** Can I just ask you more about the language "wanted to be
23 assured". I understand that when you have senior roles
24 and you're the Chief Nurse that's what you speak about,
25 "assured".

40

1 But at this point, isn't it you want to know the
2 failings and what's gone wrong? Because it's clearly
3 gone wrong for a considerable period of time and that's
4 not going to be assuring, but it's about what's gone
5 wrong and what you need to do?

6 **A.** Yes. But it was really important to look, over a period
7 of time, to understand the learning, to understand the
8 quality of those reports, and to understand the things
9 that we would need to do going forward to improve.

10 **Q.** And it identified, didn't it, this report, that there
11 was a variation in the adequacy of the reports that had
12 already been done?

13 **A.** Yes.

14 **Q.** And definitely a failure to learn from any of them. And
15 a depressingly, as we've said, similar background to the
16 earlier cases in terms of failure to risk assess.

17 Do you think, looking at that chronology, it would
18 have been far better to do a deep dive into a number of
19 cases and look at the discharges that had happened
20 around those times, at those cases, just to see what the
21 case notes demonstrated in other cases?

22 **A.** So there were a number of discharge audits and a deep
23 dives done. So there was a -- but this was in the
24 beginning of 2024, there were some done I think October,
25 November '23, where we were looking at previous

41

1 restrictive interventions is collected and two surveys
2 were completed: patient and staff experience."

3 "Data upon the use of restrictive interventions",
4 why was that being collected and what particularly were
5 you looking at in that?

6 **A.** So this was part of the National Culture of Care
7 Programme, but we were looking at a restrictive
8 interventions within an inpatient environment. So that
9 would be seclusion, observations, rapid tranquilisation
10 and restraint, and blanket restrictions as well.

11 **Q.** That can come down, thank you.

12 We know NHS England place NHFT in segment 4 in
13 February 2024. What did that mean, as far as you were
14 concerned?

15 **A.** So for me, that was around the -- it was around the
16 quality issues, and there was a need for an Integrated
17 Improvement Plan. So really clear improvement actions
18 and clear improvement outcomes.

19 **Q.** And you've set out in your written evidence about that
20 improvement plan, I'm not going to ask you anything
21 about that unless you want to say anything about that.

22 **A.** So part of that improvement plan, I was responsible for
23 quality and safety, and we included in that the
24 recommendations from the level 2 investigation and the
25 Theemis investigation and the section 48; all have been

43

1 discharges.

2 **Q.** And that could have been done in 2022, couldn't it,
3 after one of these earlier incidents that are reported
4 in that review?

5 **A.** I'm not aware if that was done or not.

6 **Q.** No. But the logic, if you did it when you saw it, was
7 it because there was a number or would one have been
8 enough for you to trigger -- (*overspeaking*) --

9 **A.** I really wanted to understand and learn. I really did.

10 **Q.** The Rapid Improvement Group if we go, please, to
11 NHFT0017453. This is a document November 2024, the
12 Rapid Review Improvement Groups.

13 So this is a response, is it, to Jonathan Warren's
14 report or is this in parallel with?

15 **A.** Some of those were set up prior to Jonathan Warren's
16 report. So the Rapid Improvement Group for Rampton was
17 in place before I started but then I took over as the
18 Chair of it. The Adult Acute Wards and Older Adult
19 Wards, I think I started, it was just before the CQC
20 inspection in 2023, because I already identified some
21 concerns.

22 **Q.** If we look at page 2 of this, you set out under
23 "Culture", third paragraph:

24 "The programme includes a series of measures against
25 which progress will be judged. Data upon the use of

42

1 completed.

2 **Q.** NHS England conducted a Well Led review after you were
3 in segment 4 and that's WITN0356028. And we see at
4 page 5, the penultimate paragraph:

5 "We heard from staff in the organisation ... they
6 are finding it difficult to understand the direction of
7 travel given multiple priorities. They also told us
8 they were not engaged in deciding priorities. [...]"

9 "Leaders below executive level said they were asked
10 to attend multiple meetings to discuss the same things,
11 with no clear output. This was impacting on morale and
12 prioritising work."

13 If we go to page 19, bottom three bullet points
14 please:

15 "Staff and some leaders expressed frustration around
16 the pace of change regarding QI rollout. They felt
17 change within the organisation was reactive rather than
18 proactive. [...]"

19 "Staff had mixed views in terms of the effectiveness
20 of incident reporting and feedback. Most staff in our
21 focus groups said they had not had any feedback after
22 reporting an incident."

23 What did you make of this report and these
24 criticisms?

25 **A.** I think it's important that we listen to staff, it's

44

1 important that we acknowledge their concerns, and many
2 of those things we are addressing. I can imagine how
3 they felt like that. You know, there were so many
4 things happening at that time. There was a need to have
5 an integrated improvement plan. We were also getting,
6 and quite rightly, many CQC visits. There was the work
7 that we needed to do around the Helen Collins review,
8 there was CQC action plans, and I can imagine how that
9 felt quite confusing at that time. And I think that's
10 why we were really clear that we needed to do things in
11 a systemic way.

12 What we didn't need is 150 kind of action plans and
13 running around ticking boxes. We needed to think about
14 the why, and that is why the Integrated Improvement
15 Plan, it had to be done at pace, but equally, it had to
16 be done in a way that brought people along with you.

17 I guess it was at the time of this report, the new
18 Patient Safety Team wasn't fully embedded. What I will
19 say about QI is that I believe we are in a different
20 position now. We have QI leaders aligned to each care
21 group. QI are involved in all of our integrated
22 improvement work but equally they're involved in our
23 PSIRF priorities, and some of the big issues for the
24 organisation.

25 **Q.** If we can go, please, to CQCM0029106. This is the
45

1 trust used clinical managers from care groups to
2 undertake investigations, and delays to the process were
3 influenced by workloads, availability and daily
4 pressures of their role. [...] In the 2024 NHS Staff
5 Survey, the trust scored significantly worse than
6 previous year results for the people promise element 'We
7 are always learning'. Each care group showed worse
8 results for this element, as did the corporate functions
9 of the organisation."

10 If we go over finally to page 46 in the third
11 paragraph:

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

17 Can you expand on that particular criticism and the
18 difference between corporate services and Patient Safety
19 Team?

20 **A.** Yes. Because the Patient Safety Team are a corporate
21 team, but they -- I guess this report highlights the
22 real positive improvements that the Patient Safety Team
23 had made. I think that this refers to the relationships
24 and how the Patient Safety Team work in a very different
25 way.

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1 January 2026 CQC Report. And despite the substance of
2 your witness statement and the work carried out, the CQC
3 still have concerns, considerable concerns, don't they?

4 **A.** Yes, they do.

5 **Q.** If we go to page 43, "Learning, improvement and
6 innovation":

7 "There was a disconnect between the vision executive
8 leaders had of the organisation and its position of
9 being a learning organisation, to how learning and
10 changes in practice had been implemented in some
11 services. Executive leaders told us the trust was
12 a learning organisation. Leaders described a move from
13 investigation and blame to a focus on learning,
14 listening and change. [...] We saw evidence that
15 whilst the trust believed a learning organisation vision
16 and culture shift was active and dynamic, we saw areas
17 where in practice, learning and a shift from blame
18 culture was not taking place as the Board may have
19 hoped."

20 And we see over the page at 44 in the bottom
21 paragraph:

22 "... we saw ... action plans, quality improvement
23 plans and learning was identified through investigations
24 ... not always coordinated and managed centrally, to
25 ensure a joined up and strategic approach [...]"

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1 **Q.** How do they work? Why are they more effective at
2 establishing relationships with care groups?

3 **A.** I think there is something around visibility and around
4 presence and around really supporting people to
5 understand and to learn. But I'm not quite sure what
6 they mean about the corporate services and which
7 corporate service, if I'm honest with you.

8 But I think our -- one of the things that we agreed
9 early on was that need to strengthen that Patient Safety
10 Team, really focus on patient safety. So it was good to
11 see in this report that that had been acknowledged as
12 well.

13 **Q.** That can come down, please. I want to ask you some
14 questions about Assertive Outreach.

15 **A.** Yes.

16 **Q.** And with this background in mind, I'll put two documents
17 on the screen. NHFT0000530, page 17. This should be
18 the Theemis Report findings:

19 "NHS England's recent review and guidance indicates
20 that assertive outreach should be a discrete resource
21 but recognises while some ICBs may already commission
22 'assertive outreach' teams or similar, others may not
23 currently commission a specific team or service focused
24 on intensive and assertive approaches. This aligns with
25 the information and evidence provided to the independent

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1 investigation that suggested the majority of dedicated
 2 assertive outreach teams as a standalone function, were
 3 disbanded over 10 years ago. Alternative models for
 4 supporting service users who do not choose to or are
 5 unable to engage with mental health services have
 6 developed but there is variation in the approach,
 7 dedicated protected resources and in outcomes for
 8 patients. VC's clinical records and interviews with
 9 community Trust staff do, to an extent, demonstrate an
 10 element of an assertive approach. However, this was
 11 constrained by the service model and workload within the
 12 team."

13 If we go now to Dr Dissayanaka's statement, please,
 14 WITN0412001, page 21, paragraph 39.

15 "The Theemis Report unfortunately represents
 16 a missed opportunity to properly consider the potential
 17 benefits of Assertive Outreach in this specific case.
 18 As has already been stated, Assertive Outreach is a very
 19 clearly defined team-based model of care. Whilst
 20 various hybrids may have been used in different areas,
 21 these cannot be referred to as Assertive Outreach Teams.
 22 Their results, derived from quasi-experimental
 23 evaluations, lack the rigour of RCT studies and cannot
 24 compare to wealth of long-term international evidence
 25 for high-fidelity ... Assertive Outreach. It is

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1 **Q.** -- did you prepare it?

2 That can come down, please, and can we have
 3 NHSE0000839. Page 4 and 5 can go on the screen. We see
 4 at page 4, paragraph 4:

5 "National guidance was published in July 2024: NHS
 6 England Guidance on intensive and assertive community
 7 mental health treatment. [Integrated Care Boards] ...
 8 were asked to use this to review policies and practices
 9 they have to identify and provide appropriate care to
 10 people with severe mental illness who might need
 11 intensive and assertive community care."

12 So you conduct the review, Findings and Action Plan.
 13 If I can take us to page 5, there's your review
 14 findings. We can perhaps have page 5 and 6 on the
 15 screen.

16 Would you like to set out your response to that
 17 request for the review?

18 **A.** So it was the -- I'm sorry, it was the Care Group Nurse
 19 Director who completed this review on behalf of the
 20 organisation. So we have a Care Group Nurse Director
 21 responsible for Community Mental Health Teams.

22 **Q.** Understood, but you read that and are aware --

23 **A.** Yes.

24 **Q.** -- of this work, clearly.

25 **A.** Yes, so --

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1 emphatically not the case that the term Assertive
 2 Outreach can ever be used to describe the work of
 3 individual staff within a wider Community Mental Health
 4 Team."

5 If we go to the "Fidelity to the Assertive Outreach
 6 Model", page 24 of his statement, if we can have 24 and
 7 25 on the screen, he's given evidence about this, the
 8 Dartmouth Fidelity Scale, and what is beneficial
 9 within it:

10 "access to specialist care ...

11 "assertive engagement.

12 "small caseloads ... A team caseload size allowing
 13 for a shared-team approach.

14 "daily planning of care.

15 "continuous assessment of risk.

16 "... dedicated ... consultant psychiatrists ...

17 "... dedicated nursing staff with similar
 18 experience."

19 And so it continues. I won't read them all out, but
 20 so we both have that backdrop of the evidence that the
 21 Inquiry has received.

22 You prepared an Assertive and Intensive Community
 23 Mental Health Care Review and Action Plan; is that
 24 right --

25 **A.** Yes.

50

1 **Q.** So what were the findings in relation to NHT and what
 2 you were providing?

3 **A.** So we don't have a dedicated Assertive Outreach Team.
 4 We have done lots of work on it. We have an Assertive
 5 Outreach plan. We have -- we are preparing to have
 6 standalone teams which will be ready for this autumn.

7 We know that having a function within our LMHT
 8 although we have been testing that out, will never be as
 9 good as the doctor describes the high fidelity model.

10 We've been doing lots of work in preparation for that,
 11 so we've identified all people who would meet currently
 12 the Assertive Outreach criteria, and that's around 300
 13 people.

14 We have --

15 **Q.** That's as of today's date?

16 **A.** As of today, but we do that weekly. We have separate
 17 dashboard that complements SafeNow so that we know
 18 exactly how many people would meet that criteria. We
 19 know how many people --

20 **Q.** What is the criteria?

21 **A.** So it would be people who have a serious mental illness
 22 or that there's levels of complexity. They would be
 23 people who maybe don't respond to a more traditional
 24 type service --

25 **Q.** How is not responding measured?

52

1 A. So it would be people who may be where there's
2 disengagement, where there continues to be a lack of
3 compliance, particularly with medication. But that
4 engagement is a really key issue.

5 It would be people who have had two or more
6 admissions. Often it's people who maybe have
7 difficulties with tenancy sustainment, that risk
8 behaviours are usually those where there is an increase
9 in violence, and there could be issues with substance
10 abuse as well.

11 Although it's predominantly people with
12 schizophrenia, there are other people with other
13 diagnoses who have that level of complexity as well. So
14 that would be the criteria, that's the criteria we are
15 measuring ourselves against.

16 Q. So you look at it weekly, and then how is it
17 implemented? You've identified the patient. Who is
18 then responsible for carrying that forward in respect of
19 that patient?

20 A. So we ensure that those patients are allocated. That
21 dashboard tells us really clearly the risk assessment
22 compliance, the care plan compliance, the CTO
23 compliance. It also allows us to see, and it has a red
24 flag function, if people have disengaged or missed more
25 than two appointments so we can then really proactively

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1 our resources, how we transform some of our community
2 teams so we can create, because we think it's really,
3 really important, these three AO teams.

4 But in preparation for that, we have ensured that we
5 have reduced the caseloads of the care coordinators who
6 were caring for people, we have invested in psychosocial
7 intervention training, so I think we've got over 30
8 people trained at the moment, another 20 already on
9 training, really important component of the Assertive
10 Outreach approach.

11 We've had training around substance misuse, some
12 additional training around working with disengagement,
13 and some coaching. We've also been out to other areas
14 that do have an AO model, including the one in Leeds as
15 well because we want to learn from the very best.

16 We're at currently -- sorry, I'm talking too much,
17 aren't I --

18 Q. No.

19 A. We're currently at the position where we're looking for
20 the right buildings to put people in so we're ready to
21 go in the autumn.

22 Q. That can come down, please. And can we have an ICB
23 document NHSE0000839, dated 14 November 2024. This is
24 the other side of that, the "Review and Action Plan"
25 obviously communicated to the ICB. We'll hear from

55

1 think about the interventions that we're going to use.

2 It measures the contact with families, and so we can
3 see the family engagement as well. So it's a real good
4 kind of on a page look. The preparation --

5 Q. On a page for each patient? All those metrics?

6 A. No, it's a bit like SafeNow actually, so it's
7 a dashboard, but you can go into each patient.

8 So if we saw a patient had two, you know, they
9 hadn't attended, you can go into there and the Care
10 Group Nurse Director is looking at that, and say, "Okay,
11 what have you done about this? What are you doing about
12 this?" And can follow that through.

13 We have, because we -- there is no additional
14 national monies at the moment, and we are repurposing --

15 Q. So no allocated budget with this request to review --

16 A. No.

17 Q. -- and you have to manage that within the resources you
18 have?

19 A. Yeah, so we did put in a kind of a business plan,
20 I think that was £4 million. There is no new national
21 monies available at the moment so --

22 Q. Who did you put that plan into?

23 A. ICB.

24 Q. ICB.

25 A. So what we've done is look at how we repurpose some of

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1 someone from the ICB, and we see at the bottom:

2 "It is acknowledged that although some assertive
3 engagement is taking place within NHT, there is no
4 standardised pathway, resulting in inconsistencies ...

5 "Workforce planning and jobs do not reflect the
6 assertive engagement ... Caseloads are not reduced and
7 largely comprise a broader mix of presentations and
8 needs".

9 Over the page:

10 "... gaps in training for new staff [...]"

11 "The review also identified more could be done to
12 support medication adherence."

13 And:

14 "The Trust has confirmed to the ICB and NHS England
15 that people who require intensive and assertive support
16 would not be discharged on the basis of non-attendance
17 or lack of engagement."

18 And the board receives and notes the outcome of
19 this.

20 But your evidence is there's no extra funding at the
21 moment that's been provided to assist with this.

22 A. Yes.

23 Q. Thank you. That can come down.

24 Can we look at another document, please, the Risk
25 Escalation Framework, WITN0263041, page 1.

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1 Can you help, please, with if I had a concern about
 2 MDT meetings not being minuted, no action plans, not
 3 following it through, and I mention that to a colleague
 4 or say it in a meeting, where do you expect that to come
 5 through this system?
 6 **A.** So I would expect it to go to the Care Unit Leadership
 7 Team then to the Care Group Leadership Team.
 8 **Q.** Sorry, where is that? Is that on the first tier?
 9 **A.** So at the top, go to "Relevant Care Unit Governance
 10 meeting".
 11 **Q.** Yes.
 12 **A.** Then to the Care Group, and then that could go into the
 13 Trust Risk Group. The top boxes.
 14 **Q.** Then that could go to the "Exec Team Urgent
 15 escalations".
 16 Now are they systemic issues, urgent escalations, or
 17 can there be individual cases?
 18 **A.** So this is the route for the more kind of if you
 19 group -- Multi-Disciplinary Team minutes is a good
 20 example. But if there was concerns around individual
 21 cases which were urgent or if there was any urgent
 22 concerns, then there is another route up, of course.
 23 You know you can talk to your direct line manager who,
 24 for the care group nurse directors, would be me, and for
 25 the clinical directors, would be Susan Elcock.

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1 "If we do not minimise and manage the risk of
 2 violence to others then patients/staff/visitors could be
 3 subject to physical and psychological harm (including
 4 serious injury and fatality) leading to: patient
 5 recovery being undermined, increased staff sickness
 6 litigation ... low staff morale and negative impact on
 7 staff retention."
 8 As a corporate risk, the violence to others seems to
 9 limit to patients, staff and visitors, doesn't it? It
 10 doesn't mention, again, risk of violence to others in
 11 the community or public.
 12 **A.** I mean it says, "violence to others" but you're right.
 13 **Q.** It does but it then describes patients, staff
 14 -- (*overspeaking*) -- those in the setting of the
 15 hospital and immediately affected by violence in the --
 16 **A.** Yeah.
 17 **Q.** -- confines of mental health service-related
 18 environments.
 19 **A.** Yes.
 20 **Q.** And this the corporate risk table that the Board see,
 21 and it maybe we'll no doubt be notified if there is,
 22 there is a corporate risk identified somewhere else in
 23 the register.
 24 But this is attempting to set out all the potential
 25 risks at Trust-wide level, is it?

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1 **Q.** Do you think this is effective to escalate risk, this
 2 structure?
 3 **A.** I think when you put this alongside the urgent
 4 escalation processes and the Serious Incident Review
 5 Group that I've described, yes, I do. I've seen good
 6 examples of when that's come through very quickly.
 7 **Q.** So where would your expanded Serious Incident Review
 8 Group filter in risks?
 9 **A.** This is -- so that's out -- that isn't within this.
 10 This is something that happens each week, it goes to
 11 ELT. However, if there was a thematic risk from that,
 12 that could go in to -- because the Trust Risk Group
 13 looks at the corporate risks as well, and one of those
 14 is around patient safety.
 15 **Q.** Can we just look at example or a page of the risk
 16 register, please, NHFT0005082, page 6. And before we
 17 have it for you to comment on, risk registers. Are risk
 18 registers kept at every level? Risks on the ward, risks
 19 at divisions, and then risks to the Board, effectively?
 20 **A.** Yes, so individual risk, operational risk, corporate
 21 risk, strategic risk.
 22 **Q.** And the one we're looking at in the Board Assurance
 23 Framework, is this corporate risk?
 24 **A.** Yeah.
 25 **Q.** So if we see in 2013, the bottom left:

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1 **A.** Yeah, there's been a lot of changes made to the risk
 2 registers and Board Assurance Framework. This one is
 3 2020. So they are set out differently now. There is
 4 a lot more focus on the interventions and the controls,
 5 and there are deep dives that take place now as well.
 6 **Q.** So what's the usefulness of this? You obviously get
 7 reports from people on wards about events, incidents,
 8 serious incidents, and the risk register, how does that
 9 add to the qualitative information that you're getting
 10 from people?
 11 **A.** I think it puts it all in one place. It allows the
 12 Board to focus, it allows the execs to focus. It allows
 13 us to see not only the operational risks but the risks
 14 to the strategic objectives as well. And these, the
 15 risk registers or the Board Assurance Framework go to
 16 each of the relevant committees so they are reviewed.
 17 So for me, in Quality Committee, the risks related
 18 to quality and safety are reviewed at every committee.
 19 **Q.** Thank you. That can go down, please.
 20 Final topic from me, please, Ms Hull. The
 21 disciplinary process, and particularly in relation to
 22 VC's case, we understand one doctor has self-referred.
 23 One doctor, we were told yesterday by the Medical
 24 Director, the GMC indicated did not meet the referral
 25 criteria. Have any others been referred by the Trust as

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1 far as you're aware to the GMC? I don't mean the names,
 2 but whether they have.
 3 **A.** I don't know about doctors. I can tell you about
 4 nurses.
 5 **Q.** How many -- what about nurses? What's the position with
 6 nurses? Not names, the numbers.
 7 **A.** Numbers. Three people have been referred to the NMC.
 8 We're in regular -- we regularly consult with the NMC.
 9 We have also committed -- I think Dr Elcock
 10 mentioned this yesterday -- to do a further review of
 11 professional standards and practice following the
 12 Inquiry as well.
 13 **Q.** We know, because he gave evidence and told us, Gary
 14 Carter resigned or retired before the investigation had
 15 concluded in his case, didn't he?
 16 **A.** Yes.
 17 **Q.** He gave evidence to the Inquiry that he remembers you,
 18 Dr Lloyd and Dr Thangavelu all being in, I think it was
 19 a meeting, and he said something along the lines of "Do
 20 you think we missed something? Do you think we could
 21 have prevented it?" And your response and the others
 22 was: "No, there was no way we could have predicted this
 23 and no way we could have prevented it."
 24 Do you remember that discussion around
 25 predictability, preventability, with Gary Carter where

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1 Likely.
 2 **A.** It may have.
 3 **MS LANGDALE:** Thank you. Those are my questions. It may be
 4 a good time for the break, Chair.
 5 **THE CHAIR:** Yes, we'll take a break until quarter to 12.
 6 Thank you.
 7 **(11.27 am)**
 8 **(A short break)**
 9 **(11.45 am)**
 10 **(Proceedings delayed)**
 11 **(11.54 am)**
 12 **THE CHAIR:** Yes, Ms Patrick.
 13 **Questioned by MS PATRICK**
 14 **MS PATRICK:** Good morning, Ms Hull. My name is Angela
 15 Patrick. I ask questions on behalf of those who were
 16 bereaved on 13 June 2023. I only want to look at one
 17 document. Could we bring up SUBS0000013, page 18,
 18 please.
 19 If we could turn to page 18, I'd like to look at
 20 paragraph 78 at the bottom of the page. Just to
 21 familiarise you, Ms Hull, this is the Trust's opening
 22 statement to this Inquiry.
 23 **A.** Yes.
 24 **Q.** I assume it's a document you'd be familiar with.
 25 **A.** Yes.

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1 he said that?
 2 **A.** I don't recall that. I do know that I went to the EIP
 3 team prior to the level 2 investigation being published,
 4 and that was to listen to people. I went, after level 2
 5 investigation, to feed back the recommendations and the
 6 learning, and I went back after the Theemis as well.
 7 But I don't remember those exact words. I know that
 8 what I would have said is that there would be -- there
 9 seldom is a single point of failure. This will be
 10 systemic, and there will be huge amounts of learning,
 11 and we accepted all of the findings from all of those
 12 reviews.
 13 **Q.** What about, would you have ever said -- well, did you
 14 think it was preventable or predictable?
 15 **A.** I think it would be difficult, and I don't think I could
 16 say that the terrible events of June 13 are -- could
 17 have been prevented, but what I can say with absolute
 18 clarity is that we failed to exhaust all of the options
 19 and all of the interventions available to us. And given
 20 the kind of things we've heard, particularly through the
 21 Inquiry, it does lead me to think that, had we -- at
 22 different points during his care and our contacts, had
 23 we and others taken different action, it might have
 24 impacted the outcome.
 25 **Q.** Well, very likely impacted the outcome, not might.

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1 **Q.** And we can see there:
 2 "The Trust acknowledges that, in hindsight, its
 3 involvement and engagement with families has not felt
 4 satisfactory."
 5 And it goes on:
 6 "In this case, the Trust has been engaging with
 7 victims' families to whom it has no duty of care as
 8 their loved ones were not patients of the Trust, and the
 9 guidance from NHS England does not adequately address
 10 how to navigate this situation."
 11 "Has not felt satisfactory." It wasn't
 12 satisfactory, was it?
 13 **A.** It wasn't.
 14 **Q.** Thank you. You've apologised for failures in your
 15 contact and engagement with the bereaved families in
 16 your witness statement, haven't you?
 17 **A.** Yes.
 18 **Q.** Now, it wasn't until December after these events that
 19 the first contact letters were received by the families,
 20 wasn't it?
 21 **A.** Yes.
 22 **Q.** That was almost six months after their loved ones were
 23 killed, wasn't it?
 24 **A.** Yes.
 25 **Q.** That was simply wrong, wasn't it?

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- 1 A. It was, and I did set out in my statement the reasons
2 for that, but you're quite right, it's wrong.
- 3 Q. Now, in your statement on behalf of the Trust, when you
4 talk about a compassionate approach, this delay lacked
5 both common sense and compassion, didn't it?
- 6 A. We should have done more to challenge the -- we should
7 have done more to find the addresses and to challenge
8 the police directive around contact, yes.
- 9 Q. These were people who had been bereaved at the hands of
10 a patient whose care you had been responsible for. NHS
11 England or other national guidance aside, didn't
12 compassion simply require you to have reached out
13 sooner?
- 14 A. I'm so sorry, yes.
- 15 Q. Now, when the Trust did meet with the families you
16 attended those meetings, didn't you?
- 17 A. I did.
- 18 Q. With the Coates brothers, the Webbers, the
19 O'Malley-Kumars and separately with Elaine Newton?
- 20 A. Yes.
- 21 Q. Do you recall the Trust being challenged in those
22 meetings?
- 23 A. About what?
- 24 Q. The families were asking hard questions about what had
25 happened, weren't they?

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- 1 Q. Now, everything you've talked about today in terms of
2 improvements made since 13 June 2023, couldn't those
3 improvements have been made much sooner?
- 4 A. I think we heard yesterday that there'd been attempts to
5 make improvements, but they were not embedded and not
6 sustained.
- 7 Q. They were not embedded. There were concerns raised in
8 2019, in 2021, in 2022. Should those concerns have been
9 remedied with real change sooner and well before
10 13 June 2023?
- 11 A. Yes.
- 12 Q. Turning back to that statement I took you to, it's still
13 on screen, was the Trust, at the opening of this
14 Inquiry, unable to simply accept that it did not engage
15 with the bereaved families appropriately and candidly
16 and to accept they should have apologised then to them
17 both for failures in communication and failures in
18 missed opportunities in the care afforded to VC?
- 19 A. I think we have always apologised for the missed
20 opportunities and for the failures, and absolutely
21 apologise for the delay in contacting and communicating
22 with families.
- 23 Q. Now look at that statement: "Has not felt satisfactory".
24 Is that a reflection of a culture of defensiveness at
25 the Trust in addressing its failures in these events and

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- 1 A. Oh, yes, yes. I remember the questions.
- 2 Q. Elaine Newton asked whether you were understaffed and
3 she recalls being told there was no problem with
4 staffing. Was that an appropriate message for her to
5 have taken away from that contact?
- 6 A. I remember that we discussed staffing, in particular
7 leadership, and the care of VC.
- 8 Q. She took away that she was told that there was no
9 problem with staffing. Was that an appropriate message
10 for her to have taken away from that meeting?
- 11 A. No, but I'm not sure that that would have been the
12 meaning of that message. I think that it would be more
13 around that staffing wouldn't have been the cause of
14 this. However, we know there has been issues with
15 staffing in the organisation.
- 16 Q. And if asked, Duty of Candour meant that you should have
17 really said, "Yes, it was a problem."
- 18 A. In the Trust, but I'm not sure if it was a problem
19 within that team.
- 20 Q. Okay. Now, everything you've talked about -- sorry,
21 pausing. We've also seen over 100 questions followed
22 your contact in August with the Coates, the Webbers, and
23 the O'Malley-Kumars, and there was no reply until many,
24 many months later; is that right?
- 25 A. Yes, that is correct.

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- 1 in relation to VC's care?
- 2 A. I could see how that may be interpreted as not as
3 compassionate as it could be. But I absolutely want to
4 assure you that we acknowledge that we should have made
5 contact earlier.
- 6 Q. Okay. Moving away from contact and moving away from
7 what was being said at the start of this Inquiry, is
8 that defensiveness reflected in what you've just said
9 today in response to questions by Ms Langdale? If the
10 Trust had done its job properly, you said it may have
11 impacted the outcome, may. Instead of accepting simply
12 that it very likely would have?
- 13 A. I don't think I have been defensive, and I apologise if
14 it's come across that way. I was just expressing my
15 belief around, and my view, about could that have been
16 prevented.
- 17 MS PATRICK: Okay. No further questions. Thank you.
- 18 THE WITNESS: Thank you.
- 19 THE CHAIR: Yes, Ms Cartwright.
- 20 **Questioned by MS CARTWRIGHT**
- 21 MS CARTWRIGHT: Good afternoon, Ms Hull. I ask questions on
22 behalf of the survivors.
- 23 Could I please display one of your paragraphs of
24 reflection, please, in your first witness statement,
25 which is WITN0133001 at page 151, please, paragraph 445.

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1 Thank you. So the paragraph before you essentially
2 reiterate the acceptance of the failings as identified
3 by the various reviews.

4 But you go on to say this:

5 "It is important to acknowledge that each review to
6 date has been carried out for a specific purpose, within
7 a particular framework, and each has had limitations.
8 It is for the Inquiry to explore this and determine what
9 further avenues of investigation it wishes to explore."

10 But then goes on to note some limitations including
11 of the earlier reviews that:

12 "... the Independent Homicide investigation
13 commission from Theemis ... included interviews with
14 some staff, but more limited engagement seems to have
15 been provided by the University of Nottingham (who
16 declined to be interviewed and Nottinghamshire Police.

17 "The Trust understands that neither of these
18 investigations sought the views of the AMHP, whose role
19 has been described earlier in this statement and whose
20 participation at key stages of VC's care is evident from
21 the chronology.

22 "The Trust's view, therefore, is that there remain
23 key aspects where further explanation is needed,
24 including through obtaining evidence from individuals
25 who were involved in VC's care. This is particularly

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1 **A.** I'm not aware of that audit, but I'm aware of an audit
2 that was completed within the EIP team, looking at
3 multidisciplinary teams, the discussion and the outcome.
4 But I'm not aware of an audit of medical colleagues'
5 input into that.

6 **Q.** Would you agree, it is completely capable for the Trust
7 to essentially interrogate RiO to look at who accessed
8 RiO when and for what period of the time they were in
9 VC's records? So that's something that's readily within
10 the Trust's ability to check whether, in fact, those
11 consultants had been in VC's record?

12 **A.** You can get that through looking at RiO, yes.

13 **Q.** But that's still not been done by the Trust?

14 **A.** I'm really sorry, I'm not aware.

15 **Q.** All right. Would you agree that that's something
16 actually that shouldn't await the outcome of the Inquiry
17 report; in fact, it's relevant evidence that should be
18 provided and disclosed to this Inquiry?

19 **A.** I will take that back.

20 **Q.** Similarly, just in respect of the contract that the
21 Trust had with the Priory, bearing in mind the issues of
22 failings relating to VC's third admission and discharge
23 from the Priory, again, there was an issue also about
24 recordkeeping for Dr Gurusinghe, and does the Trust have
25 an ability, through the contractual provision, to

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1 important where the documentary record is lacking."

2 Then you go on to set out helpfully, in the table,
3 various issues that have been identified by the Senior
4 Leadership Team, but again picking up the theme of poor
5 recordkeeping and in particular regarding VC's final
6 discharge on 22 September 2022 being a key example of
7 poor recordkeeping.

8 So can I ask, aside from obviously the Inquiry's
9 investigation, are the Trust undertaking a piece of work
10 of what additionally is needed from a clinical
11 governance perspective from the failures that are being
12 identified by the Inquiry evidence?

13 **A.** So we would be waiting until after the Inquiry, and then
14 looking at any other work that needs to be picked up.

15 **Q.** All right. Then can I ask you, in terms of the issue of
16 poor recordkeeping, the Inquiry has heard evidence from
17 a number of the significant consultants involved in the
18 care and discharge of VC over the various iterations,
19 and particularly where a common theme is very poor, of
20 complete absence of recordkeeping. And particularly for
21 Dr Thangavelu, Dr Lloyd, limited notes for Dr Seedat.

22 Can I ask you, has the Trust performed an audit of
23 the RiO system to actually look at when those
24 consultants did in fact access VC's record prior to June
25 of 2023?

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1 similarly request the Priory to undertake a similar
2 audit for the access of the consultant who discharged VC
3 for the times he was in his medical records at the
4 Priory?

5 **A.** I'm sure those are discussions that we could have, but
6 I would need to check with the Medical Director.

7 **Q.** Thank you.

8 Then the next topic I just want to briefly deal
9 with, and I apologise you've not had it in the pack, but
10 it was a document that was provided to us yesterday, and
11 I'm not going to be able to display it to you, but it
12 relates to the Theemis interview from your equivalent
13 Chief Nurse at the ICB. So it's a transcript we've
14 received, I can't display it, but I just want to check
15 one matter because it directly relates to, I think,
16 relevant evidence you can give, and particularly in
17 respect of incident reporting that you've dealt with,
18 with Counsel to the Inquiry.

19 So one of the things that your equivalent, Rosa
20 Waddingham, says, was this -- firstly, do you know Rosa
21 Waddingham at the ICB?

22 **A.** I do. I do.

23 **Q.** Just to contextualise this, she also deals within her
24 interview that, when you became the Chief Nurse, with
25 your knowledge of mental health and mental health

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1 portfolio, that has given more assurances I want to
2 contextualise that that is said earlier in this
3 interview.

4 One of the things that is said is this, particularly
5 in respect of serious incidents reports, one of the
6 things that had concerned her is the governance and the
7 flow of information, and essentially keeping the ICB
8 regularly in the loop, and essentially, then goes on to
9 say that she had an anxiety about things being on the
10 front page of the newspaper about the Trust, that it
11 never thought to tell the ICB about and she says this,
12 and in fact that does happen fairly regularly?

13 Just for the reference where I'm at for the moment,
14 sorry, because I've not identified the source for
15 others, TCLT0000177 and I'm summarising from page 33.
16 And then she goes on to say this -- and it's a bit like
17 you said about the thematic review of homicides:

18 "I have offered repeatedly, as have my staff, to be
19 involved in their own internal reviews and processes.
20 We've been kept at arm's length. I think that's
21 a shame, because I think that the leadership of their
22 technical SI process, if you like, I don't think that's
23 been done. I don't think the StEIS approach has been
24 done as strong as it could be and I think DK especially
25 ..." (As read)

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1 A. Oh, sorry. I think Rosa, in her interview, was talking
2 about 2023 and beforehand. We worked closely with the
3 ICB. We developed the SafeNow dashboard with the ICB.
4 We report monthly with the ICB at the Integrated
5 Oversight Assurance Group to NHSE, so we are working
6 together.

7 I can -- it's really hard to comment, isn't it, on
8 something that maybe was historic, but we -- I guess the
9 things I spoke about this morning about improving and
10 strengthening the Patient Safety Team, about improving
11 our governance around it, has not resolved, because you
12 can always further improve, but is in a response to some
13 of those concerns that Rosa has identified.

14 But we have a good working relationship with the
15 ICB, and we meet regularly -- I think it's Diane-Kareem
16 Charles actually -- we meet regularly with her. There
17 is a quality governance meeting as well as the quality
18 oversight group as well.

19 Q. So you think that's essentially referencing the time
20 before you came into the Trust, so your pre-July 2023
21 position?

22 A. I think so, but I think that sustained improvements do
23 take a while to happen, so it could be, you know, the
24 latter part of 2023.

25 Q. Right.

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1 Pausing there, that's potentially somebody else at
2 the ICB that could be the Deputy Chief Nurse:
3 "... given her expertise around StEIS and incidents
4 would have been a real support to the Trust that they
5 chose then not to use. So that does worry me, I suppose
6 more worry about the process. I worry about the process
7 being right and that process still escalating to me even
8 today is something that might be worrying. And I don't
9 know if that's a deliberate strategy or if it's that
10 it's just that they're so overwhelmed. And we are not
11 the regulator of the Trust and therefore in keeping the
12 regulatory and the Secretary of State and the CQC happy,
13 we constantly, as an ICB, have to fight to be on that
14 list. I don't know if that's -- I think probably some
15 but not all of it, it's poor governance and poor
16 process." (As Read)

17 So can I ask you, in terms of the issue that the
18 equivalent at the ICB is raising, do you have any
19 comment about their impression from this Theemis
20 interview from September of 2024, that your Trust is not
21 really utilising the offer of assistance, particularly
22 around the StEIS and incident reporting and their
23 expertise, and being kept at arm's length?

24 A. So I think Rosa was talking about 2023, and beforehand.

25 Q. Sorry, your voice is slightly dropping.

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1 A. However, the real improvements started to the Patient
2 Safety Team. We got new people in, when we implemented
3 PSIRF, which they were part of, early 2024.

4 Q. Thank you. Then just finally, please, just picking up
5 on the StEIS theme, can I use your witness statement
6 again, please, just to helpfully deal with that StEIS
7 issue, please. So it's your WITN0133001, and please
8 could we go to your paragraph 148 at page 44, please.
9 Thank you.

10 Thank you, we just go to 148. We've obviously heard
11 about incident reporting and Datix. I'm not going to
12 deal with the evidence we've already heard and the
13 acceptance by Mr Majid about what should have happened
14 for Feven, but you helpfully tell us:

15 "Pursuant to regulation 18 of the CQC ...
16 Regulations 2009, all healthcare providers must notify
17 the CQC of all incidents that affect the health, safety
18 and welfare of people who use services. As explained
19 below, from 2013 this was done via the National
20 Reporting and Learning System and the Strategic
21 Executive Information System ('StEIS') for Serious
22 Incidents. There then followed a programme of phased
23 replacement of these systems until June 2024 [...]"

24 If we can go over the page, please, thank you. Then
25 at paragraph 150, you go on to deal with the fact that:

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1 "... Serious Incidents were described as adverse
2 events where the consequences to patients, families and
3 carers [...] are so significant, or the potential for
4 learning is so great, that a heightened level of
5 response is justified".

6 So that StEIS can be accessed by the commissioners,
7 the CQC as was, the ICB; would you agree? So
8 essentially it's a way that it takes the learning
9 outside of just the Trust and the management internally,
10 but for instance, it is serious, it then has the
11 oversight because it has to be StEIS-ed to the CQC is --
12 sorry, the CCG as was, but the ICB as is now; would you
13 agree?

14 **A.** We don't use StEIS anymore.

15 **Q.** No, I know you don't, but I want to ask you the question
16 because it's relevant to the 2020 period and looking at
17 that definition.

18 **A.** Okay.

19 **Q.** Would you agree that the incident -- and you've already
20 referenced about the reviews to date -- haven't involved
21 the AMPHs, but would you agree under the categorisation
22 of regulation 18 and the fact that VC was assessed, not
23 admitted in May of 2020 and then went on to have the
24 further incident, would you agree that that should have
25 been considered also for StEIS-ing in respect of VC. So

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1 supporting recovery, within mitigated safety plans."

2 You offer up to the Inquiry there, don't you,
3 a Department of Health document on this in 2009. Is
4 that because that's still a very important document
5 underlying the principles that you're dealing with in
6 the witness statement on risk?

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

8 **Q.** I'll come to that in a moment. If we just move down to
9 the end of the paragraph, then:

10 "Risk assessment is recognised as a dynamic process
11 requiring continuous review based on changes in patient
12 presentation, circumstances, or engagement. Risk
13 assessment, formulation, and management are integrated
14 into ongoing therapeutic relationships and planning,
15 developed collaboratively with patients and carers."

16 If we could just go two paragraphs down, so that's
17 220, please:

18 "Patients and carers are also actively engaged in
19 risk and safety planning in line with personalised care
20 principles. Co-produced risk formulation and safety
21 plans are standard practice."

22 So I think you're describing the position now; is
23 that the case?

24 **A.** Yes, because they weren't at the time.

25 **Q.** They weren't at the time. Okay. So can we just go

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1 leaving aside Feven, bearing in mind the decision making
2 that ultimately resulted in VC then being involved in
3 a very serious incident when unwell with Feven?

4 **A.** So an incident form should have been raised at that
5 time.

6 **Q.** Yes.

7 **A.** Then that would have -- there would have been the
8 decision then around the type of review that should be
9 undertaken.

10 **MS CARTWRIGHT:** All right. Thank you very much.

11 **THE CHAIR:** Yes, Ms Heaven.

12 **Questioned by MS HEAVEN**

13 **MS HEAVEN:** Good afternoon, Ms Hull. I ask questions on
14 behalf of VC's family.

15 Now, you accepted from Ms Langdale KC earlier that
16 engagement or the lack of engagement with families by
17 the Trust was a systemic and chronic problem. So can
18 I just explore with you very briefly concepts such as
19 co-production and effective collaboration with families
20 in the formation of risk management strategies. Can we
21 start with your witness statement, please. It's
22 page 81.

23 So you explain there at the start:

24 "The Trust promotes positive risk-taking, enabling
25 patients to engage in informed therapeutic risks

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1 back, then, just to looking -- I want to show you that
2 Department of Health guidance, please, that you've
3 referenced in your witness statement. It's DHSC0000038.
4 So we see the title there, don't we:

5 "Department of Health
6 "Principles and Evidence for Best Practice in the
7 Assessment and Management of Risk to Self and Others in
8 Mental Health Services.
9 "March 2009".

10 So this is 11 years before the events that we're
11 looking at, isn't it?

12 **A.** Yes.

13 **Q.** Can we go to page 14, please:

14 "A collaborative approach to risk management."
15 Sorry, just before we go back to that, can we go to
16 page 8, I just want to put the first principle to you.
17 Okay. So fundamental 3:

18 "Risk management should be conducted in a spirit of
19 collaboration and based on a relationship between the
20 service user and [the carer] that is as trusting as
21 possible."

22 If we could now go to page 14, please:

23 "A collaborative approach to risk management:
24 "As with all aspects of mental health care, the key
25 to effective risk management is a good relationship

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1 between the service user and all those involved in
2 providing their care. A three-way collaboration between
3 the service user, carers and the care team can often be
4 established, and this relationship should be based on
5 warmth, empathy, respect and a sense of trust -- with
6 the aim of involving the service user in a collaborative
7 approach to planning care."

8 If we just go down a bit:

9 "This means that the process of risk management
10 should be explained to everybody involved at the
11 earliest opportunity."

12 Okay?

13 Then just the final entry, please, this is page 26.

14 "Sharing decision-making", so this is working with
15 service users and carers again. Just going partway
16 through, it's quite repetitive but:

17 "The service user should be offered the opportunity
18 to take the lead role in identifying the risks from
19 their point of view, drawing up plans for dealing with
20 difficult situations, and indicating the sort of support
21 they would prefer: service users and carers are often in
22 the best position to comment on the robustness and
23 practicality of the plan. The plan should include
24 negotiated and individualised advance decisions on early
25 warnings signs of a relapse to violence or self-harm or

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1 always somebody who was ahead of involvement. What
2 we've tried to do is strengthen that and have
3 a dedicated role who focuses on carer and family
4 involvement.

5 We do have a number, I think it's over 20, carer
6 peer support workers as well, and a number of them have
7 been in post for several years. So what -- I do agree
8 that more improvements should have been made sooner.
9 However, I do think attempts to do so were made.

10 **Q.** Well, how many care peer support workers were available
11 between 2020 and 2023 for community adult mental health
12 services?

13 **A.** Sorry, I don't know. I know how many now, but I don't
14 know how many then.

15 **Q.** Triangle of Care, just very briefly. In your witness
16 statement you say the Triangle of Care assessments have
17 gone up by a hundred per cent.

18 Again, this was a concept that was created in 2010,
19 wasn't it?

20 **A.** It was.

21 **Q.** Have you been able to get to the bottom of why the
22 Triangle of Care was not being applied in the Trust
23 10 years after it had been created? Was it, as the
24 Coroner indicated, to the Trust in July 2021 -- and this
25 is a direct quote:

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1 suicidality, as well as preferred early interventions at
2 times of crisis."

3 So that guidance there is envisaging working with
4 patients and carers to understand what they need to look
5 out for at some point in the future, and what sort of
6 decisions they need to make if a patient relapses, for
7 example.

8 **A.** Yes, that would be --

9 **Q.** -- (*overspeaking*) --

10 **A.** -- the purpose of an advanced directive.

11 **Q.** Okay. We can take that down, thank you.

12 So in terms of the changes that have now happened,
13 which you've touched upon, it is your witness statement,
14 page 198, you've now created a carers' strategy and
15 I think you now have a new associate Director of
16 Participation and Co-production to ensure what you
17 describe in your witness statement as "genuine
18 inclusion".

19 Bearing in mind what we've just looked at, that's
20 a 2009 document, is it not a damning indictment of the
21 Trust that it took so long for these changes to be made?
22 The principles were very well known as early as 2009,
23 weren't they?

24 **A.** So as I said earlier, I think there were many attempts
25 to make improvements. There were always -- there was

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1 "Because there was a lack of awareness of Triangle
2 of Care and limited implementation of the principles?"
3 (*As read*)

4 **A.** Again, that would be difficult to say. But I think that
5 we have worked really hard at raising the profile,
6 again, of Triangle of Care, and ensuring that people not
7 only understand it but embrace it.

8 **Q.** Well, that's what the Coroner said, wasn't it? Lack of
9 implementation, staff were not aware. You wouldn't
10 disagree with that, would you?

11 **A.** I wouldn't, but again, it's very difficult. I wasn't in
12 the Trust at that time.

13 **MS HEAVEN:** Okay, thank you.

14 **THE CHAIR:** Mr Beer.

15 **Questioned by MR BEER**

16 **MR BEER:** Thank you, Chair.

17 Four topics, if I may, please.

18 **A.** Yes.

19 **Q.** The first topic, the Trust policy on risk assessment.
20 It's been put to a small number of witnesses, including
21 you, that there was a Trust policy on risk assessment
22 written in 2012, effective from 2013, that it was not
23 updated until 2024, and that was a failure or was
24 astonishing, or other such words, yes?

25 **A.** Yes.

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1 Q. Can we look at the document on which those questions
2 have been based. NHFT0015073. And look at page 2. At
3 the bottom, under paragraph 3.2, do you see it says:
4 "August 2013: Implementation of Trustwide Policy,
5 15.09 - Treatment risk assessment and management of
6 treatment risk policy ..."
7 A. Yes.
8 Q. Do you see the word "training" does not appear in the
9 italicised part of that?
10 A. Yes.
11 Q. That the word "training" is not there, is it?
12 A. No, it isn't.
13 Q. So they, given the title of the policy without including
14 the word "training" but the policy is actually an
15 appendix to this document?
16 A. Yes.
17 Q. Can we look, what we haven't done so far, at the policy
18 itself. NHFT0015079. Thank you. Can you see at the
19 top at the policy number is 15.09?
20 A. I can.
21 Q. Yes?
22 A. Yes.
23 Q. If we just scroll down a little bit first, can you see
24 the implementation date -- sorry, the date of latest
25 ratification is October 2012, and reissued in

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1 "DUTIES:
2 "Managers have a responsibility to:"
3 Then amongst other things:
4 "Ensure all the staff attend all relevant training
5 "Enable staff to attend training on which they are
6 booked [...]"
7 Training, training, training, yes?
8 Then over the page:
9 "Individuals have the responsibility to ..."
10 You can see what it's about.
11 Then 3.3
12 "The Learning & Development Department has
13 the responsible to ..."
14 Then it's about training, yes?
15 Then if we go forward to paragraph 5, please, thank
16 you.
17 "Training:
18 "Training needs analysis has been undertaken."
19 And then:
20 "Training will incorporate" -- bullet points are to
21 do with suicide awareness training and then the next
22 bullet points, I think the fifth bullet point onwards:
23 "Risk Assessment Training which focuses on the
24 definitions of risk, the concept of risk; risk
25 assessment to risk management as a systematic process;

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1 August 2013, so the dates we saw in that earlier
2 document, yes?
3 A. Yes.
4 Q. Then if we pan out a little bit, please, and look at the
5 top of the page. Can you see the subject at the top is
6 "TREATMENT RISK ASSESSMENT AND MANAGEMENT OF TREATMENT
7 RISK TRAINING"?
8 A. Yes.
9 Q. That's the word that was missing from the earlier
10 descriptor?
11 A. It is.
12 Q. Can we see in the box:
13 "Training in the management of risk is a key
14 requirement for modern services. This Policy sets out
15 the staff that require training and at what level, in
16 a training needs analysis."
17 Does that, to your understanding, reflect the fact
18 that this is not a Trust-wide risk assessment policy at
19 all; it's about training staff about risk assessment?
20 A. I can see that, yes.
21 Q. Can we look at a couple of the passages in the document
22 itself, the policy to see what it's about, rather than
23 just using the titles, which is what I've done so far.
24 If we go to page 3, please. If we look at the bottom of
25 paragraph 3:

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1 "clinical and actuarial approaches to risk
2 assessment;
3 "categories of risk which must include violence,
4 harm to others harm to self, severe self neglect and
5 suicide/self harm; vulnerable adults."
6 Can you see that?
7 A. Yes.
8 Q. So we can see from the substance, not the title of the
9 document, that it's all about training?
10 A. It is.
11 Q. Then can we go to page 7, please. There's a long list
12 of -- if we just look at that page and then the next
13 page, and then the next page. Then go back to page 7,
14 please. A long list, down the left-hand side, of care
15 groups or directorates within the Trust and then on the
16 right-hand side a list of the risk assessment tools and
17 in some cases the risk assessment policies that are used
18 in each division.
19 A. Yes.
20 Q. Yes? So you can see that this document is not a risk
21 assessment policy, is it?
22 A. *(The witness shook head).*
23 Q. It's not a Trust-wide risk assessment policy, is it?
24 A. No.
25 Q. But this appendix lists where to find risk assessment

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1 tools or risk assessment policies in relation to each
 2 division or care group within the Trust; do you see
 3 that?
 4 **A.** It does, yes.
 5 **Q.** So perhaps, if we've established that this is a policy
 6 about training and not a policy about risk assessment
 7 itself, you gave evidence today, as did Dr Elcock
 8 yesterday, about why, to your knowledge, this policy on
 9 training was not refreshed or updated; do you remember?
 10 **A.** Yes.
 11 **Q.** Can you explain, please, because it was dealt with very
 12 quickly, both with you and Dr Elcock, exactly what your
 13 understanding was, or is?
 14 **A.** So my understanding at that time was that risk
 15 assessment was incorporated into either the Standard
 16 Operating Procedure in each care group or division, as
 17 it was, or into the integrated -- into the internal
 18 working instructions. And there was something about the
 19 speciality and the type of risk assessment that is
 20 required or used within each of those environments.
 21 **Q.** We can see here, if we go over the page, please,
 22 two-thirds of the way down, thank you. "Mental health
 23 services for older people", something called HoNOS, 65
 24 plus scores is used or was then used. If we go over the
 25 page then, please, forensic, a range of --

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1 Police; do you remember?
 2 **A.** Yes, I do.
 3 **Q.** And they ended with a question over whether that had
 4 been signed off and, if it had been, whether the Inquiry
 5 could obtain a copy of it.
 6 Can we look, please, at NHFT0019602; is this a copy
 7 of the data-sharing agreement?
 8 **A.** Yes, it is.
 9 **Q.** We can see that there's an approval date given of
 10 August 2025 in the middle. If we just scroll down,
 11 thank you.
 12 Then if we go over the page to page 2, some final
 13 amendments were made on 12 November 2025.
 14 So to your knowledge, this policy agreement between
 15 the Trust and Nottinghamshire Police is an operative
 16 policy, it's in place, it's working?
 17 **A.** Yes, alongside those other groups I spoke about earlier.
 18 **Q.** Sorry? I missed that last bit.
 19 **A.** Sorry, alongside those groups I spoke about earlier,
 20 yes.
 21 **Q.** Yes, thank you. That can come down. I'm not going to
 22 go to the, I think, 57 pages of the agreement, the
 23 Inquiry has a copy of it.
 24 Third topic, the Risk Escalation Framework. Can we
 25 look, please, at WITN0263041. Thank you. You've been

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1 **A.** Yeah.
 2 **Q.** -- tools and policies are described there, including
 3 HCR-20; do you see that?
 4 **A.** Yes, I do.
 5 **Q.** I don't suppose you're able to say whether, in the
 6 decade before you joined the Trust, in 2023, the risk
 7 assessment policies and tools that are listed on this
 8 appendix were each kept up to date?
 9 **A.** I'm sorry, I couldn't, no.
 10 **Q.** There remains the question, however, as to why this
 11 policy, which is about -- or seems to be about
 12 training -- was itself not updated over time. Can you
 13 help with that?
 14 **A.** I know that we updated the policy in 2024 -- 2025. It's
 15 really difficult, if I'm honest, because I wasn't --
 16 I wasn't in post, I'm sorry.
 17 **Q.** You weren't in post. Thank you. That can come down,
 18 thank you.
 19 The second topic, the Memorandum of Understanding
 20 with the police --
 21 **A.** Yes.
 22 **Q.** -- or the information-sharing agreement with the police.
 23 You were asked a series of questions this morning by
 24 Ms Langdale about the development of an
 25 information-sharing agreement with Nottinghamshire

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1 shown this this morning, as have some other witnesses,
 2 and a comment has been made to some witnesses that this
 3 looks complicated.
 4 **A.** Yes.
 5 **Q.** Would you agree to perhaps a person outside the
 6 organisation that it may appear complex?
 7 **A.** It may, yes.
 8 **Q.** What about for those within the organisation? Is it
 9 complicated, in your view, to a person who works within
 10 the Trust?
 11 **A.** No, I guess when you're part of something it doesn't
 12 feel complicated.
 13 **Q.** Can you expand on that answer? Why this document --
 14 I mean, it won't be the first time that a lawyer has
 15 suggested to an organisation that their process
 16 organograms are complicated, but why do you say that to
 17 those within the organisation, at all levels, that this
 18 would not be complicated?
 19 **A.** I can see how it would appear complicated. I can really
 20 see that. And I can see how it might be complicated for
 21 very junior staff. I guess for the more senior staff,
 22 who are working with it, it might not be so.
 23 **Q.** You, I think, said earlier that the process has led to
 24 speedier escalations, is that right, or speedy
 25 escalation?

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1 **A.** Yes.

2 **Q.** Can you expand upon that and explain how and why?

3 **A.** I think that the Escalation Framework -- well, because

4 of it's clarity around going to care unit, care group,

5 it means that you can go to the Trust Risk Group within

6 a four-week period. As I explained earlier, if it's

7 something urgent, obviously there's a different route

8 you can take. I think it allows you to be clearer, more

9 focused, and provides a framework.

10 **Q.** Thank you very much.

11 The fourth topic, lastly. This arises from

12 questions that you were asked about two sentences in

13 paragraph 78 of the Trust's opening statement. First,

14 had the Trust already written to the families through

15 the CEO, Mr Majid, and apologised for first not making

16 contact with them sooner; and secondly, for being too

17 deferential to the police in following their directions

18 about not making contact?

19 **A.** Yes.

20 **Q.** Secondly, did the opening statement itself contain an

21 apology for missed opportunities in relation to the

22 treatment and care given to VC?

23 **A.** Yes.

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

25 **THE CHAIR:** Just before you go, Mr Beer, are you suggesting

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1 **MR BEER:** Thank you.

2 **Questioned by THE CHAIR**

3 **THE CHAIR:** Just if I can pick up also on the risk

4 management table, because I was one of the people who

5 said that it was complicated. And I think you've said

6 it's junior staff and people on the outside, but let's

7 just have a look at it, can we?

8 That's page WITN0263041. Where, on this, do we see

9 the urgent risk escalation?

10 **A.** I think there's something about the speed of which it

11 could go through care unit and care group and doesn't

12 have to go through every part. But there is, outside of

13 this, the ability to escalate immediately. But maybe it

14 should be there.

15 **THE CHAIR:** That point doesn't include that, does it? It's

16 a sort of leapfrog procedure, if you like?

17 **A.** Yes.

18 **THE CHAIR:** Thank you.

19 Yes, I just wanted to ask about just a couple of

20 points that you raised. Just about all the work that

21 you've done, and I think you said now that it's not just

22 about learning but ensuring that it's embedded and

23 sustained. I think that's right, isn't it?

24 **A.** So that the learning is embedded and sustained.

25 **THE CHAIR:** So when the immediate effect of the spotlight

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1 that there is an alternative set of policies that we

2 haven't seen, risk assessment policies?

3 **MR BEER:** No, what I'm saying is that in each of the

4 divisions there are risk assessment policies.

5 **THE CHAIR:** Have those been provided?

6 **MR BEER:** I understand that we've answered all requests, and

7 given all information requested, yes.

8 **THE CHAIR:** Now, that you've raised it -- and I would hope

9 that we don't have to go through a Rule 9 policy -- I'm

10 going to ask for those, if they haven't been provided.

11 **MR BEER:** Yes. I suspect that's best targeted at --

12 **THE CHAIR:** Well, those who are instructing you can hear me.

13 **MR BEER:** Yes, but I suspect that's best targeted at the

14 divisions with which we're concerned, rather than

15 paediatric or geriatric, for example.

16 **THE CHAIR:** Yes, exactly, exactly. For example, just going

17 back to it, on that, we've got adult mental health,

18 I think older mental patients, I think it looks like

19 over-65s on it.

20 I think you would agree with that?

21 **A.** Yes.

22 **THE CHAIR:** And also EIP, if there's any policy for that.

23 Any relevant policies to this Inquiry? I'm not asking

24 for paediatrics, or anything which is has not been

25 covered. Thank you.

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1 being turned on the Trust by this Inquiry has perhaps

2 dimmed, are you satisfied that these processes will

3 continue? Because in the past, they haven't, have they?

4 **A.** I think -- my view is that we have to make them

5 continue, and that the tools that we put in place, the

6 systems and the structures like SafeNow and our

7 dashboards, and our absolute focus on quality and

8 safety, and the people that we've got in post will

9 ensure that happens. You're quite right. It mustn't

10 stop. It can't.

11 **THE CHAIR:** I think, without being offensive, you told us

12 you'd been in mental health nursing for 40 years,

13 I think you said; is that correct?

14 **A.** Yes.

15 **THE CHAIR:** So you would remember the effects of the Clunis

16 Report and the introduction of the measures that were

17 introduced following that, including Assertive Outreach

18 and Community Treatment Orders, and I think you've

19 probably seen the whole dismantling, if you like, or the

20 changes that have been effected over the last 30 years.

21 Do you think that those were good changes, to leave

22 those recommendations behind?

23 **A.** I do remember Clunis, and I remember, as a staff nurse,

24 how that changed our thinking and changed our practice,

25 and the introduction of CPA and then the Assertive

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1 Outreach. I had the pleasure of working within that
 2 framework.
 3 I think we did lose something when we dismantled
 4 Assertive Outreach. I think that although not every
 5 change has brought about improvement, I think that the
 6 CPA was a good thing, actually, and I think that
 7 Assertive Outreach teams are really good things.
 8 I think there's a real need to focus on people who were
 9 suffering from a serious mental illness. And I think
 10 it's fantastic that we talk more about mental health,
 11 but we need to talk about serious mental illness as
 12 well.

13 **THE CHAIR:** As far as that's concerned, the new provisions
 14 of the 2025 Act, you've talked about the need to talk to
 15 families more, and involve families. Do you see any
 16 difficulty with having, for example, a nominated person
 17 who is not a member of the family --

18 **A.** Yes.

19 **THE CHAIR:** -- and the care being provided by the families?

20 **A.** Yes, I think it puts -- not in all cases, but in every
 21 case -- not in all cases but in some cases, it puts
 22 a huge pressure on people, and you may have people who
 23 don't feel able to challenge patients.

24 I think it is important that we talk to families.

25 I think it is important that we work with families, but

1 we have to get the balance of safety and risk and
 2 collaboration right.
 3 **THE CHAIR:** Thank you.
 4 Right. Well, we'll stop there and start again at
 5 1.45.

6 **(12.44 pm)**

(The short adjournment)

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