

Wednesday, 27 May 2026

1
2 (1.45 pm)
3 **THE CHAIR:** Yes, I understand you've come back. Mr Moloney
4 is going to ask you a question that I think he omitted
5 to do previously.

6 **Further questioned by MR MOLONEY**

7 **MR MOLONEY:** I'm really very grateful to the Chair.
8 Dr Shehmar, there was one question I omitted to ask,
9 it's only a short question.
10 The Duty of Candour and the maintenance of patient
11 responsibility are obviously fundamental to medical
12 ethics. Would you please tell the Chair how many
13 medical professionals came forward to admit their
14 illegitimate access of records before their behaviour
15 was discovered?

16 **A.** None of them did.

17 **MR MOLONEY:** Thank you very much, Dr Shehmar.

18 Thank you, Chair.

19 **THE CHAIR:** Yes.

20 **MS LANGDALE:** Dr Shehmar, I understand you want to say
21 something that you haven't yet said in your evidence.

22 **Statement by DR MANJEET SHEHMAR**

23 **THE WITNESS:** Yes, I would like to. So it was our intention
24 from the beginning of today, and we had asked for the
25 opportunity, to make a formal public apology and I would

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1 **MS LANGDALE:** Mr Johnston, you have prepared a statement for
2 the Inquiry dated 10 February 2026. Can you confirm the
3 contents are true and accurate as far as you're
4 concerned?

5 **A.** Yes, I can.

6 **Q.** If we can have, please, the first two pages on the
7 screen, WITN0399001, pages 1 and 2, these set out your
8 career responsibilities and various roles and I'm going
9 to invite those to remain on the screen while you
10 summarise those for us, please.

11 **A.** Yes. I started my career as a healthcare assistant or
12 a nursing auxiliary, then went on to do my training in
13 1988 as a Registered Mental Health Nurse, and then
14 worked my way through my clinical and managerial roles
15 until the last sort of 20-odd years where I'd reached
16 sort of Hospital Director and Clinical Director roles.

17 So I'd been involved in clinical practice,
18 operational leadership and clinical leadership, and also
19 been privileged to be involved with a number of national
20 organisations to support the development of mental
21 health services, so including the National Institute for
22 Mental Health England, when it was around, CSIP when it
23 was around, and for 24/5 years, I've been an Executive
24 Director on the board of NAPICU, the National
25 Association of Psychiatric Intensive Care Units.

3

1 like to take the opportunity now, if that is okay,
2 Chair, to do that.

3 **THE CHAIR:** Yes.

4 **THE WITNESS:** So on behalf of the Trust I'm here to formally
5 publicly issue you all an apology. So for the families
6 of Grace and Barnaby and Ian, and for the surviving
7 victims, Sharon, Wayne, and Marcin, I cannot change what
8 has happened, but what I can do is formally apologise to
9 you because we have caused additional distress to you.

10 You have already had to endure unimaginable pain and
11 suffering and I know that the actions of some of our
12 staff have added to that distress and continue to add to
13 that distress.

14 I want to reaffirm our commitment to work with you
15 for the duration of these investigations and engage with
16 you. And I would also like to give the commitment that
17 we will continue to learn, we will continue to improve.
18 I acknowledge that there have been failures, and we will
19 work towards putting those right.

20 **THE CHAIR:** Thank you.

21 That does complete your evidence now. Thank you.

22 **MS LANGDALE:** May I call Mr Johnston, please, Chair.

23 **THE CHAIR:** Yes.

24 **ANDREW SCOTT JOHNSTON (affirmed)**

25 **Questioned by MS LANGDALE**

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1 So I left the NHS in 2014 after my second clinical
2 directorship and since then have worked back with
3 various organisations, provider organisations,
4 regulatory organisations, working around service
5 development, diagnostics and supporting organisations
6 with investigations and service improvement, governance,
7 et cetera.

8 **Q.** What do you think the qualities are required of clinical
9 leaders, particularly those who need to effect change in
10 an organisation as large as the NHS?

11 **A.** I don't think the qualities have changed, in my 40-year
12 plus. I think honesty, integrity, I think we often say,
13 you know, getting it, understanding what individuals are
14 going through, both in terms of the staffing groups, and
15 in terms of the patient population and the families.
16 So, you know, having a good grasp of that and
17 understanding it is really important.

18 And I think being approachable, not trying to solve
19 every problem on your own, because you can't. So, you
20 know, listening to counsel, taking good supervision,
21 taking advice. I remember a mentor of mine some years
22 ago said to me very early in my career: "Network with a
23 vengeance" and I've managed to do that because none of
24 us is as smart as all of us. So, you know, being able
25 to rely on people's support, their experiences,

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1 et cetera, has been really important to me in my career.

2 **Q.** The Inquiry has received evidence that in 2021 serious
3 concerns and failings were being identified by the
4 Senior Coroner in respect of the Trust. Where there are
5 longstanding performance challenges, how does a Clinical
6 Director or Medical Director approach those kinds of
7 issues, if change is to be effected?

8 **A.** Well, I guess I'd just like to say that that question is
9 not part of why I was here in terms of, you know, the
10 reviewing the benchmarking cases.

11 **Q.** No.

12 **A.** But what you're asking me is based on my experience.

13 **Q.** Yes.

14 **A.** And I think it's important to understand the climate
15 that we're operating in, it's important to understand
16 the levels of fragmentation and really understand
17 a patient pathway through not just one provider
18 organisation but through a system.

19 I guess what I've seen in the last 15, maybe
20 slightly longer years, is more a fragmentation in
21 services and the way that things are run. So I think,
22 you know, having a good concept of the community in
23 which you serve and what the needs are, what other
24 organisations in your community can do to support that,
25 and making use of those relationships and developing

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1 Peer Support Workers. The more we listen and work
2 collaboratively, the better services, you know, can be.
3 So I think that's been a significant change.

4 But I also think the system has offered some
5 challenges in terms of the way that it's been developed
6 and what seems like a lack of funding or
7 an under-resourcing has had a major impact, yeah.

8 **Q.** Were you ever involved in your career with assertive
9 models of care?

10 **A.** Yes.

11 **Q.** How did they work, as far as you were concerned?

12 **A.** So both the Assertive Outreach Framework and the EIP
13 Framework I first became aware of in the late nineties,
14 early 2000s. I didn't really have a lot to do with them
15 because of the role I was in at the time, but from 2009,
16 I think, to 2014 as a Clinical Director for a large
17 adult Directorate which covered six counties, we had EIP
18 teams and Assertive Outreach teams.

19 That time was a period of austerity, you may
20 remember, and so we were looking at genuine efficiencies
21 in the system, so we had lots of different community
22 services doing lots of things, and so over a period of
23 sort of 18 months, looking at the patient population,
24 both in inpatients and community, we looked at some of
25 the national and international evidence around Assertive

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1 those relationships, whether they be with a local
2 authority, with the police, with third sector
3 organisations.

4 **Q.** So inter-agency working?

5 **A.** Very important, yeah.

6 **Q.** Why is that particularly important in mental health
7 treatment?

8 **A.** Well, because all the evidence is very clear, you know,
9 mental illness phenomenon is one part of, you know,
10 a treatment process, if you like. There are often
11 multiple, multifaceted parts. So you know, housing,
12 education, development opportunities, finances, social
13 exclusion, all these things are really important, and
14 not one provider, or one service or one team can support
15 any individual through all of those things.

16 **Q.** And in your time, in terms of treatment on the ward,
17 approaches to mental health, how has that changed for
18 mental health nurses?

19 **A.** I think significantly, over the last two decades. I was
20 reflecting with some experts by lived experience
21 recently how much the system has improved. You know,
22 care and quality in lots of areas has improved because
23 of their input, because we're much more open now to
24 co-design and not just co-production. So working in
25 genuine partnership I think, you know, the advent of the

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1 Outreach, particularly around Holland, the fact, the
2 flexible Outreach community services, and used some of
3 that evidence to really review how we were doing things.

4 So, you know, understanding the basis of Assertive
5 Outreach and the basis of EIP. And how you could
6 capture and support people who often fell through the
7 gaps, if you like, in traditional service provision was
8 really helpful here.

9 **Q.** Can we have a look then, please, page 4 and 5 could be
10 on the screen from your statement, about the CQC Review
11 and what you were asked to do. You say at paragraph 15,
12 Chris Dziki contacted you, that's on page 4.

13 **A.** My screen's gone blank.

14 **Q.** Don't worry, it will come back in a moment. So has
15 mine. WITN0399001, 4 and 5, please. *(Pause)*

16 We see page 4 and 5, please, your initial contact
17 with Mr Dziki. So what were you asked to do?

18 **A.** Initially, my contact with Chris Dziki was -- we were
19 participating in a NAPICU executive meeting in
20 Northampton. He approached me informally and said
21 they'd been instructed to undertake a Section 48
22 Review -- the CQC this was -- and he wondered whether
23 I would be interested in supporting that process. So
24 that was the first part of it.

25 Chris and I had worked together for many, many

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1 years, so in his time in clinical practice, in his time
2 in NHS England, and obviously we kept in touch through
3 our NAPICU executive roles and his role in the CQC.

4 I then had a conversation and an email from Jenny
5 Wilkes outlining some of the requirements, and I think
6 initially -- do you want me to go on? Because I know
7 there's emails you might want to --

8 **Q.** Yes, there are emails. We don't necessarily have to go
9 to them. You can go to this one though, please,
10 CQCM0006060. And it's the Section 48 commission for
11 that special review. The scope of the CQC Section 48
12 Review we see on page 1.

13 **A.** Yes.

14 **Q.** That's the scope. I'll give you time to look at that.
15 Page 2, please. We see at the bullet point in the
16 middle, the further work within scope:

17 "To identify a minimum of ten other patients
18 referred into the Trust's Early Intervention in
19 Psychosis Team. To carry out full reviews of these
20 patients, including pathway tracking. Ideally, this
21 should include both patients who engaged and those who
22 did not engage".

23 It became known as the benchmarking cases, didn't
24 it --

25 **A.** Yes.

9

1 Inquiry; we're interested in the issues that have been
2 identified and we'll refer to them thematically.

3 **A.** Mm-hm.

4 **Q.** As far as the scope was concerned, what value did you
5 think it could add, looking at cases on paper? You
6 weren't presumably speaking to either patients or
7 families, for example, were you, and benchmarking them?

8 **A.** No, but it is a rare privilege to follow an individual's
9 care from their first presentation right through to the
10 point that the time ended or they were discharged. So
11 that is, you know, quite a privilege. It's something
12 I've recommended and done for many years, and
13 I recommend that services do that.

14 So it was literally looking at, from presentation
15 one, all the way through every document that was sent
16 via the Nottingham Trust to the CQC. So looking
17 holistically at all the contacts, the interventions, the
18 assessments, the rating scales that were used, risk
19 assessments, et cetera. So it --

20 **Q.** That was ten, wasn't it, from 2,528 patients who had
21 been patients of the EIP services between April 2020 and
22 February 2024; is that right?

23 **A.** That's right, yes.

24 **Q.** So who selected them? It was a random selection; was
25 that the case?

11

1 **Q.** -- this group?

2 **A.** Yes.

3 **Q.** And you were being asked, along with your colleague who
4 we'll be hearing from next, to conduct the benchmarking
5 review of other cases?

6 **A.** That's correct.

7 **Q.** If we go to page 3 of this document we see the
8 completion of the CQC Section 48 remit, who were going
9 to be involved, and Chris Dziki obviously contacted
10 you and others to implement this.

11 **A.** Mm.

12 **Q.** Were you involved -- that can come down, thank you --
13 were you involved in the consideration of how many other
14 patients should be benchmarked, as it were?

15 **A.** No.

16 **Q.** So that was a decision taken. Was it ten, or did it end
17 up being 11 cases that were reviewed?

18 **A.** As I understand it it was 11 cases. There was
19 an additional case that came up just as we were
20 completing the ten, there was an additional case that
21 came up, and I was unable to complete it and my
22 colleague Des completed that.

23 **Q.** We're not going to ask you at all, Mr Johnston, the
24 details of any of the benchmarking cases, the CPs have
25 seen those in the context of the preparation for the

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1 **A.** I've no idea.

2 **Q.** You don't know?

3 **A.** No, we were presented with ten.

4 **Q.** Six were closed, patients had been discharged and four
5 were still open to the Trust?

6 **A.** That sounds right, yes.

7 **Q.** You didn't, did you, you or your colleague, consider
8 VC's case then or subsequently, as I understand it --

9 **A.** No, we had no involvement at all.

10 **Q.** -- you didn't have access to his records, so this was
11 literally looking at the cases --

12 **A.** Yes.

13 **Q.** -- as they stood before you?

14 **A.** Yes, as I understand it, we were asked to look at the
15 benchmarking as a way of identifying whether there were
16 systemic challenges that the organisation was facing.

17 **Q.** We don't need to go to the emails. In effect, you and
18 Mr McMorro fed back to Evan Humphries your conclusions
19 on the benchmark cases and that was put into the CQC
20 Report.

21 **A.** Yes, we had no -- or certainly I had no part in
22 thematically reviewing or reviewing trends, et cetera.
23 Just fed back what we'd found.

24 **Q.** On the individual cases?

25 **A.** On individual cases, yes.

12

1 Q. So you weren't even identifying trends, you were just
2 isolating --
3 A. Absolutely.
4 Q. -- your analysis for each case?
5 A. Yeah, yeah.
6 Q. When you first got an email, you were concerned about
7 the timescale suggested?
8 A. Yes.
9 Q. That sorted itself out, did it?
10 A. It did, because initially my understanding was that
11 basically there was an expectation that I would do VC
12 and the ten benchmarking cases and some other activity
13 as well, which I very kindly declined and said that I
14 thought the timescales probably needed extending. And
15 then it was explained to me, as you showed in that
16 document, that there would be three other reviewers, and
17 that I'd be undertaking half of the benchmarking. So
18 that was okay.
19 Q. I think when the report was sent by you and for review,
20 the complete report that he'd been able to put together,
21 you said you didn't have time to read that at the time
22 it was sent to you; is that right?
23 A. Yes, yeah.
24 Q. Would you have known in any event what all of the cases
25 said or had you not discussed that with your colleague

13

1 this was the one that was in place at the time, did you
2 read this policy at the time?
3 A. Yes, I did.
4 Q. Can I take you to sections and perhaps ask for your
5 overview, it's a good policy isn't it, in overview;
6 would you agree?
7 A. I think it's an honest policy. Often policies offer
8 more aspiration than reality. And I think that the
9 policy was an honest policy. It slightly deviates from
10 the national policy, the NICE guidance, if you like,
11 because it talks about, you know, rationalising CBTp, it
12 talks about possibly having family therapy or family
13 interventions prior to CBTp, when the NICE guidance
14 suggests you can do both together, et cetera.
15 So I thought it was an honest policy, and it was
16 a standard policy I'd seen in several organisations.
17 I don't think -- nothing stood out to me.
18 Q. So if we can go, please, to page 9, firstly. Dealing
19 with "Effective Care Coordination". The policy
20 provides, doesn't it, for multi-agency comprehensive
21 assessment?
22 A. Mm-hm.
23 Q. It may seem obvious but suggesting that the service
24 would deploy that.
25 A. Mm-hm.

15

1 Mr McMorrow?
2 A. Yeah, all of the benchmarking cases?
3 Q. Yes.
4 A. Yes, we did. We had regular sort of feedback sessions
5 for themes that we'd identified, et cetera, just for the
6 ten benchmarking cases.
7 Q. You do refer at paragraph 20 of your statement:
8 "During the period between 9 and 23 February ...
9 I recall participating in a number of Microsoft Team
10 calls with CQC colleagues and with the other clinical
11 reviewers."
12 Did that include Dr Dracass and Dr Ahmed, or you and
13 Mr McMorrow alone on the ones you were doing?
14 A. All of the occasions bar one, all of the occasions bar
15 one, it was Des McMorrow, myself, and Evan.
16 Q. And?
17 A. And Evan, sorry.
18 Q. Evan.
19 A. There was one occasion where the two colleague
20 psychiatrists were present giving their feedback to him
21 and we were on the call.
22 Q. You were also sent the EIP policy. If we can have that
23 on the screen, please, CQCM0009938.
24 The Inquiry will be hearing from the document author
25 next week of this policy, but assuming for the moment

14

1 Q. Otherwise why have it in the policy?
2 A. Yes.
3 Q. Does that reflect accurately what should be there? Do
4 you think there should be something more there or less
5 there?
6 A. In terms of -- well, active care coordination?
7 Q. Yes, to ensure effective care coordination. If we go to
8 page 10 you should see what's written on page 10 as
9 well, of course.
10 A. Sorry, what was the question?
11 Q. Do you think that adequately covers what should be done
12 in terms of effective care coordination to achieve that?
13 Is there anything missing from that, in your view?
14 A. Not that I'm seeing, no.
15 Q. If we go to page 12 we see "Assessment", minimum
16 standards for assessment components. And we see at
17 fifth bullet point:
18 "Risk will be assessed using locally agreed tools
19 and recorded on the clinical record system within
20 48 hours of the initial assessment. Other standardised
21 assessment tools may be used ..."
22 And they're listed there.
23 In the benchmark cases, did you see the use of
24 standardised tools?
25 A. Yes.

16

1 Q. We also see here for assessment:
 2 "Additional information provided by the service
 3 user, family, significant others ..."
 4 Did you see that kind of source of information in
 5 the other benchmarking cases?
 6 A. Yes.
 7 Q. We see, please, page 13, "Assessment of At-Risk Mental
 8 States":
 9 "... Comprehensive assessment of At-Risk Mental
 10 States ..."
 11 Can you tell us, please, what is the role of a nurse
 12 completing such an assessment? How is that done?
 13 A. So they'll be looking at a process that will identify
 14 risks that the Early Intervention in Psychosis team need
 15 to be aware of. So it's a comprehensive process, so
 16 they'll be looking at all element of symptoms,
 17 medication concordance and management et cetera. You
 18 know, families' interactions, safety, safeguarding. It
 19 will look at all those sorts of elements. So it's quite
 20 a comprehensive -- would be fairly time consuming.
 21 Q. How long does it take?
 22 A. Well, again it would depend on the individual.
 23 Sometimes it can take much longer because of a lack of
 24 engagement. So somebody recently referred "may not
 25 engage immediately, takes time to build a rapport", the

17

1 a crisis plan and knowing, you know, what might go wrong
 2 or what might be problematic and planning for that is
 3 really important, not just for the service user but for
 4 family members and for the services involved. So
 5 there's a good understanding of what -- how to approach
 6 somebody.
 7 Q. And again, anything missing, from your perspective, on
 8 those six bullet points, in respect of formulation of
 9 a comprehensive care plan?
 10 A. I guess if that was being written today, I would expect
 11 to see something that involved the patient and the
 12 families in developing that plan and the contingencies,
 13 et cetera.
 14 Q. We do see "Working with Families", if we go to page 17,
 15 point 15:
 16 "The team will strive to engage and support all
 17 those who are important to the service user. Contact
 18 will be made with the family [...] in collaboration with
 19 the service user."
 20 The family intervention being referred to there.
 21 A. Yeah.
 22 Q. In circumstances where a patient prohibits or doesn't
 23 wish for information to be shared with the family, what,
 24 in your view, can still and should still be provided
 25 around care planning and risk management in the

19

1 relation -- you asked about the nurse's role would be,
 2 the nurse's role would be working to develop
 3 a relationship, so to form trust, to be consistent, to
 4 be reliable, to be viewed by somebody who they're trying
 5 to support as somebody they could put their trust in, if
 6 you like.

7 So sometimes that works quicker than other times so
 8 an assessment may be done in the first or second
 9 interaction or assessment. Sometimes it could take
 10 longer.

11 Q. Can we have, please, page 15 and 16 and this is the part
 12 of the policy that refers to "Formulation of
 13 Comprehensive Care Plan and CPA Review". We see a list
 14 at the bottom of 15. At the top of 16, please,
 15 alongside it, including:

16 "Give an estimated timescale by which outcomes or
 17 goals will be achieved ...

18 "Detail the contribution of all agencies ... [and]

19 "Include appropriate crisis and contingency plans."

20 Is that what you would expect to see in a care plan?

21 A. Yes.

22 Q. Why is it important to detail the contribution of other
 23 agencies and have appropriate crisis and contingency
 24 plans?

25 A. Well, everything is okay until it's not. And so having

18

1 community?

2 A. Yeah, I think it's a really poignant question.

3 Sometimes clinicians develop a view that when a patient
 4 says, "You need to respect my confidentiality, I don't
 5 want information sharing with my family members",
 6 et cetera, that doesn't mean that services can't talk to
 7 family members and support family members and maybe take
 8 collateral information from family members, which can
 9 really help formulate a picture of the individual and
 10 how to support them.

11 So involving key family members and carers is a key
 12 priority in any assessment process, in any service.

13 Q. Page 18, please. Psychosocial interventions:

14 "Family interventions will be offered to all
 15 families/close friends, presenting with a first episode
 16 of psychosis. These will range from brief interventions
 17 focusing upon normalising rationales, psychoeducation
 18 and friends & family support group."

19 Did you find evidence of that in your benchmarking?

20 A. We did find evidence of that, yes. Psychoeducation, in
 21 some of the cases really, really strong support of the
 22 family, liaison of the family, et cetera, especially in
 23 some of the very complex cases where the service users
 24 were disengaging or maybe going absent from services,
 25 et cetera.

20

1 **Q.** What does that mean "from brief interventions focusing
2 upon normalising rationales"? What does that mean,
3 "normalising rationales" --

4 **A.** It's just trying -- trying to help individuals
5 understand and contextualise what they're experiencing
6 and trying help them work through that and communicate
7 through that.

8 **Q.** One of the key features, as we've seen in this case and
9 you will no doubt have seen in others, is a person not
10 believing that they are mentally ill --

11 **A.** Yes.

12 **Q.** -- and convincing themselves and trying to convince
13 other people about their beliefs. How does this
14 psychosocial intervention assist with that and how to
15 manage that because it's a massive issue, isn't it, for
16 people dealing with mental health?

17 **A.** Yes, it is. I think, in terms of plain speaking, when
18 somebody believes something, it's not really helpful
19 just to say to them "that's not right, that's not true".
20 That's really not helpful. So trying to communicate
21 with them in a way that maybe is trying to -- sorry --

22 **Q.** Sorry, I don't know if there's a problem?

23 **THE CHAIR:** I can just hear somebody has got a radio on or
24 there's some interference coming from, I think, just
25 outside the hall. But I can hear it quite strongly.

21

1 Remaining in education with a diagnosis such as
2 paranoid schizophrenia and completing a degree, as the
3 case the Chair is examining, that's extremely rare and
4 unusual, presumably?

5 **A.** Well, I have to say in the benchmarking cases, for
6 example, we saw some excellent examples of -- and
7 I forget what the service is called in Nottingham now --
8 but some excellent examples of partnership working with
9 organisations, with employers, with universities,
10 supporting people staying in jobs, supporting people
11 returning to work, supporting people --

12 **Q.** Universities supporting them staying in jobs or staying
13 in education?

14 **A.** Staying in education, but also in jobs, staying in jobs,
15 or helping them attain new jobs. So we did see,
16 certainly in the five cases I reviewed, there were some
17 really excellent examples of that working.

18 **Q.** If we can go, please, to page 21: "Discharge before
19 Three Years", we see there:

20 "Working with a service user through an assertive
21 approach to care, multidisciplinary team discussions,
22 supervision and risk management".

23 Assertive approach, the Inquiry has heard evidence
24 about the Fidelity Model, Assertive Outreach, and that's
25 not the same as an approach.

23

1 There we go. I wonder if somebody can just go and --

2 **MS LANGDALE:** Maybe just pop out and see.

3 **THE CHAIR:** We'll just continue anyway. Thank you.

4 **A.** So, yes, approaching somebody that is experiencing some
5 delusional thinking or some ideas and just saying,
6 "that's wrong, that's not right", is not helpful. And
7 so trying to use psychoeducation and brief interventions
8 to help themselves and also family members approach them
9 and help them understand what they may be experiencing
10 in --

11 **Q.** And also what they might say.

12 **A.** Absolutely.

13 **Q.** I mean, if you don't say that, what are you supposed to
14 say is the question most people raise.

15 **A.** Yes, but often we are dealing with individuals who are
16 deeply distressed, they're traumatised, and quite
17 unwell. So, you know, being able to support them
18 through that and be present is important.

19 **Q.** Page 19, please: "Educational and Vocational Support".
20 The policy anticipates at 19, page 19, second bullet
21 point:

22 "Ongoing inter-agency working with local schools,
23 colleges, service can support service users to remain in
24 education, employment and training and can help to
25 reduce stigma and discrimination."

22

1 **A.** Mm.

2 **Q.** What do you say about that? How would you read that
3 policy and what was being meant by -- what was meant by
4 "assertive approach"?

5 **A.** I think the EIP and assertive approach differ in
6 a number of ways. The EIP approach, whilst being
7 assertive, is much more in collaboration. It's much
8 more in partnership with the individual, it's much more,
9 you know, working together to see, you know, what's
10 going to work; whereas the assertive approach is
11 slightly different. I'm not sure if that answers your
12 question.

13 **Q.** Can we have page 24 on the screen, please. And this is
14 an appendix to the policy. The "Service Response to
15 Disengagement". The Inquiry has seen policies on
16 discharge and the like that were relevant at the time,
17 and we see here "Service Response to Disengagement."

18 Again, when you read that, tell us what it says on
19 the left and what it says on the right, and what you say
20 about this policy or aspect of it.

21 **A.** Well, I can comment on the five cases which I reviewed,
22 and the individual clinician, care coordinator, EIP
23 leads, et cetera, in most of the cases was exceptional,
24 really good use of technology, telephones, emails, text
25 messages, WhatsApp messages, calling at the doors,

24

1 calling at family members, using other agencies,
 2 et cetera. Some individuals disengaged and moved to
 3 different counties et cetera, and the communications and
 4 the liaison that I reviewed in certainly the five cases
 5 I looked at was excellent.

6 **Q.** I think one of the cases you looked at, you were
 7 sufficiently concerned that a CPN, their work needed to
 8 be documented and reviewed for competence; is that
 9 right?

10 **A.** I was, yes.

11 **Q.** Can we have a look please -- that can come down -- at
 12 the templates that were available. I know you don't
 13 follow the templates but just so we understand what you
 14 were being asked to look at in respect of case.

15 **A.** Yes.

16 **Q.** If we go to CQCM0010466, page 28. If we could have
 17 page 28 and 29 on the screen, please. We see "Risk
 18 Assessment Review", page 28 and 29, including at looking
 19 whether there's a:
 20 "documented risk assessment and management plan ...
 21 co-produced and shared, where necessary with relevant
 22 agencies ..."
 23 In your view, is there a need to introduce
 24 a national standard for risk assessment and risk
 25 management training for mental health nurses?

25

1 need to educate the system a bit more on what I've just
 2 said because sometimes the system is expecting to see
 3 a low, or medium or high risk, and that's not the way
 4 things are done now.

5 **Q.** And indeed in a small sample of cases, arguably, that
 6 you saw, you were sufficiently concerned that the risk
 7 summary assessments were not detailed and reviewed
 8 regularly enough, in one of those cases,
 9 -- (*overspeaking*) --

10 **A.** In one of those cases, yeah.

11 **Q.** -- such as to suggest there should be documentation and
 12 competency assessment.

13 **A.** I think that's maybe a jump because sometimes a form
 14 that is developed to contain a risk summary or risk
 15 assessment isn't necessarily conducive to documenting
 16 that the way that things are done now. Because we do it
 17 continually, it's not a one-off, so I think --

18 **Q.** How do you avoid the cut and paste? It's not even being
 19 done continuously, then, is it; it's just a cut and
 20 paste with no updates, so it actually becomes stale and
 21 -- (*overspeaking*) --

22 **A.** Yeah, I think that's an excellent question and I think
 23 that is really what we need to look at in the cultures
 24 in organisations, in the education and supervision that
 25 we give to our clinicians; it's not just nurses. But

27

1 **A.** Sorry, can you just repeat the question?

2 **Q.** Should there be a national standard for training and
 3 empowering nurses to do risk assessment?

4 **A.** Um, should there be? I don't think -- so my question
 5 would be: why would you make a national standard just
 6 for nurses? Because nurses aren't just responsible for
 7 risk assessments.

8 **Q.** Do they do a large amount of it though, in the sense
 9 that every interaction with the patient, certainly in
 10 an inpatient setting, is some form of assessment?

11 **A.** Yeah, I think what we've seen over -- quite rightly,
 12 what we've seen over the last five years or more is
 13 a move away from old-fashioned, global stratification,
 14 you know, low, medium, high risk, we've seen a move away
 15 from that and a move to more, you know, patient
 16 experience, their stories, you know, understanding the
 17 world that they live in, the stresses, the triggers, and
 18 developing a picture of risk, continually, rather than
 19 a one-off, you know, risk assessment.

20 So I would hope that every discipline and every
 21 member of staff is continually assessing risk throughout
 22 somebody staying in an inpatient facility and somebody
 23 stay in the community. It's a constant.

24 So I'm not sure whether one type of training or
 25 standard would necessarily help that. I do think we

26

1 I think that that I've seen that pattern in a number of
 2 organisations and I think it's down to leadership,
 3 culture, supervision.

4 **Q.** If we can go, please, to page 30 of this document. It
 5 sets out the template following up if a patient didn't
 6 attend appointments and failed to engage with the
 7 service. The same CQC document number. It's page 30,
 8 please and then page 31, "Care Plan Review".
 9 Particularly number 2, looking at the fact whether it's
 10 "personalised ... holistic and recovery oriented?"
 11 Page 32, please. "Care and Treatment [and] --
 12 Medication". So you'd expect -- you're looking here
 13 for:
 14 "When medication is prescribed, specific treatment
 15 goals ... set with the patient ... risks (including
 16 interactions) ... benefits are reviewed, a timescale for
 17 response is set and service user consent is recorded?"
 18 That's the kind of matter you'd be looking for
 19 around medication?

20 **A.** Yes, absolutely.

21 **Q.** "Discharge planning and transfer of care", please,
 22 page 33. Who would you expect to contribute to
 23 discharge planning, if there was a community discharge?

24 **A.** Community discharge? Well, obviously the full MDT of
 25 the Community Team and any other stakeholders that may

28

1 be involved in a person's care once being discharged.
 2 Any third-sector organisations that may be supporting,
 3 help or support family members et cetera as well.
 4 **Q.** Page 34, please, "Interfaces with other services/[and]
 5 agencies". You were looking at that in your benchmark
 6 cases, as you said, where agencies were involved with
 7 the person.
 8 And then we see "Care Records Summary", 34 and 35,
 9 which in fact is the template effectively you did use --
 10 **A.** Yeah.
 11 **Q.** -- identifying good practice or poor practice but not
 12 using the other templates. But they were no doubt clear
 13 reminders of what you'd expect to see and hope to see
 14 and examples of good practice; is that fair?
 15 **A.** Yes.
 16 **Q.** Can we go to the report then, please, and see how
 17 they've been characterised, the benchmark cases, and if
 18 you agree with that. So it's CQCM0016518, page 2. We
 19 see how they're characterised for the purposes of the
 20 review:
 21 "A rapid review of the available relevant evidence
 22 related to the care of [VC], including available
 23 evidence made public during the criminal trial,
 24 alongside a small number of other cases (to enable
 25 benchmarking), to determine whether this evidence

29

1 **A.** Yeah.
 2 **Q.** Considering it's a random sample, as you say.
 3 **A.** Yeah.
 4 **Q.** Can we go, please, to page 5. It is characterised in
 5 clear terms:
 6 "Inconsistent approaches to risk assessment was an
 7 issue in both VC's case and the 10 benchmarking cases.
 8 ..."
 9 Can you elaborate on that? Again, I don't want you
 10 to think about a specific case, but what was
 11 inconsistent from your perspective from the number that
 12 you were looking at?
 13 **A.** Well, just first of all just to outline, I had no input
 14 into the CQC report at all --
 15 **Q.** Right.
 16 **A.** -- so we just provided the feedback on our five -- ten
 17 benchmarking cases.
 18 **Q.** When did you first read it, then?
 19 **A.** It would be April, May time. I can't quite remember.
 20 **Q.** Did you disagree with any of it, when, as far as you're
 21 aware -- you obviously only looked at part of the
 22 material?
 23 **A.** It's not about disagreeing; it's about recognising that
 24 my -- and this is often the case -- my part was a part
 25 in a larger jigsaw, and so, you know, I have to accept

31

1 indicates wider patient safety concerns or systemic
 2 issues with the provision of mental health services in
 3 Nottinghamshire. This rapid review is intended to be
 4 complementary to the Independent Mental Health Homicide
 5 Review ..."
 6 Just dealing firstly with the impact of the
 7 benchmarking cases, clearly thematically of
 8 significance, but the numbers are small, aren't they.
 9 **A.** Tiny.
 10 **Q.** And whilst looking at notes is important, it's going to
 11 be part of the picture --
 12 **A.** Yeah.
 13 **Q.** -- and it depends what you don't know may be there, how
 14 full a picture; is that right?
 15 **A.** Absolutely, yes. It's a desktop review, basically.
 16 **Q.** If we go to page 4, please. It's characterised at the
 17 bottom:
 18 "While we did not find any widespread patterns with
 19 10 other cases ... as a benchmark, many of the issues we
 20 have identified are consistent with the problems we
 21 found in our wider review of the quality of care ..."
 22 And again, use of the word "widespread" may simply
 23 reflect we've got 10 or 11 cases, that's why it's not
 24 widespread, but it's striking that the themes arise even
 25 in that small number.

30

1 that somebody else is orchestrating and understands the
 2 bigger picture and is putting it all together and is
 3 tasked with providing a report to publish.
 4 So for me, as a clinician, and I've been involved in
 5 a number of cases, it's not about agreeing or
 6 disagreeing or recognising the work that I contributed
 7 or not, it's just about recognising that I play a part
 8 and I don't have any say in the final view.
 9 What I can say, in the five cases I reviewed, four
 10 of them were, in terms of risk, were really well
 11 managed. One of them exceptionally, I did highlight
 12 a particular CPN for the EIP team, which I named in my
 13 feedback, who was exceptional in the risk approach for
 14 a particular complex client.
 15 **Q.** In a positive way?
 16 **A.** In a positive way. Very, very positive. So out of the
 17 five cases I reviewed, four of them were very good, one
 18 of them was exceptional, and I referenced that. And one
 19 of them was not so good.
 20 **Q.** Well, sufficient for you to be concerned about --
 21 **A.** Yes.
 22 **Q.** -- repeat training?
 23 **A.** Yes.
 24 **Q.** In terms of inconsistent approaches to risk assessment,
 25 nevertheless did you see that across the five or was it

32

1 not something at the time?

2 **A.** It wasn't -- I saw it in ... yeah, let me just be very
3 clear about this. In one case, I saw that
4 consistently -- in one case -- which is the case you
5 referenced that I raised a concern about.

6 In the other four cases that were good, yes, there
7 were some anomalies, but when somebody has been in the
8 service for the three years, for example, it's not
9 unusual to see, you know, one thing missed, if you like,
10 over a three-year period.

11 So I didn't see systematic inconsistencies in the
12 ones that I reviewed, other than the one that I raised.

13 **Q.** If we go, please, to page 6, second bullet point:
14 "Care plans for VC and the 10 benchmarking cases ...
15 followed national guidance. However, teams did not
16 always take a holistic approach [... hampering] ...
17 ability to identify risk factors and create
18 person-centred care plans."

19 Can you elaborate on that -- (*overspeaking*) --

20 **A.** I didn't see that in --

21 **Q.** You didn't see that --

22 **A.** I didn't see that in four of the cases, but in one of
23 the cases I did see that.

24 **Q.** Of course you didn't see the ten and you didn't see VC's
25 case?

33

1 **Q.** So there's reference here in the next bullet point:
2 "... out-of-area beds was also a wider issue that
3 [was] ... identified ..."

4 What's the difficulty about out-of-area beds in
5 terms of continuity of care and continuity of treatment?

6 **A.** So we clearly understand the evidence base is clear that
7 the most significant phenomenon which affects a positive
8 outcome in mental health care is continuity, and sending
9 somebody out of area away from their community, their
10 friends their family, and causing disruption, can have
11 a major impact on their recovery journey. And so that's
12 why I know the NHS has set new targets to end out of
13 areas in the next few years completely, but that it can
14 have a major effect.

15 **Q.** We see at page 7, discharge planning, the penultimate
16 bullet points:
17 "No problems were identified for the first 2
18 discharges between local NHS hospitals and community
19 services for VC. This reflects some of the findings
20 from our review of 10 benchmarking cases, which found
21 that, of the 4 patients discharged from NHFT, 3 were
22 handled well".

23 Indeed, that's your evidence in relation to the
24 discharge.

25 **A.** Yeah.

35

1 **A.** No.

2 **Q.** If we look, please, at the next bullet point:
3 "Whilst teams took steps to follow up and re-engage
4 people, we found large gaps between visits in the
5 records for both VC and the 3 benchmarking cases."
6 We see elsewhere reference to that being something
7 between several weeks to over two months.

8 **A.** Mm-hm.

9 **Q.** Again, did you see that, those gaps in your cases, or --

10 **A.** I profoundly recall seeing that in one case, but not --
11 I don't recall that in any of the four cases, no.

12 **Q.** If you look at the next bullet point please, families:
13 "... identified issues of families feeling excluded,
14 not listened to ... [and] staff weren't communicating
15 effectively ..."

16 Again, anything about families that you saw or would
17 like to comment upon?

18 **A.** In four of the cases I reviewed, very good family
19 liaison, the family communication. And in one of the
20 cases -- in one of the cases -- one of the cases was
21 problematic in that there were seven different family
22 members who were -- I'm just mindful of what I can say
23 because -- (*overspeaking*) --

24 **Q.** Don't worry, but one was problematic?

25 **A.** Yeah, one was problematic.

34

1 **Q.** Page 18, please. Summary, penultimate paragraph. It
2 refers to the "inconsistency in ... risk assessments":
3 "... were examples of where the 'Risk and Summary
4 Assessment' could have contained more detail and been
5 reviewed more regularly.

6 "For example, in one patient record the reviews of
7 risk were very limited in detail and no evidence that
8 the care coordinator had reviewed the patient's risks.
9 The only relevant entry across the 9 risk assessments
10 did not identify any related actions or activity that
11 were associated with the risks identified. There was
12 also uncertainty about the patient's documented
13 diagnosis and whether it was first episode psychosis or
14 drug-induced psychosis."

15 Was that poor practice?

16 **A.** That relates to the case that I reviewed that I had
17 concerns about.

18 **Q.** If we can go to page 22, please. This relates to access
19 to care:
20 "... benchmarking identified EIP teams were dealing
21 with very complicated cases, involving patients with
22 a range of mental health needs. In some cases, the
23 referral was screened on the same day and then accepted
24 onto the caseload. We saw that triage assessments were
25 completed within 0 to 7 days, and full assessments were

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1 completed, where required, alongside the CRHT.
 2 Similarly to the 10 benchmarking cases, we found that VC
 3 was taken on quickly ... and triage assessments were
 4 completed appropriately in line with best practice
 5 guidance."

6 That's --

7 **A.** Yes.

8 **Q.** -- you identified.

9 **A.** Yeah.

10 **Q.** That access to care, but then of course monitoring and
 11 treatment thereafter?

12 **A.** Yeah.

13 **Q.** You were looking at a small group of cases?

14 **A.** Small, yeah.

15 **Q.** If we go then, please, to page 24. Again:

16 "The majority of benchmarking cases ... showed ...
 17 patients did receive comprehensive assessments and
 18 packages of support that met their needs. However, in
 19 one example the patient's first language was not English
 20 and no independent translator was provided. This
 21 prevented the EIP team from creating a detailed
 22 assessment and history for the patient, and in turn
 23 hampered their ability to identify risk factors and
 24 create a person-centred care plan that met their needs."

25 My question about this relates really to it being

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1 you can do is review the documentation to see what
 2 treatment was available, what interventions, what the
 3 narrative has been around an intervention, and what
 4 measures have been used to test or monitor its value or
 5 the outcomes that have been achieved. So you can do
 6 that, but obviously you can't quality assure what you're
 7 reading because you're not observing the actual
 8 practice.

9 **Q.** Can we go to page 27, please. The penultimate
 10 paragraph:

11 "Disengagement with services is common for people
 12 with mental health problems. Through our benchmarking
 13 review, we saw examples in most of the records reviewed
 14 where patients did not attend appointments [...] In the
 15 majority of cases, the teams followed up with patients
 16 who did not attend ... in a variety of ways, such as by
 17 text, email, telephone calls and home visits, which had
 18 led in most cases to the patients re-engaging with
 19 services."

20 If we go over to page 28, please, at the top,
 21 further reference to the engagement issue. Second
 22 sentence in the top paragraph:

23 "... records showed large gaps in visits from
 24 several weeks to over 2 months in one case ... no
 25 explanation provided for these periods of non-contact.

39

1 a desktop review. Is it possible to know whether that
 2 fit their needs from single vantage points of the notes?

3 **A.** With a what fit their --

4 **Q.** The arrangements that were made -- the comprehensive
 5 assessments and packages of support to meet their needs.
 6 How could you test that, if you like, reading the
 7 documents?

8 **A.** No, that passage you've just read out in the report
 9 refers to the case of concern, specifically that
 10 I raised.

11 **Q.** But see the others, most, it says at the bottom:

12 "The majority ... did receive comprehensive
 13 assessments and packages of support that met their
 14 needs."

15 **A.** Yes.

16 **Q.** So that's a very positive assertion.

17 **A.** Yes.

18 **Q.** My question is: is it possible to be that positive
 19 without either seeing the patient or those who are
 20 affected by the support to know that it meets their
 21 needs? It's a difficult desktop review question, isn't
 22 it?

23 **A.** Well, it is and it isn't. Obviously you can't observe
 24 the relational approach and the communication and, you
 25 know, how issues are dealt with in live time, but what

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1 In another case, there was no evidence of attempts to
 2 engage or contact a patient for up to 2 weeks."

3 Why is it important to engage the non-engaging
 4 patients and to persist with that?

5 **A.** Because they have an early onset psychosis and we don't
 6 know them and we need to get to know what they're
 7 experiencing in order to ensure that we offer the
 8 support and the treatment that early intervention
 9 psychosis teams offer. So if they're not engaging,
 10 we're not giving them the support and care and treatment
 11 that they need. And just to say that the large gap of
 12 two months in one case again was a case I highlighted
 13 previously.

14 **Q.** Can we go, please, to page 30.

15 "We [also] found similar issues [this is to the VC
 16 case] ... with addresses not being up to date. [...] no
 17 evidence of ... staff member[s] ... re-routing to ...
 18 correct home address [...] no further follow up."

19 Again, that's important detail, isn't it, practical
 20 detail that people have the addresses and make sure they
 21 do?

22 **A.** Again, that pertains to the one case that I've referred
 23 to previously.

24 **Q.** That can come down, please. You suggest in your
 25 statement, you -- well, perhaps we can have it on the

40

1 screen, please, page 7 of your statement, WITN0399001.
 2 So you say at paragraph 35 --
 3 **A.** 35, yeah?
 4 **Q.** "... important to appreciate the effect on clinicians
 5 doing their everyday jobs while large scale
 6 investigations are conducted and ... crucial that those
 7 investigations are carried out with compassion and
 8 understanding. [...] equally important to highlight
 9 good clinical practice where it is found, not just those
 10 areas where it has fallen below the required standards."
 11 **A.** Yeah.
 12 **Q.** Would you like to elaborate on that?
 13 **A.** Yeah, I think it's important. I've been privileged to
 14 support the CQC as an expert adviser as well as
 15 a specialist adviser. I've been involved in many
 16 investigations. We undertake quite a lot of diagnostic
 17 assessments of services. Often staff feel things are
 18 being done to them.
 19 When organisations are under pressure and the
 20 spotlight's on them, behaviours change, they try and
 21 over-assure themselves, and that has a major impact and
 22 the impact on the staff nurse that comes in every day to
 23 do their job, the healthcare assistant, the consultant,
 24 the junior doctors, the MDT, is and can be profound.
 25 And so making sure that -- and I've made a career of

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1 **A.** No, and I published something recently on LinkedIn which
 2 was a review of 10 years of consultancy in organisations
 3 and one of the things, I think there were 15 bullet
 4 points, but one of the things was about we don't
 5 celebrate success enough. We're always looking for
 6 something to go wrong. We're always looking at when
 7 things go wrong and we don't celebrate enough. And that
 8 has an impact. It has an impact. There are some
 9 services and individuals doing some great work, but
 10 often overshadowed, so --
 11 **Q.** Well, it's difficult, isn't it, because sometimes in
 12 management or senior level documents, the individual who
 13 ought, rightly, you say, in a particular case to be
 14 celebrated can lead to an over-optimism of everything is
 15 going really well, look at this great example of work,
 16 when in fact it might be a failing organisation with
 17 a rare example of excellence.
 18 How do you get that balance right where you
 19 celebrate excellence, but you recognise failings and it
 20 might be more people are failing?
 21 **A.** They're two different things. Celebrating excellence or
 22 celebrating a good job is not the same as having
 23 blinkers on and not having insight into your own
 24 organisation's foibles or what you're intelligence data
 25 metrics tell you about your organisation. So it's

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1 ensuring that any review that I do is not just about
 2 finding things that could have been done better; it's
 3 also about highlighting good practice, it's about
 4 highlighting, you know, people who go above and beyond
 5 or people who do well in what they do. And I think
 6 that's important.
 7 I know from colleagues around the country who have
 8 experienced investigations and improvement, teams
 9 et cetera, the impact on them is significant. And that
 10 has an impact on the workforce, but it also has an
 11 impact on the service user group that are inpatients or
 12 community, et cetera.
 13 So I think it's really important and I wanted to
 14 make that as a recommendation: that organisations who
 15 are involved in these things really think about the
 16 impact of what they're doing and how we best support the
 17 teams to continue developing and delivering what we hope
 18 is high-quality, highly effective, compassionate care.
 19 **Q.** Do you think enough is made of the good examples or are
 20 you saying --
 21 **A.** No.
 22 **Q.** -- one case is an excellent example, so the person who
 23 is going above and beyond --
 24 **A.** No.
 25 **Q.** -- should be rewarded for that in some way?

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1 a balance, isn't it?
 2 So we need good, strong governance, we need good
 3 strong leaders. We need connections from, you know,
 4 ward and teams to board and vice versa to understand the
 5 impact that day-to-day running of services has on
 6 people, everybody. And where there are people doing
 7 good work and good jobs and having good outcomes, to
 8 celebrate that.
 9 Often, often, we don't know that because we look and
 10 measure sometimes the wrong thing. You know, we're
 11 looking at -- constantly looking at data which isn't
 12 necessarily really focused patient outcome data or not
 13 really focused staff-improvement delivery data.
 14 **MS LANGDALE:** Those are my questions. There will be some
 15 more.
 16 **THE WITNESS:** Thank you.
 17 **THE CHAIR:** Yes, Mr Moloney.
 18 **Questioned by MR MOLONEY**
 19 **MR MOLONEY:** Good afternoon, Mr Johnston.
 20 **A.** Thank you.
 21 **Q.** I ask questions on behalf of the bereaved families.
 22 Mr Johnston, would you agree that, with the numbers
 23 involved, of the numbers that you looked at in detail,
 24 that it's very difficult to draw general conclusions
 25 given the small numbers?

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1 A. Again, just to reiterate, I had no input into the
2 decision making about the numbers --

3 Q. Oh no, of course. I'm just asking you in terms of --
4 I'm not suggesting that you did. I'm only asking you in
5 terms of your experience. Is it -- and your
6 understanding, given the small numbers -- is it
7 difficult to draw general conclusions from your
8 tracking?

9 A. I think that, when you look at how many potential
10 clients in the IP could have been looked at, and I don't
11 remember the number, but it's about 2000-and-something,
12 ten is quite a small number, but as I understand it,
13 this was quite a rapid review in quite a short space of
14 time. So one would expect that with the other elements
15 of work and review activity that was going on, you would
16 then build a better picture using those lenses.

17 Q. Your study was to feed into others, in a sense?

18 A. Yes, of course.

19 Q. So that if we look at, say, your -- what you've said in
20 evidence in answer to questions from Ms Langdale King's
21 Counsel about risk management --

22 A. Yes.

23 Q. -- that out of the five cases that you looked at, then
24 four were very good, one of those four was exceptional.

25 A. Yeah.

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1 Q. No, of course. Of course. That's what I'm saying, it
2 should be used in conjunction with other things.

3 A. Yeah.

4 Q. Absolutely. Can I just ask you one question now in
5 terms of your expertise as a practitioner.

6 A. Yeah.

7 Q. The Inquiry heard evidence from Mr Ruck Keene King's
8 Counsel about --

9 A. From who, sorry?

10 Q. Sorry, the Inquiry heard evidence from Mr Ruck Keene
11 King's Counsel. I don't know if you saw his
12 illuminating evidence --

13 A. Right.

14 Q. -- about essentially capacity, but legal capacity and
15 how it was that, as it were patient decisions in
16 different circumstances could be overridden. And I --
17 but I'm not going to ask you in any detail about that,
18 don't worry. I'm just going to ask you this: in
19 practice, Ms Langdale asked you about when a patient
20 makes a decision to -- that their families should not be
21 involved, and that they shouldn't be given information
22 about their care.

23 A. Yeah.

24 Q. In practice, because you thought it was very important
25 to involve the families, you've said in evidence today.

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1 Q. Then one of them you thought about retraining?

2 A. One wasn't very good at all.

3 Q. Wasn't very good at all?

4 A. Yeah. Yeah.

5 Q. Now, of course, if you've got five cases like that then
6 on one view you might be saying well, that's 20% --

7 A. Yeah, of course.

8 Q. If you had a hundred cases, that might be only one, it's
9 only 1%?

10 A. Yes.

11 Q. So it's very difficult from much a small number to be
12 able to draw general conclusions about what's happening
13 right the way across service?

14 A. Yeah, and I don't know what the aftermath was for the
15 organisation, but certainly I would expect that if
16 anybody was conducting a review of ten patients in my
17 care, out of 2,400 as a benchmark, as an organisation,
18 I might want to look at more and follow a similar
19 process.

20 Q. Yes, of course, and just use it as one aspect of, as it
21 were, a more holistic knowledge of things.

22 A. Well, it's difficult to say, because I'm sure that there
23 was confidence that the lenses that were looked at
24 offered, you know, a wider picture than just my small
25 bit.

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1 In practice, as things stand, how difficult is it for
2 a practitioner to override that wish when somebody has
3 capacity?

4 A. Well, I don't think it's about overriding necessarily.
5 And I think there are several elements to what you're
6 asking. The first element is that if somebody's saying,
7 "I have capacity and I don't want these people being
8 communicated my confidential information", we would
9 respect that completely.

10 Q. Yeah.

11 A. But that in itself doesn't mean we'd have no contact
12 with family --

13 Q. Of course.

14 A. -- because family obviously are experiencing concern
15 themselves.

16 Q. Yeah.

17 A. So several years ago, and it's still live now, there's
18 a document, really good document published called the
19 Triangle of Care, I don't know if you're familiar with
20 that, which looks at, you know, your lens for the
21 patient, the lens for the family and the lens for the
22 clinician, and that document is really still strong
23 today, still very strong today.

24 So I think it's not about overriding capacity, but
25 it's also not about saying, "Okay, we'll have nothing to

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1 do with your family then," because the family are
 2 experiencing trauma and concern themselves.
 3 There are times where consideration to override
 4 wishes can be done, and I think I did mention it in the
 5 reviews I did, where there's concern about suicide, for
 6 example, and so there's genuine concern about suicide.
 7 There are ways in which people can, you know, if you
 8 like, breach confidence because of a concern.
 9 **Q.** Yeah.

10 **A.** And there's a document published, a multi-agency
 11 document called the Consensus Statement in Preventing
 12 Suicide, and I think you've got experts who will speak
 13 about that in the future.
 14 **Q.** Absolutely, and a practitioner would seek to involve the
 15 family in order to assist them with their, as it were,
 16 care of the patient?
 17 **A.** Yes, yeah.

18 **MR MOLONEY:** Thank you very much, Mr Johnston.
 19 **THE WITNESS:** Thank you.
 20 **THE CHAIR:** Thank you.
 21 Yes, Mr Straw.
 22 **Questioned by MR STRAW**
 23 **MR STRAW:** Mr Johnston, I represent VC's family.
 24 Just one very small issue. Ms Langdale earlier drew
 25 attention to risk assessments that could just be a cut

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1 **MR STRAW:** And you say a number of organisations. Does that
 2 include a number of NHS Trusts which offer mental
 3 healthcare?
 4 **A.** It would be mental health providers, both independent
 5 and NHS, yeah.
 6 **Q.** And what should happen? Instead of just cut and
 7 pasting, what should happen with risk assessments?
 8 **A.** Well, I think as I said earlier, a risk assessment
 9 should no longer be about, you know, a one-off period of
 10 time where, you know, I could do the best, most artistic
 11 risk assessment on you now and you could walk out the
 12 door and take a phone call and your risk changes
 13 completely.
 14 So it's more about constantly reviewing, monitoring
 15 and evaluating an individual's risk based on, you know,
 16 how they're presenting, their communication, the level
 17 of engagement, you know, the circumstances around them.
 18 So, you know, documenting that should be a constant
 19 process not a case of a once-a-week or a once-a-month
 20 review or visit. Does it make sense?
 21 So I much prefer where the risk monitoring is
 22 ongoing, but maybe every week or month in an MDT they're
 23 evaluating the risk to then look at themes and trends.
 24 Does that make sense? So it's being managed and
 25 monitored every day and recorded, but then every however

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1 and paste with no updates so it becomes stale.
 2 **A.** Mm, yeah.
 3 **Q.** And your answer to that included that "I've seen that
 4 pattern in a number of organisations."
 5 **A.** Yes.
 6 **Q.** By "that pattern", do you mean the cut and paste with no
 7 updates, so the risk assessment becomes stale?
 8 **A.** I think I've seen two phenomenons, and again, this
 9 nothing to do, just to be clear, this is -- what I'm
 10 going to talk to you about now is my experience, it's
 11 nothing to do with the five benchmarking cases.
 12 **THE CHAIR:** Sorry, Mr Johnston, you're being picked up by
 13 microphones here so could you slightly turn at an angle
 14 so --
 15 **A.** Sorry, is that better?
 16 **THE CHAIR:** Yes, it's better.
 17 **A.** So it's nothing to do with the five benchmarking cases.
 18 I have seen cases where, when we've undertaken
 19 investigations, for example, or diagnostic reviews of
 20 quality or governance of services where the habit of
 21 copying and pasting narratives from one patient document
 22 to another patient document, because you want to say
 23 similar things, has happened. Less so copying and
 24 pasting existing risk assessments, narratives, if that
 25 makes sense.

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1 long, the Multi-Disciplinary Team would then review the
 2 themes of that.
 3 **MR STRAW:** Okay, thank you very much.
 4 **THE CHAIR:** Thank you.
 5 Yes, Ms Richards? No?
 6 **MS LANGDALE:** That might be a good moment for the break
 7 before the next witness, thank you.
 8 **THE CHAIR:** All right, we'll take a break now until -- come
 9 back at 3.10, thank you.
 10 **(2.55 pm)**
 11 **(A short break)**
 12 **(3.10 pm)**
 13 **THE CHAIR:** Yes, Ms Langdale.
 14 **MS LANGDALE:** May I call Mr McMorrow, please.
 15 **THE CHAIR:** Yes.
 16 **DESMOND JOSEPH MCMORROW (affirmed)**
 17 **Questioned by MS LANGDALE**
 18 **MS LANGDALE:** You prepared a statement, Mr McMorrow, dated
 19 11 February 2026 for the Inquiry. Can you confirm the
 20 contents are true and accurate as far as you're
 21 concerned?
 22 **A.** They are, yes.
 23 **Q.** Can we have, please, pages 1 and 2 on the screen of your
 24 statement, so that people can see your qualifications
 25 and background while you tell us about that.

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1 A. Okay, yes. I qualified as a mental health nurse in
2 1988. I was a nursing assistant beforehand. I worked
3 in a number of clinical settings, predominantly forensic
4 mental health. I then progressed into management of
5 services up to the role of Deputy Director of Nursing.

6 I've undertaken other roles within the Irish mental
7 health system. I worked as an inspector over there and
8 I currently -- I retired from the NHS in 2014 and I have
9 a consultancy business now, which -- and I do death in
10 custody reviews, I do health needs assessments in
11 prisons, I chair Fitness to Practise Committees for
12 healthcare regulators, and -- yeah, and --

13 Q. You've done, we see here, at paragraph 7, a number of
14 homicide reviews as well. Is risk assessment or lack of
15 risk assessment a factor in those kinds of reviews that
16 you've undertaken? I'm not asking for the details of
17 any specific one; I'm asking thematically?

18 A. Yeah, it can be. And I think it's the following through
19 of the risk assessments, I think, and the earlier
20 witness referred to that, that the risk assessment is a
21 fluid document, it's not a one-off piece of work that
22 can be done, and quite often in reviews of this type of
23 work that I do I see that there isn't always that
24 fluidity, as a risk changes, that the assessment is
25 re-evaluated and that a risk management plan is put in

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1 happening with the patient, that they're also the eyes
2 and ears for the public really, and public safety as
3 well as the patient?

4 Do you think there's enough consideration of both
5 their role towards the patient and roles towards those
6 they do not know, but they may be impacted by any
7 failure to document or understand risk?

8 A. I think training is an important factor of that, but
9 I also think regular and ongoing supervision and
10 reflective practice is also important.

11 What I mean by reflective practice is when you look
12 at a caseload, whether that's an inpatient or community
13 setting, that I talk to other professionals about the
14 care that I'm giving to somebody and does it need
15 refreshing? Have I got sort of stuck in my ways,
16 perhaps, and I'm not seeing things? So it's getting
17 that fresh approach and that can be done, again, in
18 a number of ways, through supervision, from a clinical
19 perspective and also reflected in one's own practice.

20 And I don't think that's done enough. I think
21 all -- everywhere in the NHS is busy and I know that's
22 quite a global statement, but I think time needs to be
23 protected for nursing staff in particular to be able to
24 reflect on their practice and to be able to put some
25 challenge into how they operate and how they work with

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1 place.

2 Q. Reference is made to the fact that it can change with
3 one phone call on a ward.

4 A. Mm.

5 Q. So how do nurses need to be equipped to understand the
6 significance of interactions they have or observations
7 they're making on the dynamic nature of risk?

8 A. I think that is the vigilance of a nurse, as a mental
9 health nurse in particular, is to observe. Other
10 disciplines are involved as well. So again, to
11 reiterate, it's not just the nurse's responsibility, but
12 nurses are predominantly, and certainly in an inpatient
13 setting, more in contact with the patient group and
14 therefore other disciplines may rely on the observations
15 of nurses. So it's very important that nurses are
16 vigilant and are inquisitive in their thinking and their
17 observations. So we can observe people in a number of
18 ways. We can watch, we can hear, we can listen and we
19 can speak, and it's important that all of those
20 attributes are used when conducting risk assessments.

21 And looking at any subtle changes or any significant
22 changes that may be apparent in somebody's presentation.

23 Q. Do you think there's adequate training or understanding
24 from nurses that in that position that they occupy,
25 namely the eyes and ears on the ward and seeing what's

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1 their caseload.

2 Q. Time, I'm sure, is busy in the NHS, but the ability to
3 document things has got speedier than ever, hasn't it --

4 A. Yeah.

5 Q. -- in terms of gadgets, devices we can use to record
6 matters. Do you think there's sufficient recognition
7 about how detail matters and accuracy matters, and
8 recording facts? That may be really important as
9 a sequence emerges, for example?

10 A. They're of paramount importance because any professional
11 work, a span of duty, they're off duty, they're on
12 holiday. It's important that their observations and so
13 I may have as a nurse on the ward are documented clearly
14 so the next person coming on shift understands what
15 I did and the reasons why I did, and what the person has
16 presented with and what the changes in the care plan are
17 about because of my observations. It's not sufficient
18 to verbally hand that over, it has to be written down in
19 detail.

20 Q. You said I think you were a Deputy Chief Nurse at one
21 point; is that right?

22 A. The Deputy Director of Nursing, yeah.

23 Q. In terms of motivation for nursing generally, and
24 motivation particularly in mental health nursing, what
25 do you think is said about why people should be a mental

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1 health nurse, the values of it? What can be done to
 2 encourage that, and the right people to do the work?
 3 **A.** To me, it's about making positive changes in people's
 4 lives, is what being a mental health nurse is, what it's
 5 about. It's the values I had when I first went into it.
 6 It's what I profess to do, and what I try to instil
 7 through my managerial career in staff that work with me
 8 and it's impossible to know every individual member of
 9 staff, unfortunately the higher you go up the chain, but
 10 it's making sure that the people that directly report to
 11 you understand those values and hold those values, and
 12 that's what, you know, it really to me it should be
 13 about, it's making positive differences in people's
 14 lives.
 15 **Q.** You've obviously had extensive experience over decades
 16 now. What changes have you seen in the provision of
 17 mental health services in that time?
 18 **A.** I think there's more clinical opportunities for nurses.
 19 I think if I reflect on my own career when you get to --
 20 when I got to a certain level as a clinician there was
 21 no other alternative but to go into management if you
 22 wanted to progress, whereas now there's a lot more
 23 clinical specialities, there's more teams, there's more
 24 approaches, that a nurse can lead with and take. And
 25 there's more training and opportunities for nurses than

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1 **Q.** -- your review of cases? Can we have that on the screen
 2 then, please, CQCM0009938. You saw me go through it
 3 with your colleague, I'm going to do the same with you.
 4 But before we go broadly to sections, can you tell us
 5 what you made of that policy overall? Was it adequate
 6 for the time? Good? Poor? Indifferent?
 7 **A.** I think it was adequate at the time. Yeah, I didn't see
 8 anything in it that I thought -- that I took issue with.
 9 **Q.** What did you think, if there's a policy there, it may
 10 seem obvious, but what's the purpose of the policy?
 11 **A.** The purpose of the policy is to govern how the team
 12 practise and how they operate -- policies to me are
 13 minimum standards. They're really what we should be
 14 doing but there's scope to go above and beyond what's
 15 written in the policy, but the policy really should be
 16 what's adhered to.
 17 **Q.** So we see at page 9 and 10, please, "Effective Care
 18 Coordination", the needs for "Comprehensive
 19 multi-disciplinary, multi-agency assessment". If we can
 20 have both pages on the screen.
 21 Anything missing there in terms of effective care
 22 coordination or do you think that adequately covers the
 23 position? The bottom of the page.
 24 **A.** I read multi-agency assessment in a particular way but
 25 I think it could be clearer that that includes agencies

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1 there was.

2 Balanced with that, though, is pressure on -- in the
 3 system, to -- mental health nursing has become
 4 outcome-focused. It's very difficult I think to measure
 5 outcomes for people's mental state. It's hard, because
 6 a mental condition is there forever, really. It can be
 7 treated, it can be managed, but it's going to be there
 8 and I've seen -- not talking about these specific cases
 9 now, but I've seen people who disengage from services,
 10 and the mental state becomes -- they become unwell
 11 again. And quite often somebody might get to the point
 12 of "I'm well now, I don't need to carry on taking this
 13 medication" or "I'm better", and then relapse can come.
 14 And it is that importance of keeping those -- that
 15 skillset up.

16 And I think I may have gone off a little bit off on
 17 the question you asked, but I think there are more
 18 opportunities now for nursing staff to specialise, but
 19 equally there's more pressures, I think, in the system
 20 when I think back to the early days of my career. Or
 21 maybe I wasn't aware of them.

22 **Q.** That can come down, your statement, please. Did you
 23 have a look as well at the EIP policy at the time of
 24 doing --

25 **A.** Yes.

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1 not necessarily involved in healthcare settings, that
 2 other agencies outside of healthcare, and maybe made
 3 clearer.

4 **Q.** I think saying multi-disciplinary and multi-agency
 5 probably covers both, doesn't it?

6 **A.** Mm.

7 **Q.** Multi-disciplinary clinical teams, multi-agency
 8 assessment, but either way the need to share or work
 9 with others --

10 **A.** Yeah.

11 **Q.** -- in effective care coordination?

12 If we go, please, to page 12. "Minimum standards
 13 for ... assessment components", and including bullet
 14 point six, the user standardised assessment tools.

15 In the cases you benchmarked, we'll come on to that
 16 but you looked at six cases in the end, didn't you --

17 **A.** Yes.

18 **Q.** -- five and then one more that was added. Did you see
 19 evidence of using standardised assessment tools?

20 **A.** Yes, I did.

21 **Q.** And we see at page 13: "Assessment of At-Risk Mental
 22 States".

23 What does that involve, if a nurse is assessing an
 24 at-risk mental state?

25 **A.** Well, again it's that initial assessment of risk and

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1 how -- it's taking in a number of resources of how to
 2 complete that assessment. So it's not just necessarily
 3 relying on the voice of the patient. That's important,
 4 but it's also undertaking a comprehensive review of the
 5 records and seeing previous behaviours, how they were
 6 treated at the time, what medication was used at the
 7 time, what approaches were used by the team, consulting
 8 with family, consulting with other agencies.

9 In all my years of nursing, and I've come across
 10 some patients who may not have told me the truth when
 11 I'm engaging with them, so if I was to solely rely on
 12 what I was told, I may miss things, and things.

13 So I think it's important to hear what the person
 14 says to you, but then go and triangulate that and get
 15 some further collaboration, whether that is right or
 16 maybe not.

17 **Q.** Do you think that's sufficiently understood, culturally:
 18 that the patient may not be telling you the truth and
 19 you need to triangulate? In your experience of nursing?

20 **A.** I think it needs reminding. I think it often, again,
 21 through some of the work I did, not for this case, but
 22 certainly in some of the work I do in the prison setting
 23 it's often the prisoner's voice is what's relied upon,
 24 and when you say, "Well, hang on a minute, they may not
 25 be telling you the truth. Have you ever thought of

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

2 **Q.** The importance of medication, those matters, if they're
 3 identified with crisis, are matters that need to be
 4 documented and addressed?

5 **A.** Yes, medication is one area. Lack of engagement is
 6 another. Turning up for appointments but not engaging.
 7 So if someone says, "Well, I was there but they didn't
 8 do it", that it's that, you know, getting back to what
 9 we talked about earlier is that observation and using
 10 those observational skills of sort of saying: "Well,
 11 okay, you're presenting to me, but you're not really
 12 talking to me, what's going on in your life? Is there
 13 anything significant that I need to know about?" And
 14 then trying to ascertain those.

15 **Q.** Working with families at page 17. Policy refers to
 16 point 15:

17 "... team will strive to engage and support all
 18 those who are important to the service user. Contact
 19 will be made with ... family ... in collaboration with
 20 the service user."

21 What's the importance of working with families?

22 **A.** It's gaining an understanding of what happened in the
 23 developmental years of when a person was younger, how
 24 sometimes -- and again, in my work, not necessarily with
 25 this work I did here -- patients may talk better through

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1 that?"

2 And, you know, so I think it's a poignant thing and
 3 it needs reminding.

4 **Q.** Page 15 and 16, please "Formulation of Comprehensive
 5 Care Plan ..."

6 The importance -- 15 and 16, please. The importance
 7 of the care plan is?

8 **A.** It's the prescription of what we should do, what we --
 9 we should help with that person to overcome their needs.
 10 So it's identifying what their needs are and what
 11 interventions we are going to put in place to meet those
 12 needs or manage those needs, and that includes risk and
 13 another number of, you know, clinical presentations.

14 **Q.** It includes, doesn't it, the last bullet point on
 15 page 16: the appropriate crisis and contingency plans.
 16 It's always important to have contingency plans?

17 **A.** Yes, indeed, and it is because the very word itself
 18 "crisis" indicates that there's something gone wrong
 19 with that care plan and it may not have been sufficient
 20 to hold that person or to adequately treat, and
 21 therefore it's important that when that stage is here,
 22 that staff know what to do and step in and enact that
 23 crisis contingency plan.

24 **Q.** So it might be not taking medication, you referred to
 25 that earlier?

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1 their families to us than -- because there's that
 2 element of trust and that can be the counter to that as
 3 well.

4 But I think it is having that whole picture. You've
 5 talked earlier, the holistic approach, and making sure
 6 that we hear everything from everybody, and some --
 7 again, somebody may not tell us something that family
 8 are aware of and can share with us that will help us to
 9 inform that care plan, to inform that crisis plan, and
 10 to inform that contingency plan if things start to go
 11 wrong.

12 **Q.** Page 18. Reference to psychosocial interventions, the
 13 first one:

14 "Family interventions will be offered to all
 15 family/close friends presenting with a first episode of
 16 psychosis".

17 Did you see any evidence of that in the cases you
 18 benchmarked?

19 **A.** Yes, I did.

20 **Q.** What kind of offering?

21 **A.** Joint appointments. If somebody wasn't engaging, family
 22 were contacted to say, "Do you know where they are? Can
 23 you help us to engage with the person?"

24 Education on the person's illness, and the shock
 25 that that can have for a parent or a sibling of somebody

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1 who has been diagnosed with a significant mental
 2 illness. There's quite often shock, shame, a number of
 3 emotions that go through a family when they --
 4 **Q.** It goes without saying, then, that the conversations,
 5 the psychosocial interventions involve explanation of
 6 diagnosis?
 7 **A.** Precisely, it's psychoeducation.
 8 **Q.** You said earlier, your colleagues said, long-term
 9 lifelong illness in many cases.
 10 **A.** Yes, and learning to deal with that as a family, and
 11 learning to work with that to support the individual.
 12 And in all my years of nursing, I'm afraid stigma in
 13 mental health hasn't reduced. There is still a public
 14 perception that mental health is something wrong, it's
 15 a weakness or whatever. There's so much stigma attached
 16 to somebody with mental health. So it's helping the
 17 person, but also the family come to terms with that
 18 stigma to help them be stronger to help the individual
 19 be as well as they can be.
 20 **Q.** Page 19, please:
 21 "Ongoing inter-agency working with local schools,
 22 colleges, service can support service users to remain in
 23 education ..."
 24 Did you see any of that? That's point 19.
 25 **A.** Yes, I did.

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1 **A.** Okay, specialist mental health advocate is somebody who
 2 is independent, so not a family member, and they are
 3 trained to support somebody with some of the issues that
 4 I've just mentioned there earlier, the -- dealing with
 5 mental health, but also advocating on their behalf.
 6 Again, depending on what setting they're in, if
 7 they're an inpatient under the Mental Health Act,
 8 they'll have an advocate. If they're under the Mental
 9 Capacity Act, they'll have an advocate to support them
 10 through the legal process, but also to help them, be
 11 a voice where "I don't" -- I'm speaking on behalf of the
 12 patient here -- "I don't want to lumber my family with
 13 these concerns. I have an advocate who can do that for
 14 me and can do what it says, advocate on my behalf."
 15 And yes, I did see evidence of that in some of the
 16 reviews that I did.
 17 **Q.** Not all six, but some?
 18 **A.** Some.
 19 **Q.** Any indication of others that had been offered it but
 20 hadn't taken it, or you couldn't tell from the desktop
 21 review?
 22 **A.** Yeah, it would be difficult to know. And sometimes it's
 23 not always needed. You know, if the person can advocate
 24 for themselves or the family can advocate for
 25 themselves, if they're not subject to the Mental Health

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1 **Q.** Again, if someone with mental illness or serious mental
 2 illness is working or in education, it's both in their
 3 interests, and others presumably, that people understand
 4 the position and know what to expect and know what to
 5 look for and know how to support?
 6 **A.** Yes, and put adaptations in if required to support
 7 somebody staying in long-term education. And without
 8 going into great detail, one of the cases I did they
 9 were studying and went home for periods of holiday, and
 10 the EIP linked in with the team at the person's home
 11 area to make sure they were aware that they were there
 12 during whether it be the summer holidays, Christmas
 13 holidays or whatever, and there was good contact before
 14 the person went home, and then communication while they
 15 were at home, and then when they were returning, and if
 16 there was any -- they've decided they've had enough at
 17 home, they're going back to, you know, their
 18 accommodation. So there was -- in that case there was
 19 really, really good communication there which supported
 20 the person staying in their studies.
 21 **Q.** Page 20, number 23, "Advocacy":
 22 "All service users will be offered the opportunity
 23 of support from a specialist mental health advocate."
 24 First of all, what is that; and, secondly, did you
 25 see any evidence of that in the benchmarked cases?

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1 Act, Mental Capacity Act, then they may not need
 2 an advocate. And the level of depth we went into in
 3 respect of desktop review wouldn't have answered that
 4 question.
 5 **Q.** Page 21, please, "Discharge before three years":
 6 "Work will be in accordance with the Trust's policy
 7 on disengagement and missed appointments."
 8 Reference here to:
 9 "The team will continue with CPA responsibilities
 10 and the care coordinator will remain in place ...
 11 documented care plan to support the service user's
 12 non-engagement will also be developed."
 13 What do you expect around non-engagement? What do
 14 you expect to happen? Can you discharge someone for
 15 non-engagement or not?
 16 **A.** Simply, yes, you can; whether you should is another
 17 matter. And I think that's an individual assessment to
 18 be done on the risks associated with that person not
 19 engaging with services, and I touch on it, and you may
 20 well come to it in course, I'm sure you will, around
 21 professional curiosity as to why is somebody disengaging
 22 from a service? It's a theme that I've come across, not
 23 necessarily in this work but in other work, where people
 24 have disengaged and it's been a case of: "Oh well, we've
 25 written to them, we've asked them to attend, they've not

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1 attended so we'll take them off our books."
 2 To me in some cases that should be a flag to raise
 3 as to actually we do need to engage with that person and
 4 find out a little bit more why they're not engaging, and
 5 it might be something as simple as they don't like the
 6 waiting room, they don't like coming to the clinic, they
 7 don't want to see us where we want to see them.

8 So it's trying to understand why somebody is
 9 disengaging before actually pulling the plug and saying,
 10 "Right, we're discharging you, please get in contact
 11 with us should you need our service in the future."

12 **Q.** You refer to it at the conclusion of your statement with
 13 recommendations. You say:

14 "I believe a recommendation should be made on the
 15 theme of professional curiosity. It is important that
 16 all teams within a Trust are aware of the importance of
 17 professional curiosity, especially to ascertain why
 18 patients may be disengaging ..."

19 What does "professional curiosity" mean to you?

20 **A.** It is that understanding of why is somebody doing
 21 something that may be not within the realms of what we
 22 expect them to do. And that might be disengaging with
 23 the service, it might be not talking to us, it might be
 24 maybe not understanding fully their illness, and putting
 25 challenge to the team as to say, "I'm not unwell, I'm

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1 are we missing something here?

2 **Q.** In the CQC Report, we can have it on the screen for you,
 3 CQCM0016518, page 5, key findings were put together and
 4 reference is made on page 5 to:

5 "Inconsistent approaches to risk assessment was an
 6 issue in both VC's case and the 10 benchmarking cases
 7 ..."

8 Did you see inconsistent approach to risk
 9 assessment?

10 **A.** In one of the cases I did. There was a delay in doing
 11 the risk assessment, but other than that, risk
 12 assessments were pretty much done as the policy would
 13 indicate.

14 **Q.** For risk assessments to be effective, it needs to be
 15 undertaken with a view to what has happened in the past,
 16 historically, doesn't it, understanding the facts in the
 17 past, and a longitudinal view?

18 **A.** Yes, yeah.

19 **Q.** Out-of-area placements, if we go to page 6 of the
 20 report, there's reference to the concerns of the use of
 21 out-of-area beds, which is an issue that was identified
 22 by the CQC in respect of the Trust. What is the issue
 23 with the use of out-of-area beds in terms of patient
 24 outcomes, or ...

25 **A.** It's that break in continuity of care, because if

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1 not mentally ill, I disagree." And it's finding out why
 2 you think that. What's the perception? Why is that
 3 your perception, when we have a -- you know, from
 4 a professional background, we have a diagnosis for you.
 5 It doesn't mean to say diagnosis can't be challenged.

6 But it is that -- and it comes back to my point
 7 earlier around clinical supervision of where are we at
 8 with this person? Are they engaging with us? Are they
 9 not? Why are they not? Have we asked those questions?
 10 Could we do anything a bit differently to help you to
 11 engage with us? Is it something we're doing that's
 12 putting you off joining it?

13 And it's not just necessarily talking to the
 14 individual, it's talking to others who know, other
 15 agencies that are involved "Have you seen this person?
 16 We've lost contact with them, we can't find them."

17 And it is that, sort of, maybe, you know, local
 18 authority, police, whatever, of having that curious
 19 mind --

20 **Q.** Educational establishment?

21 **A.** Educational establishments, work establishments,
 22 voluntary sector, anything that you know that that
 23 person engages with because they may be seen there and
 24 maybe have that contact. So it's that curiosity that
 25 inquisitive mind of sort of like trying to ascertain:

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1 somebody has been moved far away from home, there's the
 2 break in care there, there's also the distance from
 3 family and loved ones and familiar services, and if
 4 somebody is in a hospital setting, they're likely to get
 5 leave and things at some point and it's where would
 6 somebody go? They're in a strange town, strange city,
 7 perhaps. But it is that importance for me for a number
 8 of reasons, but that continuity of care.

9 And it's again the vigilance of the care coordinator
 10 in the home area of maintaining that contact and making
 11 sure that there isn't a gap in provision and that the
 12 person doesn't stay in that hospital any longer than
 13 they need to, and they continue to visit, they continue
 14 to see the person.

15 And that when there is a return back to the home
 16 area, that that's planned. It's not just that "You're
 17 discharged, you're going back to the home area" and the
 18 home area doesn't know or wasn't aware. It's important
 19 that that communication is maintained and there is a
 20 danger of somebody going out of area that that
 21 communication chain is broken.

22 **Q.** Page 11, please, of the report. This is under a section
 23 entitled "Context" and we see the third paragraph:

24 "People experiencing delusions or hallucinations
 25 genuinely believe that what they are experiencing is

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1 happening to them. This is exacerbated when someone is
2 paranoid, as their paranoia will increase their
3 suspicions and distrust of people and organisations."

4 We've seen reference to family interventions, family
5 assistance. What kind of advice is given in relation to
6 that issue?

- 7 **A.** Again, touching on what I said earlier, it's very hard
8 for people to understand that what they're experiencing
9 isn't real, and to put challenge in may be
10 counterproductive, when one is trying to maintain
11 a relationship with that patient. The families, again,
12 it's hard for them to understand some of the content of
13 what's been said, and to not challenge it, to say
14 something like "Oh that's ridiculous, you can't honestly
15 believe that", you know, and things and again it comes
16 back to that education around the condition and that
17 whilst that might be real to the person, it isn't real.
18 We know that, but we need to work with that person to
19 get them to understand that what they're perceiving of
20 things isn't real, but again, that forthright challenge
21 is not the approach to take.
- 22 **Q.** How does one challenge that, then? What's the process
23 if they don't believe it, they keep giving you rational
24 explanations, you've got countervailing rational
25 responses?

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- 1 **A.** I think it's more likely to, because I think there's
2 that consistency and understanding, and certainly in my
3 experience when I've worked with somebody -- in my
4 clinical work, I work predominantly with offenders
5 coming out of hospitals and I'd have a small caseload
6 who I knew really, really well, and I would be able to
7 say to them, "Look, I think things are slipping a bit
8 here, we need to have, you know, maybe we need to go
9 back into hospital for a period of time, maybe I need to
10 up my visits to you," and things like that.
- 11 So again, it's coming back to that curiosity and
12 it's that understanding of somebody and it's sort of
13 like -- and it's things like "We don't agree, but I have
14 a duty of care to you that I need to make sure you're
15 safe" and things like that. So I'm actually going to
16 override what you think and I'm going to make
17 arrangements for you that are going to keep you safe and
18 subsequently keep others safe.
- 19 **Q.** Do you say that to them: "And to keep others safe?"
- 20 **A.** Depends on the individual.
- 21 **Q.** But you have said that?
- 22 **A.** Oh yeah.
- 23 **Q.** You were provided with a draft report from the CQC. Did
24 you have timetable to read it at the time, or --
- 25 **A.** Yeah, I had some time. I did make some comments on it,

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- 1 **A.** Again, without going into detail of diagnostics and
2 things, if somebody has got resistive schizophrenia,
3 it's about, can we get medication into the person that
4 gets them to a level of better understanding, that the
5 psychosis isn't as acute, perhaps, as it were, that
6 gives an opportunity to have some meaningful dialogue
7 with the person and to put a little bit of challenge
8 back in when the mental state is less acute, when it's
9 more settled, and to be able to sort of, like, say
10 "Look, you know, I'm going to give you, you know ..." --
11 and also the building up of the trust in the
12 relationship. If I'm working with somebody, I'm not
13 going to do that in the first intervention I have with
14 somebody. I'm going to take time to get to know them
15 for them to hopefully trust me enough that when I do put
16 some challenge in, there's a depth of understanding and
17 trust between us as a nurse and patient that I can put
18 that challenge in, but I think to do that to somebody
19 who is acutely psychotic, it's not the time and place to
20 do that.
- 21 **Q.** In your experience, do patients, if they have sufficient
22 trust in a clinician, want to see a clinician, go to a
23 clinician, or a practitioner, is it more likely that
24 they will receive advice from someone because they do
25 trust them or want to see them for whatever reason?

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- 1 yeah.
- 2 **Q.** So you've made comments and there's nothing you disagree
3 with what's been stated about the benchmark cases
4 therefore, is there?
- 5 **A.** No, no, not on the bit we did, and I think some of the
6 comments I made were in relation to VC, although I had
7 no input into that, and again it stems from the
8 professional curiosity which we've talked about.
- 9 **Q.** So you don't want to correct anything within that. But
10 do you take the point as well that desktop review, it's
11 a comparatively small number of cases? The full report
12 doesn't suggest it's anything other than that, but it's
13 very difficult from a small number of random cases,
14 isn't it, to extrapolate and say what is or isn't there
15 on a widespread basis?
- 16 **A.** Yeah, I don't dispute that. I think it was a small
17 sample, but it was the sample we were given to work
18 with.
- 19 **MS LANGDALE:** Thank you, there may be some more questions.
- 20 **THE CHAIR:** Yes, any questions? No?
- 21 Right, thank you very much, Mr McMorro. We'll
22 finish there for today and start again tomorrow at
23 10.00.
- 24 **THE WITNESS:** Thank you.
- 25 **(3.40 pm)**

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1 (The hearing adjourned until 10.00 am the following day)
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