Witness Name: Susan Elcock

Statement No: WITN0356001

Dated: 27 January 2026

THE NOTTINGHAM INQUIRY

FIRST WITNESS STATEMENT OF DR SUSAN ELCOCK

I, Dr Susan Elcock, will say as follows:

Introduction

1. I have been Deputy Chief Executive Officer of Nottinghamshire Healthcare NHS Foundation Trust (the "**Trust**") since October 2023 and Executive Medical Director of the Trust since May 2021. In the period from June 2020-June 2023 I was also the Executive Director of Forensic Services at the Trust. I held this role concurrently with the role of Executive Medical Director.

2. This witness statement is made to assist the Nottingham Inquiry (the "**Inquiry**") with the matters set out in the Rule 9 request dated 15 October 2025, (the "**Request**").

3. This witness statement was drafted on my behalf by the external solicitors and counsel acting for the Trust in respect of the Inquiry, with my oversight and

input, following discussions in writing by email and by video conference.

Approach and structure of my statement

4. In providing this statement, I would like to acknowledge the tragic ongoing impact of the events of 13 June 2023 on the victims, their families, and the wider community. I have actively supported the steps the Trust continues to take to learn and improve in light of the lessons learned and which will be further identified through the course of the Inquiry.

5. Working alongside my executive colleagues, particularly the Chief Executive Officer of the Trust, Ifti Majid, and the Chief Nurse, Diane Hull, I contributed to and approved the Trust's First Corporate Witness Statement [WITN0133001]. In that statement, the Trust's governance arrangements; the way these have evolved over time; the Trust's response to recent CQC inspections; the reviews and investigations carried out in response to the events involving Valdo Calocane (VC) were all addressed. I have not repeated that content here but, where helpful, I have included cross referencing.

6. As I go on to explain in the next section of my statement, I do not currently hold a clinical caseload. For completeness, I would like to note here that I had no involvement in caring for VC.

7. In terms of the overall structure of my statement, I have set it out as follows:

    a. Background and career history;

    b. Executive roles and responsibilities;

    c. Governance Generally

    d. CQC Reports

    e. Risk Assessment

f. Serious incidents and learning from deaths

g. Staffing levels, outsourcing and discharge planning

h. Multi-agency working

i. Treatment in the Community

j. Reviews

k. Reflections

Background

8. I graduated with my MBChB from Birmingham University in 1998 and completed my Pre Registration House Officer roles in 1998–1999. I then joined the Senior House Officer Psychiatry Training scheme in Leicester from 1999 to 2002.

9. After gaining Membership of the Royal College of Psychiatrists in 2002, I entered the Specialist Registrar Training Scheme in Forensic Psychiatry in Nottingham and gained my certificate of completion of Specialist Training in 2005.

10. In the same year (2005), I was appointed as a Consultant Forensic Psychiatrist in the National High Secure Service for Women at Rampton Hospital, where I worked until 2015. During this time, I held several educational leadership roles, including Training Programme Director in Forensic Psychiatry and subsequently Head of School for Psychiatry (initially for the North and later for the merged regional School) until 2015. I was also the Associate Medical Director for Appraisal and Revalidation leading on implementing this within the Trust from 2010.

11. As a Forensic Psychiatrist, it is a requirement that I hold what is known as section 12 approval. This means that I am section 12 (Mental Health Act 1983 (**MHA**)) approved as a Responsible Clinician and annually remain in good standing with the Royal College of Psychiatrists with regards my continuous professional development. I have maintained this throughout my clinical career as a Forensic Psychiatrist and have exhibited my current certificate [WITN0356002].

12. In 2015, I joined Lincolnshire Partnership NHS Foundation Trust as Executive Medical Director. During this period, I also held the role of Medical Director for Lincolnshire Community Health Trust for six months. I worked clinically in the Community Forensic Service and then the Rehabilitation Inpatient service for women.

13. In 2018, I moved to Leicestershire Partnership NHS Trust as Executive Medical Director and worked clinically in a female Psychiatric intensive care ward and a male low secure ward, before returning to Nottinghamshire Healthcare NHS Foundation Trust in June 2020 as Executive Director of Forensic Services.

14. In my capacity as the Director of Forensic Services, I had responsibility for overseeing the delivery and performance across the entire Forensic Division. The role was an Executive board level role. My responsibilities included oversight of Rampton High Secure Hospital, Wathwood Medium Secure Hospital, Arnold Lodge Medium Secure Hospital, Wells Road Low Secure Hospital, Community Forensic Services, and Offender Health Services. I was responsible for the day to day running of the services and strategic planning for forensic services.

15. I then applied for and was appointed as Executive Medical Director in May 2021. I held this role in addition to being the Director of Forensic Services. I have explained why I held both these roles concurrently and the challenges I experienced in doing so.

16. During this period, I worked clinically in a female inpatient ward at Arnold Lodge medium secure hospital.

17. The table below sets out my career history since my appointment as Executive Medical Director at Lincolnshire Partnership NHS Foundation Trust in 2015.

Role	Date
Medical Director and Consultant Forensic Psychiatrist Lincolnshire Partnership NHS Foundation Trust	February 2015 – September 2018
Interim Medical Director, Lincolnshire Partnership NHS Foundation Trust	July 2017 – December 2017
Executive Medical Director, Leicestershire Partnership NHS Trust	October 2018 – May 2020
Executive Director of Forensic Services, Nottinghamshire Healthcare NHS Foundation Trust	June 2020 – June 2023
Executive Medical Director, Nottinghamshire Healthcare NHS Foundation Trust (held concurrently with Director of Forensic Services for part of the period, as above)	May 2021 - present

My Executive Director roles and responsibilities

18. When I was appointed to the role of Forensic Director in June 2020, the Trust executive team structure included an operational Executive Director for each of the 3 divisions (Forensic, Mental Health and Community Health Divisions). This has subsequently been changed, with the introduction of the Chief Operating Officer (**COO**) role; the transfer of executive-level operational responsibilities to the COO and the consequential adjustments made to other executive roles.

19. As set out in the table above, in the initial period after my appointment as

Medical Director, I continued in both the Forensic Director and Medical Director roles. This was a pragmatic arrangement reflecting the fact that, there was ongoing discussion about the overall structure of the executive team, particularly around the potential introduction of a Chief Operating Officer, with the proposal being that any such Chief Operating Officer role would combine the three previous executive operational director roles.

20. At the same time, there were a number of retirements from the executive team. For instance, when the Mental Health Operational Director retired in December 2022, an interim change was made for the Director of Community Health Division to move to take on the Mental Health Operational Director role, and an interim Operational Director for Community Health Division was consequently appointed. Given the timings of the then CEO retirement (John Brewin) and the interim period of Anne-Maria Newham as interim CEO, a full review of the executive leadership structure was carried out by Ifti Majid following his appointment as CEO in December 2022 and then implemented in 2023.

21. All of this meant that it made sense for me to continue to hold the concurrent roles that I did.

22. As part of the implementation of the executive leadership structure changes that occurred following Ifti Majid coming into post, Becky Sutton commenced in post as the Chief Operating Officer (COO) on 1 June 2023. On this date, the post of Director of Forensic Services ceased to exist and all the operational responsibilities for that role sat with the Chief Operating Officer. This was an important distinction as I no longer held any operational executive role.

23. The Director of Forensic Services was an operational executive level role and I was responsible for the delivery of the Forensic Services, which included Rampton High Secure Hospital, Arnold Lodge Medium Secure Hospital, Wathwood Medium Secure Hospital, Wells Road Centre Low Secure Hospital, Community Forensic Services and our prison healthcare services. In practice,

this meant that I would oversee the running of the services by a combination of management and service meetings, visits to services, meetings with patients and carers and working with my divisional management team.

24. In contrast, the Executive Medical Director role has a clear focus on quality and a smaller element of operational delivery of key corporate services. As Medical Director, I am the professional lead for all doctors across our organisation. I am the medical voice at our Board of Directors and share with the Chief Nurse our role in terms of patient safety, quality and experience. I also oversee the provision of undergraduate and postgraduate medical education and our medical student and resident doctors training experiences, supported by a Director of Medical Education. I oversee research, including the Institute of Mental Health and I oversee the delivery of pharmacy services, with a Chief Pharmacist, and I am the lead for psychological professions, supported by a Chief Psychological Professions Officer.

25. As Medical Director I also hold two other roles, that of the Caldicott Guardian responsible for protecting the confidentiality of patient information ensuring it is shared within the Caldicott Principles and that of the Responsible Officer overseeing the professional performance and fitness to practice of doctors working in the organisation. The role of the Responsible Officer is a statutory role.

26. I work closely with the Chief Nurse across the entire quality portfolio, leading on Clinical Audit, the implementation of National Institute for Health and Care Excellence (**NICE**) guidance, Learning from Deaths, Suicide Prevention, Medicines Management, and Mental Health Legislation.

27. Following a restructure of the Executive Team in 2023, I continued as Medical Director, while a Chief Operating Officer role was introduced on 1 June 2023. The COO took on the operational role aspects that were previously performed by the operational Executive Directors, including me in my previous capacity

as Director of Forensic Services.

28. The Inquiry has asked me whether performing both the Medical Director and Director of Forensic Services roles concurrently gave rise to any challenges in fulfilling both roles. My overall view is that, while this would not have been ideal as a long-term arrangement, it did not give rise to challenges in fulfilling both roles.

29. In terms of capacity during the period from May 2021 to May 2023, when I was undertaking the two executive roles, as Director of Forensic Services I was supported by a full time Deputy Director of Forensic Services. They carried out the operational oversight, and I carried out the strategic oversight and external stakeholder relationships, e.g. with other high secure hospitals. Each discrete clinical service had a General Manager and a Clinical Director and during 2021-22 we introduced the triumvirate model of leadership across the forensic services with investment into additional senior nursing capacity at each level.

30. As Medical Director I was supported by an Associate Medical Director for each Division, also by a Director of Medical Education, a Chief Psychological Professions Officer and a Chief Pharmacist.

31. As such, in the shorter term, there was, in my opinion sufficient capacity and capability put in, particularly in the forensic clinical services and leadership.

32. I was subsequently appointed Deputy CEO in October 2023 and in the absence of the CEO, I lead the organisation. Part of my role as Deputy Chief Executive Officer also includes representing the Trust at regional and National forums and NHS strategic events.

33. In my role as Deputy CEO, I am the Senior Responsible Officer (SRO) for the Governance Programme within our Integrated Improvement Plan, and I line manage the Director of Corporate Governance.

The Trust's Governance

34. While aspects of the Trust's governance have changed over the time I have been employed at the Trust, many of its core features have remained constant – reflecting the requirements of its statutory status as a foundation trust. This is described in detail in Part A of the Trust's Corporate Witness Statement [**WITN0133001**].

35. In brief, however, I would draw out the following aspects.

36. The Board (described in detail at paragraphs 46-56 of the Trust's Corporate Witness Statement) is a unitary board, comprising seven executive directors (including the CEO, myself as the Executive Medical Director and Deputy CEO, Chief Nurse, Executive Director of Finance, Executive Director of People and Culture, Chief Operating Officer (COO), and Executive Director of Partnerships and Strategy) and eight non-executive directors, with one non-executive post currently vacant. The titles for some of these roles have changed during the time that I have held executive responsibilities, with the establishment of the "COO" role in June 2023 being a key change, as I have already explained.

37. The Trust's governance structure as at the current date is set out in picture-form at paragraph 38 of the Trust's Corporate Witness Statement.

38. Each executive director has specific roles and responsibilities associated with their role, as I have described above in relation to those roles I hold (or, in the case of Director of Forensic Services, previously held).

39. Foundation Trusts are required by the National Health Service Act 2006 (NHS Act 2006) to have a Council of Governors, elected from amongst the membership and comprising of local people, patients, carers, and staff. The role of the Council of Governors is described in the Trust's Corporate Witness Statement. As an Executive Director, I am not a member of the Council of Governors, but I am in attendance on occasions, sometimes in my role as deputy CEO, on behalf of the CEO, or in my role as Medical Director to contribute to the discussions and development sessions.

40. The Board is supported by a number of committees, each chaired by a non-executive director and accountable directly to the Board. These committees provide detailed scrutiny, assurance and oversight across key areas of governance on behalf of the Board. Again, the committee arrangement has changed over time, as described at paragraphs 62-76 of the Trust's Corporate Witness Statement.

41. As Medical Director I am a member of the Board and Executive Team (as I have explained, the Forensic Director role was also an Executive Board-level role). I was and remain a member of the Quality Committee, the Finance and Performance Committee, the People and Culture Committee and the Mental Health Legislation Committee, (which is being separated from the Quality Committee in November 2025, following approval at the September 2025 Board. **[WITN0356004, WITN0356003]**. I have focussed in this section on those committees that I have personally had a key role on.

Operational executive oversight as Director of Forensic Services and Medical Director

42. As an operational executive from 2020, my role/responsibility was to work with the Trust Board to set the strategic, long-term goals for the Forensic Division and provide assurance on the operational delivery of those goals and the services within the Division. As Medical Director from 2021 onwards, my role was also to bring the quality challenge and perspective into each committee, for example, at the Finance and Performance Committee, I ensure that the clinical challenge and impacts from a quality perspective are considered. We have a quality impact review process to support this (quality, equality and sustainability impact assessment process) so that the clinical perspective in terms of impact on patients, carers, families and colleagues are considered; and if sufficient mitigations are in place or can be put in place to manage the identified risks.

43. At the Quality Committee, I provide assurance on quality functions in my portfolio and contribute to the committee discussions on impacts and assurance. Staffing is a good example; in Quality Committee the discussion would focus on safer staffing and the quality impact of the people metrics such as patient safety and experience.

44. At the People Committee, when considering staffing, the focus is on people metrics such as sickness, turnover and vacancies. Committees can refer issues to each other, and the chair of the Quality Committee is a member of the Finance Committee, again supporting the ability to triangulate issues.

45. Operational Governance is the remit of the Executive Team and its associated meeting structures, supported by the Care Group structures (explained in 78-87 of the Trust's First Corporate Witness Statement).

Changes in governance during my tenure at the Trust

46. One aspect of my role as a leader is to emphasise personal and organisational responsibility, across the Forensic Division when I was the operational Executive and now across the Trust as the Medical Director and deputy CEO. Governance is the mechanism to hold individuals and teams accountable. I think that leadership and governance are interdependent and the following section sets out my views about the leadership and governance changes during my tenure at the Trust. Each subsection addresses the chronological change.

47. Earlier in my time at the Trust, I perceived a degree of defensiveness within the organisation when challenged, which at times limited openness and learning. This has shifted considerably. There is now a much stronger culture of constructive challenge, reflection, and continuous improvement across both Executive and Non-Executive members.

Executive leadership and governance

48. Since joining the Trust in 2020, I have experienced a period of significant organisational change and leadership transition. During this time, I have worked alongside three Chief Executives, four Directors of Nursing, three Finance Directors, and seven Trust Secretaries/Directors of Corporate Governance. These changes, referenced in my Theemis interview **[TCLT0000810 pp.3-4]**, reflect a phase of instability that inevitably, in my view, affected executive cohesion. However, since late 2022, the executive team has stabilised, establishing a consistent membership that has developed into a more cohesive and effective leadership group in my opinion.

49. In 2020, Executive Directors tended to operate within the boundaries of their own portfolios, with limited cross-portfolio challenge or discussion at committees or board. Non-Executive scrutiny was often focused on individual issues rather than having the systems to look at wider thematic learning and assurance. The change from three operational executives to one Chief Operating Officer (COO) plus the governance changes; in my view, have contributed to the positive changes that I describe. Through increased stability, structured Board Development Days, and shared learning sessions — for example, on Patient Safety Incident Response Framework (PSIRF), the Integrated Performance Report (IPR), Freedom to Speak Up, and the CQC Single Assessment Framework **[CQCM0016438]**— the culture has matured.

50. Prior to the current Chief Executive Officer coming into post in December 2022, meetings of the ELT were not minuted. Papers were presented for information and decision making, with decisions being recorded on an action log. With the governance changes, ELT has formally become the operational assurance meeting, there are formal minutes and agreed escalations in real time. With the Accountability Framework, this also guides what must come through ELT

either for assurance or escalation.

51. The governance work and restructure of the Executive Team were key to addressing issues. Even the conscious decision to change our services from divisions to care groups has contributed to the change in direction.

Divisional leadership and governance

52. Between 2020 and 2022, operational oversight of Trust services was delivered through divisional structures, with Executive Directors responsible for their respective areas. When I joined the Trust in 2020, a devolved leadership and governance model operated across three divisions (now care groups). This meant that in practice the divisions oversaw their own performance and decided what needed escalating, without one overall governance model and framework. So, each division had its own meeting structures, agendas and ways of working. While such a model can be effective, it lacked the necessary frameworks and principles to function optimally at that time.

53. In my opinion this separate operating model by division led to inconsistencies in a number of areas, including escalation triggers and levels of risk appetite. Without a clear framework, such as the accountability framework, now in place, individual divisional variation would have occurred. It also, in my opinion, was a driver behind the Trust's repeated feedback of not learning and not learning wider than an individual service or division. The sign off for example of SIs, was variable as to at which management level it should be done, and again this led to variable escalations in the governance structures. This was shown in the External Review of Serious Incidents by Helen Collins, as set out in the Corporate Witness Statement. [**NHFT0000423**]

54. This led to a lack of cohesive model for governance across the Trust. This contributed to silo practices including perpetuating the inability to share and

embed learning outside of each division. The flow from ward-to-board could not happen and from a helicopter view, it was therefore difficult to have complete overview of all trust services.

55. In respect of [**TCLT0000347** pp.4-5, 7, 16-17], this separate operating model by division was the model that was in place when I started as an executive director in the Trust. I also recall that the divisional autonomy and culture was very evident when I first worked in the Trust as Consultant Forensic Psychiatrist at Rampton. I am not clear whether that was a decision taken by the leadership team at that time or a culture-driven model. Each division essentially ran and undertook its operational governance itself led by the Divisional Executive Director.

Forensic Division leadership and governance

56. As Director of Forensic Services, I considered that the governance in my division needed to be reviewed, and therefore, in July 2020, I commissioned a review of the governance for the Forensic Division. My opinion was formed on the basis of having worked in other organisations at an executive level and experiencing good governance in practice and in particular the fact that a lot of information was presented at a trust wide level, which had not been seen by the forensic management team, so did not have the ward to board flow in practice in the division. Significant work was done to review all of our meetings and structures, develop consistent agendas and forward plans and structures [**WITN0356005, WITN0356006**]. All of the forensic services senior management teams were involved, as each service was keen on a consistent approach. It was also vital, as some information was being presented at sub-board committees that was not familiar to myself as the Director. In my opinion this was linked with the decision to centralise some governance functions and therefore centralise data reporting, rather than a true ward-to-board flow where the data informs upwards and downwards in the structure.

57. A report was prepared following that review which identified a number of challenges within the governance systems at a divisional and directorate level. [**WITN0356005**].

58. In December 2020, I commissioned further work to look at the governance and risk management approaches in the directorates within the forensic division. The work agreed was as follows:

    a. Advise, support and guide the five directorates in the development of their governance in line with the division's view of governance.
    b. Advise, support and guide the directorates in reviewing and refreshing their risks, understanding how their risks work and the impact of risk on their governance structures.
    c. Support the directorates to articulate their risks in the format preferred by the division.

59. This work commenced in January 2021. [**WITN0356007, WITN0356008**]

60. I periodically described this work in the Executive Leadership Team during the last six months of 2020.

61. One source of independent assurance incorporated into Trusts' governance is its Annual Internal Audit Plan, which is signed off by the Board. Operational divisional governance was included in the 2022 and 2023 Annual Internal audit plans [**WITN0356009, WITN0356010**] and significant assurance was given for the Forensic Division and the Community Health Division in February 2022.

62. The Mental Health Division received limited assurance in March 2023 from internal audit [**WITN0356011**], noting the lack of trust governance framework and inconsistent processes across the directorates (clinical services). This supported the need to further review governance Trust wide, which is one

of the 5 key programmes in the IIP started in 2024.

Trust wide governance

63. As a direct response to the CQC 2019 inspection which noted under the well led section, "The board assurance framework included a number of risks that were considered to be high impact risks", **[NHFT0002015]**. Part of the 2020-21 Trust wide governance work involved a full review of the Board Assurance Framework. These changes were considered by the Board throughout 2020 **[NHFT0000827**, p.189], **[NHFT0003812**, p.61] **[NHFT0002584**, p.10], **[NHFT0003222**, p.12]. By December 2020, each strategic risk in the BAF was assigned to a Lead Director as well as to a Lead Committee, to enable the Board to maintain effective oversight of strategic risks through a regular process of formal review.

64. As part of the response to address these issues, Accountability Review meetings of the Divisions and Corporate Services started in 2022/23 chaired by the Chief Executive Officer.

65. Building on the Accountability Reviews; in 2023, the Trust introduced an Accountability Framework in 2025 **[WITN0263018]** and a clear governance structure distinguishing between operational governance (through the Executive Leadership Team (ELT)) and assurance governance (through the Board and its committees). Accountability Meetings with each care group and corporate services have been further developed and are now chaired by the COO using the accountability framework to run alongside Quality, Performance, and Finance meetings, providing a robust mechanism for oversight and escalation.

66. Alongside devolved divisional leadership, some key governance and operational functions had been centralised pre my return to the Trust in 2020,

including the Mental Health Act (MHA) team and Medicines Management governance. In my capacity as Medical Director, during 2021/22 I aligned my Associate Medical Director (AMD) areas of responsibility in the divisions with those of the Medical Director for medicines management and mental health legislation to show the flow of accountability. This alignment supported the implementation of the triumvirate leadership model—embedding operational, medical, and nursing leadership at care group level. To enhance local accountability, I also established divisional Medicines Optimisation Groups (which focus on safe, effective and appropriate use of medicines) and Mental Health Legislation Groups (which oversee compliance with the Mental Health Act), beneath the Trust wide governance to operationalise and oversee the actual work in the divisions with clear reporting agreed then to trust wide and then to quality committee and through to board. These divisional groups report upwards through the care group triumvirate to the Trust-wide Medicines Management Committee and Mental Health Legislation Committee respectively, which in turn report to the Quality and Mental Health Legislation Committee and ultimately to the Board.

67. The CQC inspection report of 2022 **[CQCM0016478]** recognised significant governance improvements made since 2019, but it was clear that further work was required to embed these processes sustainably. This work has continued through the Integrated Improvement Plan (IIP) from 2024 onwards **[NHFT0003275]**. Paragraphs 78-125 of the Corporate Witness Statement set out these changes and the Care Group model in detail, and therefore I have not repeated that here.

68. In my role as deputy CEO, I am the Senior Responsible Officer for the governance programme of the Integrated Improvement Plan started in 2024 **[NHFT0003275]**. As part of this work, we have fundamentally reviewed with the 3 care groups and the corporate services, all of the governance structures.

We have agreed the same key meetings and structures and agendas across all 3 care groups. There has been a full review of Board and sub-Board committees re agendas and forward plans, and People Committee has become People and Culture Committee, Finance Committee has become Finance and Performance Committee and a separate Mental Health Legislative Committee is due to separate from Quality Committee in December [**WITN0263014**]. There were key workstreams for each of these aspects and the data workstream has developed coproduced data packs for each care group, so the data will be analysed through the care units up to the care group then up to the Board Assurance. Operational oversight has also been reviewed and a new Accountability Framework approved and embedded through Accountability Meetings.

Clinical leadership

69. There have also been significant changes in the clinical leadership across the Trust over the last 2 years. Prior to that, a quiet clinical voice in clinical services and care groups was noted and 5 additional Senior Nursing roles in the form of Care Group Directors of Nursing were introduced in 2023/24 linked with the patient safety team changes. As Medical Director, I aligned my Associate Medical Director roles and responsibilities with mine and worked to embed the triumvirate leadership model, and we have increased by 2 additional AMD roles mirroring the Care Group Directors of Nursing structures to align and increase capacity. Also, the line management of the Clinical Directors was formalised as being through the medical management hierarchy, as previously in the MH Division these had been managed through the Executive Operational Director.

Quality leadership and governance

70. Prior to 2024, quality performance and assurance were primarily overseen

operationally through Quality Operational Group (QOG), a sub-group of the Quality and Mental Health Legislation Committee (Q&MHLC). The QOG consolidated divisional intelligence, triangulated key indicators from the Integrated Performance Report (IPR), and escalated matters to the Q&MHLC as appropriate. [**NHFT0000736**]

71. The Q&MHLC [**WITN0263014**], chaired by a Non-Executive Director, provided Board-level assurance on governance, patient safety, and compliance with mental health legislation. Supporting groups, including the Mental Health Legislation Operational Groups (LOGs) and specialist sub-groups such as Serious Incident Review and Learning from Deaths, provided additional assurance but often operated in isolation. During this period, the limited cross-divisional triangulation sometimes restricted the Board's overall view of service performance.

72. A major area of development has been patient safety governance. In late 2023 the Trust undertook a full review and restructure of the patient safety function and team, resulting in the creation of 12.7 additional whole time equivalent (WTE) posts, an investment of £800,000 in 2024. This was funded through internal reallocation, not new investment. I am aware that, Diane Hull, in whose directorate the patient safety team sits, has covered the creation of this team has been covered in detail in her personal witness statement and in the Trust's Corporate Witness Statement. In brief, the changes have included reinstating key specialist roles such as Patient Safety Specialists, a Mortality Lead, Family Liaison and Complaints roles, a Duty of Candour Lead, and PSIRF reviewers. These were key roles to both support patients and families directly such as our family liaison colleagues who work directly with families from the point of death through the inquest and any other processes. The specialist skills these colleagues hold also supports the organisation to learn better from all incidents with patient safety specialists aligned to Care Groups and PSIRF reviewers with those specialist skills.

Data as evidence / tool to inform leadership and governance

73. Data quality and ward-to-board visibility were limited in the early years of my tenure. Much of the data presented to the Board and its committees during 2020–22 was generated at a corporate level, with limited triangulation from ward or service-level sources. The divisions were each at different stages of the development of a Trust designed "Ward to Board" live data system at that time.

74. The introduction of the Ward-to-Board dashboard was designed to bring together information at every level of the organisation. It joins Workforce, Operational, Quality and Finance data into one dashboard by team and ward then service. In 2022, the Mental Health Division had co-produced the metrics such as number of referrals, discharges, average waiting times, cancelled appointments. It was then rolled out in the Forensic Division and is currently being developed in Community Health Care Group.

75. I think that data governance has been significantly strengthened over the last five years. As part of the Governance Programme there was a data subgroup. Each Care Group now has an agreed data pack, co-designed with clinical services to ensure relevant and meaningful indicators are monitored. Work is underway to develop Care Unit data packs to embed data-driven decision-making at every level. Triangulation of data now occurs routinely across the Integrated Performance Report, committee reports, and through executive and non-executive visits to clinical areas.

76. The Integrated Performance Report itself has been comprehensively redesigned, informed by feedback from the Recovery Support Programme (RSP) colleagues, Developmental Well-Led Review and ongoing work with the RSP team sharing examples of good practice. For example,

triangulation refers to the use of multiple data sources in order to develop a comprehensive understanding of the situation. An illustration of triangulation is in the IPR [**WITN0356012**] that identifies the increasing number of clinically ready for discharge patients and the corresponding reducing AMH inpatient flow. This can then causes the use of independent sector beds and an increase in 12-hour ED breaches. As a result, there is a reduction in Liaison Services performance. There are 6 actions identified to improve this situation.

77. This work reflects the Trust's ongoing commitment to building a mature governance system that supports both assurance and continuous improvement. More detail on the Integrated Performance Report is at paragraph 55 of the Corporate Witness Statement.

78. We now use significant triangulation of data into the IPR and between committees and visits to clinical sites by non-executive and executive directors for example.

Board leadership and governance

79. I have worked within the Trust since 2020, during which time I have observed significant changes in both leadership composition and the quality of relationships between Executive and Non-Executive Directors.

80. As stated, in my first two years in post, frequent changes in executive leadership created challenges in maintaining consistent relationships and a shared sense of direction. During this period, in my experience, Non-Executive Directors (NEDs) appropriately challenged the Executive team at Board and subcommittee level but given the inability to triangulate data, the governance structures and the culture, the challenges and responses tended to be quite brief and single.

81. Over the past three years, in my view there has been a notable improvement in the quality and effectiveness of Board discussions. Enhancements to the governance framework, particularly the development of a more robust Board Assurance Framework (BAF) (as described above) and the redesign of the Integrated Performance Report (IPR), have enabled data-driven and evidence-based challenge. This has strengthened the ability of both Executives and NEDs to focus on assurance and improvement rather than interpretation.

82. From 2025, oversight has been strengthened through the Accountability and Performance Framework [**WITN0356013**], establishing clear lines of accountability from ward to Board and integrating data across quality, safety, performance, workforce, and finance. Further detail regarding the Accountability and Performance Framework can be found at paragraph 130 of the Corporate Witness Statement.

83. The Trust introduced the "SafeNow" dashboard [**NHFT0001252**] in 2024, enabling daily review of inpatient, community, and crisis services within clinical teams, escalated through Care Groups to the ELT and the Quality Committee. Further detail on the SafeNow dashboard can be found at paragraphs 521-526 of the Corporate Witness Statement.

84. Performance oversight now follows a structured tiered model: daily ward and team huddles, weekly Care Group leadership review, monthly Accountability Group oversight, and ELT scrutiny, with findings reported to Board Committees.

85. In 2025, the Finance Committee assumed [**WITN0356014**] responsibility for operational performance. Over previous years other sections of the IPR were reviewed at the relevant committee such as Quality at Quality Committee, Finance at Finance Committee and People at the People Committee. The

performance section went straight to Board in the IPR with no scrutiny in sub board committee. This change means that there is the ability for much more detailed scrutiny of performance before going the full IPR is presented at board

86. As I have explained in my statement, since 2023, governance has been significantly strengthened, replacing fragmented reporting with an integrated system linking frontline delivery to strategic oversight. Care Group structures and standardised accountability processes have improved consistency, transparency, and timeliness of assurance. As a result, the Board receives timely, triangulated assurance, with structured escalation pathways and enhanced visibility of service delivery, supporting the provision of safe, effective, and sustainable mental health services.

87. Over the last two years in particular, there has been a clear shift towards a unitary Board approach from my perspective, displayed with more levels of challenge from non-executives and executive directors, the ability to better triangulation quantitative and qualitative data, and a shared commitment to improvement and transparency. These changes show the improved governance to support robust assurance, openness, and collective accountability for quality, performance and finance.

Escalation routes that inform leadership and governance

88. As previously stated, single operational governance models in each division, in my view, contributed to the variance in reporting upwards, the inability to easily interrogate data and triangulate it and the inability to then see a Trust wide view of all of the services. Single models also lead to different cultures and again in my view would be linked to different levels potentially for escalation.

89. Today, concerns regarding the care delivered by the Trust can be formally escalated through our defined governance pathways. The concerns raised are

reviewed at Care Group level, then escalated to the Executive Leadership Team (ELT) where appropriate, and, if required, referred to the Quality Committee, Audit and Risk Committee, or Board of Directors.

90. There is also regulatory and system oversight, including feedback from the CQC, NHS England, and the Integrated Care System and Board.

91. For operational escalations, as Medical Director, my Associate Medical Directors escalate concerns for information or support, as part of the care group triumvirate leadership team (Care Group Director, Care Group Director of Nursing and Associate Medical Director) and Clinical Directors also directly escalate as part of the Care unit leadership teams. Depending on the issue, other members of the care group leadership teams also directly escalate to me or through the medical line management structure.

92. Other mechanisms include patients, families and carers reaching out directly to me as Medical Director. Using the Freedom To Speak Up Guardian route is another way. In my role as Caldicott Guardian ("CG"), concerns about access to information are escalated to me via a specific CG email or through the information governance team.

93. As Medical Director one significant route of escalation is directly by medical colleagues.

94. We have consultants, Specialty and Associate Specialist (SAS) doctors, and resident doctors (formerly junior doctors) leading and working in our clinical services and a variety of forums, both formal and informal where concerns or issues are raised. I hold Medical Q+A sessions and briefing sessions such as when the section 48 review was announced to engage proactively and hear their experiences and to share updates on the IIP work.

95. I am actively engaging with resident doctors are on the national 10 point [**WITN0356015**] plan work for resident doctors and their experiences of our clinical care and their training. We have a Guardian of Safe Working for resident doctors with regular resident doctor forums. We have SAS advocate, Tutor and British Medical Association (BMA) Representative roles.

96. The Trust also have two Medical Staff Committees that myself and executive colleagues attend on rotation or dependent on the issues. [**WITN0356016**] Key Medical Leadership colleagues also attend these forums.

97. We have a Joint Local Negotiating Committee [**WITN0356082**], which whilst it relates more to terms and conditions, issues of concern can also be escalated. A good example of this, has been staffing at Rampton Hospital, in early 2025, which was escalated by medical colleagues through a range of routes including directly with the CEO and myself and we met to understand and address the concerns and provided data and were keen to work collaboratively with medical colleagues' suggestions. Staffing at Rampton is extremely complex to manage due to the nature of the conditions of the patients, and issues are brought directly to me by the clinicians who work there in order for them to be escalated and supported rapidly.

98. Concerns can be escalated to the Council of Governors and there are key professional representatives, so for example issues can be raised to the medical consultant member or the Chair who will then escalate that in the appropriate way.

99. Key stakeholders and relevant bodies, such as MPs, Healthwatch, Health Scrutiny Committees and The Coroner will escalate concerns or queries to myself or the relevant lead director. As executives we all work closely together to understand concerns raised in order to address them and have a clear

commitment to that. An example would be concerns raised through Nottingham City and County Health Scrutiny Committees, and ensuring timely responses to any escalations with a real focus on what is the impact for people using and needing our services.

100. Another example that as Medical Director I specifically heard, was concerns raised through the Inquest process in 2021. The Director of Nursing and I arranged to meet with the Nottingham Coroner and colleagues regularly to gain understanding of the concerns and share what we were doing such as work around risk assessments and our crisis team model. [**WITN0356017**]

101. The Senior Independent Director (SID) provides an additional route for escalation and support in situations where concerns relate to the Chair or where stakeholders require an impartial escalation route. The SID is accessible to Governors, executives, staff and members of the public if conventional channels are not appropriate or effective.

102. We have held over 90 "Big Conversations" with over 2000 colleagues since 2023 and are now on the 2nd or 3rd return to some clinical and corporate services. These are a rich source of information from a wide range of colleagues who share their views in this executive led space.

103. There is also a monthly executive open forum, where colleagues are invited to ask questions and also share any concerns. An example of a concern that was raised, was the national announcement of all Trusts needing to reduce any growth in corporate workforce and the impact that could have for colleagues. A separate forum was arranged to specifically discuss and listen to those colleagues.

104. I do consider that the wide variety of routes of escalation are

effective, particularly as this ensures as many routes are available depending which one patients, colleagues and stakeholders feel most comfortable using. In my opinion, historically escalations have occurred, but the governance structures, data and culture that were linked with the then inability to triangulate, learn beyond one area and address systemically rather than reactively that prevented these from being actioned appropriately.

Mental Health Division / Care Group

105. Since returning to the Trust in 2020, concerns have been raised about the adequacy of mental health services, including in the CQC Inspections of 2019, 2020 and 2022 [**NHFT0002015, NHFT0001778, CQCM0016478**].

106. The main themes from the variety of formal and informal routes have been:

a. Patient safety and risk management – including variation in care planning, risk assessment compliance, observation practice, and therapeutic engagement that relate to individual patients care. In addition, the various reports into the care and treatment of VC also reference concerns around how well individual risk assessments reflect the risk an individual poses to the wider community.
b. Access and capacity – most often within crisis services but in other local mental health teams as well, inpatient flow, and specialist mental health pathways.
c. Workforce resilience – recruitment, retention, and safe-staffing pressures affecting service continuity.
d. Governance and data quality – the need for stronger integration of quality, performance, and risk intelligence.

107. These concerns were raised by frontline staff, patients and carers, regulators, and system partners such as the ICB and Primary Care.

108. In August 2023, following the tragic events involving VC, the executive team considered it necessary to seek external assurance on the adequacy of specific mental health services. These have been described in detail in paragraphs 496-507 of the Corporate Witness Statement and I do not propose to repeat that here.

109. As a member of the Executive Team I was involved in agreeing the terms of reference and oversight of the recommendations. From a Medical Director perspective, there is a theme around the medical capacity across the community and specialist teams. In response we have been doing significant demand and capacity work. Unlike safer staffing, there is no national tool for medical workforce planning or oversight. We have done medical workforce modelling for all of our adult mental health inpatient wards and have implemented a multiprofessional model. For the community mental health services this is being reviewed within the community care pathway redesign work to ensure there is sufficient psychiatrists in each team to also focus on time for leadership.

110. In response to concerns and findings from internal and external sources, the Board and the Executive Team have taken clear action to strengthen the safety and capacity of mental health services. I am aware that in his witness statement, Ifti Majid has set out these key actions, and I do not propose to repeat them here. I do note that a recommendation from the EIP review **[NHFT0000461]** was to introduce dedicated consultant input into the EIP team, rather than sessional input from doctors. This is an ongoing piece of work and we hope for this to be in place by Spring 2026. This work is progressing as planned.

CQC Reports

CQC Report May 2019

107. The Inquiry has asked me to comment on the CQC reports published in relation to the Trust between 2019-2022 **[NHFT0002015, NHFT0001778, CQCM0016478]**. As described at paragraph 183 of the Corporate Witness Statement, the Trust's CQC compliance team has overall oversight of CQC activity and this is led by the Chief Nurse. I note that when I joined the Trust, an Action Plan was already in place for the 2019 CQC report **[NHFT0002354]**. Action Plans for CQC reports would have been reviewed and reported through the Committee and Board structures and I would have had appropriate insight and assurance through these meetings.

108. This is the report that I referred to in my Theemis interview that I had considered as part of my interview preparation for the role of director of forensic services. When I started in post in June 2020 as the Director of Forensic Services, I was particularly focussed on the elements of the action plan pertaining to forensic services. The 2019 inspection had rated forensic services as inadequate for safe, good for effective, good for caring, requires improvement for responsive and requires improvement for well led and for overall, which had been a deterioration.

109. There had been an inspection at Rampton Hospital in July 2019, rating it inadequate overall, which I had also reviewed **[NHFT0002015]**.

110. Key must do areas for forensic services included staffing and governance. There were others, but I will focus on these two as they were similar themes to the trust overall findings and in adults of working age and PICU.

111. Recruitment and retention was also a major part of the work I led in forensic services with challenges across all of our services including High Security.

112. I worked closely with my deputy director of forensic services and the forensic Associate director of nursing (title at the time) to identify strategies for the different units as the challenges varied. We started to introduce a wider variety of roles including peer support workers to pilot.

113. As described in the overall governance section of this statement, a large element of the work I lead was to review the governance structure in the forensic division. This was a complex piece of work. When I started there was limited flow of information from wards/services through the division to our Divisional Management Team, so the governance review and implementation completely changed that, so we would have oversight of all areas across the division which then enabled me at Trust wide governance meetings to escalate and present clear actions and assurance. This also included significant work on our data across forensic services to identify meaningful metrics, rather than the previous focus on hospital occupancy figures and hours of activity undertaken by patients.

114. Another significant action I led was for us to improve the issues highlighted about clinical involvement and engagement in the forensic division. At that time I was not the Medical Director, but as the Forensic Divisional Management Team we made a clear strategy to focus on our internal relationships but also to work more closely with the other High Secure Hospitals for example, which had not always been the case.

115. In terms of some of the Trust wide findings, as a member of the executive team, we oversaw the work around well led. I have already highlighted that whilst there was a plan to build and maintain a consistent executive team, this was not possible in practice due to a mix of retirement and personal plans between 2020-22, which was an issue sighted in the 2019 report, about executives lacking the confidence to act with interim chief executives in post.

116. A review of the BAF was carried out under the remit of the corporate

governance lead and the chief executive, which I have described earlier in the governance section.

117. The then chief executive commissioned an external developmental well led review [**WITN0356018**].

118. During 2020, the Director of Nursing provided a regular CQC Response and Preparation update on the board agenda.

CQC Report September 2020

119. This was a focussed inspection of acute adult wards and PICU in July 2020 published in September 2020 [**NHFT0001778**]. The findings in particular noted the impact of the recent nursing staffing establishment reviews, and that there was sufficient staff to meet needs and that bank and agency staff were used whilst recruitment was underway for the increased band 6 posts.

120. There continued to be a CQC response and preparation report to board.

CQC Report November 2022

121. This inspection was unannounced and visited three mental health services, last assessed in 2014 (long stay psychiatric rehabilitation ward, older adults wards, older adults community teams) and four community health services, last seen in 2018 (end of life, inpatients, children, adults).

122. There is specific mention of the lack of progress on eradicating dormitories [**CQCM0016478**]. As an executive team and board, we discussed this as there were significant additional unexpected costs in one of our major capital projects to reprovide our adult mental health wards. So Board had to take the decision to delay implementation of plans to address the requirement to eradicate dormitories because of the unexpected costs that had occurred in another major capital project to have new adult mental health wards. This work remains ongoing.

123. In terms of some of the other findings, as Medical Director I was the SRO for our electronic prescribing programme, which was required to roll out at pace. I led on this and whilst we continued to roll it out across inpatient areas, this became part of our major digital programme in the IIP, Digi-Care, which I am also the SRO for. We are on track to complete digital prescribing in all of our inpatient areas by mid 2026 [**WITN0356019**].

124. I led on reviewing the Quality Impact assessment process and over the last 2 years, this has developed into a multiprofessional panel oversight with dynamic monitoring and bringing back the assessments, in addition these are overseen at Quality Committee and other committees such as Finance and Performance Committee incorporate them into the discussions as appropriate.

125. The CQC also commented on the Trust's governance, which is relevant given my earlier responses regarding governance. The improvement in the use of the BAF and organisational risk registers was noted but the need to embed the divisional governance in community health and mental health services was needed. This work has been taken forward as described earlier in my statement and in the Trust's Corporate Witness Statement through the creation of the Care Group arrangements and associated strengthened ward to board governance.

126. Issues with medicines management were highlighted and a number of actions were put in place including the roll out of electronic fridge monitoring (we are currently having to reprocure a new system). As I have described under governance earlier, I aligned the oversight of medicines management in the divisions (now care groups) through the AMDs and introduced divisional medicines management groups to have divisional ownership. As part of the IIP work I requested an external review of our medicines management governance and team structure and functions which supported the changes I had made [**WITN0356020**].

Why was the Trust still being rated as 'Requires Improvement' over a 3 year period?

127. I consider that there are a variety of reasons and context surrounding these reports. Returning to work in the Trust in the midst of Covid, clearly the pandemic had a major impact. The focus on maintaining public, patient and staff safety and changing how services were delivered literally within sometimes a couple of hours, with daily changes in a command and control situation was the focus. That is not to say that there was no work to address the failings, but clinical staff were redeployed wholescale out of corporate services (on a national basis) and maintaining core services with distancing and the required PPE/IPC all had impacts. The national guidance was to review governance, for example, and make it as light touch as was appropriate. Having worked clinically also during Covid, I professionally witnessed the level of fear for life that was felt by patients and staff during this period.

128. Closed cultures are important, and considering the level of isolation that was required during Covid, that in itself drove a 2 year period of closed cultures, which coming out of cannot be underestimated.

129. The Theemis report [**TCLT0000818**] noted that since 2019 there have been several factors that have influenced the quality and assurance of information provided to the Trust Board. Theemis heard evidence that the quality of the papers was poor and committees listened to presentations without challenge, accepting what was presented. They made note that there were attempts to address these issues, but the Covid pandemic stopped the progress.

130. I returned to work in the Trust in June 2020, so had experienced the initial impact of Covid working in another combined mental health and physical health trust. I would agree with the view expressed in the Theemis report that the pandemic slowed progress in addressing governance. This absolutely was the case, because as a health care executive, directives were given nationally and

Trusts set up incident response centres to co-ordinate the local responses.

131. The focus was absolutely on preserving life, and in my view that has been somewhat lost over time. We had clinicians redeployed from corporate and any non direct facing functions, literally overnight. Governance was approved to be light touch and in hindsight reviewing the board papers for example in 2020, there was such focus on Covid planning, impact and reporting.

132. The Covid restrictions meant all meetings were carried out virtually and the usual leadership visibility was changed to focus on protecting service environments by limiting foot fall for colleagues and patients.

133. It is also important to highlight the impact of covid and the impact of the isolation, with the increase in need for mental health services.

134. In my view, this context was one element of why some of the required improvements were not made at the speed we would have wished to be able to. However, there are other factors that I have mentioned such as the governance which has been completely reviewed. The lack of ward to board data made oversight complex but the context also made change difficult to implement in terms of decision making, which is why we have now got the Accountability Framework and a clear operational structure. The basics needed to be right for the learning to lead to major changes.

135. I have already described the silo operational and governance models, which in my view were significant contributors to the different cultures across the 3 Divisions.

136. The more recent events have also had the consequence of again a more control and command approach being taken across the organisation to ensure the pace of change that has been needed. This has been felt by colleagues and the importance moving forwards of maintaining the pace and improvements in a sustainable way will be vital for the culture of the

organisation to improve.

137. In general, we would have wanted to focus on the cultural work needed across the organisation, which would have then led to codeveloped solution. This was not possible given the speed and need for change, so we had to accept the need to do many transactional , ie must do, actions then focus on the cultural work as part of the longer term work to embed the changes and continue to improve.

Integrated Improvement Plan

138. The Integrated Improvement Plan (IIP) was developed in 2024 in response to a number of external assessments including the CQC Section 48 Review **[CQCM0016517]** and to meet the criteria for exiting segment 4 of the NHS England National Oversight Framework **[NHNB0018961].** The legal undertakings we received also specified developing an IIP.

139. Historically there were separate action plans for each assessment for example a specific CQC Action Plan for each inspection. It was discussed and agreed that it would be more appropriate to bring all elements and actions together in a way that would be clear for the organisation and key stakeholders and also for assurance.

140. As part of the executive team, I was involved in the development of the IIP. The executive team reports progress against each main programme through an Integrated Improvement Plan Portfolio Board chaired by the CEO **[WITN0356021]**, and then this reports to the Integrated Improvement Committee **[WITN0356022]** chaired by the Chair which then reports to the Board. There is also oversight at our Regional Improvement Oversight and Assurance Group (IOAG) **[WITN0263028]** chaired by the NHS England Regional Medical Director and the Chief Executive of the Nottingham and Nottinghamshire Integrated Care Board. In terms of signing off the evidence to support having delivered and sustained each individual metric, there is an

externally convened panel.

141. In terms of developing the IIP, initially all required actions from learning across the organisation were collated, including from prevention of future deaths reports (PFDs), CQC outstanding actions and other regulators, serious incident investigations (SIs), staff survey feedback, and actions to support the relicensing of Rampton Hospital. Through discussions with NHS England and the NHS Recovery Support programme colleagues, it was agreed that our first focus should be the most urgent regulatory requirements. This meant focusing on the Section 48 recommendations and findings, the CQC recommendations from inspections of Rampton Hospital and Adult and Older Adult Mental Health Inpatient Services, and the recommendations from the Themis Independent Homicide Review.

142. The IIP consists of 5 programmes:

a. Patient Safety and Quality Improvement Programme – focused on improving clinical safety, care standards, and service delivery across all settings.
b. Leading for the Future Programme – designed to build leadership capability and resilience throughout the organisation.
c. Finance and Productivity Programme – aimed at ensuring financial sustainability and improving operational efficiency.
d. People and Culture Programme – supporting workforce development, staff wellbeing, and the creation of a positive and inclusive organisational culture.
e. Governance Programme – strengthening internal controls, accountability, and decision-making processes to ensure transparency and effectiveness.

143. I am the SRO for the Governance Programme **[WITN0356023]** As SRO I chair and lead the governance programme board. We receive reports from the subgroups and direct specific pieces of work such as the roll out of governance

training across the care groups and the data pack work with the care groups. I work with the Chief Nurse on the Patient Safety and Quality Improvement Programme and also lead the Valuing Medical Leadership Project (in the People and Culture Programme).

144. In the Patient Safety and Quality Improvement programme a key workstream was on medicines management. As Medical Director i chair the Trust Medicines Management Group which oversees this work across the trust. We provide assurance via reports to the Quality Committee. Within the patient safety programme of the IIP, the first stage was to collate all outstanding actions regarding medicines management across the Trust into one place. We commissioned an independent review of medicines optimisation, governance, and pharmacy services was completed by an external expert, with the support of RSP colleagues and the final report was received in November 2024 **[WITN0356020]**. An action plan has been implemented to address the recommendations, including a review of governance arrangements and meeting structures, with ongoing monitoring of effectiveness. **[WITN0356024]** Work to deliver pharmacy service improvements has commenced and is a 5 year timeframe partly due to a need for significant investment.

145. In addition, a Rampton Medicines Governance Group has been established, reporting to the Forensic Medicines Governance Group, and a dedicated workstream aligned with Section 48 initiatives has digitalised oversight of High Dose Antipsychotic Treatment (HDAT) through development of a RiO monitoring form and an oversight dashboard, which will be rolled out trust-wide also. In the interim, mental health pharmacy services maintain a register of HDAT use to ensure oversight.

146. Regular prescription chart audits have been introduced across Local Mental Health Teams to provide assurance on compliance with prescribed treatment, and that appropriate action has been taken where non-compliance is identified.

147. The Trust has demonstrated a reduction in overall harm from medicines-related incidents despite increased reporting, indicating an improving safety culture. Following initial delays to the Electronic Prescribing and Medicines Administration (EPMA) rollout due to Windows 11 compatibility issues, accelerated implementation across remaining inpatient areas is now underway, supported by a strengthened delivery team to meet the revised schedule.

148. The Valuing Medical Leadership (VML) programme has established a lasting programme of strategic investment in clinical leadership. Through three major events in 2025, focused on leadership behaviours, quality improvement, and triumvirate working, the programme fostered a culture of collaboration and shared purpose across the organisation. These events will continue into 2026. Over sixty senior medical colleagues have engaged in a targeted three-day development course covering finance, data management, and strategic planning, equipping them to influence the trust's priorities with confidence and clarity. The formation of a dedicated VML leadership team has further strengthened the medical voice, bridging the gap between senior leaders and the wider clinical workforce. This initiative has laid the foundation for sustainable leadership, ensuring that medical professionals are empowered to shape the future of healthcare delivery in the Trust.

149. In summary, the Trust has made progress across all programmes, we have strengthened our governance, improved leadership capacity, strengthened patient safety protocols such as our waiting well and safe now dashboards. We have a patient reference group and a colleague reference group, which have been important in collaborating and testing out the plans.

150. At our second meeting with NHS England National Executive Team on the 6 December 2024 there was recognition of the significant progress made by the Trust since our RSP entry meeting. **[WITN0263036]** We had a review Board to Board meeting with the NHS England Midlands Regional Team on the 8 October 2025 **[WITN0263037]** where we were able to provide a significant level

of assurance about our IIP progress and discuss the various risks associated with the Trust current financial situation.

151. Improvements delivered through the IIP include:

a. Creating a stronger patient safety culture across the Trust with the full rollout of the Patient Safety Incident Response Framework.

b. Developing and implementing our "Waiting Well" process to make sure that all teams know how to and do oversee patients waiting to be seen or receive treatment. This means prioritisation can change if more urgent assessment or treatment is needed, within the confines of our commissioned capacity.

c. Strengthened risk assessment practices

d. Provide appropriate support for patients and families who have been identified to need the assertive outreach model work.

e. Design and implementation of the SafeNow Dashboard, which teams use to oversee their work with patients in real time.

f. Embedding a culture of family and carer participation. This is at a patient individual level through our care planning work through to at the strategic level of having an Associate Director of Participation, Co-production and Carer Experience with our Improving Care Together Plan going to Quality Committee in December 2025. This plan places a special focus on the Patient Carer Race Equality Framework (PCREF) which is a mandatory anti-racism framework launched by NHS England for all mental health trusts and service providers **[WITN0356025]**. Co-designed with patients and carers, it aims to tackle racial inequality in mental health services by improving equitable access, experience, and outcomes for people from ethnically diverse communities.

g. Achieved a sustained reduction in inappropriate out-of-area placements over 18 months.

h. Implemented a clinically led and operationally partnered model of

leadership through a triumvirate structure across Care Groups. restructure, moving toward a clinically led and operationally partnered model across all care units in the care groups.

i. Significantly enhanced and developed our clinical leadership capacity.
j. Optimised our support for clinical services and clinicians through our Digi-Care programme to get the best out of our electronic records and have clinical digital champions across the trust to be the clinical link into and out of services with digital colleagues.
k. Undertaking pathway redesign across Adult Mental Health Services, including Crisis, LMHTs, acute inpatient care, and services for older people.
l. Redesigned our trust wide governance framework, introduced an accountability framework and specifically changed our quality governance to ensure line of sight from ward to board to oversee patient care.
m. Improved Board oversight, with regular updates on CQC Section 48 undertakings, Theemis actions, and significant safety incidents.
n. Increased visibility through NED and Governor visits and approved a new Trust Accountability Framework.

Risk Assessment

152. There are a range of ways that risks are managed and overseen in the organisation. There are also different types of risks, which informs how each is managed.

153. At an individual level, operational risks are managed within the clinical and corporate services. As Medical Director I have operational risks around key areas for example, psychology vacancies, pharmacist vacancies, medical leadership capacity, mental health legislation and governance capacity. Operational risks have a Risk Owner and a Lead overseeing the risk actions, mitigations and risk level. These are dynamic in nature and are reviewed monthly within the Medical Directorate.

154. Operational risks are recorded in the Trust's Ulysses system across all levels. Each risk has an owner responsible for review and mitigation. Risks are scored using a 5x5 impact/likelihood matrix, with significant and extreme risks escalated to the Trust Risk Group and reported to the Board. The Risk Escalation Framework **[WITN0263054]** ensures timely escalation of unresolved or high-impact risks. Monthly reports highlight significant and overdue risks, reviewed by the Risk Group (chaired by the COO) and then reported to the Audit and Risk Committee and the Board.

155. Strategic risk management is about, what are the main threats and risks to our agreed organisational objectives as defined by our Strategy and Statutory Objectives. It focuses on risks that could compromise the delivery of the Trust's long-term goals — such as financial sustainability, regulatory compliance, workforce resilience, digital infrastructure, and organisational culture.

156. Risks are managed through formal governance structures, including the Board Assurance Framework and Corporate Risk Register, overseen by the Audit and Risk Committee, Executive Leadership Team, and Risk Group, with escalation to the Board when needed. This process ensures the Board has clear visibility of key strategic risks and that mitigations are effective and evidence-based

157. Clinical Risk Management is about patient care. It is about identifying potential risks, such as to self and/or to others then considering the risk on the basis of the current situation and plan with the patient and relevant others management plans and approaches. There are a range of risk assessment tools for different types of risks and also conditions. (I am aware the Inquiry has experts to advise on this.)

158. Clinical risk assessments can be static ie based on actuarials, (unchangeable factors e.g. age) or dynamic (changeable) which use structured professional judgement.

159. There are tools that have been developed to assist with clinical risk management. One such tool is the HCR-20 **[WITN0133024]**. As a forensic psychiatrist myself, the HCR-20 is generally the risk assessment used in forensic services and is a Structured Professional Judgement approach. I am trained in using HCR-20, which is a recognised tool for forensic psychiatry.

160. Formulation is important in considering a patient's risk assessment and there are a variety of models such as the "3Ps" which uses predisposing, precipitating and perpetuating factors as the framework. This is different to HCR-20 but is another example of a standard method of thinking about risks.

161. Clinical risk is governed through professional and statutory frameworks including clinical supervision, continuing professional development (CPD), peer review, incident reporting, and thematic learning reviews. Oversight is provided through quality governance structures, which ensure that learning from incidents and audits informs safe and effective practice. The Trust also develops policies on clinical risk management, see for instance the Trust's "*Clinical Risk and Safety Policy*" (01.23, version 1, October 2024) **[NHFT0003231]**, and provides training for its staff on this topic (among others). Risk management is covered in further detail in the Trust's Corporate Witness Statement, as paragraphs 218-243 and I have not repeated that content here.

162. In terms of the interplay between the types of risks, strategic risk management is to ensure the resilience and accountability of the trust as a whole, Operational risk management is to maintain safe clinical services and clinical risk management is to support clinical care. A key link is the sharing of lessons learnt including themes, across an organisation to support all clinicians and teams to learn and reflect in their areas of clinical practice.

163. A key role of Medical Director is the clinical and quality focus in any decision making. In the role of risks, we have a Quality Impact Assessment (QIA) Process which any proposal to make a change in a clinical or corporate

services eg change a service clinical model, must be reviewed by a multiprofessional panel. Colleagues review the QIAs to decide if the plans include identification of the right risks and have appropriate mitigations in place to manage them. Proposals can be rejected as not having appropriate mitigations, or further risks need considering and the level of review is considered to look at if the plans did mitigate the risks and were there any unintended consequences. As a member of the Finance Committee, the QIA status, for example, is considered.

Board approach to risk

164. The Board sets the overall approach to risk management and reviews risk appetite annually to update the BAF. It approves the Risk Management Strategy and receives regular assurance that risks are identified and managed effectively. The Board reviews the BAF at its meetings, supported by the Audit and Risk Committee, and receives an annual assurance statement through the Annual Governance Statement.

165. The Audit and Risk Committee provides independent assurance to the Board on the Trust's risk management systems. The other board sub committees review their specific categories of strategic risk and escalate any significant issues.

166. The ELT is responsible for operationalising the Trust's risk management strategy and ensuring that risk processes are embedded in day-to-day management.

167. As Medical Director I am accountable for managing risks within my operational portfolio.

168. Training is provided to individual members of Board as required. When I was appointed, our Head of Risk Management provided individual training and continues to provide support and training as needed. This is also done for all

board members as they are appointed. This ensures we all have a good understanding of the Trust's Risk Management Framework, including the purpose of the BAF, the process for determining and applying risk appetite, and the principles of risk escalation, control, and assurance.

169. The Board also undertakes an annual risk management development session for all Board members. This session provides a total review of the BAF, in terms of each key risk, its controls and assurances and re-evaluates the boards levels of risk appetite and tolerance

170. The BAF is a structured way to identify key risks to achieving our strategic objectives, the assurance in the form of controls and mitigations then the assurance and evidence that the risks are being managed. It allows board to have clear sight of risks to achieving our strategic objectives which are linked to then of our operational delivery.

171. The BAF is dynamic and is reviewed and approved at Board. Being dynamic is important as using the framework regularly allows colleagues to develop in practice using it and also in continuously considering if the actions and mitigations are sufficient and having impact or are further actions needed. Also being dynamic means any key changes to the context or in our wider settings having an impact are continuously considered.

172. In my view the BAF is effective at driving regular discussions at each committee and board about the risks to our strategic objectives and whether the actions identified do mitigate the risk and are on track or not and are there any other actions needed.

173. I currently do not hold a BAF risk as an SRO, but I do have key actions that I am the owner for. **[WITN0356026]** It allows all executives to contribute to the regular discussions about the strategic risks and also to be aware of risks across the Trust. Therefore, this allows each executive to have a wider level of awareness than just across your own portfolio, which supports the changed

structure and governance since 2023.

174. In June 2024 the head of Internal Audit Opinion noted 'we issued a significant assurance opinion for our work on the BAF: we also issued significant assurance in 2023/24". [**WITN0356011**] The NHS England developmental well led review reported in January 2025 acknowledged that areas of improvement such as reporting the BAF position at committees had been actioned and found the focus on BAF at the Board Committees and the Board is robust and adequate time is spent to discuss the mitigations and actions. [**WITN0356028**]

175. The CQC Special review of mental health services at Nottinghamshire Healthcare NHS Foundation Trust: Part 2 published in August 2024 concluded that inconsistent approaches to risk assessment was an issue in VC's case, the 10 benchmarking cases and reflected in findings from their wider review of the Trust. [**CQCM0016517**]

176. The Theemis investigation also raised concerns around risk management, specifically around operational risk management and the corporate responsibilities for the systematic approach to risk management including the absence of assurance to the Board on risk management issues, the absence of Trust discharge policy and template, poor systematic approach to the communication of risk across agencies and the Trust Board not having visibility of sub-contracted providers of inpatient beds.

177. As part of the IIP the governance programme I have already described the key structural changes to the executive team structure and the changes to board, sub board and within care groups governance. The introduction of the Accountability Framework, ward to board data flow, triumvirate leadership teams ownership with defined portfolios then clear upwards escalations has been key.

178. In terms of clinical risk assessment, there were concerns raised by the CQC and via the Coronial process. The themes were clinicians not taking a

longitudinal view of the patient, the timeliness of completion and the regularity of updating. Our risk assessment and discharge policies have been rewritten to reflect this, and we have redesigned our training which has and continues to be delivered to our staff.

179. The Audit and Risk Committee is a formally constituted committee of the Board of Directors to provide independent assurance to the Board regarding the effectiveness of the Trust's systems of integrated governance, risk management, and internal controls [**WITN0263010**].

180. I am not a member of this committee but would attend to present if there was a paper on the agenda from my portfolio, for example, an internal audit report.

181. The Audit and Risk Committee would not oversee individual clinical decision-making, which is the responsibility of registered professionals within their statutory and professional frameworks.

182. Clinical risk management in patient care is dynamic. As I outlined earlier structured clinical judgement is exactly that. Risk assessment is not always a clear right or wrong. Registered clinicians such as Doctors are required to undertake CPD each year to support their clinical work, approved by their peer group and this system is overseen by the Royal College of Psychiatrists.

183. The MHA Code of Practice provides statutory guidance to registered medical practitioners on how they should proceed when undertaking duties under the Act. Section 12 of the MHA relates to Approved Medical Practitioners, doctors who have special expertise in mental disorder and Approved Mental Health Practioners who have specific responsibilities for convening MHA assessments and any outcome.

Serious incidents and learning from deaths

184. When I returned to the trust in 2020, there was a Serious Incident Review Group (SIRG) chaired by the Associate Director of Quality, which decided

what type of investigation was required, how to disseminate learning and reviewed incident reports once signed off in Divisions **[WITN0263059]**. I was not a member of this. From my understanding, this was an operationally focussed group at the processes. ELT did not receive a regular report from SIRG although the communications updates at that time did cover feedback and updates on coronial processes and patient safety issues in care.

185. In my view, this was linked with the divisions having the oversight, rather than a trust wide governance and framework. Each division also had its own SIRG meeting with reports and action plans being done and signed off within divisions, and it was not clear how that was delineated nor the trigger for escalation. This view was supported by the review that Helen Collins carried out in relation to the quality of Serious Incident Reports at the Trust **[NHFT0000423]**.

186. At that time there was also a Reportable Issues Log **[NHFT0002375]** presented by the Director of Nursing to Private Board which gave details of complex SIs and any immediate action and learning from inquests.

187. The process has been changed and for the last two and half years ELT receives a weekly update from the Chief Nurse from the SIRG meeting the day before. This report covers all SIs, details immediate learning and next actions. The reports use individual patient names and details about their personal circumstances which gives context and brings the patient into the actual room when we are discussing what has occurred, in a very different way to using just an identifier number. SIRG has also been broadened in its remit to support triangulation with complaints, safeguarding or high risk staffing issues. **[WITN0356029]**

188. As Medical Director, in the review of my supporting structures, I have introduced a Deputy Medical Director role with a defined responsibility for patient safety, and they work in the patient safety team, closely with nursing

and other colleagues. The reviewed patient safety team structure and investment in key functions including learning from deaths has made a significant difference. [**WITN0356030**]

189. Learning from Deaths relates to NHS England guidance introduced in March 2017, through the National Quality Board (NQB) on how NHS providers should learn from the deaths of people in their care. It aimed to look at both numbers but also themes and formally reported to Quality Committee then to Board. This was to build on SI processes and frameworks. It also complements the real time surveillance work that is done through our suicide prevention work which has been aligned with the patient safety team. Now Quality Committee receives a bi-monthly patient safety report that details the numbers of serious and moderate incidents, learning from PSIRF reviews, with assurance on actions taken. The Committee also receives a Learning from Deaths quarterly report [**NHFT0001837, p.15**] which brings together learning from data, investigations and coronial enquiries.

190. The Board receives a similar report that details complex patient and staffing issues/incidents, legal issues, high level complaints and safeguarding issues [**NHFT0003521**]. This report has a significant focus on actions and learning. A key change, from my perspective is that it is in the form of a running log. This supports the continuity of oversight and learning through different stages and processes such as SI internal investigation, police investigation and coronial processes, which previously had been very challenging to follow through the governance that had been in place. This also ensures the wider board has the same level of oversight including longitudinally.

191. There has also been a significant change in the trigger to escalate across the organisation, in my opinion linked with the focus on one governance model, the Accountability Framework clarity and the triumvirate and increased capacity of clinical leadership. Both the Chief Nurse and I receive almost immediate escalations if there is a serious or complex patient safety issue. We directly

communicate that to each other and the COO in the first instance and then the CEO so the executive team can support and be aware in real time.

192. Following the changes to the Care Group operating model, SIRG and the quality assurance process in place in Care Groups reports through the quality and performance framework which provides assurance on completion of agreed actions from initial and PSIRF Reviews. In addition, the refreshing of the Patient Safety and Learning from Deaths Group **[WITN0356031]** has the specific role on behalf of the Executive Team to ensure learning, themed and specific actions are completed in relation to patient safety incidents.

Previous approach to identifying themes and system based issues

193. The Inquiry has referred me to comments I made in my Theemis interview regarding the adequacy of the **[TCLT0000810]**, Trust's previous approach to identifying themes and system-based issues from incident data being "sadly lacking". This comment was referring to what was found through the various reviews and investigations I have described earlier in my statement (including those by the CQC), in that our processes in 2020-22 did not support the ability to identify themes. Governance being carried out in the divisions with divisional sign off and oversight, did not support the ability to look at themes that were occurring in the directorates of the divisions or to look for themes across the trust and then share learning across the trust.

194. It is important for context to again consider that when i returned to the Trust it was during Covid with national guidance on focusing on maintaining life. There was not one specific moment, when some of these issues became evident. It was a growing realisation over time and also with the benefit of hindsight and time to reflect on the last 5 years.

195. As Medical Director there were discussions during Quality Committee in 2021-22 about improving the metrics presented to the committee, as a developmental piece of work. My reflection is that the data at Quality

Committee was presented at a Trust wide level, which felt different to the data I had seen through the forensic division as the forensic director and it was difficult to see the ward to board data flowed and therefore could be triangulated. This work struggled to progress, in my view because of capacity within the patient safety team to make these improvements.

196. When I described in my Theemis interview that SI investigations were poor, I was referencing the depth of the investigation, the timeliness, the appropriateness of the actions identified and the level of independence of the investigators. This was escalated as the themes became apparent and other trusts had dedicated Patient Safety Investigators rather than clinicians in the services undertaking this important work, in addition to their role. It is important that clinicians are involved to give a clinical perspective to the investigation, but in an advisory capacity.

197. A report was presented to Trust Management Team (TMT) on 17th May 2023 by Anne Maria Newham as Director of Nursing (DoN) noting the increase in patient safety work with more inquests, more complexity, a backlog of reviewing incidents and outlining staffing models to meet the demand in a timely manner. Previously in addition to clinical and managerial staff doing the investigations, we also used bank investigators and the proposal was for a dedicated team of investigators. This proposal was not supported. **[WITN0356032]**

198. I have exhibited to this statement the Learning from Deaths Reports presented at Board meetings from 2019-2023 **[WITN0356033, WITN0356034, WITN0356035, WITN0356036, WITN0356037]**

Trust groups and their role in relation to serious incidents and learning from deaths

199. The Inquiry has asked me to comment on the role and composition of various groups, and their role in relation to serious incidents and learning from

deaths. These groups are: The Quality Committee, the Serious Incident Review Group, the Patient Safety and Learning from Deaths Group, the Risk Group, the Quality Oversight Group, the Homicides, Attempted Homicides and Complex Incidents Oversight Group, Rapid Improvement Groups, the Police Liaison Operational Group and the Community Care Group.

200. The Quality Committee: this has been a board sub committee for the duration of time that I have worked in the Trust. In 2020 it was in the form of a combined People and Quality and Mental Health Legislation Committee. I have within this statement given details of its function to receive and review assurance of quality performance across the Trust and escalate relevant issues to the Board.

201. The Serious Incident Review Group: this is a weekly group that has been in place from 2020 when I returned to the Trust. It was chaired by the associate director of quality, and all incidents were discussed and it was agreed which level of investigation was required. As part of the quality governance changes, this meeting focus has been significantly broadened to also include information raised through complaints, inquests, Freedom To Speak Up and is chaired by the Director of Nursing.

202. The Patient Safety and Learning from Deaths Group was introduced in July 2024 **[NHFT0017651]** to improve the safety of patients receiving care from Trust services. This Group is co-chaired by the Chief Nurse and the Deputy Medical Director and is responsible for developing a trust wide approach to patient safety issues which includes recommending workstreams to improve patient care. The group provides oversight of this work to ensure a joined-up and consistent response is achieved across the Trust. The Group has the responsibility for the oversight of all deaths as outlined by the Learning from Deaths (LfD) guidance and all incidents as defined by Patient Safety Incident Response Framework (PSIRF), ensuring the Trust is driving quality and safety improvements by utilising a systematic approach to patient safety

incidents. It reports bi-monthly into Quality Committee. This Group replaced The Learning from Deaths Group that was established to provide Trust oversight of Trust systems and processes to report, review, analyse and learn from deaths of service users and provide scrutiny of mortality surveillance to ensure the Trust was driving quality improvement by using a systematic approach to mortality review / learning from death.

203. The Risk Group oversees the risk arrangements, chaired by the Chief Operating Officer and I am a member. This group takes an operational lens on the management of risks across the Trust and determines the appropriateness of, and manages the implementation of, the robust processes in place to manage and mitigate risks. The chair of the Audit and Risk Committee attends the Risk Group in an observatory capacity.

204. The Quality Operational Group [**NHFT0015033**] is a historical group (and was known as the Quality and Safety Operational Group in 2019). The Quality Operational Group was established to support the Quality and Mental Health Legislation Committee to deliver the Trust's Strategy, particularly objective 2 'we provide the best care and support'. The Group's intent was to continuously monitor compliance with standards and improve the quality of care provided and to reduce harm. The Quality Operational Group changed into the Quality Governance and Effectiveness Oversight Group in April 2025 [**WITN0263060**].

205. The Homicides, Attempted Homicides and Complex Incidents Oversight Group. The purpose of the Homicides and Attempted Homicides Oversight Group [**NHFT0015884**] was to provide executive oversight and governance of significant patient safety incidents which met the threshold under the Patient Safety Incident Response Framework (PSIRF) national priorities. This included mental health homicide or attempted homicides. This group was replaced by the Complex Incident Group in March 2025 and whilst the Terms of Reference [**WITN0263061**] are broadly the same, this group now includes

all complex incidents as well as homicides. The group is empowered to take decisions on matters relating to significant issues and will report monthly to the Executive Leadership Team Meeting or Quality Committee.

Rapid Improvement Groups

206. When I returned to the trust in 2020, Rapid Improvement Groups were in place for certain services and were operationally led from clinical services presenting to the Executive Team at that time Rampton Hospital would have been an example. They were originally an escalation meeting above accountability meetings and the routine governance. As the context of the scale of work has changed over time, these have been reviewed as part of the governance programme and now are focused improvement groups, chaired by the relevant Care Group Nurse Director and are central to the Improvement Programme reporting into the IIP board and NHSE led Improvement Oversight Assurance Group.

207. There are currently 5 Improvement Groups:

a. Rampton Hospital
b. Acute Inpatient mental health
c. Older Persons Care Unit
d. Offender Health
e. Community mental health and Crisis Services.

Police Liaison Operational Group

208. The Police Liaison Operational Groups (PLOG) used to be a quarterly meeting that aimed to focus more at process and protocols rather than individual cases. There were PLOG's for Adult Mental Health (AMH), Rampton, Wells Road, Arnold Lodge and Wathwood which would then fee into a Trust wide PLOG. Our Local Security Management Specialist (LSMS) also used to attend the Trust Security Health and Safety meeting and provide

a report. This changed in 2017 when NHS Protect was disbanded and the Trust removed the Trust Head of Security, Security Management Director and Local Security Management Specialist roles, and the LSMS moved across into Adult Mental Health (AMH) as a Safety & Security manager. The LSMS now chairs the Adult Mental Health (AMH) PLOG which is operationally focussed, and since September 2023 they meet weekly to look at incidents and police investigations. There is a police partnership officer in place who attends these. [**WITN0356038**]

Community Health Care Group

209. This is one of our three operational clinical care groups and reports to the Board through the governance arrangements explained above. The Community Health Care Group provides community physical health services for people registered at GP practices in Nottinghamshire. The Group also provides Intellectual and Developmental Disabilities services, and national transgender health services. Some services are also provided to the residents of neighbouring ICB areas, such Derbyshire and Leicestershire, and to other organisations, for example Nottinghamshire County Council, Nottingham University Hospitals and Sherwood Forest Hospitals. The Care Group provides the full range of community services:

a. Adult services inclusive of urgent and planned community nursing, podiatry, long term conditions and therapeutic provision.
b. End of life services inclusive of hospice provision and palliative care community nursing.
c. Bedded rehabilitation previously known as community hospitals: these are provided in Lings Bar Hospital.
d. Specialist services (this includes intellectual and developmental disabilities inpatient and community services; Transgender Services, subcontracted clinical input into Substance Misuse services provided by Nottingham

Recovery Network both outpatient and inpatient provision.

210. The majority of the above services are provided in the community. The portfolio core services are managed on a locality basis and a range of specialist services managed on a county wide basis.

Serious Incident Reports

211. Investigations were previously carried out in line with the 2015 Serious Incident Framework, for NHS Trusts **[WITN0356039]**. As described previously we have transitioned to use the new Patient Safety Incident Response Framework in 2024 **[NHSE0000054]**. In 2020, investigations were carried out using a mixture of bank staff and staff from clinical services. This led to challenges in terms of capacity, so affecting timeliness, carrying out vital investigations in addition to their main role and also to consistency. There was then a period of time when only the bank investigators carried out the investigations, which again was not supportive of good quality investigations.

212. Having dedicated investigators, would improve the quality of investigations, the timeliness and the consistency and specialism.

213. It was in 2024, when the current Chief Nurse implemented the review of the safety team structure and functions that these roles were supported to be implemented.

214. The implementation of the Patient Safety Strategy was delayed nationally because of the COVID pandemic which caused delay in the implementation of the Patient Safety Incident Response Framework (PSIRF) which was ultimately published in September 2022. Trusts were required under the NHS contract to have in place the PSIRF plan and policy ratified and published by

April 2024 with complete transition to PSIRF by August 2024. As a Nottinghamshire system it was agreed that all organisations would go for the same start date of April 2024, noting that original target. This has been set out in further detail in the Second Witness Statement of Diane Hull.

215. During 2022/23 there were significant capacity issues in the patient safety team due to a number of reasons, including senior leadership changes and sickness. There was a PSIRF implementation plan in place and a planning workshop was held in September 2023 with the project board starting in October 2023. Following the independent review of the Trust's Serious Incident processes completed by Helen Collins in January 2024 **[NHFT0000423]**; there was agreement to complete a rapid roll out of PSIRF supported by the PSIRF lead who came into post the same month, in effect increasing the pace of roll out. The Board received the PSIRF Framework and signed it off for publication at the March 2024 Board meeting **[NHFT0000454]**. On the 27 June 2024 the Board received training around PSIRF at its Board Development Day **[WITN0356040]**. The internal audit report from February 2025 gave significant assurance in the implementation and governance of PSIRF **[WITN0133030]**.

Independent Evaluation of Trust Safety Processes

216. Ifti Majid asked if we could benchmark the number of PFDs we were receiving in 2023. In 2018-22 we had received 5 then in 2023 we received 8, from 2018, 2019, 2021 and 2022. However, the data to benchmark against was not available. He raised this based on his experience in a different trust. We also looked at the number of SIs, but this was difficult to interpret as we welcome and encourage an open reporting culture.

217. The Acting Chief Nurse was asked to source an independent investigator to review the whole serious incident process. The concerns that led to this were mainly emerging concerns relating to the corporate processes around serious

incident reporting and inquest feedback and PFDs. Helen Collins, was commissioned to do this work who is an Independent Safety Specialist and Registrant Senior Nurse with over 30 years of experience of patient safety and quality working at national level as well as regionally and locally in tertiary, acute, mental health, community, forensic and commissioning sectors.

218. At the same time, with the purpose of making changes whilst the Independent Review was happening, the ELT on 7 June 2023 received a Quality Improvement Plan that addressed the Management of Serious Incidents, Inquests, Learning from Deaths (LFD) and Transition to the PSIRF. Many of the recommendations that were made in the Independent Review, were both known about and we were acting on them, such as putting in more senior support for inquests, extending the patient safety team in terms of both capacity and also specialist knowledge, focussing on completing the second part of our incident responses (known as IR2s). On 7 June 2023 ELT meeting we supported the improvement plan and a business case for the reviewed patient safety team was submitted to STEG and approved on 14 June 2023. [**WITN0356041**]. Importantly ELT agreed to appoint a substantive team of staff to carry out these investigations who had the required specialist skills and knowledge.

219. The Independent Review was comprehensive, examining more than 100 reports and speaking to 109 people, both internal and externally (coroners, CQC and commissioners).

220. The final Independent Report was presented to the Executive Leadership Team on 31 January 2024 alongside a dedicated action plan. [NHFT0000422] The report included a significant number of recommendations, with the action plan being led by the recently employed Patient Safety Experts. Leads for each of the actions were agreed and it was included/ complimented the Patient Safety Strategy action plans.

221. The Independent Review of the Trusts serious incident process was taken to the February 2024 Quality Committee **[NHFT0001610]** on behalf of the Board where a full update was provided on the findings and proposed actions. In February 2024 the Quality Committee was provided an update on the Review of the management of Serious Incidents. The Quality Committee was advised that the review found that there was a lack of Trust-wide quality improvement programmes, and where they existed, there was a lack of robust quality assurance that they were effective. In addition, there was a severe lack of Trust-wide safety incident investigation, learning and family liaison capacity and capability, a lack of standardised quality governance structures, we were not ready for PSIRF, Duty of Candour was not being performed consistently and the Trust's external stakeholders for safety were not assured of the ability of the Trust to improve processes.

222. In summary, policies and guidance were reviewed, and there was significant investment to resource a patient safety team which included dedicated investigation leads and Patient Safety Partners. A review of incident governance with the introduction of Care Group and Trust wide Safety meetings, implemented PSIRF, Learning from Deaths and Medical Examiner process occurred. Duty of Candour and inclusion of families was completely reviewed supported by guidance, training and mentorship. Incident reporting was and will continue to be a focus in supporting staff to be open and have more understanding as to what is reported. Improvements to the electronic incident system (Ulysses) to make reporting less complex and time consuming and enabling data to be more focussed for staff and clinical experts.

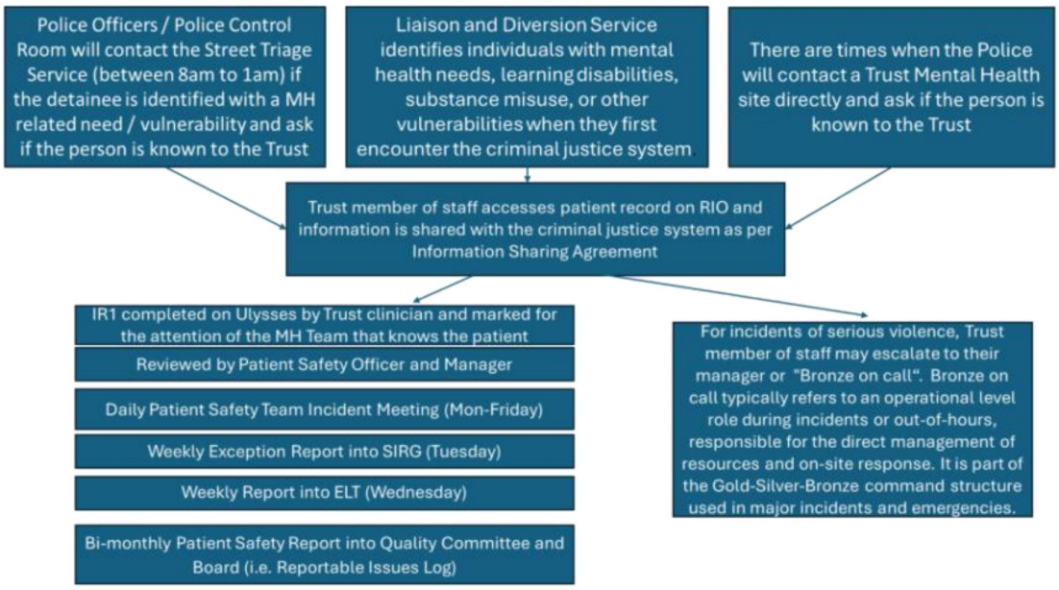
223. The action was overseen initially by the ELT, and in June 2024, it was updated that 70% of the actions had been completed **[WITN0356042]**. The actions were completed by January 2025 and closed via Quality Committee in March 2025 **[NHFT0000763]**.

224. We, and I as Medical Director accepted the findings from this report in full and have delivered against the actions, for example investing in family liaison officers to support families, with regular positive feedback about the impact directly on families. Our compliance with duty of candour regulations have significantly improved and today with a reduction of Duty of Candour open incidents from 1004 in February 2024 to 0 in March 2025. We now support learning events for staff involved in significant incidents routinely. For example, we have now held over 30 specific learning events for staff to attend and discuss learning and shared at a regional conference regarding the findings and lessons regarding the care of VC. The Trust also commissioned a Thematic Review of Homicides for the years 2019-2023. This is covered in detail at paragraphs 504-507 of the Corporate Witness Statement.

225. In terms of the repetitiveness of findings, the Review provided a mechanism to pull together all of the themes and learning from the totality of our patient safety information and learning. In my opinion we are a large organisation with diverse services that without the best governance and culture to support learning, has made it difficult. By taking the actions that we have as an ELT and as a Board through our Integrated improvement plan moving to a safety culture across all services, sharing and bringing together colleagues at learning events have been key. In terms of specifics as Medical Director I have already described the work done regarding medicines management for example and using all opportunities eg Q&A sessions with medics, to share the learning more specifically with medical colleagues.

Incidents of serious violence that occur outside the Trust

226. As set out in the Trust's Corporate Witness Statement, incidents of serious violence that occur outside of the Trust are reported into the Trust through several routes, which are shown in the diagram below.



227. The Trust's Street Triage team, working with the police in response to incidents occurring in public where there are mental health concerns, will raise with the Trust where a patient is under or has been under mental health care.

228. If patients or former patients are involved in crime, initial contacts with the Trust can be through the Liaison and Diversion Teams, who work in police custody and complete mental health screening. Where the patient is or has been under the trust services the Liaison and Diversion Teams relay required mental health information to the custody suite and inform the Trust of the incident via the on-call rota and or the Ulysses patient safety incident system.

229. Clinical care teams raise incidents when it is known to them.

230. In addition to the above, if the serious violence is a 'live' situation, the Trust may also be informed through the Local Resilience Forum (a multi-agency partnership that exists to prepare for and respond to emergencies). This is made up of representatives from local public services, including the

emergency services, local authorities, and the NHS, all of whom are designated as Category 1 Responders under the Civil Contingencies Act (2004). In such circumstances, the Trust will consider mobilising its Incident Management Team using the Trust's Emergency Preparedness, Resilience & Response (EPRR) Policy **[NHFT0005227]**.

231. Where a homicide is perpetrated/ allegedly perpetrated by a person who is in receipt or recently discharged from mental health trust care, the NHS England Regional Homicide Team NHS England Homicide Team decide whether a further investigation for the purposes of learning is required. The Trust has the following policies and procedures that give guidance on managing incidents involving serious violence:

    a. Learning from Deaths Policy **[NHFT0000596]**.
    b. Patient Safety Incident Response Plan and Policy **[NHFT0008825]**
    c. Being Open and Duty of Candour **[NHFT0003028]**

232. Reporting, Managing and Learning from Incidents Policy **[CQCM0005588]** which includes initial management and responsibilities, the Incident Co-ordination group, and specific sections on mental health Homicides, with guidance to external reporting. It provides guidance on engaging both the perpetrator and victims' families, and how to obtain contact details where necessary through Police Family Liaison Leads.

233. Police and Criminal Justice Liaison policy, updated in June 2025, which identifies the need for regular liaison between the trust and police via the Police Local Operational Groups (PLOG) to enable joint oversight of investigations. **[WITN0263069]**

234. The process for Trust to respond upon receiving Serious Incident notifications has been covered in detail in the Corporate Witness Statement and the Second Witness Statement of Diane Hull and I do not have anything to add to what has already been described there

Specific incident discussed at Board meeting on 4 May 2021

235. The Inquiry has asked me to provide my views on an incident that was discussed at a Trust Board meeting on 4 May 2021. To assist with my response, I have reviewed the clinical record relating to this patient and my involvement and the record of the discussion at 4 May 2021 Board.

236. It is not unusual, and in fact this was a good use of escalation processes to ensure that all of the clinical teams and in this case probation, were convened together to discuss a patient with a complex presentation. As Medical Director, if there are complex clinical scenarios, it is not unusual for clinical and/or operational colleagues to either advise me or seek advice. As MD I will get patients escalated to me where there are different views between services about the patient's suitability.

237. As Medical Director, it is not my role, nor do I, decide the course of an individual patient's care. Via escalation, my role is to convene the correct colleagues and chair the meeting to discuss whatever the relevant issues are.

238. This patient had recently been GRO-D and was being

GRO-D

239. This patient had been escalated to me given the complexity of the clinical presentation and range of clinicians and services involved, so I convened and chaired a case conference on 1 April 2021. I convened the doctor who had undertaken the medium secure assessment, two doctors from the crisis team, senior operational colleagues from our community forensic team and adult mental health division and a senior probation officer. The records of the case conference are in the medical records [**WITN0356079**]. There was feedback from a recent review by a crisis consultant and the teams discussed pathway options.

240. Using myself as an escalation brought service leaders of different teams together to plan GRO-B care. We were able to agree GRO-D

GRO-D

241. The formal escalation route for our East Midlands Provider Collaboratives is through each member Trusts' Medical Director. I will attend escalation meetings for example if there are different views regarding where a young person should be admitted to through our CAMHS Provider Collaborative or secure forensic services or adult eating disorders services.

242. I convened a case conference and at the start did not know what the outcome would be. I was there to ensure everyone was brought to work together instead of, what can sometimes occur when services all feel a patient does not meet their criteria and also bring together those with different types of expertise.

243. The full minutes of the board meeting say, *"SE responded explaining the management teams had decided to convene meetings to discuss how best to manage the needs of the patient and where they would be best support, with a carefully thought through plan about their discharge. A learning event had been arranged for all involved to plan for future admission of this nature. SE assured the discharge was clinically carried out appropriately as she had attended all of the meetings.... JA (MH Director) confirmed there had been* **GRO-D** **GRO-D** *JA added this was the only case the service had to have alternative arrangements for.....SB sought further assurance, asking if the patient was to cause harm in the community, whether the trust was confident all the appropriate risk assessments had been carried out from a clinical point of view and would withstand scrutiny. SE confirmed this had been the reason she had chaired the meetings, overseeing an expanded community offer on immediate discharge ensured the patient was supported and receiving the best care, safeguarding Trust reputation from a clinical point of view."* [**NHFT0003414**]

244. As medical director I answered the question a non executive director asked me and in my view I was clear I was talking from a clinical perspective. It is vital that the public has confidence in its mental health services to ensure people come forwards to access treatment and support at the time it is needed.

Individuals under the care of the Trust who committed acts of violence

245. The Inquiry has asked about several incidents of violence committed by patients who were under the care of the Trust at the time or shortly before these acts were committed. I have reviewed the incident reports to assist with identifying when and how I became aware of them, when they were discussed at board, what investigation and action plans were put in place, and changes have been made as a result and do I consider they have been adequately considered.

246. I have re-reviewed the Board papers that refer to these individuals.

247. To complete my statement, I have re-read and reflected on the learning and recommendations regarding each patient detailed. I have reviewed relevant Board and ELT minutes also. This has also led me to reflect on the changes to the processes and sign off already described being seen in practice over the 5 years this covers.

GRO-B

248. There was an Incident Management Review dated 7 July 2021 completed by a Team Leader in the Mental Health Division [**WITN0356044**]. It was discussed at SIRG on 13 July 2021 and I first became aware of this when it was on the reportable issues log at ELT on 28 July 2021. It was then shared in the Reportable Issues Log to Private Board on 3 August 2021, presented by the Director of Nursing. The minutes of the private board meeting note that the two additional patients, 1 of whom was GRO-B, on the reportable issue log were noted. The majority of the discussion was focussed on covid themes including a staff death and some staff not being vaccinated for covid and what could be done. There was also a discussion about two other staff linked with a different incident. [**NHFT0004539**]

249. A Level 1 Concise investigation was assigned, and this was initially on hold due to the Police investigation. This was then completed by a patient safety investigator on 15 June 2022 with final sign off by the Mental Health General

Manager on 28 June 2022 and the Mental Health Head of Nursing on 4 July 2022.

250. I believe the findings and associated action plan were overseen through the Mental Health Division Quality and Risk Group. The Investigation report also notes that the learnings will be shared through the Mental Health Learning Lessons bulletin and with individual teams through business meetings. The main learning identified was clinicians relied heavily upon regular reports from family members to report GRO-B mental state of GRO-B whilst there was often an interpreter present for reviews with the Consultant Psychiatrist.

251. In my perspective no changes would have been made as a result of this case at that time.

252. In hindsight, this case shows how the governance model in 2020-2023 of Divisional oversight worked in practice and was a barrier to being able, as Medical Director, to follow the whole learning from start to end around a serious incident, which has now completely changed.

253. I have reviewed the Investigation Report considering from a clinical perspective if the learnings were appropriate which in my view they are. However, as a Trust my view now is that this incident was not appropriately considered through the Trust in the way we would have wished it to be.

254. Also, by using a broader framework now under PSIRF, I believe there would have been some initial learning found in terms of GRO-B family having contacted the service GRO-C but also a more broader point about GRO-B having GRO-C but also the GRO-D received GRO-C

GRO-B

255. This patient was discussed at SIRG on 25 May 2021. A concise level 1

investigation was agreed from the records to include looking at the follow-up to the partial visit on the 9th May and then failed contact on the 10th May and was there any previous knowledge of domestic violence or aggression towards females and how was that assessed. It was shared with ELT via the reportable issues log agenda item on 28 July 2021, when I first became aware. It was presented at Private Board in the reportable issues log on 3 August 2021, alongside GRO-B I have already described the discussion from the minutes recorded. [**NHFT0004539**]

256. The Immediate Management Review was completed by a Team Leader in the Mental Health Division and was noted that corporate safeguarding would oversee this. There was a Level 2 concise investigation conducted by a Consultant psychiatrist, a team leader and a safeguarding lead dated 8 June 2022 and signed off by the Mental Health General Manager on 10 June 2022. It was then signed off by the Mental Health director of nursing on 5 April 2024 and the Deputy Director of Nursing on 15 July 2024. [**WITN0356080**]

257. A Domestic Homicide Review was completed [**WITN0356081**], and the Overview Report was dated October 2022 and reviewed in October 2023.

258. The Trust Investigation Report described its route for sharing as through the Mental Health Divisional Quality and Risk Meeting and with the clinical team and NHSE commissioners. The report identified a number of key learning points: The discharge Co-ordinator was not aware of attending the discharge planning meeting which meant that they were unable to gather usual detailed information about **GRO-C** **GRO-C** including risks to others, clinical staff had not considered whether GRO-B was a **GRO-C** as they had not asked GRO-B and had accepted GRO-B description of it being relationship difficulties and this was described as a lack of professional curiosity, GRO-B address details were not checked and updates on discharge **GRO-C** **GRO-C** so the 3 day follow up did not happen although contact was made the

following day with GRO-B

259. The Domestic Homicide Review made a range of recommendations across organisations. For the Trust they included training and awareness raising about professional curiosity, embed the Think Family Approach, mandatory domestic violence training and increase awareness of the Police's role in domestic violence and how to communicate with the Police.

260. In the Trust Investigation Report it was noted that the Quality Improvement Plan would be overseen in the Mental Health Division by the Divisional Management Team.

261. As for GRO-B this is a practical example where our previous governance processes were a barrier to seeing the learning across the organisation and also follow the cases through.

262. The timeline for the investigation process goes from May 2021 to the final sign off of the Trust Investigation Report in July 2024 with the Police investigation and criminal proceedings and the Domestic Homicide Review. I would reflect that this again practically shows the difficulties to manage different processes across different statutory agencies.

263. I am not aware that learning from this case were presented back to board.

264. In my view the learnings identified were appropriate and whether changes have been made is complex given the very specific element about a lack of curiosity about the nature of the relationship that GRO-B described. The investigation noted GRO-B had GRO-D, firstly in

GRO-D

GRO-D GRO-C

GRO-C

GRO-C This links with the debate of how to balance what is known versus what is unknown and relationship issues are a very common factor in causing acute stress responses. I would reflect that this links with the debate about confidentiality in different situations.

265. There has been a lot of work done, not just in response to this tragedy, about sharing learning about domestic abuse and our safeguarding team have encouraged a low threshold to liaise with their single point of access to discuss any potential concerns.

GRO-B

266. GRO-B fatally stabbed GRO-C on GRO-D 2022. The Trust Investigation was carried out under PSIRF and was unable to start any earlier due to the police investigation. It was noted at SIRG 16.08.22 and I became aware at ELT on 31 August 2022 through the Reportable Issues log. It was shared on 6 September 2022 at Private Board through the reportable issues log **[NHFT0004569]**

267. The Domestic Homicide Review is pending.

268. Updates were given in Private Board on 28 March 2024 and 26 September 2024 **[NHFT0000423]** at which time the draft Investigation Report conducted by an externally chaired group was with the Chief Nurse and planning to go to the next private part of Quality Committee. On 28 November 2024 Board, the Reportable Issues log stated that the report was with the Chief Nurse for final sign off **[NHFT0000818]**. On the 27 March 2025 Private Board **[NHFT0000535]** a new and much broader report, the Patient Safety Exception Report was introduced by the Chief Nurse. It updated that the Safety Action Plan regarding GRO-B was being reviewed by the Patient Safety Team and at Board on 31 July 2025 the Chief Nurse shared the learnings.

269. Reviewing the relevant Private Board minutes shows that the quality

governance changes that have been made visibly demonstrate board being kept updated over time as to both processes but also learning. The updates also include personal context to help us hold GRO-B in mind beyond the processes.

270 GRO-B had evidence of a severe and enduring mental illness and was detained in hospital through being found guilty of manslaughter by reason of diminished responsibility.

271. This investigation evidences in practice the impact of the changes in process that we have made. It is focussed on thematic learning, was undertook by an external expert and had executive level sign off once all areas had been investigated.

272. There were two main thematic findings, a lack of curious enquiry related to presentations with probable symptoms of psychosis and an opt in approach for patients felt to not meet the criteria for detention under the MHA.

273. The question of "masking", used to describe when people can quite well not show or share some of their symptoms, is raised and again there needs to be the ability to weigh that up.

274. The work done nationally for all trusts to identify patients that would need the Assertive Outreach approach, and continue to dynamically do this, supports the reflection of not being able to have one model for everybody and needing to identify those who do need a much more intensive and adaptive model of engaging with as compared to the more opt in model which is suitable for some people based on level of risk and formulation, rather than being linked with their criteria to be detained under the MHA.

275. In my opinion this incident has been reviewed and well considered and will continue to be considered as the Domestic Homicide Review is conducted.

276. This incident was noted at SIRG on 21 February 2023 and I had become aware on 15 February 2023 via a briefing to executives. The briefing outlined the details, and a summary of care provided. **[WITN0263071]** It was on the board reportable issues log in Private Board on 30 March 2023 **[NHFT0000592]**. In February 2024 following the completion of the criminal trial, an independent chair (Psychological Approaches Ltd.) was approached to lead the panel to review the Trust's care and treatment of GRO-B A draft of the investigation report was shared with the ELT on 13 May 2024 for early learnings. The action plan was developed and the final report signed off by the Chief Nurse on 26 November 2024.

277. There are a range of learning points identified, and changes made. In my view again the amended quality governance has enabled me to be able to follow the progress of processes and the learning and actions in a logical way. Risk assessment training has been enhanced for community mental health services which includes capacity and risk to others. EIP Internal Working Instructions were updated to include purpose and expectations in relation to medication drop offs and a Trust wide Clinical Risk and Safety Policy has been developed. Local mental health and community forensic interface meetings now occur to support clinical discussions. A review of the Police and Criminal Justice policy in collaboration with the police was commissioned to improve the flow of information between clinical teams and the police.

GRO-B

278. GRO-B stabbed a stranger GRO-C on GRO-C 2023. This was reported at SIRG on 18 April 2023. **[WITN0356045]**

279. An investigation was carried out as a Level 1 by a Team Leader and signed off in the Mental Health Division by the General Manager and Head of Nursing. Having reviewed the report, it again highlights why the governance changes that have been made would have resulted in more learning being

identified.

280. Learning identified included relying on the supported accommodation to get updates on GRO-B mental state for a period of time between 16 November 2022 - 3 January 2023 when tablet medications were being dropped off but GRO-B was not directly assessed.

281. In my view this warranted further consideration on reviewing the Investigation Report as there were wider opportunities for learning, including the process of exploring transition from CAMHS services to adult services, which ultimately did not occur, and GRO-B was discharged to the GP.

GRO-B

282. **GRO-B** attempted to stab a member of the public **GRO-C** and suffered a fatal stab wound **GRO-C** This was noted at SIRG on 11 July 2023. At that time only minimal information was known and it was some time before the Police agreed we could proceed with our investigation. It was first noted in Private Board on 28 September 2023 [**NHFT0000571**]. An update at Private Board in January 2024 [**WITN0263076**] noted that the Trust were awaiting police agreement. An independent chair was asked to lead the investigation with a draft report prepared by August 2024 and an update noted in the private board on 26 September 2024 the status of the report [**NHFT0000525**], and an update at private board in November 2024 [**NHFT0000818**] noted the action plan was awaiting sign off. The draft report was reviewed at PSII/SIR Scrutiny Panel on 28 February 2025. The final report was approved by the Deputy Chief Nurse on 31 March 2025.

283. The report was independently chaired and also included a consultant psychiatrist and a clinical director. It identified a number of learnings involving the EIP Team (different EIP team to VC). This was a planned discharge from EIP in discussion with the patient. The Care co-ordinator went with the patient to a GP appointment to share the plan. There was a finding that the risk

assessment had not recognised the risk to others as significant and this was based on the clinicians having over relied on how open GRO-B was about GRO-B symptoms and not previously having acted upon GRO-B psychotic symptoms. GRO-B had a diagnosis of GRO-B

GRO-D

284. I have been able to follow the longitudinal process and learnings over this period. A key area of learning was recording MDT discussions clearly in medical records. A template was drawn up in the EIP service and a cycle of audits was put in to monitor this. This is also supported by a discharge checklist and audits of discharges to give clinical feedback

285. In relation to discharge, the EIP team devised a discharge checklist to be used as an aide memoir and guide conversations and documentation to ensure the discharge is clinically appropriate and robust.

286. There are monthly EIP discharge audits in situ, which gives direct feedback to clinical staff and audits are also built in to identify anyone who we have not had contact with and reconsider options. Waiting well is also in place.

287. I do consider that this case has been adequately considered and learning addressed.

GRO-B

288. GRO-B The Trust were made aware of the community incident on GRO-C GRO-C 2024 when reported as a Blue Light incident via the Trust reporting system the same day. The incident within the prison took place on GRO-C 2024 and the Trust were again notified of this as a Blue Light incident via the reporting system on the same day. I received notification via the incident reporting Blue

Light system. The first incident was noted at SIRG on 3 June 2024 and a Patient Safety Investigation (PSII) was commissioned. The second incident was escalated to SIRG on 2 July 2024 and agreed to add into the already planned PSII.

289. Both incidents were included in the Reportable Issues Log to Private Board on 26 September 2024 [**NHFT0000445**].

290. The final investigation was signed off on 20th June 2025.

291. I have been directly involved in the actions as there was learning identified about a doctor's clinical practice and as would be usual, the Associate Medical Director has worked directly with the doctor to review their practice and consider the learning. As part of the wider actions there has been training about when and how to advise the Ministry of Justice if conditionally discharged patients presentation and/or risks changes. There was also felt to be a lack in the risk assessment and formulation of appreciating the different elements of GRO-B diagnosis and not focussing on the **GRO-D** as well as the mental illness.

292. The Standard Operating Procedures now includes guidance for community forensic teams when a person is remanded to prison to ensure that clinical information is transferred and handed over. [**NHFT0016005**]

293 **GRO-B** inquest is pending so there are further processes yet to determine facts. The Patient Safety Incident Response Framework (PSIRF) Investigation Report raises the question of whether in this instance GRO-B should have been recalled through the Ministry of Justice and how to balance risk in a complex clinical presentation with voiced and personality disorder.

GRO-B

294. The incident took place on **GRO-C** 2024 and was reported the same day as a Blue Light incident via the Trust reporting system [**WITN0263081**]. I

received notification via the incident reporting Blue Light system. A confidential briefing was shared by Patient Safety Team with the Executive team on 12 December 2024.

295. The case was reviewed at the Trust SIRG on 10 December 2024 and 17 December 2024 **[NHFT0016003, p.2 and NHFT0016004, p.3]** to provide an overview of the incident, including details of GRO-B contact and treatment with Trust mental health services, immediate learning and actions. In line with PSIRF a PSII was commissioned.

296. The case details were included in the SIRG Exceptions Report dated 10 December 2024 and 17 December 2024 **[NHFT0016003 and NHFT0016004]**. The incident was included in the Reportable Issues Log paper dated 30 January 2025 **[NHFT0000779]**.

297. An ILR was completed at the time of the incident and telephone recordings between service and patient/family were shared with the Chief Nurse on 10 December 2024. **[WITN0263082, WITN0263090A, WITN0263090B]** A meeting was held on 10 December 2024 **[WITN0263083]** with Associate Director of Nursing, Care Group Nurse Director, Clinical Team Leaders, Operational Manager, Service Manager and Patient Safety Team to discuss incident the incident and to identify immediate learning and actions. An After-Action Review (AAR) occurred on 6 January 2025 **[NHFT0016457]** where both good practice was highlight and recommendations for improvement defined. The review determined that the crisis team service involved were to develop new internal working instructions to ensure patients who use substances do not face exclusion from accessing services and are thoroughly triaged.

298. The areas of learning identified are to ensure the risk assessment is updated to reflect current clinical presentation which is now audited by the Care Group Leadership Team through actions taken where improvements are required. Crisis Resolution Home Treatment (CRHT) Triage form will be audited to

ensure it is completed to the required standard and Discharge and Transfer policy has been reviewed (August 2025) to ensure greater involvement of community service on discharge. **[NHFT0017676]**

299. There is now guidance ensuring that all patients are categorised for an urgent 4 hour or 24 hour response by the Crisis Teams. Internal Working Instructions were updated to ensure that patients who use substances are not excluded from services and receive thorough triage. **[NHFT0017677]**

300. Bespoke substance misuse training has been delivered to the Crisis Teams.

GRO-B

301 GRO-B The incident was reported via the Trust reporting system on 15 November 2024 **[NHFT0015973, NHFT0015974]**. It was discussed at SIRG on 26 November 2024, an overview of the incident was provided, including details of GRO-B's contact and treatment with Trust mental health services. The case was included in the SIRG ELT Exceptions Report dated 26 November 2024 **[NHFT0014969]**. Details of the case were included the Reportable Issues Log for the reporting period: 13 November 2024 – 23 December 2024 **[NHFT0000779]**. In line with PSIRF, a Safety Incident Review was commissioned.

302. An ILR was completed at the time, and it was agreed the incident met the PSIRF requirements and a Safety Incident Review was commissioned. A draft Safety Incident Review report is completed **[WITN0356046]** and will be presented to the PSII / SIR Scrutiny panel and the Complex Incident Meeting in November 2025 **[WITN0356047]**

Are these incidents expected? How can they be prevented?

303. I am aware that Ifti Majid has been asked a similar question and that he has explained the difficulties of coming to an informed view as to whether the number of incidents the Trust has experienced is expected or unexpected.

From my own perspective, I agree with the points he has made about the limited data analysis on a national level that would inform a benchmarked view as to where the Trust sits.

304. I would also highlight that there are multiple determinates of crime that may also need to be considered, such as social, environmental and economic factors.

305. There is a range of factors that touch any one person in the community and it is difficult to have a linear view of just their mental health care. When investigations are conducted, this is why on occasions actions are referred to as missed opportunities. NHS England stopped the requirement to assess whether an incident was predictable or preventable in early 2020 and in 2022 stopped the requirement to clarify an incident as predictable and/or preventable with the introduction of the Patient Safety Incident Response framework.

Staffing

306. The Inquiry has asked me a series of questions relating to staffing levels at the Trust, how these were determined, including by reference to any guidelines or requirements, and any issues the Trust has experienced in relation to staffing. In answering these questions, I have expanded on the content included in the Trust's Corporate Witness Statement and also included information about medical staffing

307. Recruitment and retention has been a significant problem in my view, over the last 5 years in the Trust. Given the diversity of the organisation, this has occurred in different services at different times for different reasons.

<u>Safer Staffing and establishment</u>

308. Safer staffing relates to nursing staff. As a member of the executive team and board it is important that I am involved in considering firstly what our safer staffing data is describing, what the impacts of that are in terms of patient safety and what is needed to be done.

309. During my 5 years working in the Trust, there has always been a real commitment to ensure that there are sufficient staff to meet clinical need. Whilst the staffing data presented during that time, has shown hotspot areas at different times and for different reasons, we have filled to the clinical need by using significant agency and more latterly bank staff.

310. Whilst recognising that for continuity of care, agency staff in particular, should only be used in extreme situations.

311. Staffing has been a large focus on quality committee, people committee and board over the last 5 years.

312. I am aware Diane Hull, in her Second Witness Statement, has described how establishment reviews are done within Safer Staffing, in line with the NHS England 'National Quality Board's Guidance on Safe Staffing' (2016). The tool used to support the establishment review process for the Mental Health inpatient areas is the Mental Health Optimal Staffing Tool (MHOST). There is no similar guidance for community settings and MHOST does not apply to doctors.

313. It is a very complex situation when considering staffing across the size of the organisation. It is also very important to consider the balance between a set staffing establishment with its in built assumptions (such as being able to cover one set of enhanced observations for mental health within existing staffing numbers) when sickness levels can vary and the level of patient acuity/support can also vary. We have been committed to filling our vacancies to the established levels during my entire time working in the trust from my perspective. There has been a national issue during this period with roles for

registered mental health nurses (RMNs) far outweighing the number of vacancies nationally.

314. Skill mix is also important as an establishment includes a balance of registered nurses with healthcare assistants (HCAs) per shift. At times strategies such as over-recruiting to HCAs when it has been difficult to recruit registered nurses have been used for example when i was the forensic director.

Medical Staff

315. From a medical perspective, there is not a similar national staffing establishment tool. As teams and clinical services have been set up there is an allocated number of medical posts or sessions, often based on the original service clinical staffing model.

316. We employ a range of doctors. We have Consultant Psychiatrists who in the inpatient wards are often called by the name Responsible Clinician, which is the technical term used in terms of their role within the Mental Health Act for patients who are detained under the Mental Health Act. We also have resident doctors (previously known as Junior Doctors). Resident doctors are qualified doctors who are undertaking specialty training. Foundation year 1+2 doctors are on their foundation training programme, so in years 1-2 post medical qualification from university. We then have Core Trainees 1-3, who have done their foundation training and have chosen to train in psychiatry. We also, have resident doctors who are on a GP training scheme doing psychiatry placements. Then we have Resident doctors in their Higher Specialty Training working towards their Certificate of Completion of Specialty Training (CCST), such as General Adult psychiatry, forensic psychiatry, Intellectual disability psychiatry, Children and young people's psychiatry, Older Adult Psychiatry and Psychotherapy. The third group is SAS (specialty, associate specialist and specialist) doctors. SAS doctors are a growing group of doctors in our

organisation to support clinical services. They have 4 years of postgraduate training and two of those must be in psychiatry to be a SAS in psychiatry.

317. In terms of processes, we have a medical workforce team within the people and culture team that support medical leadership colleagues (clinical directors and associate medical directors) with recruitment and support.

318. In terms of medical recruitment during 2023, 2024 and 2025 we have focussed on reducing our reliance on doctors from agencies and recruiting substantively into our clinical services. This has been a key objective directly linked with patient safety and quality.

319. I have also been able to increase the medical leadership capacity in the organisation, with the recruitment of a permanent deputy medical director and 2 additional Associate Medical Directors, to double the capacity in the Mental Health Care Group and the Forensic Care Group. As well as capacity, the roles now clearly are to oversee patient safety and quality and experience, working closely with the senior nursing and operational colleagues. The strengthening of clinical, and specifically medical leadership in the care groups has been vital with moving processes away from being directly driven and carried out operationally to being done and lead clinically.

320. I also moved the Clinical Directors in the Mental Health Care Group, who were line managed through the operational executive director into my direct medical line management structure, which meant I then had a complete medical structure and capacity for leadership throughout the hierarchy of the organisation.

321. I have changed the structure to create a robust medical leadership model, and in line with our multiprofessional approach, the Clinical Director posts and the newly introduced Deputy Clinical Director posts, are open to non-medical colleagues and also to our Speciality and Associate Specialist doctors (SAS)

which is also inclusive of for example non-medical clinical directors.

Staffing guidelines for doctors

322. As I have said there is no equivalent of safer staffing for psychiatrists. The Royal College of Psychiatrists (RCPsych) 2019 standards for inpatient mental health services provides guidance on appropriate systems that should be in place for nursing staff to respond to low or unsafe staffing levels, how they should report this and how these staffing levels can be escalated within the service. The standards state that a duty doctor should be able to attend the ward within 30 minutes in the event of an emergency.

323. We have onsite resident doctors on an on call rota 24 hours per day across our adult acute inpatient wards.

324. In terms of other guidance, it is a complex area as teams vary in terms of their make up of different professional roles and supporting roles, so there is not one overall formula to plan the numbers of consultants, SAS and resident doctors by team. We regularly review our medical capacity and do move posts or put a new post in if more support is needed in a particular area. Where resident doctors are placed for their training, depends on the presence of an approved clinical supervisor as a consultant and the resident doctors training needs. We have been increasing our numbers of SAS doctors across the Trust to support consultants and teams and ensure we can focus on the resident doctors having a positive training experience. This is also part of our recruitment and retention work to provide internal training and support for SAS doctors who wish to either broaden their portfolio or develop their clinical career progression.

Impact of staffing deficiencies

325. In terms of the impacts of not having enough staff on that shift or in the community service to provide the services to patients as we would all like, are broad. For patients in wards, we know that can mean there is less time being

spent directly with patients and less therapeutic activities. It can mean less time spent with families and carers and less time to follow up on actions linked with patient care. Overall, this can affect how long people have to stay on a ward, away from their friends and family. In some specialist inpatient settings, it can result in patients not getting as much access to fresh air or other activities. In community and specialist teams, this can result in people having to wait longer for the first time being seen or longer for specialist assessments and treatments.

326. We know that for colleagues, the impact of not having enough members to meet the patients needs, can result in further sickness, stress and burnout. It also had impacts in terms of the ability to have time for supervision, which is really important to be able to think about clinical practice situations and personal development. We also know that there is a higher risk of errors occurring such as medicines errors.

327. It is because of these impacts, that we have always committed to our staffing levels as needed. The IPR presented to board during the last 5 years shows areas that have above 125% above or 85% below staffing establishment, but through a combination of high vacancy levels, sickness levels and clinical need, colleagues have routinely raised feeling there is insufficient staffing. This has come at a time when there was a national focus on reducing agency staff then over the last year on reducing bank staff being used.

328. In terms of the impact of medical vacancies specifically, again this has varied over the last 5 years across different specialty services. In 2021 we had significant consultant vacancies in our Children's and Young Peoples services and incentivised to recruit with positive impact. We had consultant vacancies in Older adults services, which again was another national shortage, and now we have been able to recruit. We manage medical absences, in a different way to nursing, in that if it is emergency short term other consultant colleagues provide cover whilst we agree how to provide if it will be longer term. We do use locum agency doctors, if we have to, but try to ensure these are well suited and stay

for the time period we need to improve consistency. We will also use doctors directly employed by us through our bank in preference to agency. We know that having a consistent Consultant Psychiatrist is key to a multidisciplinary team (MDT)

329. Given the impact of having consultant vacancies on patients care and services, we have a weekly medical leadership group that proactively plans by vacancy as they come up, what is the short term then longer-term recruitment plan. Historically, medical recruitment was overseen in the divisions, and in 2023 I changed the medical leadership structure so the Clinical Directors all report through to me and I am the executive lead for medical recruitment and chair all of the consultant interviews. I feel this is a very important aspect of my role, to be internally focused on our doctor's experience right from when they are considering working in the trust through their whole career.

Monitoring of staffing levels

330. Over the last 5 years, staffing has been one of the most discussed issues from my perspective. Recognising the breadth of services provided by the Trust, where and why staffing pressures are felt has varied over time and I now look at it in 3 areas:

    a. The actual establishment, - so is the establishment set at the correct level for patient need.

    b. the availability of staff, taking into account staff sickness and vacancy impact, as well as recruitment and retention; - so even with the right establishment if there are high levels of sickness or vacancies that will not be sufficient to meet patient needs.

    c. clinical need for staffing – this can be impacted on range of patient needs eg seclusion, enhanced MH observations, physical healthcare transfer with staff escorts/support) – so there are clinical drivers that are pushing

the staffing need higher

331. It is closely monitored through a variety of ways, both formal and informal and escalations are made formally and informally. As forensic director, I saw through the forensic divisional structures our safer staffing data before it was then collated into the trust wide governance. As medical director I see staffing escalations at ELT, then as a member of Quality Committee I see the quality element of the IPR which reports wards that are either 85%below or 125% over their staffing establishment. We look at why this is and then also look over time where staffing is consistently needing to be over 125%. As a member of People Committee, we see the People elements of the IPR, which shows turnover, vacancies and sickness for example. A recent example was people + culture committee commissioned a deep dive into the reported 1000 vacancies across the Trust, which has resulted in each area reviewing whether these are true vacancies. The full IPR is discussed at Board.

332. At People and Culture Committee, we are introducing a dedicated medical staffing report as well as the dedicated medical educational report. This is to ensure that doctors metrics can all be seen clearly together and add to the triangulation across the services.

333. We have been increasingly reporting medic related staffing in more detail through People Committee. We report the same statistics as for all other professional groups, but have again started to deep dives and give more information and assurance against our work with our SAS colleagues to support their development and opportunities, having signed up to the SASsix campaign, our progress against our Resident doctor 10 point plan, our progress with our Valuing Medical Leadership programme under the IIP. We are also doing a Quality improvement project on the 2025 RCPsych Retention Charter [**WITN0356048**].

334. Reviewing this data in People Committee allows us to ensure we always have

enough staff to provide enough clinical care for patients and also look for hotspots and areas that consistently need oversight from us. If these areas do exist, we question as to whether we need to a deep dive, or an establishment review. In addition, the data allows us to triangulate and identify areas where we are always having to have more staff than we should, and question if there a general trigger for that clinical ward or service.

335. Another important, more informal element is direct clinical and patient feedback. As Medical Director I have a lot of contact with medical colleagues across the Trust and host Q+A and briefing sessions, so I directly get feedback if there are areas of staffing pressures. One example would be Rampton Consultant colleagues contacting me earlier in 2025 about a staffing situation and members of the Executive team met to hear and then support the work the care group is doing to continue to improve its staffing availability work.

336. There has been a people related risk on the Trust's strategic risk register (the Board Assurance Framework - BAF) for a long time. It is fair to say that from 2019 until 2024, the people BAF risks focused on concerns about staffing levels. From 2024, following in depth conversations at People Committee and Board, it was felt that our staffing levels had improved in the vast majority of services and the people BAF risk was now about employee and engagement and morale, which had deteriorated post-

Concerns about staffing

337. I have reflected on my interview with Theemis [**TCLT0000810**], where I stated that staffing was a significant concern. Having reviewed the transcript, I was asked, "*...how they (Freedom to Speak Up (FTSU) reports) were being considered by the board in terms of how they informed your understanding of safety risks. So particularly around staffing, low staffing numbers.*"

338. My answer clearly started by acknowledging that I was very aware of staffing as a risk and then I went on to describe the complexities given the size and the

variance and gave examples where there had been staffing pressures. From a forensic perspective, Arnold Lodge and Rampton were discussed through the IPR.

Problems with staffing levels

339. For some services we have struggled to recruit and be an attractive employment option – this was the case at Arnold Lodge. Our adverts said the Nottinghamshire Healthcare NHS Foundation Trust, and Arnold Lodge sits in a different geography.

340. In some areas we have a variety of reasons – for example, at Rampton Hospital, we focussed on recruiting and had actually over recruited HCAs successfully but then found that our retention was an issue back in 2020-22. This was a similar pattern in offender health, where there was an added process of staff having to wait much longer to start in post due to dual processes of gaining security clearance in the Trust and in the prison service.

341. In acute mental health services, there has been a national pressure on registered mental health nurses compared to the number of posts, which is what we have also experienced. We also, through our Mental Health Transformation programme, created specialist mental health posts in the community with primary care networks and clinical staff moved out from our local mental health teams. Career expectations for nursing staff have changed and some colleagues progress from a Bd5 to a Bd6 nurse in 6 months and do not see the career opportunities or the flexibility they want in inpatient services roles.

342. Sickness has also played a large part in some of our services both in terms of short-term sickness and long term sickness.

343. There is then the element of need driving staffing. An example of is when escorting patients to health appointments or as an emergency, out of secure

hospitals. This can require between 4-6 staff per patient, which in the eventuality of 2-3 patients requiring emergency healthcare, can take upwards of 18 additional staff being needed urgently. In terms of thinking about need, it is also important to think about experience of staff. To have relational security, which is about knowing your patients and having therapeutic relationships to help support treatment and risk, the use of agency and to a degree bank staff, which we have had to maintain patient safety and care, does not support that.

Targets for numbers of beds

344. There are not any targets in terms of the number of beds. We do not have waiting times for beds, and use Nottingham based independent beds or OOA if needed.

Out of area placement

345. The Trust's governance structures of out of area (OOA) beds have been covered in the Corporate Witness Statement. In my Theemis interview **[TCLT0000810]**, I referenced that historically there had had been little oversight through the existing governance structures in respect of out of area beds. For more detail, from 2020 to 2022, the monitoring of out of area placements was monitored by the operational executive director for mental health. I am aware that she had regular meetings with the out of area providers. This changed in 2023 with agreement that the patient safety team would monitor that and report in the same way as oversight of trust quality was.

346. We had done a lot of work in becoming the Lead Provider for Impact (adult low and medium secure services commissioner for east midlands) to develop and embed a quality assurance process to oversee the care of all 9 providers involved in the collaborative. We used this model to include OOA quality surveillance in what to date had been an internal oversight of our own services. This was supported by a new role in the patient safety team and in our routine monitoring and escalations through to quality committee and board as needed.

347. The Inquiry has referred me to a Board meeting in January 2023, in which concerns were raised in regard to an incident at an out of area hospital. I can confirm that when incidents such as these are raised at Board level, they would be considered and any actions agreed. In this case, it was agreed that the Trust would review all care plans for patients at that provider, and a Quality Improvement Group had been stepped up, to ensure patient safety. This was a typical response to the concerns raised.

Concerns regarding inappropriate or premature discharge, including family involvement

348. I have not had any concerns raised directly to me about premature discharge of a patient or patients apart from, through the various investigation reports relating to the care and treatment of VC. I note earlier in my statement the questions in the board meeting of 4 May 2021 regarding assurance given about a discharge for a complex patient.

349. In my Theemis interview [**TCLT0000347**], I agreed that there was additional work to be done in relation to family involvement in discharge. I was clear that I and as part of the Trust are committed to improving the experience that all of our patients and carers and families experience and that this must be a continuous process. I was referring to not one single piece of work but that we were ambitious to completely change the culture and approach to participation across all services.

350. Embedding a safety culture and refreshing our approach to participation has been key. We appointed an Associate Director of Participation, Co-Production, and Patient and Carer Experience to develop a co-produced Carers Involvement Strategy which is being presented at Quality Committee in December 2025. We are in the process of recruiting to 33 carer leads across the 3 care groups, which are new roles in the organisation and linked with our safety and experience culture. Some of the work has been more

transactional such as having agreed discharge standards to be met involving families via a 8 point plan, developing consistent carer and family information booklets and having a patient and carer reference group and including family involvement in our training. We have families and patients who want to work with us to inform future training and share their experiences' of services to drive improvements.

351. Overall, in my Theemis interview, I was referring to the need to continue our planned work, which impacts across lots of areas, not just discharge alone.

Multi-agency working

352. The Trust has in place information sharing agreements with relevant partners and as Caldicott Guardian I sign these on behalf of the organisation. The format we use is in line with the Information Commissioner and NHS England guidelines

353. Information sharing agreements are the framework to agree that information can be shared between the identified organisations. On occasions they may include what specific information will be shared such as medical records when we are transferring a clinical service to or from another provider. I must stress that these again are frameworks, and enable sharing, rather than dictate sharing must occur or in what circumstance or the specific clinical context.

354. I appreciate that the Inquiry is specifically examining how information was shared regarding VC and Information Sharing Agreements are between organisations rather than about specific clinical care. [**WITN0356049**]

355. There is a general agreement and understanding that clinical information for the provision of health services is shared between, for example primary care and GPs and Local Authorities, who will have a key role in the overall health provision.

356. Information sharing between the Police and health services, is less clearly agreed upon or defined in terms of when and how much information is needed to be shared as one clear framework.

357. If a patient is subject to or comes under the criteria of Multi Agency Public Protection Arrangements, (MAPPA), Multi Agency Risk Assessment Conference (MARAC) or Preventing Radicalisation (Prevent), which are national statutory arrangements, these arrangements include and confer the right to share proportionate clinical information depending on the context.

358. An important point is whether the organisations are involved in the patient's care or not.

359. In terms of information sharing with the Police. The Police work to their guidance and there are two main circumstances when they may share information, either sharing health concerns about someone they may have come into contact with or sharing risk information based on criminal processes. They may seek information from health providers to assist from an operational perspective, such as the street triage team and liaison and diversion services, or they make seek clinical information to assist with coming to a decision about potential criminal proceedings. I highlight these to show just some of the various different information sharing scenarios that occur.

360. Adding to this is the basis that a medical record is an individual's record of their healthcare and that in order to share clinical information patient consent is needed, unless they are deemed to be lacking in capacity then it would be considering their best interests through the relevant framework. The same holds for information in the criminal justice system.

361. Guidance on confidentiality is very clear that the level of risk must be taken into account when taking a decision to share clinical information.

362. For organisations such as Universities, it is again complex as their students

are over the age of 18 and therefore adults, Information sharing could again take the format of the organisation wishing to share information with a clinical team (in secondary care or primary care) to raise concerns about or share information to support a student to get the right treatment.

363. It is absolutely considered good practice to engage with patients' families and to agree with the patient and the family members together how best to do that. We should be doing that from the first point of contact and during the care. Families are key sources of support and information, remembering that services and clinicians are only a part of a patient's contact.

364. When I was the forensic director, concerns were raised to me about information sharing with families in one of our secure hospitals and we worked with clinicians to agree how to decide what information can be shared in the eventuality a patient did not want to share any information with a family member and how family members information can be listened to, which is different to not sharing information about a patient's care.

365. Whilst I have not and do not have a formal role in liaising with the police, as Caldicott Guardian I do give advice to colleagues across the Trust about the proportionality of information that should be shared in some individual situations. When I was forensic director we had appropriate liaison with police via each of our clinical services as needed and also from a clinical perspective. As Medical Director I do think that our multiagency working is robust, but I have highlighted that there are different legal frameworks relevant to different sectors and different situations.

366. I also think it is important to note that any framework is guidance and allows for clinical or other professionals to make judgements so it will always be difficult to ensure consistency for each individual clinical or risk decision.

Treatment in the Community

367. In July 2024, NHSE tasked Integrated Care Boards (ICBs) to review community services for patients with serious mental illness, who require intensive community treatment and follow-up but where engagement is a challenge. The Trust has an Assertive Outreach Oversight Group who meet weekly to oversee pathway developments and includes the ICB. A role of this group is to oversee the completion of the national maturity index (benchmarking tool) to assess the service provision for patients who require an assertive outreach approach. Based on the results, an action project plan was created to improve and strengthen the current service provision. These include:

a. Development of the pathway's internal standards (expected contact frequency)

b. Pilot for personalised care plans co-produced with people who have lived experience – Personalised Care Policy based on national guidance currently (November 2025) being consulted on.

c. Introduction of patient rated outcome measures (PROMS)

d. Commissioned specific psycho-social intervention training

e. Patient and listening events delivered

f. Development of a specific Assertive Outreach clinical dashboard which includes total patient demographic, compliance with risk assessment and care plans and the number of appointments not attended. This information is reviewed weekly to ensure robust and assertive plans are in place alongside the opportunity to escalate any need for additional support.

Mortality Surveillance and Learning from Deaths Report

368. The Inquiry has referred me to a Mortality Surveillance and Learning from Deaths Report [**NHFT0001248**, p. 76] that I presented to the Board on 7 June

2022 and asked me specifically to explain what I understood as being meant by a comment included in Appendix 2 of that report, namely "The approach of the Crisis Resolution Home Treatment (CRHT) Team of considering their role to be limited to avoiding the need for patients to receive inpatient treatment". The Inquiry has also asked me whether the Trust took any action in response to this and whether there was generally pressure on clinicians to discharge patients into the community and/or prevent admission to inpatient treatments.

369. In order to respond to these questions, I have refreshed my memory as to the contents of this report and, having done so, I can see that it was linked with feedback received through inquests, that the crisis team would describe the purpose of their service as to prevent hospital admission by providing intensive interventions in the community [**NHFT0017677**]. Where admission does occur, the Crisis team will aim to deliver a package of care that reduces the length of this admission and works to achieve discharge as soon as possible. Whilst that accurately describes the primary function, the crisis service offer is much broader and needs to be described as such. The actual crisis model, as set out in the Working Instructions is to provide bespoke and enhanced support when people experience a deterioration in their mental health ie in a crisis. This can include admitting an individual but may also include assessment and treatment at home, support at Haven House or signposting and referral to other services.

370. As the role of the Crisis team is so varied and can change significantly depending on the patient, we have seen feedback in PfD reports that the full breadth of the Crisis team is not being well understood [**NHFT0001248**], and when staff would appear at inquests, they would tend to only speak about admissions avoidance. We have since encouraged staff who work in the Crisis team and give evidence at inquests to talk about the wider variety of the work they do and make clear that the team offers support beyond avoiding admission to hospital.

371. In addition, as part of the IIP programme we have a specific piece of work on

our crisis clinical model including the immediate telephone access support. This is significant in that the immediate telephone access allows a patient in crisis to access support very rapidly, with the aim for the patient to understand the other options available to them and engage appropriately. The hope is that this process guides a patient towards alternative treatment options, which may avoid the need for admission, but is of course complicated depending on the patient's condition.

372. As Medical Director, I have always been robustly in support of a clinician's assessment if they believe a patient needs admission, I would support that. This is linked with our out of are bed usage and use of our section 136 beds at times to manage pressures whilst identifying a bed.

373. There was not generally pressure on clinicians to discharge patients into the community inappropriately but there is acknowledgement that being in an inpatient setting should be for the time period it is needed, given the separation from a person's usual context, home and family. Clearly when a patient is assessed as being clinically ready to move into the community it is important that this is not delayed and we have had issues of this with a lack of supported accommodation placements for example, The clear national drive has been to move to community models of clinical care and the breadth of crisis support offers was in response to this and it remains a drive in the 10 year Health Plan.

Discharge schemes and impact on admission prevention – November 2022 IPR

374. The Inquiry has referred me to an IPR from November 2022 [**NHFT0000901, p.32**] I have reviewed the IPR referred to and whilst this excerpt was in the Mental Health Executive Director update, i do recall a focus on discharge schemes in the Mental Health Transformation Programme.

375. I understand the discharge schemes were short term schemes funded from

the Mental Health Investment Standard as part of winter planning. One was a contract with Improving Lives and Nottingham Community Housing Association (NCHA) which provided support for patients to prevent admission/ support discharge and these were integrated into our community rehabilitation service model providing recovery workers.

Reviews commissioned by or in relation to the Trust following VC's attacks

376. The Board's involvement in all of the internal and external reviews commissioned into the attacks committed by VC has been covered in detail in the Corporate Witness Statement and I do not propose to repeat that detail here. I am aware, and I have referenced it earlier in this statement, that the internal review into the EIP and LMHT teams contain specific recommendations directed at the medical workforce, which is being considered.

GMC referrals

377. As Executive Medical Director in my capacity as Responsible Officer for the Trust, I oversee the revalidation of doctors and their professional practice. As part of this I hold regular meetings with our General Medical Council (GMC) liaison officer to discuss any concerns I want to share and discuss any referrals I may be considering to the GMC.

378. In terms of investigations into doctors practice, this is governed by the Trust Maintaining High Professional Standards (MHPS) Policy which is in line with the national MHPS guidance: In December 2003, the Department of Health issued the document High Professional Standards in the Modern NHS; a framework for the initial handling of concerns about doctors and dentists in the NHS [**WITN0356050, WITN0356051**]. The purpose of this nationally standardised approach is to ensure that capability issues regarding doctors are managed in the same way for all doctors.

379. When a concern of any type is raised about a doctor, the first action is to

understand the concern and see if there any immediate patient safety concerns that mean we need to put immediate actions in place. Such an example may be supervised practice or doing non clinical activities whilst the concerns are looked into further. At that stage I would also ask for triangulation to be done to see if there have been any other concerns raised via other routes, such as by line managers, Serious Incidents (SIs) or complaints. Our policy includes a restorative justice approach, and the initial stage is to determine the facts to inform what the next steps should be.

380. The next step in our policy is to hold a Decision Making Group (DMG). This is convened of myself, the deputy director of people and culture and deputy medical director/associate medical director (another senior medical management colleague).

381. If the concerns are felt to need further investigation by the DMG, there would be a discussion with the GMC liaison officer and the Practitioner Performance Advice (PPA). The discussion with the GMC is to inform and discuss any other necessary actions at this stage eg making a referral to GMC. Practitioner Performance Advice was established in 2001 and is now a service delivered by NHS Resolution under the common purpose, to provide expertise to the NHS on resolving concerns fairly, share learning for improvement and preserve resources for patient care. PPA were set up to provide impartial advice to healthcare organisations to effectively manage and resolve concerns raised about the practice of individual doctors, dentists and pharmacists.

382. Once an Investigation under MHPS has been commissioned by the Medical Director, the CEO is informed and a non executive director is named as the Designated Board member. Their role is to oversee the Case Manager and Case investigator, ensure process is followed, for example keeping to the timescales set for the investigation, receive any representations and arbitrate on matters raised by the doctor, such as the composition of any panel.

383. An investigator is appointed, depending on the issue, Terms of Reference are drawn up and once completed the Investigation Report is submitted to the Medical Director, as the Case Manager and the DMG is reconvened.

384. The available outcomes then are:

a. There is a case of misconduct that should be put to a conduct panel.
b. There are concerns about the practitioner's health that should be considered by the NHS body's occupational health service.
c. There are concerns about the practitioner's performance that should be further explored by the PPA.
d. There are intractable problems, and the matter should be put before a capability panel.
e. Restrictions on practice or exclusion from work should be considered.
f. There are serious concerns that should be referred to the GMC.
g. No further action is needed.

385. A large element of the outcome will depend on the specific concern or issue and the doctor's response to date in terms of insight and understanding.

386. In the context of VC's care and the tragic events, it is important to note that as the different investigative processes took place, more information about the different doctors' involvement and actions became known. I am aware that it might seem unusual for a Trust investigation not to have been launched initially into the doctors' practices who had been involved in VCs care. This is why I have outlined the MHPS policy as this is the process that must be followed.

387. In terms of the primacy of investigations, the Trust SI report was conducted

and then the Independent Homicide Review would take place, which, as the independent investigation, I had believed would interview all relevant clinicians to understand the clinical rationales for their decision making, in completing that report. When the Chief Executive, Chief Nurse and myself met with the 3 families of those killed by VC, in August 2023, when asked about GMC referrals I explained that none had been made to date and I was awaiting the Independent Homicide Review (IHR). It would not have been appropriate for us to do a separate investigation at that stage, given the primacy of the independent homicide review. If it had not been about clinical practice, such as concerns about behaviours or conduct, that would have been different.

388. In between these, there was the CQC Section 48 review which considered "all available evidence" to consider the care of VC. It is important to highlight that as such, this did not involve any of the involved clinician's being interviewed in line with the reviews Terms of Reference. I say this to point out how over time and processes, the level of detail and what is known has developed.

389. During this time period, one doctor was advised to self refer to the GMC as their clinical care was criticised in the Independent Homicide Review and I worked with that individual to do that.

390. In the initial period when we knew VC's identity and the doctors involved in significant parts of his care, I considered and checked for any triangulating concerns about the doctors and deemed that there were no grounds for immediate exclusion for example based on patient safety.

391. I appreciate that may seem unusual given the absolute gravity of the deaths and life altering injuries but the MHPS process applies in all situations. As the investigations continued and what have been termed "missed opportunities" in his clinical care have been highlighted we have continued to assess.

392. In order to try to answer the families questions submitted in August 2023 to the best of our ability, clinicians were interviewed using the complaints process and a chronology was drawn up by the Patient Safety Team. This gave some more information into the clinical rationales for some of the decisions, except for the discharge decision [**WITN0356052**].

393. We then set up a Professional Practice Review Process, based on MHPS. This was specifically done to have a framework to review all doctors involvement in VC's care. [**WITN0356053**]

MHPS Decision Making Group

394. The Trust initially set up an extra-ordinary Decision-Making Group (DMG). The DMG described in the MHPS policy was extended both in terms of membership and remit for this purpose. The Decision-Making Group included [**WITN0356054**]:

a. Dr Sue Elcock, Executive Medical Director, Nottinghamshire Healthcare NHS Foundation Trust

b. Lorna Lord, Deputy Director of People and Culture, Nottinghamshire Healthcare NHS Foundation Trust

c. Dr Itai Matumbike, External Medical Director (Northamptonshire Healthcare NHS FT) - as an independent MD to ensure process, not as a decision maker **[WITN0356055]**.

395. The extra-ordinary DMG met on 4th February 2025 [**WITN0356056**] to review the timeline of all clinical interactions with VC. Anna Hiley, Deputy Medical Director was in attendance to present as she interviewed the Doctors to respond to the questions about care.

396. On 17 February 2025, myself and Dr Anna Hiley met with the doctors in scope to verbally explain the process that was to take place. This meeting

was not minuted, nor was a formal record taken, but a brief summary was emailed to me by Dr Hiley after the meeting.

397. The DMG reviewed each doctor and their personal contact with VC. **[WITN0356057]** At a further meeting with myself, Dr Anna Hiley and Lorna Lord on 19 February 2025, it was agreed that Dr Hiley and Ms Lord would review each doctor to separate out the interactions with VC by individual doctor rather than chronologically. This review concluded on 7 March 2025. This was an iterative process of reviewing all the relevant documents, and general and specific clinical queries, and therefore took some weeks to finalise.

398. By 21 March 2025, a list of outstanding questions from the DMG had been produced [**WITN0356058**]. An Extraordinary IOAG meeting was convened to review all the decision-making clinicians on 21 March 2025 **[WITN0356059]**. On 21 March 2025, I met with Jacqueline Gilbey (PPA) and sent a formal request for advice on 31 March 2025.

399. Once the iterative process of reviewing each individual doctor had concluded, further questions were identified for 3 doctors **[WITN0356060]**. At this time, 1 doctor had self-referred to the GMC on the advice of their defence body to ask if what was stated in the public domain regarding their care met the threshold, with the support of the Responsible Officer (RO).

400. On 28th March 2025 in line with the Trusts MHPS Policy a DMG was set up this included:

d. Dr Sue Elcock, Executive Medical Director and Deputy CEO

e. Anna Hiley, Deputy Medical Director

f. Lorna Lord, Deputy Director of People and Culture

401. With advice and guidance from the PPA I advised 3 Doctors that formal

investigations regarding their care of VC would commence under our MHPS Policy. It was further agreed that we would seek further advice from the PPA and the GMC about potential formal investigations under the MHPS policy.

402. At a meeting on 1 April 2025, the PPA supported the DMG to identify a suitable clinician to conduct the investigation [**WITN0356061, NHFT0014420**]. As this Doctor is a GP who has experience of similar investigations it was agreed he would be supported by a psychiatrist to provide clinical professional expertise for the two cases that involve clinical decision making. The PPA followed up in writing on 2 April 2025, setting out the agreed approach. [**WITN0356062**]

403. On the suggestion of the NHS England Regional Medical Director, Lorna Lord met with the Associate Medical Director of the regional NHS England team on 14 April 2025 to provide an update on the process of reviewing the doctors who had been involved with VC's care. It was agreed at this meeting that the Trust DMG would follow the MHPS policy clearly and decision making would be recorded in relation to any referrals to the GMC [**WITN0356063**].

404. A follow up meeting took place the following day, 15 April 2025, which I attended with Lorna Lord and Dr Anna Hiley. It was agreed that when the DMG formally advised the Chief Executive of the start of the MHPS process, it would state that the composition of the DMG had been considered and the current membership was deemed appropriate.

405. On 13 May 2025 Dr Colin Fitzpatrick agreed to undertake the investigations [**WITN0356064**]. Lorna Lord approached the Chair of the Trust on 14 May 2025 to request a Non-Executive Director to support with the MHPS process. [**WITN0356065**].

406. At the time of writing, the 3 cases are at the following position:

a. One case is concluded, and the Doctor has been advised that there is no further formal action, and he will submit a reflection as part of his next appraisal. This remains an open case with the GMC. [**NHFT0004707, WITN0356067, WITN0356068, WITN0356069, WITN0356070, WITN0356071, NHFT0004741, WITN0356073**]

b. The other two cases are still at investigation stage [**NHFT0015050, NHFT0015049**].

407. It should be noted that this process is ongoing and it is possible that other clinicians may be the subject of a fact find through a DMG.

Other actions in response to VC's attacks

408. I was involved in planning which high secure estate VC was admitted to from prison.

409. I have led Medical professional practice reviews.

410. I led a series of briefings to all doctors, including some specifically for resident drs relating to the publication of the various reports including S48 review, Independent Homicide Review and entry into NHS England Oversight Framework 4. These continue as regular Q+ A sessions.

411. I have led and convened development sessions for doctors directly or more indirectly involved in VC's care.

412. With my deputy, we have been in liaison with the Chair of the Royal College of Psychiatrists working group on the Effect of Suicide and Patient Perpetrated Homicide on Clinicians regarding support.

Reflections on care provided to VC

413. Firstly, I would again wish to reiterate my own apology and that of the Trust to all of those so impacted by the tragic events of 13 June 2023. I appreciate an apology can make no difference and we all want to ensure, that this does not occur again.

414. As Medical Director I support the Corporate Witness Statement, and we have publicly stated that the Trust accepts the findings and recommendations conducted to date regarding VC's care. I add my personal agreement with this, as Medical Director.

415. I remain committed to continue to bring about the ongoing improvements with my colleagues.

416. I have reflected over the duration of time since this tragic event and in light of the various investigations and am obviously mindful that further information may be shared during the Public Inquiry.

417. My main reflections about VC's care are about the clinical risk assessment and record keeping elements as well as the systemic model of care that was in place for people with severe and enduring mental illness. There were clear issues regarding record keeping and the need as clinicians to document the basis on which decisions are being made. I would reflect particularly on VC's discharge back to his GP in September 2022 and the need to be clear on the rationale, all attempts that had been made to adapt the approach to engage with VC and appropriate safety netting with others around him. My reflection is that the clinical rationale should have been more carefully recorded in respect of this discharge and that more detail was required, especially given as a mental health service we are only a small part sometimes of a patient's network. This has been recognised and features in the "Quality Standards for Early Intervention in Psychosis Services (Third Edition)" published 1 April 2025 [**WITN0356076**].

418. The importance of records is also to support the ability to use them to understand the longitudinal presentation and any patterns to assist with formulating treatment and risk management plans. This is another area highlighted and as a Forensic Psychiatrist, I am very aware that risk assessments are central to our training to become forensic psychiatrists and a core part of our clinical way of working with patients and families, in a way that I personally feel is not necessarily the same in other specialty psychiatry training.

419. Risk assessment cannot always be precise and balancing the use of the MHA against applying the least restrictive measures. It is a fine balance and nothing is completely predictive. I feel it is important to say that while risk assessments are essential, they cannot predict every outcome.

420. The importance of Multiprofessional Team decision making is an area. In order for this to be the way of working, a consistent team is needed. This is not about staffing but having strong multiprofessional teams that can jointly make decisions which is underpinned by having a consistent team. This is the same for any team at any level of the organisation.

421. There is also a need for clinical services to work closely together and for more specialist services to support more universal services to best support patients and each other by using their expertise. We have supported closer working between our community forensic service and adult mental health services to support consultations and advice.

Additional actions the Trust could have taken in respect of VC

422. The Trust's Corporate Witness Statement has set out in detail the additional actions that could have taken place in respect of VC's care, and I endorse that here but do not repeat it in detail. In particular, as set out in section above, I have reflected that the quality of analysis and discharge documentation in relation to VC's final discharge in September 2022 could

have been of better quality and much more detailed.

Reflections generally

423. My main reflections about the care provided to VC involve the risk assessments, record keeping, decision to discharge and the systemic lack of a clear model for supporting people with a severe and enduring mental illness.

424. Accepting the findings and recommendations, I have also considered in particular the clinical findings. There were clearly different views about the prescribing of a depot antipsychotic medication between the community care co-ordinator and the inpatient consultant psychiatrist during the last hospital admission. From processes to date, there was a clinical rationale as to why the depot was not prescribed and it was considered during a number of clinical discussions. I appreciate the clinical rationale as to why that decision was made, i would also reflect that should VC have been on a depot antipsychotic, patients do still choose to stop accepting a depot, the same as for tablet medications.

425. In clinical care there are occasions when clinicians form different views and it is important that those are all considered. It is difficult to view mental health care in the context of there is always a clear right or wrong view and we are guided by frameworks to try to balance and guide the decision making but ultimately the decision will be a judgement by the guiding clinician.

426. The NICE guidance for treating schizophrenia says , "1.*5.5.3: Consider offering depot/long-acting injectable antipsychotic medication to people with psychosis or schizophrenia: who would prefer such treatment after an acute episode where avoiding covert non-adherence (either intentional or unintentional) to antipsychotic medication is a clinical priority within the treatment plan*".

Then: 1.5.6.1, "*When initiating depot/long-acting injectable antipsychotic medication: take into account the service user's preferences and attitudes towards the mode of administration (regular intramuscular injections) and organisational procedures (for example, home visits and location of clinics)*" **[NICE0000017]**

427. Linked with that point, I think there needs to be considerations about what balance is there between the Mental Health Act principle of care being in its least restrictive form to the patient and the level of risk. As a clinician, it is my responsibility to take decisions within the Mental Health Act and my clinical rationale would be considered in the Act's rights, for example at Mental Health Act Review Tribunals. This goes to the finding that not being subject to a Community Treatment Order was a missed opportunity in Theemis.

428. A CTO allows for a patient to be recalled to hospital to receive treatment such as depot medication if there are signs of a deterioration or risk escalates. If a patient is not subject to a CTO, but there are concerns about their mental illness and risks to themselves or others, powers exist within the MHA to arrange a MHA assessment.

429. The national and international focus on restrictive practice is high. As a Trust and in the 10 year Health Plan there is a high focus on Health Inequalities. We report on detentions under the MHA by ethnicity for example, because of the evidence of black men being detained under the MHA at a significantly higher rate than others. There are questions such as are, in the broader sense, our mental health services able to reach out to underserved populations? Traditionally services have talked about patients who disengage and the term DNA has been used – did not attend. Culturally we have to move to clinical services that do meet the needs truly of their populations.

<u>Theemis findings</u>

430. Some of the Theemis findings could be considered in the current review of

the Mental Health Act in my view. There was a question about why responsibility sits with the inpatient consultant but Chapter 29 of the Code of Practice [**DHSC0000007**] clearly lays out it is the current Responsible Clinician's decision with an Approved Mental Health Practitioner (AMHP) to make a patient subject to a CTO. I fully agree that there should be involvement in the decision making with the community team, who should be best placed to make such a decision to support their ongoing care and with the patient's family.

Risk assessments

431. In terms of the risk assessments, all findings note the lack of longitudinal formulation taken into account to inform the risk assessments.

432. Developments over the last 20 years in mental health services have seen more specialist services developed and there are many more transitions for patients. For VC's care he was admitted to different wards under different consultant psychiatrists care as well as to out of area services beds, and he had involvement from both the Crisis and EIP teams. Considering this on one hand, specialist teams have brought benefits with different clinical models to support patients at different times of their illness, but with that brings an inherent challenge to a longitudinal view taking. It can absolutely be done, but I wanted to reflect that the models themselves have brought in more points of transition.

433. It is highlighted in Theemis Report that the risks in the community were seen as a list of risks [**NHSE0000298**]. There was not a formulation such as of predisposing, precipitating and perpetuating factors leading to scenario risk planning which is an approach used often in forensic services, and we have included the focus on formulation planning in our Trust wide risk assessment training.

434. I remember the introduction of both specialist Assertive Outreach Services

and Early Intervention in Psychosis Services during my clinical work. AO services were specifically introduced to have a much smaller caseload of patients so that staff could be much more flexible and repetitive in their attempts to work with patients with severe and enduring mental illness. Whilst some of the functions have been maintained in community mental health services, the loss of the AO services has had an impact. There has been recent work guided nationally for all Trusts to review patients who would benefit from this approach and function which will be of significant benefit.

Decision to discharge

435. In terms of the decision to discharge VC from the EIP Service, the findings to date show that the record keeping is limited as to what breadth of clinical discussion had been held to make this decision and had he been seen from a longitudinal perspective, would more signposting to other services, such as the Police, University, family and Primary Care been done at the time of discharge. There is a balance of from a team perspective, keeping a patient open to a service that you are not seeing clinically but there are options in the eventuality of taking that decision as to how to flag the risks and put a safety net in place. I am particularly minded that decisions were taken during his care as to how staff worked with VC, and specifically a change to needing two staff and for him to come to the service rather than being seen in his accommodation. These decisions showed an appreciation of his risk to others, such as to staff but it is unclear if that translated to the broader environment and public. (there is currently an MHPS investigation into involving this decision and I am mindful that through the Public Inquiry this area will be considered further)

VC's fourth admission

436. One finding in the Trust's Serious Incident Investigation, the CQC section 48 investigation and the Theemis Report that further information has become

known about is the finding that VC should have been detained for his fourth admission under a section 3 and not a section 2. When this was originally made as a finding, I could fully appreciate the basis that with an individual with a known severe mental illness such as schizophrenia, it is considered good practice that a section 3 be used which allows for treatment and is for a longer duration than a section 2. In this specific instance, however, the doctor involved has given his clinical rationale which I believe is in line with decision making within the MHA. From my perspective the assessment concluded that the nature of the mental disorder was met but not the degree of the disorder in terms of detention under the MHA and therefore I can understand the clinical view ultimately reached that a section 2 was used and not a section 3.

Could more information about VC have been provided to the Trust?

437. Since the attacks and the subsequent reports, it has become apparent that there were missed opportunities for better information sharing between external agencies and the Trust, that would have impacted care and discharge planning. However, I do not consider this as a particular failure of the agencies themselves, but rather the lack of clear protocol for them to follow, in which they could have informed the Trust of their own concerns.

438. In my experience, if a colleague in primary care had any concerns, eg if VC had presented at his GP practice they would contact us to discuss or rerefer. For patients with similar diagnoses to VC, the individual clinicians providing care need to provide as much detail as possible to all agencies when required, to assess the level of risk and provide any additional information required for other agencies to discharge their own duties adequately. It is vital for those providing care to give a full description of an actual situation or event, and this needs to be accurately described rather than simply labelling it eg hostage situation. Undertaking MHA assessments, for example, a clinician needs to be presented with an accurate description with as much information as is known at that time to assess that level of risk.

439. For cases that fall under the MAPPA guidance, there are very clear guidelines for how agencies should work together. For those cases that do not, there is an absence of clear procedure such that inter-agency working is dependent on clinicians' views. I do consider that this could be improved by the introduction of an additional policy at a national level.

List of questions submitted by bereaved families

440. I was involved with the CEO and Chief Nurse in agreeing how to address the questions and oversee their signoff for sending. The questions had come directly to the Trust and also to NHS England, the regional Medical Director co-ordinated the meeting referenced in **NHSE0000852**. The questions had been shared with NHS England prior to this meeting, and the decision was taken that the Trust would answer them independently. The questions were also submitted for consideration for inclusion in the Independent Homicide Review Terms of Reference. When the CEO, Chief Nurse and I met with the families of Barnaby Webber, Grace O'Malley Kumar and Ian Coates in London (need specific date in June 2024) we undertook to address the questions noting that the expectation would be that the Independent Homicide Review would have primacy to address within the full context of that review. I also presumed that the Independent Homicide Review process would involve an interview with each of the key clinicians, as was my experience with previous Independent Homicide Reviews.

441. An independent psychiatrist to the Trust (Dr Jason Read) and the Dr Anna Hiley, Deputy Medical Director, led on organising input from the relevant clinicians[1] to answer the questions sent by the families, by undertaking discussions with each doctor to gather responses to the questions. The purpose of the discussions with the doctors was to answer the families' questions, rather than undertake formal interviews; therefore, these discussions were not recorded as individual clinician statements or interview notes. The discussions with the doctors took place on 8 and 9 October 2024, and were recorded separately by Dr Read and Dr Hiley, each using a single proforma to record all clinicians' responses that assisted with answering the questions, with the exception of Dr Lloyd. Dr Read and Dr Hiley then merged

[1] The eight doctors that contributed to the response were Dr Jonathan Gibson, Dr Khuram Malik, Dr Mike Skelton, Dr Omar Manzar. Dr Karthik Thangavelu, Dr Ben Lomas, Dr Ben Di Mambro, Dr Faizal Seedat and Dr Tuhina Lloyd.

their proformas into a summarised, single proforma that was subsequently used to respond to the families' questions. [**NHFT0004868**].

442. Dr Lloyd was away from work and provided a written response on her return. Dr Read then had a conversation with Dr Lloyd, and some additional notes were added to her initial response (in red text). [**NHFT0015626**].

443. Unfortunately, I do not consider that given the time frame the questions were asked at (before we had sight of the Theemis report), the questions could ever have been answered in a way that was entirely satisfactory to the families, as we were missing context that became available as Theemis was published and in the resulting next actions. was provided to us at a later date. However, as a Trust, we wanted to share as much information as openly and as quickly as we could, whilst being cognisant of the fact that this information was based on incomplete knowledge, and more context would be provided upon the publication of the Independent Homicide Review.

444. The primacy and independence of the IHR is very important in this. Some of the questions were very factual which I think we did address, some needed more context or were linked with confidentiality which at that time we were not in a position to share but were aware that further processes would be carried out that would share.

445. My view that the IHR should take primacy was based on the national process for investigating when a person known to mental health services carries out a homicide, and my previous experiences with such processes. I was interviewed for the IHR, but I had believed that wider clinical colleagues involved directly in VC's care, would have been interviewed in order to give their clinical rationales for decisions they made. The CQC section 48 review regarding VC's care was based on a review of the available information at the time, noting he had just been sentenced. From a primacy perspective, the section 48 learnings were based on the available evidence and not any

interviews with clinicians as per its Terms of reference at that time, and I had expected the Theemis homicide review to include interviewing all of the relevant clinicians including those involved in what have been deemed as missed opportunities.

Contact with survivors and families (including VC's family)

446. My previous experience with IHRs had been that we would not make contact with the families until this had been completed. However, in this case, as medical director I have worked closely with the CEO and Chief Nurse in particular around all of our responses and focus on our work with the survivors and families of victims and VC's family and to address their concerns as much as we have been able to. Whilst I have only met with the families once, we have worked together on every communication we have had as a Trust with the families, and I have assisted both the CEO and the Chief Nurse in responding to various queries from the families and preparing for the meetings they have had.

Did the Trust provide adequate information to survivors and families?

447. I think that on reflection we provided information within the confines of the expected processes which inhibited it being timely or of the broadest context. At the time we shared what we felt we could and in as timely a way as was possible. As stated in the previous paragraph, I have worked closely with our CEO and Chief Nurse in particular on communicating directly with the families as frankly as possible. on communicating directly with the families as frankly as possible.

448. It is a very complex situation with a lack of guidance for us, as the organisation that provided clinical care for the patient and our duty regarding his confidentiality and balancing that with the absolute desire to be as open as possible with victims and families of victims. In my view by sharing the internal SI we demonstrated a wish to strive to be open, within what was and,

in my view, remains an unclear area, and I consider that this is an area where the Inquiry could make a recommendation for improvement. I acknowledge there was a long gap to first make contact, and we have apologised for this.

Improvements locally and nationally to multi-agency working and information sharing

449. This is a really complex area. There is the GMC Guidance which focuses on medical professionals' ethical and legal duties of confidentiality. **[WITN0356077]** This outlines 8 principles to consider when thinking about sharing patient information. As doctors and nurses, registered clinicians, we have to balance the principle that a patient should be asked if we want to share their information, except for in some specific circumstances. Whilst these do include public protection, it is guidance and will rely on each individual's judgement of the weighing up of factors.

450. There will always be a tension particularly between sharing medical information with the police and criminal justice systems as to who decides what is proportionate to share. This has come through from when Multi Agency Public Protection Arrangements were put in place in 2003 through to everyday health and police interactions about Crown Prosecution Service (CPS) decisions to charge or not charge people who have mental health conditions and are in contact with services. Some will believe that all of the medical record would be needed for a charging decision to be made, whilst clinicians would not feel that. At Rampton there has been work trying to agree between ourselves and Police what is the required level of medical information needed if a potential crime has been reported such as violence to staff.

451. Earlier I described the wide variety of scenarios that organisations in different sectors may wish to share information and the fact that there are different frameworks and I wonder if there needs to be consideration of

whether their underlying principles cause a lack of clarity, that could be supported by national protocols about determining primacy.

452. As the Caldicott Guardian in the Trust, I have escalations from clinicians internally seeking discussions and guidance in complex decisions about sharing clinical information. This would be at the discretion of the clinician to seek and I do wonder about the awareness of this role to non-health agencies, as it is rare that I get directly approached by another organisation. I was recently and made a decision to share some information due to a public safety concern.

453. The UK Caldicott Council describes the role: "A Caldicott Guardian is a senior role for an organisation which processes health and social care personal data. They make sure that the personal information about those who use the organisation's services is used legally, ethically and appropriately, and that confidentiality is maintained". Caldicott Guardians should be able to provide leadership and informed guidance on complex matters involving confidentiality and information sharing.

454. The Caldicott Guardian should play a key role in ensuring that their organisation satisfies the highest practical standards for handling person-identifiable information. Their main concern is information relating to individuals and their care, but the need for confidentiality extends to other individuals, including their relatives, staff and others. Organisations typically store, manage and share personal information relating to staff, and the same standards should be applied to this as to the confidentiality of patient information.

455. Caldicott Guardians should apply the eight Caldicott Principles wisely, using common sense and an understanding of the law. They should also be compassionate and courageous, recognising that their decisions will affect

real people—some of whom they may never meet. The importance of the Caldicott Guardian acting as "the conscience of the organisation" remains central to trusting the impartiality and independence of their advice.

456. In all but the smallest organisations the Caldicott Guardian should work as part of a broader information governance function, with support staff contributing to the work required. A key relationship is with the Senior Information Risk Officer (SIRO). The SIRO is the director of partnerships and strategy which includes the data function.

457. There are 8 Caldicott Principles:

Principle 1: Justify the purpose(s) for using confidential information
Every proposed use or transfer of confidential information should be clearly defined, scrutinised and documented, with continuing uses regularly reviewed by an appropriate guardian.

Principle 2: Use confidential information only when it is necessary
Confidential information should not be included unless it is necessary for the specified purpose(s) for which the information is used or accessed. The need to identify individuals should be considered at each stage of satisfying the purpose(s) and alternatives used where possible.

Principle 3: Use the minimum necessary confidential information
Where use of confidential information is considered to be necessary, each item of information must be justified so that only the minimum amount of confidential information is included as necessary for a given function.

Principle 4: Access to confidential information should be on a strict need-to-know basis

Only those who need access to confidential information should have access to it, and then only to the items that they need to see. This may mean introducing access controls or splitting information flows where one flow is used for several purposes.

Principle 5: Everyone with access to confidential information should be aware of their responsibilities
Action should be taken to ensure that all those handling confidential information understand their responsibilities and obligations to respect the confidentiality of patient and service users.

Principle 6: Comply with the law
Every use of confidential information must be lawful. All those handling confidential information are responsible for ensuring that their use of and access to that information complies with legal requirements set out in statute and under the common law.

Principle 7: The duty to share information for individual care is as important as the duty to protect patient confidentiality
Health and social care professionals should have the confidence to share confidential information in the best interests of patients and service users within the framework set out by these principles. They should be supported by the policies of their employers, regulators and professional bodies.

Principle 8: Inform patients and service users about how their confidential information is used
A range of steps should be taken to ensure no surprises for patients and service users, so they can have clear expectations about how and why their confidential information is used, and what choices they have about this. These steps will vary depending on the use: as a minimum, this should include providing accessible, relevant and appropriate information - in some cases, greater engagement will be required.

458. I highlight some of this to show the range of guidance and law on data sharing in different settings, but all is a judgement. I think the role of Caldicott Guardians is little known and perhaps could be built into this nationally.

Improvements that could be made to the Trust and the healthcare sector generally

459. We have been making a broad range of improvements as agreed with our regulators and stakeholders through our IIP and its assurance processes. These will continue and the need to be embedded and sustained. Some of our work will continue as redesigning our LMHTs will be a longer piece of work to complete for example.

460. The definition of what presentations are supported by mental health have broadened over decades and the focus on Severe Mental Illness (SMI) has lessened. I think the national focus back on to Assertive Outreach (AO) function and the recent RCPsych Early Intervention (EI) standards are helpful [**NHSE0002336**].

461. I also think the focus on an arbitrary split between physical health and mental health has become unhelpful. We should see a person in the whole and the move to neighbourhood team models, where as a person you shouldn't be bounced between different services not meeting service criteria, but a model of what is the right support or treatment needed even if it is signposting.

462. I fully appreciate our country's and the NHS's financial position, but the focus on parity of esteem has been lost. We do need to have better patient reported outcome measures so we can demonstrate by outcomes, rather than by activity the value linked with good outcomes for people with mental health conditions.

Recommendations

463. As Medical Director, I was involved in and support the recommendations in our Trust Corporate Witness Statement.

464. As I have stated earlier in this statement, I think that a clearer process in relation to the publication of IHRs should be considered. In my previous experience, prior to the VC case, where we had been in receipt of an IHR, we would not make any contact with families until the report was finalised, and they would be provided with a redacted copy of the report through the independent homicide review process. It would also not have been usual to have provided families with an unredacted version of the SI investigation report. Having reflected on this specific case, I do consider that this previous approach could create an information vacuum and leaves families without the full details that they need. I consider that it would be beneficial for there to be clear and consistent guidelines over when and how IHRs are published and shared with families and how this impacts on the provider's ability to respond to questions pending completion of the IHR. This will enable providers to support families in a more measured way, and additionally ensure families are aware of the process, and will be able to ascertain when and how their key questions will be answered.

465. I also think that there needs to be a national approach to learning across the NHS with it being set that all relevant Trusts would learn from the most serious incidents and show that learning through to boards. Having national learning and data to support all organisations being required to learn together and hold NHS corporate memory.

Statement of Truth

I believe the content of this statement to be true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Signed: GRO-B

Dated: 27 January 2026

Index to First Witness Statement of Susan Elcock

No.	Inquiry URN	Document Description
1.	WITN0133001	First Witness Statement of Diane Hull on behalf of Nottinghamshire Healthcare NHS Foundation Trust
2.	WITN0356002	Certificate for Section 12 MHA showing approval as Responsible Clinician
3.	WITN0356004	Terms of Reference Paper - Public Board of Directors - 25 September 2025 - MHL Separation from QC
4.	WITN0356003	Ratified Private Board of Directors Minutes – 25 September 2025 approval for Mental Health Legislation Committee separation from Quality Committee in November 2025
5.	TCLT0000810	Susan Elcock Theemis Interview Transcript dated 6 June 2024
6.	CQCM0016438	CQC Single Assessment Framework
7.	NHFT0000423	External Review of Serious Incidents by Helen Collins
8.	TCLT0000347	Susan Elcock Theemis Interview Transcript dated 14 June 2024
9.	WITN0356005	Forensic Division Progress Report July 2020
10.	WITN0356006	Report undated, compiled by unknown, re: Report on the work undertaken to support the Directorates in the Forensic Division on the development of their governance arrangements
11.	WITN0356007	Quarterly Report to FDMT – Anna Pridmore 19 July 2021

12.	WITN0356008	Quarterly Report to FDMT – Anna Pridmore 20 October 2021
13.	WITN0356009	2022 Annual Internal Audit Plan
14.	WITN0356010	Audit Committee on 2 March 2023 from Public Board Meeting on 30 March 2023
15.	WITN0356011	2023-2024 Internal Audit Plan
16.	NHFT0002015	2019 CQC report
17.	NHFT0000827	Public Board Papers – 4 August 2020
18.	NHFT0003812	Public Board Papers – 06.10.2020
19.	NHFT0002584	Public Board Papers – 03.11.2020
20.	NHFT0003222	Public Board Papers – 01.12.2020
21.	WITN0263018	Version 2.0 Quality and Performance Management Terms of Reference
22.	CQCM0016478	CQC Inspection Report 2022
23.	NHFT0003275	Integrated Improvement Plan IOAG Update: Progress against S48 Recommendations
24.	WITN0263014	Mental Health Legislative Committee – Terms of Reference – separation from Quality Committee
25.	WITN0356012	Integrated Performance Report 27 November 2025
26.	WITN0356013	Accountability Framework Minutes – 2025
27.	NHFT0001252	SafeNow Dashboard
28.	WITN0356014	Finance Committee Terms of Reference
29.	WITN0356015	NHS England National 10 Point Plan to improve resident Doctors working lives.
30.	WITN0356016	Medical Staff Committee Terms of Reference
31.	WITN0356082	Joint Local Negotiating Committee

32.	WITN0356017	Note from meeting with coroner
33.	NHFT0001778	CQC Inspection 2020
34.	NHFT0000461	EIP Review
35.	NHFT0002354	2019 CQC Action Plan
36.	WITN0356018	Grant Thornton Well-Led Review
37.	WITN0356019	Integrated Improvement Plan Programme Board – Digi-Care Project Highlight Report
38.	WITN0356020	External review of medicines management governance
39.	TCLT0000818	Level 2 Comprehensive Investigation Report dated 22 February 2024
40.	NHNB0018961	NHS England National Oversight Framework
41.	WITN0356021	Integrated Improvement Plan Portfolio Board
42.	WITN0356022	Integrated Improvement Committee Terms of Reference
43.	WITN0263028	Regional Improvement Oversight and Assurance Group (IOAG) Terms of Reference
44.	WITN0356023	Governance Programme Terms of Reference
45.	WITN0356024	Action Plan for Medicine Management
46.	WITN0263036	NHFT RSP Review Meeting– 6 December 2024
47.	WITN0263037	Board to Board meeting with NHS England Midlands Regional Team - 8 October 2025
48.	WITN0356025	Patient Carer Race Equality Framework (PCREF) our Improving Care Together Plan going to Quality Committee in December 2025
49.	WITN0263054	Risk Escalation Framework
50.	WITN0133024	HCR-20

51.	NHFT0003231	Clinical Risk and Safety Policy
52.	WITN0356026	Board Assurance Framework (BAF): November 2025
53.	WITN0356028	NHS England developmental well led review reported in January 2025
54.	CQCM0016517	CQC Special review of mental health services
55.	WITN0263010	Audit and Risk Committee Terms of Reference
56.	WITN0263059	SIRG Terms of Reference 2020
57.	NHFT0002375	Private Board of Directors meeting on 06.10.2020
58.	WITN0356029	Current Serious Incident Group Terms of Reference
59.	WITN0356030	Deputy Medical Director Job Description
60.	NHFT0001837	Example Learning from Deaths report
61.	NHFT0003521	Example Board report – Private Board of Directors - 27 March 2025
62.	WITN0356031	Patient Safety and Learning from Deaths Group Terms of Reference – July 2025
63.	WITN0356032	Inquest Team - TMG Paper May 2023
64.	WITN0356033	Board of Directors – Public Meeting on Mortality Surveillance and Learning from Deaths Reports – May 2023
65.	WITN0356034	Board of Directors – Public Meeting – 06.10.2020
66.	WITN0356035	Board of Directors – 28 November 2019
67.	WITN0356036	Board of Directors – Public Meeting – 7 June 2022
68.	WITN0356037	Board of Directors – Public Meeting – 4 May 2021

69.	NHFT0017651	Patient Safety and Learning from Deaths Group – Terms of Reference – September 2024
70.	NHFT0015033 (pages 431 – 434)	Quality Operational Group Terms of Reference
71.	WITN0263060	Quality Governance and Effectiveness Oversight Group Terms of Reference
72.	NHFT0015884	Homicides and Attempted Homicides Oversight Group Terms of Reference
73.	WITN0263061	Complex Incident Group Terms of Reference
74.	WITN0356038	Police Liaison Operational Groups Terms of Reference
75.	WITN0356039	2015 Serious Incident Framework
76.	NHSE0000054	PSIRF Framework – signed off at March 2024 Board
77.	NHFT0000454	Board Meeting (Public) 28 March 2024
78.	WITN0356040	Board Development Day minutes – 27.06.2024
79.	WITN0133030	Internal audit report – April 2025
80.	WITN0356041	STEG – 14.06.2023
81.	NHFT0000422	Executive Leadership Team - 31 January 2024
82.	NHFT0001610	Quality Committee - February 2024
83.	WITN0356042	June 2024 ELT update
84.	NHFT0000763	Quality Committee – March 2025
85.	NHFT0005227	Emergency Preparedness, Resilience & Response (EPRR) Policy
86.	NHFT0000596	Learning from Deaths Policy
87.	NHFT0008825	Patient Safety Incident Response Plan and Policy

88.	NHFT0003028	Being Open and Duty of Candour
89.	CQCM0005588	Reporting, Managing and Learning from Incidents Policy
90.	WITN0263069	Police and Criminal Justice Liaison policy - June 2025
91.	WITN0356079	Case Conference notes 01.04.2021
92.	NHFT0003414	Private Board of Directors – 01.06.2021
93.	NHFT0004569	Private Board Minutes – 6 September 2022
94.	WITN0356044	Report dated 07/07/2021, compiled by Sharron Jones (NHFT), re: Initial Management Review - serious incidents and deaths
95.	NHFT0004539	Private Board of Directors – 3 August 2021
96.	WITN0356080	Level 2 Comprehensive Investigation Report
97.	WITN0356081	Domestic Homicide Review
98.	NHFT0000818	Board of Directors Meeting (in Private) 28 November 2024
99.	NHFT0000535	Minutes of the Board of Directors – Private Meeting - 27 March 2025
100.	WITN0263071	Briefing to Executives GRO-B 16 February 2023
101.	NHFT0000592	Private Board - 30 March 2023
102.	WITN0356045	SIRG for GRO-B – 18 April 2023
103.	NHFT0000571	Private Board - 28 September 2023 – GRO-B GRO-B
104.	WITN0263076	Private Board - January 2024 - GRO-B
105.	NHFT0000525	Private Board – 26 September 2024
106.	NHFT0016005	Standard Operating Procedures guidance for community forensic teams when a person is remanded to prison
107.	WITN0263081	Blue Light incident – GRO-B – 9 December 2024

108.	NHFT0016003	Trust SIRG - 10 December 2024
109.	NHFT0016004	SIRG Exceptions Report dated 17 December 2024
110.	NHFT0000779	Reportable Issues Log dated 30 January 2025
111.	WITN0263082	Initial Learning Review – IR1 Number
112.	WITN0263090A	Telephone recordings from 7 December 2024
113.	WITN0263090B	Telephone recordings from 7 December 2024 Transcript
114.	WITN0263083	Meeting to discuss GRO-B 10 December 2024
115.	NHFT0016457	After Action Review summary report dated 24 March 2025
116.	NHFT0017676	Transfer and Discharge Policy
117.	NHFT0017677	Internal Working Instruction: Crisis Resolution and Home Treatment (CRHT)
118.	NHFT0015973	Blue Light Incident Details - 15 November 2024 @ 16.30
119.	NHFT0015974	Blue Light Incident Details – 15 December 2024 @ 18.49
120.	NHFT0014969	SIRG ELT Exceptions Report dated 26 November 2024
121.	WITN0356046	PSIR report - Scrutiny panel October 2025
122.	WITN0356047	Complex Incident Meeting November 2025
123.	WITN0356048	2025 RCPsych Retention Charter
124.	WITN0356049	List of information sharing agreements
125.	NHFT0001248	Mortality Surveillance and Learning from Deaths Report
126.	NHFT0000901	IPR - November 2022
127.	WITN0356050	Trust Maintaining High Professional Standards Policy

128.	WITN0356051	NHS England Guidance - Maintaining High Professional Standards
129.	WITN0356052	Call with medical colleagues – 17 February 2025
130.	WITN0356053	DMG Process for VC – timeline
131.	WITN0356054	Terms of Reference for an Extraordinary DMG
132.	WITN0356055	Email with Itai Matumike
133.	WITN0356056	Decision Making group meeting agenda 4 February 2025 - Timeline of Professional Review
134.	WITN0356057	Doctor by Doctor review
135.	WITN0356058	Professional Practice Review – 21 March 2025
136.	WITN0356059	Extraordinary IOAG - 21 March 2025.
137.	WITN0356060	Further questions identified for doctors
138.	WITN0356061	Email attaching PPA advice call note – 1 April 2025
139.	NHFT0014420	Advice Request Form – 1 April 2025
140.	WITN0356062	Letter from PPA – 2 April 2025
141.	WITN0356063	Meeting with Associate Medical Director – 14 April 2025
142.	WITN0356064	13 May 2025 email with Dr Colin Fitzpatrick
143.	WITN0356065	14 May 2025 – request for NED support
144.	NHFT0004707	Interview with Claudia Birtles
145.	WITN0356067	Record of Interview for Jonathan Gibson, dated 22/07/2025
146.	WITN0356068	Record of Interview for Ella Harrison, dated 24/07/2025
147.	WITN0356069	Record of Interview for Becky Ash, dated 30/07/2025

148.	WITN0356070	Record of interview for Karthik Thangavelu dated 7th July 2025.
149.	WITN0356071	Report dated 2nd September 2025, compiled by Dr Colin Fitzpatrick, Marina Gibbs, and Dr Kemi Mateola, Re: NHFT Investigation Report v.3 Karthik Thangavelu.
150.	NHFT0004741	Investigation Terms of Reference
151.	WITN0356073	Report undated, compiled by unknown, Re: Why and how I arrived at a decision to not prescribe depot.
152.	NHFT0015050	Guidance, Re Investigation Terms of Reference, Dr Colin Fitzpatrick [NHFT], and Marina Gibbs [NHFT]
153.	NHFT0015049	Policy Document, Re: Investigation - Terms of Reference, NHFT
154.	WITN0356076	Quality Standards for Early Intervention in Psychosis Services – 1 April 2025
155.	NICE0000017	NICE guidance Psychosis and schizophrenia in adults: prevention and management
156.	DHSC0000007	Code of Practice: Responsible Clinician's decision with an Approved Mental Health Practitioner (AMHP)
157.	NHSE0000298	Theemis Report - list of risks
158.	NHSE0000852	Medical Director Meeting
159.	NHFT0004868	Single proforma used to respond to the families' questions
160.	NHFT0015626	Dr Lloyd Response
161.	WITN0356077	GMC Professional Standard Confidentiality: Good Practice in handling patient information
162.	NHSE0002336	RCPsych Early Intervention (EI) standards
163.	NHFT0000445	Board Meeting (held in Private) – 25 January 2024

164.	NHFT0000736	Integrated Improvement Plan – January 2025