

Wednesday, 3 June 2026

1
2 (10.00 am)
3 **THE CHAIR:** Yes.
4 **MR CARR:** Chair, may I call, please, Sir Robert Behrens CBE.
5 **THE CHAIR:** Yes.
6 **SIR ROBERT BEHRENS (sworn)**
7 **Questioned by MR CARR**
8 **THE CHAIR:** Yes, Mr Carr.
9 **MR CARR:** Yes, thank you. You've prepared a statement dated
10 12 November 2025, haven't you?
11 **A.** Yes.
12 **Q.** Is that statement true to the best of your knowledge and
13 belief?
14 **A.** Yes.
15 **Q.** You've set out in your statement your professional
16 background and, significantly for the purpose of the
17 questions I'm going to ask you, you were the
18 Parliamentary and Health Service Ombudsman from
19 April 2017 to March 2024, weren't you?
20 **A.** Correct.
21 **Q.** Previously, you had been Secretary to the Committee on
22 Standards in Public Life?
23 **A.** Yes.
24 **Q.** Complaints Commissioner to the Bar in England and Wales,
25 and the Higher Education Ombudsman?

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1 **A.** You have, sorry?
2 **Q.** You don't have to go through your MP, is that the point?
3 **A.** *(No audible answer given).*
4 **Q.** What you describe, it's the bottom of this page,
5 page 11, where you deal with the work of the Policy and
6 Public Affairs Team is that through the complaints that
7 you receive there can emerge themes, trends, systemic
8 issues, and where there are such patterns, the Ombudsman
9 Service will report on those?
10 **A.** The purpose of the Ombudsman is not merely or only to
11 resolve individual or group complaints, but to use that
12 material to draw out broader themes to allow government
13 and the Health Service to think about the policy and
14 operational issues that come out of that.
15 **Q.** Yes, so the Service is looking for themes that emerge
16 from complaints, systemic issues, and where it produces
17 a report, it's because it's identified patterns and
18 systemic issues?
19 **A.** That's right.
20 **Q.** The intended purpose of putting together all the reports
21 is with a view to bringing about change.
22 **A.** Absolutely. I mean, there is a debate in the ombudsman
23 world about whether you should focus on complaints or on
24 the policy issues. In my view, you can't do one without
25 the other. They are intimately connected.

3

1 **A.** Correct, yeah.
2 **Q.** If we start please with the role of the Parliamentary
3 and Health Service Ombudsman, you set it out, it's
4 paragraphs 5-7 of your statement on page 2, and you
5 explain that it's an independent and impartial body,
6 it's accountable to Parliament, and its role is to
7 investigate complaints where there is concern or belief
8 that there has been injustice or hardship, or that the
9 body has not acted properly or fairly or has given
10 a poor service.
11 **A.** That's correct. The key issue is that this is a free
12 service to the public and it is the last resort for
13 those seeking redress from the Health Service or
14 government departments.
15 **Q.** Yes, and indeed is it right, it's dealt with in
16 paragraph 8, initially the individual will have had to
17 try to resolve their case with the organisation first
18 and then they can come to the Ombudsman where that
19 hasn't resulted in a proper resolution?
20 **A.** That's right, and the difference between the Health
21 Service law and the Parliamentary law is that with
22 Parliamentary complaints about government departments,
23 you have to go through your MP first; you don't have to
24 do that with Health Service complaints.
25 **Q.** You don't have to go through your MP --

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1 **Q.** Yes, and it's the complaints that inform the policy
2 issues, isn't it?
3 **A.** Yes.
4 **Q.** Because looking at the complaints is where you can
5 identify what the problems are that need solving?
6 **A.** Yes.
7 **Q.** If we look at your paragraph 14, so it's the next page,
8 page 4, you identify there some of the reports,
9 publications from the ombudsman in the mental health
10 sphere, and say there was a 2018 publication on
11 maintaining momentum, which I'll turn to in a moment;
12 a 2019 paper on learning from the failings in north --
13 at the North Essex Partnership Trust; and then a 2020
14 paper on a survey of experiences in healthcare.
15 **A.** Correct.
16 **Q.** Towards the end of your tenure, published in 2024, there
17 was a report on discharge from mental health care?
18 **A.** Yes.
19 **Q.** I want us to look at both the 2018 and the 2024 reports.
20 Dealing first with the 2018 report. It's PHSO000006
21 document number 6. It's about to come up on screen,
22 Sir Robert, if that's easier. You see there title:
23 "Maintaining momentum: driving improvements in
24 mental health care".
25 If we can turn to page 11 we can see an explanation

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1 of the methodology. So we want to go down, it's the
2 column on the left, the bottom two paragraphs, and it's
3 explaining that at first you looked at complaints from
4 150, so 150 complaints, and that led to common themes
5 emerging which we then see in the column on the right.
6 We might need to scroll up slightly on the screen?

7 The themes that emerged from those complaints, we
8 see them there: "Failure to treat".

9 **A.** This is correct.

10 **Q.** "Inadequate assessments (including risk assessments)"
11 and in that paragraph, it states:

12 "Failings in assessments of symptoms, as well as
13 risk assessments of patient safety and the safety of
14 others, were present in 21% of the sample."

15 Just reflecting there on the reference to safety of
16 others, so the Ombudsman was receiving complaints that
17 concerned improper risk assessments, concerning public
18 safety --

19 **A.** Yes.

20 **Q.** -- risk to others?

21 **A.** Yes.

22 **Q.** "Treatment or care plans", "communication", and then
23 "Coordination of services". And in "Coordination of
24 services" we can see included in that is the issue of
25 discharge arrangements, transfer from one service to

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1 the second part of the methodology is looking at the key
2 failings that were found when investigating the
3 complaints, and they're set out there: diagnosis and
4 failure to treat, risk assessment and safety, dignity
5 and human rights; communication; inappropriate discharge
6 and provision of aftercare?

7 So the failures that you were finding were mirroring
8 the complaints that were coming in?

9 **A.** This is what we call compounded harm. That is the issue
10 that people are complaining about is replicated in the
11 way in which the complaint was investigated by the body
12 and jurisdiction. And that is traumatic for the people
13 who are bringing complaints who are already traumatised
14 and bereaved by what has happened.

15 **Q.** Is that reflective of a lack of candour?

16 **A.** I mean, the lack of candour is a consistent theme across
17 my seven years in office, which I drew attention to time
18 and time again. And it is shocking. I had not
19 expected, when I became Ombudsman, that public servants
20 would either not tell the truth or fail to volunteer the
21 truth about patient safety issues, and unfortunately
22 that is a consistent theme.

23 **Q.** That's part of the culture that you experienced within
24 the NHS?

25 **A.** Yes.

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1 another, and that was 15% of the sample.

2 **A.** One of the key themes about mental health complaints
3 throughout my tenure was these issues in 2018 arose time
4 and again up until 2024 without effectively being
5 addressed, even though we lobbied hard to draw attention
6 to these issues.

7 **Q.** Nothing changed?

8 **A.** I won't say nothing changed, but there wasn't a radical
9 change.

10 **Q.** As we've discussed, the purpose of doing a report like
11 this is in order to bring about change?

12 **A.** Yes. I'm conscious that during my tenure as Ombudsman,
13 there were 40 different Ministers of Health in the
14 department during that time, and six different
15 Secretaries of State. That kind of churn is not
16 conducive to a continuous reform and
17 reflection consistently across the piece.

18 **Q.** Why is that? Is it because with each change of
19 personnel you have to start again, build a relationship?

20 **A.** Absolutely.

21 **Q.** We'll come back to the response or lack thereof to this
22 report on the 2024 report. But just going back to the
23 methodology. So, firstly, there's an analysis of the
24 complaints to look at the themes that emerged from the
25 complaints. If we go to the next page, we can see that

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1 **Q.** And --

2 **A.** I need to be clear that in -- I visited a lot of NHS
3 Trusts and bodies in jurisdiction during my time because
4 I felt you couldn't do this in a paper-based way, you
5 know, you had to go and see, you had to talk to people
6 and experience it.

7 And my experience, which is just one set of
8 experiences, is that you cannot talk about "the culture"
9 in the NHS, that there are so many disparate cultures
10 overlapping with each other and, actually, hiding the
11 fact that there are countless numbers of dedicated
12 health workers in the public service who give their time
13 and commitment to promote patient safety. But that sits
14 alongside pockets of lack of candour, defensiveness, and
15 an inability to treat complainants as individuals who
16 deserve respect and integrity.

17 **Q.** What do you think causes those pockets, as it were,
18 those cultural pockets where you see lack of candour,
19 lack of frankness?

20 **A.** Sure. Well, there are a number of things. There is no
21 magic bullet, as far as this is concerned. First of
22 all, I think in the time that I was in office, there was
23 a lack of ministerial focus on that issue of
24 defensiveness. Secondly, there was a feeling that, from
25 the centre, that issues in the Health Service were

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1 primarily about the way in which it should be organised
2 and funded and there was a concentration on that to the
3 expense of the people working in the organisation.

4 Thirdly, you can see from repeated staff surveys in
5 the NHS, and reports by the National Audit Office, that
6 working in the NHS is a highly difficult and stressed
7 environment in which to work, and we shouldn't
8 underestimate that.

9 So 18% of absences in 2024 -- in the 2024 survey
10 were about stress in the workplace. The National Audit
11 Office reckoned that 30% of all people who left the NHS
12 did so because of stress at work, and from material that
13 I unearthed that places like Birmingham University
14 Trust, there was continuous bullying of staff and
15 a sense of people who worked in the Health Service not
16 feeling valued for the very difficult job that they had
17 to do. Sorry --

18 **Q.** So you've got a stressed workforce?

19 **A.** Sorry?

20 **Q.** A stressed workforce --

21 **A.** Yes.

22 **Q.** -- is one of the issues you've identified. And you've
23 mentioned defensiveness.

24 **A.** Yes.

25 **Q.** Is that institutional? Does that come from the top, the

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1 a hospital] to downplay or bury the truth", and it's in
2 particular the reference to "burying the truth", the
3 examples that you saw of that, were they isolated or was
4 that something that you consider reflected this culture
5 you're describing?

6 **A.** Well, I think first of all, as academics have pointed
7 out, culture is a mosaic; it's not a consistent set of
8 behaviours across an institution. That's the first
9 point.

10 The second point is that we have to remember, I have
11 to remember that the Ombudsman only sees generally those
12 cases where there is a belief that something has gone
13 wrong. So, you know, that has to be appreciated in
14 coming to a judgement about how extensive this is.

15 And thirdly, if you look at the figures, the results
16 are that only a very small but significant proportion of
17 cases that we investigated were found to be justified.
18 So in the majority of cases, you could not say that that
19 defensiveness existed. And I think it's important to --

20 **Q.** Provide that balance.

21 **A.** Yes.

22 **Q.** In the penultimate paragraph on this page, when asked
23 "How can the 'cover-up' culture be ended?" the answer
24 you give is:

25 "First of all, you have to recognise that it exists

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1 executives, or is it throughout in your experience?

2 **A.** Well, I think there is a governance issue that in my
3 experience the boards of NHS Trusts that I dealt with
4 were -- and this is brought out by people like
5 Bill Kirkup in his reports of East Kent and other
6 places -- were reluctant to get involved in operational
7 issues and to believe that they didn't have to take
8 a position on patient safety issues.

9 And too often, clinicians, good clinicians who
10 brought patient safety issues to the attention of the
11 Board were disciplined as a result of doing that and
12 sent to the General Medical Council, which is
13 outrageous.

14 **Q.** Yes, and that reflects a culture, doesn't it, which
15 isn't encouraging honesty, isn't encouraging --

16 **A.** Sorry?

17 **Q.** Sorry, that reflects a culture that isn't promoting
18 safety, not promoting honesty, not promoting candour.

19 **A.** That's right.

20 **Q.** And you have given an interview, there's an article,
21 it's a document -- we'll come back to the document on
22 screen, but it's document PHSO000019, an article you
23 gave to the Guardian, reported in March of 2024. And on
24 page 2 of that document, please, just in the middle of
25 the page what's described there are "efforts [by

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1 and secondly you have to make leaders accountable for
2 how the culture operates' ..."

3 Do you think the NHS is learning and is making
4 changes in respect of issues as to candour, and
5 cover-up, and burying the truth?

6 **A.** I think it's been very slow. I think leadership is
7 a key problem in the NHS. These are my views. These
8 are not the views of the Ombudsman. If you want to know
9 the views of the Ombudsman, you have to ask her. So
10 I left office --

11 **Q.** You're no longer the Ombudsman.

12 **A.** Exactly. And I speak for myself, I don't speak for
13 anybody else. But my sense during my time was that the
14 role of training and development of leaders in the NHS
15 was not grasped appropriately, despite the commissioning
16 of the Messenger Report, which reported in 2022, dealing
17 with leadership issues. It's not clear to me that that
18 has had a resounding impact on the way in which people
19 behaved.

20 Now, part of that is cultural, part of it is also
21 about the law. So if you have strong whistleblowing
22 laws and Duty of Candour laws to provide the context in
23 which the culture operates, then there are incentives to
24 leaders to change their behaviour, which I don't think
25 was the case during the majority of my time in office.

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1 Q. There's obviously now Freedom to Speak Up, there is the
2 proposal for the introduction of a statutory duty on
3 public authorities and public officials, imposing a Duty
4 of Candour, are there any other changes that you would
5 recommend that would improve culture and improve it
6 quickly?

7 A. Well, I've looked in the supplementary bundle, which you
8 kindly provided me with. There are encouraging signs
9 that in terms of Good Practice Guides, in terms of
10 proposed legislation on whistleblowing and Duty of
11 Candour, there are possibilities that these issues are
12 being addressed, but first of all, it's a long time
13 overdue. Secondly, what is going to happen in the NHS
14 is a fundamental transformation by merging the
15 Department with NHS England, which is going to have
16 consequences and a need to settle down.

17 So there's no guarantee that one can say with
18 confidence that it's going to change. And, with
19 respect, one of the difficulties is that Inquiries like
20 this make important recommendations, but then they
21 disappear, and time and time again, the recommendations
22 are not implemented because there's no body to oversee
23 the implementation, which is independent from the
24 government.

25 Q. Yes, that's a point you make in your statement, the

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1 Q. Now, going back, there was the 2018 report that I had on
2 screen earlier, and I'm not going to go back to it. But
3 the methodology we looked at, and what the report went
4 on to do, was to look at a series of case studies in
5 order to highlight the damaging consequences of some of
6 those failures that we looked at.

7 A. Yes.

8 Q. One of those failures concerned the issue of discharge.

9 A. Yeah.

10 Q. Having raised the issue of discharge in that 2018
11 report, concerns around discharge were then the focus of
12 the 2024 report?

13 A. Yes.

14 Q. That's PHSO000003 document number 3, please. So this
15 is now focusing on a concern that had been reported on
16 by the Ombudsman in 2018, and so does it follow and
17 reflect the evidence that you gave earlier that there
18 hadn't been any change or sufficient change or progress
19 on the concerns that you identified or saw earlier on in
20 your tenure?

21 A. We're dealing with a period of continual political
22 crisis between 2017 and 2024. You know, with Brexit,
23 referendums, and so on and so forth. I, as the
24 Ombudsman, was not convinced that when I wrote to
25 ministers, they promptly responded to my reports and my

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1 tendency for recommendations to be implemented. You
2 refer to a lack of effective scrutiny and monitoring.
3 What would you recommend is put in place to ensure
4 effective scrutiny and monitoring?

5 A. Sorry, I didn't get that.

6 Q. Sorry, what would you suggest is put in place to ensure
7 that there is proper scrutiny and proper monitoring to
8 make sure that recommendations by Inquiries are properly
9 implemented?

10 A. I've read the Parliamentary debates about this and there
11 have been two developments, in inverted commas: one is
12 the creation in the Cabinet Office of a unit to provide
13 some support and continuity for new Inquiries, so that
14 you're not reinventing the wheel each time. The second
15 is the idea that there needs to be a Parliamentary
16 Committee which has oversight of the recommendations to
17 see the extent to which they have been implemented, and
18 to question ministers and officials if those have not
19 been implemented.

20 Q. So you would endorse a Parliamentary Committee --

21 A. Absolutely. I don't think the Cabinet Office is the
22 place where you seek an independent view about the
23 implementation of recommendations. There needs to be
24 a Parliamentary device to question reluctant ministers
25 about these issues.

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1 letters associated with those reports.

2 Q. Because they were distracted by the crises that you're
3 describing?

4 A. Well, I assume so. I mean, that's -- you know,
5 everybody is a good person unless you hear to the
6 contrary. But the fact is that they had
7 a responsibility to respond and it often took
8 three months and more for ministers to respond to my
9 letters, and I think the fact that we produced a report
10 in 2024 which was not fundamentally different from the
11 2018 study suggests that despite the excellent work
12 attempted by mental health officials, and they did good
13 work, and they were honourable people, the change was
14 not delivered in a way which made a significant
15 difference.

16 Q. Was that part of the motivation for doing the 2024
17 report? Because having identified problems in 2018,
18 identified problems elsewhere, you find that you're
19 writing to ministers, they're taking an age to respond,
20 there's a churn in any event, and change isn't
21 happening.

22 A. Yes. I mean, that is very disappointing, and for people
23 who are traumatised and bereaved by what happened to
24 them, in the case of discharge cases and, you know,
25 you're dealing with that and my respect and sympathies

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1 go out to the people who are bereaved and whose -- who
2 suffered horrific injuries, and I was a student at
3 Nottingham University, so I have -- I feel a connection
4 to these issues. It's not good enough to respond in
5 such a lacklustre way.

6 **Q.** Well, the problem, is it fair to say, with responding in
7 a lacklustre way, with delaying responses, delaying
8 implementing change, is that it risks these things
9 happening again and again --

10 **A.** Correct.

11 **Q.** -- in the meantime. And your report identifies, or your
12 2018 report identifies that whilst some of the
13 complaints that you received might not have serious
14 consequences, some of them really do.

15 **A.** Yeah. We know, and it's in my evidence, that some of
16 the issues about discharge we reported on with the
17 Nottingham Trust prior to the events that you're
18 investigating. So this was not a new issue, although it
19 was dramatically more serious.

20 **Q.** If we look at page 6 of this document, please. It's
21 your foreword, and in the paragraph just under the
22 title, and it reflects the evidence that you're giving,
23 you describe there "unsafe discharge" as being "nothing
24 new." And in fact your "predecessor had seen patients
25 not being assessed or consulted properly before

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1 time and again by my office not being taken as seriously
2 as I felt it needed to be by ministers when we brought
3 issues before them. Particularly in the area, the
4 all-important area, of patient safety, and if ministers
5 had behaved differently, then some of the things that
6 happened might not have happened, but who knows.

7 **Q.** If we go to page 9 of this document, please, and if we
8 look at the third paragraph down, when describing the
9 issues on transition from inpatient to community care
10 and beyond, what is written there is:

11 "The temptation is to concentrate on speed, with
12 data focused on the number of days from admission to
13 discharge."

14 But it goes on to be said in that paragraph:

15 "... [that] cannot come at the cost of patient
16 safety ..."

17 Now just in respect of that temptation to
18 concentrate on speed, what do you think drives that
19 temptation? Why is there that temptation to concentrate
20 on getting patients out quickly?

21 **A.** Sure, because first of all, government put an emphasis
22 on the financial management of the Health Service as
23 an indicator of its effectiveness. Secondly, mental
24 health services have been, by the consensus of
25 everybody, been underfunded in comparison to other

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1 discharge, carers not being informed ..."

2 So this was an issue that had been raised by your
3 predecessor --

4 **A.** Yeah.

5 **Q.** -- 2018 report and now again in the 2024 report.

6 **A.** One of the key issues for the Ombudsman is that she or
7 he does not have binding powers. So you make
8 a recommendation but it is entirely up to the judgement
9 of the body in jurisdiction whether or not to accept it.

10 **Q.** Do you consider that that's problematic? Because the
11 benefit, it might be said, of the Ombudsman Service is
12 that you're receiving complaints, so you're able to
13 consider when things go wrong, how they've gone wrong,
14 and to identify patterns and themes that are emerging.

15 And isn't that a reason why, when you're making
16 recommendations or identifying patterns, that action
17 really ought to be taken?

18 **A.** It's a missed opportunity for government and for the
19 Health Service to take advantage of rigorous and
20 systemic investigation and findings which are
21 transparent and in the public domain, and not to take
22 advantage of this is unfortunate.

23 **Q.** What do you think the reason is for advantage not being
24 taken of it?

25 **A.** *(Pause)* I can't answer that. I am -- I was frustrated

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1 health services, and that has put pressure and stress on
2 the people making these decisions which we should not
3 underestimate.

4 So the Ombudsman is not about blame. The Ombudsman
5 is about accountability and learning and, in my view --
6 and it comes back to the point you asked me about
7 before -- the cultural issues about dealing with people
8 as individuals and as whole people has tended to get
9 lost in the desire to have KPIs that reflect better
10 performance.

11 **Q.** So it's a focus on data outcomes and efficiencies, would
12 you say?

13 **A.** I mean, that has been it, and I'm not going to say you
14 shouldn't do that, but there has to be a balance between
15 that and treating people with dignity as individuals and
16 it is -- *(overspeaking)* --

17 **Q.** Well, that's the point you make about the cost of --
18 well, it can't come at the cost of patient safety,
19 because rushing patients out of the door quickly in
20 order to achieve good data results obviously creates
21 risks, doesn't it?

22 **A.** Yes, and I -- sorry, I'm not sitting here saying this is
23 easy. It is immensely difficult and it is particularly
24 difficult in the area of mental health and discharge
25 because you're relying on the views of a disparate set

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1 of people who sometimes are not in a position to make
2 the best judgements about what is best for themselves.
3 So all that, to me, indicates that unless you treat the
4 people who work in the Health Service with the respect,
5 dignity and development that they need, then that is not
6 going to change.

7 Could I just add one thing? So I told you before
8 that I would go round hospitals and meet people and go
9 into wards, and what struck me was that a ward -- two
10 wards in the same hospital could be very different,
11 depending on the leadership of the nursing staff in the
12 ward. So you can't generalise too much -- but one of
13 the things that struck me is that the Chair and the
14 Chief Executive would always welcome me very courteously
15 and say, "It's good to see you, Rob, we're one team
16 here, we're all in it for each other". And then I would
17 go round and I would meet different people and I'd meet
18 the complaints team and they would say, "Help! If you
19 don't help us, no one else is going to help us because
20 we're not respected for what we do in this
21 organisation".

22 And that happened time and again, and that was very
23 distressing.

24 **Q.** So the reality that you were seeing was different to
25 what was being presented to you by the welcoming

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1 That echoes something that was in your 2018 -- or,
2 sorry, the Ombudsman's 2018 report where it was
3 identified -- we don't need to bring that up, it is page
4 9 of that report -- that mental healthcare accounts for
5 nearly a quarter of NHS activity but receives only 11%
6 of spending.

7 You also identify in that report that 40% of Mental
8 Health Trusts in England receive a real terms decrease
9 in their operating income.

10 The Inquiry heard evidence earlier this week from
11 Professor Lade Smith, the President of the Royal College
12 of Psychiatrists, that that gap in funding, so between,
13 as it were, the need and the amount of funding that's
14 being received, remains.

15 Why do you think there is that gap? Why isn't
16 mental health funding given proportionate or given in
17 proportion to, as it were, the burden it represents?

18 **A.** Again, this is not because they're nasty, evil people
19 making these judgements. These are very difficult
20 judgements to make, and we know that in the seven years
21 that I was Ombudsman, there was an increase in the
22 amount of money spent on mental health care. So the gap
23 did change to some extent.

24 But post the pandemic, the amount of need for mental
25 health care increased dramatically in a way which put

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1 committee of executives, essentially?

2 **A.** Yes.

3 **Q.** Was it your view that the difference was because the
4 Executive Team were just not in touch with what was
5 going on in their hospital, or was it part of the
6 cover-up culture that you've described?

7 **A.** I think it's a mixture of those things. You can't just
8 call out one thing.

9 **Q.** So it's both?

10 **A.** In my view, NHS boards were reluctant to get involved in
11 operational issues because of the clinical
12 qualifications of the people who were making these
13 judgements.

14 **Q.** There's a disconnect there?

15 **A.** Yeah, and I think that was a mistake.

16 **Q.** One of the points that you raised was in respect of
17 funding, and if we just go back from this page, please,
18 it's to page 7, and here, in the text on the left, you
19 identify, you say:

20 "Although we have seen valuable steps to change
21 access and attitudes towards mental health conditions
22 and care, reaching the point where mental health is
23 given equal priority to physical health in terms of
24 access and outcomes of care still remains a long way
25 off."

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1 further pressure on mental health services, and I don't
2 think that was envisaged at the time, and that remains
3 an issue today.

4 **Q.** Thank you. Again, with this report, and I'm not going
5 to go through the case studies, but this follows
6 a similar pattern, doesn't it, to the 2018 report where
7 particular cases have been identified to highlight the
8 consequences that can result from the problems with
9 discharge. But in respect of all of them, so if, for
10 instance we look at page 14 of this document, the first
11 theme identified is "failings in patient, family and
12 carer involvement in discharge planning".

13 And then there are a couple of -- in fact there are
14 three case studies given where family aren't involved.
15 And then page 31, the next theme identified is "poor
16 record-keeping". Forgive me, page 18.

17 **A.** Yeah.

18 **Q.** And then page 20, "poor communication between clinical
19 professionals" and "poor joint-working".

20 Now, the problem with all of those, and the case
21 studies bear it out, is essentially it comes down,
22 doesn't it, to risk management, which is another problem
23 that you identified in the 2018 report. It's where
24 you're not involving a patient's family where there
25 isn't joint working, where there's poor recordkeeping,

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1 there is an inability to manage the risks that arise on
2 discharge.

3 **A.** Yes. These are three interconnected strands which
4 affect the quality of risk management being taken in
5 mental health discharge. So in one of these cases,
6 they're all very sensitive, a discharged patient was
7 given the wrong information about who to contact and
8 where to contact if they were in difficulties. You
9 know, that is very distressing.

10 **Q.** Now we've reflected on the fact that there's a 2018
11 report, there's a 2024 report dealing with issues
12 highlighted in the 2018 report. You've already
13 explained how problems remained in your tenure, and
14 you've given evidence along similar lines to the Lampard
15 Inquiry, so it's PHSO000015 document, page 63, where
16 you say -- and again, there, you're talking about the
17 discharge report, it's from line 19 onwards. You say:

18 **"Answer:** ... these issues don't go away. They are
19 there time and time again. We keep talking about poor
20 communication, the defensiveness of institutions,
21 I don't think these are fundamentally addressed as far
22 as things go that I can, that I could see to the end of
23 my term."

24 What are the obstacles as you see them, or the
25 barriers as you see them to the NHS changing and

25

1 Now, some things have happened to address that, but
2 not in a way which yet suggests that there's going to be
3 a fundamental cultural review, change.

4 **Q.** My final question is this: it's paragraph 28 of your
5 statement, page 9, and there you're describing
6 a proposal for the Ombudsman to have "powers of its 'own
7 initiative'", and the question is this: how -- well,
8 firstly, why is it required? But also, how would it
9 operate? So if the Ombudsman did have the power of its
10 own initiative, what would that mean in practice?

11 **A.** In the few meetings that I had with ministers, they were
12 all very nervous about giving the Ombudsman the power of
13 an initiative, despite the fact that across Europe, more
14 than 70% of counterpart institutions already have this
15 power and it's regarded as routine.

16 If you look at the kinds of people who come to the
17 Ombudsman and make complaints, you will find that in the
18 UK and in Europe generally, vulnerable people are not
19 properly represented in our caseload. So if you are
20 older, if you have mental health issues, if you come
21 from minority backgrounds, and if you are young -- that
22 is also very important -- you're less likely to make
23 a complaint.

24 Now, where you have a system which relies on
25 individuals proving that they were affected by something

27

1 improving? Is it the issues that you've already
2 identified: the churn of ministers, distraction of other
3 political issues? Or are there other factors?

4 **A.** Could I just say, and it needs putting on record, that
5 when we published the -- when we researched the
6 discharge report in 2024, there was good interaction
7 with the Department about the issues that we were
8 raising, and these were broadly reflected in the
9 guidance which the government published shortly before
10 we published our report. And that is a sign of good
11 practice. So that the guidance which has been issued is
12 only guidance, but it does address a lot of the issues
13 that we're talking about.

14 And I -- that needs to be clear that, you know,
15 there has been change, there has been an attempt to
16 address these issues.

17 When I look at the Good Practice Policy and the
18 operational management in the Health Service, what
19 I don't see is a coherent strategy to change the culture
20 in NHS Trusts in a way that incentivises disclosure and
21 promotes patient safety. And I don't think that you can
22 create an environment where you learn from mistakes that
23 you make and change the culture in that way without
24 investing in the development and incentivising the
25 leadership.

26

1 that happened in the Health Service and asking them to
2 resolve it before they come to you, you are very
3 dependent on a select group of people defining what the
4 issues are. And the power of own initiative operates
5 entirely satisfactorily in parts of the United Kingdom
6 already, in Northern Ireland and in Wales, and in
7 Northern Ireland there is provision in the legislation
8 to make sure that the Ombudsman consults with other
9 quasi-regulators to see if an "own initiative" inquiry
10 is already being properly handled by another body.

11 So it's not a radical change. It would not involve
12 a large number of people. In Holland, for example, the
13 Netherlands, in Wales and Northern Ireland, a small
14 proportion of the office would be involved in
15 own-initiative investigations and it would give
16 confidence that the Ombudsman would be able to look at
17 issues which are not brought to them but which still
18 need looking at.

19 **Q.** Is the kernel of it this: for the people who do complain
20 to the Ombudsman, they may have been traumatised by
21 whatever act or omission by the Health Service that they
22 say has caused harm?

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

24 **Q.** They may then be traumatised by having complained to the
25 health organisation where there's this culture of

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1 cover-up and burying the truth, and so relying on people
2 to jump -- traumatised, vulnerable people, to jump over
3 those two hurdles before coming to you, the concern is
4 you're missing, actually, a significant number of people
5 who may have serious issues with NHS treatment?

6 **A.** Our 2020 survey done by YouGov on mental health users of
7 the Health Service showed that a significant number of
8 people had no confidence that their issue would be taken
9 seriously if they made a complaint about it. So we have
10 to think about that very carefully.

11 **Q.** It's with a view to learning from mistakes, that's a --

12 **A.** I mean, how many -- there are countless examples of good
13 practice on own initiative which the government of both
14 parties has failed to address.

15 **MR CARR:** Thank you very much, those are my questions.

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

17 Mr Moloney.

18 **Questioned by MR MOLONEY**

19 **MR MOLONEY:** Sir Robert, I ask questions on behalf of the
20 bereaved families.

21 **A.** Thank you.

22 **Q.** You highlighted in your statement the tendency for the
23 recommendations of both public and independent Inquiries
24 not to be implemented through a lack of monitoring and
25 scrutiny, and you've just raised the issue in your

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1 doesn't it?

2 **A.** Absolutely.

3 **Q.** They go through an Inquiry, they secure positive
4 recommendations for change, government commit to
5 implement in full, and then nothing happens and they
6 have to -- their tragedy has to endure in trying to
7 secure the implementation?

8 **A.** That's absolutely right. And, again, I come back to
9 Bill Kirkup's views about these issues, because he has
10 chaired a number of critical inquiries, and he has
11 pointed out that there's a kind of ritual ceremony that
12 goes on, that the report is published, that the Minister
13 says, "This must never happen again" and then the
14 Inquiry goes away and there is no body, institutionally,
15 around to be able to campaign for that. So it falls
16 upon the families, who are either bereaved or
17 traumatised or distressed, and those people they can
18 gather round them, there are MPs that do that, and
19 newspapers and so on, but it shouldn't be down to the
20 families and there needs to be an institutional focus
21 for this, and there isn't at the moment.

22 **Q.** Can I ask you about that institutional focus, finally?

23 **A.** Yeah.

24 **Q.** In your evidence this morning, you've suggested
25 a Parliamentary committee. Would that be preferable to

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1 evidence with Mr Carr.

2 In the absence of effective monitoring and scrutiny,
3 does it too often fall to victims and survivors of
4 a tragedy--

5 **A.** I'm sorry?

6 **Q.** I'm so sorry. In the absence of that monitoring and
7 scrutiny, does it too often fall to victims and
8 survivors of a tragedy to campaign to implement the
9 recommendations of Inquiries?

10 **A.** This is a very serious point and without the campaigning
11 of distressed and vulnerable and traumatised people we
12 would be a lot further back in addressing the issues
13 that need addressing.

14 Unfortunately, too often the successful resolution
15 of these cases has depended upon bereaved families
16 campaigning at a time when they are least well prepared
17 to do that, and it is an outstanding public service that
18 they perform.

19 **Q.** Sir Robert, you've used the term in your evidence this
20 morning about essentially "compounding the difficulties"
21 --

22 **A.** Yes.

23 **Q.** -- when a complaint is made. Victims and survivors
24 having to campaign to ensure the implementation of
25 recommendations necessarily compounds their trauma,

30

1 an independent oversight mechanism, independent of
2 Parliament, in your view, or not?

3 **A.** Yeah, it's a very good question, and I can't
4 authoritatively give you the answer to that. I think --
5 so I sit on the Infected Blood Compensation Authority
6 which is an arm's length independent body set up to
7 award compensation. And that is immensely distressing
8 for people who have waited 40 years to get their
9 compensation, and the regulations since the public
10 Inquiry reported are now into their fourth iteration.

11 So this is very difficult, and I'm not sure that
12 just creating an independent body in addition to
13 whatever exists in the Cabinet Office is going deal with
14 that.

15 In Parliament, at least you have the opportunity to
16 summon ministers and scrutinise them in a way which puts
17 them under pressure, but it's not a solution in itself.

18 I would prefer that, rather than not to have anything at
19 all.

20 **MR MOLONEY:** Thank you very much, Sir Robert.

21 **THE CHAIR:** Thank you.

22 Ms Cartwright.

23 **Questioned by MS CARTWRIGHT**

24 **MS CARTWRIGHT:** Good morning, Mr Behrens. I ask questions
25 on behalf of the survivors.

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1 Can I just pick up on that theme also around
2 monitoring recommendations. Would you also agree that
3 there may be a time where actually, giving Chairs of
4 their own Inquiries the mechanism to monitor their own
5 recommendations could actually be the best way of
6 ensuring what a Chair intends and identifies to be
7 implemented takes place?

8 **A.** Yes. I've read the discussions in the House of Lords
9 about this issue and I'm aware that in the Infected
10 Blood Public Inquiry, the Chairman was so angry at the
11 lack of speed with which the recommendations he made
12 were being addressed that he reconvened the Inquiry.
13 And I think that's an important development.

14 I read in the Parliamentary debates that there are
15 problems about Chairs of Inquiry who are judges being
16 compromised by pursuing recommendations, and I'm not
17 a lawyer, so I can't address that. But from where I'm
18 sitting as an independent non-lawyer, with experience of
19 the ombudsman world, there are too few mechanisms to
20 incentivise implementation after the publication of
21 a report, and I do think we need an institutional focus,
22 and that could be supplemented by Chairs as well after
23 the event, but there does need to be a fundamental
24 institutional focus.

25 **Q.** Thank you. Can we briefly display, please, your

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1 was a culture of investigation and learning on the
2 frontline.

3 But too often, I think the Ombudsman is used as
4 a safe "pass the parcel", and we need to encourage
5 bodies in jurisdiction to be more rigorous in the way in
6 which they investigate these issues.

7 **Q.** Thank you. Now you've obviously touched upon the
8 accountability that's so needed at board level,
9 managerial level, at Trusts. Obviously it was one of
10 the recommendations of Sir Brian Langstaff in his
11 Infected Blood Inquiry. There has been the separate
12 Department of Health and Social Care review and the
13 potential regulation that's now being considered.

14 But can I ask you then, from your perspective, do
15 you believe that that time has now come where there
16 needs to be the appropriate regulation of the Board
17 also, in respect of these factors?

18 **A.** Fundamentally, yes. I mean NHS boards have been like
19 a club in which historically people have gone from one
20 board to another without an appropriate accountability
21 for what they did, so that too often people have got
22 away with inappropriate things and then gone on to
23 another job. That is beginning to change, but there's
24 no reason why an NHS board should be treated differently
25 from another board, and they should be properly

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1 paragraph 27 of your witness statement, WITN0228001, at
2 page 9. Thank you. You tell us at paragraph 27, and
3 it's obviously been a theme, through all of your
4 evidence explored with Mr Carr, that there needs to be
5 the elimination of the culture of cover-up, that you as
6 well personally experienced from your time as Ombudsman.
7 But you say this:

8 "Learning from mistakes should be part of daily
9 practice not the sole duty of regulators, the Ombudsman
10 or public inquiries."

11 And would you agree what needs to ensure it's part
12 of daily practice is the incident reporting mechanism of
13 Datix, proper investigations so that in a very prompt
14 and timely way, identification of either system
15 failures, or professional failures of individuals, is
16 needed to be taking place every day on the ground, in
17 Trusts?

18 **A.** That's the cultural change that is desperately needed.
19 My small contribution to that was to introduce
20 a Complaints Standards Framework which has become
21 important in trying to change the culture of complaints
22 handling and investigation on the frontline, and my view
23 is that if it comes to the Ombudsman, it's already too
24 late. It should have been picked up before that, and
25 many times it could be picked up before that if there

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1 accountable for what they do, individually as well as
2 collectively.

3 **Q.** Thank you. Then, finally, you recommended that what's
4 desperately needed is a coherent strategy to change the
5 culture in NHS Trusts. Who do you identify as the body
6 or organisation that should be giving guidance about
7 what that coherent strategy looks like?

8 **A.** I mean, I don't have the answers to these questions.
9 Fundamentally, the political accountability rests with
10 the Minister. If the Minister does not support these
11 issues, then it's not going to happen, and the political
12 responsibility needs to be addressed in order to make
13 these things happen, and without that there's not going
14 to be the fundamental change that is needed.

15 But everybody in leadership positions in the Health
16 Service has a responsibility to reflect on how they
17 behave individually to make sure that they're not part
18 of the sections of a culture which is inappropriate.

19 **MS CARTWRIGHT:** Thank you.

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

21 **Questioned by MS HEAVEN**

22 **MS HEAVEN:** Good morning. I just have some questions on
23 behalf of VC's family and it relates to poor
24 communications with families and carers.

25 **A.** Yeah.

36

1 **Q.** Now, Mr Carr has taken you through some of the repeated
2 systemic failures identified in the 2018 report and the
3 2024 report, and the Inquiry can see that poor
4 communication with families and carers, in relation to
5 care, in relation to discharge planning, and indeed what
6 happens after discharge is something that has come up
7 repeatedly; is that correct?

8 **A.** Yes.

9 **Q.** I think by 2024, Mr Carr showed it to you, that that
10 report describes it as the most common failing that you
11 identified?

12 **A.** Yes.

13 **Q.** Now, the Inquiry has heard some evidence about concepts
14 and ideas introduced within the NHS as long ago as 2010,
15 Triangle of Care, peer care and support workers,
16 designed to remedy this issue of poor communication.

17 **A.** Yeah.

18 **Q.** But despite these changes, it appears as though
19 communication with families is getting worse. Do you
20 have any insight into why that systemic failure is
21 continuing, and what changes need to be considered to
22 improve communication?

23 **A.** If you -- so I don't have a magic wand here and I'm not
24 pretending that this is so obvious that I can see it and
25 other people can't. That would be naive. But if you

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Questioned by THE CHAIR

2 **THE CHAIR:** If I can just ask you one question, really,
3 which is in relation to the governance issues and
4 boards.

5 **A.** In relation to?

6 **THE CHAIR:** Governance and boards.

7 **A.** Yeah.

8 **THE CHAIR:** At present, I don't think that boards have to,
9 as it were, sign off a declaration at the end of the
10 year, saying that they've complied with any
11 recommendations which have been made and if not, why
12 not.

13 **A.** Yeah.

14 **THE CHAIR:** Do you think it would assist if -- because we
15 have a fragmented service and each NHS Trust is dealing
16 with its own governance to some extent. If there was an
17 annual declaration required as to compliance signed by
18 the Board --

19 **A.** Absolutely.

20 **THE CHAIR:** -- for which they would be responsible, it would
21 be published and also collatable as data?

22 **A.** We know too many examples of patient safety issues in
23 Trusts where the board did not want to know and looked
24 the other way. And that is not acceptable. And what
25 you are suggesting would be one device to be able to

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1 don't have people working in the Health Service who feel
2 supported, properly invested in, working in conditions
3 that are appropriate for the kinds of difficult
4 decisions that they have to take, who are not stressed,
5 who don't have to take time off work because of the
6 stress involved, then you're not going to get people
7 able to focus on that issue, because they're part of the
8 problem as well. And I don't think you can separate how
9 the NHS workforce is supported from how they support
10 families in communicating.

11 I think the other thing is that unfortunately, there
12 is a longstanding tradition in clinical practice where
13 first of all, there's a lack of communication between
14 professions within the clinical community, between
15 nurses, midwives, doctors and so on. And there's also
16 an unfortunate tradition that clinicians have tended to
17 patronise patients in a way which doesn't treat them as
18 part and parcel of the issue to be addressed. And of
19 course, you can't resolve discharge issues without fully
20 involving not only patients but their families and
21 supporters in what needs to be done. It's not easy, but
22 there are some fundamentals that need to be addressed.

23 **MS HEAVEN:** Thank you very much.

24 Thank you, Chair.

25 **THE CHAIR:** Thank you.

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1 make people more accountable than they currently are.

2 **THE CHAIR:** I think you've said there should be incentives,
3 and it does produce some accountability, doesn't it?

4 **A.** Yes, absolutely.

5 **THE CHAIR:** Thank you.

6 **A.** Incentives and accountability to promote learning.

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

8 Well, thank you very much. We'll stop now --

9 **MR CARR:** Take a break now, yes.

10 **THE CHAIR:** -- take a break now, until 11.25. Thank you.

11 **(11.07 am)**

(A short break)

13 **(11.25 am)**

14 **THE CHAIR:** Yes, Mr Weston.

15 **MR WESTON:** Chair, I call Dr Jessica Sokolov.

DR JESSICA SOKOLOV (sworn)

Questioned by MR WESTON

18 **MR WESTON:** Dr Sokolov, you have prepared a witness
19 statement for this Inquiry dated 19 December 2025.

20 **A.** That's correct.

21 **Q.** In that statement you attest to certain parts of the NHS
22 England corporate witness statement prepared by
23 Mr Dale Bywater, and that statement from Mr Bywater was
24 dated 8 December 2025.

25 **A.** That's correct.

40

1 Q. Mr Bywater has since prepared a further statement dated
2 2 June 2026 in which he corrects a detail at
3 paragraph 506 of his first statement where he states
4 that:
5 "The Director of Corporate Governance at the
6 Nottinghamshire Healthcare NHS Trust resigned and was
7 not removed as a result of capability issues." (As
8 read)
9 Is that correct?
10 A. That's correct.
11 Q. To the best of your knowledge and belief that updated
12 position is correct; is that right?
13 A. It is.
14 Q. Aside from that one correction is the statement that you
15 prepared on 19 December 2025 true to the best of your
16 knowledge and belief?
17 A. It is.
18 Q. Dr Sokolov, you are the Medical Director for NHS England
19 Midlands Region.
20 A. Yes.
21 Q. The Inquiry has heard evidence from Dr Adrian James, the
22 National Medical Director for Mental Health and
23 Neurodiversity at NHS England.
24 He gave evidence as regards NHS England from
25 a national perspective. As a regional Medical Director,

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1 As regards the relationship between NHS England and
2 Integrated Care Boards and providers of NHS services
3 such as NHS Trusts, NHS England has a statutory
4 accountability for those bodies; is that correct?
5 A. Yes, we have roles and oversight of those organisations.
6 Q. And that oversight, that assurance is primarily worked
7 through NHS England's Oversight Framework.
8 A. Yes.
9 Q. Part of that Oversight Framework is as regards quality
10 of care, access and outcomes.
11 A. Yes.
12 Q. What is the role of NHS England as regards commissioning
13 and funding care at a Trust level?
14 A. There is a commissioning element to NHS England in that
15 NHS England commissions specialised services. So there
16 are particular services that are used by a smaller
17 number of patients and are highly specialised, and where
18 it makes sense to commission on behalf of a number of
19 systems or a number of populations rather than doing
20 that 42 times. Otherwise, our responsibility is to,
21 particularly at the point in time that we are talking
22 about in 2021/2022, and 2022/2023, our role was to
23 oversee through the systems, so our primary interface
24 with the service would be through the ICBs.
25 Q. If an ICB considers that it needs more money to meet

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1 you are giving evidence on the interactions between NHS
2 England and the Nottinghamshire Healthcare NHS
3 Foundation Trust; is that correct?
4 A. Yes.
5 Q. As regards your background, you trained as a General
6 Practitioner?
7 A. That's right, yes.
8 Q. In 2015 you became a part-time Clinical Director at the
9 Shopshire Clinical Commissioning Group.
10 A. Yes.
11 Q. And you became a full-time Clinical Director there in
12 2018; is that right?
13 A. Yes.
14 Q. In 2020 you joint NHS England and were appointed Medical
15 Director for System Improvement and Professional
16 Standards for the Midlands Region.
17 A. Yes.
18 Q. In 2022, you became the interim Medical Director for the
19 Midlands Region, and then you took up the substantive
20 role you now have in January 2024.
21 A. That's correct.
22 Q. We've already heard from Dr James as regards the role of
23 NHS England, in particular its position in the statutory
24 and NHS ecosystem, and in particular on the point of
25 providing guidance, advice and policy to NHS Trusts.

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1 a particular need for its population, it can interact
2 with NHS England in relation to those funding issues,
3 can't it?
4 A. Funding allocations to the ICBs are managed by NHS
5 England, but obviously we don't have free reign to
6 increase beyond what is allocated to the NHS and then
7 the allocations per region are determined and the
8 allocations per system are determined and coordinated at
9 a national level.
10 Q. But if a Trust considers it needs more money for
11 a programme or for an improvement, it will seek to work
12 with the Integrated Care Board, and the Integrated Care
13 Board can, if it considers that further resources are
14 needed, work with NHS England and the Department of
15 Health for further resources. It is an interaction
16 between all of those relevant stakeholders.
17 A. They would certainly highlight to us if there were
18 concerns and there is an oversight of finance that
19 identifies where there are pressures which might arise
20 from some of those service issues, yes.
21 Q. Following the Nottingham attacks, the Nottinghamshire
22 Healthcare NHS Trust prepared its own incident
23 investigation and report. That final report was
24 prepared on 15 March 2024. Following that, NHS England
25 decided to commission its own independent investigation

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1 into the care provided to VC.

2 **A.** I'm not sure about the timing. I think we may have
3 determined to undertake an independent investigation
4 just prior to the publication of the Trust report,
5 actually.

6 **Q.** I'm grateful for that clarification. It's referred to
7 in your witness statement and elsewhere as an
8 independent investigation. Can you just explain what
9 you mean by an independent investigation, and why an
10 independent investigation was deemed necessary?

11 **A.** Yes. So an independent investigation is commissioned
12 when there has been a homicide committed by somebody
13 who's been under the care of mental health services
14 within the last six months, approximately. The purpose
15 of an independent investigation is to try and reduce the
16 risk of that incident recurring. So it's focused on
17 what's called systems learning, which is drawn from
18 safety science, and the purpose is to understand the
19 factors, the context and circumstance, under which that
20 sequence of events took place so that we can reduce the
21 likelihood of that happening again. They are --

22 **Q.** Thank you. You've explained why and the purpose, but
23 could you just assist with what you mean by an
24 "independent investigation"?

25 **A.** Yes. So an independent investigation means it's not
45

1 expected timetable.

2 There will be a conversation at the end when they
3 think they're ready to move into a factual accuracy
4 period, and that is when there is a degree of quality
5 assurance about what is contained within the report
6 because transcripts of interviews and details that have
7 been gathered are checked with the interviewees and the
8 organisations involved to make sure that what is
9 contained is accurate.

10 The independent investigation group in the region
11 then receives the report and determines whether or not
12 they accept the findings.

13 **Q.** The investigation report in this matter was undertaken
14 by Theemis?

15 **A.** Yes.

16 **Q.** The final report is dated January 2025 and that was
17 published in full in February 2025?

18 **A.** That's correct.

19 **Q.** The report does not name any clinicians that provided
20 care to VC. Who made the decision not to name any of
21 the clinicians in that report?

22 **A.** That's actually standard for an independent
23 investigation. I believe I described in the Corporate
24 Witness Statement there's some detail on this, but there
25 is a significant amount of evidence drawn from high-risk
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1 undertaken by NHS England, it's not undertaken by
2 a provider. An organisation outside of the NHS will be
3 commissioned with a set of Terms of Reference that
4 determine exactly what we want them to do in that space.
5 But they will be commissioned from outside the NHS to
6 undertake that investigation and then produce a report
7 at the end.

8 The purpose of the independence is to avoid the
9 possibility of any perception or reality of conflict of
10 interest with regards to what might be found by the
11 investigation.

12 **Q.** When commissioning the report, NHS England will provide
13 Terms of Reference or a Letter of Instruction --

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

15 **Q.** -- indicating what it wants looked at?

16 **A.** Yes.

17 **Q.** But in terms of the content of the report thereafter,
18 that is a matter for the independent reporter?

19 **A.** Yes, we don't undertake checks and challenges with the
20 content of the report because that would undermine the
21 independence and could lead to a perception that we were
22 trying to steer the outcome. So the way it works is,
23 once we've determined the Terms of Reference, we'll have
24 regular contact with the investigation team to
25 understand that progress is being made according to the
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1 industries such as aviation and healthcare and others,
2 that we do need to look at the system separate from
3 individual accountability.

4 There are processes that manage individual
5 accountability, either professional regulatory
6 processes, or employer disciplinary processes, but in
7 order to reduce the risk of recurrence of an incident,
8 what we want to understand is the broader context. And
9 so an investigation like this would not be focused on
10 individuals but would be focused on culture, policy,
11 accepted practice, and opportunities that should have
12 been taken that weren't.

13 **Q.** So just so I can understand who made the decision not to
14 name any of the clinicians, was that Theemis or was that
15 NHS England, was it someone else?

16 **A.** It's NHS England that -- it's the standard approach. It
17 wasn't an exceptional decision in the circumstance;
18 that's the approach we take to these reviews generally.

19 **Q.** So you've talked about the importance of not naming
20 individuals to prioritise systemic learning. Clearly
21 naming individuals can also be a potential infringement
22 of their privacy as well, can't it?

23 **A.** *(No audible answer given).*

24 **Q.** On the other hand, that all needs to be balanced,
25 doesn't it, against arguments for naming clinicians?
48

1 A. Yes.

2 Q. Providing names, inevitably, provides a greater level of
3 transparency, doesn't it?

4 A. I'm aware that there are multiple perspectives on this,
5 and I think -- I do understand where those perspectives
6 come from.

7 When it comes to the privacy element, the regulatory
8 processes that I've discussed also afford individuals
9 a level of confidentiality up until the end of that
10 process and that's for the same purpose: we want people
11 to feel able to engage with these processes. We want to
12 make sure that people are confident to speak out, and
13 whether it is the intent or not, the reality of naming
14 people early in a process does tend to foster a culture
15 of fear that can impede that.

16 Q. If individuals are named, if they've been providing bad
17 care, that can be linked to other cases of bad care,
18 can't it?

19 A. That's why those individual professional regulatory
20 processes exist. There is a standard framework that is
21 used across the country. For instance, for doctors,
22 there is a framework used called Maintaining High
23 Professional Standards which is applied in the same way,
24 regardless where in the country you are, and ultimately
25 leads to a liaison with and referral to the GMC, if

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1 consideration, but it's that we weren't stepping outside
2 of the bounds of normal practice in what was done here.

3 If I give an example, I don't want anybody to walk
4 away from this thinking that we went: well, computer
5 says no. That would be highly inaccurate.

6 There has been an awful lot of work to try and make
7 sure that we are managing things appropriately. Those
8 professional regulatory processes, I have been meeting
9 with the GMC, the NMC, NHS Resolution, and the Trust and
10 the Embedded Improvement Director on a regular basis to
11 make sure everybody has a shared understanding of where
12 we are on those, whether they are leading to referrals
13 and what's happening with them. Because we want to have
14 assurance that the right processes are being carried
15 forward and I recognise that it is uncomfortable that
16 some of these processes are not open to everybody to
17 see. So I wanted to know that that was happening, and
18 I made sure that I understood that was happening.

19 Q. So not naming clinicians, standard practice, no
20 discretion?

21 A. No, it's not that there is no discretion, there is
22 always a consideration here, but the standard process
23 exists for a reason, and the standard process exists
24 because clinicians should be afforded due process. At
25 the end of a GMC process, at the very end of it, it does

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1 necessary.

2 Referrals can be made by an NHS Trust?

3 A. *(The witness nodded)*

4 Q. They can be made by NHS England?

5 A. Yes.

6 Q. They can be made by patients or those that have been
7 affected by an incident, can't they?

8 A. Yes, they can.

9 Q. Those that don't know the names of clinicians can't make
10 those referrals, can they?

11 A. No, that's true. That's why there's a responsibility on
12 the Trust to make sure that these processes are
13 undertaken and findings from reviews, such as Theemis,
14 are folded into those processes, and I have been given
15 assurance that that is the case here.

16 Q. In this particular case, when the names, the decision --
17 there wasn't really a decision made as regards names, it
18 was just standard process was followed; is that correct?

19 A. Yeah.

20 Q. So issues as regards the particular public interest in
21 this case, matters about accountability in this case,
22 and concerns about potential referrals that those
23 affected might want to make, those weren't brought into
24 the consideration when the names weren't included?

25 A. No, it's not that they weren't brought into the

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1 become public, but a concern has to be understood before
2 it should be shared, for the reasons that I've
3 explained.

4 Q. Can I take you to NHSE0000816, please, page 3.

5 This is an email from you to the CEO of the Trust,
6 Mr Majid. It is dated 14 October 2024, and it's headed
7 "Outstanding family questions".

8 "Dear Ifiti", it starts with. It then talks about
9 some outstanding questions which I'm not going to touch
10 upon and then the second paragraph:

11 "In addition to these, one of the families has been
12 in touch again with the regional team and asked an
13 additional question. I have shared this in full with
14 you below, but effectively they are asking for the names
15 of all clinicians involved.

16 "We appreciate that you may wish to seek your own
17 legal advice on this and would welcome your thoughts on
18 this."

19 It then goes on to set out the email from the family
20 and, in the third sentence there says:

21 "The report ..."

22 Presumably they've seen a draft of it at this stage:
23 "... lacks the detail of who the attending
24 consultants were, their names, or who (registrars, SHOs)
25 from the consultant's team actually saw VC each time and

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1 on ward rounds or discharge."

2 But no mention of a standard approach in this email,
3 is there?

4 **A.** No.

5 **Q.** So we've got an independent report commissioned by NHS
6 England, an issue has arisen as regards the contents of
7 the report specifically naming clinicians. The Trust is
8 the employee (*sic*) of those clinicians, and if
9 a decision is made by NHS England to name clinicians,
10 you would want to give them an opportunity to respond to
11 that, wouldn't you, if you are going to name
12 individuals?

13 **A.** No, that's not what's represented here. NHS England has
14 never had the names of those individuals because we're
15 not the employers, we're not running the professional
16 regulatory processes, and we didn't have access to the
17 notes in the way that Theemis did.

18 **Q.** But if Theemis --

19 **A.** And we wouldn't --

20 **Q.** If Theemis or NHS England wanted to name the
21 individuals, that would be something that you would --
22 if that was a decision that was made, you'd then want to
23 consult the Trust at that stage about naming them so
24 that they're aware of it and they can make
25 representations to you about the privacy rights and

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1 the outset, on this particular issue. No reference to a
2 standard procedure, you're working with the Trust to
3 decide this particular point, aren't you?

4 **A.** I'm not working with the Trust to decide this point; I'm
5 deferring a question that NHS England cannot answer to
6 the organisation that holds the information. Because
7 the processes we've undertaken, including commissioning
8 an independent investigation, does not give us access to
9 that information, because it's not necessary for the
10 purposes of the report.

11 **Q.** Dr Sokolov, you were involved in the decision as regards
12 publication of the report.

13 **A.** Yes.

14 **Q.** The initial position from NHS England was that only
15 a summary of the report should be made public. Why was
16 that decision taken, please?

17 **A.** So, again, the details within the corporate witness
18 statement, but you'll be aware that we have been taking
19 generic legal advice on what we should do with the
20 publication of these reports since at least 2020,
21 because concerns have intermittently been raised that
22 publishing the report in full, with the inclusion of all
23 the patients' medical data, is in breach of data
24 protection, and the advice that we received in 2020,
25 2023 and 2024, on that point, was consistent that

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1 various other concerns in relation to their employees?

2 **A.** No, what this shows is me asking the Trust how they want
3 to respond to that question because it's not a question
4 I can respond to. I don't have the names of the
5 clinicians and they were not included in the Theemis
6 Report because the Theemis Report is a system learning
7 report and not intended to focus on or identify
8 individuals.

9 So I am therefore not able to manage this question,
10 I am therefore passing it to the Trust for their
11 response. The NHS England response, with regards to an
12 independent investigation, is that we would not include
13 those names because it's not the purpose of the report,
14 so we wouldn't include that information in the report to
15 begin with, therefore we can't disclose it.

16 The Trust are in a different position. They know
17 who those clinicians are, and can make a choice as to
18 what they would do under their policy with regard to
19 sharing that information. That's what's shown here.

20 **Q.** Rather than NHS England forming its own view on this
21 particular issue and then asking the Trust to respond to
22 it, it's right at the outset liaising with the Trust on
23 this particular point, isn't it?

24 **A.** I don't know what view you are referring to.

25 **Q.** I'm referring to the fact that you are liaising right at

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1 actually that is the case: publishing all this
2 information is in breach of the Data Protection Act and
3 of GDPR. We were therefore trying to find a way to be
4 as transparent as possible with those affected and to
5 make sure that we could publish what was necessary for
6 a public conversation about this.

7 So the full report was shared with those affected,
8 having gained the consent of VC to do that. The summary
9 report contained the findings, failings and issues that
10 had been identified and contained the recommendations
11 and actions needed, but didn't contain the special
12 category data that would have put us potentially in
13 breach of data protection.

14 **Q.** Those affected raised a real concern about the
15 publication of only a summary report.

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

17 **Q.** They were concerned that by not publishing the report in
18 full, albeit anonymised, public debate, discussion,
19 learning, would all be seriously hampered.

20 **A.** Yes, and I do understand that perspective. It wasn't
21 one we initially subscribed to because we felt the
22 summary report did include the information that would
23 enable that public debate. It did include
24 identification of the findings and failings and it did
25 include the actions that were needed, so we would have

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1 been able to have that conversation. But I do
 2 understand there are different perspectives on this.
 3 **Q.** You say it was not a position that you initially
 4 subscribed to at NHS England. There was a change of
 5 position, wasn't there?
 6 **A.** Yes.
 7 **Q.** Why?
 8 **A.** Well, there were further conversations that I wasn't
 9 party to, but that are summarised in the Corporate
 10 Witness Statement where a discussion about the public
 11 interest reached a different conclusion about
 12 publication. You will be aware from the advice that's
 13 part of the evidence pack that the term "substantial
 14 public interest with regards to data protection" isn't
 15 defined and it is open to interpretation. There was
 16 a different conclusion reached in different
 17 conversations.
 18 **Q.** Accordingly, on 5 February 2025, the report was
 19 published in full.
 20 **A.** *(The witness nodded)*
 21 **Q.** Going forwards as regards other independent
 22 investigations commissioned by NHS England, the default
 23 position now is that NHS England will publish patient
 24 safety reports in full?
 25 **A.** Yes, with the understanding that that tension between

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1 publishing information related to patient safety
 2 incident investigations."
 3 So a default position but plenty of room there for
 4 that not to be the outcome going forwards; do you agree?
 5 **A.** Yes.
 6 **Q.** What will be the principles used to determine when the
 7 default position will not be followed?
 8 **A.** There are a number of considerations that come into
 9 play. One of them, the obvious one, is around
 10 safeguarding, sometimes it's not appropriate to share
 11 information because of safeguarding concerns. There is,
 12 with any publication and with any sharing of any data,
 13 the principle is you share what is proportionate in
 14 order to achieve the aim. It is not always necessary to
 15 share everything with everybody.
 16 **Q.** Safeguarding principles don't usually apply to
 17 clinicians.
 18 **A.** I'm sorry, I thought we were talking about patient
 19 safety data.
 20 **Q.** Well, we were also talking about publishing information
 21 about clinicians as well, aren't we?
 22 **A.** No, this is about publishing the reports, isn't it? The
 23 reports are system learning reports, they're not focused
 24 on individuals.
 25 **Q.** Can I take you to page 4, please, paragraph 14:

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1 the desire to be open and transparent and to adhere to
 2 Data Protection Law hasn't gone anywhere. It's now the
 3 responsibility of the author to write in order to be
 4 read. So they have to be mindful at each point in time
 5 what they're putting into the report because they know
 6 that it's going to be read and that consideration as to
 7 whether or not it's in breach of Data Protection is the
 8 responsibility of the author not the publisher at this
 9 point.
 10 **Q.** Can I take you, please, to NHSE0002938, page 1. This is
 11 the "NHS England policy on the publication of NHS
 12 England-commissioned patient safety incident
 13 investigations".
 14 In the second paragraph, it states that:
 15 "NHS England's default position is that all patient
 16 safety incident investigation reports commissioned or
 17 undertaken by NHS England should be published. This
 18 means the full final report generated by an
 19 investigation is to be made publicly available in
 20 accessible formats on an NHS England webpage."
 21 It then turns to principles and we can see at 1 and
 22 2 that any publication has to be considered by the
 23 privacy, transparency and Trust subdirectorates, and then
 24 at 2, it says:
 25 "There is no one size fits all approach to

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1 "It is not normally considered appropriate to name
 2 staff members or provide information by which they can
 3 be identified, although case law (the Abbasi judgment)
 4 indicates that in some circumstances, naming staff may
 5 be lawful. Patient safety incident investigations are
 6 not conducted to assign blame or liability to
 7 individuals, and they proceed from the assumption that
 8 the events in question relate to issues with work
 9 systems and are not the fault of individuals".
 10 So that's the assumption, but it's right that
 11 sometimes poor clinical care can be the result of
 12 individual clinical failures?
 13 **A.** Yes, of course, and that's why, as I referenced earlier,
 14 and what this says next, is that if concerns are raised
 15 through the process or there are concerns about
 16 individual care, they'd go through to the professional
 17 regulatory process.
 18 **Q.** That decision of what is valid to go through to the
 19 professional regulator is one that's made by NHS England
 20 or the Trust?
 21 **A.** The receiving organisation will have the information
 22 about what's happened and they will decide, that that
 23 needs then to move on to a regulatory process.
 24 **Q.** But the decision whether those affected want to make
 25 referrals, as they're entitled to do, that is closed to

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1 them because they won't be provided with the names?
 2 **A.** That's true.
 3 **Q.** At paragraph 15, it refers to the fact that if
 4 a report -- if the decision is that:
 5 "... a report should not be published, [the] reasons
 6 need to be documented and shared with those affected who
 7 will be given the chance to challenge this decision."
 8 What is the mechanism of that challenge, please?
 9 **A.** I don't know. If it's important to the Inquiry we can
 10 find out and follow up.
 11 **Q.** Thank you.
 12 Can I move on to a different topic. Take that
 13 document down, please.
 14 In February 2024, the Nottinghamshire Healthcare NHS
 15 Trust was placed in segment 4 --
 16 **A.** Yes.
 17 **Q.** -- of the NHS Oversight Framework, which is the highest
 18 level of oversight. It was mandated to require
 19 intensive support from NHS England?
 20 **A.** Yes.
 21 **Q.** There was a Recovery Support Programme put in place?
 22 **A.** Yes.
 23 **Q.** That decision to place the Trust into level 4 and
 24 Recovery Support Programme, that was an NHS England
 25 decision?

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1 There is at the bottom, paragraph 1:
 2 "NHFT entered the RSP [that's the Recovery Support
 3 Programme] in February 2024 due to quality, safety and
 4 financial concerns across a range of service provisions
 5 within the Trust. Drivers for entry were:
 6 "The Trust has been rated [Requires Improvement]
 7 since May 2019. Rampton Hospital has fluctuated between
 8 inadequate and [Requires Improvement] since March 2017.
 9 The most recent inspection in June 2023 saw Rampton
 10 Hospital move from [Requires Improvement] to inadequate
 11 again for the Safe, Effective and Well-Led domains".
 12 The second bullet point:
 13 "The 2023 Nottingham[shire] homicides."
 14 And the third driver is identified there as:
 15 "Concerns about the ... financial position."
 16 Can I take you, please, to page 3. Five thematic
 17 programmes at paragraph 8, for the Integrated
 18 Improvement Plan, as we can see on screen.
 19 And then there's a box below, refers to:
 20 "Patient Safety & Quality Improvement".
 21 And says:
 22 "To significantly improve the quality and safety of
 23 care provided by services across the Trust in line with
 24 the actions and recommendations received through the
 25 regulatory notices and external inspections."

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1 **A.** Yes.
 2 **Q.** As a result, an Improvement Oversight and Assurance
 3 Group was set up. You co-chaired that?
 4 **A.** (*The witness nodded*)
 5 **Q.** You're nodding, that's correct, is it?
 6 **A.** Yes.
 7 **Q.** You co-chaired that with Amanda Sullivan of the
 8 Nottingham and Nottinghamshire ICB.
 9 **A.** Yes.
 10 **Q.** We'll hear from her later today. Can I take you to
 11 NHSE0000454, page 1. This is a Regional Support Group
 12 document dated 25 July 2024. It's been prepared by
 13 Dominic Raymont, Director of Improvement. I should say,
 14 it's an NHS England Midlands document. I presume,
 15 therefore, Dominic Raymont is someone you work with?
 16 **A.** Yes.
 17 **Q.** This document is one that sets out what the proposed
 18 plan is in terms of improvements, and so therefore it's
 19 something you will have seen before?
 20 **A.** Yes.
 21 **Q.** No doubt approved when it was prepared?
 22 **A.** Yes, well we received it together at the Regional
 23 Support Group.
 24 **Q.** Now, as I say, it's dated 25 July 2024, so a few months
 25 after the Recovery Support Programme has been set up.

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1 So that would be, for example, the CQC Report --
 2 **A.** Yes.
 3 **Q.** -- the Section 48 report, and also this is before the
 4 Theemis report but (*unclear*) when it comes into play
 5 a little later on.
 6 **A.** Yes.
 7 **Q.** Further down, "People & Culture":
 8 "To significantly improve the quality and safety of
 9 care provided by services across the Trust in line with
 10 the actions and recommendations received through the
 11 regulatory notices and [extant] ... inspections."
 12 Can I take you over the page, please, to
 13 paragraph 17.
 14 We see there that in terms of the arrangements:
 15 "[The] Region and the ICB have established a monthly
 16 Improvement Oversight Assurance Group ... [and that's]
 17 jointly chaired by [you] and Amanda Sullivan. [And
 18 that] ... receives progress updates on ... quality and
 19 finance and appropriate representation from all key
 20 stakeholders [at] ... present."
 21 Can I take you to page 6, please. Paragraph 25. It
 22 says:
 23 "The proposed date for transition from the RSP is
 24 31 March 2026."
 25 That date has now passed. Has the transition taken

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1 place?

2 **A.** No. If I can be a little specific about this, though.

3 The Recovery Support Programme, which was the process of

4 mandated support nationally has retired. It retired at

5 the end of March 2026. But there is an ongoing embedded

6 Improvement Director, and ongoing embedded focus on

7 improvement. We will continue to monitor the IIP and

8 they continue to be in the highest level of escalation.

9 But for absolute clarity, though, they didn't exit; it

10 doesn't exist any more.

11 **Q.** The plan, at paragraph 25, was that the specific level 4

12 improvements, this intervention, would finish by March

13 of 2026.

14 **A.** Yes.

15 **Q.** And that intervention programme is still necessary,

16 isn't it?

17 **A.** Yes. To add a little to that, the Section 48 and

18 Theemis recommendations are completed. There's been

19 work done on other elements of the IIP but there are

20 some areas which have deteriorated over time. The

21 financial position for the Trust is significantly

22 challenged now in a way that it wasn't at entry, and

23 there's still a good amount of work to be done on

24 culture and leadership which is why we've decided to

25 extend.

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1 Can I take you to page 6, please.

2 Third column, "Key Progress to Date". It talks

3 about:

4 "New (external) Director of Corporate Governance

5 appointed and taking up post in September."

6 Why is that a matter of key progress, please?

7 **A.** One of the issues that was identified in part 3 of the

8 Developmental Well-Led and also through the RSP

9 diagnostic, was that the internal governance of the

10 organisation, the route by which information moves from

11 individual services through to board sight was not

12 functioning in the way it needed to, and what that meant

13 was the organisation as a whole couldn't have sight of

14 risks in the way that they needed to. So that's a

15 significant area for improvement.

16 **Q.** Can I take you over the page to page 7. The "Transition

17 Criteria -- progress". "Culture" on the left-hand side,

18 first column:

19 "Improving culture engagement, inclusivity, safety,

20 [which I'm going to focus upon in a moment]

21 accountability and continuous improvement".

22 Then if we go to the right-hand column in terms of

23 "Risks", it talks about:

24 "Variable medical engagement across the trust.

25 "Staff engagement and poor staff survey results".

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1 **Q.** At the bottom of the page it refers to the CQC Report

2 and in the second sentence it says:

3 "Areas highlighted relate to risk assessment and

4 recording keeping ..."

5 **A.** Yes.

6 **Q.** "... care planning and engagement, medicines management

7 and optimisation and discharge planning."

8 Those therefore have to be critical parts of the

9 Improvement Programme, don't they?

10 **A.** Yes.

11 **Q.** After this particular document, the Theemis Report was

12 published in February of 2025. That made a number of

13 recommendations echoing some of the points here,

14 particularly about risk assessment and discharge, and

15 again, those recommendations are part of the -- became

16 part of the intervention programme?

17 **A.** Yes.

18 **Q.** Targets that had to be met?

19 **A.** Yes.

20 **Q.** Can I take you please to NHSE0002351, page 1, please.

21 This is a document referred to in your statement. It

22 appears from your statement to be the latest disclosed

23 Improvement Work Plan that we have. So that's why I'm

24 referring to this particular document. It's dated

25 July of 2025.

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1 Just so I can understand, were there actually

2 concerns that there was variable medical and staff

3 engagement as regards safety initiatives in particular?

4 **A.** No. This isn't reflecting that we thought that there

5 were formal concerns that some people weren't engaging

6 with the focus on safety. Actually the feedback has

7 been that there's been really significant focus and

8 dedication across the Trust to try and improve things.

9 This is more broadly that you are not going to see

10 significant improvement across the Trust as a whole if

11 you don't have the clinical leads and medical leads on

12 board and able to engage in the right way; and that

13 requires the structures to be right, it requires them to

14 really be aware of what's going on, the detail of these

15 plans; it requires clinical leadership at all levels

16 within the organisation, and that's a lot of work that's

17 taking place.

18 **Q.** So a good level of engagement is, in summary --

19 **A.** Yes.

20 **Q.** -- is what you're saying. This is just a risk that's

21 being identified --

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

23 **Q.** -- or a difficulty that could rise.

24 How does NHS England satisfy itself that there is

25 a good level of engagement?

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1 A. Well, this is something we're working through the
 2 IOG(?).
 3 So we understand the actions that the Trust has
 4 taken, but the impact that has, we recognise that's not
 5 the same thing. Action doesn't always equal output. So
 6 we're keeping a close eye on what is happening with
 7 regards to the medical engagement. The Staff Survey
 8 results that are described there, these are National
 9 Staff Survey results that get reported formally and part
 10 of the Staff Survey is also about engagement and how
 11 clinicians feel, the staff feel as a whole, that they
 12 are engaged with, that they have a voice, that they are
 13 valued, all of which improves engagement and which we
 14 know through Michael West and others actually improves
 15 safety outcomes.
 16 Q. Can I take you over the page, please, to page 8.
 17 Section 3 "Outcome", "Quality & Safety":
 18 "Good standards of quality and safety demonstrable
 19 across the organisation" is the target.
 20 It then talks about "Key Progress to Date". The
 21 third bullet point there states:
 22 "Mapping of S[ection]48, Theemis and CQC actions
 23 into improvement groups. Care Groups asked to reported
 24 on embedded actions."
 25 So when you're referring there to Theemis and CQC

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1 A. No, the Improvement Director who is embedded as part of
 2 RSP has sight of a significant amount of detail, as do
 3 the other people who are working within the Trust for
 4 NHS England, but we are not inspectors of services.
 5 That's the remit of the CQC and we're reliant on their
 6 feedback for that level of detail.
 7 Q. So in terms of discharge planning as well, has NHS
 8 England undertaken its own investigation, for example
 9 looking at whether discharges are unsafe or anything
 10 like that, or is that left to others?
 11 A. We don't inspect services. We are reliant on the CQC as
 12 inspectors of services, and reliant on Trust
 13 information. But with this Trust, there is also an
 14 Improvement Director embedded within the organisation
 15 who can see the information that the organisation has,
 16 and we have mental health improvement teams embedded in
 17 the organisation working on those pathways who are also
 18 able to work with --
 19 **THE CHAIR:** You're dropping your voice.
 20 **THE WITNESS:** Sorry.
 21 **THE CHAIR:** Keep your voice up, please.
 22 A. We also have the mental health improvement team who are
 23 working within that organisation, and that information
 24 is also flowing through to the Improvement Director. So
 25 there are additional structures in place for the Trust

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1 actions, they're the sorts of recommendations we talked
 2 about before --
 3 A. Yes.
 4 Q. -- in regards risk management, discharge planning, and
 5 also Assertive Outreach was another matter that was
 6 raised by the Theemis report, wasn't it?
 7 A. Yes.
 8 Q. It refers to care groups asked to report on embedded
 9 actions. What are the care groups, please?
 10 A. So that's the structure within the Trust. I mean, the
 11 Trust will be better able to describe their internal
 12 governance to you than I am, but the care group is one
 13 of their subsections within the Trust that manages
 14 a particular area of work.
 15 Q. So in terms of checking that actions are embedded,
 16 that's based upon care group, Trust care group reports?
 17 A. Yes. So the people who are responsible for those
 18 services will report on the actions that they've
 19 undertaken and whether or not they're being enacted,
 20 whether they're having an impact and whether they've
 21 been embedded.
 22 Q. Does NHS England undertake its own independent
 23 investigations of where the practice is, as regards,
 24 let's say, risk assessment, whether that's improved at
 25 the Trust, for example by dip sampling or by audit?

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1 and RSP, but more generally, no. NHS England does not
 2 inspect services. That is the role of the CQC and we
 3 received their information and put it to use.
 4 **MR WESTON:** NHS England doesn't inspect, but it's got an
 5 assurance role, hasn't it?
 6 A. Yes.
 7 Q. Has it assured itself that discharge planning is now
 8 happening safely, for example by seeing reports as
 9 regards audits of discharge planning, past audits of
 10 discharge plans?
 11 A. We have -- there is some information that's brought
 12 through IOAG with regard to this and, as I say, the
 13 Improvement Director, who is embedded within the
 14 organisation and who attends IOAG and is therefore able
 15 to challenge if there is misrepresentation there, has
 16 sight of all the Trust reports and all the Trust actions
 17 but we do not inspect the Trust.
 18 Q. No, but you need to assure yourself that this -- that
 19 this particular area is improving?
 20 A. -- (*overspeaking*) --
 21 Q. Have you asked the Trust whether they have reviewed and
 22 audited past discharges to check that they're safe,
 23 particularly in the EIP team?
 24 A. I am sure that we will have asked those questions.
 25 I can't speak to the specificity of that question, but

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1 every month we meet with this is organisation to
 2 understand how they are progressing these and there is
 3 a detailed conversation between nursing, medical, and
 4 ops leads within NHS England, the ICB and the Trust to
 5 understand how this is working.

6 **Q.** So you think it has taken place, but you can't point to
 7 when or how or when it was reported?

8 **A.** That kind of question wouldn't be minuted, so I can't
 9 give you the specifics of when it would have been asked.

10 **Q.** Risk assessment. Has the Trust assured you that there's
 11 been a look or an audit or dip sampling to check that
 12 those are being done properly now?

13 **A.** Yes, and if I can just explain a little bit, the actions
 14 that relate to Theemis in section 48, when the Trust
 15 says that they have done them, they have to provide
 16 evidence to that, but that evidence then goes to an
 17 externally chaired assurance group and it is only at
 18 that point that completion of the action is signed off.
 19 So there are external eyes interrogating this and we
 20 received the output of that externally chaired assurance
 21 group.

22 **Q.** Who is the chair of that external group?

23 **A.** It's from a neighbouring Mental Health Trust from
 24 Northants.

25 **Q.** One of the key recommendations of the Theemis Report and

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1 out at a Trust level?

2 **A.** Yes, there was -- and I think Adrian James spoke to this
 3 as well -- there was an attempt to quantify what would
 4 be required for that and that was built into a spending
 5 review submission, but it wasn't accepted.

6 **Q.** If more money isn't being provided for this
 7 resource-intensive step, it's not realistic that it's
 8 going to be met, is it?

9 **A.** I think it's realistic that people would try to meet it,
 10 but the funding has to come from somewhere else.

11 So if I give you the example within the Midlands, at
 12 the start of this process we knew we had two systems
 13 that had Assertive Outreach teams rather than a Model of
 14 Care. We've now got six with dedicated teams, but
 15 without an expansion of the resource, that means that's
 16 being funded through something else being reduced.

17 **Q.** Can I take you to WITN0075014, please.

18 This is a Lancet article prepared by three
 19 academics, one of whom is Professor Seena Fazel who the
 20 Inquiry has heard from. It's dated February 2020, and
 21 it, in the background, talks about:

22 "Calls for increased funding for mental health
 23 services require many lines of evidence in support,
 24 including estimates of economic impact. One
 25 understudied source of cost is violence perpetrated by

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1 of NHS England following the Theemis Report regards
 2 assertive community outreach?

3 **A.** Yes.

4 **Q.** We're going to hear from Amanda Sullivan this afternoon
 5 in relation to the Integrated Care Board and I'm going
 6 to take her to documents that she had sight of certainly
 7 at the time with regard to how Assertive Outreach has
 8 been rolled out or attempts to roll it out at the Trust?

9 In summary, there's been difficulties rolling it
 10 out.

11 **A.** Yes.

12 **Q.** That's a summary, I don't need to go into the detail at
 13 this stage, but that's fair, isn't it?

14 **A.** I think it's fair.

15 **Q.** Best practice for Assertive Outreach requires dedicated
 16 teams; do you agree? That's the best practice?

17 **A.** That's the model that has the research.

18 **Q.** Even if something short of that is being put in place,
 19 for example, an assertiveness of approach as opposed to
 20 teams, that still requires more intensive intervention?

21 **A.** Yeah, these are resource intensive models of care.

22 **Q.** More clinical time, more resources?

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

24 **Q.** But it's right, isn't it, that NHS England hasn't made
 25 more money available for Assertive Outreach to be rolled

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1 individuals with severe mental illness. Estimating this
 2 economic impact can inform budget planning across
 3 several government sectors and emphasise the importance
 4 of violence prevention."

5 Then if we go over the page, please:

6 "Outcomes

7 "The estimated annual economic impact of violence
 8 perpetrated by people with severe mental illness was
 9 £2.5 billion in England and Wales in 2015-16."

10 Then it breaks down the various ways in which that
 11 2.5 billion is made up.

12 Has this sort of research, that considers the wider
 13 societal cost of not dealing with or not providing
 14 resources to get to the most hard-to-reach patients, has
 15 this sort of resource been considered when funding
 16 decisions were being made or when they were being asked
 17 for by NHS England?

18 **A.** I do not know the answer to that. My role as Regional
 19 Medical Director does not involve me in the
 20 determination of national policy or in the development
 21 of business cases to go to Treasury, so I don't know.

22 If because it feels rather siloed, doesn't it?

23 There's not the money here to roll out this programme,
 24 but that's having other societal impacts is the outcome
 25 of this -- is the inference that one can draw from this

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1 document?

2 **A.** As I say, I think the evidence that we've got is that
3 more and more systems and providers are trying to
4 provide the high fidelity model that requires a specific
5 team, but because it comes from existing resources, it
6 has implications elsewhere within the health system and
7 probably specifically within the mental health spend.
8 That's what people are doing. They're not ignoring the
9 importance of this model, that learning has been shared
10 and you'll be aware that there have been system letters
11 from national colleagues about this to providers. But
12 the reality of the funding position for the NHS at the
13 moment is that if we want more, in one area, without
14 additional funding, it has to come from somewhere else.

15 **Q.** Do those system letters refer to this societal cost?

16 **A.** No.

17 **Q.** NHS England is due to be abolished and its functions
18 taken over by the Department of Health. At that point,
19 the Trust may still be under segment 4 improvement
20 programme. Will that continue, and who or what team at
21 the Department of Health will take over the role of NHS
22 England or your role as a co-chair? How will that work,
23 please?

24 **A.** So the specifics aren't understood at this moment in
25 time because the model for the new Department of Health

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1 understood, but there is a commitment that that will be
2 accepted by the new department as a responsibility.

3 **Q.** Can I take you back to a document that we looked at
4 before, please, NHSE0000454, page 1. Now, I read this
5 particular part of paragraph 1 out earlier and it refers
6 to the drivers for entry, the key reasons why the Trust
7 was placed into an improvement programme. I just want
8 to go through those three drivers, please, with you, and
9 just focus on them a little more.

10 So the first bullet point as regards CQC ratings,
11 isn't it?

12 **A.** May I just point out that this is a summary of a paper
13 that was presented in February which contained more
14 information and more drivers than are captured here. So
15 this isn't the whole rationale. That was contained in
16 the paper by itself which has been submitted.

17 **Q.** So other reasons have been expressed elsewhere?

18 **A.** Yes.

19 **Q.** But when this document was produced and the drivers were
20 identified, those reasons weren't mentioned, were they?

21 **A.** No, because people were already familiar with them and
22 this is an update summary to remind people of where we
23 were. The detail is contained within the paper from
24 February 2024 when the decision was made.

25 **Q.** But what it suggests is that while there may have been

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1 is still being worked through, but there is an absolute
2 understanding that there are a number of functions
3 currently undertaken by NHS England which absolutely
4 have to be carried forward.

5 One of them is continuing managing the organisations
6 that are most challenged and organisations of concern.
7 Another, as included in the Corporate Witness Statement,
8 is making sure that the outcome of this Inquiry is
9 reflected into practice.

10 **Q.** You've given evidence in relation to the NHS England
11 approach to independent investigations, and we've looked
12 at the policy that's been prepared by NHS England. Will
13 that approach, will those policies, remain the position
14 post the merger or post the abolishment of NHS England?

15 **A.** I'm not aware of any plans to change, but that doesn't
16 mean that, in future years, somebody may decide that
17 they need to revise this. Obviously I can't predict
18 that. But there's no current plan to change the policy
19 that's been shared here.

20 **Q.** This Inquiry has heard evidence from NHS England. It
21 may make recommendations that are relevant to NHS
22 England. In terms of implementing any recommendations,
23 where will that sit in the Department of Health? Can
24 you assist with that?

25 **A.** Again, the structure of the future department isn't it

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1 other reasons, the key reasons, the drivers, as is
2 expressed here in this document that you approved, are
3 these three particular bullet points, aren't they?

4 **A.** Firstly, I did clarify that I did not approve this
5 document. My name is not on this document. I was part
6 of a group that received this document in order to
7 enable a discussion.

8 Secondly, one of the key drivers, speaking very much
9 to the culture within the organisation -- and it is
10 really important -- that was captured in that February
11 piece was about the staff suspensions and the
12 falsification of records. That's really significant.
13 It's not in here. It doesn't mean it's not important.

14 **Q.** Well, if it was really significant, with respect, it
15 would be here in this document, wouldn't it --

16 **A.** No, because -- (*overspeaking*) --

17 **Q.** -- (*overspeaking*) -- because you're framing why this has
18 happened and what the programme is to meet that. I'm
19 not saying it's not relevant, but if it was a key
20 driver, it would be in here, wouldn't it?

21 **A.** No, because the description of why we were entering RSP
22 was in full in the February paper, which we could refer
23 to. This is a summary to remind people of some of the
24 aspects that led to entry to RSP. It is not
25 a comprehensive description and it shouldn't be taken as

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1 such.

2 **Q.** If you remove these drivers, which I think you agreed
3 earlier was the key reasons, if you remove them, there
4 wouldn't have been a need for an improvement programme,
5 would there?

6 **A.** If we didn't have CQC concerns and didn't have the
7 deteriorating financial position and didn't have the
8 cultural concerns and didn't have the emerging
9 information about these homicides, then no.

10 **Q.** Can I take you to the first bullet point, please. That
11 is regarding CQC ratings. The Trust were deemed to
12 Require Improvement by the CQC since 2019, weren't they?

13 **A.** Yes.

14 **Q.** There was a concern at Rampton Hospital, and that became
15 emphasised in June of 2023 when it was moved from
16 Requires Improvement to Inadequate. But the concerns
17 with Rampton were again longstanding, weren't they?

18 **A.** Yes.

19 **Q.** So in terms of the concerns expressed by the CQC and
20 their ratings, that goes back many years before the
21 Nottingham attacks.

22 **A.** That's true.

23 **Q.** The third bullet point, financial position, it's right
24 that in early 2023, indeed on 9 February 2023, to be
25 precise, the Trust advised the region that its financial

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1 **Q.** Have you gone back to check whether that was something
2 that was actually known by NHS England, given the
3 importance of this matter from the evidence that we've
4 heard from those at the Trust?

5 **A.** I haven't personally checked that, no.

6 **Q.** The evidence from the Board was that the delay in
7 dealing with these, or investigating two of these at
8 least, was a serious governance failure. Have you gone
9 back to check whether NHS England were aware of this
10 serious governance failure as part of your assurance
11 requirements?

12 **A.** So one of the things we have done since we started the
13 RSP process quite early on was to ask the Trust to give
14 us a summary of homicides and attempted homicides over
15 a defined time period to understand whether there were
16 commonalities in the lead-up, whether they'd occurred in
17 the same services, whether there were cross-cutting
18 themes and whether there was anything that linked to the
19 VC attacks, because we wanted to know whether this was
20 a learning organisation and whether these events, the
21 sequence of these events meant that they weren't
22 learning or whether they were individual failings,
23 separate failings.

24 **Q.** Despite the importance of these previous events, you
25 can't assist with whether NHS England knew about them at

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1 forecasts would not be delivered and would be
2 deteriorated by £12.5 million to a year end overrun of
3 £23.5 million. So there were financial concerns back in
4 February of 2023.

5 **A.** Yes.

6 **Q.** The second point, the 2023 Nottingham homicides.
7 Now obviously NHS England can't have known about the
8 homicides before they take place. But there were other
9 serious incidents that we've heard about. In September
10 of 2022 there was a homicide that came to the attention
11 of the Board, some learning from that -- was delayed by
12 some years, but some learning from that was as regards
13 risk assessment and discharge.

14 In February 2023, there was an attempted homicide --

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

16 **Q.** -- and that was brought to the attention of the Board.
17 And then there was a third attack that we know about
18 that was brought to the attention of the Trust in April
19 of 2023.

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

21 **Q.** Did NHS England know about those serious incidents that
22 occurred before the Nottingham attacks?

23 **A.** I'm speaking to a period of time before I was in post so
24 I would assume through the normal processes at that time
25 that we would have had sight of those attacks.

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1 the time or not?

2 **A.** As I say, our normal process would be that we would have
3 had sight of them but if it's important we will follow
4 that up outside.

5 **Q.** In any event there were these concerns about violent
6 attacks --

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

8 **Q.** -- one of them a homicide. They were things you would
9 agree that NHS England should know about?

10 **A.** Yes.

11 **Q.** Either by being told by the Trust or by finding out
12 through its assurance mechanisms?

13 **A.** Yeah.

14 **Q.** So when we look at these three drivers for entry to the
15 Improvement Programme, the CQC concerns, the homicides
16 or attempted homicides, and the financial concerns, they
17 were all there before June 2023?

18 **A.** Not to the same extent. If -- can I walk through
19 a little bit? Is that okay?

20 **Q.** Please do, but do you agree those key drivers were all
21 there beforehand?

22 **A.** No, not to the extent that they were at the point that
23 they were admitted. The CQC concerns were absolutely
24 raised in 2019, and there'd been ongoing concern about
25 the Rampton. But actually through '21 and '22, there

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1 had been improvement made against the specific issues
2 that were raised there. The CCG at the time was leading
3 an assurance process against specific recovery plans
4 around the concerns that had been identified. There was
5 some stabilisation of leadership for the organisation,
6 and it looked, at the beginning of 2023, that we were
7 starting to see improvements, and that was the assurance
8 that was coming through.

9 That did change in the second half of 2023, when the
10 CQC published their report, and we saw the change in
11 ratings and saw some of the concerns that they had. So
12 we responded to the change in information at that time.

13 The deteriorating financial position, yes, that was
14 something that was present before. By itself it
15 wouldn't trigger escalation into segment 4, which is for
16 multi-domain, multi-issues, that are proving
17 intractable.

18 And the reason I wanted to stress the culture issue
19 with regard to those staff suspensions, and with regards
20 to the falsification of records, is that information
21 that came to light in the second half of 2023; it was
22 not available to us at the point of June.

23 Obviously the information about the homicides became
24 clearer through the course of that period as well, with
25 the conviction in January '24.

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1 have the information at that point in time to share
2 with us.
3 **Q.** So NHS England were aware of the delays?
4 **A.** Yes.
5 **Q.** You were allowing those processes to take place. Did
6 NHS England -- you've seen evidence of that?
7 **A.** We -- yes, we know that there's a 72-hour report and we
8 were awaiting the Head of Independent Investigations --
9 **Q.** For these specific incidents, you were aware --
10 **A.** Yes.
11 **Q.** -- you've seen. I wasn't quite clear on your evidence
12 from before. So NHS England were aware of these three
13 incidents and were awaiting the outcome of further
14 investigations, or it can't assist?
15 **A.** NHS England was aware because we were notified as part
16 of Operation Plato. So yes, we were aware.
17 **Q.** Not the VC attack, the other three --
18 **A.** Oh I'm sorry, I'm sorry. We're talking at cross
19 purposes.
20 **Q.** Yes.
21 **A.** I don't know about that.
22 **Q.** Can I suggest that the inference is that the Trust --
23 NHS England weren't aware of these particular serious
24 incidents because there's no document trail and, if it
25 had been aware, the Improvement Programme would have

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1 So the situation did change. We work with the
2 information we've got available to us. At the beginning
3 of '23 we had a picture where we thought there was some
4 improvement against the CQC concerns that had been
5 raised. There was a report towards the end of that year
6 from the CQC that demonstrated that was not the case and
7 there'd been a deterioration and our assessment changed
8 in response to the change in information.

9 **Q.** You agree that the homicides and attempted homicides
10 were very serious incidents?

11 **A.** Yes.

12 **Q.** And if NHS England had been aware of that, there would
13 have been a paper trail, wouldn't there, of them asking
14 questions about what is being done and what learning
15 there is, but that's just not there, is it?

16 **A.** The process we were working to at that point in time was
17 that after an event like this, there would be
18 an immediate 72-hour review by the Trust to put in any
19 immediately necessary safety actions. There would then
20 be a level 2 report, commonly referred to as a level 2
21 report, which would bring through the information about
22 what had happened, and then, as we've discussed, we'd
23 move on to the independent investigation.

24 So at this point in time, we were allowing those
25 early processes to take place. The Trust didn't itself

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1 started much earlier and would have been triggered by
2 the serious incidents.
3 **A.** The two don't follow, if I may. The Oversight Framework
4 and entering into RSP is not a response to a serious
5 incident by itself; it is a response to an organisation
6 being identified as having multiple intractable issues.
7 **Q.** Can I pause you there? There were multiple issues.
8 There was the CQC concern --
9 **A.** -- (overspeaking) --
10 **Q.** -- there was the financial concern -- (overspeaking) --
11 **A.** Of a level -- (overspeaking) --
12 **Q.** -- and then there were these three incidents. If NHS
13 England had been aware of all of that, the improvement
14 programme would have started well before the June 2023
15 attacks.
16 **A.** No, no. They have to be of a level. The section 4, the
17 segment 4 and entering into RSP is for our most
18 challenged organisations. With respect to all the
19 organisations within the NHS, having a difficult
20 financial position is not unique.
21 **Q.** By not being aware of these further incidents, NHS
22 England lost an opportunity to better understand the
23 risk faced by patients and faced by the public, and
24 could have taken steps, as they have taken since, to
25 improve the Trust and to try and put in steps to prevent

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1 the attacks, the Nottingham attacks.

2 **A.** My not being aware of something that happened before

3 I was in post is not the same as NHS England not being

4 aware of these attacks. I would expect, through the

5 normal reporting process, that they did have sight of

6 them. But as I've said, the Oversight Framework is not

7 a mechanism for reflecting the seriousness of individual

8 incidents; that's not how it is used.

9 **MR WESTON:** Chair, those are all the questions I have.

10 **THE CHAIR:** Ms Patrick.

11 **Questioned by MS PATRICK**

12 **MS PATRICK:** Thank you for your patience, Chair. *(Pause)*

13 Good afternoon, Dr Sokolov. My name is Angela

14 Patrick and I ask questions on behalf of the bereaved

15 families.

16 Just briefly, where you've answered a number of

17 questions by saying you weren't in post, your current

18 post, at various times before June 2023, and

19 I understand you did hold an Interim Director post from

20 2022; is that right?

21 **A.** From the end of 2022, yes.

22 **Q.** And what role was that? Was that Interim Director in

23 the same role that you became Permanent Director for the

24 Regional Lead?

25 **A.** Yes.

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1 contacted you about the data breach issue, hadn't they?

2 **A.** Yes.

3 **Q.** And this was you again reaching out to the Trust that

4 was responsible saying, "What's your take on this,"

5 wasn't it?

6 **A.** Not asking for their take; asking for their response.

7 We don't hold information about the data breach, so

8 I wasn't able to answer but I wanted to facilitate

9 a response.

10 **Q.** But they were essentially raising their concerns with

11 you as NHS England, the body above the Trust, saying,

12 "This is happening, we're really concerned, and we think

13 you should know about it," weren't they?

14 **A.** That wasn't my -- if that was the intent of the contact,

15 then I apologise. That wasn't understood by myself or

16 anybody else who read the email, and the context. What

17 we had understood was that there were a series of

18 questions that they had that we needed to help answer.

19 But a lot of them we did not hold the information for,

20 and so we went to the organisations that did hold that

21 information to try and facilitate an answer.

22 **Q.** Okay. Can we go to that issue, the contact with the

23 bereaved families. There's a lot of correspondence.

24 I'm not going to go through it in great detail, but

25 could we look at NHSE0002237.

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1 **Q.** Thank you. Now I've got two main questions I want to

2 ask you about, and only two documents. They're broadly

3 around first contact with Trusts and, second, contact

4 with the bereaved families.

5 Firstly, on contact with Trusts, Mr Weston asked you

6 about your email exchange with Dr Majid. I won't come

7 back to that, but can we look at a separate contact?

8 The document is WITN0406016. Can you see that

9 there, Dr Sokolov?

10 **A.** Yes.

11 **Q.** You see there there's an email exchange between you and

12 Manjit Shehmar of Nottingham University Hospitals Trust.

13 If we scroll down a little we can see there, Manjit

14 Shehmar writes on 6 October:

15 "Regarding your email this morning about the

16 families concerns over the data [breach] investigation.

17 This is the last email I sent and it gives you

18 a summary."

19 We scroll up. Your reply saying you're not sure

20 about the level of detail you'll need but you'll come

21 back in touch. And if we scroll up again, we see

22 Dr Shehmar replies and says: If I see you tomorrow at

23 leadership summit we can "expand there", offering

24 conversation.

25 Just to take that briefly, the families have

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1 This is a very lengthy document but I want to look

2 at page 1. Can you see that Dr Sokolov?

3 **A.** Yes.

4 **Q.** This is an NHS England document. It looks like it's

5 a cut and paste of a letter sent by Dr Kumar, isn't it?

6 Can you see there at the top? There's your name and

7 Claire Murdoch. Can you see that there?

8 **A.** Yes. This is a letter addressed to us.

9 **Q.** Yes, and it came from Dr Kumar. But you can see it's

10 annotated, and can you see the annotation there on the

11 right?

12 **A.** Yes.

13 **Q.** It's a letter that was sent to Dr Kumar raising his

14 concerns and additional questions following the Theemis

15 report, isn't it?

16 **A.** Yes.

17 **Q.** And you can see that someone has annotated it on the

18 right-hand side, can't you?

19 **A.** Yes.

20 **Q.** And they've annotated there. Somebody said they would

21 like -- they're categorising the concerns and the

22 questions raised. And you see:

23 "Yellow ...seeking naming clinicians".

24 "Blue", they were raising "process questions".

25 They were raising process questions about the

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1 appointment of Theemis, weren't they?
 2 **A.** Yes.
 3 **Q.** Their experience and their qualifications.
 4 And then "Pink". They were looking for the detail
 5 of the Theemis investigators, weren't they?
 6 **A.** *(The witness nodded)*
 7 **Q.** They wanted to know who they were --
 8 **A.** Yes.
 9 **Q.** -- and what their experience was. And "Red" is marked
 10 as "clinical information" that was being sought; is that
 11 right?
 12 **A.** Yes.
 13 **Q.** Now these were all matters being pursued by Dr Kumar on
 14 behalf of the bereaved families, weren't they?
 15 **A.** Yes.
 16 **Q.** They were pursuing those questions because they had
 17 concerns that there were gaps and limitations in the
 18 Theemis Report that would limit the capacity of NHS
 19 England to learn lessons for the future, weren't they?
 20 **A.** Yes.
 21 **Q.** And they were doing this at a time when they didn't have
 22 access to the underlying documents, did they?
 23 **A.** No.
 24 **Q.** They were entirely reliant on the Trust, the CQC, and
 25 Theemis, under your appointment --
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1 VC's privacy?
 2 **A.** Right. Okay. Yeah, we had received -- NHS England had
 3 received three sets of very consistent advice about
 4 publication generally, and there was a draft approach to
 5 publication which included the summary report and then
 6 the long report. So we were following that guidance.
 7 We did, however, take additional steps to seek VC's
 8 approval to share all the information with the families
 9 because we did recognise that that was really important
 10 to them and with the VC's consent we could adhere to
 11 that, that guidance that we'd previously had.
 12 **Q.** You took additional steps to seek VC's approval to share
 13 all the information. What was the response?
 14 **A.** He gave consent. That's why we shared the full document
 15 with the families.
 16 **Q.** Okay. Can we look at another exchange in the
 17 correspondence, WITN0409050. Ah, I think this must be
 18 a rogue reference. It should be another letter. Let me
 19 check it. Thank you.
 20 You see there's another exchange, a letter from you
 21 to Dr Kumar on 12 September 2025?
 22 **A.** *(The witness nodded)*
 23 **Q.** I'll give you a little moment to read that. You say:
 24 "We are mindful that the Inquiry's Terms of
 25 Reference confirm it will produce and review a detailed
 95

1 **A.** *(The witness nodded)*
 2 **Q.** -- to understand what had happened in VC's care.
 3 **A.** *(The witness nodded)*
 4 **Q.** What the failings were, and what needed to happen to
 5 address those failings, weren't they?
 6 **A.** That's true.
 7 **Q.** Now, Mr Weston's addressed the naming clinicians. We
 8 won't go over that ground again. We've seen that red
 9 was the marker for clinical info. Was one of the
 10 concerns about NHS England, about engaging with these
 11 questions, concerns for VC's privacy?
 12 **A.** There's a Data Protection concern that we've already
 13 discussed that we had -- we have a responsibility to
 14 adhere to the law of the land, and the information we'd
 15 had was that we couldn't share some of that information.
 16 So that would be a consideration for some of these
 17 questions, but clearly not for all of them.
 18 **Q.** Clearly not all of the questions. Was advice taken on
 19 the extent to which further information could be shared
 20 with the families?
 21 **A.** The position that we took was based on what we had
 22 previously received. So there were -- sorry, just to be
 23 absolutely clear, are you speaking with regard to the
 24 Data Protection issue?
 25 **Q.** Any issue, however you package it, as to concerns for
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1 timeline of VC's interactions, and [so forth]."
 2 You outline that you're providing a comprehensive
 3 statement and significant disclosure to the Inquiry.
 4 And you say:
 5 "We do not hold the information to answer a number
 6 of your questions. However, based on the Terms of
 7 Reference, and our review of your letter, we consider
 8 that these points will be addressed through the Inquiry
 9 process by the parties who do hold information."
 10 If we can go over the page:
 11 "We understand your wish to meet, but given the
 12 above, our view is that the Inquiry will provide much
 13 more comprehensive answers than we can offer by
 14 correspondence or in person."
 15 You were disinclined at this point to engage
 16 further pending the consideration by the Inquiry?
 17 **A.** That was the decision that was taken. I will reflect
 18 that we had failed, when it comes to the engagement with
 19 families, we have comprehensively failed. It truthfully
 20 isn't for lack of effort. The engagement of Oliver
 21 Shanley, as advisor to the investigation, was an attempt
 22 to make sure we had additional expertise about what good
 23 looks like when trying to deal with people who are going
 24 through something completely horrific like this, but we
 25 had failed.
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1 At the point this letter was sent, we'd had repeated
2 attempts to try and explain what we could do. That had
3 been met, absolutely understandably, with anger and
4 frustration from the families involved and repeated
5 questioning, and I understand why. I do. But we didn't
6 have that information and there was now a statutory
7 mechanism by which those questions could be answered
8 outside of what had become clearly a frustrating and
9 unhelpful relationship with us.

10 So actually, it felt like the cleanest approach, and
11 I again appreciate that that may have landed extremely
12 poorly, but nothing in this was done without thought,
13 and I will only -- I'll reflect -- Chair, I will
14 reflect.

15 I think one of the things that we need to consider,
16 going forward, is how we do manage to engage with
17 families. Because it's not the responsibility of the
18 bereaved or the affected to make this work, and we
19 failed to do this in the way that we wanted to.

20 **Q.** Thank you. Just to follow up on that process of
21 reflection, after Dr Kumar had raised substantive
22 concerns about the conduct of the Theemis review, did
23 you or anyone else at NHS England, internally raise
24 questions about how Theemis had been appointed, how the
25 Review had been conducted, whether there were gaps in

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1 to reduce the risk of recurrence. And I think that
2 speaks to the fact that a methodology can vary, but if
3 the output is robust, then we can take a level of
4 confidence from that.

5 NHS England, as a national organisation, received
6 this report and put in place actions to enact the
7 recommendations on the basis of the findings being
8 reasonable and robust, and nothing I've heard through
9 this Inquiry -- and of course I've been paying
10 attention -- runs counter to that.

11 **Q.** Of course, entirely. You've been paying attention. And
12 of course you've said and accepted that you've failed
13 engagement with this family, who -- these families who
14 saw gaps in the report. The report raised for them more
15 questions than you could answer.

16 Now, not every family who loses a loved one to
17 mental health homicide will have a public Inquiry that
18 lasts several years. Do you accept that there were
19 questions that were being asked by these families that
20 could and should have been reflected on by NHS England
21 without awaiting the conclusion of this Inquiry process?

22 **A.** As I say, we have been looking at the requests. I think
23 one of the issues we had is that there was a fundamental
24 difference in expectations of what the report would
25 deliver. It was never intended to deliver anything with

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1 the Review?

2 **A.** So we read through the concerns that were raised by
3 Dr Kumar. The appointment was easy for us to
4 understand, because we'd run that process and we knew
5 we'd used the framework that exists within NHS England,
6 we knew we'd seen the biographies of those involved, and
7 while Theemis as a company was a new company, the people
8 involved had been involved in mental health homicides
9 before, they'd been involved in Patterson and the David
10 Fuller Inquiry and Mid Staffs and Baby P. These were
11 people with extensive experience of multi-organisational
12 learning. So we felt confident that they were the right
13 people to undertake this review.

14 **Q.** Has there been any process of reflection within NHS
15 England, and by you, about the effectiveness of the
16 review in light of the evidence which has been heard by
17 this Inquiry?

18 **A.** I think what we've heard -- what we've heard is some
19 concern about the process, and some concern about
20 terminology, but what we haven't heard is that the
21 findings about dynamic risk assessment are wrong, or the
22 findings about engagement with the family are wrong, or
23 that the findings about discharge processes are wrong.

24 The findings of that review I think stand up to
25 scrutiny and they are important to be enacted in order

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1 regard to individual accountability. That's not the
2 purpose of this type of report. But I understand that
3 that was significantly important to the bereaved
4 families and for obvious reasons.

5 **Q.** Thank you.

6 **A.** It's not something we can deliver through this mechanism
7 and that led to, I think, issues in communication.

8 **Q.** Has the experience of engaging with these bereaved
9 families prompted any reconsideration within NHS
10 England, as it is now, as to how the future of mental
11 health homicide reviews, independent reports, when
12 tragedies like this occur, how they might be conducted
13 and how the details of a patient's care might more
14 effectively be shared so that individual people who have
15 lost loved ones in circumstances of extreme trauma may
16 not have to go through the frustration that these
17 families have had to face?

18 **A.** I think, in part, that's what the new publication policy
19 reflects. It reflects a desire not to have that
20 difficulty and that tension that was introduced in this
21 case with regard to what could be shared publicly and
22 what could only be shared with a few with consent.
23 I think the fact that we developed that policy shows
24 that we have considered that.

25 With regard to the purpose for independent

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1 investigations, the basis of that is really sound, and
2 the first reason for doing these investigations is to
3 reduce the risk and reduce the risk of recurrence and we
4 need to follow safety science in how we commission these
5 in order to achieve that aim.

6 **Q.** Now, finally, you've said in response to questions from
7 Mr Weston that the process for change at NHS England,
8 and its abolition, is still being worked through.

9 **A.** Mm.

10 **Q.** Is there a process in place for securing any value in
11 the reflection that you and your colleagues may have
12 arising from the evidence heard in this Inquiry, and
13 your experience of dealing with these bereaved families,
14 and how that should inform how NHS England, as it may
15 become, or the Department of Health and Social Care,
16 will simply do things better?

17 **A.** Yeah. So firstly, there will be a structure in place to
18 make sure that any recommendations from the Inquiry are
19 taken forward. But on that, on that engagement level,
20 on that softer level, the reflection, I've already had
21 conversations with the National Chief Nurse about the
22 fact that we need to work out how to do -- how to speak
23 to people in these circumstances in a way that reaches
24 and a way that answers because we didn't. And I am so
25 sorry that we didn't.

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1 **Q.** So the Board, to be absolutely clear, NHS England, would
2 be aware of concerns raised to the Board by Coroners;
3 those would come directly to you?

4 **A.** Yes.

5 **Q.** Okay. Now, the Inquiry has seen that there's a slightly
6 different process where the Coroner has meetings with
7 Quality Operational Group, for example, within the
8 Trust, where lower level -- well, more generic concerns
9 are raised across a cohort of cases that might not reach
10 the threshold for a PFD. And the Inquiry has seen many
11 examples of serious systemic issues being raised,
12 communication with families, risk assessments --

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

14 **Q.** -- discharge planning, being raised by the Coroner
15 over -- well, we've seen from the beginning of 2021 up
16 and towards mid to the end of 2022. So consistently
17 being raised. But not in the context of a PFD.

18 Are those sorts of concerns fed back up to NHS
19 England, including to the regional level, so to your
20 level?

21 **A.** We don't have direct contact with the Coroners, so the
22 information we receive about Coronial processes is when
23 it hits that kind of there's an inquest and there's
24 a Reg 28 or a Prevention of Future Deaths Notice issued.

25 We don't have any liaison about the areas that

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1 **MS PATRICK:** Thank you. No further questions.

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

3 **Questioned by MS HEAVEN**

4 **MS HEAVEN:** Good afternoon. Some questions on behalf of
5 VC's family, if you just bear with me a moment.

6 I want to ask you, please, about regulation -- well,
7 preventing future deaths reports issued by coroners. We
8 don't need to get it up, but you say in your statement
9 that your:

10 "... team manages Regulation 28 requests ...
11 oversight or mortality and safety, and the clinical
12 senates for the Midlands, as well as multi-disciplinary
13 clinical leadership across the Region."

14 So in terms of PFD reports, are you referring there
15 to ones directed solely to NHS England?

16 **A.** Yes.

17 **Q.** Okay. So is the position, then, that NHS England, and
18 including yourself as a regional director, have
19 absolutely no oversight of Preventing Future Death
20 Reports given to individual trusts within your region?

21 **A.** No, we have a mortality group, we have a regional
22 mortality group, where information comes from,
23 providers, and from systems and the Regional Medical
24 Examiner attends. And Prevention of Future Death
25 Reports do come through that forum.

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1 you're speaking about that don't quite hit that
2 threshold.

3 **Q.** So if the Board is being informed, in Nottinghamshire
4 Trust, about systemic concerns arising out across
5 a cohort of cases that haven't resulted in a PFD --

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

7 **Q.** -- that is not notified or that was not being notified
8 to NHS England in any way?

9 **A.** No, so remember -- sorry, I don't mean to say
10 "remember". I know you know this. The Trust Board is
11 the first unit of account. They have absolute
12 responsibility for the delivery of the services that
13 they provide.

14 **Q.** Yes, so if they're aware of concerns across a cohort of
15 cases from the Coroner --

16 **A.** Yeah.

17 **Q.** -- which may not have resulted in a PFD.

18 **A.** Yes.

19 **Q.** But still there are serious systemic concerns over a
20 number of years --

21 **A.** Yes.

22 **Q.** -- are those things that NHS England would ask the Board
23 to be notified of or expect to be notified of?

24 **A.** No. That's not information we would see. The oversight
25 role that NHS England undertakes sits alongside the

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1 oversight role of a Trust board, the oversight role of
 2 a commissioner, and the oversight role of the CQC, for
 3 instance, and there is a reliance on each part within
 4 that system undertaking their role. It isn't standard
 5 for us to receive those notifications.

6 **Q.** So if that information is known within the Board,
 7 serious systemic failure, there's no PFD, where does
 8 that information go, if not to NHS England? Where else
 9 does it go up the chain?

10 **A.** So the next level of escalation is the Integrated Care
 11 Board as the commissioner.

12 **Q.** So the commissioning boards?

13 **A.** Yes, and the system quality oversight structures that
 14 sit within the Integrated Care System; there are quality
 15 assurance structures that sit there where those kind of
 16 conversations could take place.

17 **Q.** And is there then a conversation between NHS England and
 18 the ICBs about Coronial concerns?

19 **A.** The ICB will exercise their discretion as to what they
 20 escalate to us.

21 **Q.** Okay. Do you think, reflecting back now, because some
 22 of the systemic issues that came out in the Theemis
 23 Report were the very ones that were being raised by the
 24 Coroner for a number of years.
 25 Do you think that NHS England should be, rather than
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1 essence -- and this was raised by Julian Hendy --
 2 determined by someone who has, leaving aside the mental
 3 health issue, caused the death and injury which is being
 4 looked at.

5 Do you think that's right, that the people that are
 6 most affected, that the disclosure to them is determined
 7 by the consent of that person?

8 **A.** To my understanding, it's the law. There is
 9 a confidentiality that --

10 **THE CHAIR:** I'm asking whether you think it's right, having
 11 dealt with this sort of thing for quite a long time.

12 **A.** I think it's very difficult to make a decision to breach
 13 confidentiality.

14 Confidentiality exists for many reasons. We need
 15 our patients to feel confident to share information with
 16 us that they wouldn't share with anybody else. We need
 17 our clinicians to feel confident in documenting what is
 18 shared with them, and if there is an understanding,
 19 particularly in a sector like mental health, if there is
 20 an understanding that some of that may end up in the
 21 public domain, it may change behaviour. And I don't say
 22 that is right or wrong, but the reality is scrutiny does
 23 tend to change behaviour. And we need to have open and
 24 trusting therapeutic relationships with our patients.
 25 I don't know how you change this framework without
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1 leaving it to the discretion of the ICBs, appreciating
 2 that the structure is changing, but whatever does come,
 3 do you think there should be some more proactive system
 4 in place to be seeking out those Coronial concerns that
 5 fall short of Prevention of Future Death Reports, in the
 6 new structure, whatever it may be?

7 **A.** I can't speak to what the new structure will do.
 8 I understand the point of the question, which is there
 9 was information which should have enabled us to get
 10 ahead of what happened here. I do understand. I don't
 11 have an answer as to how that looks or how we could
 12 construct differently, but obviously you're aware
 13 there's a process in place whereby there will be a lot
 14 of changes, and the reflections from this Inquiry will
 15 go into that, I'm sure.

16 **MS HEAVEN:** Okay, thank you very much.
 17 Thank you, Chair.

18 **THE CHAIR:** Thank you.
 19 Any questions?
 20 **Questioned by THE CHAIR**

21 **THE CHAIR:** Yes, I just wanted to ask you about the reports
 22 that you commissioned, the independent reports, which
 23 you say are on a system basis and a learning basis.
 24 You also say that disclosure to those that have
 25 perhaps been most affected, victims, families, is in
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1 potentially impacting that.

2 **THE CHAIR:** I see.
 3 Just the correction that was made right at the
 4 outset, I think you said that there was a question of
 5 somebody resigning rather than being removed. Did he
 6 resign before he was removed, in the sense was that on
 7 the cards before he resigned?

8 **A.** The process of -- the sequence of events that
 9 I understand is that the RSP process identified concerns
 10 about that area of work, and area of leadership that was
 11 shared with the Chair and Chief Exec. My understanding
 12 is they didn't disagree with that assessment and further
 13 conversations took place, but that this was a voluntary
 14 resignation.

15 **THE CHAIR:** Yes, so those concerns had been raised?

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

17 **THE CHAIR:** Thank you.
 18 Yes, thank you. I have no further questions, and
 19 we'll break now until 1.50.
 20 **(12.50 pm)**
 21 **(The short adjournment)**
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